DUDLEY HEALTH AND WELLBEING BOARD

THURSDAY 26TH SEPTEMBER 2013

AT 3.00 PM
COMMITTEE ROOM 2
COUNCIL HOUSE
DUDLEY

If you (or anyone you know) is attending the meeting and requires assistance to access the venue and/or its facilities, could you please contact Democratic Services in advance and we will do our best to help you

JOE JABLONSKI
ASSISTANT PRINCIPAL OFFICER (DEMOCRATIC SERVICES)
Internal Ext – 5243
External – 01384 815243
E-mail – josef.jablonski@dudley.gov. uk

You can view information about Dudley MBC on www.dudley.gov.uk

health &wellbeing
looking after our borough

Dudley
Metropolitan Borough Council

IMPORTANT NOTICE

COUNCIL MEETINGS

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There is to be no smoking on the premises in line with national legislation. It is an offence to smoke in or on these premises.

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Please turn off your mobile phones and mobile communication devices during the meeting.

Thank you for your co-operation.

Directorate of Corporate Resources

Law **and Governance,** Council House, Priory Road, Dudley, West Midlands DY1 1HF
Tel: (0300 555 2345)
www.dudley.gov.uk

Your ref:	Our ref:	Please ask for:	Telephone No.
	JJ/jj	Mr J Jablonski	815243

18th September, 2013

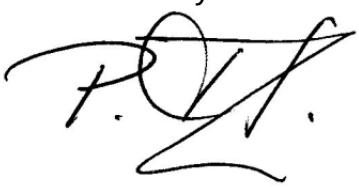
Dear Member

Dudley Health and Wellbeing Board

You are requested to attend a meeting of the Dudley Health and Wellbeing Board to be held on Thursday, 26th September, 2013 at 3.00 pm in Committee Room 2, the Council House, Dudley to consider the business set out in the Agenda below.

The agenda is available on the Council's Website www.dudley.gov.uk and follow the links to Councillors in Dudley and Committee Management Information System.

Yours sincerely



Director of Corporate Resources

A G E N D A

1. APOLOGIES FOR ABSENCE

   To receive apologies for absence from the meeting

2. APPOINTMENT OF SUBSTITUTE MEMBERS (IF ANY)

   To report the names of any substitute members serving for this meeting.

3. DECLARATIONS OF INTEREST

   To receive Declarations of Interest in accordance with the Members' Code of Conduct

The attention of Members is drawn to the wording in the protocols regarding the general dispensation granted to Elected Members and the voting non-elected representative from requirements relating to other interests set out in the Members' Code of Conduct given the nature of the business to be transacted at meetings.

However, Members and the voting non-elected representative (and his potential substitutes) are required to disclose any disclosable pecuniary interests. In such circumstances, the voting Member would be required to withdraw from the meeting.

If Members have any queries regarding interests would they please contact the Director of Corporate Resources, Philip Tart, prior to the meeting.

4. MINUTES

To approved as a correct record and sign the minutes of the meeting of the Board held on 26th June, 2013 (copy herewith)

5. MECHANISMS FOR THE BOARD TO BE ASSURED OF QUALITY AND SAFETY (Pages 1 - 8)

To consider a joint report of Officers

6. KEOGH ACTION PLAN (PAGES 9 - 22)

To consider a report of the Chief Executive, The Dudley Group HNS Foundation Trust

7. QUALITY AND SAFETY - UPDATE ON DUDLEY RESPONSE TO WINTERBOURNE VIEW REPORT (PAGES 23 - 28)

To consider a joint report of the Director of Adult, Community and Housing Services and the Chief Officer, Dudley Clinical Commissioning Group

8. THE ANNUAL REPORT OF THE DUDLEY SAFEGUARDING ADULTS BOARD 2012 (PAGES 29 - 72)

To consider a report of the Director of Adult,Community and Housing Services

9. THE ANNUAL REPORT,BUSINESS PLAN AND WORK PROGRAMME OF THE DUDLEY SAFEGUARDING CHILDREN'S BOARD (PAGES 73 - 146)

To consider a report of the Director of Children's Services

10. DUDLEY CCG PRIMARY CARE DEVELOPMENT STRATEGY (PAGES 147 - 165)

To consider a report of the Chief Officer, Dudley Clinical Commissioning Group

11 TRANSFER OF RESOURCES TO DUDLEY MBC 2013/14 TO SUPPORT SOCIAL CARE AND THE HEALTH AND SOCIAL CARE INTEGRATION TRANSFORMATION FUND (PAGES 166 - 168)

To consider a joint report of Officers

12. THE NHS BELONGS TO THE PEOPLE : A CALL TO ACTION (PAGES 169 - 196)

To receive a report of the Finance Director, Birmingham, Solihull and the Black Country, NHS England

13. UPDATE ON HEALTHWATCH DUDLEY PROGRESS (PAGES 197 - 201)

To consider a report of the Chief Officer of Healthwatch Dudley

14. TO ANSWER QUESTIONS UNDER COUNCIL PROCEDURE RULE 11.8 (IF ANY)

MEMBERSHIP OF THE
BOARD

Councillors Branwood, Crumpton, Miller and S.Turner

Director of Adult, Community and Housing Services, Director of Children's Services and Assistant Director of Planning and Environmental Health

Director of Public Health

Roger Clayton – Chair of Safeguarding Boards

Dudley GP Clinical Commissioning Group

Dr. D Hegarty and Mr P Maubach with I vacancy

Alison Taylor – Local Area Team - NHS Commissioning Board – Lead Director for Dudley

Andy Gray – Dudley CVS CEO

tbc - Healthwatch Dudley

Chief Superintendent Johnson – West Midlands Police

OFFICER SUPPORT

Cc Brendan Clifford Assistant Director, Health Reform Programme Lead (DACHS)

Assistant Director Quality and Partnership (Children's Services)

Mr N. Bucktin,Head of Partnership Commissioning.(CCG)

Ms K.Jackson, Consultant in Public Health (Office of Public Health)

DUDLEY HEALTH AND WELL-BEING BOARD

Wednesday, 26th June, 2013 at 10.00 am
in Room EV335 at Dudley Evolve, Tower Street, Dudley

PRESENT:-

Councillors Crumpton, Lowe, Miller and S Turner.

A Pope-Smith, Director of Adult, Community and Housing Services, V Little, Director of Public Health, P Sharratt, Assistant Director, Children and Families (Directorate of Children's Services), S Holmyard, Assistant Director, Planning and Environmental Health (Directorate of the Urban Environment); Dr D Hegarty and P Maubach - Dudley GP Clinical Commissioning Group, F Baillie, Local Area Team, NHS Commissioning Board, R Clayton – Chair of Safeguarding Boards, A Gray - Dudley CVS CEO.

N. Bucktin, Head of Partnership Commissioning - Clinical Commissioning Group, K Jackson, Consultant in Public Health (Office of Public Health) and S Griffiths, Democratic Services Manager (Directorate of Corporate Resources)

Also in attendance

Chief Superintendent S Johnson, West Midlands Police
S Ramsay, Sanofi Pasteur MSD

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1 ELECTION OF CHAIR

RESOLVED

That Councillor S Turner be elected as Chair of the Board for the 2013/14 municipal year.

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2 APPOINTMENT OF VICE-CHAIR

RESOLVED

That Councillor Crumpton be appointed as Vice-Chair of the Board for the 2013/14 municipal year.

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3 APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of Councillor Branwood, J Porter, Director of Children's Services, J Emery, Healthwatch and A Taylor, Local Area Team – NHS Commissioning Board – Lead Director for Dudley.

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4 SUBSTITUTE MEMBERS

It was reported that Councillor Lowe was serving in place of Councillor Branwood and F Baillie was serving in place of A Taylor for this meeting of the Board only.

5 DECLARATIONS OF INTEREST

No member declared an interest in any matter to be considered at this meeting.

6 MINUTES

RESOLVED

That the minutes of the meeting of the Board held on 29th April, 2013, be approved as a correct record and signed.

7 DATES OF BOARD MEETINGS IN 2013/14

RESOLVED

That future meetings of the Board be held at 3pm on:-

Thursday, 26th September, 2013;
Tuesday, 28th January, 2014; and
Wednesday, 26th March, 2014.

8 SUPPORT ARRANGEMENTS FOR THE HEALTH AND WELLBEING BOARD 2013/14

A joint report of officers was submitted on the support arrangements for the Board during 2013/14. The support arrangements included the transfer of the lead officer functions to the Office of Public Health and the establishment of a Health and Wellbeing Board Development Team with associated key support functions.

RESOLVED

(1) That the proposed support arrangements for the Dudley Health and Wellbeing Board during 2013/14, as set out in the report now submitted, be approved.

(2) That the Director of Corporate Resources, in consultation with the Cabinet Members for Health and Wellbeing and Adult and Community Services, be recommended to amend the membership of the Dudley Health and Wellbeing Board to include a representative of West Midlands Police and that subsequently Chief Superintendent S Johnson be appointed to serve on the Board for the 2013/14 municipal year.

The meeting ended at 10.15 a.m.

CHAIR

Agenda Item No 5

DUDLEY HEALTH AND WELLBEING BOARD

26th September 2013

Joint Report of the Director of Public Health, Director of Adult, Community and Housing Services, Director of Children's Services, Director of the Urban Environment and the Chief Officer of the Dudley Clinical Commissioning Group

MECHANISMS FOR THE BOARD TO BE ASSURED OF QUALITY AND SAFETY

PURPOSE OF REPORT

1. For the Dudley Health and Wellbeing Board (H&WBB) to consider the new quality and safety assurance arrangements in the health and social care system and to agree the process for deciding how the board can be assured that these processes are in place and are robust.

BACKGROUND

2. The Francis enquiry has highlighted how crucial it is that any health and care system has a 'relentless focus' on patient quality and safety standards. The Health & Wellbeing Board, as a forum which brings together the key commissioners across Dudley, potentially has an important role in ensuring that local commissioning and providing maintains that focus on quality and safety.

3. The Health and Wellbeing Board does not have a statutory or legal role to regulate services, however, as system leader for the health and care system, it is suggested that the Board has 2 roles:

    a. Strategic oversight- in terms of awareness and understanding of the quality and safety implications and actions required from local partners in the health and care system
    b. Receiving assurance- that quality assurance frameworks and action plans are agreed and being implemented by relevant partners. It is not intended to replicate existing processes and governance arrangements but for the Board to be assured that these processes exist and are robust.

4. The Board therefore needs to be equipped to assure, scrutinise and challenge the quality and safety of service commissioning and delivery across the system. The Board also needs to be able to maximise any opportunities for collective positive impact for continuous improvement in quality, as well as identify actions individual board members might need to take individually or collectively to mitigate any risks.

5. Quality should be viewed as everyone's business and as the measure of how health and care services are treating and caring for patients and service users in their care. Where services fall below the quality bar, there are not only regulatory or financial consequences, but an impact on real people's lives, their health, both physically and psychologically, for themselves and their families. Across the system, everyone must take their responsibilities seriously to prevent serious failure and to put it right where it does occur.

6. The health and care delivery system is complex. Local health and care services in Dudley are commissioned through the Clinical Commissioning Group (CCG), the Local Authority and the NHS Commissioning Board (NHS CB). Services are commissioned from an enormous range of providers including NHS organisations, public sector, private, independent and third sector providers. The GP members of the CCG and the Local Authority are also providers of health and care services themselves. The providers also vary greatly in their size and the magnitude of the contracts on which they deliver.

THE NEW SYSTEM - QUALITY ASSURANCE

7. Structures in the NHS and social care sector have undergone considerable change as a result of the Health and Social Care Act 2012. Relationships and arrangements continue to evolve. This section gives an overview of the key bodies and their responsibilities in relation to quality and safety, as these will be important mechanisms that the H&WBB can draw on for assurance purposes.

Definition of Quality

8. There is an agreement on the definition of quality across the health and care sector, which has been enshrined in legislation through the Health and Social Care Act 2012. The definition sets out three dimensions that must be present in order to provide high quality service:

    - **Patient experience** – quality care is care which looks to give the individual as positive an experience of receiving and recovering as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect, and to how far it meets their aspirations and required health outcome
    - **effectiveness** –quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes, including achieving their personalised outcomes and value for money
    - **Safety** – quality care is care which is delivered so as to avoid all avoidable harm and risks to the individual's safety (without taking away personal control)

9. Any system that strives for quality improvement must at the same time, ensure that essential standards of quality and safety are maintained.

Roles and Responsibilities

10. The high level roles and responsibilities generally fall into 4 categories:

- **Individual health and care professionals**, their ethos, behaviours and actions, are the first line of defence in maintaining quality
- The **leadership within provider organisations** is ultimately responsible for the quality of care being provided by that organisation
- **Commissioners** are responsible for commissioning services that meet the needs of their local populations. They must assure themselves of the quality of care that they have commissioned
- **Regulators** should perform their statutory functions with the best interests of patients at heart.

10. **The Care Quality Commission (CQC)** remains the statutory regulator for the quality of health and social care in England. The CQC's role is to drive improvement in the quality of health and social care services through regulating and monitoring services, listening to people and putting them at the centre of its work, providing an authoritative voice on the state of care and working with strategic partners across the system

11. **Monitor** has become the new sector regulator for all NHS funded care. It will focus on promoting value for money in the provision of services, for example, by regulating prices and taking action against anti-competitive behaviour that harms the interests of patients. As sector regulator, Monitor will issue licences jointly with the CQC to providers of NHS funded care. There are duties on Monitor in exercising its functions to protect and promote the interests of people who use healthcare services by promoting services that maintain or improve the quality of care to patients.

12. **The Health Service Ombudsman** will continue to resolve complaints for individuals and feeds information to sector and professional regulators where there are concerns about patient safety.

13. **Professional regulators** continue to be responsible for setting the standards of behaviour, competence and education of regulated healthcare professionals, and taking action where those standards are not met. There are statutory duties on the **professional regulatory bodies**, such as the General Medical Council and the Nursing and Midwifery Council, to ensure that the public are protected from unsafe professional practice.

14. The **NHS Trust Development Authority** has been established to oversee the performance of NHS trusts and support them to provide sustainable, high quality services as they work to achieve foundation trust status.

15. **NICE** has become the **National Institute for Health and Care Excellence**, setting standards across health, public health and social care to help further the integration of services and outcomes.

16. There is **a duty on the Secretary of State for Health** to exercise his functions in relation to health services with a view to securing continuous improvement in the quality of services and the outcomes that are achieved from the provision of services.

17. A network of new **Quality Surveillance Groups** (QSGs) has been established across the country, which bring together different parts of the health and care economy to routinely and methodically share information and intelligence about quality in order to spot the early signs of problems and to take corrective and supportive action to prevent early problems becoming more serious quality failures. The QSGs are supported and facilitated by the NHS Commissioning Board. QSGs operate both **locally**, on the footprint of the NHS Commissioning Board's Area Teams; and **regionally**, on the footprint of the NHS Commissioning Board's four Regional Teams. Members of the local QSGs are determined locally but include as a minimum:
    - All local commissioners in the area e.g. LA, CCG
    - Representatives from the NHS Trust Development Authority (TDA)
    - The Local Education and Training Board (NHS LETB)
    - Local HealthWatch
    - Public Health England Centres
    - Monitor
    - The Care Quality Commission.

18. Any statutory organisation – local, regional or national – who has concerns about the quality of care of a provider should alert other QSG members to their concerns by triggering a **Risk Summit.**

19. The **National Quality Board** provides oversight of the system. It brings together the leaders of national statutory organisations across the health and care system, alongside expert and lay members. It was established in 2009 following the NHS Next Stage Review and the publication of *High Quality Care for All,* with a remit to consider quality across the NHS system and at the interface between health and social care.

20. The NHS and adult social care outcomes frameworks intend to provide a national overview of how well the NHS and social care are performing. They set out the national quality goals which the NHS and social care are aiming to deliver.

<u>The role of Local Commissioners</u>

21. The **CCG, Local Authority and NHS CB** as direct commissioners of health and care services have a statutory duty to assure themselves of the quality and safety of the services they commission. They have quality and safety assurance frameworks in place and processes to assure their own Boards, flag potential issues early and agree learning. Within these processes they
    - commission 'regulated activities' from providers that are registered with the appropriate regulatory body e.g Care Quality Commission (CQC) or OFSTED as required and should contract with their providers to deliver continuously improving quality of care, as well as to identify any actual or potential quality

problems or failings. They should take into account NICE guidance and quality standards for social care, where it is available.

- Use the information that the regulatory bodies collects in their Quality and Risk Profiles as well as their own information and intelligence about their providers, collected through contract monitoring, engagement with patients and the public, and general interaction in the local health economy.
- Where commissioners have significant concerns about the quality of care provided inform the appropriate regulator.

22. The **CCG** also has a statutory duty in relation to the quality of primary care services, although the lead commissioner for these services is the NHS CB

23. The **NHS CB** also has an overview and assurance role in relation to the CCG, in that it has a responsibility for allocating funding to the CCG and supporting them to commission high quality services.

24. The Local Authority as a provider of Social care and children's services has processes in place to assure its board of the quality and safety of services it provides The provision of these services is done in a regulated / inspectorial environment where the influence of CQC and OFSTED is also noteworthy. As far as commissioning is concerned, assurance is achieved through contract specification at point of procurement and ongoing monitoring at individual service user and organisation levels. A range of good practice guides and policies inform overall expectations. Specific safeguarding responsibilities for the local authority also contribute to overall governance for quality and safety in local services.

The Role of Health Scrutiny

25. The Council has a statutory function to hold the NHS and social care bodies to account for the quality of their services through **health scrutiny** and scrutiny committees will be in a position to assist boards to assure the quality and safety of services. Health scrutiny sets its own priorities for scrutiny to reflect the people's needs and acts across the health community, however there is opportunity for the Health and Wellbeing Board to work with health scrutiny on agenda setting and implementation.

26. The Dudley H&WBB has an agreed protocol in place that sets out working arrangements between the Health and Adult Social Care Overview and Scrutiny Committees (OSCs) and the H&WBB. Within it, the H&WBB has the authority to recommend items for inclusion on the OSC workplan, so that where the board identifies issues they feel warrant more detailed scrutiny they can ask the OSC to investigate and make recommendations to the council and other stakeholders or the board. The Board also provides strategic steer of the OSC workplan to reflect H&WBB priorities. This potentially provides a valuable mechanism to the Board for assuring quality and safety.

The role of Healthwatch

27. **Local Healthwatch** is the local consumer champion for health and social care representing the collective voice of people who use services and the public. It will

build up a local picture of community needs, aspirations and assets and the experience of people who use services. It has a role to report any concerns about services to commissioners, providers and council health scrutiny.

28. The H&WB Board needs to be able to assimilate intelligence about providers drawn from sources that includes clinical quality, patient safety, workforce and patient experience. Healthwatch is therefore a valuable source of information and intelligence- through its engagement processes –which are critical as early warning signs. Through its seat on the H&WBB, local Healthwatch can be a key mechanism for quality and safety assurance.

The Role of Adult and Children Safeguarding Boards

29. **Safeguarding Boards** ensure that each agency works together to protect adults, children and young people from abuse and the risk of abuse. They monitor the referrals, assessments and what is then organised to protect a person or child who has experienced abuse and ensures that the person is reviewed and remains safe.

30. Key linkages are in place between the Dudley Adult Safeguarding and Children Safeguarding Boards and the H&WBB in that the Safeguarding Boards have an shared independent Chair who is also a member of the Dudley's H&WBB.

Independent Inquiries

31. There are a number of inquiries that occur on an ad-hoc basis as a result of the serious failure of standards and care- e.g. the Francis inquiry, Winterbourne View and Keogh inquiry.

32. The H&WBB has a pivotal local leadership role in ensuring the delivery of resulting recommendations and commitments, especially those that relate to joint strategic planning, joint commissioning plans, agreeing pooled budgets, challenging the level of ambition in the plans and ensuring the right clinical and managerial leadership and infrastructure is in place to deliver plans. A letter from the Minister of State for Care and Support to H&WBB Chairs in relation to the Winterbourne View inquiry affirmed this remit from a national perspective.

33. It is likely that further inquiries may occur that will need to be considered by the H&WB Board.

34. It should also be noted that whilst individual Board members will be held to account in different ways (for example, clinical commissioning groups by the NHS Commissioning Board), the health and wellbeing board can also be collectively held to account for their effectiveness through the independent LA health scrutiny function.

QUALITY AND SAFETY ASSURANCE FOR THE H&WBB- THE WAY FORWARD

35. The Dudley Health & Wellbeing Board has not specifically considered its role in relation to quality and safety assurance in the new system. This report is

intended to start that discussion and for the Board to think about how it can be assured that these systems are in place and working across partners, any opportunities there might be to increase its collective positive impact in the drive for continuous improvement in quality, as well as the actions to be taken individually or collectively to mitigate the risks.

36. It is clearly still early days in the new health and social care system, including the new quality assurance system, but it may be timely for the Health & Wellbeing Board to begin a discussion about quality assurance and its potential role, in its capacity as system leader.

37. Within this discussion it is proposed that the board consider 3 elements:

    a. The safeguarding of adults and children
    b. The quality and safety assurance frameworks of commissioners across the health and social care sector and how they monitor quality and assurance of all their providers.
    c. The scrutiny and challenge of emerging quality and safety issues. Currently there is the Francis inquiry, Winterbourne View and Keogh Report into hospital mortality. When issues occur the board needs to be assured that corrective actions are being taken and monitored appropriately

38. Practically, it is also important not to burden any of the statutory boards or the Health and Wellbeing Board, commissioners or providers, with more reporting than is necessary to provide the Board with assurance in the system.

39. The Health & Wellbeing Board is asked to consider the following

    d. What is the role of the H&WBB in relation to quality assurance across the health and social care agenda?
    e. What systems will the H&WBB need to rely on to assure itself that the arrangements are/remain satisfactory?

40. It is proposed that a small board development session is timetabled to consider these issues.

FINANCE

41. Any financial implications resulting from these proposals will be met within existing budget arrangements.

LAW

42. The statutory duties of the Health and Wellbeing Board are detailed in the Health and Social Care Act 2012 and related guidance.

EQUALITY IMPACT

43. Improving equality and tackling health inequalities are key priorities of the Health and Wellbeing Board and will be discharged through implementation of the Board's Joint Health and Wellbeing Strategy. The establishment of the Dudley Health and Well-Being Board provides an opportunity to extend the influence of the Council in working more closely with partners, particularly GP and Clinical Commissioners, to consider equality issues through the work of the Board.

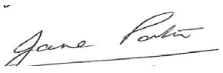
RECOMMENDATION

44. That the Dudley Health and Well-Being Board comment as needed on the content of this report and discussion points in relation to its potential role in quality and safety across the system.

45. That the Board agree to an additional (short) development session to agree quality and safety role and mechanisms

Valerie A Little
Director of Public Health

Andrea Pope- Smith
Director – DACHS



Jane Porter
Director – DCS

John Millar
Director – DUE

Paul Maubach
Chief Officer
Dudley CCG

Contact Officers:

Karen Jackson
Consultant in Public Health
Office of Public Health, DMBC

Brendan Clifford
Assistant Director –DACHS
DMBC

Ian McGuff
Assistant Director –DCS
DMBC

Sue Holmyard
Assistant Director –DUE
DMBC

Neill Bucktin
Head of Partnership Commissioning
Dudley CCG

Josef Jablonski
Principal Officer –CRD
DMBC

Agenda Item No. 6

Health and Wellbeing Board, 26th September 2013

Report of the Chief Executive, The Dudley Group NHS Foundation Trust

Keogh Action Plan

Purpose of Report

1. Trust response to the Keogh Review and update on progress to date.

Background

2. The Keogh Review visits took place during May 2013. The initial report was received in early June to inform the Risk Summit with NHS Midlands and East Region and an action plan was requested to cover both the urgent, high and medium priorities. The attached gives the Trust's response and progress to date.

   The progress against actions will be monitored via Monitor, the Foundation Trust Regulator and by the Dudley CCG as our commissioners. It is envisaged that all the actions will be completed by the late autumn however embedding the outcomes of the actions will be ongoing, such as further embedding a learning culture and improving patient experience.

   The full Review Report and supporting information can be found on the NHS Choices website.

Recommendation

1. It is recommended that:-

   - The Health and Wellbeing Board receive the Action Plan for information and assurance.

Paula Clark

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Paula Clark
Chief Executive

Keogh Investigation Action Plan – July 2013

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Quality Governance Structure	1. The Trust should undertake a comprehensive review of the effectiveness of its governance structure. This should review all committees and group agendas and the information reviewed to ensure that all the Trust's quality priorities have a clear focus at an appropriate level.	**High**	1.1 Engagement of Deloittes to conduct a review of the quality governance structure. (The review will cover (though not exclusively) the following areas: Board of Directors composition, background skill sets, gaps in knowledge/ experience etc. • Portfolios of Directors • Backgrounds of NEDs Scope and working of the Board and its Sub Committees: • Do we have the 'right' public, private agendas? Is NED challenge appropriate and well evidenced? • Do we have good Sub Committee coverage or do we miss things? • Do we do work in Committee that should be done at Board or vice versa? • Should we reorganise our Committees to facilitate better working and make responsibility and accountability clearer? Relationship between Board and Council of Governors • Is the degree of Governor Challenge adequate, appropriate and well evidenced? • Does the Council have an appropriate Sub Committee structure? • Recruitment and retention of appropriately qualified and experienced governors Board relationship with Clinical Directorates and Departments • Can the Board be assured that its decisions are being implemented? • Adequacy of Board Assurance Framework • Relationships with the Clinical directorates • Trust Management Executive and clinical directorates roles and responsibilities Clinical and business governance processes and assurance. We are anxious that the review should promote best practice from Deloittes exposure to the wider NHS and the best of the public and private sectors.	**PA**	**September 2013**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Quality Governance Structure	2. The Board should consider how it reviews management information provided to it to demonstrate adequate challenge on the progress being made on the Trusts quality priorities.	**High**	2.1 This will be covered by the terms of the Deloitte Review at 1.1 above and the Board's response to it.	**PA**	**September 2013**
	3. Following the HAY group training the Trust should ensure that all senior clinical staff are aware of their responsibility for governance in their directorate and are held accountable for this. If this is still not embedded, further training may be required.	**High**	3.1 **Delivering governance** Developing the outcome of the work undertaken by Deloittes (1.1 above) agree with directorate management teams what good governance looks like (via an engagement piece of work) a) Meeting agendas and minutes b) Reports to Board c) Directorate review balanced scorecard	**RC/JC**	**September 2013**
			3.2 **Accountability** Clearer framework for accountability via peer reviews (balanced scorecard, with consequences) – this needs to be both bottom up and top down.	**RC/RB**	**September 2013**
			3.3 **Training** This will be delivered via the governance team during the engagement piece above and as required thereafter to the current structure.	**RC/JC**	**September 2013**
Understanding of Trust's quality objectives in the organisation	4. The Trust should ensure that its quality priorities, are embedded at ward level through dissemination at regular ward and directorate meetings. The Trust should also consider how it uses lessons learnt from the review of mortality indicators to further inform its quality priorities	**High**	4.1 Review communication and information cascade systems in general and specifically in relation to quality governance. (To be reported to the September Board). 4.2 Review the mortality alerts and outliers at directorate performance meetings. 4.3 Utilise the output from above in the next quality priority setting process. Refer also to Section 9	**PC**	**September 2013** **September 2013** **November 2013**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Quality impact assessment of CIPs	5. All CIPs should be fully assessed for their quality impact prior to implementation and should be regularly reviewed. Where a concern over quality is identified, this risk should be properly mitigated before the plan is allowed to go ahead/continue.	**High**	5.1 All CIPS are assessed by the Medical and Nursing Directors for their quality impact prior to implementation. The process has been amended to require Clinical Directors and General Manager's attendance. This is now part of the procedure 5.2 Identified concerns will be followed up at the Directorate Performance Review meetings (*Refer to 6. Below)*	**D Mc / PH**	**Implemented**
	6. Executives and senior staff should be able to clearly and consistently articulate the impact assessment and monitoring process within their area of responsibility.	**High**	6.1 Review the format and agenda of the Directorate Performance Review meeting to incorporate the quality impact of CIPs. **6**.2 Governance - See template Directorate meeting agendas at 3.1 above. Ensure that new and extant CIP quality Impact assessments are reviewed at Directorate level – escalated or terminated.	**PA** **RC**	**Implemented** **Implemented**
Role of Governors in challenging the Board	7. Governors should consider how they can be more proactive in their role of holding the Board to account on all aspects of quality.	**High**	7.1 Undertake a review of the CoG effectiveness. Self assessment to be undertaken by the COG Development Group. 7.2 Review and confirm the current arrangements for Governor participation and challenge of the Quality Agenda including the quality accounts.	**JE/RJ** **PA / DMC**	**October 2013** **October 2013**
Developing a learning Culture	8. The Board should review its approach to learning and ensure there is a clear focus in the organisation on learning from incidents and when things go wrong. It should disseminate this approach through the clinical and operational leadership and ensure that regular audits are undertaken to monitor progress.	**High**	8.1 Investigation Manager to review incident reporting process including the opportunities to learn from incidents and ensure that incident reporting is robust, investigations are completed in a timely manner and lessons shared and results monitored. 8.2 Audit process to be confirmed and added to Forward Audit Programme.	**DMc** **DMc**	**In progress** **As part of above**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Understanding of mortality issues throughout the Trust	9. The trust should review how it can introduce more rigour and challenge into the overall mortality review process. This should include developing a clearer understanding of the root causes of mortality data at both Board level and within Directorates and prioritised action plans to drive improvements in care pathways.	**High**	9.1 The Medical Director and Deputy Medical Director will review the mortality process in light of the comments received from the investigation team. 9.2 The detailed information from the Mortality and Morbidity Review meeting will be formally received at the CQSPE and Board. 9.3 Mortality and Morbidity review data and learning will be discussed at the Directorate Performance Review Meetings and disseminated at Directorate level. 9.4 Mortality data education training sessions will be held for all Clinical Directors and Medical Service Heads. 9.5 The mortality tracker will be linked to the M&M meetings and clinical coders / matrons will be involved in future meetings (with immediate effect). 9.6 Feedback and learning from mortality reviews initiated as a result of the mortality tracker data will be fed into the Mortality and Morbidity meetings. The mortality reviews themselves will now involve nursing and coding staff. 9.7 The Trust will engage with the North West AQuA programme including Board development. 9.8 The Trust will audit against the AQuA mortality checklist, reporting the outcome to the September CQSPE.	**PH** **PH** **RC** **PH** **PH** **PH** **PC/PH** **PH**	**With immediate effect** **With immediate effect** **Implemented** **October 2013** **Implemented** **With immediate effect** **Implemented** **September 2013**
Mortality review process and dissemination of lessons learnt	10. The Trust has an opportunity to build on the work already carried out in this area. The current systems could be better joined up to ensure the benefits are being realised and themes from reviews can be summarised and shared more effectively.	**High**	10.1 *Refer to 9.5 & 9.6 above.*	**PH**	**As above**
	11. There is a need to engage clinical teams more in the mortality review process and emphasising clinical director leadership of this issue	**High**	11.1 *Refer to 9.3 & 9.4 above*	**PH**	**As above**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
	12. Consider having coding representation in mortality review meetings.	**Medium**	12.1 *Refer to 9.5 above*	**PH**	**Implemented**
	13. Given the emphasis on Palliative care coding the Clinical Coding team may wish to focus one of their internal audits solely on this	**Medium**	13.1 Department to attend a workshop that provides training to ensure consistency of coding for treatment and full understanding	**PA**	**October 2013**
Infection Control Concerns	14. The Trust should review how it can further embed the infection control audit programme at ward level, including the lessons learnt from the overall board monitoring.	**High**	14.1 The Trust will develop a ward dashboard of quality indictors to be monitored at the Directorate Performance Meetings with Executives. 14.2 The Saving Lives audit and MRSA screening audit will be added to the Trust Audit Plan and reviewed at Audit Committee (Committee of Board).	**DMc**	**August 2013** **Implemented**
Managing capacity including bed management and patient flows.	15. The Trust should discuss more sustainable solutions to the high capacity levels and bed management challenges with its key stakeholders such as the CCG and social care colleagues.	**Urgent**	15.1 Play a constructive part in the Dudley Urgent Care Board, Black Country Urgent Care Board Area Team Urgent Care Board to: a) Identify an innovative solution to ambulance diversion to appropriate solutions b) Review Ambulance handover measurement and fining processes c) Ensure that capacity chases demand using WMAS predictions to influence availability of staffing in ED d) Construct working relationship with Sandwell MBC to support their patients repatriation	**RC**	**November 2013** **Implemented** **September 2013** **August 2013**
Care bundles	16. The trust should audit use of the new care bundles and ensure that all wards are using them effectively.	**High**	16.1 The Falls Care bundle and Pressure Ulcer Care bundles will be added to the Clinical Audit Programme and audited.	**DMc**	**September 2013**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Patient Experience Strategy	17. The board should review its approach to developing a patient experience strategy and ensure it is clear how its priorities in this area will be measured and monitored.	**High**	17.1 The Patient Experience Strategy will be reviewed in conjunction with the CCG and other partners. A stakeholder event will be held on 10th July to review the Strategy, priorities and systems for measuring and monitoring these. 17.2 Through the review of the governance arrangements (*1.1 above*) the Trust will evaluate the effectiveness of establishing a Patient Experience Group reporting to a Board Committee.	**PC**	**Implemented** **October 2013**
	18. Ensure the friends and family test is embedded across all ward and all staff members are aware of their responsibilities	**High**	18.1 The results of the Friends and Family Test will be displayed in all wards and public areas and will be discussed at directorate meetings. This will added to the Nursing Care Monthly Audits and reported to Directorate Performance Meetings with executives.	DMc & PC	**Implemented**
Complaints process	19. Review of the Trusts compliance against the DH and Ombudsman requirements for complaints management and also to improve the patients experience from this process including: • Ensuring responses to complaints are timely and patients' expectations are managed. • Reviewing style of response to complaints to address patients in an empathetic manner and use language that is easy for non-clinicians to understand.	**Urgent**	19.1 The Complaints and PALS teams will be amalgamated from October 2013 as part of organisational restructure. 19.2 An Interim Quality Manager has been engaged to undertaken a review of the Complaints processes against the Ombudsman's requirements	DMc	**October 2013**
	20. Implement a more effective process to capture learning for the Trust from complaints and ensure these are shared at ward level.	**Urgent**	20.1 Development of a complaints liaison role to support patients and capture learning from complaints. 20.2 Review the arrangements for capturing the learning from both complaints and incidents and develop and share ward level information. Report quarterly to the CQSPE Committee on complaint outcomes, learning and implementation.	DMc DMc	**August 2013** **October 2013**
Patient experience themes.	21. The Trust should consider the themes noted in the broad patient experience feedback obtained in this review. This should be used to further review its strategic approach to responding to patient feedback	**High**	21.1 *Refer to 16.1*	PC	**Implemented**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Management of Outpatient Appointments	22. The Trust should review its outpatient appointments process to consider how it can address the frequent complaints.	**Medium**	22.1 The Trust is conducting a phased demand and capacity review across all outpatient specialties, starting with areas that have issues with meeting the current demand levels for appointments and have frequent complaints about the service. Ophthalmology, Dermatology and Respiratory are due to be complete by November 2013 with all other specialties completed by December 2014. The output from these reviews are being managed through the Outpatient Steering Group.	**RB**	**Initial November 2013** **All December 2014**
Process to capture informal feedback from patients	23. Continue to promote informal feedback routes and ensure staff and patients are aware of the methods that can be used.	**Medium**	23.1 *Refer to 17 above* 23.3 Continue to distribute 'How did we do today' information cards to patients. 23.3 Continue to promote feedback mechanisms on the Trust website 23.4 Further develop patient experience information on the intranet to raise staff awareness	 PC PC PC	 **Implemented** **Implemented** **October 2013**
Workforce and Safety					
Staff engagement and Survey rates	24. The trust should continue to undertake its own work on staff engagement to understand what improvements staff would like to see.	**High**	24.1 A Draft Staff Engagement Strategy will be presented to the CQSPE Committee in August 2013 24.2 The Trust will explore further opportunities to capture staff views e.g. Graffiti boards. 24.3 Staff Engagement Officer appointed.	PC PC PC	**August 2013** **September 2013** **Implemented**
Theatres staff engagement	25. The Trust should review the staff engagement in theatres and obtain assurance that learning from the whistle blowing case and external review findings have been fully addressed.	**Urgent**	25.1 Review to be undertaken in theatres utilising team meetings and opportunities for individuals to raise concerns. Reviewer engaged to deliver project.	PC	**End of August**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Mandatory Training	26. The Trust should monitor and take action where mandatory training is below expected levels, particularly on significant areas where there have been recent incidents such as information governance and resuscitation.	**High**	26.1 The HR team will continue to track Mandatory Training levels and report performance to the Finance and Performance Committee, and directorate management teams. We aim to show a steady increase in performance each month to achieve our target of green in all subjects.	AR	**Continuing**
			26.2 Information governance is a 12 month renewable target The Trust will invest in a dedicated trainer for this subject to achieve green by October 2013. This will also enable us to show staff how to access the on line training for future years and therefore make it a sustainable figure.	AR	**October 2013**
			26.3 Resuscitation training is being reviewed to make the training easier to access and to look at the level at which staff are completing the training.	AR/ DMc	**September 2013**
			26.4 Mandatory training is the completion of basic resuscitation only, and a review of the training needs analysis will ensure that the right people receive the right training.	AR/ DMc	**October 2013**
Nurse staffing levels and skill mix	27. The Trust should take urgent action to ensure there are sufficient registered nurses to unregistered staff on all shifts.	**Urgent**	27.1 Nursing staffing escalation procedures to be reviewed to ensure all shifts working below identified staffing levels are supplemented with extra nurse / bank/agency staff. All Shifts working below this level after escalation will be reported on Datix and to the Senior Nurse / Manager out of hours	DMc	**Implemented**
			27.2 Nurse to patient ratios have been added to the Nursing Care Indicators. Manual data collection to be completed in June whilst electronic process is being developed.	D Mc	**Implemented**
			27.3 NCIs reported to Director of Nursing monthly then to CQSPE and the Board of Directors. Exceptions that fall below acceptable standards will be monitored and action plans and a recovery meeting held.	DMc	**August 2013**
			27.4 Recruitment of 18 more qualified nurses. Adverts placed (circa 3 months to complete). Short listing completed	DMc	**September 2013**
			27.5 An application for further staff to support the ongoing process to take between 40 – 50 newly qualified graduates (at risk) will be made. Interview process to commence week beginning 24 June 2013 for graduates qualifying in Sept 2013).	DMc	**September 2013**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
	28. An updated review of nurse staffing; levels and staff mix should be undertaken by the Trust which reflects patient dependencies, ideally using a nationally accredited tool e.g. AUKUH Safer Nursing Care Tool. This should focus on reviewing staffing on the high risk wards. The risk assessment should take into account dependency of patients and also other factors such as high temporary staff usage and high incident and infection rates. It should also ensure Francis recommendations are fully reflected in the new staffing model.	**High**	28.1 The Trust has committed to use the AUKUH / Safer Nursing Care tool . A Commissioning control plan is being developed. The initial start up briefing meeting was held on 25th June, following which the timeline for staff training and data collection was confirmed. The 20 day data collection process finishes on 31/07/13 28.2 A Staffing audit of all wards will be undertaken. The outcome of this review will be reported to the Board of Directors.	DMc	Implemented **August 2013** **October 2013**
Nurse staffing levels and skill mix	29. The Trust should review its nursing staff rotas and embed the consistent use of the Allocate e-rostering that it is implementing.	**High**	29.1 Implementation of new e rostering system with Allocate in accordance with the approved project plan and timeline. The Trust currently operates an electronic roster system "SMART" the functionality of which is inferior to ALLOCATE with regard to the management information available. The implementation of Allocate will be rolled out as per the project plan. The immediate action until full roll out is to ensure that the SMART system is being operated effectively which will be delivered through the Matrons and the General Managers in Directorates.	PA/ DMc	**September 2013**
	30. The trust should review its use of bank and agency staff to minimise this as a solution for capacity challenges and vacancy cover.	**High**	30.1 An extra capacity nurse pool team has been developed to roster extra nurses daily that are used to supplement staffing. These nurses report to the site co-ordinator who will deploy to appropriate areas. The extra graduates (those who are not identified for substantive vacancies) are being placed in posts where nurses are on long terms sick leave and maternity leave. This will reduce the use of bank and agency staff and improve continuity. These nurses will be moved into a vacancy as they arise which will minimise both the trained nurse and sickness vacancy levels.	DMc / RC	**Implemented**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
	31. The Trust should consider conducting an internal audit to check that the hours worked by its bank nurse are complaint with the European Working Time Directive.	**High**	31.1 An audit of compliance with the European Working Time Directive will be undertaken by Internal Audit. This has been added to the internal audit plan	PA	**Quarter 2** **Implemented**
Equipment and safety checks	32. The trust should reiterate its processes to staff to ensure important equipment and safety checks are completed. Compliance should be regularly audited and non compliance should be followed up urgently.	**Urgent**	32.1 The audit of equipment and safety checks now forms part of the NCI monthly audit and daily checks are undertaken. Additional checks are also undertaken by the Practice Development Team. The Audit has been added to the annual plan and is reported via Audit Committee and CQPSE. It also forms part of the Matrons presentation (monthly) to Board.	DMc	**Implemented**
Quality of Root cause analysis (RCA)	33. The trust should review its process for RCAs to ensure there is sufficient time and review built in to improve the quality of analysis and learning to be shared from the incident. The Trust may wish to use the NPSA toolkit to support the analysis.	**High**	33.1 A full review of the incident reporting and investigation process (including RCAs) has commenced. (Refer also to 8.1 – 8.2) 33.2 The use of the NPSA toolkit will be explored as part of the above review.	DMc	**WIP**
Inconsistent pressure ulcer preventative care	34 Systems should be reviewed to ensure staff can readily identify those patients with high need for pressure ulcer preventative care. White boards already in use on wards could be used to identify patients more effectively – using a magnet or silicone identifier.	**Urgent**	34.1 Magnets (depicting pressure ulcers) will be added to whiteboards on all wards.	DMc	**September 2013**
	35. Systems are needed to ensure that staff are made aware of how well their ward is doing in terms of number of PU free days and of the themes coming out of the RCAs. Ward managers to find effective methods of feedback to staff how well their area is doing and how many PU free days they have achieved. Consider display poster in the clinical area.	**High**	35.1 Laminated wall signs depicting pressure ulcer free days will be displayed on all wards. 35.2 A "How we are doing" board will be displayed on every ward covering the Quality Indicators.	DMc DMc	**Implemented** **Implemented**
	36. TVN to ensure all ward managers are looking at the 50 day dash charts available via the Tissue Viability (TV) intranet site to encourage competitiveness.	**Medium**	36.1 Tissue Viability team to publish a plan of the initiatives to raise awareness of harm free days	DMc	**September 2013**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Availability of equipment and delays from external provider.	37. Repose mattresses were available in the department – link nurses to promote and encourage their use.	**Urgent**	37.1 Buffer stock of 20 mattresses now on site which has eliminated the delay of equipment.	DMc	**Implemented**
	38. Performance indicators need to be reviewed for the contract with Karomed and penalties implemented where failings are occurring.	**Urgent**	38.1 Contract amended.	RB	**Implemented**
	39. TVN team to work with A&E link nurses to develop education in the department and carry out weekly audits of equipment use.	**Urgent**	39.1To develop a team of link nurses within the A&E department to provide in department education and training. 39.2 Weekly audits to be completed as per point 37	DMc	**Commencing July 2013** **Implemented**
Availability of equipment and delays from external provider	40. Staff should report equipment delays via datix so that management and the TV nursing team are made aware of how often this is occurring in real time.	**High**	40.1 To work with the communications department and link nurses to raise awareness of the reporting requirements for equipment delays via datix. 40.2 Datix Manager to ensure TV team receive an alert for each incident reported.	DMc DMc	**July 2013** **July 2013**
	41. Documentation audit by TVN team and/or link nurses to identify extent of delays.	**Medium**	41.1 Tissue Viability will review with the link nurses the possibility that their audit can identify delays 41.2 Tissue viability will discuss the audit of records with equipment coordinators.	DMc	**September 2013**
	42. Consider use of Anderson score in A/E rather than Waterlow to encourage assessment of all patients.	**Medium**	42.1 Tissue viability has looked at Anderson tool. This is a tool that is a useful prompt prior to Waterlow. As our emergency department are already using waterlow there is no need to add the Anderson tool	DMc	**Complete**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Divergence from guidelines and inaccurate documentation	43. Ward teams to carry out weekly SSKIN bundle audits of a minimum of 5 sets of notes per area with an aim to achieve 100% compliance.	**High**	43.1 Weekly auditing of PU prevention and Management documents is ongoing – Link Nurses to audit 6 sets of notes per ward area where possible. 43.2 Link Nurses are provided with protected time to complete this (7.5 hours per week)	DMc DMc	**Implemented** **Implemented**
	44. Action plans need implementing where compliance is not reaching 100% with particular focus on those elements of the bundle most commonly not being followed.	**High**	44.1To develop an escalation process for those wards not achieving 100% 44.2To relook at audit questions to ensure questions are achievable 44.3Link nurses are guaranteed protected time (7.5 hours per week) to provide training/education and facilitate audits.	DMc DMc DMc	**July 2013** **July 2013** **Implemented**
	45. TVNs to support link nurses to educate re waterlow assessments. Consider use of flash cards or other quick grab educational tools which can be displayed (posters etc)	**High**	45.1Waterlow guidance has been added to the pressure ulcer prevention document to offer guidance to nurses in real time 45.2 E- Learning package to be created to test knowledge and to offer guidance on the assessment and completion of the waterlow. 45.3Visual campaign to be created regarding waterlow accuracy	DMc	**Implemented** **September 2013** **September 2013**
	46. Link nurse and TV team to educate in this area.	**High**	46.1 Lead Nurse and Link Nurse from vascular ward to re-educate staff around the use of dynamic systems – spreadsheet of training to be held by TV Team.	DMc	**WIP**
	47. Link nurses to audit Waterlow assessments and implementation of preventative actions.	**High**	*This forms part of the PU prevention and management audits. See actions in points 37 & 38*	DMc	**Implemented**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Communication	48. TV Team and matrons to feedback the themes to all involved and set actions for staff locally to improve practice.	**High**	48.1 RCAs completed for all pressure ulcers above a stage 2 48.2 Weekly meetings to discuss pressure ulcer RCAs and share learning	DMc	**Implemented**
	49. A patient information leaflet should be designed if there isn't one already in use. Documentation should demonstrate that the patient has received the leaflet and their risk has been discussed.	**High**	49.1 There is a patient information leaflet in the back of the pressure ulcer prevention document which is perforated so can be removed to issue to the patient. There is space on the document for the nurse to sign to demonstrate the leaflet has been given and discussed 49.2 To monitor compliance by adding to the monthly Nursing Care Indicator Audits	DMc DMc	**Implemented** **September 2013**

Agenda Item No. 7

Dudley Health & Wellbeing Board 26th September 2013

Report of the Director of Adult, Community and Housing Services and the Chief Officer, Dudley Clinical Commissioning Group

Quality & Safety – update on Dudley response to Winterbourne View Report

Purpose of Report

1. As part of its overall leadership on Quality and Safety issues in Dudley, to update the Health and Wellbeing Board on developments relating to response in Dudley to the implications of the Winterbourne View.

Background

2. Dudley Health and Well Being Board received a Report at its meeting of 29th April 2013 on the response of the Dudley Safeguarding Adults Board and the Learning Disabilities Partnership Board to initial activity in Dudley to the Winterborne View report.

3. Winterbourne View Hospital was a private hospital for adults with learning disabilities and autism, mostly accommodating patients detained under the provisions of the Mental Health Act 1983.

4. On 31st May 2011 BBC Panorama uncovered serious physical and mental abuse of patients, which was being perpetrated by staff at the hospital. The investigation led to the prosecution of eleven staff members; the commissioning of a Serious Case Review by South Gloucestershire, and the Care Quality Commission's review of 150 learning disability hospitals and homes. The final Department of Health report and the Concordat outlining the actions were published in December 2012. The Director of Adult, Community and Housing Services, Andrea Pope-Smith, has represented the Association of Directors of Adult Social Services on this strand of work at a national level.

5. Amongst its finding, the national review:

    a. Found that too many people are placed in in-patient services for assessment and treatment, and remain there for too long. These units were often far from the patient's home and family.
    b. recommended that people should have access to the support and services they need locally, which should evidence long term support to families, which is preventative.
    c. With regard to Safeguarding, The South Gloucestershire Serious Case Review highlighted a range of concerns which needed to be considered nationally It was judged that the safeguarding process which was followed did not

sufficiently challenge other professionals' attitude, or the hospital's failure to produce reports when investigating concerns. The review also found that other alerts existed which should have also raised concerns i.e. use of advocacy services, attention to complaints and the frequency with which patients were restrained or absconded.

d. Asserted that Winterborne View failed in the recruitment, training and retention of staff, and that staff had not attended adequately to the mental and physical needs of patients.
e. The following 150 inspections of Treatment & Assessment Centres (CQC) highlighted similar concerns across these services nationally

Update since April 2013

6. In line with local, regional and national frameworks and agreed actions, specific local plans and progress has been made under the auspices of::

    a. All local authorities and CCG's are required to provide a Joint Strategic local Plan out lining current positions and plans for improvement relating to the requirements in the DH Report 'Transforming Care' and the Post Winterbourne View Concordat
    b. Dudley has established a Learning Disabilities Partnership – based on the WInterborne View Concordat actions which will be monitored at the Joint Learning Disability Commissioning Group and will include:

        i. The responsibility of the Clinical Commissioning Group to develop local registers of all people with challenging behaviour in NHS funded care; (this has been completed)

        ii. the NHS and Councils to ensure that systems and processes are in place to provide assurance that essential requirements are being met with governance systems in place to ensure they deliver high quality and appropriate care;

        iii. presumption in favour of pooled budgets;

        iv. use of contracts for holding providers to account;

        v. development of a quality assurance framework;

        vi. the review of care arrangements and update support plans for individuals with learning disabilities in NHS funded placements by June 2014; (These Reviews have been completed and plans are in place for those who will be ready for discharge to return to Dudley. All have workers allocated from Community Learning Disability Team.) A further cohort of 85 people with learning disabilities who have complex needs have been included on the database and are in the process of being reviewed as part of this process.

        vii. ensuring that there is a joint commissioning plan for learning disabilities in the area; There is an existing Joint Commissioning plan in place but

this is in the process of being refreshed to include post Winterbourne View actions.

viii. updating advice and advocacy support as needed; and

ix. starting planning for people with a learning disability from childhood

x. The completion of the national Stock Take (Joint Improvement Board) the NHS 'Count Me In Census' and the new Self Assessment Framework for LD (Joint health & social care)

c. Dudley Safeguarding Adults Board – has integrated its actions in response to Winterborne into its current Business Plan for 2013/14. This is available at the end of the Dudley Safeguarding Adults Board Annual Report which is being considered at the Meeting today The main areas for action following formal consideration of the Winterbourne Reports and their implications for safeguarding adults in Dudley are:

i. Assessment and Treatment – actions include agreeing a protocol for regular reporting to Board on follow up actions; identifying patterns of safeguarding issues linked to assessment and treatment units; and involving people with Learning Disabilities and family carers in safeguarding process to consider and address their desired outcomes and concerns
ii. Commissioning and Safeguarding – actions include identifying trends, and methods to monitor, investigate and respond; and information sharing and response partnership with CQC
iii. Restraint and control: - actions include scoping Methods of restraint being used in local services, how these are recorded and identified in the context of safeguarding referrals and how these are reported to the Safeguarding Board

7. Although there is more work to do as per the Action Plan (such as consolidating work on control and restraint and agreeing definitions) Progress has been made through a range of actions to date including:

- report from the Learning Disability Partnership Board having been made to the Safeguarding Board on implications for Winterborne in Dudley
- West Midlands Police presented an initial report on use of control and restraint amongst partners
- The Safeguarding Adults Training Strategy has changed to focus more on prevention and use of Mental Capacity Act
- A report on advocacy and how advocacy is used within safeguarding and with a view to further improvements
- Consideration of use of Deprivation of Liberty Safeguards in Dudley

8. Through its sector-led improvement work, the Winterborne View Joint Improvement Programme supported by the Local Government Association and the NHS

Commissioning Board required responses to a "stocktake" of local and regional responses. This adds to the performance and outcomes management environment for learning disability services locally and in addition stocktake outcomes will be monitored through a regional group where feedback will be provided on 27th September 2013.There will also be national feedback and analysis. The work is being overseen by the Minister for Care Services, Norman Lamb.

9. As described in the Report to the Health and Well Being Board of April 2013, a number of assurance arrangements are in place in Dudley which include bi-monthly meetings amongst regulatory, commissioning and assessment partners from the Council, the Clinical Commissioning Group and the Care Quality Commission.

11. The Annual Learning Disability Self Assessment process provides a comprehensive data set for the Partnership Board on a range of issues to provide assurances to Board members regarding the services commissioned and provided to people with a learning disability within Dudley. In addition the Board will receive quarterly data sets covering a range of subjects including safeguarding An annual Learning Disabilities Self-Assessment is also underway to be returned to the Department of Health by the end of November 2013

12. Other national developments - In te context of considering this report on local response to the Winterborne View Report, the Dudley Health and Well-being Board will wish to note two national pieces of work which are also impacting locally.

13. Confidential Inquiry - As part of a response to Mencap's 2007 report, *Death by Indifference*, the Department of Health established a Confidential Inquiry into premature deaths of people with learning disabilities and findings were reported earlier this year.

14. It reviewed the deaths of 247 people with learning disabilities within 5 Primary Care Trusts in the South-West of England. It also reviewed the deaths of 58 people without learning disabilities to place the findings in context.

15. The study reveals that the quality and effectiveness of the health and social care given to people with learning disabilities was deficient in a number of ways. Key recommendations have been made which will lessen the risk of premature death amongst people with learning disabilities. The Department of Health has recently issued a formal response to the findings of the Confidential Inquiry and recognises that we all have a part to play in reducing premature deaths of people with learning disabilities. There will representation from Dudley at events being organised by the Confidential Inquiry team this autumn.

16. "Six Lives Progress Report" – First published in March 2009, 'Six Lives' was the Ombudsmen's report looking at the care given to six people with learning disabilities who died. 'Six Lives.' A Progress report was published this year and found both positive things and things which still need to be improved and link to the outcomes of the Winterborne View Reports.

17. Positively, people with learning disabilities and their carers described some hospitals and GP practices as having improved their care and treatment of people with a learning disability a lot in recent years. Reasonable adjustments were thought to be made and staff seem to have a more positive attitude towards people with a learning disability. It is perceived that greater involvement of people with a learning disability and their families/carers takes place and there has been wider employment of learning disability nurses. Overall, the progress report states that people in hospitals do what the law says in the Mental Capacity Act.

18. However, the Report also finds that it takes too long to find out what is wrong with someone with a learning disability and start treatment. Annual health checks are not always done properly and it is felt that People with learning disabilities are not given information in a way they can understand. The Reports findings include the perception that people who work in hospitals do not always realise when someone with a learning s disability is in pain and people with learning disabilities are not always included in decisions about their care.

Finance

19. The Council, in accordance with our lead responsibility, funds most of the partner agency activities with regard to Safeguarding. The Council also funds most of the joint agency training programme through the Social Care Training Grant and the Mental Capacity Act grant. The Learning Disability Development Fund has commissioned an advocacy contract to work with people with complex needs.

Law

20. The main legislation currently governing adult protection is contained in sections 21, 26 and 28 of the National assistance Act 1948, the Community care Act 1991, the Mental Health Acts 1983 and 2007, the Mental Capacity Act 2005 and the Human Rights Act 1998.

Equality Impact

21. The Safeguard and protect policy and Procedures are consistent with the equal Opportunities Policy of the Council.

Recommendation

22. The Health and Wellbeing Board is asked to consider and comment update on the response to Winterborne View in the context of its overall concern for Quality and Safety ion the Borough and the services used by people in Dudley. .

Andrea Pope-Smith
Director – DACHS

Paul Maubach
Chief Officer – Dudley CCG

Contact Officers

- **Brendan Clifford, Assistant Director**
- **Anne Harris, Head of Safeguarding**
- **Ann Parkes, Head of Learning Disabilities**
- **Neill Bucktin – Head of Partnerships, Dudley CCG**

Agenda Item No. 8

DUDLEY HEALTH & WELL-BEING BOARD - 26TH September,2013

Report of the Director of Adult,Community and Housing Services

THE ANNUAL REPORT OF THE DUDLEY SAFEGUARDING ADULTS BOARD 2012

PURPOSE OF THE REPORT

1. To present to the Health & Well-Being Board the Annual Report of the Dudley Safeguarding Adults Board.

BACKGROUND

2. In 2000 the Department of Health issued the "No Secrets" Guidance which gave local authorities the lead role in setting up a multi-agency committee and to establish policy, procedures and guidance for work with vulnerable adults.

3. The Dudley Adult Protection Committee was established in 2004 and became the Vulnerable Adults Board in 2009. The Board includes senior representation of all key agencies – DMBC, the CCG, Dudley Group NHS FT, the Police, the Mental Health Trust, Probation and the Independent Sector.

4. The Board has three sub-groups - Policy, Audit and Training. The Board collects statistical information on the number of safeguard incidents reported in the borough of Dudley and is responsible for the governance of multi-agency safeguard work.

5. The Board had 6 strategic priorities for 2012.
    - To ensure that the structure and the remit of the board addressed the needs of adults at risk within the borough.
    - To ensure that partner agencies recognised their responsibility for safeguarding and have staff trained and equipped to respond to safeguard incidents.
    - To ensure the safeguard and protect procedures were updated and address local and national initiatives.
    - To raise public awareness
    - To develop strategies which prevent abuse to vulnerable adults

- To monitor the effectiveness of safeguarding interventions and to ensure this delivers better outcomes for victims and their carers.

6. The Annual Report demonstrates the progress achieved in these priorities in 2012.

7. 2012 saw a number of national reports into the care and treatment of the most vulnerable adults in our society. In July 2012 the Serious Case Review into Winterbourne View was published, which instigated a Programme of Action for Safeguard Boards nationally.

8. The Draft Care and Support Bill which was published in 2012 set out the legal framework for Safeguarding Adults Boards and outlined the responsibilities of partners. This provided opportunity for safeguard boards to consolidate those partnerships in preparation for the Support Bill.

9. Locally the West Midlands Safeguard Procedures were developed and launched in 2012 providing consistency across the region for the safeguard process;enabling partners who covered several authorities to work under the same procedures.

10. A decision to appoint a Joint Independent Chair to the Safeguarding Board for both Children & Adult Services was progressed in 2012 .An appointment to the post was made in May 2013

FINANCE

11. In accordance with our statutory responsibilities the council funds a Head of Service post, an administrator and administrative support staff. The council also funds most of the cost of the Annual training program.

LAW

12. The main legalisation governing adult protection is contained in sections 21, 26 & 29 of the National Assistance Act 1948, the Community Care Act 1991 and the Mental Health Acts 2005.

EQUALITY

13. The Safeguard & Protect Policy and Procedures are consistent with the Equal Opportunities Policy of the Council.

RECOMMENDATION

14. The Health & Well-Being Board is asked to consider and comment on the Annual Report.

Andrea Pope-Smith
Director – Adult, Community and Housing Services

Contact Officer:
Brendan Clifford - Assistant Director – Quality and Commissioning
Ext 5804

Safeguard & Protect

Dudley Safeguarding Adults Board

Annual Report 2012

Introduction

This is the 2012 Annual Report for Dudley Safeguarding Adult Board.

The Board provides the governance framework for shaping and agreeing how relevant organisations work together to protect vulnerable adults within Dudley borough.

Dudley Safeguarding Adults Board oversees the effectiveness of the arrangements made by individual agencies and the wider partnership to safeguard adults.
The remit of the board is not operational but one of co-ordination, planning and commissioning. It also contributes to the wider goals of improving the well being of adults.

The Board had 6 strategic priorities for 2012.

- To ensure that the structure and the remit of the Board addresses the needs of adults at risk within the borough.
- To ensure that partner agencies recognise their responsibility for safeguarding and have staff trained and equipped to respond to safeguard incidents.
- To ensure the safeguard and protect procedures are up-dated and address local and national initiatives.
- To raise public awareness of the potential risks to vulnerable adults' safety and what to do if they are concerned about an adult being abused.
- To develop and implement strategies which prevent abuse to vulnerable adults
- To monitor the effectiveness of safeguarding interventions and to ensure this delivers better outcomes for victims and their carers.

Dudley has made progress against all priorities outlined in 2012 and has identified priorities for 2013.

The National Picture

Safeguarding Adults continues to operate within the Government Guidance "No Secrets" published in March 2000 and the Association of Directors Social Services (now ADASS) national framework of 11 standards for good practice, which was published in 2005.

2011 – 2012 has seen a number of reports and investigations into the care and treatment of society's most vulnerable adults. The BBC broadcast their investigation on the BBC Panorama Programme into the abuse of adults with

learning disabilities who were patients in Winterbourne View, an independent hospital run by Castlebeck. Throughout 2011 – 2012 staff involved in the abuse were arrested and charged and the Care Quality Commission has reviewed and significantly changed its inspection regime and process for future years. This led to the Serious Case Review published in July 2012 by South Gloucestershire Safeguarding Adults Board and the Department of Health Winterbourne View Concordat: - Programme of Action published in December 2012. These reports have instigated a Programme of Action for Safeguarding Adults Boards and other partnerships nationally add to this.

In February 2012 the NHS Commission was established following the publication in February 2011 of the Care and Compassion report which was produced by the Parliamentary and Health Service Ombudsman, which exposed failures in the care of older people. The draft report set out ten key recommendations for hospitals and ten key recommendations for care homes to help them tackle the underlying causes of undignified care.

In March 2012 “Which” produced a report into Domiciliary Care and exposed examples of poor home care of vulnerable people. The report indicated concern that people living at home with increasingly complex care needs have their safety compromised by poorly managed care. However the report also indicated some excellent care, showing how it can be delivered effectively to vulnerable people.

In July the Department of Health consulted with Safeguard Boards on whether there should be a new power to support the duty to make enquiries.
Dudley Safeguard Adult Board members and operational staff were consulted about this and a response was sent to the Department of Health together with a response to the Draft Care and Support bill published in July 2012 which set out the framework for Safeguarding Adult Boards and identified the local authority responsibilities and those of local partners.

The Bill is to be welcomed in that it puts the Adult Safeguarding Board on a statutory footing like the Children’s Board. It also states that Adult Safeguard Boards must make (or cause to be made) whatever enquiries it thinks necessary where it considers there may be a safeguard concern. This will give power and authority to the decisions made in a strategy meeting and reflects the duty to co-operate and attend those meetings. It might determine too that partner agencies are sometimes best to lead in an investigation if their knowledge of the situation, victim or alleged perpetrator equips them to do so.

The Queens Speech included mentions of the Health & Social Care Bill in May 2013 highlighting the statutory framework for Adult Safeguarding and the statutory requirements to commission/support prevention as a result of the issues arising in 2012. This indicates a shift in direction and approach for Adult Safeguard Boards for 2013.

National reports and enquiries have influenced and will continue to influence how Dudley Safeguarding Adults Board aims to protect vulnerable adults in Dudley from harm and abuse.

Some of the key achievements against the 2012 priorities:

Priority 1 - The Structure and Remit of the Board

- The Board reviewed its governance and reporting arrangements to reflect the changes within partner agency and local authority structures as shown in Appendix 1 at the end of this document.

- In 2012 at each of the Boards six meetings, sections of the Business Plan were updated to reflect the action taken by Board members.

- An Away-Day was held in September 2012 which agreed that partner agencies would routinely report their progress to the Board. Case Studies would be presented at meetings to inform board members and assist partner agencies in understanding the complexity of safeguarding concerns.

- A decision to appoint a Joint Independent Chair to the Safeguarding Board for both Children & Adult Services was progressed in 2012 with an appointment planned for 2013.

- Attendance at the three sub-groups of the Board – Support and Learning, Policy & Implementation and Quality & Performance was varied and the workload of the sub-groups has reflected this deficit in 2012.

- The Support and Learning Sub-Group developed a Competency Framework for Training in Adult Safeguarding for 2013 alongside a revised training programme which reflected the need to look at the prevention of safeguard concerns.

- The Quality and Performance Sub-Group considered the outcome of the Citizen Survey conducted in October 2012 and the survey of the Safeguarding Experience of Vulnerable Adults in 2012 and reflected on the work required by Safeguard Boards in regard to the Winterbourne review which was consolidated in January 2013 at the Board meeting. Details of this work are indicated within this report.

- The Policy & Implementation Group considered the consultation documentations from the Department of Health re the Draft Care & Support Bill and Powers of Entry. It also agreed the workshop arrangements for information on the West-Midlands Safeguard and Protect Procedures which were launched in July 2012 and will be operational in Dudley in 2013.
- The Safer Recruitment sub-group considered the information on the Protection of Freedoms Bill and the establishment of the Disclosure and Barring Service (combination of the independent Safeguarding

- Authority and the Criminal Records Bureau). Presentations were made to the Board members in September and December concerning this development.

Priority 2 - Work of Council Directorates and Partner Agencies

Multi-agency Public protection arrangements (MAPPA)

The purpose of the multi-agency public protection arrangements (MAPPA) is to reduce the risks posed by sexual and violent offenders in order to protect the public from serious harm. The responsible authorities in respect of MAPPA are the Police, Prison & Probation Services. Within Dudley partners from Children, Adult Social Care, Probation and Police meet on a regular basis to monitor the arrangements for offenders within the community.

Multi Agency risk assessment conferences (MARAC)

Within Dudley partners meet fortnightly to manage high risk cases of domestic abuse; stalking and honour based violence to ensure there is a multi agency response to issues and that information is shared in a timely and appropriate manner.

Within Dudley both MAPPA and MARAC are managed by West Midlands Police.

Dudley CCG

Dudley CCG focused on achieving high quality care for Dudley residents by continuing to use the Positive Assurance Framework which was presented to the Board in January 2012. This framework requires care homes to self assess against an agreed set of key performance indicators and submit the data to the CCG and the local authority.

It is anticipated that this framework is better able to support a home with quality issues if they are aware of problems early. This tool highlighted concerns around the number of falls in one residential home and led to support around falls management and care plan recording in that home during 2012.

The PCT/CCG recognised it is important to have an Adult Safeguard lead who has been instrumental in providing advice and support on healthcare matters in many safeguard concerns in 2012 and has contributed to training for Residential, Nursing and Domiciliary care staff and has undertook health related investigations and positive assurance visits to residential homes.
The PCT/CCG has a Safeguard Forum which report directly to the Quality & Safety Committee within the PCT/CCG.
Housing Services

Housing divisions with Dudley Adults & Community Housing Services have historically concentrated on staff safeguard awareness training. This has led to a positive contribution in a number of complex safeguarding cases and examples of case studies have been presented to the board to demonstrate that more positive outcomes can be achieved for vulnerable people by working together to combine resources and expertise.

Housing Services have also worked with Churches Housing Association of Dudley and District (CHADD) and West Mercia Housing Group to provide a domestic refuse for women, men and children who are seeking to break free from domestic abuse.

West Midlands Police

In December 2011 the two operational safeguard managers and the Head of Adult Safeguarding met with the Police to confirm pathways and to improve working relationships.

The Police within the Public Protection Unit were committed to attend strategy and case conference meetings when appropriate throughout 2012. A further meeting in February 2012 consolidated improvements and further liaison throughout the year ensured that partner agencies were aware of up to date contact information. A new secure email and direct telephone line was established to ensure recording of information being shared.

The Police PPU also supported the Safeguard agenda and presented a series of training sessions within a Home where poor recording had led to the failure of a prosecution in the autumn of 2011.

In November 2012 the Access Team and the Detective Sergeant from the safeguarding team met together with safeguarding leads to discuss the information regarding safeguard referrals and to update the proposed changes within the West Midlands Police.

The Detective Chief Inspector regularly attended the Safeguard Board in 2012 and supported the agenda by a presentation to the board in September 2012 regarding the Police and Crime Commissioner.

November 2012 saw significant developments with the planning and organisation of the West Midlands Vulnerable Adults hub based at West Bromwich Police station covering Walsall, Wolverhampton, Dudley and Sandwell and planned for 2013.

Dudley Probation Service

During 2012 the probation service established an effective mental health service for Dudley offenders. Probation staff have worked with Dudley and Walsall Mental Health Trust to establish referral pathways and protocols for current cases and court mandated orders.

Throughout 2012 the service was subject to an internal and external audit of outcomes on how the service prevented harm to communities. The report from these audits demonstrated the probation service's effective approach to managing offenders at risk towards vulnerable adults.

The Probation service in 2012 were safeguarding partners at MARAC, the Children's Board and the Domestic Abuse Forum alongside other agencies within the borough.

Age UK Dudley

Age UK has adapted their recruitment process following the developments of the Disclosure and Barring Service and tailored checks to reflect regulated activity.

The referral pathway to Adult Safeguarding from Age UK has ensued that cases have been dealt with appropriately and Age UK have sought advice and support from safeguard leads within Dudley Adult & Community Housing Services to support vulnerable adults.

The number of volunteers and staff who need to attend the Safeguard Awareness Training remains an issue for Age UK and bespoke courses have been offered to support the organisation.

Dudley Group NHS FT

Within the NHSFT 72.5% of staff have now received Adult Safeguarding Training. Where there have been difficulties with compliance because of the nature of the work, then bespoke training sessions were planned for specific staff groups.

Training for the Private Finance initiative partners has been introduced and is expected to be completed by June 2013. To date 50% of all porters and 60% of all security staff have been trained. This is in direct response to Serious Case Review requirements.

In October 2012 Strategic Health completed a Learning Disabilities Review within the Trust. The reviewers supported the trust's work with the Clinical Commissioning Group to secure funding for a Learning Disabilities Liaison Role. An action plan to address the key findings identified in the Winterbourne report has been developed and includes:

- Improving staff attendance at Mental Capacity Training
- Raising awareness of best interests meetings and the role of the Independent Mental Capacity Advocate.

The Trust has reviewed its restraint policy. Its CRB policy has also been updated to reflect changes in the Disclosure and Barring service and the Trust has also worked with partners to implement the multi-agency policy & procedures and the changes to the Deprivation of Liberty process.

Community Safety Team and Safe and Sound Partnership

The Team and Partnership have continued to contribute to the Safeguard Agenda in 2013.
The Team organised the Substance Misuse Safeguard Forum and the Domestic Abuse Strategy group throughout 2012 and progressed these agendas. A meeting between DACHS, Access team and the substance misuse providers progressed learning about the safeguard process and referral pathways.

The Community Team facilitated a Hate Crime Stakeholder event in March 2012 and worked with partners to develop and implement the third party reporting system.

In 2013 there was collaboration over several safeguard cases while vulnerability assessments in respect of victims of ASB cases and hate incidents were carried out by the Community Safety Team and the appropriate support service offered.

The routine work of contract monitoring and information sharing continued to ensure safe recruitment processes and support to vulnerable adults.

Black Country Partnership NHS Foundation Trust (BCPFT)

Dudley Learning Disability Specialist Health Services have been part of BCPFT for over two years. In 2012 there was a focus on safeguarding values and meaningful activities for service users.

A training programme has included all members of the Inpatient service. Allied health professionals have updated their safeguarding training through a range of approaches including e- learning and face to face sessions.

In 2012 the service continued its work in relation to Essence of Care Standards ensuring Dignity in Care and the 6 C's linked (but not exclusive) to nursing practice (compassion; courage; commitment; competency; care and communication remains a consistent theme of service delivery). The organisation has taken on board the findings of the Winterbourne and Francis report and service improvements have been developed and implemented following CQC, and Advocacy audits.

The service continues to strengthen its service user feedback approaches to ensure services are outcome focused.

Centre for Equality and Diversity

In 2013 the Centre for Equality and Diversity improved its selection and recruitment procedures to ensure the appointment of suitable people to work

with vulnerable adults. Key policies in relation to safeguarding were updated within the organisation with a commitment to safeguard training amongst its staff groups. The Board of Directors have agreed to highlight key achievements within the organisation through a report to Board members in 2013 by the Chief Officer who attends the Board meetings.

Dudley and Walsall Mental Health Partnership Trust NHS Trust (DWMHPT)

DWMHT have a Safeguarding Strategic Group which meets bi-monthly to monitor policies and procedures and provide assurance to its Governance and Quality Committee.

The Trust contributes to both Dudley and Walsall MBC Adults Safeguarding audits and adopts the recommendations from these audits into clinical record keeping. In August 2012, CQC and OFSTED undertook a thematic inspection for parental mental health and substance misuse. The trust are active participants in a delivery plan recognising the outcomes of that inspection. This includes the level of safeguarding training offered to mental health service providers; the developments of protocol and care pathways between children and adult services in respect of parental mental health and safeguarding children. Links between children and mental health services are being promoted by a conference planned for 2013.

DWMHPT has continued to commission training relating to adult and child care safeguards and specialist training regarding mental capacity, and investigation skills are delivered to front line staff and their managers.

Children's Services

Dudley Safeguarding Children's Board has again worked collaborately with the Adult Safeguard Board in 2012.
An emphasis on raising awareness of children safeguarding within Adult Social Care was one of the priorities of 2012 with information shared with staff on children's safeguard training, safeguard pathways and transition arrangements.
The Head of Services for Children Safeguarding updated the Adult Board on changes to the Vetting and Barring scheme in September 2012 and the Children's Safeguard Newsletter was shared with all Adult Board members throughout the year, providing valuable information upon service developments.
During 2012 Dudley was inspected by Ofsted and Care Quality Commission regarding joint work between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems.
The inspection identified the issues to be improved in 2013 in an Action Plan,
These included:

- Implementation of Think Family Approach
- Evidence to be gathered of effective working between Children's services and substance misuse services leading to good outcomes.
- Providers of mental health services to be involved in early intervention

- Improvement in safeguard training for Mental Health service providers
- Work on pathways and protocols between both Children and Adult services in respect of parental mental health and safeguarding children. 2012 also saw joint agreement on the recruitment of an independent Chair for both Adult & Children Safeguard Boards planned for 2013.

  Joint training on violent extremism and on changes to DBS were also planned for the 2013 training programme for both boards.

West Midlands Care Association

This organisation supports the Care Homes and the Domiciliary Providers in Dudley. As part of the Safeguarding Board, the Association ensures that providers are aware of any changes, reports and prevention initiatives considered important by the Board. The Association ensures that the Board understands the practicalities of the industry, which ensures that support can be put in place to minimise the risk of safeguarding incidents occurring.

The Association works with the training sub group to put in place regular and targeted safeguarding training. This is based on the assessed risks and issues identified as needing to be targeted. Training courses have covered Mental Capacity, Deprivation of Liberty Safeguards, Care Planning, Disclosure and Barring Services referrals, understanding the Safeguarding Procedures, Winterbourne, and Bogus Callers with trading standards. There has also been an emphasis on the Care Managers and Owners having a chance to discuss the training and work through case studies, so they fully understand the issues and can pass them on to their staff.

Priority 3 - **Safeguard and Protect Procedures**

In July 2012 the Pan West Midlands procedure was launched with authorities adopting the procedures throughout 2012/2013. Dudley launched the procedures in April 2013.

Following this launch a series of workshops with Adult Social Care staff, with Partner Agencies at board meetings and with West Midlands Care Association were held in the autumn to raise awareness of the up-to-date information obtained within these procedures.

A report to the Board and to the management team in Adult Social Care raised awareness of the mechanisms for assurance that were in place to ensure the present procedures were followed. This highlighted the quarterly meetings with CQC and Commissioning and the update information from complaints and MIT regarding repeat referrals in response to the Winterbourne recommendations.

Case studies of safeguard situations were introduced as a standing item on the board and partner agencies felt this promoted better understanding of the safeguard procedures that partner agencies dealt with.

The adherence to the Safeguard and Protect procedures was audited in August 2012 by the Head of Service and Managers within Adult Social Care and this led to reinforcement with staff groups throughout the autumn regarding the use of the Risk Assessment tool and Mental Capacity assessments.

The Children's Board section 11 Audit also drew attention to the need for Adult Social Care staff to become more familiar with the Children's Safeguard procedure and this was facilitated by Children's Service Managers attending Senior Management Team and Team Managers meetings within DACHS in 2012.

An appointment of an Assistant Safeguarding Team Manager in 2012 within Adult Social Care reflected the need to collate safeguard referral processes with the safeguard managers to track more efficiently the safeguard referral process and outcomes.

The Safeguard & Protect procedures continued to lead to complex strategy meetings throughout 2012 in residential and nursing homes where there was a failure to adhere to safeguard practices strategically. Improvement Plans were developed in conjunction with CQC - Dudley & Walsall Mental Health Trust - CCG and the Police to improve their recording, their training, policies and practices and staff recruitment processes. One home closed in 2012 following the failure to maintain adequately the proposed improvement plan.

Priority 4 - Promotion of the Safeguard Agenda

In 2012 two Practice Learning Events were delivered to Partners in Dudley to offer the opportunity for operational professionals involved in Safeguarding Adults to discuss issues in relation to a specific local incident; to reflect on that practice; relate it to their own; to share best practice and to suggest improvements to organisational practice. The multi- agency remit meant that operational staff learnt about the roles of colleagues and discussed potential conflicts and potential resources within safeguard situations.

The Learning and Development team have continued to promote the safeguard agenda and have delivered the following courses in 2012.

Course title	Number of courses in 2012	Total number of delegates in 2012	LA delegates	Health delegates	Other delegates	Total number of delegates since 2006
Full day abuse awareness	37	520	41	16	463	7021
Abuse awareness	17	85	28	0	57	862

briefings						
Practice Issues	9	118	23	25	70	1083
Who's After Your Money	11	129	95	1	33	441
Practice Learning events	2	67	37	18	12	67
TOTALS	76	919	224	60	635	9474

The recipients of bespoke abuse awareness training included: Micro Providers, Dudley College staff, Dudley Council Plus Advisors and volunteers from a Faith Organisation.

In 2012 two update meetings were held with Team Managers to share information about developments within safeguarding and discuss operational aspects of that work.

The use of webinars was also developed in 2012 and training to promote awareness of Deprivation of Liberty issues was delivered using this media.

World Mental Health Day was supported on 13.10.12 and awareness of safeguarding was raised at a local event planned within the borough.

In 2012 West Midlands Care Association hosted two safeguard events, one for domiciliary care providers and the second for managers of residential services. Promotion of the West Midlands procedures; Rogue Trader issues; Pressure Sore Care and good planning were delivered at these events. The success of these events has lead to a structured programme of events planned for 2013.

In March 2012 a Hate Crime Stakeholder Event was held with Police, Community Safety, Victim Support and DACHS. This was attended by over 90 participants, this event included a strategic/ operational analysis of hate crime across the borough; perspectives from a variety of partners and the development of third party reporting to encourage members of the public to report hate crime more effectively throughout the borough.

In October 2012 nineteen safeguard partners promoted the safeguard agenda by asking people who used their services to complete a questionnaire to learn whether citizens were able to identify and act upon safeguard concerns and to enhance communications with citizens on issues concerning safeguarding. The survey confirmed awareness of abuse and where to report it but indicated the need to raise awareness of the need to report situations where people have concerns which may indicate safeguard issues and how to recognise signs of abuse. Most citizens were not aware of the role of the Safeguarding Board and this deficit was incorporated in the development of the Communication Strategy for 2013. Just under half of the questionnaires completed indicated that people had seen the information about keeping

vulnerable adults safe. This was incorporated into the plans for the Communication Strategy in 2013, and other tools to advertise the key messages have been agreed.

The West Midlands Safeguard Forum developed a Threshold Framework for Safeguarding to assist operational staff and those providing services to develop an awareness of the thresholds for Safeguarding referrals. This aims to promote good practice and was shared with operational managers in 2012 and was revised to be shared with partners in 2013 when it will become fully operational.

At a Safeguard Board Away Day in September 2012 it was agreed that the safeguard agenda should be promoted by information presented to the Board concerning Serious Case Reviews and a yearly plan for 2013 where Partner Agencies demonstrated their key achievements in Safeguarding and Initiatives they had used to promote Safeguarding.

These have all become custom in 2013 and promoted the partnership arrangements in the Safeguarding agenda and its implementation.

Priority 5 - Development of the Preventative Strategy

The Safeguard and Awareness Training alerts staff to the signs of abuse but continues to encourage staff to consider practices which can become abusive.

The Pressure Sore Protocol and the Positive Assurance Framework were embedded in practice in 2012 within Partner agencies to enable staff to work to prevent safeguard concerns developing within their setting.

Care Quality Commission, the Clinical Commissioning group, Adult Community and Housing Services, Safeguarding and Commissioning managers continued to meet every two months to ensure that issues regarding care providers were shared to confirm similar concerns and highlight areas where collaboration may be required.

Following incidents at Winterbourne View and SCR a system of identifying repeat referrals in domiciliary and care settings was developed with statistical information obtained each month. This information was shared with Safeguard managers, the Quality and Performance sub-group at the Board and will be part of the Information Sharing Protocol with partners in 2013. This will highlight providers of care who not only have had repeat referrals, which are substantiated but may highlight providers where other support is required, when there appears to be emerging issues, such as inadequate training, care plan recording or medication management.

Within the wider safeguard agenda the Adult Safeguard Boards agreed to take the lead in arranging multi- agency training regarding Prevent for 2013. Prevent is part of the Governments Counter- Terrorism Strategy, which was created to protect the UK from terrorism. Prevent focuses on working with individuals and communities who may be vulnerable to the threat of violent

extremism and terrorism. The Workshop gives an overview of the work of Prevent and how to recognise the initial signs of individuals who are vulnerable to radicalisation as well as those who radicalise.

The Board members were also given two presentations in September and December regarding the creation of the Disclosure and Barring Services and the implementation of the provisions within the Protection of Freedoms Act 2012 to ensure staff within partner agencies were aware of staff recruitment practices. West Midlands Care Association ensured that staff working within commissioned services were updated about this information too as partners in this preventative safeguard agenda.

Winterbourne View raised many and significant issues for Adult Safeguard Boards regarding the care of vulnerable adults. The safeguard Board addressed these issues by developing an Action Plan of requirements for Board members, which is included in the 2013 Business Plan and will dominate much of the work of the board throughout the year.

The prevention of Safeguard issues is the focus of 2013 programme of training arranged for the Safeguard Board. It is recognised that parties need to understand and apply the principles of Legislation; the Mental Capacity Act and Deprivation of Liberty Safeguards in particular and training throughout 2013 will focus on this agenda amongst partner agencies. The training programme for 2013 is attached at the end of this document to reflect that commitment to the Prevention Strategy. *Appendix 3*

Deprivation of Liberty

The Mental Capacity Act 2005 provides a statutory framework for acting and making decisions on behalf of individuals who lack the mental capacity to do so themselves.

The Deprivation of Liberty Safeguards were introduced to provide a legal framework around the deprivation of liberty. The safeguards exist to provide suitable protection for those most vulnerable, who have (for their own safety and best interest) been accommodated under care and treatment regimes that may have the effect of depriving them of their liberty.

Dudley has a group of qualified and experienced Best Interest Assessors and Doctors who undertake this role for the local authority and the clinical commissioning group.

85 assessments were undertaken in 2012. 53 of those assessments concluded there was a deprivation of liberty and the remaining 32 did not conclude that a deprivation was occurring. (What actions were taken?)

In 2012 registered care and nursing homes had to recognise whether the care planning process they were adopting was likely to result in a deprivation of liberty and apply to the Deprivation of Liberty administrator for authorisation. If required, training and support to these commissioned services remains a

focus to ensure that Homes apply the Deprivation of Liberty safeguards in the correct circumstances and undertake the conditions set as a result of the deprivation.

Priority 6 - Quality & Performance

The two safeguard managers within Adult Social Care were supported by Management Information Team and Business support staff to improve the management of safeguard concerns in 2012.

In Learning Disability and Mental Health services the Team and Clinical Managers continue to bring their expertise to managing the safeguard process for people who use their service.

In 2012 there was one audit carried out to monitor performance and practice alongside an Adult Social Care audit which included 12 safeguard concerns. Each six months management information teams have also collated information on the number, types and timescales for safeguard referrals together with outcomes of those referrals.

As a response to these audits, staff training on mental capacity has been organised for 2013 to reinforce the importance of mental capacity within the safeguard arena. In 2012 risk assessments were also highlighted as an area of development.

Timescales for strategy meetings continue to fall outside of the procedural requirements but the audits indicate people are made safe if appropriate on receipt of the referral and mechanisms have been put in place to work to improve this recognising however, the number of referrals and the pressures upon existing workforce.

The auditors felt however there was good evidence of proactive multi disciplinary working, that the victim had been involved in the process and advised about the outcomes.

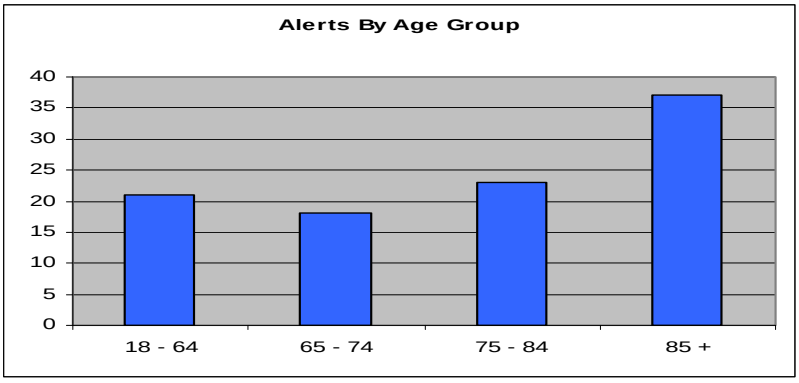
- **Data Information**

Alerts

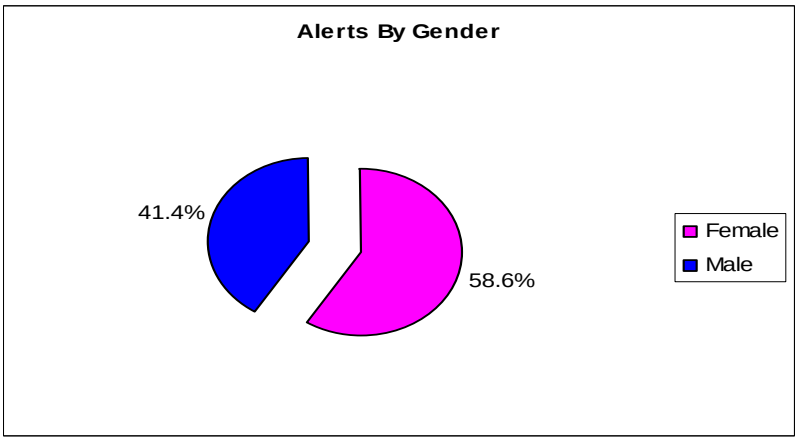
In July 2012 an alert system was introduced whereby other agencies inform the local authority of a possible safeguard concern and the local authority staff undertake some initial information gathering to decide whether the safeguard process should be initiated and a safeguard referral raised.
The number of cases which stopped at alert and did not progress was 99 and this is not a full year figure as this was only introduced in July 2012.

2012			
Age Group	**Female**	**Male**	**Total**
18 - 64	13	8	21
65 - 74	10	8	18

75 - 84	12	11	23
85 +	23	14	37
Total	**99**		



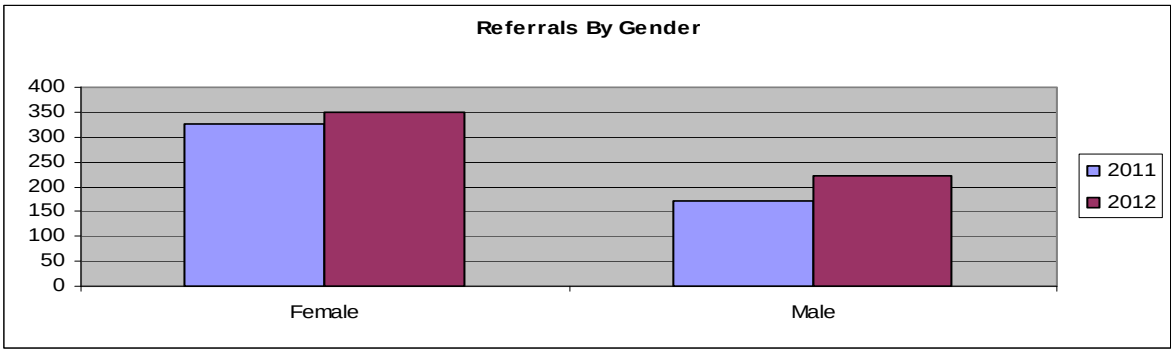
This is encouraging as the 85 + age group has always historically been the highest group for referrals and demonstrates people are aware of the vulnerability of this group and are raising alerts.

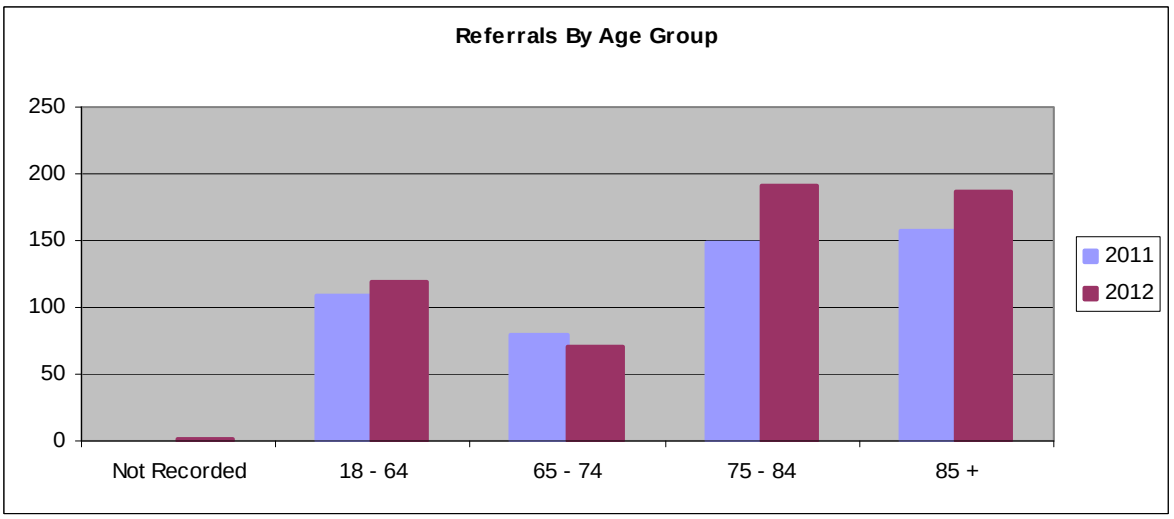


Referrals

2011			
Age Group	**Female**	**Male**	**Total**
Not Recorded	0	0	0
18 - 64	53	56	109
65 - 74	50	30	80
75 - 84	97	52	149
85 +	125	32	157
Total	**495**		

2012			
Age Group	**Female**	**Male**	**Total**
Not Recorded	0	1	1
18 - 64	59	60	119
65 - 74	45	26	71
75 - 84	114	77	191
85 +	130	57	187
Total	**568**		



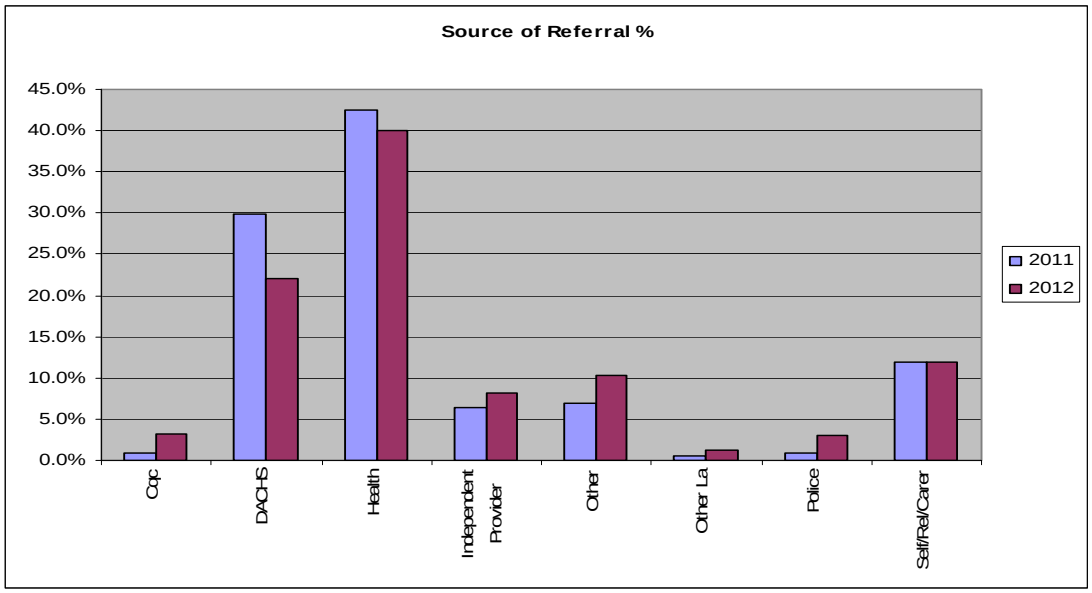


The number of referrals (excluding Alerts) has increased from 495 during 2011 to 568 during 2012, this equates to a 14.7% increase.

The majority of this increase can be seen in the number of referrals for males increasing from 170 during 2011 to 221 during 2012, an increase of 51 referrals, with the increase of referrals for females at 23 during the same period. This could suggest an acceptance that safeguarding applies to, and is reported more readily, for males as well as for females which may be as a result of promotion of this issue locally and nationally. The questionnaire organised for 2013 will explore this further with male victims.

The highest increase of referrals for males can be seen in both the 75-84 and 85+ age groups when an increase of 25 referrals within both cohorts.

Referrals Source



The source of referrals during 2012 compared with during 2011 shows very similar proportions, with the most noticeable reduction within the DACHS source however, numbers here are very small with only 7 referrals less during 2012 than 2011 within this cohort.

An increase in the number of referrals from CQC, the Police and Independent Providers may be due to the increased liaison with these groups in 2012 to strengthen joint working around the implementation of the safeguard procedures.

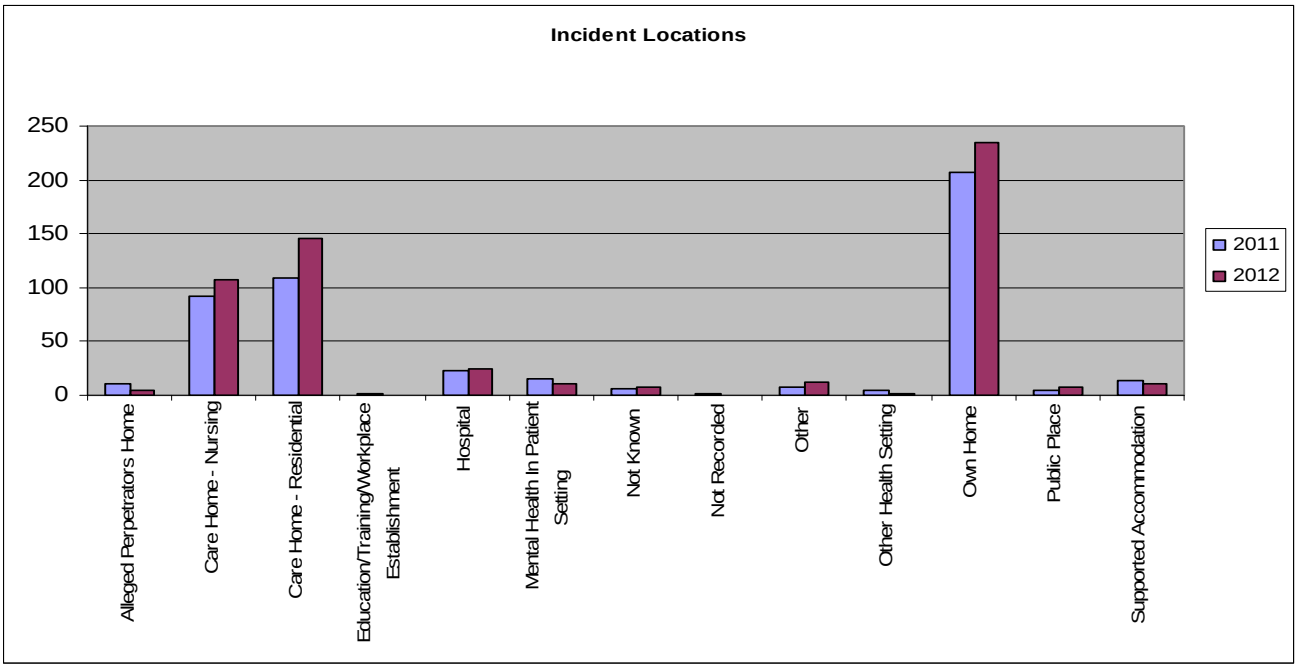
Abuse Categories for Referrals During 2011 and 2012

Victim Abuse Category	2011	2012
Discrimination	5	4
Emotional/Psychological Abuse	96	141
Financial/Material Abuse	95	105
Institutional Abuse	17	40
Neglect - Medication	0	1
Neglect - Pressure Sore	0	15
Neglect and Acts of Omission	215	251
Physical Abuse	164	174
Physical Abuse - Domestic	0	10
Sexual Abuse	30	23
Total	**622**	**764**

622 abuse categories have been recorded for 495 referrals in 2011 and 764 abuse categories for 568 referrals in 2012 suggesting that in both years more than 1 abuse category has been recorded for some referrals. Proportions

during each year are similar with the majority in both years being Neglect and Acts of Omission.

However, it is interesting to see the increase in emotional/psychological abuse, neglect and acts of omission – The Safeguard Training has reinforced these complex safeguard categories and may indicate people's willingness to label concerns which they did not do previously.



These statistics give credence to the work undertaken with commissioning, the CCG and CQC to monitor care and nursing homes.
This also reinforces the value of the work with West Midlands Care Association to deliver training to commissioned services concerning pressure sore care, care planning and safer recruitment.

Investigation Decisions for Investigations Carried Out During 2011 and 2012

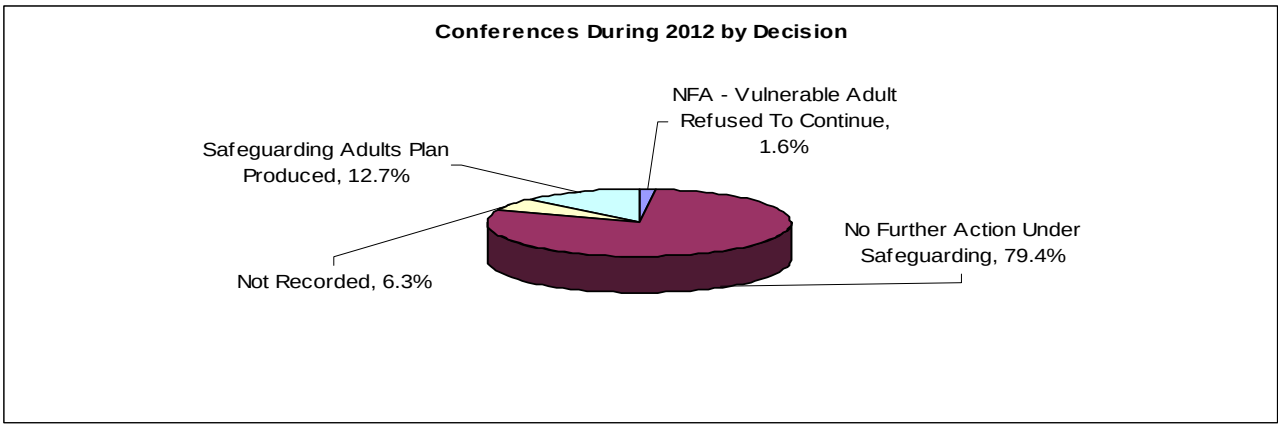
Investigation Decision	2011	%	2012	%
Not Recorded	1	0.6%	1	0.7%
Case Conference Required	88	51.8%	70	48.3%
Incorporated Into existing Investigation	8	4.7%	9	6.2%
NFA - Not Safeguarding Adults	61	35.9%	48	33.1%
NFA - Safeguarding Issues Resolved	0	0.0%	15	10.3%
NFA - Vulnerable Adult Refused to Proceed	12	7.1%	2	1.4%
Total	**170**	**100.0%**	**145**	**100.0%**

Of the 495 referrals during 2011, 170 progressed to investigation which equates to 34.3%; of these half required a conference (51.8%). As would be expected with the introduction of recording alerts, the number of investigations has reduced during 2012 with the majority of these also requiring a conference to take place (48.3%). This implies that the appropriate cases are reaching the investigation and case conference stage.

Conferences Completed During 2011 and 2012

Conference Decision	2011	%	2012	%
NFA - Vulnerable Adult Refused To Continue	2	2.3%	1	1.6%
No Further Action Under Safeguarding	61	70.9%	50	79.4%
Not Recorded	3	3.5%	4	6.3%
Safeguarding Adults Plan Produced	20	23.3%	8	12.7%
Total	**86**	**100.0%**	**63**	**100.0%**

During 2011 of the 88 investigations requiring a conference, 86 were recorded, with the majority (70.9%) of these with a decision of No Further Action Under Safeguarding. During 2012 of the 70 investigations requiring a conference, 63 were recorded with the majority (79.4%) also being recorded with a decision of No Further Action Under Safeguarding. Conferences may have been held in January 2013 and fall outside the data remits.



Conference Outcomes for Clients During 2011 and 2012

Conference Outcome	2011	2012
Client - Advocacy	1	1
Client - Application to Change Appointeeship	1	0
Client - Community Care Assessment and Services	7	10
Client - Counselling Support	0	1
Client - Guardianship/Use of Mental Health Act	1	0
Client - Increased Monitoring	13	15
Client - Moved to Increased/Different Care	8	4
Client - No Further Action	29	17
Client - Other	1	2
Client - Referral to Advocacy Scheme	0	1
Client - Referral to Counselling/Training	2	0
Client - Restriction/Management of Access to Alleged Perpetrator	4	2
Client - Unable To Consent To Acceptance Of Protection Plan	5	0
Client - Vulnerable Adult removed from Property or Service	1	0
Client - Yes Acceptance Of Protection Plan	3	5

Substantiated Incidents during 2011 and 2012

Substantiated Incidents	2011	%	2012	%
Substantiated - Fully	40	63.5%	60	62.5%
Substantiated - Partially	23	36.5%	36	37.5%
Total	**63**	**100.0%**	**96**	**100.0%**

Of the 495 referrals recorded in 2011, 63 were substantiated which equates to 12.7%, compared with 96 of the 568 referrals in 2012 which is 16.9%. This suggests that it is beginning to show that by undertaking that initial screening at Alert point fewer safeguarding referrals are recorded and progressing which are actually Alerts. This fact should be evidenced much more during 2013. This ensures that the victim is not subject to a process where other processes may be more appropriate such as staff training, HR and disciplinary processes.

In October 2012 a report was compiled for the Safeguard Board on the outcomes from the experience of a further ten victims of abuse.

The report demonstrated an improvement in the safeguard process outcomes for victims in comparison to the same data collected in 2011. Victims felt listened to, felt they understood the process and were given choices about the outcome they wished to achieve.

The report in 2011 proposed a number of actions following the findings of that year.
These were to:

- Ensure that those using the service are aware of the different steps in the process, particularly the role of the Strategy meeting and Case Conference.
- Ensure that those using the service are aware that they do have a choice to proceed.

There is some evidence from this year's findings that this action has been successful.

The serious concerns that arose from Winterbourne led to a presentation to Board Members in 2012 by the Head of Learning Disabilities. In December 2012 Andrea Pope-Smith, Director of DACHS, consolidated this learning and gave focus for issues to be identified by the Safeguarding Board, the Health & Well-being Board and the Learning Disability Partnership Board.

The actions required of the board members arising from Winterbourne concerning assessment and treatment, commissioning and safeguarding links, restraints and controls were added to the 2013 business plan within this report.

Priorities for 2013

At an away day in September 2012, the safeguarding Board members indicated that the focus and direction for the Board should be updated to reflect safeguarding national initiatives within its 2013 – 2014 business plan. The following priorities were agreed:

1. Board members to assure the Board that their agencies are partners in safeguarding and understand the safeguarding process and the issues it raises for its workforce and Dudley residents.
2. The experience of victims of abuse influences the work of the Board.
3. Promotion of the adult safeguarding agenda through partnership working.
4. To improve the consistency and quality of inter-agency adult safeguarding practice.

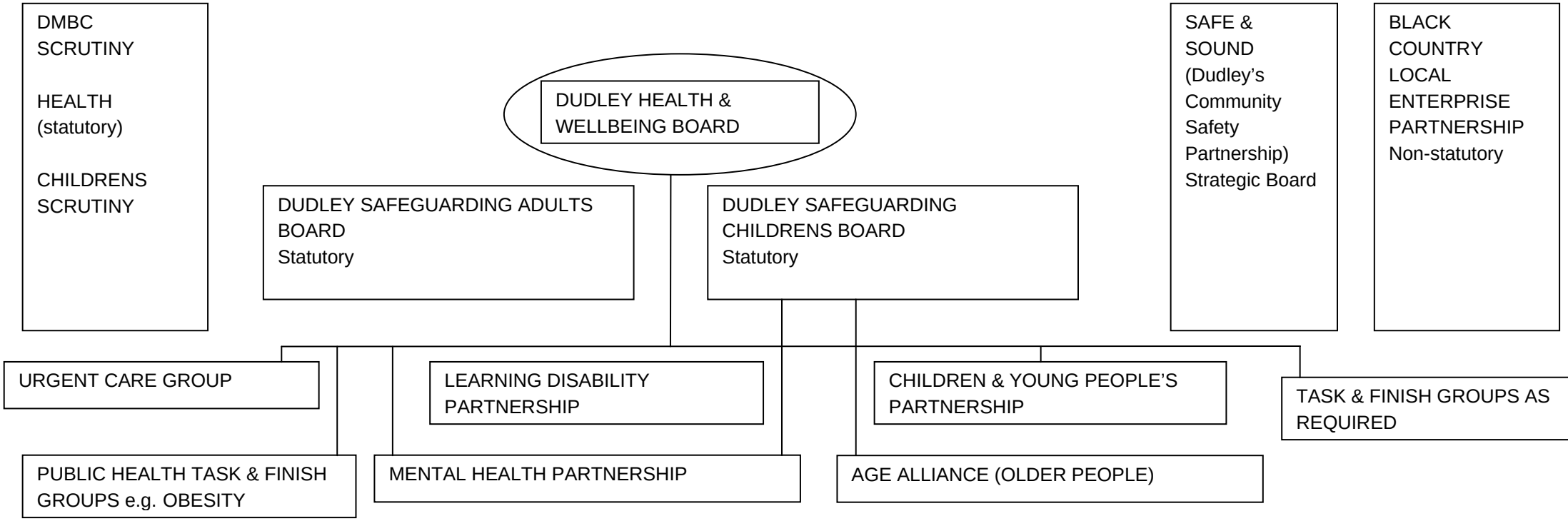
Following the work undertaken in 2012 regarding Winterbourne the business plan has also been updated to reflect the work plan for the Board in 2013 - 2014. The business plan 2013 – 2014 is attached Appendix 2

Appendix 1

Dudley Safeguarding Adults Board – reporting structure

The diagram and table set out reporting arrangements for the Dudley Safeguarding Adults Board. The Board reports once a year to other Boards, Partnerships and Committees. Reporting is based on the Annual report published in May. The table indicates the key contact to whom the reports are sent and the DSAB members, chief officers and other senior managers who will be in attendance.

Reporting and Partnership environment in Dudley:



Reporting Arrangements for Safeguarding Board Annual Report.
Board members take responsibility for reporting back to their own Agencies or other relevant meetings as follows:
All reports will be presented in May /June

MEETING	CONTACT	ATTENDANCE
Health and Wellbeing Board	Aaron Sangian 01384 814757	Brendan Clifford
Health and Social Care Scrutiny Committee	Aaron Sangian 01384 814757	Brendan Clifford
Dudley Community Partnership	Dennis Hodson 01384 814756	Andrea Pope-Smith
Older Peoples Board	Savi Kaur 01384 815806	Brendan Clifford
Learning Disability Board	Savi Kaur 01384 815806	Brendan Clifford
Mental Health Board	Neil Bucktin 01384 32174	Matt Bowsher
Physical Disabilities Board	Savi Kaur 01384 815806	Brendan Clifford
Safe and Sound Partnership Board	Jill Dixson 01384 814735	Anne Harris/Brendan Clifford
Dudley Safeguarding Childrens Board	Suzanne Robinson 01384 814735	Anne Harris
Community Cohesion and Tension Monitoring Executive	Rosina Ottewell 01384 811563	Andrea Pope-Smith
CGG (PCT)	Jane Atkinson 01384 322156	Jane Atkinson
Dudley Group of Hospitals	Denise McMahon 01384 453170	Denise McMahon
Black Country Partnership Trust	Darinka Novak 01384 323065	Darinka Novak
Dudley & Walsall Mental Health PT	Suki Sidhu 01384 324502	Hassan Omar
Dudley LINk (Healthwatch)	Jayne Emery 01384 267410	Jayne Emery
Care Providers Liaison Meeting	Debbie Le Quesne 0845 4566785	Debbie Le Quesne

Appendix 2

Dudley Safeguarding Adult Board
Business Plan 2013-2014

Prepared by: Anne Harris, Head of Adult Safeguarding
on behalf of Dudley Safeguard Adult Board

Dudley
Metropolitan Borough Council

Safeguard & Protect

Business Plan 2013 – 2014

1. PRIORITY ONE:

Board members to assure the Board that their agencies are partners in Safeguarding and understand the safeguard process and the issues it raises for its workforce and Dudley residents.

	Key Actions	Outcomes Sought	Responsible Managers	Timescale	Impact/Outcome Measures
1.1	Each board member to accept and take responsibility for the governance arrangements of the board.	To ensure safeguard issues are disseminated within Partner Agency Organisations.	All Board Members	April 2014	• Partner Agency Report to Board • Multi-Agency Audits • Feedback from Service Users Quality Assurance reports to be submitted to Board annually
1.2	Partners to ensure that information regarding the West Midlands Safeguard procedure is disseminated throughout their agency.	To ensure a consistent response to Adult Safeguarding throughout the borough.	All Board Members	April 2013	• Partner Agency staff awareness of Safeguard Procedures confirmed through supervision, Training outcome • Agency audits of Safeguard cases Agencies to sign up to new procedures at Launch
1.3	Partner Presentations to the Board regarding agency safeguarding initiatives to be organised throughout 2013.	Demonstration of multi-agency commitment to safeguarding Shared Good Practice	All Board Members	April 2014	• Examples of impact of improvements on vulnerable adults well being • Questionnaire to Service Users demonstrates improvements to service Included in meeting planner

1.4	The sub-group remits to be reviewed to ensure multi-agency input to the work of the Board	To improve multi-agency working in the Safeguard Agenda	All Board Members	April 2014	• Work of the sub-group submitted to the board for scrutiny. Remit of each group to be presented to the Board
1.5	Partner agencies to recognise the training requirements of their staff and ensure that staff receive appropriate training commensurate to their post.	Partner Agency staff to develop and maintain skills to deal with safeguard issues, safer recruitment and knowledge of partner agency responses.	All Board Members	April 2014	No of training courses attended by staff presented to the Board.

2. PRIORITY TWO:

The experience of Victims of Abuse influences the work of the Board.

	Key Actions	**Outcomes Sought**	**Responsible Managers**	**Timescale**	**Impact/Outcome Measures**
2.1	Practice learning events and case studies to demonstrate the victim's story to Board members and partner agencies	The Victim's story improves safeguard practice.	Anne Harris Head of Safeguarding	December 2013	• Questionnaire to service users demonstrate improvements • Partner Agency audit outcomes • DACHS audit outcomes
2.2	The Board receives information on serious case reviews at Board meeting throughout 2013	To learn lessons from National serious case reviews to improve practice across partner agencies	Anne Harris Head of Safeguarding	December 2013	• Application of serious case review outcomes demonstrated in Partner Agency Reports to the Board and local initiatives. Research information brought to Board on at least two occasions during 13/14

2.3	Outcomes of interventions of those who have gone through a safeguard incident to be relayed to Board members to ensure that victims are central to the safeguard process	To demonstrate influence of the victims experience on Partner agency practice	All Board Members	April 2014	• Partner agency audits • Feedback from service users to agencies • Questionnaires to victims and their carers carried out throughout the year
2.4	Board Members demonstrate engagement of their agencies with people who use services as part of their safeguard role.	A multi-agency response to safeguarding confirmed	All Board members	December 2013	• Reports to the Safeguard Boards of Partner Agency initiatives included in Meeting Planner • Governance arrangements of Partner Agencies demonstrates Service User engagement

3. PRIORITY Three:

Promotion of the Adult Safeguard Agenda through Partnership working.

	Key Actions	**Outcomes Sought**	**Responsible Managers**	**Timescale**	**Impact/Outcome Measures**
3.1	To demonstrate that links are in place with Children's Services through Safer Recruitment Initiatives and Forced Marriage Training. To learn from inspection outcomes from both services.	Partnership working addressing common themes and issues for both services.	Anne Harris Head of Safeguarding Graham Tilby Head of Children's Safeguarding	April 2014	• Safer recruitment information shared at both Boards • Training for Forced Marriage for both Board members. • Case File Audits • Sharing of serious case review outcomes
3.2	To continue to link with the Community Safety Partnerships with regard to Hate	To promote Hate Crime, Substance misuse and Domestic	Anne Harris Head of Safeguarding	April 2014	• Number of referrals for Domestic Violence. • Case example of

	Crime, Substance misuse and Domestic Abuse.	Abuse within the Safeguard Agenda.	Sue Haywood DAAT Manager		
3.3	Adult Safeguard messages are actively promoted to the public. The Partnerships use their information and publicity strategy to communicate its work.	To ensure that members of the public are aware of the Adult Safeguarding Agenda and aware of Partners.	Marcomms and Work of Policy Implementation Sub-group	September 2013	• Examples of initiatives from partner agencies to raise public awareness. Communications Strategy to Board
3.4	Plans and targets for Safeguarding adults are included in other strategies for Older People who use Mental Health and Learning Disability Services	To ensure that other strategies within Partner Agencies address safeguard concerns	Heads of Services	September 2013	• To promote the Safeguard Agenda within the wider agencies within agencies Other strategies reported to Board

4. PRIORITY FOUR:

To improve consistency and Quality of Inter-Agency Adult Safeguard Practice

	Key Actions	**Outcomes Sought**	**Responsible Managers**	**Timescale**	**Impact/Outcome Measures**
4.1	The Board members to assure themselves that robust quality assurance arrangements and performance management strategies are in place for safeguarding.	Improved Quality of Adult Protection Practice across key partners	All Board members	December 2013	• Partner agency audits reported to the Board. • Questionnaire to service users demonstrate practice improvements.
4.2	Data is collected on the number/quality of referrals/investigations/protection plans and outcomes with interpretation of trends.	Data scrutinised and analysed to inform practice improvements	Anne Harris	December 2013	• Data set analysed by Quality and Performance Sub-Group and trends presented to the board.
4.3	All agencies of the Board to audit recording against current individual agency practice.	Performance Management across partner agencies is	All Board members	December 2013	• Partner Agency Reports to the Board throughout 2013

	standards to ensure the totality of the work with any individual is recorded	Strengthened to ensure that vulnerable adults within Dudley arte managed appropriately.			On meeting planner
4.4	Procedures for the management and collation of repeat referrals/contacts relating to individual vulnerable adults should be developed and implemented.	The outcome of the Winterbourne review demonstrated the importance of analysis of repeat referrals for Safeguard Board.	Anne Harris	September 2013	• Data set developed to look at repeat referrals and significance for Safeguarding Agenda.

Priority Five: Local response to the Winterbourne View Reports

Action plan for the response to Winterbourne View reports in the Dudley Area

	Key Actions	**Outcomes Sought**	**Responsible Managers**	**Timescale**	**Impact/Outcome Measures**
5.01	Formal consideration of Winterbourne View reports	Overview of circumstances and impact on local practices considered	Board Members	Immediate	Impact -Awareness of circumstances Measures -Considered at Away Day (Sept 2012) Presentation by HofS LD Joint seminar with LDPB, health and wellbeing boards, presentation by DACHS Director and workshop
5.02	Agreed protocol for regular reporting to Board on follow up actions	Planned follow-up for relevant actions	Board Members	May 2013	Impact – visible relevant action taken Measures – report to Board on specific areas in May Follow up actions agreed by May and further action timescales to be negotiated by July 2013

	ASSESSEMNT AND TREATMENT				
5.03	Identify patterns of safeguarding issues linked to assessment and treatment units	Key trends identified, response actions agreed	Darinka Novak Debbie Cooper	Aug 2013	Impact – focus on assessment and treatment units Measures – report to Board May 2013. Follow up agreed by Aug 2013
5.04	Involve people with LD and family carers in safeguarding process to consider and address their desired outcomes and concerns	Present involvements identified, improvements outlined and actions agreed	Darinka Novak With Anne Parkes	Aug 2013	Impact – Board aware of present actions and improvements Measures – report to Board May 2013, recommendations considered and actions agreed by Aug 2013
	Key Actions	**Outcomes Sought**	**Responsible Managers**	**Timescale**	**Impact/Outcome Measures**
5.05	Identify trends, and methods to monitor, investigate and respond.	Methods of monitoring, investigating and reviewing proposed and agreed	Darinka Novak Debbie Cooper	Aug 2013	Impact – Board aware of how trends are monitored/investigated. Measures, report to Board in May, recommendations considered and actions agreed by Aug 2013. Review to be provided by Aug 2014.
5.06	Information sharing and response partnership with CQC	Information sharing and response protocol with CQC agreed and published	Anne Harris	Aug 2013	Impact – Board members using of protocol Measure – protocol presented to Board, published on Safeguarding web site, and linked to procedures.

5.07	Assurance of quality and safety of Assessment and Treatment units that take into account the views of the service users, their families, professionals and other visitors.	Present practice identified, considered at Board and actions agreed	Darinka Novak Debbie Cooper	Aug 2013	Impact – partners consider practice of main providers, improvements discussed and actioned Measures – report to Board May 2013, actions agreed and implementation plan brought to Board by Aug 2013.
5.08	Method of identifying competences required and achieved by staff in Treatment and Assessment units	Competencies identified, training recommendations produced, reporting intervals for Board agreed	Darinka Novak Debbie Cooper	Aug 2013	Impact - Board assured on competences of staff Measures – report to Board May 2013, actions agreed and implementation plan produced by Aug 2013
5.09	Available means and resources to follow up concerns about units.	Resources required identified, establish appropriate response protocol	Darinka Novak Debbie Cooper	Aug 2013	Impact – Board aware of follow up processes and providers clear on action required. Measures – report to Board May 2013, protocol agreed by Aug 2013
5.10	Monitoring and responses to issues relating to Learning Disability Services	Identify range of issues applicable to LDS, monitoring and response methods described	Brendan Clifford Anne Harris With Ann Parkes	May 2013	Impact – Partners aware of issues and monitoring. Measure – report to Board in May
	Key Actions	**Outcomes Sought**	**Responsible Managers**	**Timescale**	**Impact/Outcome Measures**
	COMMISSIONING AND SAFEGUARDING				
5.11	Issues from contract monitoring inspections and client reviews collated and linked to safeguarding referrals, patterns reported to	Identify process to link inspections and reviews to safeguarding referrals. Patterns	Anne Harris	May 2013	Impact – assurance on links between commissioning and safeguarding. Continuing

	the Safeguarding Board	to be reported to the Board			reports to board to identify trends Measures – report to Board in May, link to data analysis process
5.12	Commissioners of services for learning disabilities and autism, mental health problems or behaviours described as challenging to assure Board that these are properly monitored	Identify links to commissioning of services and monitoring	Anne Harris	May 2013	Impact – Board aware of monitoring process Measures – report to Board in May, link to data analysis process
5.13	Independent Advocacy providers identify and report key issues/trends in safeguarding to Safeguarding Adults Board	Establish feed back from Advocacy providers	Anne Harris Matt Bowsher	Aug 2013	Impact – adds to review process/information Measures – report to Board in May, link to data analysis process
5.14	Links/accountability of the Board with the Health and Well Being Board	Identify links and reporting processes with Health and Wellbeing Board	Brendan Clifford	May 2013	Impact – Board aware of formal links with health and Wellbeing Board Measure – report to Board in May, added to annual report
	RESTRAINTS AND CONTROLS				
5.15	Methods of restraint being used in local services and how these are recorded and identified in the context of safeguarding referrals. Is this reported to the Safeguarding Board?	Identify methods of restraint in use and recording within safeguarding referrals	Martin Hurcomb	May 2013	Impact – Board aware of methods and to consider reporting protocol Measure – report to Board May 2013
5.16	Is the use of the Mental Health Act and its application in these complex cases monitoring and trends identified and reported to the Board?	Inform Board of use of mental health Act and trends. Board to consider frequency required for feedback	Hassan Omar Darinka Novak	Aug 2013	Impact – Board aware of use of Mental Health Act Measure - report to Board in May, further actions agreed by Aug 2013

	Key Actions	Outcomes Sought	Responsible Managers	Timescale	Impact/Outcome Measures
5.17	Are the Deprivation of Liberty Safeguards being applied appropriately across Learning Disabilities and Mental Health Services, and regularly reported to the Safeguarding Board?	Board regularly updated on DoLS	Anne Harris	May 2013	Impact - Board aware of appropriateness of DoLs applications. Measure – report to Board in May, link to data analysis process.

Appendix 3

Adult Safeguarding Training– March 2013 – March 2014

Course title	**Target Audience**	**Duration**	**Dates**	**Delivery**	**Course aims**	**Competencies** (see separate document)
Abuse Awareness	Everyone	E learning	Availability to be confirmed	In house/ SCIE	Learners become competent and confident in recognising abuse & neglect and in reporting their concerns	1, 2, 3, 4, 5,
Preventing abuse	Care and support workers (new in post)	½ day	Availability to be confirmed	In house	Learners are encouraged to work in ways that reduce the risk of abuse whilst knowing the correct procedure to follow when abuse if identified.	1, 2, 3, 4, 5
Practice Issues	Provider managers	1 day (x3) ½ day (x4)	7/3/13 22/3/13 28/3/13 23/5/13 (am) 24/7/13 (pm) 23/10/13 (pm) 11/12/13 (am)	In house	Learners become competent and confident in dealing with disclosure or concerns of abuse, in accordance with government policy, guidance & legislation and local policy & procedures	1, 2, 3, 4, 5, 6, 7, 8, 10, 11
Managing Safer Services	Provider managers	2 x ½ days (x4)	12/6 & 3/7 (pm) 10/9 & 1/10 (pm) 6/11 & 27/11 (am) 23/1 & 13/2/14	In house	Learners are supported to ensure that the risk of abuse and neglect to the people who use their service is minimised.	1, 2, 3, 4, 5, 6, 7, 8, 10, 11

Course title	Target Audience	Duration	Dates	Delivery	Course aims	Competencies (see separate document)
			(am)			
Who's after your money	Staff working with people who live independently	½ day	14.3.13 (am) 30.4.13 (pm) 19.6.13 (pm) Further dates TBC	In house (with trading standards)	Learners are empowered to help prevent adults at risk from becoming victims of doorstep crime and other scams	2, 3, 4, 5, 6, 8, 10
Practice Learning Events	Social workers and relevant agencies	2 hrs (x4)	26/4/13 (am) Further dates TBC	In house	Further develop their own safeguarding practise as a result of personal& shared reflection and facilitated discussion, in relation to a specific local safeguarding incident which resulted in positive outcomes	5, 6, 7, 8, 10, 13, 14
"Prevent" workshops	Multi-agency staff working with young adults	2 hrs (x4)	20/4/13 (am) 10/6/13 (pm) 6/9/13 (am) 12/11/13 (pm)	Police	Learners will know how to recognise the initial signs of individuals vulnerable to radicalisation as well as those who radicalise. It will provide a better understanding of *Prevent*, reporting procedures and multi-agency counter-terrorism arrangements	2, 5, 8, 10, 13

Course title	Target Audience	Duration	Dates	Delivery	Course aims	Competencies (see separate document)
Safeguarding Adults – Interface with the MCA	Social workers	1 day (x5)	15/3/2013 25/4/13 14/5/13 9/10/13 12/2/14	External consultant	To assist learners in effectively applying the key principles of the Mental Capacity Act within the safeguarding adults process.	5, 7, 8, 10
Safeguarding Adults – Overview of Adult Safeguarding Legislation	Adult Safeguarding Board members	½ day (x1)	7/6/13 (am)	External consultant	For delegates to develop an overview of the legislation, policy & new developments that govern safeguarding adults directives and understanding how they link to safeguarding adults practices	5, 7, 8, 10, 14, 17, 19
Safeguarding Adults – The Law in Relation to Safeguarding Adults (Including the MCA)	Operational Board members, TM's and ATM's	1 day (x1)	11/9/13	External consultant	To further develop delegates knowledge of the legislative and policy framework and apply this knowledge to safeguarding adult practice	5, 7, 8, 10, 15
Safeguarding Adults – The MCA & DoLS for Managing Authorities	Managers of Nursing and residential homes	½ day (x3)	24/4/13 (1.30pm) 10/9/13 (1.30pm) 23/1/14 (1.30pm)	External consultant	For delegates to gain a clear overview of the main aspects of Deprivation of Liberty Safeguards linking it to MCA principles	5, 10

Course title	Target Audience	Duration	Dates	Delivery	Course aims	Competencies (see separate document)
Safeguarding Adults - Investigative Skills	Social workers	1 day (x2)	6/6/13 19/11/13	External consultant	For delegates to have a clear understanding of their roles and responsibilities within the safeguarding adult assessment/interview process. For delegates to fine tune their interview skills in relation to 'Achieving Best Evidence' approaches and interview techniques	6, 8, 9, 11, 12
Impact of Sexual Abuse	Staff working with families affected by sexual abuse	2 days (x4)	18 & 19 4/13 5 & 6 6/13 23 & 24 10/13 26 & 27 10/14	DCSB	Raise awareness of the impact of child sexual abuse upon child victims, adult survivors, non abusive parents and the wider community	2, 5 ,8, 10,
New technologies and child sexual abuse	Staff working with adults who use the internet	1 day (x4)	13/6/13 2/10/13 31/1/14 8/4/14	DCSB	Raise awareness of risk, increase familiarity of behaviours in the "virtual" world and explore the impact.	2, 5, 8, 10
Domestic abuse basic awareness	Staff working with domestic violence	½ day (x4)	11/6/13 12/9/13 9/12/13 27/3/14	DCSB	Awareness of what constitutes domestic abuse & responses to adults experiencing domestic	2, 3, 4, 5, 8, 10

Course title	Target Audience	Duration	Dates	Delivery	Course aims	Competencies (see separate document)
					abuse as well as child protection issues.	
Emotional abuse and neglect	Staff working with victims of emotional abuse & neglect	2 days (x2)	1 & 2 7/13 10 & 11 12/13	DCSB	Awareness of what constitutes emotional abuse & neglect and likely impact on children and parenting capacity	5, 8, 10, 11
Forced Marriage	Staff working with children and young adults	½ day (x3)	8/5/13 20/9/13 11/11/13	DCSB	Awareness of indicators and key warning signs relating to Forced Marriage and Honour Based Violence and how to report concerns	2,5,8,10,13
Parental substance and alcohol misuse	Staff working with parents/carers who have problematic drug/alcohol misuse issues	1 day (x3)	2/5/13 19/9/13 15/1/14	DCSB	Learn about assessment of parental drug/alcohol misuse and thresholds of concern. Explore the impact of problematic drug/alcohol use by parents on their children	2, 5, 8, 10, 13
Working with parents with learning disabilities/difficulties	Staff working with parents with learning disabilities or difficulties	1 day (x4)	22/5/13 21/10/13 17/1/14 13/3/14	DCSB	Identify the support available to parents who has learning disabilities or difficulties	2, 5, 8, 10, 13
Safer Recruitment	Managers and HR staff working in social care	1 day (x5)	29/4/13 4/7/13 22/10/13 22/1/14	DCSB	Awareness of how safer recruitment fits within the context of safeguarding. Positive selection practices	1, 4, 5, 11

Course title	Target Audience	Duration	Dates	Delivery	Course aims	Competencies (see separate document)
			29/4/14		& rejecting unsuitable applicants	

Agenda Item No.9

Health and Well Being Board

Report of the Director of Children's Services

The Annual Report, Business Plan and Work Programme of the Dudley Safeguarding Children's Board

Purpose of Report

1. To present to the Health and Well Being Board the annual report, business plan and work programme of the Dudley Safeguarding Children's Board.

Background

2. Safeguarding and promoting the welfare of children requires effective co-ordination in every local area. For this reason, the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB).
3. The Local Safeguarding Children Board is the key statutory mechanism for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children in that locality and for ensuring the effectiveness of what they do.
4. The core objectives of the Local Safeguarding Children Board are set out in Section 14(1) of the Children Act 2004 as follows:

- To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority
- To ensure the effectiveness of what is done by each such person or body for that purpose
- Protecting children from maltreatment
- Preventing impairment of children's health or development

- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care

- Understanding that role so as to enable those children to have optimum life chances and enter adulthood successfully

5. The scope of Local Safeguarding Children Board's role includes safeguarding and promoting the welfare of children in three broad areas of activity

- Activity that affects all children and aims to identify and prevent maltreatment, or impairment of health or development and ensure children are growing up in circumstances consistent with safe and effective care

- Proactive work that aims to target particular vulnerable groups

- Responsive work to protect children who are suffering or at risk of suffering harm

6. An independent chair of the DSCB (Roger Clayton) has recently been appointed.

The chair is accountable to the Local Authority via the Director of Children's Services for the effectiveness of the work of the Board. The Director of Children's Services will be held to account for the effective working of the Local Safeguarding Children Board by the Chief Executive and challenged where appropriate by the Lead Member

7. Chief Executives are responsible for satisfying themselves that their Director of Children's Services is fulfilling their managerial responsibilities for safeguarding.

8. Lead Members for Children's Services

- Are politically accountable for ensuring that the local authority fulfils its legal responsibilities for safeguarding and promoting the welfare of children and young people

- Provide the political leadership needed for the effective co-ordination of work with other relevant agencies with safeguarding responsibilities

- Should also take steps to assure themselves that effective quality assurance systems for safeguarding are in place and functioning effectively

9. The Lead Member is a 'participating observer' of the Local Safeguarding Children Board

10. Whilst the Dudley Safeguarding Children's Board has a role in co-ordinating and ensuring the effectiveness of local individuals and organisations work to safeguard and promote the welfare of children, it is not accountable for their operational work. Each Board partner retains their own existing lines of accountability for safeguarding and promoting the welfare of children by their services.

11. At the heart of the establishment of Dudley Safeguarding Children's Board is the desire to develop a shared sense of responsibility across all agencies working with children and their families and communities to keep children safe from harm.

12. In order to achieve this Dudley Safeguarding Children's Board recognise the need to develop a more preventative and community-based approach to safeguarding children and young people with a strong emphasis on partnership, integration, information sharing, participation and accountability at all levels.

13. There is now a statutory requirement (through the Apprenticeships, Skills, Children and Learning Act 2009) for Local Safeguarding Children Board's to publish an annual report including achievements and challenges that still remain.

Finance

14. The annual budget for the Board for 2012-13 was £231,179.00, including contributions from partner agencies, which fund the core expenditure and training programme of the board.

Law

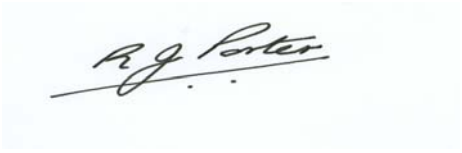
15. The establishment of a Local Safeguarding Children's Board is a statutory requirement under the Children Act 2004, which places a duty on local agencies to work together to safeguard and promote the welfare of children.

Equality Impact

16. The work of the Dudley Safeguarding Children's Board supports parents, families, communities and partner agencies in providing safe homes and environments, security and stability for all children and young people in the Borough. The Dudley Safeguarding Children's Board responds to the needs of vulnerable groups to minimise the incidence of child abuse and neglect to ensure that all children can maximise the opportunity to achieve positive outcomes.

Recommendation

17. That the Health and Well Being Board receive and note this up-date and receive the annual report from Dudley Safeguarding Children's Board in due course.



……

Jane Porter
Acting Director of Children's Services

Contact Officer: Graham Tilby
Telephone: 01384 813158
Email: graham.tilby@dudley.gov.uk

Dudley Safeguarding Children Board

'Working Together to Keep Children & Young People Safe'

Dudley Safeguarding Children Board
C/O Safeguarding & Review Service
Directorate of Children's Services
6 St. James's Road
Dudley
West Midlands
DY1 3JL
01384 813061

This Report has been prepared by Graham Tilby, Head of Safeguarding & Review Service on behalf of the Chair of Dudley Safeguarding Children Board

Dudley Safeguarding Children Board
Working together to keep children and young people safe

Foreword

Welcome to Dudley Safeguarding Children Board's Annual Report for 2012-13. The report aims to reflect the breadth and depth of work that is undertaken by the Board's partner agencies to safeguard and promote the welfare of children and young people in our borough. The breadth of work relates to how we support children, young people and their families at an early stage when difficulties arise right through to how we protect some children who are at risk of harm and in need of safeguarding. The depth is more difficult to portray within a report of this nature, but important nevertheless to acknowledge, as increasingly child protection agencies are working with very complex family needs and forms of abuse that were either not perpetrated or not recognised until recently.

I took over the Chair of Dudley Safeguarding Children Board in November 2011, in an interim capacity, whilst the Board considered options for future chairing arrangements. I have been impressed by the dedication and passion of colleagues across the statutory and voluntary sector, and the commitment they have demonstrated to working in partnership with families and with each other to safeguard and protect children and young people. There is of course always more that we can do to support children and their families, always ways that we can improve the quality and consistency of what agencies do in protecting children from harm. I believe that we are well placed, despite the risks and challenges we face in the public sector, to continue to improve the effectiveness of the help and protection provide to children, young people and their families and the effectiveness of our Local Safeguarding Children Board in co-ordinating our safeguarding responses and arrangements in Dudley.

May I take this opportunity to thank you for your contributions to safeguarding children and young people and I wish our newly appointed Independent Chair, Roger Clayton, every success in this role and my continued support as the Chief Executive Officer of Dudley MBC in fulfilling this ambition.

John Polychronakis
Chief Executive Officer, Dudley MBC
(Chair of Dudley Safeguarding Children Board, November 2011 – June 2013)

Foreword

Contents

INTRODUCTION

Local background and context

Dudley is a large metropolitan urban borough comprising of five distinct townships on the southwest edge of the West Midlands and forms the western part of the Black Country industrial region. The south and west fringes of the borough are relatively affluent but a number of wards close to Dudley town centre are among the most deprived nationally and are identified in Dudley's anti-poverty strategy.

Children and young people constitute 24.5% of the total population with 74,830 children and young people aged 0-19. The birth rate has been falling and the number of children of school age has declined but there is now some growth in primary education. The proportion of children and young people from minority ethnic groups is rising and now represent almost 17% of the school population. More than 52 nationalities are represented in schools in the borough and 10.5% of children and young people do not have English as their first language. The proportion of children and young people entitled to free school meals is 18%.

As at 31st March 2013:

⇒ *3082 children (around 4% of all children and young people) were defined as 'in need' by children's social care,*
⇒ *248 children subject to a child protection plan*
⇒ *730 looked after by the local authority*

During 2012-13:

⇒ *386 children were reported as missing from home to the Police, an average of 32 children per month;*
⇒ *989 children (under 18 years of age) were victims of recorded crime, of which 26 were victims of knife crime and 6 victims of gun crime*
⇒ *40 young people (under the age of 18 years) were charged with drug related offences, 39 of whom were in respect of Class B drugs and 1 young person in relation to Class A drugs*
⇒ *There were 6,653 referrals made to Children's Social Care leading to*
⇒ *Section 47 child protection investigations took place in respect of 625 children and young people*
⇒ *There were 281 child abuse recorded crimes by the police and 90 cases were detected as child abuse related offences*
⇒ *1,516 notifications were made to children's social care involving children living within the household where a domestic abuse incident had taken place*
⇒ *117 child protection medicals were undertaken by a Consultant Paediatrician or other suitably qualified clinician*
⇒ *Enquiries were made by partner agencies to Safeguarding & Review for checks in respect of 779 children and 336 adults*
⇒ *Advice and supported was provided in respect of 170 concerns/allegations concerning people who work with children, of which 80 were taken to a Position of Trust Strategy Meeting*

What is Dudley Safeguarding Children Board (DSCB)?

The Local Safeguarding Children Board (LSCB) is the key statutory mechanism for agreeing how relevant organisations will co-operate and work together to safeguard and promote the welfare of children and young people in Dudley, and for ensuring the effectiveness of what they do.

Safeguarding and promoting the welfare of children is about

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; *and*
- Taking action to enable all children to have the best outcomes

The Board is made up of senior representatives from a range of organisations (see full list of membership – Appendix 1). DSCB is not accountable for operational work, but should hold partners to account on the effectiveness of their safeguarding services for Dudley's children and young people.

The Board has a number of defined functions and responsibilities, which are outlined within statutory guidance known as *'Working Together to Safeguard Children'* and underpinned by the Children Act 2004 and LSCB Regulations 2006.

The Board discharged these functions largely through its sub-groups and task groups (see DSCB Partnership Structure – Appendix 1).

What are DSCB's key objectives?

Since its inception in April 2005, Dudley Safeguarding Children Board has been working to 3 key objectives:

OUR KEY OBJECTIVES:

promoting an understanding that safeguarding is everyone's responsibility
improving the safety and wellbeing of children and young people across all communities
developing safer services and employment practices across all organisations

In order to achieve this Dudley Safeguarding Children Board (DSCB) will work to ensure that:

- *All* children and young people have safe environments to help promote their welfare and well-being
- Action is targeted at *vulnerable groups* such as disabled, children in care; *and*
- *Responses* to children who have been harmed to minimise lifelong impact are co-ordinated and effective

What is the purpose of an Annual Report?

The revised *'Working Together to Safeguard Children'* guidance (2013) requires the Chair of the LSCB to publish an annual report on the effectiveness of child safeguarding in their local area. The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services, identify areas of weakness, the causes of those weaknesses and the action being taken to address them.

This report aims to set out two key elements:

- DSCB's responsibility to **co-ordinate** work to safeguard and promote the welfare of children and young people
- DSCB's responsibility to ensure that local work to safeguard and promote the welfare of children and young people is **effective**

This Annual Report is submitted to the Chief Executive and Leader of Dudley Metropolitan Borough Council, the Local Police and Crime Commissioner and a range of statutory partnerships. It is part of the way that DSCB accounts for its work, celebrates good practice and raises challenge issues for partners to address.

The report is dispersed with a number of 'so what boxes', which aim to describe the difference that the Board is making in terms of safeguarding outcomes for children, young people and their families.

How does DSCB fit with other Partnerships?

DSCB aims to work with, and alongside, a range of statutory and non-statutory partnerships in the knowledge that co-ordinating and maximising the effectiveness of safeguarding and promoting children's wellbeing is best achieved through collaboration, and holding to, or being held to, account.

For example,

⇒ *The work of DSCB contributes to Dudley Children & Young People's Partnership goals of improving the wellbeing of vulnerable children;*

⇒ *DSCB works alongside Dudley Health & Wellbeing Board in aiming to reduce health inequalities that affect children and young people lives;*

⇒ *DSCB works with Dudley Safeguarding Adults Board to promote a 'Think Family' approach to children and young people who live in households where there is parental mental health*

⇒ *DSCB works in tandem with Dudley's Safe & Sound (Community Safety) Partnership to tackle domestic abuse and sexual violence*

What difference did we make?

Members of Dudley Safeguarding Children Board have taken a leadership role in respect of:

Developing new guidance to improve cross-border working in terms of child protection arrangements when children and their families move between local authorities in the West Midlands area

Producing a Self-Assessment Checklist for Local Authority Designated Officers to support their arrangements of the management of allegations/concerns in respect of people in the children's workforce

Producing an LSCB Self-Assessment Checklist in relation to Children & Young People Affected by Gangs

Producing a Child Sexual Exploitation Toolkit to improve awareness of people working with children, and their screening and responses to young people who may be at risk of sexual exploitation

'So What Box' (1)

Members of DSCB therefore provide a wide range of representation on other partnerships to strengthen mutual support and challenge. There is also strong collaboration with a number of regional partnerships and networks such as:

⇒ *West Midlands Regional Safeguarding Network and its sub-groups*

⇒ *West Midlands Strategic Management Board for Multi-Agency Public Protection Arrangements (MAPPA)*

⇒ *West Midlands Network for Designated Lead Dr's and Lead Nurses for Safeguarding*

What do the DSCB sub-groups do?

DSCB has four standing sub-groups:

The work of DSCB is also supported by a number of Task Groups, which often reflect the Board's priorities and objectives. During 2012-13, these were:

The **Vulnerable Children & Young People's Task Group,** overseeing inter-agency responses to child sexual exploitation, child trafficking, children who go missing and private fostering. The Task Group also oversees the work of the ***Young People at Risk of Sexual Exploitation (YPSE) Panel***

The **Quality & Performance Management Group** develops and implements work in respect of quality assurance and performance management on behalf of DSCB. It is also delegated to work on a range of strategic issues such as governance, self-assessment, Section 11 audit, peer review and challenge.

The **Policy, Procedures & Practice Sub-Group** is responsible for keeping Dudley Safeguarding Children Board procedures up-to-date in the light of national, regional and local developments. It also provides support and guidance in respect of single agency procedures.

The **Training & Development Sub-Group** develops and implements the Board's multi-agency training strategy, overseeing the delivery, commissioning and quality assuring of safeguarding training and awareness-raising across the borough

The **Serious Case Review (SCR) Sub-Group** is responsible for advising DSCB in respect of cases that should be considered for an SCR and managing the process. It also oversees other case reviews, monitors action plans, linking closely to the Child Death Overview Panel where appropriate

The **Child Death Overview Panel** is responsible for reviewing all child deaths in the borough and rapid response arrangements in respect of children who die unexpectedly

The **E-Safety Strategy Group,** taking a lead on promoting e-safety across the borough and tackling abuse associated with new technologies

The **Safer Recruitment & Employment Task Group,** promoting safer working practices, safer recruitment and the effective management of allegations against people in the children's workforce

There are a range of thematic safeguarding forums and boards which also contribute to the wider work of DSCB and play a key role in implementing safeguarding developments across and within organisations.

SECTION 1

Co-ordinating work to safeguard and promote the welfare of children and young people

What progress did we make against what we set out to do?

DSCB agreed 3 key priorities for 2012-13. These were:

- To improve the consistency and quality of inter-agency child protection practice
- To provide support and challenge to embed common assessment and deliver early support to vulnerable children, young people and their families; *and*
- To improve inter-agency responses to children & young people at risk, or who have suffered, sexual exploitation or abuse

PRIORITY ONE:
Improve the consistency and quality of inter-agency child protection practice

What did we do?

- *Revised our Quality Assurance Framework*
- *Produced new inter-Agency Child Protection Standards*
- *Published Quality Assurance Overview Report of agency audit outcomes*
- *Secured additional funding to appoint a temporary Quality Assurance Officer*
- *Commissioned and published a Significant Incident Learning Process (SILP) in respect of Child D*
- *Revised Performance Data Set taking account of national framework and regional activity*
- *Produced an evaluation report of the use and impact of Signs of Safety within frontline practice, commissioned additional multi-agency Signs of Safety Training for practitioners and briefed range of frontline managers across key partner agencies*

This work was led by the DSCB Quality & Performance Management Group

PRIORITY TWO:
Provide support and challenge to embed common assessment and early help to vulnerable children and their families

What did we do?

- *Continued to promote use of common assessment across key agencies such as Children's Centres, Health and other partners*
- *Developed Early Help Offer, supported by Locality Teams compromising of social care, Children's Centres and Health as part of Early Help Strategy*
- *Completed a 'Turning the Curve' process to analyse children on the edge of care and develop actions to promote safe reduction of care population*
- *Developed Troubled Families support through a Family Intervention Programme targeted to include children on the edge of care and in need of protection*

PRIORITY THREE:
Improve inter-agency responses to children & young people who are at risk of, or who have been, sexually abused or exploited

What did we do?

- *Contributed to the development and implementation of a West Midlands Regional Strategy to tackle Child Sexual Exploitation*
- *Held a 'CSE in 2012' Conference ahead of the Olympic Games to promote work with hoteliers and other organisations and produced a summary report published in June 2012*
- *Reviewed and implemented changes to our Young People at Risk of Sexual Exploitation (YPSE) Panel arrangements to improve the effectiveness of screening, risk assessment and specialist support*
- *Secured additional investment (10k) for Street Teams to undertake more targeted work with children's social care*
- *Developed a CSE Framework and Directory of Services to support the introduction of a Delivery Plan during 2013-14*
- *Secured short-term funding to support the development of a regional Sexual Assault Referral Centre (SARC)*
- *Undertook self-assessments in respect of national reports and reviews of CSE and trafficking and contributed to the Deputy Children's Commissioner Inquiry*

This work was led by our Vulnerable Children & Young People's Task Group

What difference did we make?

Case Study – Child Sexual Exploitation and the work of Street Teams

Leanne, aged 14 years, has been on Street Teams' *Keep Safe* Programme for a year. Since working with her around concerns about who she was contacting over the internet, Leanne has made changes. She no longer contacts people that she does not know, having understood and accepted the risks inherent with this behaviour. Leanne is now seen on a monthly basis, to help her transition from our specialist input. During this time she will be assisted to build a positive relationship with a youth worker from a more generic youth work agency, who can help her in the next stages of her life, so that change can be maintained.

Caitlin, aged 15, does not enjoy being at home, so stays out late in town. She and her mates like hanging around shopping centres and through doing so they have made friends with another group of people, some of whom are much older. They now meet up on a regular basis and Caitlin often stays at one of their houses to avoid going home, and has sex with them to pay for the favour. Caitlin was moved into foster care as she became violent following her parents enforcing boundaries to keep her safe. Caitlin cannot see how she is being manipulated as she thinks she is making her own choices. Street Teams has carried out intensive work with Caitlin raising her awareness regarding friendships, relationships, going missing, sexual health, personal well-being and decision making. She has now returned home and has re-engaged with education and has no contact with her old friendship group. Street Teams are now continuing to working to support her in police proceedings to give evidence against the offending males.

'So What Box' (2)

Policy, Procedures & Practice

The main activity in respect of new procedures and guidance during 2012-13 came as a result of the Serious Case Review in respect of Child C. This led to new guidance in respect of:

- ⇒ Professional Resolution and Escalation
- ⇒ Protecting Children Living in Highly Resistant Families
- ⇒ Protecting Children who move across Local Authority Borders
- ⇒ Notification of Serious or Significant Safeguarding Incidents
- ⇒ Inter-Agency Case Recording Standards

Further guidance arising from the Serious Case Review in respect of neglect and faltering growth will be published during 2013-14 (see DSCB Work Programme for more information).

Training & Development

Safeguarding training is co-ordinated and overseen by the Training & Development Sub-Group.

How much did we do?

Based on the data reported by partner agencies to DSCB, a total of 8914 safeguarding training places delivered during 2012-13, compared to 8507 the previous year, which represents a increase of just under 5%. Of these, 1741 places were part of the multi-agency training programme (2% increase) and 731 were briefings conducted by DSCB (a 43% increase compared to 2011-12). There was a 25% decline in e-learning, largely as a result of the increased opportunities for face-to-face training available to the education sector.

FIGURE 1: Training per month 2012-13

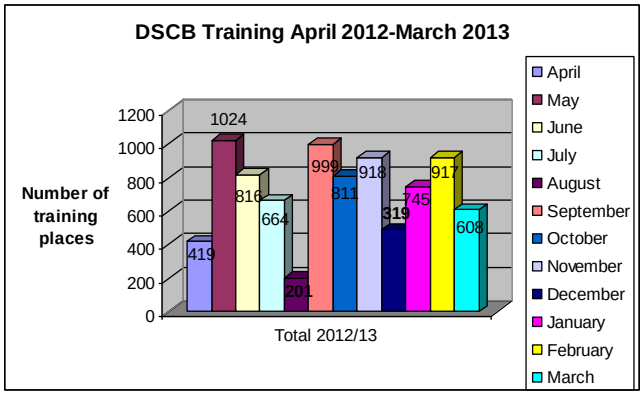
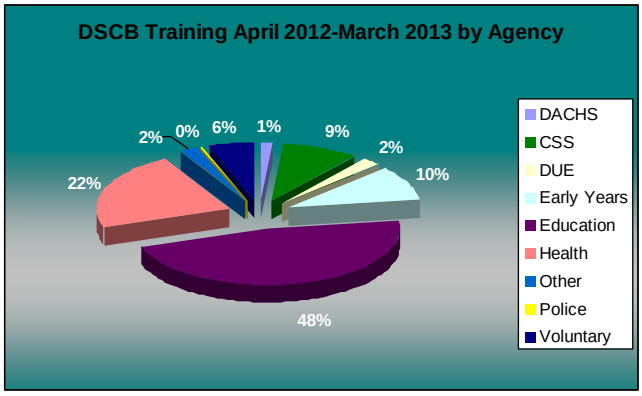


FIGURE 2: Training by Agency 2012-13



During 2012-13, the Board delivered a total 83 days of inter-agency training or briefings across 83 separate sessions, ranging from half-days to two day courses.

How well did we do it?

The overall evaluations of training at the time of course completion are largely very positive. In terms of the % of delegates who stated either 'excellent' or 'very good'.

Usefulness of training in terms of their practice - 92%
Course met the aims & objectives – 93%
Quality of training – 92%

Addressed equality & diversity – 85%
Administrative process – 89%
Venue – 70%

What difference did it make?

DSCB conducts post-course follow-up evaluations (around 3-6 months after the completion of the course) to assess what difference the training has made in respect of safeguarding practice.

A more detailed report in respect of outcomes from safeguarding training will be presented to DSCB in September 2013. Overall, there is strong evidence that safeguarding training contributes to supporting our workforce to

- ⇒ know of the predisposing factors and signs and indicators of abuse and have a clear understanding of what to do if they have concerns about a child's welfare
- ⇒ be able to exercise professional skill in terms of effective information sharing and the ability to analyse this information;
- ⇒ have an understanding of how to collaborate and communicate with other agencies and disciplines in order to safeguard the welfare of children; and
- ⇒ have a basic understanding of the legislative framework and the wider policy context within which they work, as well as familiarity with local policy and procedures.
- ⇒ have a basic understanding of the DSCB Safeguarding Children Procedures and those relating to their own organisation; and
- ⇒ be clear about their roles and responsibilities during assessment, planning, intervention and reviewing processes for children in need, including those requiring safeguarding

Every year, DSCB will conduct a series of inter-agency briefings in respect of various themes, dependent in part on its priorities and taking into account national and regional developments. During 2012-13, there were briefings in respect of:

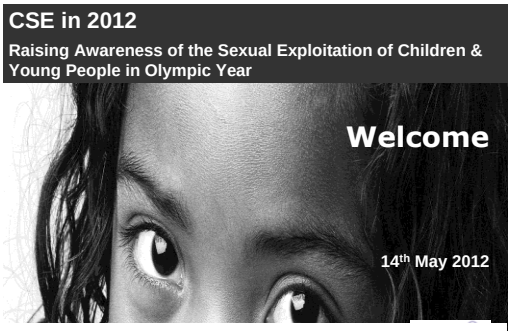
For more information about the DSCB Training Programme (Calendar) go to: *http://safeguardingchildren.dudley.gov.uk/what-is-the-safeguarding-children-board/safeguarding-children-board-sub-committees/training-and-development-subcommittee/*

Communicating and Raising-Awareness

DSCB's Communication Strategy 2011-12 outlines the key ways in which the Board will communicate to various audiences, from professionals and partner agencies to communities and the public.

Special Feature: 'CSE in 2012'

The Conference was held to raise awareness amongst professionals in respect of trafficking and child sexual exploitation and its impact and to leave a legacy in '2012' in respect of safeguarding young people at risk of sexual exploitation.



The Keynote Speaker, Sheila Taylor is the Chair of the National Working Group in respect of Child Sexual Exploitation. The Conference also featured presentations from Children's Society about their work with hoteliers and the campaign 'Say Something if You See Something', and the first performance to a professional audience of the play 'Love Struck', by the Saltmine Theatre Company. It marked the launch of our local awareness-raising campaign entitled "memories last a life time…"

The key messages from the Conference were

- ***we can all do something*** –

  raise public awareness to deter potential traffickers and perpetrators, educate young people as to the potential risks, be vigilant to the signs of sexual exploitation, and be prepared to act…

- *trafficking starts in a community and it will be stopped by the community*
- *we can only prevent and combat CSE by working together – globally, nationally, regionally and locally*

Saltmine Theatre Company

For a copy of the Conference Summary Report go to
http://safeguardingchildren.dudley.gov.uk/download-documents/

The Board's Communication Strategy will be refreshed during 2013-14 to include:

⇒ identification and launch of priorities for public awareness campaigns
⇒ re-modelling and launch of new DSCB website
⇒ establishment of a joint Communications Group with Dudley Safeguarding Adults Board
⇒ re-design of the DSCB SafER Newsletter

The Board will be appointing a Business & Communications Officer in the autumn of 2013 to support this work

Monitoring and evaluation

Safeguarding Inspection

The Board has contributed to monitoring the implementation of action plans arising from the Ofsted and Care Quality Commission Inspection of Safeguarding and Looked After Children arrangements conducted in November-December 2011.

Section 11 Scrutiny Arrangements

Board partners conducted Section 11 audits during 2011-12. During the last 12 months, partner agencies were asked to present a summary of the self-assessments in respect of their duty to safeguard to the Board as part of its scrutiny programme. For more information go to page 33 of this report.

Chairing Arrangements

In November 2011, John Polychronakis, Chief Executive of Dudley MBC took over the chairing of Dudley Safeguarding Children Board as an interim arrangement. After considering a number of options for new chairing arrangements, in July 2012 the Board formally approved plans to commission an Independent Chair, with the preference that this would be a joint arrangement with Dudley Adults Safeguarding Board.

Roger Clayton was appointed as the Independent Chair for both safeguarding Boards in March 2013. The commission commenced in June 2013.

Lay Advisors

As a lay adviser to the DSCB, I have a background in Social Work, with extensive experience in child care/child protection work. The Safeguarding Board is extremely well attended by key personnel from both the public & voluntary sectors. It has been chaired by various senior managers - Assistant Directors of Children's Services, and the Chief Executive of Dudley MBC - until the recent appointment of an Independent Chair.

Members have forged close working relationships and meet on a regular basis in other forums, such as Vulnerable Children's Task Group and YPSE panel .There is evidence of collaborative and purposeful work, including joint training and what is paramount is both the desire and commitment to improving outcomes for children & young people living in the Borough. Nevertheless, this collaborative work does not deter members from challenging attitudes and opinions in a constructive and respectful manner.

There is a clear focus on delivering key messages from research and changes in legislation at Board level, and ensuring they are disseminated to staff at "grass-roots". Therefore, training courses are run on an extremely regular basis which I have been fortunate enough to attend. I have experienced the passion, particularly from staff within the Safeguarding & Review Unit on, for example, topics such as Child Sexual Exploitation, and I have witnessed the effectiveness of this. Prior to the Summer Olympics 2012, training on CSE was delivered to local hoteliers to heighten their awareness. This proved most effective when at least 1 local hotelier contacted the Police when 2 young girls were booked into a room, only to be visited by a group of older men.

The Safeguarding Board has incorporated presentations in its meetings which I believe have been most beneficial. For example, members from key agencies delivered a short synopsis of their work which clarified their roles and responsibilities. Most recently, a comprehensive case study was presented to the Board detailing the potential pitfalls and difficulties of working with an individual highly resistant family. It was a very useful learning exercise for the agencies involved, with appropriate suggestions for improved practice, endorsed by the Board.

Karen Palk, Lay Advisor to DSCB

Quality & Performance Management

The Quality & Performance Management Group takes a lead role on behalf of the Board in overseeing the development and implementation of DSCB's Quality Assurance Framework and monitoring performance in respect of key indicators and measures.

In respect of Quality Assurance, the Board launched new Inter-Agency Child Protection Standards on 1st September 2012 – the document includes:

- ⇒ overarching outcome and quality standards
- ⇒ child protection practice standards

A copy can be downloaded from the DSCB website:
http://safeguardingchildren.dudley.gov.uk/information-for-professionals/safeguarding-children-procedures/part-a/?assetdet549=236293

DSCB has an annual audit programme, details of which can be found within the Board's Business Plan and Work Programme for 2013-15.

During 2012-13, DSCB has been reviewing its Performance Data Set in the light of national, regional and local changes. Although this remains under development, it can be found within Appendix 3 of this report.

Some key headlines in terms of performance are:

DSCB Score Card	
Examples of performance has improved or is good	Examples where performance has declined or is poor
↑ Proportion of Child Protection Review Conferences held within statutory timescale ↑ Reduction in the number of child protection plans lasting two years of more	↓ Proportion of Initial Child Protection Conference that took place within statutory timescale ↓ Proportion of children subject to a child protection plan for a second or subsequent time ↓ Proportion of cases where the lead social worker has seen child or young person in accordance with the Child Protection Plan
Examples where performance has remained largely static	
⇒ % of initial and core assessments carried out within statutory timescale by social care	

Participating in planning and commissioning

The DSCB Annual Report for 2011-12 was presented to a number of other partnerships including:

- ⇒ *Dudley Children & Young People's Partnership – July 2012*
- ⇒ *Dudley Safeguarding Adults Board – July 2012*
- ⇒ *Dudley Safe & Sound Partnership – July 2012*
- ⇒ *Dudley MBCs Children's Services Select Committee – September 2012*

Alongside this report, DSCB receives a number of other themed annual reports in respect of the following:

- ⇒ *Private Fostering arrangements – July 2013*
- ⇒ *the Child Death Overview Panel (CDOP) – due November 2013*
- ⇒ *Local Authority Designated Officer (LADO) for the management of allegations against people who work with children – due September 2013*
- ⇒ *Independent Reviewing Service – due September 2013*

The various sub-groups of the Board also produce a number of strategies and plans, influenced by the priorities. Some examples of this are:

- ⇒ *Training & Development Strategy*
- ⇒ *E-Safety Strategy*
- ⇒ *Child Sexual Exploitation Strategy & Delivery Plan*

For more information please go to the Board's Business Plan & Work Programme for 2013-15.

Serious Case Review, Child Death Overview and Case Reviews

Serious Case Review in respect of Child C

In December 2011, the Chair of DSCB commissioned a Serious Case Review in accordance with statutory guidance following the death of Child C. The purpose of a Serious Case Review (SCR) is to:

- establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children;
- identify clearly what those lessons are, how they will be acted on and what is expected to change as a result; *and*
- as a consequence, improve inter-agency working and better safeguard and promote the welfare of children

Child C died on 3rd December 2011, aged 18 months old. She lived with her mother, older sibling and mother's partner in a flat in Dudley, having moved there in May 2011. Child C and her family were known to a number of statutory services. Child C's life appears to have been characterised by lack of stability, faltering growth from a very early age, and poor physical health. There was a history of domestic and alcohol abuse within the family. At the time of her death, Child C was subject to a Child Protection Plan in Sandwell and a temporary Child Protection Plan in Dudley. The cause of her death remains unascertained, although the Coroner's Inquest considered that hypothermia has been a strong factor in her death.

A total of 21 agencies, mainly from Dudley and Sandwell authorities were involved with the family and submitted an Individual Management Review or Information Report as part of the SCR. A total of 60 recommendations were made by the agencies that contributed to the SCR. In addition, the Health Overview Report made the following recommendations:

Clinical Commissioning Groups:

- advise GPs about the need to be vigilant to identify and act on indicators of neglect and remind staff about the Royal College Guidance about use of centile charts to identify faltering growth.

Every provider of children's health services should:

- ensure their safeguarding training programme included robust information on indicators of neglect and that regular audit is undertaken to ensure learning is effective'
- develop and implement guidance for monitoring weight growth based on UK-WHO guidance
- ensure record keeping policies include a requirement to document the voice of the child, names and relationship of any people who are seen to have a contribution to the lives of children

Dudley and Sandwell LSCBs

- require robust evidence that the above recommendations have been implemented in health providers in their respective areas and that their respective Child Death Overview Panels (CDOPs) advise their public health departments about this case and request that they take public health action related to the detrimental effect on children's health of living in cold conditions.

The full independent Overview report in respect of was published on 23 April 2013. It identified four key learning points - *thresholds including early intervention and cross-border working; disguised compliance; inter-agency working; and faltering growth* – and made a total of 8 recommendations for Dudley and Sandwell LSCB partner agencies. A full copy of the Overview Report and Executive Summary can be downloaded from the DSCB website:
http://safeguardingchildren.dudley.gov.uk/download-documents/

Significant Incident Learning Processes (SILPs)

The Board published a second Significant Incident Learning Processes (SILPs), in respect of Child D in June 2012. The report identified the following key areas of learning:

⇒ *improvements to management of young people with mental health issues within hospital settings*
⇒ *improvements to record keeping and risk assessment within specialist mental health services*
⇒ *improvements to the timeliness of notification to children's services by Youth Offending Services when young people are remanded in secure provision*
⇒ *improvements to communication between School Health Advisors, GPs and Child & Adolescent Services, notably when appointments are missed*
⇒ *improvements to communication between schools and school health advisors*
⇒ *improvements to Strategy Discussions, emphasising the role and engagement of health*
⇒ *Revision of safeguarding procedures in respect of children who display inappropriate sexual behaviour*

The SILP made specific recommendations to the LSCB:

⇒ The LSCB needs to commission a forum comprising CPS, YOS, Police and Children's Social Care to determine:
i. the flow of communication to and from Courts/CPS/ Police/YOS/Children's Social Care on notifications of bail conditions, bail addresses, etc.
ii. in particular, who is responsible for notifying Children's Social Care on the placement of a risky adult and/or young person into a family setting?
In progress

⇒ The LSCB should consider writing to the Lord Chief Justice Department to advise them of the learning in this case and invite them to contribute or consider its implications for the practices of Judges, particularly in respect of decision-making processes within Chambers.
Completed

⇒ For future SILPs the same level of planning and scoping as in Serious Case Reviews, i.e. Terms of Reference and a consistent agency report format.
Implemented

A third SILP was commissioned in February 2013, the independent report from which is due to be presented to DSCB in September 2013.

Child Death Reviews

During 2012-13, the Child Death Review Panel completed 35 reviews of child deaths and assessed 3 of these deaths as having modifiable factors. The issues and learning identified from reviews included:

⇒ the development of a water safety strategy and campaign following the accidental drowning of a young person within a quarry reservoir – launched in summer of 2013;

⇒ improvements to care pathways in respect of the management of asthma, although legal changes to the provision of spare 'inhalers' have led to this issue being identified as a potential risk by the Board;

⇒ improvements to response to faltering growth and the management of children with disabilities who are 'tube-fed'

During 2012-13, there was a reduction in capacity for provision of 24/7 cover by health agencies as part of rapid response arrangements for unexpected child death. This issue was escalated and has led to some improvements, but remains subject to further scrutiny by the Board.

The Annual Report from the Child Death Review Panel is due to be presented to DSCB in November 2013.

Reports from other Sub-Groups and Forums

E-Safety Task Group

The E-Safety Task Group was first established in 2006 to develop and implement an e-safety strategy for Dudley and support partner agencies in embedding e-safety within their work. During 2012-13, the E-Safety Strategy Group supported the co-ordination of Dudley's Anti-Bullying Week in November 2012 and took a lead role in respect of European Safer Internet Day 2013.

Special Feature: Safer Internet Day 2013

Online Reputation, Responsibilities and Risks

How clean is your digital footprint?

The theme for last year's European Safer Internet Day was 'online reputation and responsibilities'. In collaboration with Safe & Sound Partnership, Dudley Safeguarding Children Board facilitated a series of events between 5th and 8th February 2013, attended by over 500 professionals and young people. The events included:

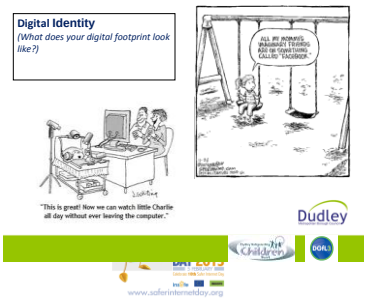
⇒ **Online Reputation: Are you a Responsible Professional?**
350 professionals attended a total of 6 two-hour sessions during the week, exploring people's digital identity and footprint

⇒ **Safer Internet Day Schools Debate**
13 Dudley schools took part in the Schools Debate

⇒ **Safer Internet Day Primary Survey**
330 Dudley primary school pupils ranging from 7-11 years of age completed the Safer Internet Day for 2013.

⇒ **Cyber bullying and e-safety**

A small group of practitioners attended a session with Adrienne Katz, one of the UK's leading experts on bullying and cyber bullying.



'Wot I do online has nuffin 2 do wiv nel else'

Dudley's Safer Internet Day Debate 2013

safe & sound

What difference did we make?

The sessions looked at online **reputation, responsibilities** and **risks.** Delegates were asked a number of questions linked to the aims of the events as part of the evaluation:

- 86% said that were more or much more aware of how they could monitor their digital footprint
- 86% said that their knowledge and understanding of how they could protect their identity online has improved
- 83% said that their knowledge and understanding of policies and guidelines relating to social media/networking has improved

"Make sure my digital footprint is clean"

'So What Box (3)'

The full report can be downloaded from the DSCB website -
http://safeguardingchildren.dudley.gov.uk/download-documents/

Safer Recruitment & Employment Task Group

The work of this Task Group supports one of the key objectives of the Board in 'developing safer services and employment practices across all organisations'. It has three key strands of focus:

- ⇒ developing safer working practices within organisations
- ⇒ promoting safer recruitment and employment practices across organisations
- ⇒ strengthening the management of concerns and allegations in respect of people in the children's workforce

Safer Working Practices

The Board issues a range of inter-agency practice guidance for all people and organisations to support them and their staff and volunteers in their safer working practices. These include:

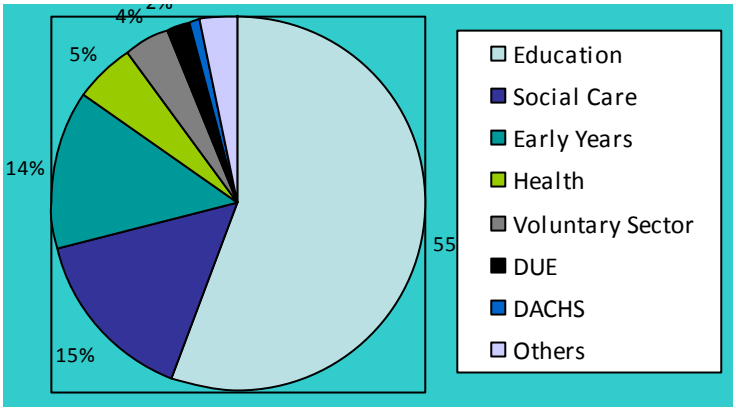
- ⇒ Safer Working Practice guidance
- ⇒ Use of Images guidance
- ⇒ Use of social networking guidance

All of these can be located within Section D of the safeguarding procedures manual

Safer Recruitment

The Board continues to support organisations through the provision of 'Safer Recruitment' training and advice with regards to policies and procedures concerning safer recruitment. For example, during 2012-13, Dudley MBC has made considerable changes to its policies with regards to Disclosure & Barring Checks (formerly Criminal Records Bureau checks).

FIGURE 3: Safer Recruitment Training 2012-13 By Agency



A total of 94 delegates attended the Board's 'Safer Recruitment' training delivered by trainers accredited by the Children's Workforce Development Council. Figure 3 provides a breakdown of the delegates by agency (percentage)

Managing Allegations

The Local Authority Designated Officer (LADO) is responsible for the oversight and management of allegations and concerns with regards to people who work with children. During 2012-13, the LADO service provided advice, support and co-ordination to over 170 concerns or allegations in respect of people who work with children, including chairing 114 'Position of Trust' Complex Strategy Meetings concerning 80 individual members of the workforce, which represents a 30% increase in activity since last year.

Figure 4 shows the employment sector in respect of the 80 individuals who were formally subject to a 'Position of Trust' Strategy Meeting. In comparison to 2011-12, the proportion from education has continued to fall and foster carers has remained relatively the same – the largest increase relates to people from voluntary and faith groups.

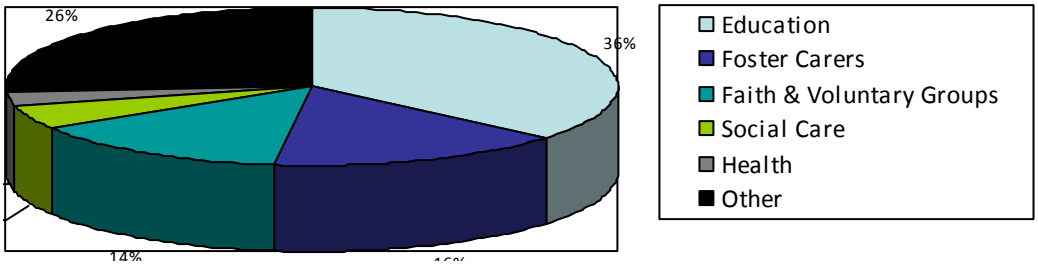


FIGURE 4: % of Positions of Trust Concerns or Allegations (only subject to a Complex Strategy Meeting) by employment sector

NB Other includes people working within leisure/sport and taxi drivers/escorts

Young People at Risk of Sexual Exploitation (YPSE) Panel

Panel Developments

Over the last twelve month period there have many been significant changes made to the way in which the YPSE panel is run:

- ⇒ new Terms of Reference have been introduced;
- ⇒ membership of the panel members has been reviewed to ensure those who are attending are the most appropriate from their service in order that the best possible outcomes for the young people discussed at panel are achieved;
- ⇒ there is now a named social worker on panel which previously had been missing;
- ⇒ there are improved links between Targeted Youth Support (TYS) Panel and YPSE Panel

The YPSE process has changed significantly in order to bring panel in line with other panels across the Black Country. Panel has consistent and much improved input from West Midlands Police with the Detective Inspector from the local Public Protection Unit taking on the role as co- chair.

There has been sign off by all partners in respect of the information sharing protocol. Report templates have recently been introduced for those members attending panel, and who are providing services to the young person/persons. Members are now requested to complete a written update on the young person for each panel meeting.

Referrals to Panel

There have been 40 referrals made to panel in the last 12 month period of which 37 were female and 3 male. All of the referrals have been offered some level of intervention dependent on their risk assessment score. Whilst panel should be concentrating on medium and high risk assessments, low risk assessment cases have been signposted to appropriate services that can meet the needs of that young person. The main agencies providing intervention are; Street Teams, for predominately high level cases and some medium risk cases, Phase Trust works in partnership with Respect Yourself and the two services work with the low and medium risk cases. This allows Street Teams to work more intensively with the higher level cases across the borough.

Missing Children and Young People

Missing Children are a standing item on the YPSE panel. The names of the missing children are shared prior to panel so that each agency can undertake the relevant checks on the young people. A representative from the Youth Offending Service attends panel and will feedback on their return interviews and highlight any actual or potential risks of CSE so that appropriate intervention can be initiated.

Pauline Owens, Designated Lead Nurse for Safeguarding, *Chair of YPSE Panel*

Health Safeguarding Forum

The Health Safeguarding forum is established within the Quality and Safety Committee structure in accordance with Dudley Clinical Commissioning Group's (CCG) constitution, standing orders and scheme of delegation.

During the last 12 months the Forum's main focus has been to monitor health's action plans in response to the last Ofsted and Care Quality Commission (CQC) inspection, whilst maintaining an essential oversight of the wider safeguarding agenda. The forum has a responsibility to ensure that the voice of the child is considered by all health organisations in Dudley and to provide a mechanism for discussion and dissemination of best practice across the health economy in respect of safeguarding children and young people.

The forum will seek assurance from providers that they are compliant with their statutory responsibilities under Section 11 of The Children Act 2004 and their requirements under Section 7 of The Care Quality Commission (CQC) Essential Standards. In order for the forum to achieve this and to effectively provide the necessary assurances the membership has been reviewed to ensure it has safeguarding leads from the CCG, Dudley Group of Hospitals, Dudley and Walsall Mental Health Partnership Trust, the Black Country Partnership Trust and West Midlands Ambulance Service.

Rebecca Bartholomew
Safeguarding Lead – Dudley Clinical Commissioning Group

Substance Misuse Safeguarding Forum

The Substance Misuse Safeguarding Forum was established in November 2010. Initially meeting quarterly the Forum now meets twice per year. The main areas of business for the Forum include:-

- Safeguarding practice issues for professionals working with those misusing substances, taking into account the impact that an individual's substance misuse could have on children, young people, "significant others" and vulnerable adults.
- Policy development, implementation of procedures and polices and quality assurance.

During 2012/13 the work of the Forum focussed on revising the Joint Local Protocol between Adult Drug and Alcohol Treatment Services and Local Safeguarding and Family Services. The Protocol has been approved by both the Safeguarding Children Board and the Safeguarding Adults Board.
This Protocol was held up as an example of good practice during the Ofsted Thematic Inspection in August 2012. The Forum has also:-

- Received feedback in respect of the DSCB Quality Assurance Framework – Audit Activity Report
- Considered the findings from the Ofsted/CQC Report What about the Children?
- Received updates in respect of new and revised procedures in respect of Safeguarding Children and Safeguarding Adults

In 2013/14 the Forum will undertake a piece of qualitative work in respect of the impact of the implementation of the Joint Local Protocol between Adult Drug and Alcohol Treatment Services and Local Safeguarding and Family Services.

Sue Haywood
Acting Head of Community Safety and Substance Misuse
Chair of the Substance Misuse Safeguarding Forum

SECTION 2

Ensuring that local work to safeguard and promote the welfare of children and young people is effective

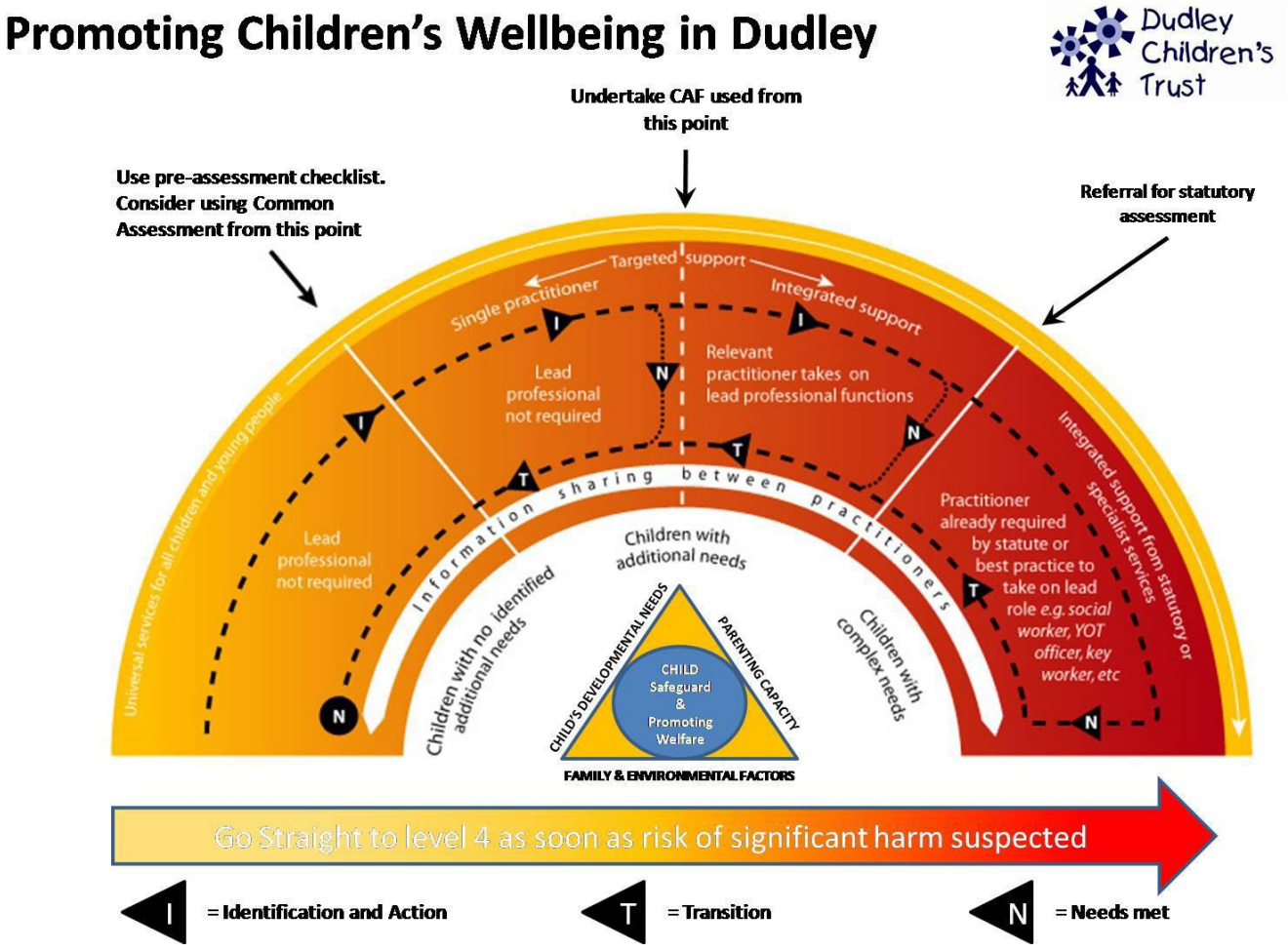
A Continuum of Need

It is essential that organisations working directly with children, young people and their families ensure they receive the 'Right Services, at the Right Time, in the Right Place'. The aim is that as far as possible children's needs should be met within universal provision, but that flexible support should be introduced to meet additional needs with the consent of the child and parents, at the earliest possible stage, thus helping to achieve good outcomes. Our approach is based on encouraging practitioners to:

⇒ Think clearly and achieve a holistic approach

⇒ Understand the child and young person in the context of their family and wider community

⇒ Develop ideas and solutions with children, young people and their families, in order that children and young people can receive timely additional support whenever this is needed.



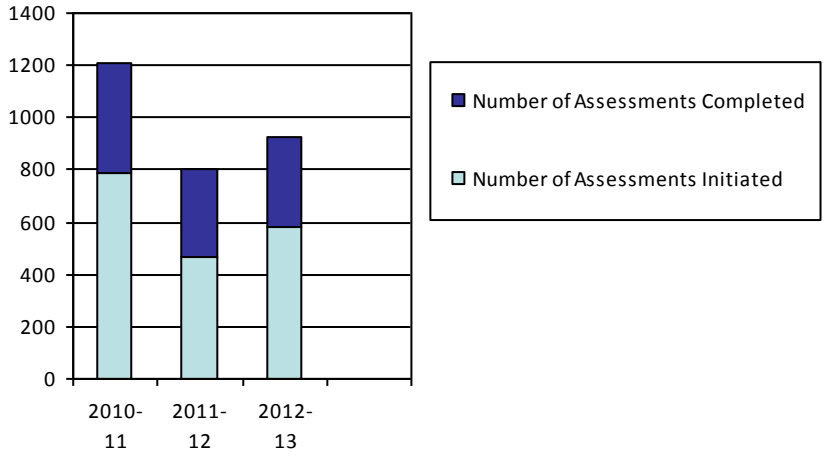
The model describes how the Common Assessment Framework can be used by all services to provide a standard holistic assessment. At Level 3, where needs are more complex, the model describes a multi-agency 'Team Around the Child/Family' approach facilitated by a Lead Professional. Level 4 describes children with acute specialist needs where statutory/specialist assessments are required and the 'Team Around the Child' will need to be led by a statutory/specialist service.

Early Help and Support to Vulnerable Children

In Dudley, if a child or young person is considered to be vulnerable and in need of early support, then it is expected than the professional who identifies this need will initiate a common assessment. This can only be undertaken with the consent of the parents/carers or young person themselves. This may lead to a number of professionals working with the child and family, commonly referred to as a 'team around the child' (TAC) or 'team around the family' (TAF). These arrangements are often formalised into a plan which outlines the help and support being provided to the child and their family.

During 2012-13, 584 common assessments were started of which 345 (59%) were completed – 119 more common assessments were started compared to 2011-12, a rise of just over 25%. The number of assessments being completed amounted to a 7% increase compared to 2010-11.

FIGURE 5: Number of Assessments Initiated and Completed 2010-13



The 3 key agencies completing common assessments are schools, children's centres and health professionals:

⇒ *In 2012-13, 40% were completed by schools, compared to 47.5% the previous year; 24% were completed by children's centres, a rise of 13% compared to 2011-12; and 6% were completed by health professionals, compared to 17% the previous year*

What difference did we make?

Young people, parents/carers and practitioners were asked whether the early help provided as a result of common assessment had made a difference in terms of resulting in 'positive outcomes':

- 93% of children and young people reported yes
- 89% of parents and carers reported yes
- 87% of practitioners reported yes

'So What Box' (4)

Contacts and Referrals to Children's Social Care

The number of contacts with, and referrals made to, children's social care is a measure of the number of children and young people who may be requiring early support and more targeted services, including those children who are in need of protection.

In 2012-13, there were 14,826 contacts, which represents a slight decrease of 1% compared to the previous year in the context of an overall increase of 61% compared to 2007-08. 25% of all contacts with social care come from the police; 13% from education; 13% from a relative/friend and 12% from health agencies.

There were 3,082 open referrals to Children's social care as at 31st March 2013, compared to 2,797 as at 31st March 2012 and 2,593 as at 31st March 2011. There were a total of 6,653 during the whole of 2012-13, which represents a downward trend due to the way in which domestic abuse notifications are initially recorded as contacts (not necessarily referrals)

FIGURE 6: Trend in Contacts between 2007 - 2013

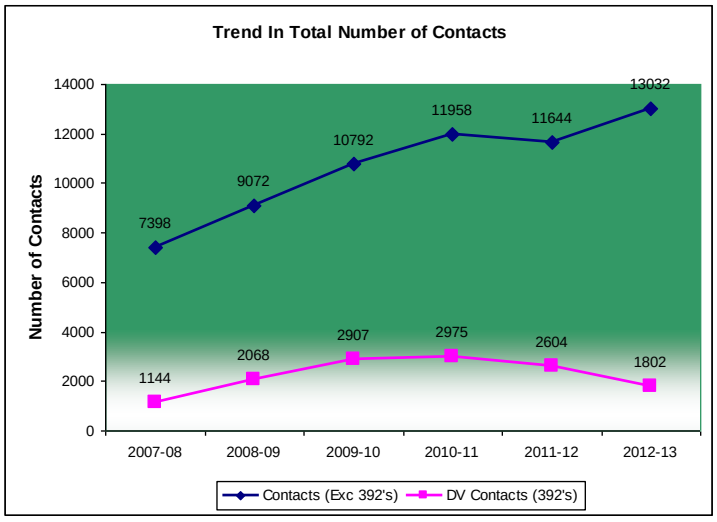
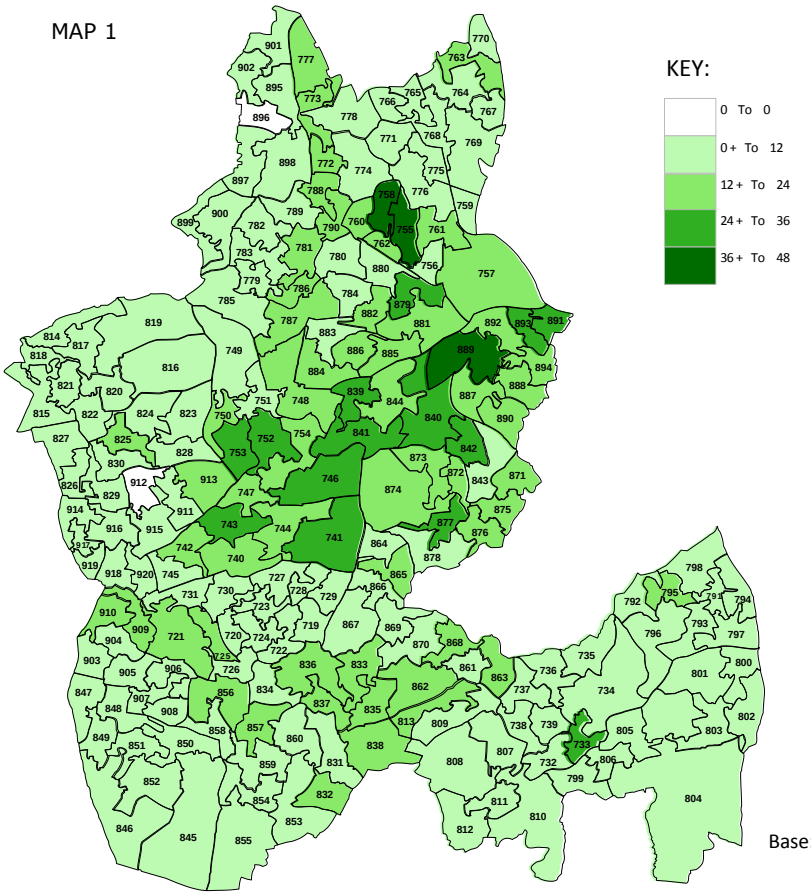


Figure 6 (left) shows the number of contacts to children's social care has been following an increasing trend over the last six years. The overall numbers of contacts (achieved by adding 392 police domestic abuse contacts and non 392 contacts together) have increased from 8402 in the 2006-07 year to 14248 in 2011-12, an increase of 70%.

In respect of Domestic Abuse notifications there were 1,802 notifications involving 1,516 children, a fall of just over 32% from the previous year (notifications). In total since 2008, there have been 12,428 notifications involving 7,656 children. It is likely that more than 33% are 'repeat victims' as more than one notification was received for 2,515 children over the five year period.

Map 1 (below) shows Children In Need supported in their families as at 31st March 2013, grouped by Super Output Areas (which are numbered) and then colour graded according to the levels of concentration in each area. For example, in one of the Halesowen Super Output Area (SOA) labelled '804', there are between 1 and 12 Children In Need as it is shaded in white. In contrast, in SOA area '889' in the centre of Dudley is shaded in the Darkest Green which indicates that between 36 and 48 children in need live in this area.

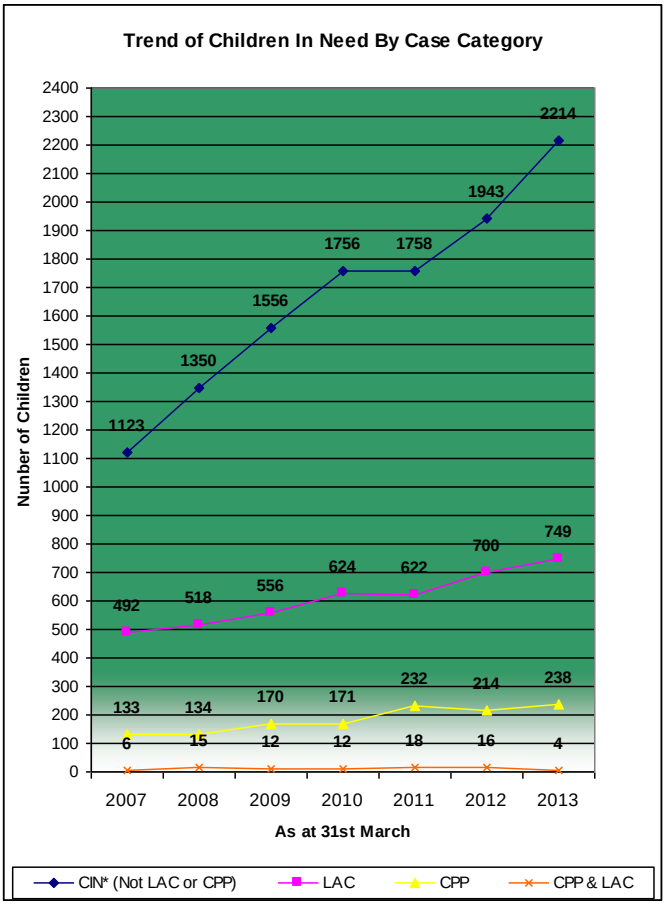
MAP 1



Base: 2,319 children in need (excludes looked after children).

Children in Need

FIGURE 7: Trend o Children in Need by Case Category



In accordance with Section 17 (10) of the Children Act 1989, a child is a 'Child in Need' if:

- ⇒ He/she is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority;
- ⇒ His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services; or
- ⇒ He/she is disabled

Figure 7 (left) shows the numbers of open cases to children's social care as at 31st March 2007-13 by category of case. The blue line shows numbers of children supported at home in their families, the pink line is the number of Looked After Children and the yellow line is the number of Child Protection Plans, all of which have shown a rising trend over the last 7 years.

Children in Need of Protection

Some of the children referred to Children's Social Care, are referred due to concerns about their safety and wellbeing. Where a child is believed to have suffered 'significant harm' or is 'at risk of suffering significant harm', there will be a Strategy Discussion with the Police (under Section 47 of the Children Act 1989). A proportion of these cases will result in the initiation of a Child Protection Conference, whereby a decision will be made as to whether the child remains at risk of suffering significant harm, in which case they will be made subject to an inter-agency child protection plan. For some children, it may be necessary to protect them using emergency powers to secure their immediate safety (police protection powers or emergency protection order by the local authority) or to safeguard and promote their welfare by instigating care proceedings with a view to them becoming looked after by the local authority.

The headlines in respect of child protection data are as follows:

- Of the 6,653 referrals made to Children's Social Care during 2012-13, 454 resulted in a Section 47 child protection investigation. Of these, 37% were referred by education, 23% by the police, and 11% by health agencies. An additional 171 child protection investigations were conducted in respect of children who were already 'open' to social care services
- Of the child abuse investigations undertaken during 2012-13, there were 281 child abuse recorded crimes by the police and 90 cases were detected as child abuse related offences

- There has been a 55% increase in the number of Section 47 Strategy Discussions over the last 5 years – on average, 97% of all strategy discussions during 2012-13 resulted in a child protection investigation

- In 2012-13, just under 39.5% of all S47 Investigations resulted in an Initial Child Protection Conference, compared to 35% the previous year and an average conversion rate of 41.9% over the last 5 years

- There were 182 Initial Child Protection Conferences during 2012-13, 21 'Receiving-In' Conferences and 332 Review Conferences – the total of 354 children were the subject of an Initial Child Protection Conference during the year.

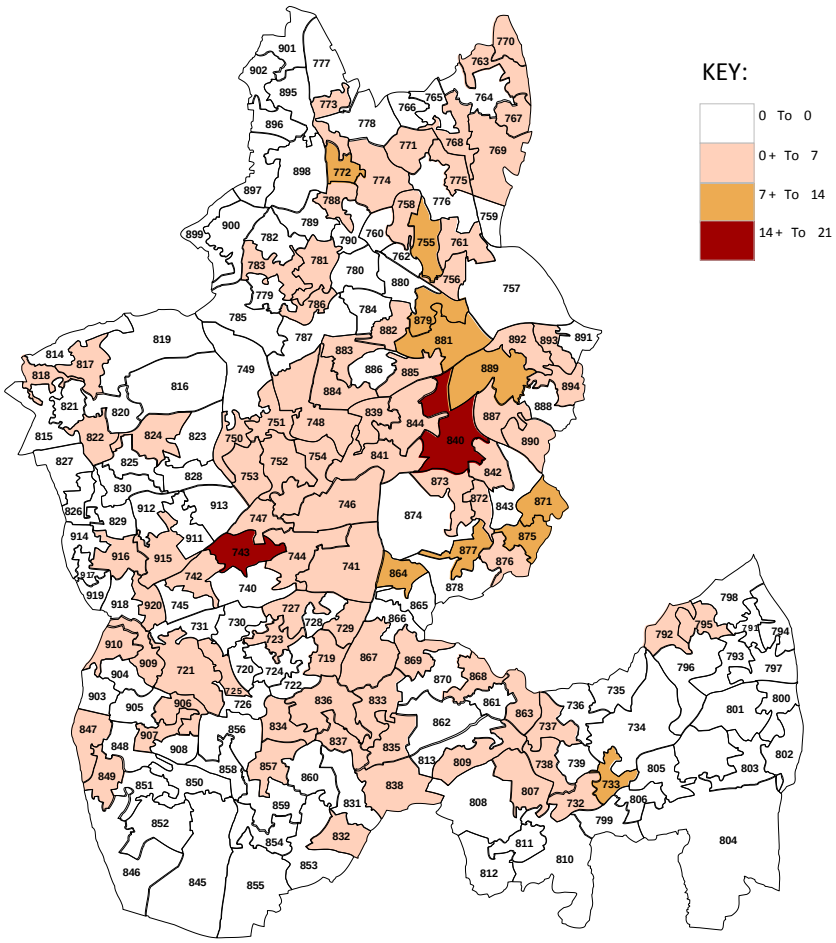
- There were 327 children made subject to a Child Protection Plan during 2012-13, which represents a 18% increase compared to the previous year – on average, 88% of all Initial Child Protection Conferences result in a Child Protection Plan for one or more children;

- Black and minority ethnic communities accounted for 22.3% of child protection plans as at 31/03/2013;

- In 2012-13, 47% of children becoming the subject of a child protection plan were male, 38% were female and 15% were unborn

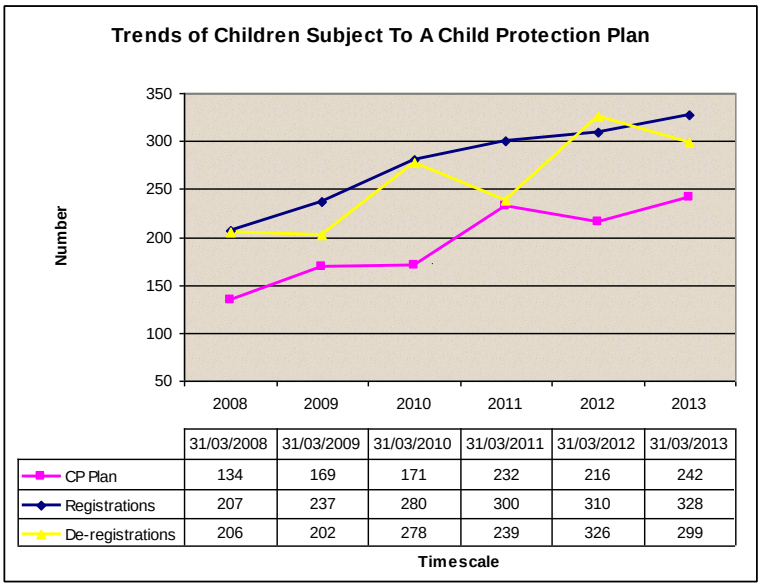
- 47% of all Child Protection Plans in 2012-13 were due to 'Neglect', with 30% due to emotional abuse – there has been a significant fall in the proportion of child protection plans relating to sexual abuse, from 19% in 2007-08 to just 5% in 2012-13 (although the rise in admissions to local authority care may in part explain this decline);

MAP 2



Map 2 (above) shows the number of children who became subject to child protection plans between 1st April 2012 and 31st March 2013 by Super Output Areas. The darker shaded areas indicate where there were higher numbers of child protection plans. The highest numbers within individual SOA's can be seen in St Thomas's Ward (SOA Code 840) and Brierley Hill (SOA 743) where 15 and 16 new Plans respectively began in the year.

FIGURE 8: Trends of Children Subject to a Child Protection Plan

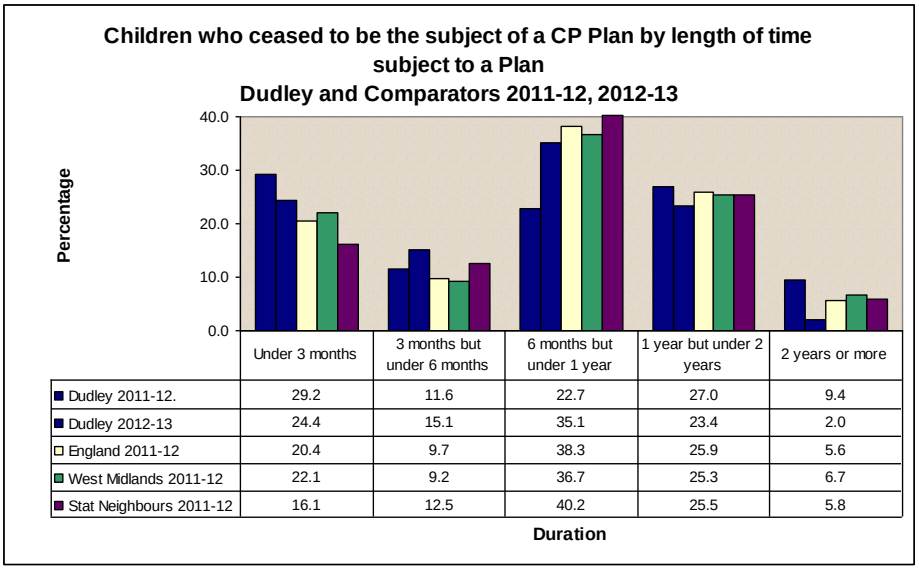


	31/03/2008	31/03/2009	31/03/2010	31/03/2011	31/03/2012	31/03/2013
CP Plan	134	169	171	232	216	242
Registrations	207	237	280	300	310	328
De-registrations	206	202	278	239	326	299

Figure 8 (left) illustrates the 6- year trend in respect of child protection plans @ 31.3, taking into new child protection plans (registrations) and ending of child protection plans (de-registrations) – both of these rates have increased which means that the duration for which children are remaining on a child protection plan is reducing overall.

FIGURE 9: Children ceased to be subject of a CP Plan by duration

Figure 9 (right) illustrates the length of time that children are subject to a child protection plan. The graph also shows that the pattern of duration for children subject to a child protection plan in Dudley during 2012-13 has broadly become more consistent with comparative averages through benchmarking with England, West Midlands and Statistical Neighbours (based on 2011-12 data).



	Under 3 months	3 months but under 6 months	6 months but under 1 year	1 year but under 2 years	2 years or more
Dudley 2011-12.	29.2	11.6	22.7	27.0	9.4
Dudley 2012-13	24.4	15.1	35.1	23.4	2.0
England 2011-12	20.4	9.7	38.3	25.9	5.6
West Midlands 2011-12	22.1	9.2	36.7	25.3	6.7
Stat Neighbours 2011-12	16.1	12.5	40.2	25.5	5.8

FIGURE 10

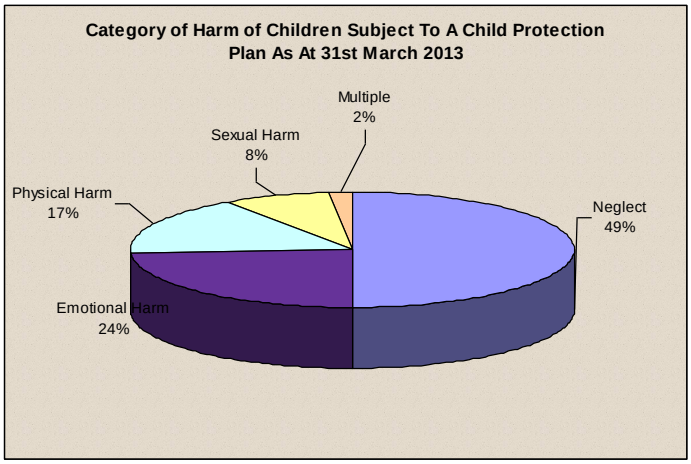


FIGURE 11

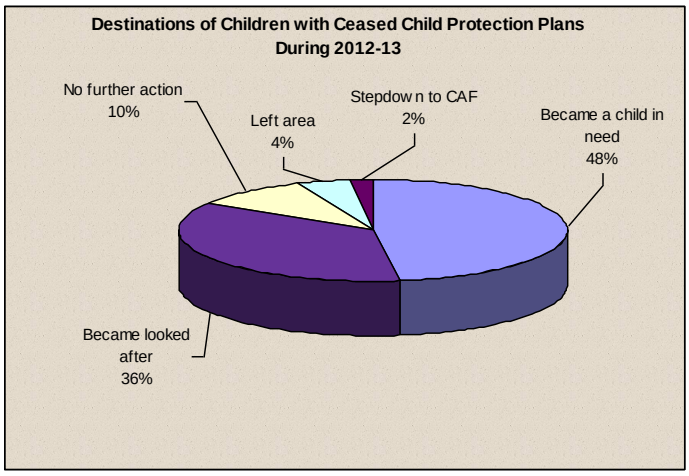


Figure 10 (left) shows the category of harm for all children who were registered on a CP Plan at the end of 2012-13. Of all CP cases, 49% were registered due to neglect only. Almost a quarter of all CP cases (24%) were registered due to emotional harm.

Figure 11 (right) shows the percentage of CP plans which ended during 2012-13 with the recorded outcome. Of all CP Plans that were ceased during the year, 48% continued to be a child in need and 10% ended with no further action. The proportion becoming looked after was 36%, an increase from 22% in 2011-12.

Children who are looked after by the local authority

At 31st March 2013, there were 730 children and young people looked after by Dudley, around 73% of whom came into the care of the local authority as a result of 'abuse or neglect'.

FIGURE 12:

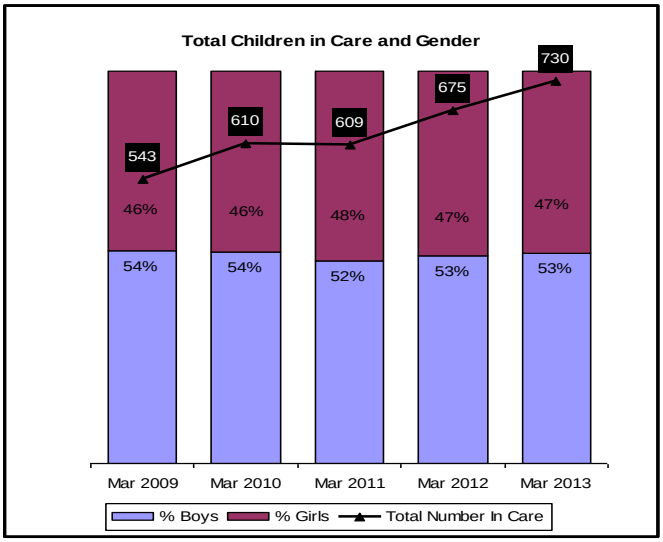


Figure 12 shows the increasing trend in the overall numbers of CIC. Numbers have increased by approximately 43% over a 5-year period from 509 as at March 2008 to 730 as at March 2013 (figures exclude overnight short breaks). Nationally the number of CIC has increased by 12.9% from 59,380 in 2008 to 67,050 in 2012.

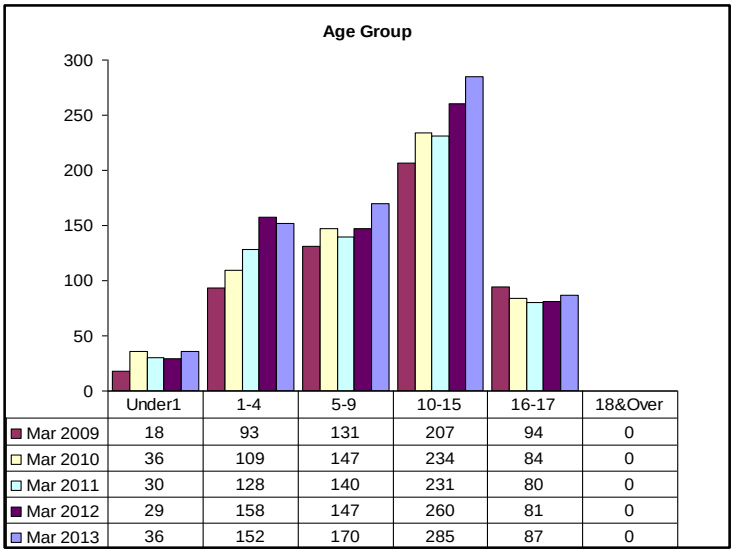
Dudley CIC population is made up of 53% of boys and 47% of girls, as can be seen in Chart 1, and these proportions have altered little over the last 5 years. Nationally[2012] CIC statistics show that 55% of CIC are male and 45% are female.

Age Group[i]

Figure 13 shows the numbers of CIC by age group at the end of each financial year (figures exclude overnight short breaks). The largest group is the 10 to 15 age group which has seen the biggest increase since 2009 of 78 children. The average age of CIC is falling has fallen slightly from 9.8 in 2009 to 9.1 in 2013.

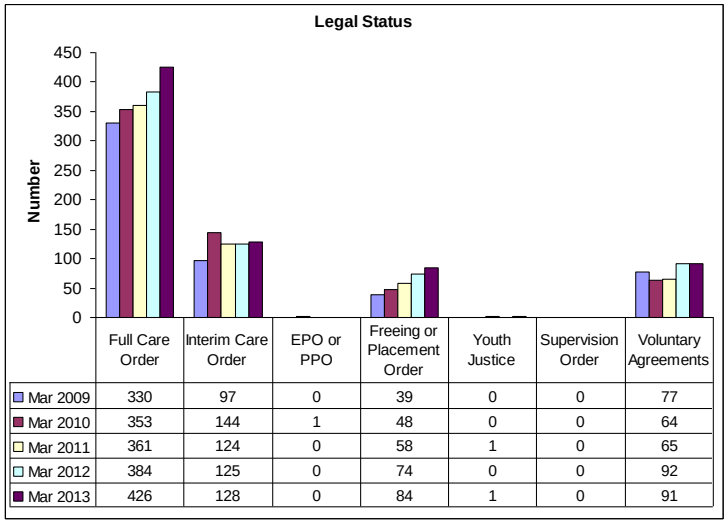
Nationally[2012] CIC statistics show that 6% of children as at the 31st March 2013 were Under 1, 19% aged 1 to 4, 19% aged 5 to 9, 36% aged 10 to 15 and 20% aged 16 and over. Locally 5% were Under 1, 21% aged 1 to 4, 23% aged 5 to 9, 39% aged 10 to 15 and 12% aged 16 and over

FIGURE 13:



	Under1	1-4	5-9	10-15	16-17	18&Over
Mar 2009	18	93	131	207	94	0
Mar 2010	36	109	147	234	84	0
Mar 2011	30	128	140	231	80	0
Mar 2012	29	158	147	260	81	0
Mar 2013	36	152	170	285	87	0

FIGURE 14:



	Full Care Order	Interim Care Order	EPO or PPO	Freeing or Placement Order	Youth Justice	Supervision Order	Voluntary Agreements
Mar 2009	330	97	0	39	0	0	77
Mar 2010	353	144	1	48	0	0	64
Mar 2011	361	124	0	58	1	0	65
Mar 2012	384	125	0	74	0	0	92
Mar 2013	426	128	0	84	1	0	91

Legal Status[ii]

It can been seen in Chart 3 that the largest group is the number of CIC on Full Care Orders which has increased from 330 as at March 2009 to 426 as at March 2013 (figures exclude overnight short breaks). Interim care orders account for 18% (2013) of all legal statuses in Dudley LAC, slightly below the National[2012] figure of 20%. 76% of all Dudley LAC were on a care order (either interim or full) compared with 60% of LAC nationally.

Voluntary Orders make up 12% of the total. National[2012] rates are currently higher at 29%.

Ethnicity

The proportion of children in care from a minority ethnic group has remained largely static over the last 5 years at between 11-15%.

Type of Placements

In respect of placements, in March 2009, 45% of the looked after population was placed with Dudley foster carers – in March 2013, 26% of the looked after population is placed with 'in-house' foster carers. During the same period, the proportion of looked after children placed with independent foster carers has risen from 12% to 31% whilst the proportion of children placed either with their parents or 'family and friends' carers has remained largely static (risen from 27% to 30%).

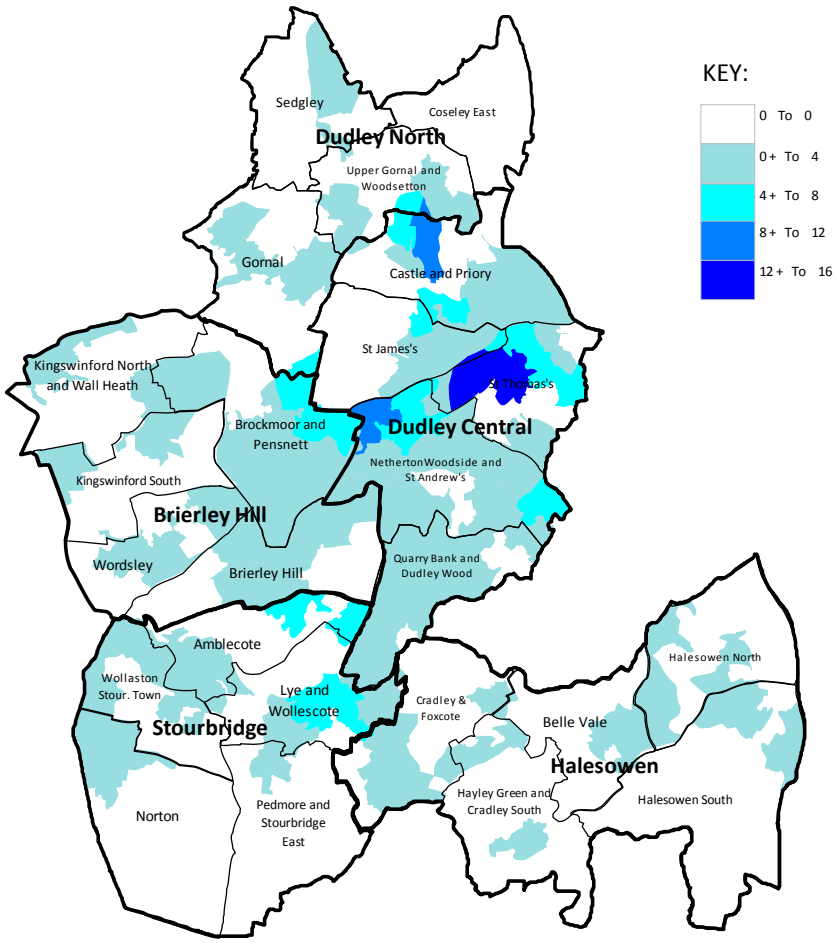
What happened during 2012-13?

During 2012-13, 210 children and young people became looked after by the local authority, 151 (72%) of whom as a result of 'abuse or neglect' compared to 55.5% nationally (2011-12). Of these new admissions:

⇒ 46% were under the age of 4 years and 33% between the ages of 10-15 years – this is broadly in line with national data for 2011-12;

⇒ 58% were previously subject to a child protection plan prior to becoming looked after – of these, 30% had been subject to a child protection plan more than once

MAP 3: Looked After Children by residence



Map 3 (right) shows the children who became looked after in the 12 months to the quarter end and shows where they were living at the time of becoming looked after.

Please note, that for those children who were living outside the area at the time of becoming looked after, the latest postcode where the child had lived during the borough was used. Where addresses were confidential, in a small number of instances, these have been excluded from the data.

The highest proportion of admissions appears to be in Dudley Central, particularly St Thomas's Ward and also in Castle & Priory and Netherton, Woodside & St Andrews Wards.

During 2012-13, 161 children ceased to be looked after, 33% as a result of returning home and 25% due to being adopted or made subject to Special Guardianship (44 young people reached the age of 18 years). The average duration they were looked after was 3.5 years (1277), compared to 2.6 years (933) days in 2009.

Children & Young People who go missing

During 2012-13, the Runaways Team within the Youth Offending Service received a total of 238 reported missing episodes to the police, involving 126 children and young people (between the ages of 8 and 17 years old). These include children who are missing from local authority care or home.

The data presented below has been compared to data collated by the Children's Society during July 2010 – June 2011, in their report to Dudley Safeguarding Children Board on the scale, reasons and risks to young people running away in Dudley.

Of the 126 children,

- ⇒ 65 (52%) were male and 61 (48%) were female – this compares to 39% male and 61% female during the period July 2010 – June 2011;
- ⇒ 50% were aged 15-16 years of age – the average age compared to 2010-11 has increased marginally;
- ⇒ 79% of children were White, 10% Black/Black British and 6% Asian/Asian British – this indicates that children from a minority ethnic background are over-represented in comparison to the wider population
- ⇒ 29% (90 young people) were reported missing to the police on more than 1 occasion, of which 11 young people were reported missing on 4 or more occasions

Of the 238 missing episodes,

- ⇒ 58% (138 young people) were missing for under 24 hours
- ⇒ 15% (35 young people) were missing for up to 48 hours
- ⇒ 8% (19 young people) were missing for between for up to 7 days (in excess of 48 hours) and 5% (13 young people) were missing for over 1 week

The Runaways Team offer each young person a 'return home' interview to establish the 'push and pull factors' and reasons for why the young person was reported missing to the police, with the a view to identifying vulnerabilities and needs and if necessary signposting or referring them on to a range of other services or sharing relevant information with professionals already involved with the child. Some of the children reported missing are at risk of sexual exploitation.

Young People at risk of Sexual Exploitation

During 2012-13, 40 referrals were made to Young People at Risk of Sexual Exploitation (YPSE) Panel of which 37 were female and 3 male. Since the commencement of the YPSE Panel in 2008, over 150 young people have been discussed and assessed by the Panel as being at either as low, medium or high risk. Of the 56 young people referred to Panel between 1st January 2012 – 31st December 2012, 3 were believed to be experiencing child sexual exploitation in a group context, the remainder involved (in accordance with intelligence known at the time) individual perpetrators.

During the last 12 months, the Street Teams Project has worked directly with 47 young people either individually or in a group-work setting. The Project provided an annual report to DSCB in July 2013, further outlining their work and the impact on young people's lives.

For more information about the DSCB's work in respect of child sexual exploitation and children who go missing from home or care, email Jackie.jennings@dudley.gov.uk

Summary Statement of Safeguarding Effectiveness

How safe are children and young people in Dudley?

External Inspections

The last full inspection of safeguarding arrangements in Dudley by Ofsted and the Care Quality Commission was in November 2011 (published in January 2012) – the overall effectiveness of safeguarding was rated as 'adequate' with 'good' capacity for improvement. The report made a total of 13 recommendations to be actioned within 3 or 6 months – Dudley Safeguarding Children Board has contributed to the implementation and monitoring of improvement activity during 2012-13 alongside conducting further self-assessment work in respecting of safeguarding outcomes.

In August 2012, Ofsted and the Care Quality Commission undertook a 3-day thematic inspection of adult services' arrangements for the safeguarding of children where they are parental substance misuse or mental health services. Dudley was one of 10 local authorities to be inspected – the report of the findings from these inspections was published in March 2013. An action plan has been developed in respect of the feedback to address key areas of improvement identified by the inspectors.

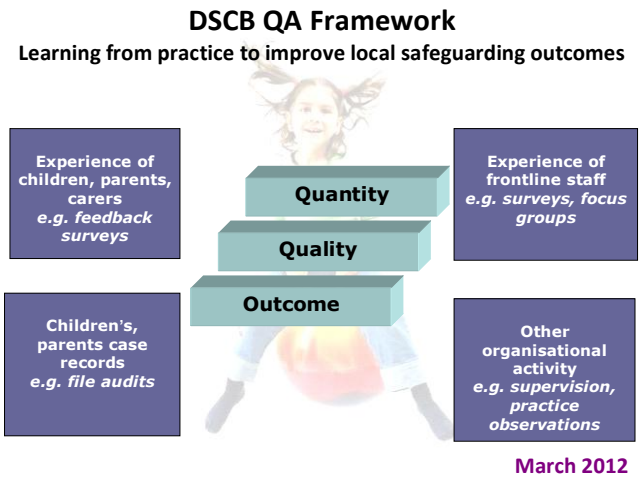
Other regulatory services to be inspected during 2012-13 include:

- ⇒ Early years – *as at 31st March 2013, 84% of Dudley's childcare providers who were inspected by Ofsted were rated as 'Good' or 'Outstanding' with regard to the extent to which children feel safe and with regard to safeguarding practice, policy and the recruitment of suitable people into the workforce.*
- ⇒ Health – *a strategic review of Black Country Partnership Foundation Trust in respect of the 'Health Visiting Offer' identified a number of strengths within the service but identified professional support with regards to safeguarding as an area for further development.*
- ⇒ Children's homes – *all of the local authority's children's homes are rated as 'good' or 'outstanding' during at the end of March 2013. In at least two of the homes, safeguarding children and young people is judged as 'outstanding'*
- ⇒ Youth Offending Services - *took part in a pilot inspection for HMI Probation during June-July 2012 involving inspectors from Probation, Ofsted and Care Quality Commission. In respect of 'protecting the young person' the service was rated as good. The overall inspection was rated us as good*

How well are agencies safeguarding children and young people in Dudley?

Quality Assurance

The main mechanism for self-assessing how safe children and young people are in Dudley is through the application of the Board's Quality Assurance Framework, which was revised in March 2014, with 4 key components (see below).



In September 2012, DSCB published new inter-agency Child Protection Standards to help improve the quality and consistency of child protection practice across key agencies.

In February 2013, DSCB published a report outlining the emergent themes from audit activity across a range of partners, and examples of how organisations has identified lessons and were implementing improvements as a result of their single-agency audit activity.

The report can be downloaded at: http://safeguardingchildren.dudley.gov.uk/quality-and-practice/

DSCB Complaints Procedures

During 2012-13, DSCB held 1 Complaints Panel in respect of appeals concerning the outcomes of child protection conferences. The key issues identified by the Panel were:

The Panel was conducted in accordance with Stage 2 of Section 17 of Dudley Safeguarding Children Procedures (Complaints & Appeals). The Panel consisted of DSCB representatives from Children's Social Care, Dudley Primary Care Trust, West Midlands Police, Early Years and Dudley Council for Voluntary Service and was supported by the Safeguarding & Review Unit. The panel was attended in part by the child's father and paternal grandfather and met with the Independent Reviewing Officer (Chair of the Conference).

The Panel identified a number of opportunities where agencies could have been more proactively engaged in providing earlier support and help to the child either under the auspices of common assessment and team around the child or via a child in need plan. Both of these approaches would have required the co-operation of family members and a lead professional role.

There was some evidence of the need to bring the concerns for the child's welfare to an Initial Child Protection Conference, due to the likely risk of significant harm rather than evidence that he had actually suffered significant harm.

The Panel felt that on balance the Initial Child Protection Conference should have been adjourned by the Chair due to inconsistencies in the information being presented and key professionals not being in attendance, but recognise that the Chair had to weigh this up against not wanting to pose additional risk to the child through undue delay and the need for managing a distressed parent. In the event of the Conference not being adjourned, the panel felt that on balance a Child in Need Plan may have been sufficient to address the issues being identified.

The appeal was therefore upheld, leading to the Child Protection Conference being reconvened.

Section 11 Audits

Section 11 of The Children Act (2004) places a statutory obligation on a number of agencies to safeguard and promote the welfare of children and young people whilst carrying out their normal functions. One of the functions of the LSCB is to monitor the effectiveness of arrangements in a locality to safeguard and promote the welfare of children and young people. This includes monitoring compliance with Section 11 of Children Act 2004 and Section 175 of Education Act 2002.

During 2011-12, key partner agencies undertook an audit of their Section 11 compliance using an online tool provided by Virtual College e-safeguarding children academy. It contains 11 standards:

- Senior management commitment to the importance of safeguarding children (1)
- A clear statement of the agency's responsibilities towards children available to staff (2)
- A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children (3)
- Service development takes account of the need to safeguard and promote welfare (4)
- Service development is informed by the views of children and families (5)
- Individual case decisions are informed by the views of children and families (6)
- Effective inter-agency working enabling information sharing to service users (7)
- Staff training on safeguarding and promoting the welfare of children for all staff working with or in contact with children and families (8)
- Safe recruitment (9)
- Effective inter-agency working to safeguard and promote the welfare of children (10)
- Effective inter-agency working and information sharing in order to ensure safeguarding and promoting children's welfare (11)

A report of organisational performance against Section 11 standards was included within our Annual Report for 2011-12:

Summary

Overall Compliance

- The **average compliance** score against all of the criteria within the standards for all organisations/agencies is **81.8%**

Standards

- The strongest areas of compliance (on average) relate to:
  - Safe recruitment
  - Senior management commitment to the importance of safeguarding children
  - Service development takes account of the need to safeguard and promote welfare
- The weakest areas of compliance (on average) relates to:
  - Service development is informed by the views of children and families
  - Effective inter-agency working and information sharing in order to ensure safeguarding and promoting children's welfare
  - Effective inter-agency working to safeguard and promote the welfare of children

During 2012-13, the Board has been receiving scrutiny reports from each of the key agencies in respect of their strengths and areas for improvement. Each partner agency will be refreshing their Section 11 audit during the first half of 2013-14. Information from these audits will be included in next years Annual Report.

Statement of DSCB Effectiveness

Board Attendance

One of the measures of partner engagement and LSCB effectiveness is attendance at Board meetings and engagement in the sub-structure of the Board. In 2011-12, the Board introduced monitoring and reporting of attendance by partner agencies at the main DSCB meetings – overall average attendance is recorded as 72.7%. During 2012-13, average attendance has marginally declined to 71.7%.

From a total of 22 agencies, 8 partner agencies maintained a 100% attendance record for the last two years; there were 5 partners agencies whose attendance was 25% or below.

Agency	Attendance		Average (both years)
	2011-12	2012-13	
Social Care	100	100	100%
Dudley PCT – CCG from Jan 2013	100	100	100%
DWMHT	100	100	100%
West Mids Fire Service	100	100	100%
DACHS	100	100	100%
Community Safety	100	100	100%
Dudley Children's Trust	100	100	100%
Education Services	100	100	100%
DGOH	100	83.3	92%
Childcare Services Strategy	80	100	90%
Voluntary	80	100	90%
BCPFT	-	83.3	83%
DUE	80	83.3	82%
Youth Offending Service	100	50	75%
Connexions	80	66.6	73%
West Midlands Police	80	50	65%
Probation	40	83.3	62%
Primary Schools	60	50	55%
Colleges	60	33.3	47%
Special Schools	20	50	35%
CAFCASS	20	16.6	18%
Secondary Schools*	0	0	0%
West Midlands Ambulance Service**	0	0	0%

* Head Teacher representative from Secondary Schools Forum in place for 2013-14
** West Midlands Ambulance Service are unable to attend LSCB meetings due to lack of organisational capacity

LSCB Self-Assessment

DSCB conducted a self-assessment of its own effectiveness using the Ofsted Good Practice Checklist (published in September 2011). A summary of the Board's self-assessment against the 5 key areas is outlined below:

Good Practice Area	**Self-Assessment**	
	2012	2013
Governance arrangements	Satisfactory	Satisfactory
Partnership working	Good	Good
Engagement with children and young people	Satisfactory	Satisfactory
Business planning and relationship with Children's Trust/Partnership	Satisfactory	Satisfactory
Quality Assurance	Poor	Satisfactory

LSCB Support & Challenge

DSCB has a key role in supporting agencies in respect of their safeguarding arrangements, largely through the provision of services provided by Safeguarding & Review. There are occasions when the Board, usually via the Head of Safeguarding or Chair, are required to challenge agencies where it is considered that safeguarding issues are not being sufficiently addressed, either in respect of an individual child or at a more strategic level.

During 2012-13, largely as a direct consequence of the Serious Case Review in respect of Child C, the Board developed and disseminated new guidance in respect of professional resolution and escalation. During 2013-14, a formal Register of Challenge will be introduced by DSCB and examples of how this guidance has been formally used will be included in next year's annual report.

Acknowledgments

The Board wishes to thank the following colleagues for 'stepping-up' to chair and lead work on behalf of DSCB:

Pauline Sharratt
Christine Ballinger
Pauline Owens
Jackie Jennings
Sue Haywood
Rebecca Bartholomew
Rachael Doyle
Ian McGuff

The Board also wishes to thank the administrative staff who provide support through co-ordination and minuting of meetings:

Sue Robinson
Helen Pryor-Andrews
Helen Fowler
Heidi Williams
Vivien Vasey

Finally, thank you to everyone who has contributed to improving the safety and wellbeing of children and young people in our borough

SECTION 3

Looking Ahead: Key Challenges and Priorities

The final section of the DSCB Annual Report outlines some of the key challenges, risks and priorities for DSCB looking ahead to the next 12 months and beyond.

Key risks and challenges

There are a number of risks and challenges that will require action to mitigate against and minimise. Some of these risks are more specific to partner agencies, others to the work of the Board:

Safeguarding Risks and Challenges:

- capacity of front-line services to respond to increasing demand and complexity of child protection work, notably at a time of recession with the impact of poverty increasing pressures within some families and cuts within public sector services on the provision of early intervention and some areas of more specialist assessment and intervention;
- the continued impact on frontline practice of continued national and regional organisational change and reform within health and police;
- the impact of the Family Justice Review in terms of capacity to adhere to timescales and additional requirements with family court proceedings, particularly in view of the increasing complexity of the circumstances of some children who are subject to care proceedings;
- lack of consistency in respect of child protection planning and review evidenced through quality assurance activity and case reviews
- potential for increased risks to children who suffer from asthma as a result of legal changes with regards to the provision of emergency inhalers

Board Risks and Challenges:

- capacity to deliver key priorities and improvements identified within business plan and work programme
- the loss of 24 hour rapid response cover within health for unexpected child deaths
- the lack of timely distribution of child protection conference minutes

A formal Risk Register will be introduced by the Board during 2013-14

The Board appointed an Independent Chair in June 2013. Roger Clayton's initial priorities are to:

⇒ review and set a work programme for improving LSCB communications, including the development of the website in-conjunction with Dudley Safeguarding Adults Board

⇒ review and set a work programme to improve the engagement and participation of children and young people with the LSCB

⇒ review and set a work programme to improve partnership engagement and leadership across the Board structure

Key Priorities for 2013-15

The key priorities for 2013-15 are:

PRIORITY 1

Improve the protection of children from abuse and neglect, through more effective inter-agency working and consistent approaches to minimising risk and strengthening resilience within families

PRIORITY 2

Improve the effectiveness of early help and intervention for children and young people who are vulnerable

PRIORITY 3

Strengthen the effectiveness of support and challenge provided by partners of the Board to improve safeguarding outcomes for children, young people and their families

PRIORITY 4

Improve inter-agency responses to young people who are at risk of, or who have suffered, sexual abuse or exploitation

PRIORITY 5

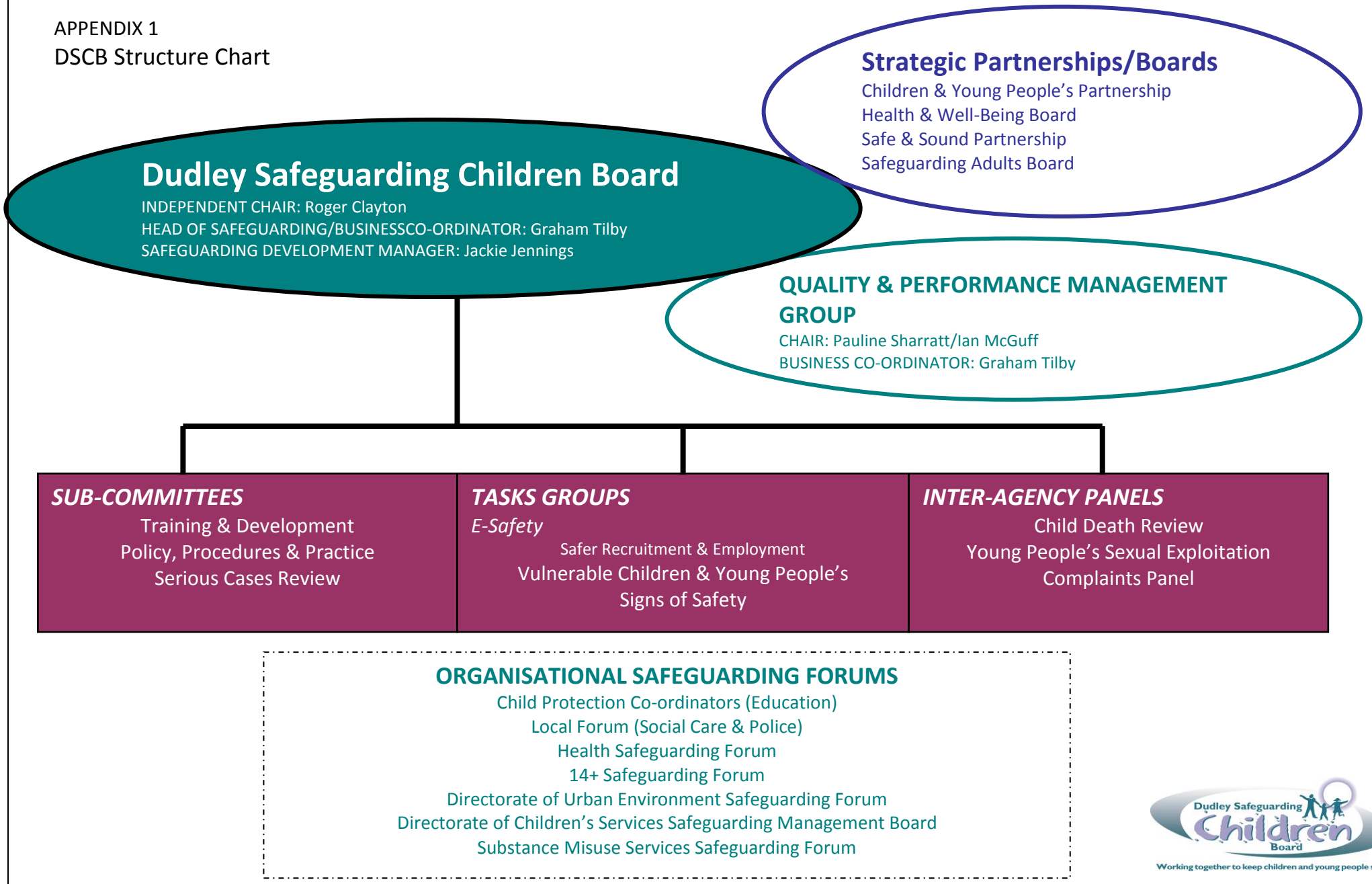
Improve the safeguarding and protection of children and young people who are living in households where there is domestic abuse, parental mental health and parental substance misuse

For further information go to the DSCB website and download the Board's Business Plan and Work Programme for 2013-15 or contact graham.tilby@dudley.gov.uk

APPENDICES

APPENDIX 1

DSCB Structure Chart



Dudley Safeguarding Children Board

Working together to keep children and young people safe

APPENDIX 2

DSCB Budget 2012-13

INCOME – Core Budget	**AMOUNT**		**EXPENDITURE – Core Costs**	
AGENCY/SOURCE				
Directorate of Children's Services	123,700.00		Salaries	131, 595.54
Clinical Commissioning Group	57,700.00		Travel Expenses	1, 591.82
West Midlands Police	5,575.00		Street Teams Project	10,000.00
Income Carried Forward*	18,829.00		Serious Case Review	11,450.70
TOTAL	**203,804.00**		Support for Runaways Service***	-
INCOME – Training Budget			General Office Costs	13,590.55
AGENCY/SOURCE			Prevention/Communication****	-
Dudley Group Hospitals NHS Trust	4,000.00		LADO Software	2,450.00
Black Country Partnership Foundation NHS Trust**	-		Virtual College – Section 11	3,000.00
Dudley & Walsall Mental Health NHS Trust	-		Independent Chair	2,857.75
West Midlands Police	3,000.00		Web Application Maintenance & Support	550.00
West Midlands & Staffordshire Probation Trust	3,000.00		**TOTAL**	**177, 085.66**
Cafcass	550.00			
FE Colleges	1,000.00		**EXPENDITURE – Training Costs**	
Schools	3,900.00		Virtual College E-learning	3,500.00
Training Courses - Internal	5,670.00		Trainers & Training Materials	10,291.03
Training Courses - External	6,255.00		Room Hire & Catering	2,459.24
TOTAL	**27,375.00**		**TOTAL**	**16,250.27**
TOTAL INCOME	**231,179.00**		**TOTAL EXPENDITURE**	**193, 336.93**

***** Income carried forward to contribute to the appointment of a 12 months Quality Assurance Officer

** 4,000 contribution agreed for 2013-14

*** 2,000 rolled-forward to 2013-14 to contribute to service review of young runaways (children who go missing from home or care)

**** 5,000 budget set for Prevention and Communication Work during 2013-14

APPENDIX 3

Dudley Safeguarding Children Board Membership

Names in italics are no longer members of DSCB

Name	Role	Agency
John Polychronakis	*Chief Executive Officer(Chair from November 2011)**	Dudley MBC
Pauline Sharratt	Assistant Director – Children & Families	Directorate of Children's Services, Dudley MBC
Jane Porter	Director of Children's Services	Directorate of Children's Services, Dudley MBC
Ian McGuff	Assistant Director – Quality & Partnership	Directorate of Children's Services, Dudley MBC
Christine Ballinger	Divisional Lead – Social Work	Children's Social Care, Directorate of Children's Services, Dudley MBC
Graham Tilby	Divisional Lead - Safeguarding & Review **	Quality & Partnership, Directorate of Children's Services, Dudley MBC
Jackie Jennings	Safeguarding Development Manager	Safeguarding & Review, Directorate of Children's Services, Dudley MBC
Christine Russell	Divisional Lead – Family Support	Directorate of Children's Services, Dudley MBC
Donna Farnell	Child Care and Quality Manager	Early Years, Directorate of Children's Services
Pauline Owens	Designated Lead Nurse for Safeguarding	Dudley Clinical Commissioning Group (CCG)
Rebecca Bartholomew	Director of Nursing (Safeguarding Lead)	Dudley CCG
Jayne Clarke	Safeguarding Lead Nurse	Black Country Partnership Foundation Trust
Yvonne O'Connor	Deputy Director of Nursing	Dudley Group of Hospitals NHS Foundation Trust
Dr. Zala Ibrahim	Consultant Paediatrician (Designated Dr for Safeguarding)	Dudley Group of Hospitals NHS Foundation Trust
Adrian McNulty	Head of Dudley Probation	Staffordshire & West Midlands Probation Service
Anna Dodd	Divisional Director – Children, Young Peoples & Families	Black Country Partnership Foundation Trust
Sue Marshall	Director for Children, Young People & Families	Black Country Partnership Foundation Trust
Anne Boden	Domestic Abuse Co-ordinator	Community Safety Team, Dudley MBC
Sue Haywood	Assistant Head of Community Safety	Community Safety/DAAT, Dudley MBC
Anne Harris	Head of Safeguarding (Adults)	Directorate of Adults, Community & Housing Services, Dudley MBC
DCI Jane Parry	Detective Chief Inspector	Public Protection Unit, West Midlands Police
Chris Wood	Station Commander	West Midlands Fire Service
Julie Winpenny	Partnership Officer	West Midlands Fire Service
Jo Hartill	Head Teacher	Mount Pleasant Primary School (Primary Schools Forum Representative)
Helen Johnson	Head Teacher	Quarry Bank Primary School (Primary Schools Forum representative)
Judi Kings	Head Teacher	Halesbury Special School Special Schools Forum
Michelle King	Head Teacher	Castle High School (Secondary Schools Forum Representative)
Gill Coldicott	Assistant Principal – Student Support Services, Recruitment and Safeguarding	FE Colleges
Rosie Musson	Head of Governance and Partnership	Dudley & Walsall Mental Health Trust
Helen Ellis	Divisional Lead – Targeted Youth Support	Connexions Service, Dudley MBC
Helen Hipkiss	*Programme Consultant – Children's Services*	*Strategic Health Authority*

Jayne Sargeant	Manager	The Phase Trust, Children, Young People's & Families Voluntary Sector Forum
Nicki Burrows	Children, Young People & Families Development Officer	Dudley Council for Voluntary Service
Karen Palk	Lay Member	Lay Advisor
Mike Galikowski	Service Manager	Youth Offending Services, Dudley MBC
Rachael Doyle	Principal Sport & Psychical Activity Manager	Directorate of Urban Environment, Dudley MBC
Mike Wood	Children's Trust	Dudley Children & Young People's Partnership
Richard Clark	Principal Solicitor (Legal Advisor)	Legal Services, Dudley MBC
Heidi Crampton	Service Manager	CAFCASS
Cllr Tim Crumpton	Lead Member for Children's Services (Participant Advisor)	Cabinet Member – Children's Services, Dudley MBC

* Roger Clayton was appointed as Independent Chair of DSCB in April 2013 – the commissioned arrangement commenced in July 2013

** Business Co-ordinator to DSCB

APPENDIX 4

Summary of Child Protection Data

TABLE 1

	2008-09	2009-10	2010-11	2011-12	2012-13	5 year average
Strategy Discussion						
Number of children subject to Strategy Discussions	604	705	812	809	935	773
Number Requiring S.47 Investigation	560	686	779	797	887	742
% Requiring S.47 Investigation	92.7%	97.3%	95.9%	98.5%	94.9%	96.0%
Section 47 Investigation						
Number of Section 47 Investigation	546	659	785	783	879	730
Number Requiring Initial Case Conference*	286	263	362	273	347	306
% Requiring Initial Case Conference	52.4%	39.9%	46.1%	34.9%	39.5%	41.9%
Initial Case Conference						
Number of Initial Case Conference*	262	311	360	312	354	320
Number Subject to Child Protection Plan	217	267	295	277	328	277
% Subject to Child Protection Plan	82.8%	85.9%	81.9%	88.8%	92.7%	86.6%
Child Protection Plan						
Number of Child Protection Plans	169	171	232	216	242	206
New Child Protection Plans	237	280	300	310	328	291
Ceased Child Protection Plans	202	278	239	326	299	269
CPP Category of Harm						
Neglect	91	86	92	95	121	97
Physical	28	31	44	27	40	34
Sexual	8	18	15	14	19	15
Emotional	35	34	64	66	58	51
Multiple	7	2	17	14	4	9
Total	169	171	232	216	242	206
Review Case Conferences						
Number of Review Case Conferences	471	604	603	710	676	613

TABLE 2

	Dudley			West Midlands		Statistical Neighbours		England	
	2010-11	2011-12	2012-13	2010-11	2011-12	2010-11	2011-12	2010-11	2011-12
Referrals during the year, rate per 10,000 children	555	419	444	622	570	581	590	557	533
Conversion rates from Referral to Initial Assessment	58%	82%	77%	65%	72%	87%	85%	72%	75%
Initial Assessments, rate per 10,000 children	322	354	342	405	408	503	499	398	398
New CP Plans, rate per 10,000 children	46	47	46	45	50	56	58	44	46
Repeat CP Plans, rate per 10,000 children	13%	14%	19	14%	15%	13%	13%	13%	14%
Ended plans in year, rate per 10,000 children	36	50	36	45	48	54	58	41	46

APPENDIX 5

DSCB Performance Data Set 2012-13

Risk Indicators								
A number of risk indicators are under development and will be in place for monitoring during 2013-13								
Child Protection Activity								
Measure	2010/11	2011/12	2012/13	Status	Target 12/13	Target 13/14	Lead	Commentary
Percentage of referrals to children's social care going on to initial assessment NI 68	52.2%	81.7%	70.5%	↓	N/A	TBC	Social Care	The 2011-12 figure showed an increase in performance on the previous year, with 81.7% referrals going on to IA. Provisional results for 2012-13 = 70.5%. The Eng average performance 2011-12 was 74.6%
Rate of assessments per 10,000 of the CYP population (N7)	322	343	342	→	340	340	Social Care	Numbers of initial assessments only have been counted. England Rate in 2011-12 was 398. Initial and Core Assessments will be replaced shortly by a single assessment
% of initial assessments for children's social care carried out within 10 working days of referral NI 59. *	64.4%	69.8%	69.3%	→▲	72.5%		Social Care	2011-12 data showed an improvement of the % of IAs carried out within 10 days. The All England performance in 2011/12 was 77.4%. * To be superseded by single assessment indicator of assessments undertaken within 45 days
% of core assessments for children's social care carried out within 35 working days of start NI 60*	75.7%	80.8%	79.5%	→▲	87%		Social Care	Year End 2011-12 figure of 80.8% was an improvement in performance. The All England performance in 2011-12 was 75.5%. * As above
Rate of S47 enquiries per 10,000 of the CYP population (N8)	108	116	118				Social Care	England rate 2011-12 was 110, an increase from 101 in 2010-11. Rate of S47 investigations in Dudley are following an increasing trend
Rate of Initial Child Protection Conferences per 10,000 CYP population (N13)	56	46.7	53.5				Social Care	All England average rate 2011-12 was 49.6. Rate of Initial Conferences have increased in Dudley in 2012-13.
Median days between initiation of S47 and Initial Conference (N15)		15	16	↓	14	13	S&RU	Comparator group's averages are all 13. Room for improvement
Children becoming the subject of a CPP for physical, emotional, and sexual abuse or neglect :rate per 10,000 CYP population (% of total) as at 31st March (N12)	PHY: 8.9 (21%) EMO: 11.0 (30%) SEX: 3.2 (7%) NEG:18.6 (43%)	PHY:6.0 (13%) EMO: 13.6 (33%) SEX:3.5 (7%) NEG:21.1 (47%)	PHY: 2.7 (17%) EMO: 7.9 (25%) SEX: 2.5 (8%) NEG: 15.9 (51%)	N/A			Social Care	England 2011-12 PHY: 4.1 (14%) EMO: 10.9 (32%) SEX:2.0 (6%) NEG: 16.1 (48%)

% of Child Protection Review Conferences held within timescale NI 67	89.4%	88.5%	98.6%	↑	100%	100%	S&RU	All England 2011-12 performance was 96.7%
Child Protection Plans lasting 2 years or more NI 64	0.4%	9.4%	2.0%	↑	TBC	TBC	S&RU	England performance 2011-12 was 5.6%. Of the 294 children de-registered in 2012-13, 6 had been subject to a plan for over 2 years
% of cases where the lead SW has seen the CYP in accordance with the CP Plan for all child subject to a CP Plan during the year (N20)	N/A	N/A	24%		75%	85%	Social Care	As at 31/03/2013, 24% of latest visits had been undertaken in accordance with the CP Plan. This figure is known to be affected by teething issues with the recording of visits and frequency and work is being undertaken to address this. More robust data should be available in Qtr 1 13-14.
% of cases where the Core Group took place within timescales			New indicator under development					Core Groups should take place within 10 working days of the ICC and then every six weeks. Reporting of this new indicator is expected to be in place by the end of Qtr1 2013-14
N° of children subject to a CP Plan for a 2nd or subsequent time (NI 65)	39	43	57	↓	40	35	S&RU	57 children equates to 17.4% of all new plans. This compares with an England average rate of 13.8% and a West Midlands average of 14.6% (2011-12 published results)
Number of new CP Plans per 10,000 population for children aged 0-17	46	42	48	N/A	48	48	S&RU	Comparator data 2011-12 ; England average rate of 46 and West Midlands rate of 50
Children and young people subject to a child protection plan per 10,000 population aged under 18 as at 31 March (N19)	35.6	33.3	36.6	N/A	TBC	TBC	S&RU	Comparator data 2011-12 ; England average rate of 38 and West Midlands rate of 41
Number of looked after children per 10,000 population	95	104	109	↓	N/A	N/A	Social Care	Numbers of Looked After Children continue to follow an increasing trend
Other Indicators								
Measure	2010/11	2011/12	2012/13	Status	Target 12/13	Target 13/14	Lead	Commentary
The number of incidents where police have attended a children's home in the Dudley borough regarding a missing/absent child	322	424	370		350	325	Police	Information extracted from the police Command and Control system using the list of homes and using a final classification code Public Safety & Welfare / Missing / Unauthorised Absence
Number of children whose death has been categorised as having modifiable factors	1	1	3	N/A	N/A	N/A	S&RU	CDOP reviewed 35 child deaths, 3 of which were categorised as having modifiable factors
Total number of meetings in respect of concerns/allegations in respect of people who work with children	117	64	111	N/A	N/A	N/A	S&RU	
Number of police DV Reports leading to a Social Care Referral	-	176	157	N/A	N/A	NA/	Social Care	Fewer police reports lead to a Social Care referral in 2012-13. This should be looked at in conjunction with the number of DV reports with an outcome of CAF Recommendation in the Priority Indicators section.

Number of Police Protection orders (all)	22	19	49		N/A	N/A	Police	There has been a significant increase in the number Police Protection Orders from 19 in the 2011-12 year to 49 in the 2012-13 year. This represents an increase of 158%
Number of Police Protection orders leading to an Episode of Care (% of all PPO's)	17 (77%)	15 (78%)	40 (82%)		N/A	N/A	Social Care	The proportion of police protection orders leading to an episode of care has been following an increasing trend over the last 3 year period, rising from 77% in 2010-11 to 82% in 2012-13.
Number of children subject to missing children reports	265	240	386		N/A	N/A	Police	YOS are Supplying Data for 2012-13 – awaiting response
Dudley Safeguarding Children Board Priority Indicators								
1. Improve the protection of children from abuse and neglect through more effective inter-agency working								
The % of plans with identified risk and protective factors			New indicator under development					DSCB have introduced Signs of Safety tools during the last two years – this indicator will reflect whether an analysis of risk and protective factors is being included within child protection planning
The % of children aged 4 to 17 whose views contributed to their latest CP Conference			New indicator under development					Contribution can be direct (attending conference) or Indirect (incorporated in a report to conference etc) Reporting of this new indicator is expected to be in place by the end of Qtr1 2013-14
2. Improve the effectiveness of early help and intervention for children and young people who are vulnerable								
Number of police DV reports which result in a recommendation of a CAF	Not Collected	Not Collected	94		N/A	N/A	DART	Newly collected information
Number of CAFs which started during the year*	417	296	306		N/A	N/A	IST	The total number of new CAFs recorded dropped in 2011-12 from 417 to 296. This number then increased slightly in 2012-13 to 306. (*CAF dataset is under development and will be included in appendices in future editions)
Number (%) of new referrals to Children's Social Care Teams where a CAF had been initiated within the previous 12 months	120 (3.0%)	78 (2.6%)	53 (1.7%)		N/A	N/A	IST	
3. Strengthen the effectiveness of support and challenge provided by partners of the Board to improve safeguarding outcomes for children, young people and their families								
Under development for 2013-14								

4. Improve the inter-agency responses to young people who are at risk of, or who have suffered, sexual exploitation								
Number of new referrals from any agency to YPSE Panel *	17	11	10		N/A	N/A	PCT	* Regional CSE dataset has been proposed and will be included in appendices in future editions)
5. Improving the safeguarding and protection of children and young people who are living in households where there is domestic abuse, parental abuse, parental mental health and parental alcohol and substance misuse								
Number children (within household) in Domestic Abuse notifications (392s) reported.	2290	2318	1798	N/A			Social Care/ Police	On average 150 Domestic Violence Notifications (392's) are now received and recorded each month
Number of MARAC cases of Domestic Abuse reported to police where children are reported as present at the time			New indicator under development				Police	Reporting of this new indicator is expected to be in place by the end of Qtr1 2013-14
Number of cases open to Adult Mental Health Services for parents			New indicator under development				Adult Mental Health	Reporting of this new indicator is expected to be in place by the end of Qtr1 2013-14
Number of children assessed by Social Workers as having parental mental health issues as a factor			New indicator under development				Social Care	Reporting of this new indicator is expected to be in place by the end of Qtr1 2013-14
Number of cases open to drug/substance/alcohol misuse adult Services for parents			New indicator under development				Adult Drug and Alcohol Services	Reporting of this new indicator is expected to be in place by the end of Qtr1 2013-14
Number of children assessed by social workers as having parents with drug/substance/ misuse issues as a factor			New indicator under development				Social Care	Reporting of this new indicator is expected to be in place by the end of Qtr1 2013-14

APPENDIX 6

DSCB Attendance by Partner Agencies (main Board)*

Agency	May 11th 2012	Jul 11th 2012	Sep 21st 2012	Nov 14th 2012	Mar 22nd 2013-04-Planning & Dev session	Mar 22nd Business Meeting	Total times acting member attended	% over last six meetings	No of times representative sent	Total % with member/rep
Social Care	Y	Y	Y	Y	Y	Y	6/6	100		100
Dudley PCT – CCG from Jan 2013	Y	Y	Y	Y	Y	Y	6/6	100		100
Black Country Partnership FT		Y	Y	Y	Y	Y	5/6	83.3		83.3
Dudley Group of Hospitals	Y	Y	Y		Y	Y	3/6	50	2/6	83.3
FE Colleges	Y				Y		2/6	33.3		33.3
Education	Y	Y	Y	Y	Y	Y	6/6	100		100
Primary Schools	Y	Y			Y		3/6	50		50
Secondary Schools							0/6	0		0
Special Schools				Y	Y	Y	3/6	50		50
Dudley & Walsall Mental Health Trust	Y	Y	Y	Y	Y	Y	6/6	100		100
CAFCASS				Y			1/6	16.6		16.6
Youth Offending Service	Y		Y			Y	3/6	50		50
Probation Service	Y	Y	Y	Y		Y	5/6	83.3		83.3
Connexions	Y		Y		Y	Y	4/6	66.6		66.6
West Midlands Fire Service	Y	Y	Y	Y	Y	Y	6/6	100		100
West Midlands Police		Y	Y		Y		3/6	50		50
Community Safety	Y	Y	Y	Y	Y	Y	6/6	100		100
Dudley Children's Trust	Y	Y	Y	Y	Y	Y	6/6	100		100
Directorate of Urban Environment		Y	Y	Y	Y	Y	5/6	83.3		83.3
Childcare Services Strategy/Children's Centres	Y	Y	Y	Y	Y	Y	6/6	100		100
Directorate of Adults, Community & Housing Services	Y	Y	Y	Y	Y	Y	6/6	100		100
Voluntary Sector	Y	Y	Y	Y	Y	Y	6/6	100		100
West Midlands Ambulance Service							0/6	0		0

Key:

Red	*DSCB agency member did NOT attend*
Amber	*DSCB agency member did NOT attend, but another person attended in their place or DSCB agency member attended for part of the meeting*
Green	*DSCB agency member attended*

APPENDIX 7

Key Contacts for Designated Safeguarding Professionals

For safeguarding advice in respect of the key sectors of children's workforce please contact:

Early Years	kim.sharratt@dudley.gov.uk
GPs	pauline.owens@dudleyccg.nhs.uk
Black Country Partnership Trust	jayne.clark@bcpft.nhs.uk or lisa.chiltern@bcpft.nhs.uk
Education (Schools & Colleges)	funbir.jaspal@dudley.gov.uk or jayne.underwood@dudley.gov.uk
Youth Services	amanda.grove@dudley.gov.uk or jean.garwood@dudley.gov.uk
Sport & Physical Activity	rachael.doyle@dudley.gov.uk
Police	w.bird@west-midlands.pnn.police.uk
Social Care	jackie.jennings@dudley.gov.uk or angela.plant@dudley.gov.uk
Dudley Group of Hospitals	carol.weston@dgh.nhs.uk or sally.abbatiello-burns@dgh.nhs.uk
Dudley & Walsall Mental Health Trust	debbie.cooper@dwmh.nhs.uk
DSCB Administration	suzanne.robinson@dudley.gov.uk
Child Death Review Co-ordinator	helen.fowler@dudley.gov.uk
DSCB Training Programme	helen.pryor-andrews@dudley.gov.uk
Child Death Rapid Response Nurse	diane.hall@bcpft.nhs.uk
Quality Assurance	sue.caddick@dudley.gov.uk
Safeguarding Trainers	kim.sharratt@dudley.gov.uk or alyson.sayers@dudley.gov.uk

APPENDIX 8

JARGON BUSTER

CAF	Common Assessment Framework - main assessment tool used by agencies, often applied to vulnerable children
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel -responsibility for reviewing deaths of all children in the borough to inform learning
CIN	Child(ren) in Need - Children in need of services as defined by Section 17 of the Children Act
Core Group	Core Group - core group of professionals responsible for implementation of child protection plan
CQC	Care Quality Commission
CSE	Child Sexual Exploitation - Sexual exploitation of children and young people up to the age of 18 years
DART	Domestic Abuse Response Team – virtual team of professionals who meet regularly to screen/risk assess all incidents of domestic abuse involving children
DACHS	Directorate of Adults, Community & Housing Services - part of Dudley Metropolitan Borough Council
DCS	Directorate of Children's Services - part of Dudley Metropolitan Borough Council
DSCB	Dudley Safeguarding Children Board
DUE	Directorate of Urban Environment - part of Dudley Metropolitan Borough Council
ICPC	Initial Child Protection Conference
IRO	Independent Reviewing Officer
LAC	Looked After Child(ren)
LADO	Local Authority Designated Officer – the role provides advice, guidance and management of allegations against people who work with children
LSCB	Local Safeguarding Children Board
MAPPA	Multi-Agency Public Protection Arrangements – provides inter-agency management of risks posed by sexual and violent offenders in the community
MARAC	Multi-Agency Risk Assessment Conference – inter-agency co-ordination of support and intervention to high risk adult victims of domestic violence
SCR	Serious Case Review – conducted when a child dies or is seriously injured and abuse or neglect is suspected and lessons in terms of inter-agency working
Section 17	Section 17 of the Children Act 1989 – children in need
Section 47	Section 47 of the Children Act 1989 – child protection enquiries
SILP	Significant Incident Learning Process – systems methodology for learning from significant or serious cases
TAC	Team Around the Child – professionals working with children and their families, usually having completed a Common Assessment
TYS Panel	Targeted Youth Support Panel – inter-agency meeting to respond to the needs of children 'on the edge of becoming looked after'
'Working Together'	Working Together to Safeguard Children – statutory guidance which outlines how agencies should collaborate to safeguard and promote the welfare of children
YPSE Panel	Young People at Risk of Sexual Exploitation Panel – inter-agency meeting to respond to young people at risk of sexual exploitation

promoting an understanding that safeguarding is everyone's responsibility

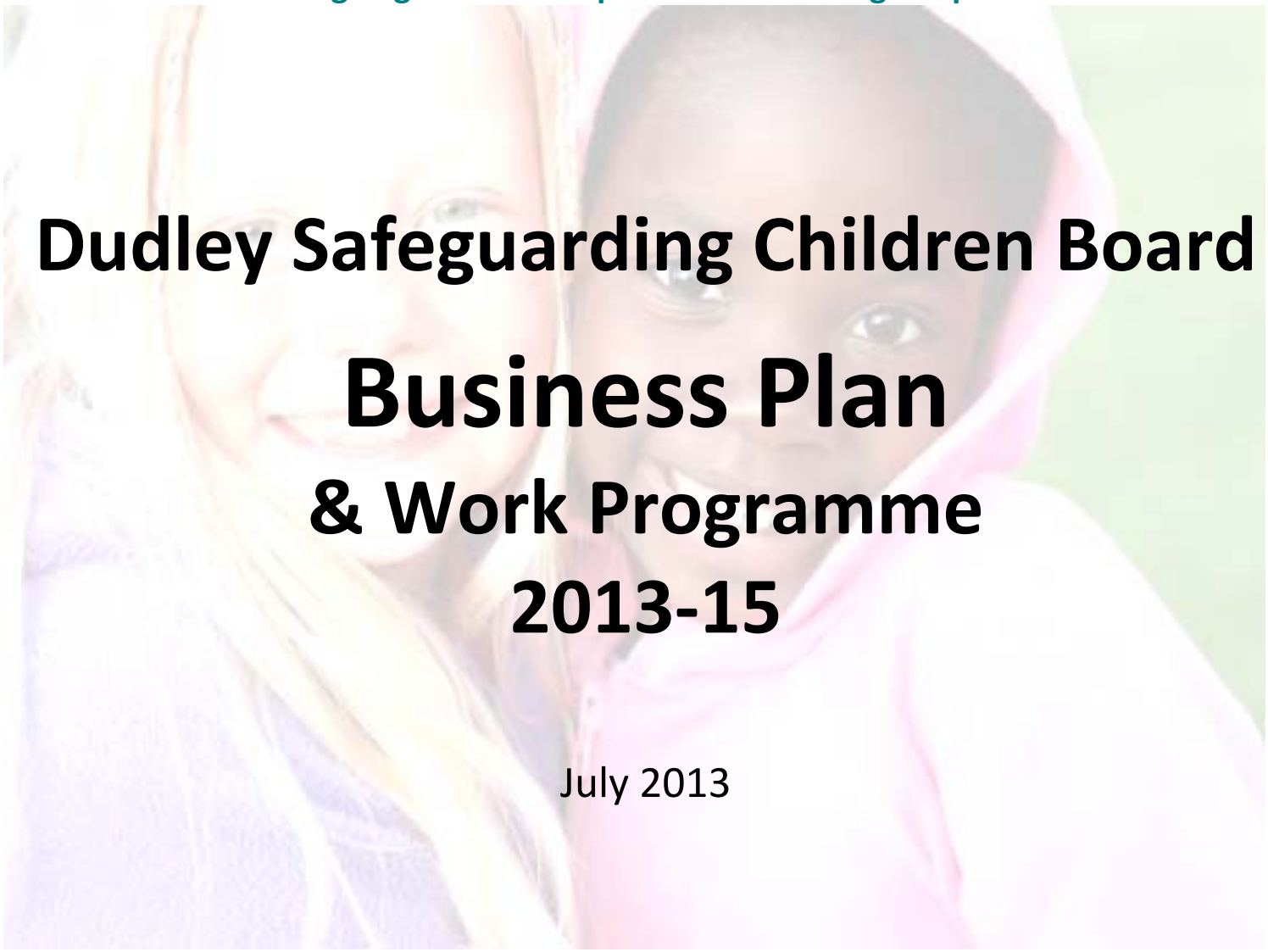
improving the safety and wellbeing of children and young people across all communities

developing safer services and employment practices across all organisations

For more information about the work of Dudley Safeguarding Children Board write to Graham Tilby, Safeguarding & Review Service, 6 St. James's Road, Dudley, West Midlands, DY1 3JL, or telephone 01384 813061 or email graham.tilby@dudley.gov.uk

Dudley Safeguarding Children Board

'Working Together to Keep Children & Young People Safe'



Dudley Safeguarding Children Board

Business Plan

& Work Programme

2013-15

July 2013

Introduction

Welcome to the Dudley's Local Safeguarding Children Board (LSCB) Business Plan and Work Programme for 2013-15. The LSCB is the key statutory mechanism for agreeing how relevant organisations will co-operate and work together to safeguard and promote the welfare of children and young people in Dudley, and for ensuring the effectiveness of what they do.

Safeguarding children – the action we take to promote the welfare of children and protect them from harm – is *everyone's responsibility.'* Whilst the work of Dudley Safeguarding Children Board (DSCB) contributes to the wider goals of improving the well-being of all children, its core objectives are to safeguard and protect children, defined as:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
  Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best outcomes

Our Business Plan & Work Programme for 2013-15 should be read in-conjunction with the DSCB Annual Report for 2012-13.

This document is in three main parts:

PART ONE: DSCB Key Priorities for 2013-15
PART TWO: DSCB Work Programme for 2013-15
APPENDICES: DSCB Action Plan and Partnership Structure

Setting the Scene

In March 2013, HM Government published *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children',* which covers the legislative requirements and expectations on individual services and a clear framework for the Local Safeguarding Children Boards (LSCBs) to monitor the effectiveness of local services.

The guidance is underpinned by the Children Act 2004, which places a duty on a range of service to co-operate (Section 10) and safeguard and promote the children's welfare (Section 11). These duties and organisational responsibilities are outlined within Chapter 2 of '*Working Together to Safeguard Children'.*

Section 13 of the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) and Section 14 sets out the objectives of the LSCB's, which are to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area and to ensure the effectiveness of what is done. Regulation 5 of the Local Safeguarding Children Board Regulations 2006 sets out the functions of the LSCB (see Appendix 1) – these form the basis of our work programme.

OUR KEY OBJECTIVES:

promoting an understanding that safeguarding is everyone's responsibility
improving the safety and wellbeing of children and young people across all communities
developing safer services and employment practices across all organisations

Ofsted Inspection of Children's Services

The new Ofsted Framework for Inspection of services for children in need of help and protection, children looked after and care leavers, planned for introduction from September 2013, will most likely to introduce key judgements in respect of the experience and progress of children who need help and protection. The proposals also include introducing a review of the LSCB and a judgment as to whether it is performing as 'outstanding', 'good', 'requiring improvement' or as 'inadequate'.

The LSCB is likely to be judged as 'good' if:

- The governance arrangements enable statutory partners (including the Health and Well-Being Board and the Children's Trust) to assess whether they are fulfilling their statutory responsibilities to help (including early help), protect and care for children and young people. There is evidence that this leads to clear improvement priorities being identified that are incorporated into a delivery plan that improves outcomes.
- There is evidence of regular and effective monitoring and evaluation of front-line practice and the quality of management oversight. This extends across the breadth of child protection, services for children who are looked after and those who are leaving or who have left care. It leads to improvements in the quality of service that children and young people receive.
- The local authority is made aware of the findings and analysis of case audits, including the impact on children, young people and families. The experiences of children and young people are used as a measure of improvement. There is evidence of audit findings improving practice.
- Practitioners working in core groups with families are able to be involved in practice audits, identifying strengths, areas for improvement and lessons to be learned. These experiences are used effectively to improve practice and front-line management.
- The LSCB is an active and influential participant in informing and planning services for children, young people and families in the area and draws on its assessments of the effectiveness of multi-agency practice to help, protect and look after children and young people.
- The LSCB ensures that sufficient, high-quality multi-agency training is available and can demonstrate its effectiveness and its impact on improving practice and the experiences of children, young people, families and carers.
- The LSCB through its annual report provides a rigorous and transparent assessment of the performance and effectiveness of local services. It identifies areas of weakness, the causes of those weaknesses, evaluates and where necessary challenges the action being taken. The report includes lessons from management reviews, serious case reviews and child deaths within the reporting period.

During 2013-14, DSCB will conduct an assessment of its effectiveness taking account of the above judgements, which have been incorporated (where possible) into this business plan and work programme.

PART ONE

Our Key Priorities for 2013-15

DSCB key priorities for 2013-15 have been established taking into account

- Key national guidance and policy changes
- Progress in respect of recommendations from Ofsted and Care Quality Commission Inspection of Safeguarding and Looked After Children Services in Dudley (January 2012)
- DSCB Self-Assessment of Effectiveness (March 2012), refreshed in March 2013
- Progress in respect of Action Plan following Munro Review (July 2011)
- Learning from Section 11 audits, case reviews and other quality assurance and audit processes
- Progress in respect of DSCB priorities from 2012-13 (see Annual Report)
- Risks management, prevalence and impact on children and their outcomes

The Business Plan & Work Programme will be largely delivered through the Board's sub-groups and task groups and its overall co-ordination, implementation and impact monitored by the Quality & Performance Management Group. DSCB will produce an annual report assessing the effectiveness of safeguarding in Dudley and progress against this business plan.

The Board has agreed the following key priorities for 2013-15:

PRIORITY 1

Improve the protection of children from abuse and neglect, through more effective inter-agency working, with specific reference to:

- Strengthening the analysis of **risk and protective factors** in children and their families
- Improving the consistency, quality and timeliness of **information-sharing** across partner agencies
- Evidencing the **'voice' of children**, young people and their families within practice and the impact on the improving quality of services and outcomes

Lead Group: Quality & Performance Management Group supported by Signs of Safety Task Group and Policy, Procedures & Practice Sub-Group
Lead Agencies: Directorate of Children's Services, CCG

PRIORITY 2

Improve the effectiveness of early help and intervention for children and young people who are vulnerable, with specific reference to:

- Embedding **common assessment** across key partner agencies, with the ambition of developing **single-assessment** processes in the long-term
- Enabling children and young people to receive the right services at the right time in the right place through clear application of **thresholds**
- Ensuring that key strategic approaches around **early help** are joined-up and communicated effectively

Lead Group: Quality & Performance Management Group supported by Early Help & Intervention Task Group
Lead Agencies: Directorate of Children's Services, CCG

PRIORITY 3

Strengthen the effectiveness of support and challenge provided by partners of the Board to improve safeguarding outcomes for children, young people and their families, through:

- Embedding **quality assurance** across partner agencies, including the engagement of children, young people and their families in learning
- Developing an **outcomes-based approach** to performance management and improvement activity
- Promoting **professional resolution and escalation i**n respect of individual and strategic safeguarding issues
- Undertaking self-assessment, peer review and challenge to inform safeguarding improvement activity

Lead Group: Quality & Performance Management Group supported by Policy, Procedures & Practice Sub-Group
Lead Agencies: Directorate of Children's Services, CCG

PRIORITY 4

Improve inter-agency responses to young people who are at risk of, or who have suffered, sexual exploitation through

- Strengthening **prevention** and earlier intervention across partner agencies and raising awareness and recognition of sexual exploitation
- Improving the **protection** of young people who are involved in sexually exploitative relationships
- Maximising opportunities to disrupt the activities of perpetrators and **prosecute** them wherever possible
- Improving inter-agency responses to children and young people who are **victims of sexual offences** or at risk of being sexually abused, including their experiences of criminal justice system

Lead Group: Vulnerable Children & Young People's Task Group
Lead Agencies: Directorate of Children's Services, West Midlands Police, CCG

PRIORITY 5

Improve the safeguarding and protection of children and young people who are living in households where there is domestic abuse, parental mental health and parental substance misuse, through:

- Embedding a **'Think Family' approach** across the children's and adults workforce
- Clarifying **pathways between children's and adults' services** to ensure that safeguarding issues are addressed in a timely and effective way
- Developing and implementing **evidence-based strategies** to minimise risks for children & young people, including inter-agency responses to 'troubled families'
- Improve inter-agency **screening and risk management** of domestic abuse and responses to high risk victims who are parents/carers

Lead Group: Quality & Performance Management Group supported by Domestic Abuse Service Improvement Group, Substance Misuse Safeguarding Forum and Policy, Procedures & Practice Sub-Group
Lead Agencies: Directorate of Children's Services, Community Safety, Dudley & Walsall Mental Health NHS Partnership Trust, Directorate of Adults, Community & Housing Services

A more detailed Action Plan is available at Appendix One

PART TWO

DSCB Work Programme 2013-15:

The work programme is divided into 6 parts in accordance with the key functions of Local Safeguarding Children Board's:

- Thresholds, policies and procedures
- Training & Development
- Communicating and raising awareness
- Monitoring and evaluation
- Participating in planning and commissioning
- Functions relating to child deaths and Serious Case Reviews

Thresholds, policies and procedures

Improving the safeguarding and protection of children and young people through ensuring that practitioners have to sound guidance and procedures

- Revise safeguarding procedures in light of the publication of *Working Together to Safeguard Children* 2013 *(all priorities)*
- Produce a joint protocol in respect of parental mental health and safeguarding children and review the joint protocol between substance misuse services and children's services in the light of the thematic inspection, August 2012 *(priority 5)*
- Develop new practice guidance in respect of neglect and faltering growth *(priority 1)*
- Review guidance in respect of thresholds and information-sharing *(priority 1)*
- Finalise protocol in respect of multi-agency risk assessment conferences concerning high risk victims of domestic abuse
- Progress implementation of Signs of Safety within operational practice, processes and systems *(priority 1)*

Lead Group: Policy, Procedures & Practice Sub-Group

Training and development

Improving the safeguarding and protection of children and young people through ensuring that practitioners have access to good quality training and development opportunities

- Review Training & Development Strategy, with a particular focus on outcomes *(all priorities)*
- Introduce new training in respect of parental mental health & safeguarding children*(priority 5)*, management of allegations against staff and specialist child protection investigation training *(priority 1)*

Lead Group: Training & Development Sub-Group

Communicating and raising awareness

Improving prevention of abuse and neglect of children & young people through awareness-raising of potential risks and protective factors, safer practices and what to do if a child or young person is suspected of being at risk of significant harm

- Review LSCB Communications Strategy to include awareness-raising & education programmes and improvements to DSCB website *(all priorities)*
- Establish LSCB Communications Group with marketing and communications leads across key partner agencies *(all priorities*

Lead Group: Training & Development Sub-Group

Monitoring and evaluation

- Conclude commission of Independent Chair *(all priorities)*
- Recruit to additional Lay Advisors to the Board *(all priorities)*
- Complete Section 11 audit and review scrutiny programme *(all priorities)*
- Undertake skills audit of LSCB Members to identify training and development needs (all priorities)
- Review LSCB Self-Assessment and implement improvements in respect of governance, partnership working, engagement of children & young people, business planning and quality assurance *(priority 3)*
- Participate in Peer Diagnostic, Challenge and external Scrutiny activity *(priority 3)*
- Introduce Risk Register and Management *(priority 3)*
- Develop a Participation Strategy to improve the engagement of children, young people and their families in child protection and safeguarding *(priority 3)*

Lead Group: Quality & Performance Management Group

Participating in planning and commissioning

- Appoint to LSCB Business & Communications Officer *(all priorities)*
- Implement improvements from local evaluation of the Domestic Abuse Response Team *(priorities 5)*
- Complete review of arrangements for children missing from home or care *(priority 4)*
- Complete and implement CSE Strategy & Action Plan *(priority 4)*
- Produce score cards for simple data analysis of key activity/trends *(priority 3)*
- Support and challenge improvements arising from Ofsted/CQC Inspections in 2011 in respect of Safeguarding & Looked After Children *(all priorities)* and Joint Working between children's and adults services in 2012 *(priority 5)*

Functions relating to child deaths and Serious Case Reviews

- Evaluate rapid response arrangements and implement changes *(priority 3)*
- Implement action plans arising from Serious Case Review (Child C) and other significant case reviews to secure improvements to practice and services *(priority 3)*

Lead Group: Serious Cases Review Sub-Group and Child Death Overview

For more information about Dudley Safeguarding Children Board:
Safeguarding & Review Service, 6 St. James's Road, Dudley, West Midlands DY1 3JL
01384 813061
http://safeguardingchildren.dudley.gov.uk

Appendices

Action Plan: KEY PRIORITIES 2013-15

PRIORITY 1 Improve the protection of children from abuse and neglect, through more effective inter-agency working, with specific reference to:	KEY ACTIONS	MILESTONES/ TIMESCALES	KEY PERFORMANCE MEASURES	LEAD GROUP	LEAD PARTNER AGENCY(s)
• Strengthening the analysis of **risk and protective factors** in children and their families	Embed Signs of Safety tools within frontline practice (common assessment, children in need, child protection) • Amend relevant planning documentation to include 'risk and protective factors' • Include signs of safety tools within intermediate/advanced safeguarding training • Commission additional training targeted at social care, children's centres and health • Evaluate impact of signs of safety on frontline practice and outcomes for children & families	By 30/09/13 By 30/08/13 By 30/09/13 By 31/12/13	Proportion of CAFs/TAC Plans, Child in Need Plans and Child Protection Plans including analysis of risk and protection factors	Signs of Safety Implementation Group Quality & Performance Management Group	Directorate of Children's Services Assistant Director – Quality & Partnership Clinical Commissioning Group *All Partner Agencies*
• Improving the consistency, quality and timeliness of **information-sharing** across partner agencies	• Disseminate '7 Golden Rules' of Information-Sharing to all practitioners • Conduct specific audit of information-sharing	By 31/07/13 By 31/12/13			
• Evidencing the **'voice' of children**, young people and their families within practice and the impact on the improving quality of services and outcomes	• Produce practice standards for 'voice of the child' • Implement 'feedback' processes as part of QA Framework • Conduct specific audit of practice	By 31/07/13 By 30/09/13 By 31/12/13			

PRIORITY 2 Improve the effectiveness of early help and intervention for children and young people who are vulnerable, with specific reference to:	KEY ACTIONS	MILESTONES/ TIMESCALES	KEY PERFORMANCE MEASURES	LEAD GROUP	LEAD PARTNER AGENCY
▪ Embedding **common assessment** across key partner agencies, with the ambition of developing **single-assessment** processes in the long-term	• Implementing range of strategies to promote common assessment including evaluation of its impact of outcomes for children, young people & their families	*On-Going*	Number of CAF's per quarter Proportion of assessments completed leading to a positive outcome	Early Help Strategy Group	Directorate of Children's Services Assistant Director – Children & Families Clinical Commissioning Group *All Partner Agencies*
	• Developing and implementing a 'single-assessment' framework in accordance with *Working Together, 2013*	*By 31/04/14*	Profile of CAFs across key partner agencies		
▪ Enabling children and young people to receive the right services at the right time in the right place through clear **thresholds**	• Reviewing and up-dating thresholds guidance, taking account of changes in respect of child protection within *Working Together, 2013*	*By 30/10/14*			
	• Concluding and implementing protocol work in respect of transition with regards to vulnerable young people	*By 30/10/14*			
	• Progressing the development of Early Help Locality Teams to ensure more effective and timely response to vulnerability	*On-Going*			
▪ Ensuring that key strategic approaches around **early help** are joined-up and communicated effectively	• Implementing the Early Help Strategy across key partner agencies	*As per strategy*			
	• Implementing the Troubled Families Programme for children on the edge of care and in need of protection	*As per programme*			

PRIORITY 3 Strengthen the effectiveness of support and challenge provided by partners of the Board to improve safeguarding outcomes for children, young people and their families, through:	KEY ACTIONS	MILESTONES/ TIMESCALES	KEY PERFORMANCE MEASURES	LEAD GROUP	LEAD PARTNER AGENCY
▪ Embedding **quality assurance** across partner agencies, including the engagement of children, young people and their families in learning	Revise QA Framework to take account of new Working Together to Safeguard Children (2013) guidance and Implement all 4 components of the QA Framework • Case audit • Feedback from children & young people, parents/carers • Feedback from practitioners • Practice observations	By 31/03/14	Proportion of case file audits rated as good or outstanding Proportion of service users giving positive feedback in response to the 3 simple questions Proportion of practice observations rated as good or outstanding	Policy, Procedures & Practice Sub-Group Quality & Performance Management Group	Directorate of Children's Services Assistant Director – Quality & Partnership Clinical Commissioning Group *All Partner Agencies*
▪ Developing an **outcomes-based approach** to improvement	• Disseminate outcome-based standards • Conduct Section 11 audits across key partner agencies and report findings to DSCB, highlighting evidence of impact on outcomes and improvement	By 30/10/13 By 30/09/13	Proportion of agencies that have improved in terms of % compliance against Section 11 standards		
▪ Promoting **professional resolution and escalation i**n respect of individual and strategic safeguarding issueS	• Promote as part of Practice Learning Events	By 30/06/13	Proportion of professional escalation processes that result in a positive outcome for the child/family		

PRIORITY 4 Improve inter-agency responses to young people who are at risk of, or who have suffered, sexual exploitation through	KEY ACTIONS	MILESTONES/ TIMESCALES	KEY PERFORMANCE MEASURES	LEAD GROUP	LEAD PARTNER AGENCY
▪ Strengthening **prevention** and earlier intervention across partner agencies and raising awareness and recognition of sexual exploitation ▪ Improving the **protection** of young people who are involved in sexually exploitative relationships ▪ Maximising opportunities to disrupt the activities of perpetrators and **prosecute** them wherever possible ▪ Improving inter-agency responses to children and young people who are **victims of sexual offences** or at risk of being sexually abused	Finalise CSE Strategy & Action Plan for 2013-15 (taking account of regional work) to include: • Awareness-raising across communities • Kite Mark for Hotels and Licensed Premises • Training for front-line practitioners • Induction Programme for children's workforce • Screening and Risk Assessment Tools • Information-Sharing Protocol (Operation Protects) • Protocol with Crown Prosecution Service • Develop Child Sexual Abuse (CSA) Prevention Strategy • Improve investigative and service responses to victims of child sexual abuse, including medical care via the Sexual Abuse Referral Centre (SARC) and preparation for court • Audit sexual abuse cases to identify key improvement themes	See Action Plan *From 01/09/13* *From 01/09/13* *From 01/09/13* *From 01/10/13* *By 30/10/13* *From 01/09/13* *By 30/12/13*	Number of young people assessed as at risk of CSE Proportion of interventions leading to positive outcome Proportion of investigations resulting in a successful prosecution	Vulnerable Children & Young People's Task Group	Directorate of Children's Services Assistant Director – Quality & Partnership West Midlands Police Clinical Commissioning Group *All Partner Agencies*

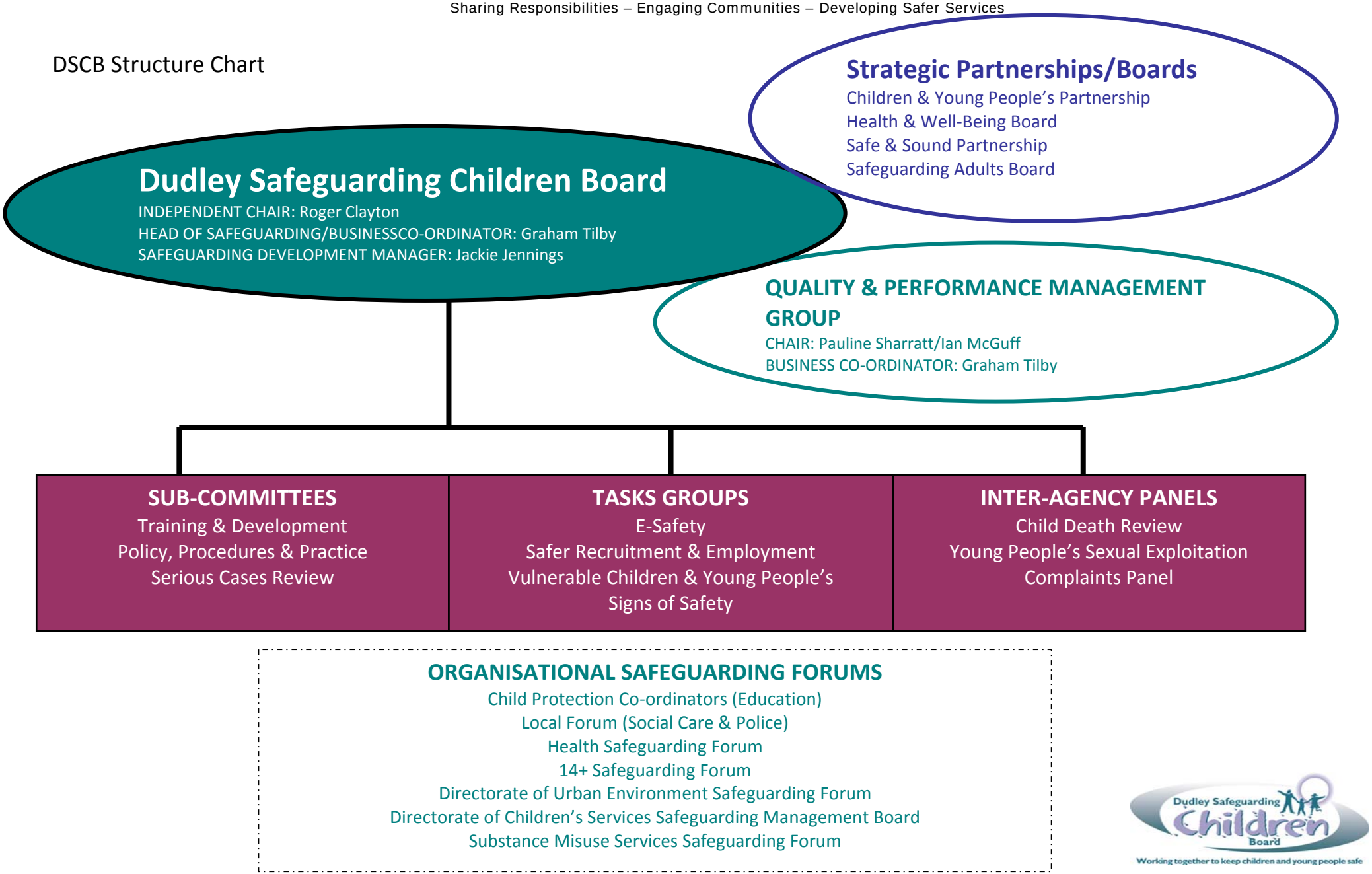
PRIORITY 5 Improve the safeguarding and protection of children and young people who are living in households where there is domestic abuse, parental mental health and parental substance misuse, through:	KEY ACTIONS	MILESTONES/ TIMESCALES	KEY PERFORMANCE MEASURES	LEAD GROUP	LEAD PARTNER AGENCY
▪ Embedding a **'Think Family' approach** across the children's and adults workforce	Implement action plan arising from thematic inspection, and taking account of 'Bridging the Gap' Conference Report to include: • Incorporating 'Think Family' approach with key strategies affecting children and parents, including parents with mental health issues • Develop and implement joint training strategy across children and adult workforce	As per action plan	Proportion of assessments completed holistically taking account of children's and adults needs Proportion of Domestic Abuse Cases leading to a positive outcome	Quality & Performance Management Group	Safeguarding & Review - Directorate of Children's Services Assistant Director – Quality & Partnership Dudley & Walsall Mental NHS Trust Community Safety – Chief Executives, Dudley MBC
▪ Clarifying **pathways between children's and adults' services** to ensure that safeguarding issues are addressed in a timely and effective way	• Finalise and implement pathways guidance for practitioners • Undertake audit of cases where there parental mental health and safeguarding children issues	By 31/07/13 By 31/03/13			
▪ Developing and implementing **evidence-based strategies** to minimise risks for children & young people	• Implement practice guidance for practitioners in respect of neglect	By 30/10/13			
▪ Improve inter-agency **screening and risk management** of domestic abuse and responses to high risk victims who are parents/carers	• Implement actions from evaluation of DART • Implement improvements in respect of MARAC	By 31/03/14 By 31/12/13			

Action Plan: WORK PROGRAMME 2013-15

FUNCTION	KEY ACTIONS	MILESTONES/ TIMESCALES	LEAD PARTNER AGENCY	LEAD GROUP
Thresholds, policies and procedures Improving the safeguarding and protection of children and young people through ensuring that practitioners have access to sound guidance and procedures	▪ Revise safeguarding procedures in light of the publication of *Working Together to Safeguard Children* 2013 *(all priorities)* ▪ Produce a joint protocol in respect of parental mental health and safeguarding children and review the joint protocol between substance misuse services and children's services in the light of the thematic inspection, August 2012 *(priority 5)* ▪ Review guidance in respect of thresholds and information-sharing *(priority 1)* ▪ Progress implementation of Signs of Safety within operational practice, processes and systems *(priority 1)*	*By 31/12/13* *By 31/08/13*	Directorate of Children's Services	Policy, Procedures & Practice Sub-Group
Training and development Improving the safeguarding and protection of children and young people through ensuring that practitioners have access to good quality training and development opportunities	▪ Review Training & Development Strategy, with a particular focus on outcomes *(all priorities)* ▪ Introduce new training in respect of parental mental health & safeguarding children, management of allegations against staff *(priority 5)*	*By 30/09/13* *By 31/12/13*	Directorate of Children's Services	Training & Development Sub-Group
Communicating and raising awareness Improving prevention of abuse and neglect of children & young people through awareness-raising of potential risks and protective factors, safer practices and what to do if a child or young person is suspected of being at risk of significant harm	▪ Review LSCB Communications Strategy to include education programmes, e-safety and safer working practices *(all priorities)* ▪ Establish LSCB Communications Group with marketing and communications leads across key partner agencies *(all priorities*	*By 31/12/13* *By 31/12/13*	Directorate of Children's Services	Communications Sub-Group

FUNCTION	KEY ACTIONS	MILESTONES/ TIMESCALES	LEAD PARTNER AGENCY	LEAD GROUP
Monitoring and evaluation Improving the monitoring and evaluation of the effectiveness of safeguarding practices within and across partner organisations	▪ Conclude commission of Independent Chair (all priorities) ▪ Recruit to additional Lay Advisors to the Board (all priorities) ▪ Complete Section 11 audit and review scrutiny programme (all priorities) ▪ Undertake skills audit of LSCB Members to identify training and development needs (all priorities) ▪ Review LSCB Self-Assessment and implement improvements in respect of governance, partnership working, engagement of children & young people, business planning and quality assurance (priority 3) ▪ Develop a Participation Strategy to improve the engagement of children, young people and their families in child protection and safeguarding ▪ Conclude review of inter-agency response to children who go missing from care or home	*By 30/06/13* *By 30/10/13* *By 30/09/13* *By 30/10/13* *By 31/08/13* *By 31/12/13* *By 30/10/13*	Directorate of Children's Services	Quality & Performance Management Group
Participating in planning and commissioning Participating in wider strategic planning and identifying gaps in services to inform commissioning strategies and priorities	• Appoint to LSCB Business & Communications Officer (all priorities) • Implement improvements from local evaluation of the Domestic Abuse Response Team (priorities 5) • Complete review of arrangements for children missing from home or care (priority 4) • Complete and implement CSE Strategy & Action Plan (priority 4) • Produce score cards for simple data analysis of key activity/trends (priority 3) ▪ Support and challenge improvements arising from Ofsted/CQC Inspections in 2011 in respect of Safeguarding & Looked After Children (all priorities) and Joint Working between children's and adults services in 2012 (priority 5)	*By 30/09/13* *By 31/12/13* *By 30/10/13* *By 31/03/13* *By 31/08/13* *By 31/08/13*	Directorate of Children's Services	Quality & Performance Management Group
Functions relating to child deaths and Serious Case Reviews Undertaking child death reviews, serious case & other case review activity to identify lessons & contribute to inter-agency improvements and within organisations	▪ Review Rapid response arrangements and implement changes *(priority 3)* ▪ Implement action plan arising from Child C ▪ Conclude SILP-3 and Implement action plan *(priority 3)*	*By 31/07/13* *By 30/09/13* *By 31/12/13*	Directorate of Children's Services Clinical Comm Group	Child Death Overview Panel Serious Case Review Sub-Group

DSCB Structure Chart



Dudley Safeguarding Children Board

'Working Together to Keep Children & Young People Safe'

http://safeguardingchildren.dudley.gov.uk

What is Dudley Safeguarding Children Board (DSCB)?

The Local Safeguarding Children Board (LSCB) is the key statutory mechanism for agreeing how relevant organisations will co-operate and work together to safeguard and promote the welfare of children and young people in Dudley, and for ensuring the effectiveness of what they do.

Safeguarding children – the action we take to promote the welfare of children and protect them from harm – is *everyone's responsibility.'* Safeguarding means:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best outcomes

The Board is made up of senior representatives from a range of organisations from the statutory and voluntary sector. The LSCB is not accountable for operational work, but holds partners to account on the effectiveness of their safeguarding services for Dudley's children and young people.

The Board is chaired independently by Roger Clayton.

Dudley Safeguarding Children Board
Working together to keep children and young people safe

promoting an understanding that safeguarding is everyone's responsibility
improving the safety and wellbeing of children and young people across all communities
developing safer services and employment practices across all organisations

What does DSCB aim to achieve?

Since its inception in April 2005, Dudley Safeguarding Children Board has been working to 3 key objectives. In order to achieve this Dudley Safeguarding Children Board (DSCB) will work to ensure that:

- *All* children and young people have safe environments to help promote their welfare and well-being
- Action is targeted at *vulnerable groups* such as disabled, children in care; *and*
- *Responses* to children who have been harmed to minimise lifelong impact are co-ordinated and effective

The revised *'Working Together to Safeguard Children'* guidance (2013) requires the Chair of the LSCB to publish an annual report on the effectiveness of child safeguarding in their local area:

- DSCB's responsibility to **co-ordinate** work to safeguard and promote the welfare of children and young people
- DSCB's responsibility to ensure that local work to safeguard and promote the welfare of children and young people is **effective**

How will the Board achieve its aims?

The Board has a number of defined functions and responsibilities, which are outlined within statutory guidance known as *'Working Together to Safeguard Children'* and underpinned by the Children Act 2004 and LSCB Regulations 2006. These are:

- Thresholds, policies and procedures
- Training & Development
- Communicating and raising awareness
- Monitoring and evaluation
- Participating in planning and commissioning
- Functions relating to child deaths and Serious Case Reviews

What safeguarding activity happened during 2012-13?

From a population of 74,830 children and young people aged 0-19, during 2012-13:

⇒ *386 children were reported as missing from home to the Police, an average of 32 children per month;*
⇒ *989 children (under 18 years of age) were victims of recorded crime, of which 26 were victims of knife crime and 6 victims of gun crime*
⇒ *40 young people (under the age of 18 years) were charged with drug related offences, 39 of whom were in respect of Class B drugs and 1 young person in relation to Class A drugs*
⇒ *there were 6,653 referrals made to Children's Social Care*
⇒ *Section 47 child protection investigations took place in respect of 625 children and young people*
⇒ *there were 281 child abuse recorded crimes by the police and 90 cases were detected as child abuse related offences*
⇒ *1516 notifications were made to social care involving children living within the household where a domestic abuse incident had taken place*
⇒ *117 child protection medicals were undertaken by a Consultant Paediatrician or other suitably qualified clinician*
⇒ *40 young people were referred to the Young People's at Risk of Sexual Exploitation Panel*
⇒ there were 170 concerns or allegations in respect of people who work with children, leading to 114 independently chaired 'Position of Trust' Complex Strategy Meetings concerning 80 individual members of the workforce
⇒ there were 182 Initial Child Protection Conferences, 21 'Receiving-In' Conferences and 332 Review Conferences – a total of 354 children were the subject of an Initial Child Protection Conference

As at 31st March 2013:

⇒ *3082 children (around 4% of all children and young people) were defined as 'in need' by children's social care,*
⇒ *248 children and young people were subject to a child protection plan*
⇒ *730 children and young people were looked after by the local authority*

What did we do during 2012-13?

⇒ Made progress in respect of our previous years 3 key priorities, for example:

- Introduced new inter-agency child protection standards aimed at improving the consistency and quality of inter-agency child protection practice
- Increased the number and completion of common assessments to help ensure that children and young people who are vulnerable received earlier support and help to meet their needs;
- Strengthened inter-agency responses to children & young people at risk, or who have suffered, sexual exploitation or abuse

⇒ Introduced new inter-agency guidance for frontline practitioners and their managers in respect of professional resolution/escalation, serious or significant safeguarding incidents, standards of recording, protecting children living in highly resistant families or who move across local authority borders

⇒ Facilitated a total of 8612 safeguarding training places, of which 1730 places were part of the multi-agency training programme, with an additional 730 people attending briefings conducted by DSCB

⇒ Facilitated a major Conference and launched a public awareness campaign on Child Sexual Exploitation in May 2012, just ahead of the London Olympics

⇒ Concluded and published a Significant Incident Learning Process (SILP) in respect of Child D in June 2012 and a Serious Case Review in respect of Child C in April 2013

⇒ Conducted 35 reviews of expected and unexpected child deaths

⇒ Held a series of events as part of European Safer Internet Day in February 2013, attended by over 500 adults and children

How well did we do it and what difference are we making?

The Board is highly committed to improving both the consistency and quality of safeguarding practice across services working with children, young people and their families.

During 2012-13, over 500 individual cases were audited by partners on the Board and a range of improvements implemented to improve both the quality and effectiveness of safeguarding practice.

In respect of multi-agency safeguarding training, 92% of delegates said that the training was excellent or very good in respect of 'usefulness in terms of their practice' and 92% described the quality of training as 'excellent' or 'very good'.

The Board's will be working to strengthen the 'voice' and participation of children, young people and their families during the next 12 months as part of its commitment to continuous learning and improvement.

The full annual report contains some examples of impact and how agencies and safeguarding is making a difference in promoting the wellbeing of children and young people in Dudley. The Board will continue to strive to improve the outcomes of all, and the most vulnerable children, through effective partnership working at all levels. For most, this will mean continuing to live with their families and in their communities, but for a small number it is necessary to ensure that their welfare is safeguarded through the provision of 'care' – in 2012-12, 151 children became looked after by the local authority as a result of 'abuse or neglect'.

What difference are our safeguarding arrangements?

The last external judgement of Dudley's safeguarding arrangements was made by Ofsted in January 2012 – they were deemed to be 'adequate with good capacity to improve'.

In August 2012, Ofsted and the Care Quality Commission undertook a 3-day thematic inspection of adult services' arrangements for the safeguarding of children where they are parental substance misuse or mental health services. An action plan has been developed in respect of the feedback to address key areas of improvement identified by the inspectors.

Inspections in respect of regulatory services such as early years, schools, children's homes and health trusts include their safeguarding arrangements. For example, in September 2012, 93% of child care providers in Dudley were judged by Ofsted to be either good or outstanding.

How effective are we as a Board?

Currently, there is no formal judgement of the Board's effectiveness, although this is likely to be introduced into the national inspection framework during the coming 12 months.

The Board has refreshed its own self-evaluation against the Ofsted good practice criteria as:

Good Practice Area	Self-Assessment	
	2012	2013
Governance arrangements	Satisfactory	Satisfactory
Partnership working	Good	Good
Engagement with children and young people	Satisfactory	Satisfactory
Business planning and relationship with Children's Trust/Partnership	Satisfactory	Satisfactory
Quality Assurance	Poor	Satisfactory

What are the Board's key priorities for the next 12 months?

The Board's full Business Plan & Work Programme outlines in greater detail planned activity during the next year, taking account the risks and challenges that we face.

DSCB has set 5 key priorities for 2013-15. These are

PRIORITY 1
Improve the protection of children from abuse and neglect, through more effective inter-agency working and consistent approaches to minimising risk and strengthening resilience within families

PRIORITY 2
Improve the effectiveness of early help and intervention for children and young people who are vulnerable

PRIORITY 3
Strengthen the effectiveness of support and challenge provided by partners of the Board to improve safeguarding outcomes for children, young people and their families

PRIORITY 4
Improve inter-agency responses to young people who are at risk of, or who have suffered, sexual abuse or exploitation

PRIORITY 5
Improve the safeguarding and protection of children and young people who are living in households where there is domestic abuse, parental mental health and parental substance misuse

For more information about the work of Dudley Safeguarding Children Board go to http://safeguardingchildren.dudley.gov.uk or contact Graham Tilby at Safeguarding & Review Service, 6 St. James's Road, Dudley, 01384 813016 – graham.tilby@dudley.gov.uk

Agenda Item No.10

Dudley Health and Wellbeing Board – 26th September,2013

Report of the Chief Officer,Dudley Clinical Commissioning Group

Dudley CCG Primary Care Development Strategy

Purpose of Report

1. To present the final version of the Primary Care Development Strategy as approved by the CCG Governing Body.

Background

2. The attached Primary Care Development Strategy, has been developed over a series of months and the priorities it sets out are based on input from CCG members and local patient and community groups. It also takes account of the NHS England and local Area Team priorities for primary care as we understand them at the present time.

3. Whilst developing the strategy, early discussion papers and later drafts of the strategy have been shared with a number of groups and individuals including:
- CCG members (including membership development events)
- Practice managers
- CCG Locality forums
- CCG Communications and Engagement Committee
- Healthcare Forum
- CCG Patient Opportunities Panel
- CCG Executive Team
- A core group established specifically for the purpose of developing the strategy which included GP members, a practice manager, Local Medical Committee and managerial support.

4. The focus of the strategy is on developing local primary care and supporting practices to provide high quality services for patients. This means that, rather than focussing in the first instance on specific clinical or service priorities, instead the intention has been to describe approaches which will build strong, high quality primary care providers who are as well placed as possible to meet new service challenges and deliver clinical priorities now and into the future. Primary care is the cornerstone of local healthcare, so if we don't tackle the challenges facing local practices, then it is unlikely that the CCG will be able to deliver the improvements in health outcomes and health services it aims to achieve.

5. The CCG will be developing an implementation plan for the strategy. This process will be led by the Head of Membership Development and overseen by the Primary Care Development Committee. The strategy and its implementation will be discussed at a forthcoming membership development event and CCG Locality

forums. Local patient groups will be a central part of the development and monitoring of the implementation plan. There is good evidence to show that direct patient involvement helps to maintain momentum, drive agreed change and therefore will increase the likelihood of achieving the aims of the strategy.

Finance

6. To be agreed as part of the implementation plan

Law

7. To be agreed as part of the implementation plan.

Equality Impact

8. By supporting the development of high quality primary care, this strategy is also designed to ensure that local primary care providers are best placed to play their part in the delivery of Dudley's 'Joint Health and Wellbeing Strategy Wellbeing for life – our plan for a healthier Dudley borough 2013 -2016'.
The aim of this plan is to improve the health and wellbeing of local people and reduce health inequalities.

Recommendation

9. It is recommended that:-

    - To note the contents of the Primary Care Development Strategy that supports Dudley's 'Joint Health and Wellbeing Strategy Wellbeing for life – our plan for a healthier Dudley borough 2013 -2016'.

……..
Paul Maubach
Chief Officer, Dudley CCG

Contact Officer: Daniel King
Telephone: 01384 321868
Email: Daniel.king@dudleyccg.nhs.uk

List of Background Papers

NHS
Dudley
Clinical Commissioning Group

Primary Care Development Strategy 2013

Our Values:

We will be a **caring** organisation

We will be a **patient-centred** organisation.

We will **work together** as teams
within the organisation and with partners

Quality and **safety** will be the foundation
of everything we do.

We will be an organisation which **leads** by example.

We will be a **learning** organisation.

We will be an **inclusive** organisation.

We will have a focus on prevention and **health** promotion.

We will be an **innovative** organisation.

We will promote excellent **financial** management.

Foreword

Primary care is facing unprecedented challenges.

We have the biggest change in the NHS since its inception, severe national economic constraints, an ageing population and increase in demand. Over the last decade, general practice has become more robust in its governance and clinical practice and is in a much better place to face the rigours of modern health care.

There are, however, further demands on primary care which are currently underway or which we will face in the coming years. Care Quality Commission registration, revalidation, GP workforce issues and changes to the general practitioner contract will mean that we will have to contend with a more difficult working environment in the future.

In developing this strategy we have taken into consideration the objectives set by NHS England to improve quality and reduce variation in general practice. We have listened to what patients want, which is improved access to services and continuity of care with their family doctor. The CCG membership has been clear that the main issue that they have to deal with is of increasing workload.

The problems have arisen because of a lack of service capacity due to increasing demand and underinvestment in primary care over the last few years.

The strategy looks at increasing capacity in general practice and investment in primary and community care along with the development of integrated extended primary care teams using innovative solutions which the Health and Social Care Act offers us.

Primary care is at the heart of the delivery of the new NHS agenda and it is only by recognising that it has this pivotal role and by supporting practices to deliver good quality general practice that we can meet these challenges.

Dr. Jas Rathore
Clinical Executive
Finance and Performance

Contents

Author
Mrs Gillian Goodlad

Contributors
Dr Jas Rathore
Dr Tim Horsburgh
Dr Kevin Dawes
Dr Richard Gee
Mr Daniel King
Mr Paul Maubach
Mrs Carol Jones
Ms Helen Ashford

Related CCG Documents
CCG Primary Care Premises Planning Framework
CCG IT Strategy
CCG Research and Development Strategy
CCG Innovation Strategy

Primary Care Development Strategy Summary on a Page

Our Vision and Aims

"To ensure high quality, accessible primary care for the people of Dudley"

- To support local practices to maintain an improve the quality of primary care provision for patients
- To support the CCG's strategic aims by continuing to reduce health inequalities, improving health outcomes, improving services and improving health & safety

Priorities for Developing Primary Care

Improving Access & Managing Workload	Developing Locality-based Services	Managing the shift from Secondary to Primary Care
Primary Care's role in delivering the Urgent Care Strategy	Building Resilient Primary Care & Supporting Practices to Thrive	Reducing Unwanted Variation & Rewarding Excellence

Local Clinical Priorities for Primary Care

Local Quality Premium Areas	Quality and Productivity Indicators in QOF
Dementia	OPD Pathways: Cardiology, Pain Management, Ophthalmology
Atrial Fibrillation	Reduction in Avoidable A&E Attendances
Hypertension	Emergency Pathways: Atrial Fibrillation, Acute Asthma, Frail Elderly UTIs

To contribute to the CCG's wider strategic priorities for improving health & health services

Related CCG Strategies and Policies

Premisis Planning Framework	CCG Communications and Engagement Strategy	CCG Research and Development Strategy
CCG Innovation Strategy	Quality Monitoring Process	CCG Financial Plan
CCG OD Strategy	-	CCG IT Strategy

1. Introduction

Dudley Clinical Commissioning Group (CCG) has identified a need for a primary care development strategy which supports local practices to further improve the quality of primary care and helps the CCG to meet its overall strategic aims.

Primary care services are the bedrock of local healthcare. Over 90% of all patient contact with the health service happens in primary care. In addition, general practitioners are the key gatekeepers to hospital and other specialist healthcare services. Achieving the aims and priorities of the CCG's wider strategic commissioning plans will in large part be dependent upon local practices being able to deliver improvements and participate fully in the prevention agenda. Ensuring stable, high quality, accessible primary care services is therefore essential to meeting the healthcare needs of our population.

As a clinically-led membership organisation, Dudley CCG is uniquely placed to deliver change and improvement in primary care. This strategy aims to build on this opportunity, whilst acknowledging the freedoms and restrictions of the new NHS arrangements for the direct commissioning of primary care.

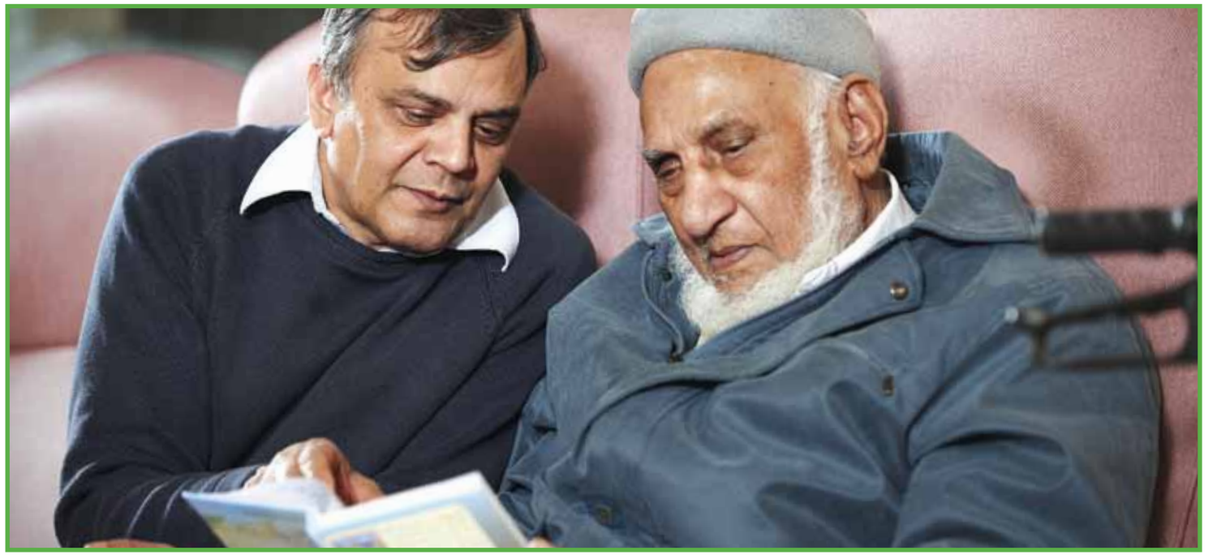
The priorities set out in this strategy are based on:

- What **member practices have told us** about their key concerns and how these should be addressed
- What **patients and our local communities have told us** about their current primary care services
- The **CCG's agreed strategic aims** and priorities (and those of Dudley's Health and Wellbeing Strategy)
- The **national 'must do's'** and performance management requirements.

The priorities which have been identified locally also mirror many of the key elements of the top ten priorities for commissioners published by the Kings Fund in 2012 and updated this year. A key feature of the priorities set out by the King's Fund is the extent to which they involve a change in primary care itself and the way in which primary care works with the rest of the system.

If CCGs are to maximise the opportunities afforded by the direct engagement of GPs in commissioning, then it will be necessary to invest in developing it members, growing as a strong commissioning organisation and building good working relationships across the health system. These aspects are addressed in the CCG's Organisational Development Plan.

This strategy also builds upon some of the aims and ambitions set out in Dudley PCT's primary care strategy 2009-14 **'Reaching Excellence'**.



2. Vision and Aims

The vision for primary care in Dudley is:

"To ensure high quality, accessible primary care services for the people of Dudley."

The **aims** of the strategy are:

- To support local practices to maintain and improve the quality of primary care provision for patients
- To support the CCG commissioning strategy by contributing to reduce health inequalities, improving health outcomes, improving services and improving health and safety.

3. Arrangements for Commissioning Primary Care from April 2013

As part of the new NHS organisational arrangements from April 2013, there have been significant changes in the way in which primary care services are commissioned. In summary:

NHS England commissions national primary care services. They hold primary care contracts and are responsible for planning, securing and monitoring services commissioned by them in respect of primary care.

CCGs are responsible and accountable for commissioning local enhanced services. In addition, CCGs have a statutory duty to assist and support NHS England in securing continuous improvement in the quality of primary medical services.

These new arrangements have implications for the remit, development and implementation of this strategy, as they determine what the CCG has direct control over and what is outside its direct control in relation to the commissioning of primary care.

It is clear that CCGs will now be required to play an active role in supporting NHS England to exercise its responsibilities. This means that close working between the CCG and The NHS England local Area Team (AT) will be essential. Neither organisation will be able to bring about the required changes alone or by focussing solely on those services over which they have direct budgetary control. This reinforces the need for Dudley to have a clear local strategy for primary care, with agreed aims, processes and policies. This will offer clarity and assurance to the AT that Dudley CCG is equipped to meet any national performance requirements for primary care and is likely to give the CCG more freedom to address its local priorities in the way it thinks best for its local communities.

4. Scope of the Strategy

This strategy focuses on general medical services and does not directly cover pharmacy, dentistry and eye care services. This reflects the fact that the CCG's membership is comprised of general practitioners and the CCG's responsibility to ensure the continuous improvement of primary medical services.

5. Primary Care in Dudley

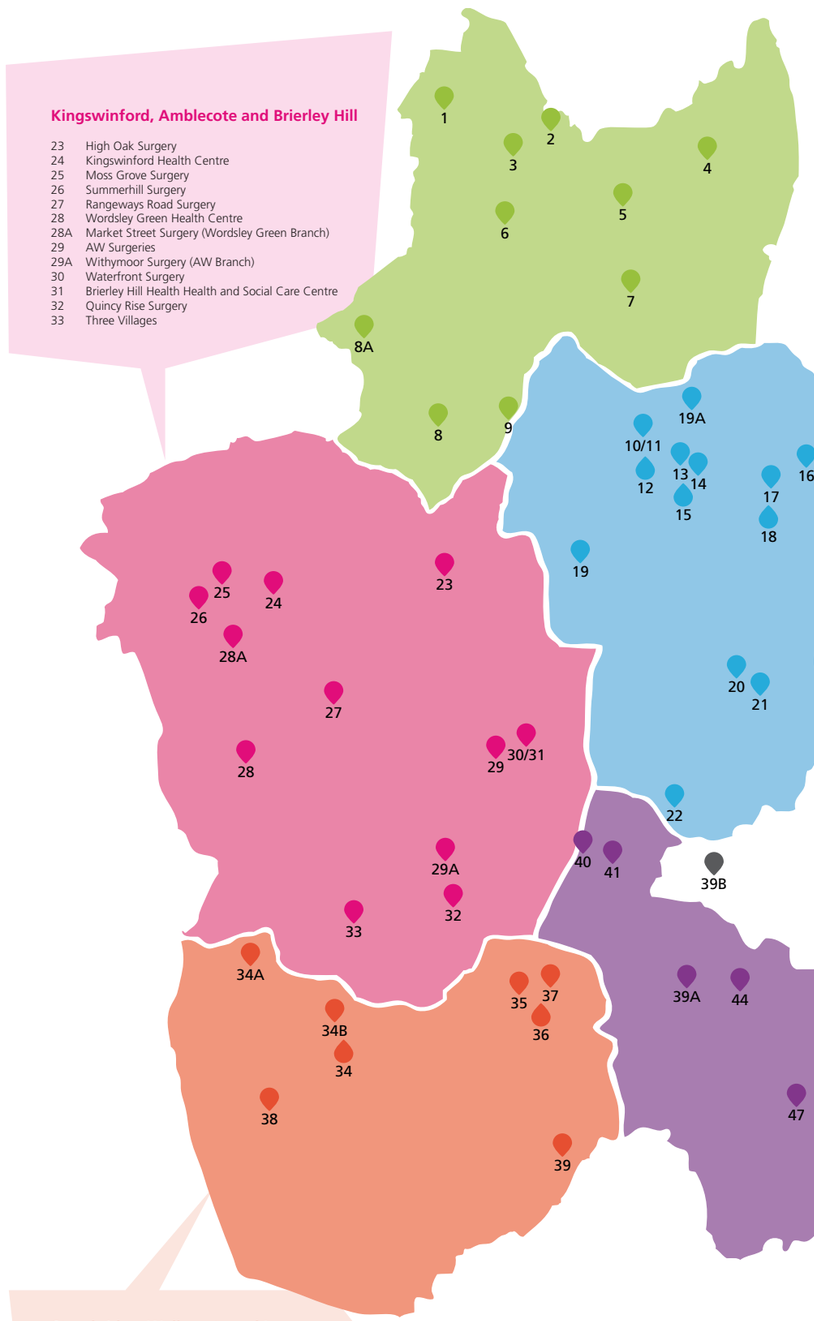
Many of the features of the local population and the current primary care delivery models remain unchanged from those described in the PCT strategy 'Reaching Excellence'. General issues affecting primary care in Dudley, and as reflected in the local Health and Wellbeing Strategy, include:

- Rising demand for healthcare services
- A slower than average rate for improving the health of local people
- Persistent long-term inequalities, (despite targeted action having been taken in the past)
- Worsening trends in lifestyle risks, particularly from obesity and alcohol
- Significant levels of undetected and untreated disease.

Facts and Figures

- Dudley CCG has a population of approximately **314,500.**
- There are **49 General Practices** plus a Walk in Centre in Dudley. These practices occupy 47 main practice premises and 9 branch surgery sites, making a total of 58 facilities. The CCG has organised its practices into 5 geographical localities. (see map below)
- There are **199 General Practitioners, (174 WTEs)**.
- Almost **27% of Dudley GPs are aged 55 or over** (compared to a national average of 22%). More worryingly, **over 10% (21) GPs are aged 65 or over** compared to a national average of only 4%. In some practices half or more of the GP workforce is over 60. (This is important because over a quarter of GPs may retire during the next ten years.)
- Practices vary in size. Total **list sizes** range from just over **1,000 patients to 25,000 patients**. Nearly **one fifth of practices in Dudley are single handed** which is almost double the national average. Over **40% of practices in Dudley have 2 partners or less**, compared to a national average of 28.5%. (see Attachment 1)
- Practice list sizes per WTE GP vary, with the average being **1,808 per WTE GP** (national average 1,765). Further work is required to understand the impact of the availability of other community and primary care services alongside GPs has on the WTE requirement.
- Current accessibility for existing primary care facilities in terms of geography appears good and **most of the population are within 30 minutes walking distance of a GP surgery**. The majority of residents have good access to public transport, with **most residents living within 10-20 minutes of their nearest GP practice**.

Surgeries by Locality



Sedgley, Coseley and Gornal

1 Northway Surgery
2 Bath Street Surgery
3 Bilston Street Surgery
4 Coseley Medical Centre
5 Woodsetton Medical Centre
6 The Ridgeway Surgery
7 The Greens Health Centre
8 Lower Gornal Health Centre
8A Masefield Road Surgery (Lower Gornal Branch)
9 Castle Meadows Surgery

Kingswinford, Amblecote and Brierley Hill

23 High Oak Surgery
24 Kingswinford Health Centre
25 Moss Grove Surgery
26 Summerhill Surgery
27 Rangeways Road Surgery
28 Wordsley Green Health Centre
28A Market Street Surgery (Wordsley Green Branch)
29 AW Surgeries
29A Withymoor Surgery (AW Branch)
30 Waterfront Surgery
31 Brierley Hill Health and Social Care Centre
32 Quincy Rise Surgery
33 Three Villages

Dudley and Netherton

10 St James Medical Practice (Dr White)
11 St James Medical Practice (Dr Porter)
12 Eve Hill Medical Practice
13 Tinchbourne Street Surgery
14 Cross Street Health Centre
15 Steppingstones Medical Practice
16 St Thomas's Medical Practice
17 Central Clinic
18 Bean Road Surgery
19 Keelinge House Surgery
20 Netherton Surgery
20A Hazel Road Surgery (Netherton Surgery Branch)
21 Netherton Health Centre
22 Quarry Road Surgery

Halesowen and Quarry Bank

39A Chapel House Lane (Wychbury Branch)
40 Thorns Road Surgery
41 Quarry Bank Medical Centre
42 Clement Road Medical Centre
43 Feldon Lane Surgery
43A Hawne Lane Surgery (Feldon Lane Branch)
44 Crestfield Surgery Ltd
45 Alexandra Medical Centre
46 Lapal Medical Practice
47 Meadowbrook Surgery
48 Halesowen Health Centre
48A Tenlands Avenue Surgery (Halesowen HC Branch)
48B Coombs Road Surgery (Halesowen HC Branch)
49 St Margaret's Wells Surgery

Out of Area

39B Cradley Road Surgery (Wychbury Branch)

Stourbridge, Wollescote and Lye

34 Worcester Street Surgery
34A Meriden Avenue Surgery (Worcester St Branch)
34B Greenfield Avenue Surgery (Worcester St Branch)
35 Pedmore Medical Practice
36 Chapel Street Surgery
37 The Limes Surgery
38 Norton Medical Practice
39 Wychbury Medical Group

Data correct as of April 2013

6. Challenges Facing Primary Care in Dudley

There are a range of significant challenges facing primary care generally and GP practices in particular. These include:

- **Rising workload and pressure on access**. Rising demand from patients within the context of limited and stretched capacity in primary care has been placing increasing pressure on practices. This is a major barrier to practices being able to maintain or improve quality standards and impedes their ability to support new care pathways.

- Proposed changes to the **national contract** and other national initiatives will have a significant impact on general practice in a range of ways. The detail of the impact of the various changes on individual practices is difficult to calculate, but we know that most practices will need to make significant adaptations to their organisational arrangements to implement these changes successfully, meet required performance standards and maintain income. Changes include:

    - Changes to the Quality and Outcomes Framework indicators with increased thresholds
    - Introduction of new Directed Enhanced Services
    - Equitable funding proposals from 2014 onwards will impact differentially on practices.

In addition to the concerns regarding the impact of these changes on workload and income, there are also concerns that this will be a negative impact on patient access, and recruitment and retention to general practice in the medium term.

- A changing **workforce and labour market** point to the need for detailed and proactive succession planning and recruitment and training plans. For example, up to one quarter of Dudley GPs may retire within the next 10 years. In addition, other issues such as **CQC registration, revalidation** and the national contract changes outlined above will have a direct effect on the primary care workforce.

- **Pressure on practice income** due to cost inflation, static 'pay settlements' and increasing activity. The proposed national contract changes and the introduction of capitation based budgets will affect practices differentially and the full implications of this for future primary care provision in Dudley need to be gauged.

- **Historic funding differences** between practices and between GMS/PMS overall is a specific challenge within Dudley and there is a need to understand the impact of the proposed contract changes and develop strategies to manage the change smoothly, fairly and safely.

- Increased **transfer of work from secondary to primary care.**

- **Pressure on premises** which are too cramped and/or not of a sufficiently high standard for modern day primary care service provision.

- Too much **unwarranted variation** in GP practice performance and the quality of service offered to patients.

- **Reduced organisational and management capacity at Area Team level** due to the recent NHS reorganisation. In addition to the expected teething problems, this seems also to be resulting in significant delays to decision-making processes for crucial issues e.g. practice merger requests.

The priorities and actions set out in this strategy must enable the CCG and its members to meet these challenges. This will require willingness from members to:

- work together
- adopt best practice
- think and act innovatively

7. Being Accountable to our Patients and Communities

The CCG already has a great deal of information regarding local patients' views of primary care services and their priorities for improvement. The CCG has established a range of processes for involving local patients and community groups in the work of the CCG which are overseen by the CCG's Communications and Engagement Committee. Many of the issues most regularly raised by patients mirror those of local practices. Especially those focussed on access issues which directly relate to practices' concerns regarding the increasing pressures on their available capacity. The key messages and issues have been consistent over the last few years and are set out below.

Patient Concerns

- **Telephone access and access to appointments** – especially same day access. NB this is by far the greatest concern raised by local people.

- Ensuring **continuity of care** between primary and secondary care and vice versa.

- **Communication** needs of those with sensory impairment.

- **More time** during consultations for explanation and checking patients have understood.

- Taking proper account of **carers' needs** and their views regarding the needs of those they care for.

- Improved **links** with social services and sign-posting.

- Being treated as an equal and with **dignity and respect**.

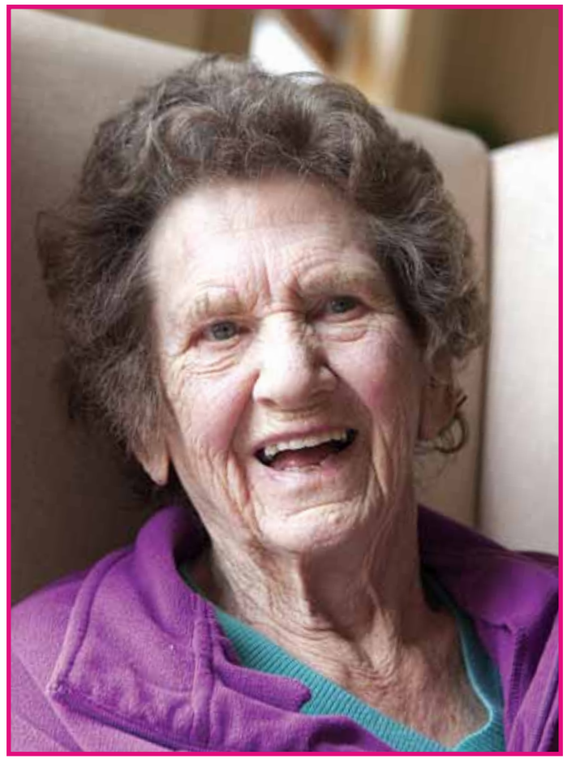
- Understanding patients' needs and helping them to get the right help at the right time.

- **Informed choice** – more advice. (GPs, patients and specialists do not always share a common understanding of why a referral is being made, for example, whether it is primarily for diagnosis, investigation, treatment or reassurance.).

- More **telephone consultations**.

- **Lack of understanding re role of nurses and nurse practitioners** – feeling of being offered a lesser service if not seeing a doctor.

The way in which the priorities identified in this strategy are addressed will take account of these views and address the concerns of local people.



8. Priorities for Primary Care Development

This section forms the most important part of the strategy as it sets out the key priority areas for developing primary care locally and the ways in which the CCG will seek to address these.

Managing Workload and Improving Access

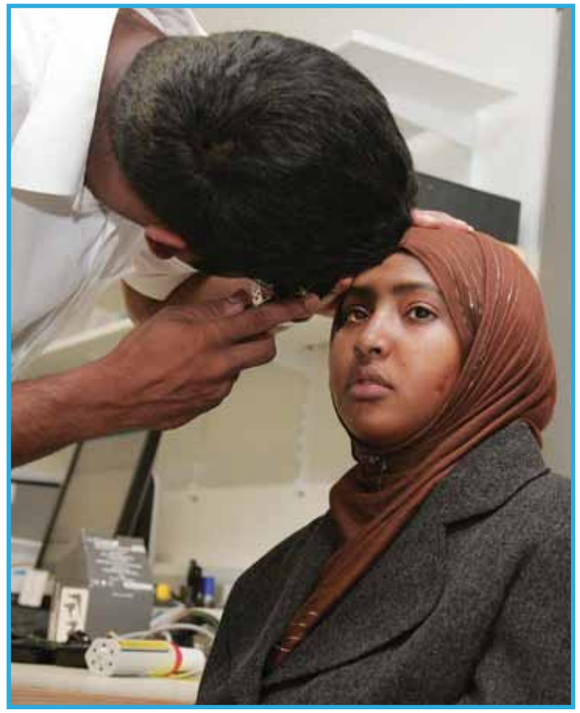
Why this is a priority

During work on this strategy, the consistent message we received from member practices was that the workload in primary care has become unmanageable within the existing capacity and is in danger of compromising the quality of the service offered. This is mirrored by the views we have consistently received from patients - that difficulty in getting appointments continues to be their number one concern. There is a need therefore to develop plans which create capacity in primary care, help to reduce pressure on practices and improve access for patients.

Whilst the average national list size per GP has dropped since over the last 20 years, the average consultation rate has risen. (The consultation rate is the average number of consultations per patient on the practice list, per year.) The current average consultation rate across Dudley is 5.26, which is marginally below the expected rate of 5.62. (The expected rate is the rate adjusted for local demographic characteristics.)

National trends have seen a fairly stable trend upwards since 1994 when the rate was 3.5 and rising by about 1 per decade. Most of this is driven by increasing numbers of treatments and procedures available in the community, less hospital based follow up and an aging population living longer with more disease.

None of these factors have eased during the last 5 years since the latest national consultation rate figures were published and the local Dudley rates, (calculated in March of this year, would appear to demonstrate that this trend has continued. The impact of this rising trend is huge for individual practices. For example, for a practice with a list size of 10,000 patients, an increase of 1 in the consultation rate represents an additional 10,000 consultations per year, (nearly 200 per week) which need to be accommodated. This rise in demand has not been matched by an increase in resource within primary care.



Solutions

- The CCG has funded the Primary Care Foundation to conduct a **baseline audit** of the current workload in terms of appointments, telephone traffic, opening times etc. This is helping individual practices to quantify the pressures on their current capacity, identifying where and when these are greatest. This will inform **individual practice development plans**. There is some evidence to show that some relatively simple modifications can improve patient satisfaction and help to make the workload more manageable. The PCF has therefore been working with practices to identify modifications to current working practices to help them better manage demand. The headline findings from this work when taken collectively have also helped the CCG to identify the key issues and help to produce plans to mitigate these pressures. The key messages are:
  - The need to improve **continuity of care** for patients – there is good evidence that this reduces emergency admissions, leads to reduced consultation rates and, as this is also the top of the majority of patients' wish lists, improved patient satisfaction
  - The need to ensuring **effective telephone response**
  - The need to **re-balance practice systems**, particularly appointments systems, to ensure that, as far as possible, they do not work against continuity of care. (As the expected consultation rates are adjusted to account for local demography, a higher consultation rate is not normally an indication of a greater health need or a more deprived population. Rather, it is often an indication that patients are being seen more often than is necessary for the overall health needs of the practice population. This can be caused by a number of factors, but foremost amongst these is practice systems which work against continuity of care)
  - There is evidence of a link between high patient satisfaction scores and high QOF scores and vice versa. In addition, there is evidence that **ease of access for patients can affect their use and interaction with those services and therefore any connected services e.g. A&E.**
  - Need to review current practice with regard to the **clinical assessment of home visit requests** to ensure that requests are assessed quickly and any resulting urgent home visits are completed earlier in the day.
- The CCG is putting in place plans to build on the GPs with a special interest (GPWsI's) **development programme** to improve capacity in primary care, help with the retention of GPs, aid service development and help succession planning.
- Ensuring that the CCG thinks carefully about **the way in which it procures additional services** from primary care (including any new **Local Enhanced Services (LES')**. This includes:
  - Planning new procurements carefully and avoiding hurried introduction of new schemes
  - Ensuring procurements cover a time period which is long enough for practices to make sensible choices regarding any additional staffing to cover the procured service requirements and ensure that this represents a genuine increase in capacity within primary care where this is required
  - Newly procured services should be monitored to ensure they are delivering the agreed improvements for patients and commissioners. This includes agreeing in advance the outcome measures and the action which should be taken if these outcomes are not being achieved either by individual practices or across the board.
  - Ensuring that the improvements afforded by the introduction of newly procured services in primary care will be available to all patients across the CCG area irrespective of which practice they are registered with.
- Further development to encourage **increased self-management by patients**. Around 70% –80% of people with long-term conditions can be supported to manage their own condition (Department of Health 2005).There are a number of well-established self-management programmes that aim to empower patients to improve their health. Evidence has highlighted the importance of ensuring the intervention is tailored to the condition (de Silva 2011). For example, structured patient education can be beneficial for people with diabetes, while people with depression may benefit more from cognitive and behavioural interventions. Recent work conducted by the Richmond Group of Charities and The King's Fund (2012) called for patients to be offered the opportunity to co-create a personalised self-management plan which could include the following:
  - patient and carer education programmes
  - medicines management advice and support including advice about diet and exercise
  - use of tele-care and tele-health to aid self-monitoring
  - psychological interventions (e.g., coaching, including telephone based coaching)
  - pain management
  - patient access to their own records.

Developing Integrated Locality Based Services

Why this is a priority

Both practices and patients have identified the need for much better coordination and integration between services. Highly integrated primary care systems that emphasise continuity and co-ordination of care are associated with better patient experience (Starfield 1998; Bodenheimer 2008).

Few practices now have the close links they would wish with colleagues in the wider primary healthcare and community services team – particularly District Nursing. The coordination and integration of care seems to be quite variable for patients with on-going health needs. Nursing services across GP practices and the community are not always well coordinated and carers and voluntary sector services are not seen as being an essential part of the primary care system. This leads to more fragmented care for patients and their carers and more pressure on GPs and other professionals struggling to provide this care in isolation. In addition, there are some services which should be provided as close to patients' homes as possible, but which smaller practices do not have the capacity to provide.

Solutions

- the CCG will support the **development of the role of localities**, to enable them to gain more control over the development of services within their area. This will **promote integration** between local health services and also **with social services and other community and voluntary groups**.
- The CCG will develop plans to **commission 'community' services** in a way which requires providers to ensure they are **locality based and are directly linked to individual practices** (or groups of practices) to enable a more integrated approach to planning and delivery of services within the locality.
- CCG members will agree a **minimum range and quality of services** which will be available, (over and above core GMS), at practice and locality level. Building up a core of services based around **multi-disciplinary teams** and extended teams including primary care based mental health services, psychology services, pharmaceutical advisers, counsellors etc.
- Developing **locality based education, research and training.**
- Further work to learn from best practice elsewhere, where moves towards community-based multi-**professional extended primary healthcare teams based around general practices** that include generalists working alongside specialists and care coordinators have delivered significant improvements in patient experience, outcomes and satisfaction.
- The CCG and localities will support **closer working between practices** in order to ensure that the full range of services are available to all patients within their locality irrespective of which practice they are registered with. In addition, closer working should help practices to build resilience and manage costs. This will need to be done in a way which does not undermine continuity of care for patients.
- Localities will build links with local community and voluntary sector groups to further support the delivery of coordinated care for patients.

Managing the Shift from Secondary to Primary Care Service Provision

Why this is a Priority

Recent years have seen a steady increase in the transfer of work and services to primary care which were previously carried out in secondary care settings. This includes care pathway changes such as;

- reduced number of hospital follow-up appointments
- earlier discharge from hospital
- more post-operative care done in primary care
- more primary care led management of long term conditions.

These changes, together with an ageing population and increased prevalence of chronic diseases, call for a strong shift away from the current emphasis on acute and episodic care, towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated and integrated. To date, however, movements towards more care being provided in primary care and community settings have not generally been matched by a shift in resources.

The scale of the change management task to achieve this fundamental shift has generally been underestimated and moves to change the balance in the way in which care is provided have often been under planned and left to drift. There has been an assumption that doing more in primary care and community settings will result in savings. This does not happen however unless the increased investment in community services has been accompanied by a clear and planned strategic disinvestment from hospitals. The CCG needs to be able to make a robust case for such disinvestment where it is clinically justified, and will need strong communication and political skills in order to overcome resistance to such change – whether from local communities or from local practices.

Solutions

- The CCG will commission **improved access to diagnostics and secondary care advice** e.g. extending direct access to imaging and electrophysiological diagnostics. Commissioning more accessible specialist advice without the requirement for an outpatient appointment.
- The CCG will make **further use of Local Enhanced Services** (or other procurement vehicles) which ensure that primary care is appropriately resourced to develop and participate in new care pathways which address local priorities and provide better services for patients.
- The CCG will develop a comprehensive and **innovative IT Strategy** which supports better coordination and integration across services and allows commissioners to track spend at each stage of the patient journey.
- Ensuring that the primary care aspects of the CCG's strategy for **Long Term Conditions** are appropriately implemented via specifically commissioned services and care pathway development and implementation for conditions such as diabetes, rheumatic diseases, knee replacements, hip replacements, gallstones etc.
- The CCG will consider the further development of **locality attachments for hospital consultants** based on the paediatrics model currently being implemented. This will promote closer working and learning and education.
- The CCG will ensure that local **Quality Premium** targets are introduced in a way which enables Primary Care to be supported to deliver them.
- The CCG will seek to ensure that **primary care premises** are developed to support service delivery in primary care settings where this is clinically appropriate.

Urgent Care – Primary Care's Role

Why this is a priority

Both nationally and locally, urgent care services continue to be a high priority. Urgent care services consume a large part of the available healthcare resource. These are costly services which should only be used when necessary. Dudley has a higher than average admission rate for conditions which would not normally require hospital admission. National benchmarked data suggests that there are higher than expected numbers of patients going to hospital A&E with conditions that can readily be treated in primary care. In addition, once patients reach the hospital they are often admitted with conditions for which admission is largely preventable. This is especially true of ambulatory care-sensitive conditions (ACS) such as congestive heart failure, diabetes, asthma angina and hypertension. According to the Kings Fund, ACS conditions account for 15.9% of all emergency admissions and national evidence demonstrates that there is a significant variation in how effectively ACS conditions are managed in primary care which impacts upon admission rates. This issue is therefore directly linked to primary care. It is interesting to note that at the CCG's Urgent Care event with the local Healthcare Forum most of the issues raised by patients related to the difficulties in accessing primary care which they felt contributed to pressure on A&E services. See patient comment boxes.

PATIENT COMMENTS

"Need improved access to primary care outside of routine work" hours"

"Greater co-operation between practices to cover longer hours e.g. rota"

"Spend money on GP surgeries instead so they provide out of hours"

"More receptionists to receive calls to avoid the engaged tone"

"CCGs to be stricter with GP practices – set standards of what GPs have to do"

"Need to see GPs as required – difficulty to speak to GP or get an appointments and the problems start when you need emergency access"

"Standardised set up for all GP practices with criteria"

"More availability of appointments in primary care including extended hours"

"Better telephone access to GP surgery"

Solutions

- To ensure that the **CCG's Urgent Care Strategy takes full account of primary care's current and potential contribution** to managing urgent care across Dudley.
- to develop and evaluate a pilot scheme which sees **a step change in the quantum and nature of primary care commissioned with the express aim of reducing avoidable A&E attendances and admissions**, and improving coordination and integration across services in and out of hours.
- To take a pro-active and appropriate approach to consider the role of primary care in relation to **innovative responses** to the national move towards **7 day primary care and community services** and the availability of key health and social care services at evenings and weekends. To work with local practices to design solutions which fit local circumstances and meet the needs of patients and practices.
- To ensure that the urgent care strategy includes specific actions such as the use of risk stratification tools, clinical decision support software within GP practices, and a range of relatively simple primary care based interventions to improve the early identification and **successful management of ACS patients**
- Other **primary care based aspects of urgent care** will also be reviewed within the context of the urgent care strategy including:
  - disease management and support for self-management for those with long-term conditions (see also workload section above)
  - telephone health coaching
  - increased continuity of care within GP practices (see also workload section above)
  - ensuring effective out of hours arrangements
  - providing effective signposting to help patients choose the right service
  - the ability to flex primary care and community services in response to short-term changes in demand
  - processes within practices for the timely review and management of requests for home visits (see also PCF work above)
- The **use of real time information and IT** to support early decision-making in primary care

Building Resilient Primary Care and Supporting Practices to Thrive

Why this is a priority

As has been outlined in the earlier section, general practice is facing a series of major challenges over the coming months and years. Whilst all practices will be affected, it is likely that some practices may be more adversely affected than others, or that some practices are less well placed than others to weather the changes and challenges. If Dudley CCG is to be successful and ensure high quality healthcare services for local people, it is essential that it has stable and strong primary care primary providers. By anticipating the likely local impact of planned changes at a national level and by mapping local trends in terms of retirements, recruitment and retention etc., CCG members will be much better placed to develop agreed strategies for successfully coping with these changes.

Solutions

- **Close working with the NHS England local area team** to ensure that the CCG has some influence over the direct commissioning of primary care, for example following the retirement of a single-handed practitioner, and can shape local services in line with agreed local strategies.
- To compile clear plans based on the **detailed modelling of anticipated local changes** e.g. retirements, premises changes, income changes.
- Supporting each member practice to develop a **practice Organisational Development plan**, (which also meets AT requirements), and to ensure that wider CCG strategies and plans reflect these individual plans
- Support practices (and practice managers) to explore **cooperative approaches** within a locality model, (where this is desirable and supported by local practices) e.g. sharing 'back room' functions e.g. payroll, centralising call and recall, choose and book. NB such cooperative models could be of any size or shape (of 2 practices or more) to suit local practice requirements and would not need to encompass a whole locality
- To develop a **CCG based primary care support team** with senior clinical and managerial leadership
- To explore the establishment of **a shared locum bank** for local practices in order to improve quality and effectiveness of locums
- To support and **further develop the practice managers' group** to lead innovative solutions to issues facing primary care and to support high quality practice management consistently across the CCG area
- Develop a **practice nurses group** to provide professional support, lead innovative solutions to service provision in primary care and support high quality service provision consistently across the CCG area
- To **increase the number of training practices** in Dudley
- To **continue initiatives which support and enable member practices to participate in the work of the CCG and be kept informed**. For example, the practice engagement LES which supports practice attendance at meetings, improving practices' ability to engage with the CCG support team and produce practice development plans
- To **support workforce training and development**, (e.g. CCG wide procurement where this benefits members), developing the mentorship schemes, statutory training/revalidation/support, remediation etc The CCG will ensure appropriate links with education and training networks including Local Education and Training Boards (LETB's)
- To develop the **Primary Care Quality Monitoring Group** to ensure on-going close liaison between the CCG, the AT, LMC and Responsible Officer. (See diagram Attachment 4)
- To ensure that the **CCG Organisational Development Strategy has an emphasis on supporting the development of CCG members.** This should set out how CCG members will work together to support each other to build a strong, high quality CCG, and how CCG membership benefits members and ultimately their patients.

Processes for supporting the CCG member practices are summarised in the diagram below:

Reducing Unwarranted Variation and Rewarding Excellence

Why this is a priority

At a national level, we know that there is substantial variation between practices in the range, quality and experience of services such as the systematic implementation of approaches towards secondary prevention. For example, disease registers where only a minority of patients receive all recommended interventions. Current information and benchmarking data for Dudley demonstrates that locally there is some significant variation in the quality and outcome of services offered by individual practitioners, practices and localities. Some of these differences can be readily explained and may even be desirable given the different needs of individual localities and patient preferences. Other differences, however, are not readily explained and demonstrate differences in access and quality between practices which are not acceptable for patients and which need to be addressed to ensure improved equitable health outcomes in Dudley. Dudley CCG as a membership organisation is committed to driving up quality, rewarding excellence and driving out poor quality primary care services.

Solutions

- The CCG will complete further work to **share detailed benchmarking information** regarding primary care service delivery with practices and agree actions arising from this.
- CCG members will agree a **process for monitoring and managing primary care** performance against the national assurance framework (and any locally agreed indicators), and will work closely with NHS England local Area Team to ensure that local knowledge is applied to raw data.
- The CCG fully acknowledges the central role practice managers have in the delivery of high quality primary care services and will work with practices to **ensure all practices have access to consistently high quality practice management and organisational skills**. There is good evidence to demonstrate that the achievement of clinical priorities (particularly those related to prevention and management of long term conditions), are directly influenced by how well practices can organise their activities to ensure that they consistently reach all targeted patients. In addition, those areas which are of most concern to patients i.e. access to appointments etc. are those which are most directly affected by the way in which the practice is managed.
- The CCG will **build on the PMS Review work** undertaken by the PCT to agree further quality measures with practices and support sustainable moves towards equitable resource distribution. In doing this the CCG will work with the NHS England local Area Team to take account of national initiatives in this respect.
- CCG members will agree a **scheme which incentivises** good performance against agreed indicators and rewards excellence as judged against national benchmarks.
- The CCG will ensure that methods of **procuring services** from primary care will ensure equality of access for all patients.

9. Clinical Priorities for Primary Care

The priorities identified in this primary care development strategy are designed to support primary care to deliver high quality services generally and any specifically identified clinical priorities. Primary care has a crucial role in delivering all of the national priorities across each of the 5 domains as set out in attachment 3. In addition to the national priorities, there are specific local clinical priority areas for primary care linked to the quality premium and the quality and productivity indicators for QOF.

Local Quality Premium Areas	Quality & Productivity Indicators in QOF
Dementia	OPD Pathways: Cardiology, Pain Management, Ophthalmology
Atrial Fibrillation	Reduction in Avoidable A&E Attendances
Hypertension	Emergency Pathways: Atrial Fibrillation, Acute Asthma, Frail Elderly UTIs
To contribute to the CCG's wider strategic priorities for improving health & health services	

10. Health and Wellbeing - Delivering Public Health Priorities and Reducing Health Inequalities

By supporting the development of high quality primary care, this strategy is also designed to ensure that local primary care providers are best placed to play their part in the delivery of Dudley's 'Joint Health and Wellbeing Strategy Wellbeing for life – our plan for a healthier Dudley borough 2013 -2016'. The aim of this plan is to improve the health and wellbeing of local people and reduce health inequalities.

Dudley is changing and although in national comparisons it scores average for deprivation, the health of people in Dudley lags behind the rest of the country. Some people are living longer and fewer are dying from the big killers – cancer, respiratory disease and heart disease - but not all. There are stark differences across the Borough, with certain wards experiencing disproportionately high levels of ill health and deprivation. Improvements over the last decade have been partly due to improved living conditions and treatments but are also due to people reducing risks to their own health by stopping smoking and reducing cholesterol levels. Rising obesity levels and alcohol consumption are increasing risks into the future. Primary care in Dudley has a crucial role to play in responding to these changes.

More systematic primary prevention in general practice has the potential to improve health outcomes and save costs (Health England 2009). For example, five minutes of advice in a general practice setting to middle-aged smokers to quit smoking can increase quit rates and save £30 per person for a cost of £11 per person.

Evidence suggests that the 'inverse care law' applies and those in greatest need are least likely to receive beneficial services. Identifying those at risk and intervening appropriately is one of the most effective ways in which GPs can reduce the widening gaps in life expectancy and health outcomes (Marmot Review 2010). More systematic and proactive management of long term conditions and preventative healthcare initiatives will improve health outcomes, reduce inappropriate use of hospitals, and have a significant impact on health inequalities. In order to ensure this systematic approach it is crucial that practices are organised and managed to excellent standards (see sections above), and the CCG is committed to supporting all practise to ensure that they have access to this.

More specifically, primary care has a key role in delivering a range of public health initiatives including:

- Immunisation programmes
- Child health
- Cytology/breast screening
- NHS Healthchecks
- Early detection programmes
- Diabetes, hypertension

The CCG will continue to ensure that practices are supported and monitored to ensure that these initiatives are successfully delivered.

11. Measuring and Monitoring Quality in Primary Care

National Assurance Framework

Phrases such as 'improving the quality of primary care' are used frequently, but in order for this to be meaningful for practitioners and patients there is a need to define what is meant by 'good' or 'high quality' and identify how this would be measured or demonstrated. Inevitably different practitioners have different perspectives on this and service users often have yet another view. There are now, however, some performance indicators which have been nationally determined. NHS England has provided a suite of measures which are intended to be transparent and consistent. This indicator set applies to all practices and Area Teams nationally and allows for comparisons to be made across CCGs, nationally or in customised clusters for practices or CCGs with similar characteristics. This tool is called the Primary Medical Assurance Framework: web interface and has recently been launched.

The web interface provides pre-analysed data to facilitate relationships between area teams and practices. Unique practice profiles are also available. It will be important for member practices to understand how to use the tool to compare their practice with peers. Events to introduce practices to the tool are being held nationally and the CCG will be arranging workshops locally. Local workshops will be focussed not just on how practice can use the tool but also on understanding how the tool will be used by NHS England and CCGs.

Local Processes for Monitoring Quality

CCG members will need to agree which other sets of data and benchmarking information should be used locally in addition to the national assurance tool. This will be based on processes currently in use, but these will need to be updated and streamlined in order to reduce duplication and focus on areas of most interest locally e.g. local priority areas. The organisational arrangements for how this data is reviewed and acted upon will also need to be agreed. An outline process built around a joint primary care quality monitoring group has been drafted. Attachment 4 summarises this and shows how this will link directly to the CCG's wider Committee structure and therefore governance arrangements. The CCG is currently in the process of discussing this with the Area Team in order to ensure that the CCG and Area Team processes are dovetailed as far as possible.

12. Premises

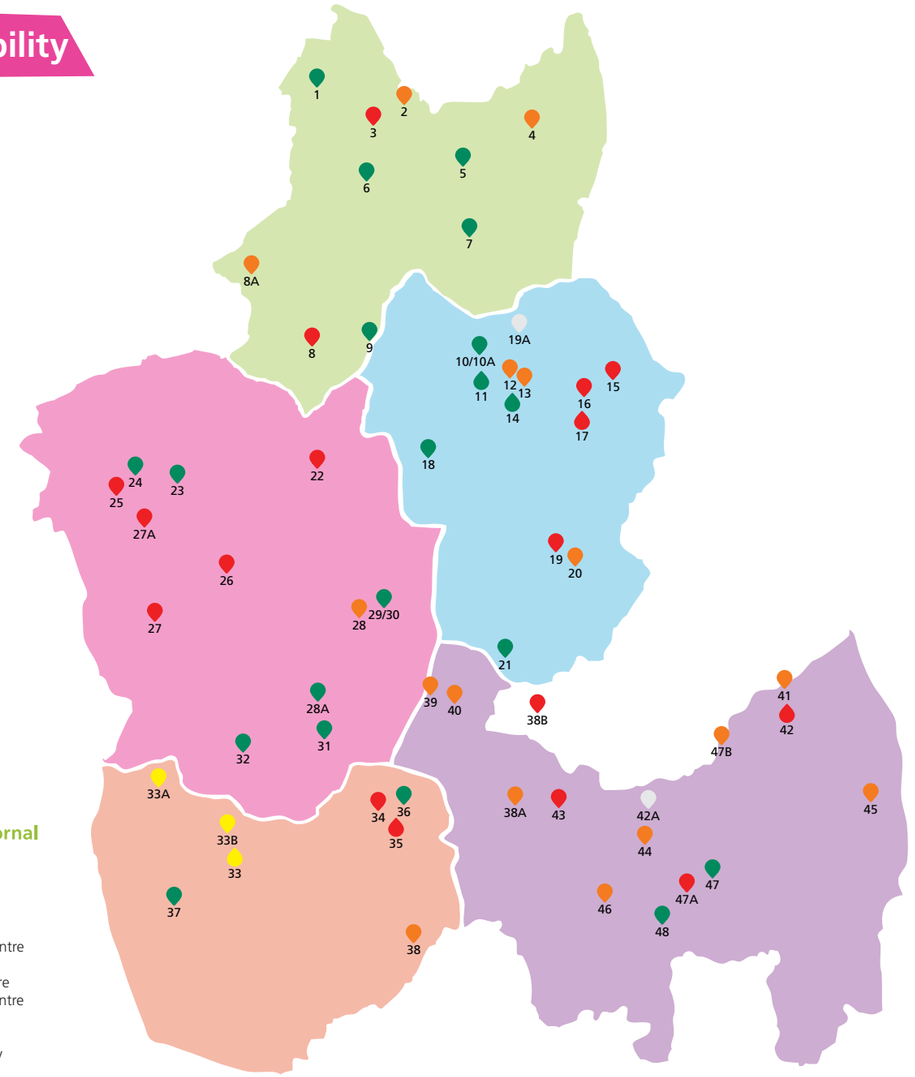
If the CCG is to respond local health needs and develop service models which provide opportunities for more integrated care, closer to patient's homes, primary care premises development will be essential. The CCG is fast moving towards a position where the lack of suitable premises will lead to sub-optimal arrangements for service delivery and the loss of opportunities for closer working between practices to deliver a wider range of services. This is of even more concern when one considers that the areas with the most pressing need for re-developed premises are those with the highest deprivation scores and where there are the greatest health inequalities.

As a result of the recent NHS reorganisation, the process for approving and funding new primary care premises developments is currently unclear, although we do know that this will be under the control of NHS England and its local Area Teams. Whatever the process, however, it is almost certain that this will involve prioritisation between different CCG areas and that decisions to fund new developments will only be made where it can be demonstrated that they address pressing needs and are congruent with local strategic plans. It is essential, therefore, that the CCG has a clear idea of its preferred direction of travel and its premises development priorities in order to be able to act promptly once the process is known and influence funding decisions in ways which support its strategic service development plans.

As part of this process, the CCG has undertaken an initial review of local primary care premises to begin informing this process. This is summarised in the map below. This review, together with existing data and the previous PCT Commissioner Investment & Asset Management Strategy (CIAMS), helps the CCG to begin to focus on potential priority areas for premises development. In order to move forward with this crucial area the CCG will need to ensure that the following actions are incorporated into the implementation plans for this strategy:

- The CCG will ensure that it keeps abreast of **local Area Team plans for managing the premises development process** and participate fully in this.
- The CCG will ensure that the local Area Team is fully aware of the **urgency** of the need for premises developments to ensure that patients are receiving care in facilities which are fit for purpose and to enable the delivery of service developments in areas of greatest health need. (i.e. putting all new developments 'on hold' indefinitely is not an option.)
- The CCG will agree a view regarding its **preferred procurement route** and whether it wishes to have a choice -at the very least some clarity regarding the application of the LIFT exclusivity agreement to the CCG is required. (Some schemes, especially small individual schemes, are unlikely to be considered viable via a LIFT route and the CCG needs to have the flexibility to devise innovative solutions to these.)
- CCG members will agree **prioritisation criteria for new premises developments** which take account of both known and opportunistic aspects of premises development. These then need to be applied to the current information and priorities agreed.
- CCG members will agree the **minimum criteria** which will be applied to new premises developments in order to ensure that these meet the strategic service needs.
- The CCG will consider pulling together **broad outline costs for a replacement/development programme to address the most urgent needs** in order to provide a basis for planning and discussion with the local Area Team.

Premises Suitability



Colour Key

- Not Suitable
- Limited Suitability
- Suitable
- Incomplete Data
- New Premises Under Construction

Sedgley, Coseley and Gornal

1	Northway Surgery
2	Bath Street Surgery
3	Bilston Street Surgery
4	Coseley Medical Centre
5	Woodsetton Medical Centre
6	The Ridgeway Surgery
7	The Greens Health Centre
8	Lower Gornal Health Centre
8A	Masefield Road Surgery (Lower Gornal Branch)
9	Castle Meadows Surgery

Dudley and Netherton

10	St James Medical Practice (Dr White)
10A	St James Medical Practice (Dr Porter)
11	Eve Hill Medical Practice
12	Tinchbourne Street Surgery
13	Cross Street Health Centre
14	Steppingstones Medical Practice
15	St Thomas's Medical Practice
16	Central Clinic
17	Bean Road Surgery
18	Keelinge House Surgery
19	Netherton Surgery
19A	Hazel Road Surgery (Netherton Surgery Branch)
20	Netherton Health Centre
21	Quarry Road Surgery

Kingswinford, Amblecote and Brierley Hill

22	High Oak Surgery
23	Kingswinford Health Centre
24	Moss Grove Surgery
25	Summerhill Surgery
26	Rangeways Road Surgery
27	Wordsley Green Health Centre
27A	Market Street Surgery (Wordsley Green Branch)
28	AW Surgeries
28A	Withymoor Surgery (AW Branch)
29	Waterfront Surgery
30	Brierley Hill Health Health and Social Care Centre
31	Quincy Rise Surgery
32	Three Villages

Stourbridge, Wollescote and Lye

33	Worcester Street Surgery
33A	Meriden Avenue Surgery (Worcester St Branch)
33B	Greenfield Avenue Surgery (Worcester St Branch)
34	Pedmore Medical Practice
35	Chapel Street Surgery
36	The Limes Surgery
37	Norton Medical Practice
38	Wychbury Medical Group

Halesowen and Quarry Bank

38A	Chapel House Lane (Wychbury Branch)
39	Thorns Road Surgery
40	Quarry Bank Medical Centre
41	Clement Road Medical Centre
42	Feldon Lane Surgery
42A	Hawne Lane Surgery (Feldon Lane Branch)
43	Crestfield Surgery Ltd
44	Alexandra Medical Centre
45	Lapal Medical Practice
46	Meadowbrook Surgery
47	Halesowen Health Centre
47A	Tenlands Avenue Surgery (Halesowen HC Branch)
47B	Coombs Road Surgery (Halesowen HC Branch)
48	St Margaret's Wells Surgery

Out of Area

38B	Cradley Road Surgery (Wychbury Branch)

Data correct as of April 2013

13. Principles to Inform Decision-making Processes for Primary Care Development and Investment

Reaching agreement regarding future models of service delivery and making investment decisions is not a straightforward process. For any issue, it is likely that there will be a range of varying, strongly held views across the patch and it is important, therefore that members have an agreed set of underlying principles which guide future strategic and investment decisions and ensure that these are made fairly and in an open and transparent way.

Underlying Principles for Decision-making

- Decisions should improve services and outcomes for patients
- Investment decisions must be made in line with locally agreed policies for managing conflicts of interest and procurement (which are compliant with national and statutory requirements)
- Priorities for investment should be in line with CCG strategic aims e.g. reducing health inequalities, and support the achievement of local priorities for quality and service improvement
- Decisions must be transparent and made via agreed processes as set out in the CCG's Constitution
- Decisions should, wherever possible, seek to reduce unwarranted variation
- Investment decision-making should allow for the encouragement of innovation and rewarding excellence
- That all member practices will be consulted and have the opportunity to give appropriate consideration on future models of service delivery

14. Implementing the Strategy and Monitoring Progress

Once the final strategy is agreed and signed off by CCG members there will need to be a clear process for implementing and monitoring progress for each of the priority areas and action plans. This process will be overseen by the Primary Care Development Committee which will approve the implementation plan and will receive regular reports on progress against this plan. The implementation of the Strategy will be led and coordinated by the Head of Membership Development. Reports on progress will also be made to individual locality groups and to the CCG membership engagement events. In addition, regular reports on progress will be made to key patient groups including the CCG Patient Opportunities Panel (POPs) and the local Healthcare Forum.

Patient groups will be central to the process for developing and monitoring the detailed implementation plans. Research has shown that direct involvement of patients can be a great driver for change and for ensuring actions are delivered. As a minimum, each action/priority will have an outcome measure or measures, together with milestone measures. These outcome measures will be agreed with CCG membership.

Strategic Commissioning Plan on a Page Summary

Our Vision:

To promote good health and ensure high quality health services for the people of Dudley

What We Do:

- Set the vision and objectives for healthcare in Dudley
- Hold the local health economy to account for delivery
- Facilitate improvements and transformational changes
- Engage with our public and patients
- Support quality improvement with our members
- Ensure good governance and work with key partners

Our Objectives:

Reducing Health Inequalities
- Reducing premature mortality
- Reducing emergency hospital admissions due to alcohol
- Reducing childhood obesity
- Reducing CVD mortality
- Improve AF review and treatment rates

Delivering Best Possible Outcomes
- Improve patient experience of healthcare (use of friend and family test)
- Increased early detection of dementia
- Reducing the levels of undetected hypertension and diabetes
- Improve access and choice of services

Improving Quality and Safety
- Reduce incidence of pressure ulcers
- Reduce unwarranted variations
- Reduce incidence of Clostridium Difficile
- Zero tolerance of MRSA bacteraemia
- Safeguarding children and adults

Our Commissioning Priorities:

Children's Services
- Reducing childhood obesity
- Safeguarding children

Improving Urgent Care
- Reducing avoidable emergency inpatient admissions

Primary Care Mental Health
- Improving the levels of diagnosis of dementia

Improving Care for Older People
- Reducing incidence of pressure ulcers
- Safeguarding adults

Improving Diabetes Services
- Reducing the levels of undetected hypertension and diabetes

Improving Access to Cardiology
- Reducing cardiovascular disease mortality

Ophthalmology Pathway
- Improving access to ophthalmology services

Improving Stroke Care
- Reducing mortality rate from stroke
- Improving AF review and treatment rates

Community Nursing Services
- Improving care to people with limiting long term illmess, health problem or disability

Alcohol Service
- Reducing emergency admissions linked to alcohol

Primary Care Strategy
- Supporting quality improvement in primary care sevices
- Reducing unwarranted variation in performance

Prioritisation of Resources
- Improving productivity to achieve financial sustainability
- Redesigning services to provide more efficient care to patients

Our Key Documents and Government Processes:

Membership & Public Engagement | Health & Wellbeing Board Strategy | National Planning Guidance

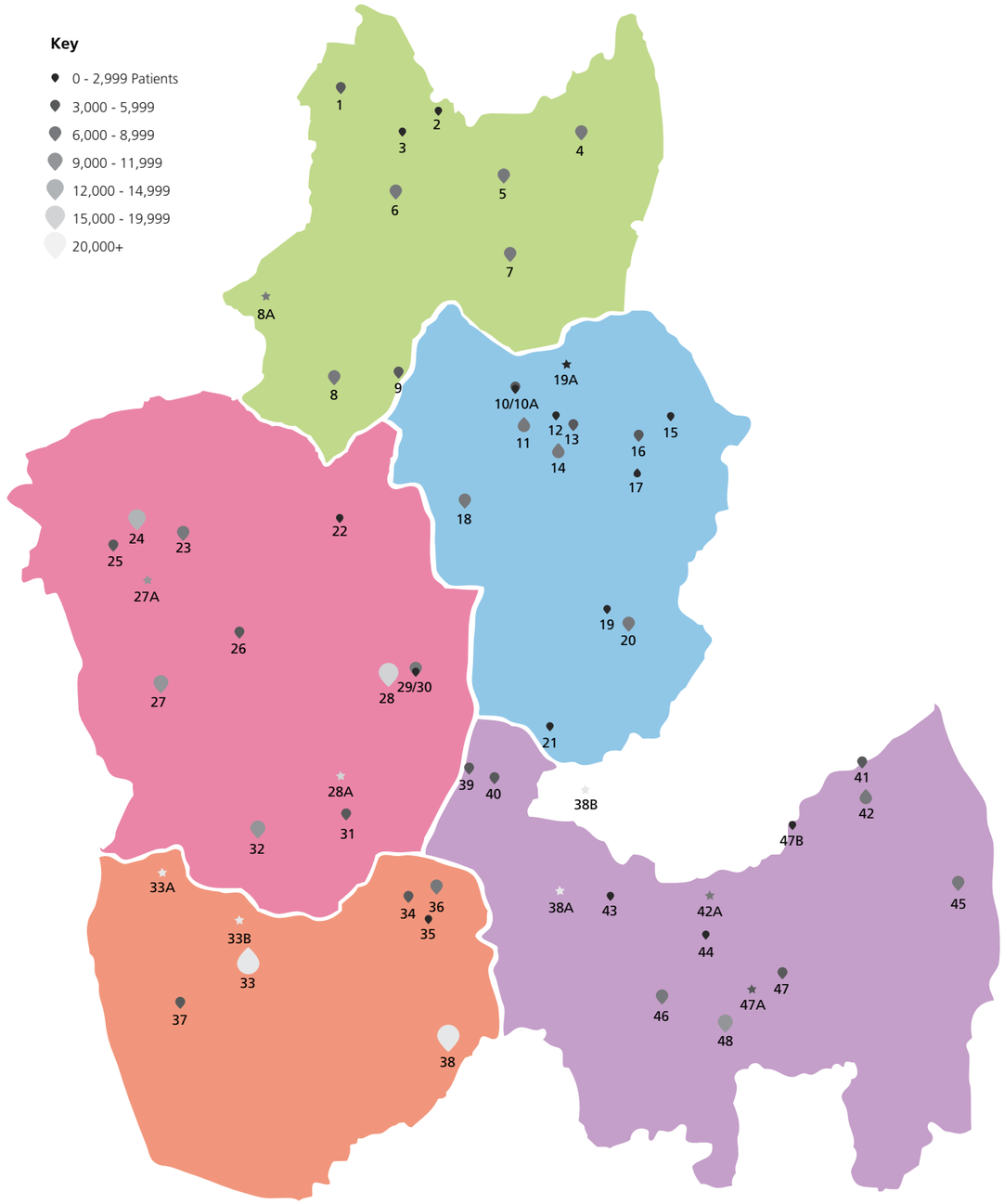
Strategic Commissioning Plan

Financial Plan | QIPP Plan

Finance and Performance Framework | CCG Constitution and Committees | Communications and Engagment Strategy | Equality and Diversity Strategy | Quality and Safety Strategy and Framework | Research, Innovation and Change Models

Supporting Organisational Development Plan

Surgery Patient List Sizes



Surgery Patient List Sizes Key

Sedgley, Coseley and Gornal

●	1	Northway Surgery	5,459
●	2	Bath Street Surgery	2,727
●	3	Bilston Street Surgery	2,999
●	4	Coseley Medical Centre	7,026
●	5	Woodsetton Medical Centre	6,328
●	6	The Ridgeway Surgery	8,994
●	7	The Greens Health Centre	7,754
●	8	Lower Gornal Health Centre	8,970
★	8A	Masefield Road Surgery (Lower Gornal Branch)	*
●	9	Castle Meadows Surgery	4,781

Dudley and Netherton

●	10	St James Medical Practice (Dr White)	2,307
●	10A	St James Medical Practice (Dr Porter)	5,135
●	11	Eve Hill Medical Practice	7,077
●	12	Tinchbourne Street Surgery	1,702
●	13	Cross Street Health Centre	4,363
●	14	Steppingstones Medical Practice	6,385
●	15	St Thomas's Medical Practice	1,205
●	16	Central Clinic	4,155
●	17	Bean Road Surgery	2,091
●	18	Keelinge House Surgery	6,351
●	19	Netherton Surgery	2,582
★	19A	Hazel Road Surgery (Netherton Surgery Branch)	*
●	20	Netherton Health Centre	7,253
●	21	Quarry Road Surgery	2,787

Kingswinford, Amblecote and Brierley Hill

●	22	High Oak Surgery	2,800
●	23	Kingswinford Health Centre	7,861
●	24	Moss Grove Surgery	14,685
●	25	Summerhill Surgery	5,644
●	26	Rangeways Road Surgery	5,049
●	27	Wordsley Green Health Centre	9,849
★	27A	Market Street Surgery (Wordsley Green Branch)	*
●	28	AW Surgeries	18,763
★	28A	Withymoor Surgery (AW Branch)	*

Kingswinford, Amblecote and Brierley Hill

●	29	Waterfront Surgery	6,418
●	30	Brierley Hill Health Health and Social Care Centre	2,151
●	31	Quincy Rise Surgery	3,218
●	32	Three Villages	9,346

Stourbridge, Wollescote and Lye

●	33	Worcester Street Surgery	24,995
★	33A	Meriden Avenue Surgery (Worcester St Branch)	*
★	33B	Greenfield Avenue Surgery (Worcester St Branch)	*
●	34	Pedmore Medical Practice	3,704
●	35	Chapel Street Surgery	1,877
●	36	The Limes Surgery	7,962
●	37	Norton Medical Practice	5,810
●	38	Wychbury Medical Group	21,395

Halesowen and Quarry Bank

★	38A	Chapel House Lane (Wychbury Branch)	*
●	39	Thorns Road Surgery	3,680
●	40	Quarry Bank Medical Centre	3,777
●	41	Clement Road Medical Centre	3,386
●	42	Feldon Lane Surgery	8,390
★	42A	Hawne Lane Surgery (Feldon Lane Branch)	*
●	43	Crestfield Surgery Ltd	1,555
●	44	Alexandra Medical Centre	2,884
●	45	Lapal Medical Practice	6,679
●	46	Meadowbrook Surgery	7,455
●	47	Halesowen Health Centre	4,871
★	47A	Tenlands Avenue Surgery (Halesowen HC Branch)	*
●	47B	Coombs Road Surgery (Halesowen HC Branch)	2,295
●	48	St Margaret's Wells Surgery	9,108

Out of Area

★	38B	Cradley Road Surgery (Wychbury Branch)	*

* Branch data is included with the Main Practice data with the exception of 47B Coombs Road Surgery (Halesowen HC Branch)

Data correct as of April 2013

NHS Outcomes Framework 2011/12 at a Glance

One framework
defining how the NHS will be accountable for outcomes

Five domains
articulating the responsibilities of the NHS

Ten overarching indicators
covering the broad aims of each domain

Thirty-one improvement areas
looking in more detail at key areas within each domain

Fifty-one indicators in total
measuring overarching and improvement area outcomes

* Shared responsibility with Public Health England

**EQ 5D™ is a trademark of the EuroQol Group. Further details can be found at: www.euroqol.org

***Indicator also included in the Adult Social Care Outcomes Framework

Indicators in italics are placeholders, pending development or identification of a suitable indicator

1 Preventing people from dying prematurely

Overarching indicators

1a Mortality from causes considered amenable to healthcare (The NHS Commissioning Board would be expected to focus on improving mortality in all the components of amenable mortality as well as the overall rate)
1b Life expectancy at 75

Improvement areas

Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease*
1.2 Under 75 mortality rate from respiratory disease*
1.3 Under 75 mortality rate from liver disease*
1.4 Cancer survival
i One- and ii five-year survival from colorectal cancer
iii One- and iv five-year survival from breast cancer
v One- and vi five-year survival from lung cancer

Reducing premature death in people with serious mental illness
1.5 Under 75 mortality rate in people with serious mental illness*

Reducing deaths in babies and young children
1.6.i Infant mortality*
1.6.ii Perinatal mortality (including stillbirths)

2 Enhancing quality of life for people with long term conditions

Overarching indicator

2 Health-related quality of life for people with long-term conditions (EQ-5D)**

Improvement areas

Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition***

Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions

Reducing time spent in hospital by people with long-term conditions
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
2.3.ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers
2.4 Health-related quality of life for carers (EQ-5D)**

Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness

3 Helping peopleto recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 28 days of discharge from hospital***

Improvement areas

Improving outcomes from planned procedures
3.1 Patient-reported outcomes measures (PROMs) for elective procedures

Preventing lower respiratory tract infections (LRTIs) in children from becoming serious
3.2 Emergency admissions for children with LRTIs

Improving recovery from injuries and trauma
3.3 An indicator needs to be developed.

Improving recovery from stroke
3.4 An indicator needs to be developed.

Improving recovery from fragility fractures
3.5 The proportion of patients recovering to their previous levels of mobility/ walking ability at i 30 days and ii 120 days***

Helping older people to recover their independence after illness or injury
3.6 The proportion of older people (65 and over) who werestill at home 91 days after discharge from hospital into rehabilitation services***

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
4b Patient experience of hospital care

Improvement areas

Improving people's experience of outpatient care
4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to inpatients' personal needs

Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services

Improving access to primary care services
4.4 Access to i GP services and ii dental services

Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
4.6 An indicator needs to be developed based on the survey of bereaved carers

Improving experience of healthcare for people with mental illness
4.7 Patient experience of community mental health services

Improving children and young people's experience of healthcare
4.8 An indicator needs to be developed.

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

Overarching indicators

5a Patient safety incident reporting
5b Severity of harm
5c Number of similar incidents

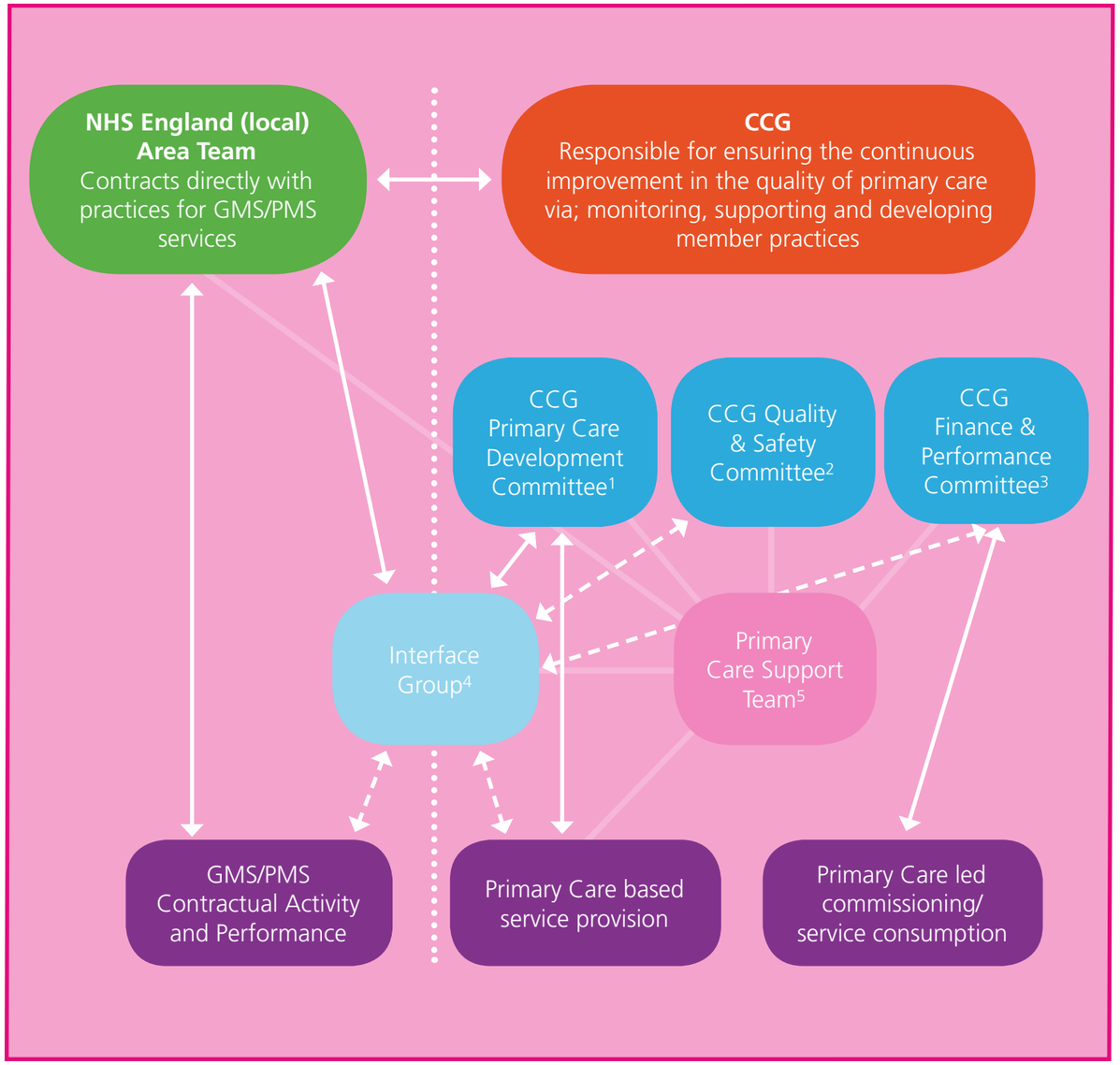
Improvement areas

Reducing the incidence of avoidable harm
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2 Incidence of healthcare-associated infection (HCAI)
i MRSA
ii C difficile
5.3 Incidence of newly acquired category 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing serious harm

Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings
5.6 Incidence of harm to children due to 'failure to monitor'

Monitoring Quality in Primary Care - Proposed Process



Note 1: CCG Primary Care Development Committee is responsible for overseeing all CCG activity in relation to the development of primary care. This includes mentoring, training, education, research initiatives.

Note 2: CCG Quality and Safety Committee is responsible for monitoring CCG wide quality indicators and ensuring action is taken to improve quality where this is falling below agreed standards.

Note 3: CCG Finance and Performance Committee monitors performance in relation to commissioned services

Note 4: Interface Group has joint membership from Area Team, CCG and LMC. Reviews and monitors primary care quality using data and soft intelligence. Agrees appropriate actions and keeps progress under review. Actions could range from mentoring, training and support, to the instigation of a more formal process in relation to contract compliance which would be led by the AT.

Note 5: CCG Primary Care Support team is led by Head of membership Development and GP Engagement Lead. It supports each element of the process. Reviews data and other relevant intelligence and provides reports to appropriate committees. Has day to day liaison with AT.

Glossary: Abbreviations

Abbreviation	Meaning
A&E	Accident and Emergency
ACS	Ambulatory Care sensitive Conditions
AT	NHS England local Area team
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CHD	Coronary Heart Disease
CIAMS	Commissioner Investment and Asset Management Strategy
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CVD	Cardio Vascular Disease
DES	Directed Enhanced Service
DNA	Did not attend
DoH	Department of Health
EMI	Older People with Mental Illness (Elderly Mentally Ill)
EPP	Expert Patients Programme
FOI	Freedom of Information
GMS	General Medical Services
GP	General Practitioner
GPAQ	General Practice Assessment of Quality
GPwSI	GPs with Special Interest
HR	Human Resources
HV	Health Visitor
IAPT	Improved Access to Psychological Therapies
IT	Information Technology
LETB	Local Education and Training Board
LES	Local Enhanced Service
LIFT	Local Improvement Finance Trust
LMC	Local Medical Committee
LTC	Long Term Conditions
MDT	Multi Disciplinary Team
NGMS	New General Medical Services
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NRT	Nicotine Replacement Products
OD	Organisational Development
OPD	Out Patient Department
OOH	Out of Hours
PCDC	Primary Care Development Committee
PCF	Primary Care Foundation
PCT	Primary Care Trust
PMS	Primary Medical Services
POPS	Patient Opportunity Panel
PSA	Public Service Agreement
QIPP	Quality, Innovation, Productivity and Prevention
QMAS	Quality Management and Analysis System
QP	Quality Premium
QOF	Quality and Outcome Framework
SLA	Service Level Agreement
SSDP	Strategic Services Development Plan
THR	Total Hip Replacement
TKR	Total Knee Replacement
UTI	Urinary Tract Infection
WIC	Walk in Centre
WTE	Whole Time Equivalent

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Dudley Clnical Commissioning Group

Brierley Hill Health and Social Care Centre

Venture Way

Brierley Hill

West Midlands

DY5 1RU

Telephone: **01384 322777**

Email: **contact@dudleyccg.nhs.uk**

Website: **www.dudleyccg.nhs.uk**

Twitter: **@dudleyccg**

Facebook: **www.facebook.com/dudleyccg**

Dudley Health and Wellbeing Board – 26th September,2013

Report of the Chief Officer, Dudley Clinical Commissioning Group, Director of Adult, Community and Housing Services and Director of Children's Services

Transfer of Resources to Dudley MBC 2013/14 to Support Social Care and the Health and Social Care Integration Transformation Fund

Purpose of Report

1. To advise the Board of the proposed use of resources to be transferred to Dudley MBC for the purposes of supporting social care in 2013/14.

2. To note the national announcement of £3.8billion of funding to ensure closer integration between health and social care.

Background

3. The Board will be aware that in 2011/12 and 2012/13, the former Dudley PCT was required, as part of the annual operating framework, to transfer resources from within its allocation to Dudley MBC, using the provisions of Section 256 of the NHS Act 2006.

4. This transfer was designed to deal with the impact of changes to the local authority grant settlement and prevent unnecessary admissions to secondary care/facilitate speedy discharge from secondary care.

5. A similar transfer is to take place for 2013/14. This transfer will be made by NHS England rather than the CCG but will be done so on the basis of a local agreement being reached on the use of these monies.

6. This report sets out the proposed use of the resources available, as discussed by officers and reported to the CCG Board.

7. In addition, this report advises the Board of the announcement of £3.8billion to support closer integration between health and social care.

Proposed Use

8. The proposed use of the £5.589m available is set out in the table below. The schemes to be funded, a combination of schemes to avoid admission and speed up discharge, follow a similar pattern to that in previous years.

Scheme	Amount £000
Tiled House Intermediate Care Facility	1,745
Social Care Emergency Response Service	968
Residential Care	1,526
Home Care	1,100
Care Packages for Children	250
Total	5,589

9. Subject to agreement, further discussion will take with regard to the number of discharges that this level of investment can support. This will be reflected in a revised Memorandum of Agreement between the CCG, Dudley MBC and Dudley Group NHS FT. Performance of the schemes will be reported to the Urgent Care Board on a monthly basis.

Health and Social Care Integration Transformation Fund

10. In the June 2013 spending round the Chancellor announced that a sum of £3.8billion would be available nationally to ensure closer integration between health and social care. This was described as "… a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities".

11. For Dudley, an initial estimate of this "Health and Social Care Integration Transformation Fund", equates to around £15 million coming into full effect from 2015/16. This is not new resource but funding to be pooled from the CCG's existing baseline and existing allocations.

12. Each locality is required to develop a local plan for this resource, which can be deployed locally on social care and health, by March 2014. This will require the agreement of this Board.

13. Discussions on the use of this fund, which represents an opportunity to secure significant system change, have begun in the context of existing work on service integration. Strategically, given pressures on both adult social care budgets and the budget pressure the pooling of these monies will create for the CCG, the collective objective for the health and social care economy will be to reduce expenditure on care home placements and urgent hospital care through joint investment in integrated community health and social care services.

Law

14. The Transfer above is made using Section 256 of the NHS Act 2006 which gives the power to make payments to a local authority "…in connection with the performance of the authority's functions". The conditions attached are that the functions must have an effect on the health of individuals, have an effect on or be affected by any NHS functions or be connected with any NHS function."

Recommendation

15. That the proposed resource transfer of £5.589m be approved and NHS England advised accordingly.

16. That a further report on the use of the Health and Social Care Integration Transformation Fund be received in due course.

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Paul Maubach
Chief Officer, Dudley Clinical Commissioning Group

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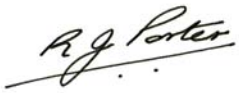
Andrea Pope-Smith
Director of Adult, Community and Housing Services



……
Jane Porter
Director of Children's Services
Contact Officer: Neill Bucktin
Telephone: 01384 321745
Email: neill.bucktin@dudleyccg.nhs.uk

Agenda Item No.12

Dudley Health and Well Being Board 26th September 2013

Report of Alison Taylor, Director of Finance, Birmingham Solihull and the Black Country Area Team, NHS England

The NHS belongs to the people: A Call to Action

Purpose of Report

1. The document 'The NHS belongs to the people: A Call to Action' was published by NHS England on 11th July. The full paper is attached as Appendix 1.

   The document sets out the case for transformational change across the NHS.

Background

2. The document describes the future challenges both on the growing demand for NHS services through;

- the growth in the elderly population
- the rise in the incidence of people with long term conditions
- the rising expectations that patients have on the standards of care that they receive and the pressures on the supply of NHS services through:
- the increasing costs of providing care
- the limited scope for further productivity gains
- the constraints on public resources

The document states that continuing with the current model of care will result in the NHS facing a funding gap of around £30bn between 2013/14 and 2020/21 (although it should be noted that this estimate does not take into account productivity improvements and assumes the health budget will remain protected in real terms).

The document, having identified the pressures for change, also describes some of the future opportunities including:

- working with Public Health England to improve prevention
- enabling patients to gain greater control of their own health
- harnessing new technologies

Call to Action is a programme of engagement with staff, stakeholders, patients and the public in a debate about healthcare provision in England. It is intended to be the broadest, deepest and most meaningful public discussion that the service has ever undertaken. Its aims are to:

- build a common understanding about the need to renew our vision of health and care services particularly to meet the challenges of the future
- give people an opportunity to tell us how the values that underpin the health service can be maintained in the face of future pressures
- gather ideas and potential solutions that inform and enable CCGs to develop 3 to 5 year commissioning plans
- gather ideas and potential solutions to inform and develop national plans, including levers and incentives, for the next 5 to 10 years.

Call to Action will offer a number of ways for people to engage including:

- A digital call to action via an on line interactive platform on NHS Choices, to share ideas and receive feedback
- Local engagement events led by clinical commissioning groups and if agreed, Health and Well Being Boards
- Regional events in major cities across the NHS engaging local government, regional partners, business and the public
- National engagement events

Themes for Debate

3. Consideration is being given to having themed months commencing in September/October which would focus on:

- Putting patients first
- Prevention and early diagnosis
- Achieving parity of esteem between mental and physical health
- Collaboration of care
- Sharing success (including adoption and spread)

This is not a formal consultation and as such will be an iterative process with no absolute end point. It is, however anticipated that the bulk of the engagement will run from September to December. This is intended to allow some of the outputs to be captured in the 2013/14 planning round.

Communications to Date

4. Call to Action was launched on 11th July and attracted significant media interest. It is featured both on the NHS England website and on the NHS Choices website.

CCGs have been informed through communication from the Commissioning Assembly and by the CCG bulletin and are now organising events

Area Teams from NHS England are working with and advising and supporting CCGs on local engagement and 3 to 5 year strategy development. We also want to work with partners to build momentum and will support local engagement to ensure population coverage. In terms of our direct commissioning of services, it is important that we hear from patients, the public and stakeholders about their views on the future of primary care, Specialised Services and the public health services which we directly commission.

We will also be offering engagement and presentations to local Healthwatch organisations.

Improving General Practice

5. In the context of General Practice, on Wednesday 14th August, NHS England published its intention to engage with local communities, clinicians and stakeholders, about the best possible way to develop general practice for the future. As part of NHS England's 10 year strategy to transform the NHS, it is reviewing the current primary care system and engaging with key partners, including frontline clinicians, to develop a long term, effective solution. The main purpose is to stimulate debate in local communities, among GP practices, CCGs, area teams, health and wellbeing boards and other community partners, on the best way to develop general practice services. NHS England is inviting comments about how it can best support local changes, for example through the way national contractual frameworks are developed. NHS England is also developing its strategic approach to commissioning primary dental, pharmacy and eye care services and will carry out separate engagement exercises at a later stage. A date for an engagement event on Improving General Practice has been agreed as 6pm on Thursday 26th September 2013, at St Chad's Court in Birmingham.

Role of Health and Well Being Boards

6. Health and Well Being Boards are seen as critical partners in the design and delivery of a Call to Action and particularly in supporting the alignment of plans and encouraging the wider participation of local stakeholders. In addition, the Call to Action needs to inform the development of plans for the use of the integrated health and social care budgets during 2014/15, ready for 2015/16.

Finance

7. The Call to Action will be delivered with the resources available.

Law

8. No legal implications.

Equality Impact

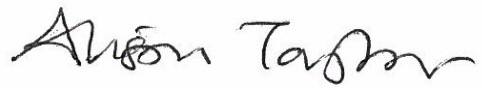
9. There will be no equality impact.

The Call to action is a consultation and therefore will include children and young people as part of the consultation process.

Recommendation

10. It is recommended that:-

- Note the publication of 'The NHS belongs to the people: A Call to Action'
- Comment on its content and intention
- Discuss and agree how to participate in the process of engagement



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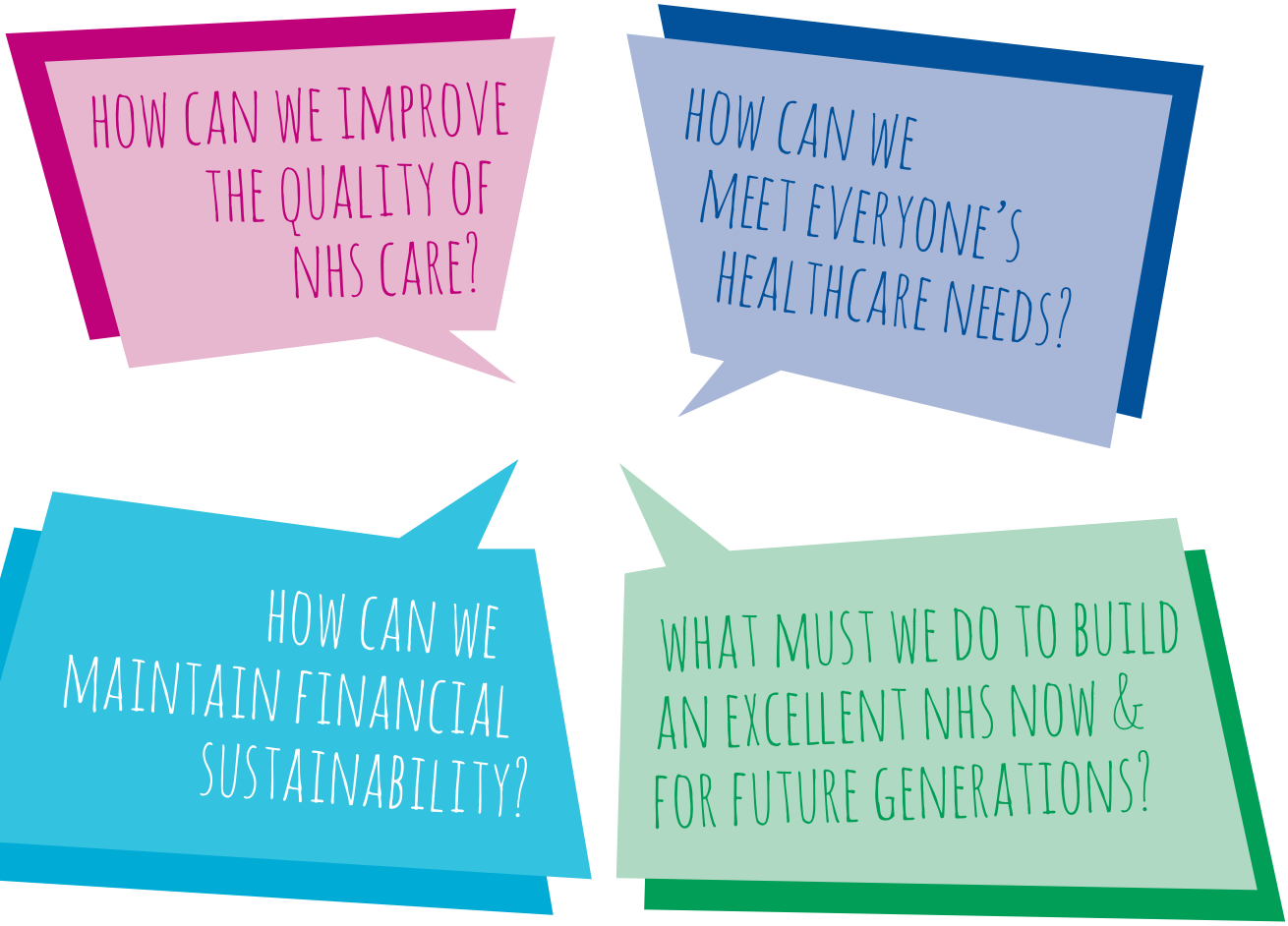
Alison Taylor
Director of Finance, Birmingham, Solihull and the Black Country Area Team, NHS England

Contact Officer: Chris Parsons
Telephone: 011382 51689
Email: chris.parsons3@nhs.net

List of Background Papers
NHS belongs to the people: A Call to Action document

NHS England



The NHS belongs to the people

A CALL TO ACTION

Index

Foreword: NHS Call to Action

The NHS is 65 this year: a time to celebrate, but also to reflect. Every day the NHS helps people stay healthy, recover from illness and live independent and fulfilling lives. It is far more than just a public service; the NHS has come to embody values of fairness compassion and equality. The NHS is fortunate in having a budget that has been protected in recent times, but even protecting the budget will not address the financial challenges that lie ahead.

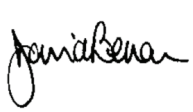
If the NHS is to survive another 65 years, it must change. We know there is too much unwarranted variation in the quality of care across the country. We know that at times the NHS fails to live up to the high expectations we have of it. We must urgently address these failures, raise performance across the board, and ensure we always deliver a safe, high quality, value-for-money service. We must place far greater emphasis on keeping people healthy and well in order to lead longer, more illness-free lives: preventing rather than treating illness. We also need to do far more to help those with mental illness.

There are a number of future pressures that threaten to overwhelm the NHS. The population is ageing and we are seeing a significant increase in the number of people with long-term conditions - for example, heart disease, diabetes and hypertension. The resulting increase in demand combined with rising costs threatens the financial stability and sustainability of the NHS. Preserving the values that underpin a universal health service, free at the point of use, will mean fundamental changes to how we deliver and use health and care services.

This is not about unnecessary structural change; it is about finding ways of doing things differently: harnessing technology to fundamentally improve productivity; putting people in charge of their own health and care; integrating more heath and care services; and much more besides. It's about changing the physiology of the NHS, not its anatomy.

For these reasons, this new approach cannot be developed by any organisation standing alone and we are committed to working collectively to improve services. This is why Monitor, the NHS Trust Development Authority, Public Health England, National Institute for Health and Care Excellence (NICE), the Health and Social Care Information Centre, the Local Government Association, the NHS Commissioning Assembly, Health Education England, the Care Quality Commission (CQC) and NHS England want to work together alongside patients, the public and other stakeholders to improve standards, outcomes and value.

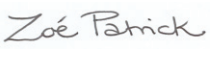
We are all committed to preserving the values that underpin the NHS and we know this new future cannot be developed from the top down. A national vision that will deliver change will be realised locally by clinical commissioning groups, Health & Wellbeing Boards and other partners working with patients and the public. That is why we are supporting a national 'Call to Action' that will engage staff, stakeholders and most importantly patients and the public in the process of designing a renewed, revitalised NHS. This is all about neighbourhoods and communities saying what they need from their NHS; it is about individuals and families saying what they want from their NHS. Above all, this is about ensuring the NHS serves current and future generations as well as it has served those in the past.



David Behan,
Chief Executive
Care Quality Commission

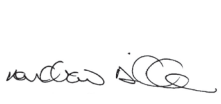
Alan Perkins,
Chief Executive
Health and Social Care Information Centre

Ian Cumming,
Chief Executive
Health Education England



Zoe Patrick,
Chair of the LGA Community Wellbeing Board
Local Government Association

David Bennett,
Chief Executive
Monitor



Andrew Dillon,
Chief Executive
National Institute for Health and Care Excellence

Peter Melton,
Chief Clinical Officer, North East Lincolnshire CCG, Co-chair of NHS Commissioning Assembly steering group

David Nicholson,
Chief Executive
NHS England

David Flory,
Chief Executive
NHS Trust Development Authority

Duncan Selbie,
Chief Executive
Public Health England

The NHS belongs to the people: a call to action

Executive Summary

Every day the NHS saves lives and helps people stay well. It is easy to forget that only 65 years ago many people faced choosing between poverty if they fell seriously ill or forgoing care altogether. Over the decades since its inception the improvements in diagnosis and treatment that have occurred in the NHS have been nothing short of remarkable. The NHS is more than a system; it is an expression of British values of fairness, solidarity and compassion.

However, the United Kingdom still lags behind internationally in some important areas, such as cancer survival rates.[1] There is still too much unwarranted variation in care across the country, exacerbating health inequalities.[2] As the Mid-Staffordshire and Winterbourne View tragedies demonstrated, in some places the NHS is badly letting patients down and this must urgently be put right.

But improving the current system will not be enough. Future trends threaten the sustainability of our health and care system: an ageing population, an epidemic of long-term conditions, lifestyle risk factors in the young and greater public expectations. Combined with rising costs and constrained financial resources, these trends pose the greatest challenge in the NHS's 65-year history.

The NHS has already implemented changes to make savings and improve productivity. The service is on track to find £20 billion of efficiency savings by 2015. But these alone are not enough to meet the challenges ahead. Without bold and transformative change to how services are delivered, a high quality yet free at

[1] Christopher Murray et al. (March 2013), "UK health performance: findings of the Global Burden of Disease Study 2010", The Lancet.

[2] For example, unwarranted variation in common procedures and in expenditure. See John Appleby et al. (2011), "Variations in health care: the good, the bad and the inexplicable", King's Fund and Department of Health (2011), "NHS Atlas of Variation in Healthcare: Reducing unwarranted variation to increase value an improve quality".

the point of use health service will not be available to future generations. Not only will the NHS become financially unsustainable, the safety and quality of patient care will decline.

In order to preserve the values that underpin it, the NHS must change to survive. Change does not mean top-down reorganisation. It means a reshaping of services to put patients at the centre and to better meet the health needs of the future. There are opportunities to improve the quality of services for patients whilst also improving efficiency, lowering costs, and providing more care outside of hospitals. These include refocusing on prevention, putting people in charge of their own health and healthcare, and matching services more closely to individuals' risks and specific characteristics. To do so, the NHS must harness new, transformational technology and exploit the potential of transparent data as other industries have. We must be ready and able to share these data and analyses with the public and to work together with them to design and make the changes that meet their ambitions for the NHS.

So this document is a 'Call to Action' – a call to those who own the NHS, to all who use and depend on the NHS, and to all who work for and with it. Building a common understanding of the challenges ahead will be vital in order to find sustainable solutions for the future. NHS England, working with its partners, will shortly launch a sustained programme of engagement with NHS users, staff and the public to debate the big issues and give a voice to all who care about the future of our National Health Service. This programme will be the broadest, deepest and most meaningful public discussion that we have ever undertaken.

Bold ideas are needed, but there are some options we will not consider. First, doing nothing is not an option – the NHS cannot meet future challenges without change. Second, NHS funding is unlikely to increase; it would be unrealistic to expect anything more than flat funding (adjusted for inflation) in the coming years. Third, we will not contemplate cutting or charging for core NHS services – NHS England is governed by the NHS Constitution which rightly protects the principles of a comprehensive service providing high quality healthcare, free at the point of need for everyone.

The Call to Action will not stifle the work that clinical commissioning groups and their partners have already accomplished. It is intended to complement this work and lead to five-year commissioning plans owned by each CCG. The Call to Action will also shape the national vision, identifying what NHS England should do to drive service change. This programme of engagement will provide a long-term approach to achieve goals at both levels.

The NHS belongs to all of us. This Call to Action is the opportunity for everyone who uses or works in the NHS to have their say on its future.

"DOING NOTHING IS NOT AN OPTION – THE NHS CANNOT MEET FUTURE CHALLENGES WITHOUT CHANGE."

How is the NHS currently performing?

Quality at the core

Over recent years, the quality of NHS services has improved and, as a result, so has the nation's health. However, there is still too much unwarranted variation across the country. In England the Government measures the quality of care in five areas, collected together in the NHS Outcomes Framework. Each of these areas is discussed below.

Preventing people from dying early

As a nation we are living longer than ever before. Between 1990 and 2010, life expectancy in England increased by 4.2 years.[3] The NHS has made significant improvements in reducing premature deaths from heart and circulatory diseases but the UK is still not performing as well as other European countries for other conditions.[4]

Preventing disease in the first place would significantly reduce premature death rates. Early diagnosis and appropriate treatment of disease can also reduce premature deaths.

Around 80% of deaths from the major diseases, such as cancer, are attributable to lifestyle risk factors such as excess alcohol, smoking, lack of physical activity and poor diet.[5]

[3] Office for National Statistics (2011) http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-227587
[4] World Health Organisation (2013) http://data.euro.who.int/hfadb/
[5] World Health Organisation (2011) "Global Status Report on Non-communicable Diseases"

Enhanced quality of life for people with long-term conditions

Long-term conditions (LTC) or chronic diseases cannot currently be cured, but can be controlled or managed by medication, treatment and/or lifestyle changes. Examples of long-term conditions include high blood pressure, depression, dementia and arthritis.

Over 15 million people in England have an LTC. They make up a quarter of the population yet they use a disproportionate amount of NHS resources: 50% of all GP appointments, 70% of all hospital bed days and 70% of the total health and care spend in England.[6] People living at higher levels of deprivation are more likely to live with a debilitating condition, more likely to live with more than one condition, and for more of their lives.[7]

The NHS, working with local authorities and the new health and wellbeing boards, needs to be much better at providing a service that appropriately supports these patients' needs and helps them to manage their own conditions. Better management of their own conditions by patients themselves will mean fewer hospital visits and lower costs to the NHS overall, and more community-based care, including care delivered in people's homes

"BETTER MANAGEMENT BY PATIENTS WILL MEAN FEWER HOSPITAL VISITS & LOWER COSTS TO THE NHS OVERALL."

Helping people recover following episodes of ill health or following illness

Demand on NHS hospital resources has increased dramatically over the past 10 years: a 35% increase in emergency hospital admissions and a 65% increase in secondary care episodes for those over 75.[8] A combination of factors, such as an ageing population, out-dated management of long term conditions, and poorly joined-up care between adult social care, community services and hospitals accounts for this increase in demand.

Compounding the problem of rising emergency admissions to hospital is the rise in urgent readmissions within 30 days of discharge from hospital. There has been a continuous increase in these readmissions since 2001/02 of 2.6% per year.[9]

New thinking about how to provide integrated services in the future is needed in order to give individuals the care and support they require in the most efficient and appropriate care settings, across health and social care, and in a safe timescale. For example, the limited availability of some hospital services at weekends has a negative impact on all five domains of the NHS Outcomes Framework: preventing people from dying prematurely; enhancing the quality of life for people with long-term conditions; helping people to recover from ill health and injury; ensuring people have a positive experience of care; and caring for people in a safe environment and protecting them from avoidable harm.

[6] Department of Health (2012), "Long Term Conditions Compendium" (3rd edition).
[7] The Marmot Review (2010), "Fair Society Healthy Lives".
[8] Royal College of Physicians (2012), "Hospitals on the edge? The time for action".
[9] Health and Social Care Information Centre
http://www.hscic.gov.uk/searchcatalogue?q=title%3A%22Hospital+Episode+Statistics%2C+Admitted+patient+care+-+England%22&area=&size=10&sort=Relevance]

This is why the first offer in *Everyone Counts: Planning for Patients*, is to support the NHS in moving towards more routine services being available seven days a week. The National Medical Director has established a forum to identify how to improve access to more comprehensive services seven days a week which will report in the autumn of 2013.

NHS England recently announced a review of urgent and emergency services in England, which will also recommend ways to meet the objective of a seven-days-a-week service. Not only will this offer improved convenience for patients, full-week services will also improve quality and safety.

Patient experience

The UK rates highly on patient experience compared to other countries. A 2011 Commonwealth Fund study[10] of eleven leading health services reported that 88% of patients in the UK described the quality of care they had received in the last year as excellent or very good, ranking the UK as the best performing country. However, the data also show that the UK has improvements to make in the coordination of care and patient-centred care.

Everyone working in the NHS must strive to maintain and improve on this high level of patient satisfaction and extend it to everyone who uses the NHS. People from disadvantaged groups including the frail older population, some black and minority ethnic groups, younger people and vulnerable children, generally access poorer quality services and have a poorer experience of care (some also have lower life expectancies). This can be made worse by these groups having lower expectations of the experience of care and being less likely to seek redress. We must act to improve access and the quality of services for these less advantaged groups.

> "Everyone working in the NHS must strive to maintain and improve on this high level of patient satisfaction and extend it to everyone who uses the NHS."

[10] Commonwealth Fund (2011), "International Health Policy Survey".

Patient safety

Although great improvements in patient safety have been made, the findings from the Mid-Staffordshire public inquiry set out starkly what can happen when safety is not at the heart of everything the NHS does. The NHS must work to ensure that all patients experience the safe treatment they deserve. Global healthcare expert Professor Don Berwick was recently asked by the Prime Minister to look into improving safety in the NHS and will report back with his findings later this year.

In addition to reducing harmful events, we must make it easier for staff to report incidents. In 2011, 1,325,360 patient safety incidents were reported to the National Reporting and Learning System,[12] of which 10,916 or less than 1% were serious. Despite this large number of reports we know we have not captured everything, and are working to make it easier for staff and patients to report incidents or near-misses. Learning from even largely minor incidents is important as it helps the NHS to avoid more serious incidents in the future.

Over the past 15 years, international studies have suggested that around 9 in 10 patients admitted to hospital experience safe treatment without any adverse events and our NHS is no different. But even these relatively low levels of adverse events are far too high. Of those people who do experience adverse events a third of them experienced greater disability or death.[11]

Health inequalities

Health inequalities is the term that describes the unjust differences in health, illness and life expectancy experienced by people from different groups of society. In England, as elsewhere, there is a so-called 'social gradient' in health: the more socially deprived people are, the higher their chance of premature mortality, even though this mortality is also more avoidable. People living in the poorest areas of England and Wales, will, on average, die seven years earlier than people living in the richest areas.[13] The average difference in disability-free life expectancy is even worse: fully 17 years between the richest and poorest neighbourhoods.[14] Health inequalities stem from more than differences in just income - education, geography, and gender can all play a role.

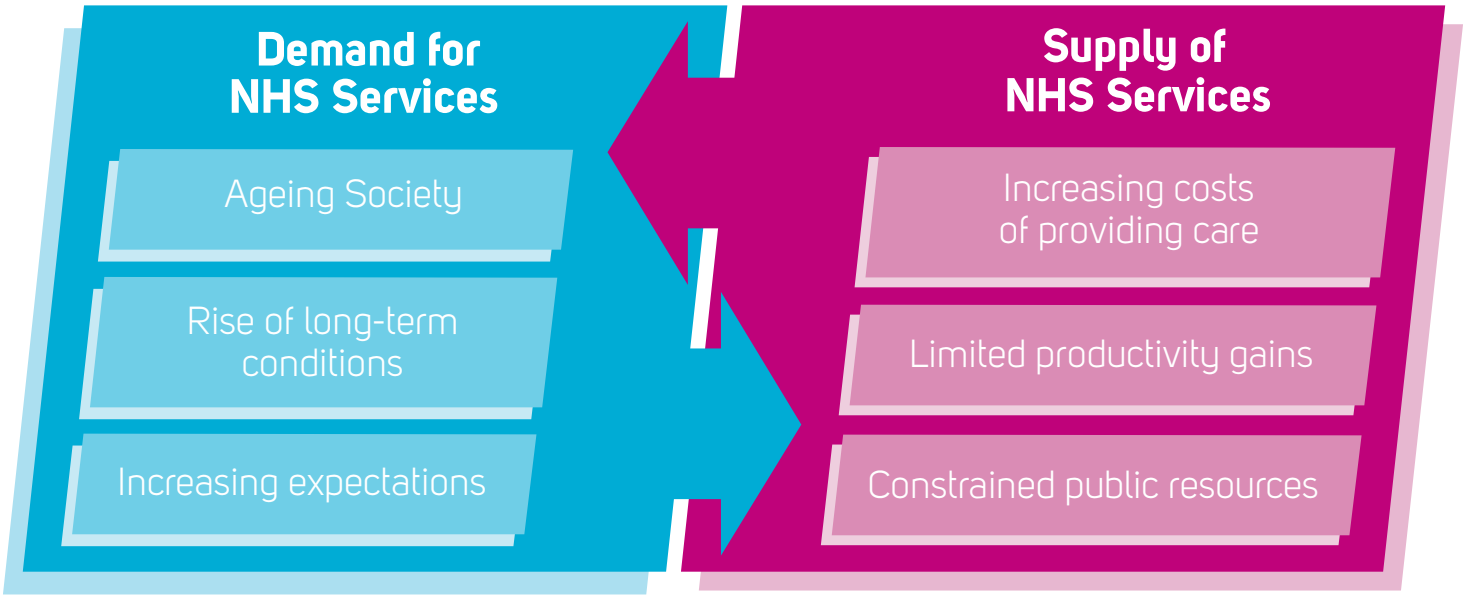
The NHS cannot address all the inequalities in health alone. Factors such as housing, income, educational attainment and access to green space are also important (the "wider social determinants of health"). In fact, it is estimated that only 15-20% of inequalities in mortality rates can be directly influenced by health interventions that prevent or reduce risk. If the NHS is to help tackle these inequalities we must work closely with Government departments, Public Health England, local authorities and other local partners to ensure the effective coordination of healthcare, social care and public health services.

[11] Charles Vincent, Graham Neale and Maria Woloshynowych (2001) "Adverse events in British hospitals: preliminary retrospective record review", British Medical Journal.
[12] National Patient Safety Agency (2012), "National Reporting and Learning System Quarterly Data Workbook" http://www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries/?entryid45=135153
[13] The Marmot Review (2010), "Fair Society Healthy Lives"
[14] The Marmot Review (2010), "Fair Society Healthy Lives"

What challenges will the health and care service face in the future?

As the NHS strives to improve the quality and performance of current NHS services and to live up to the high expectations of patients and the public, we must anticipate the challenges of the future - trends that threaten the sustainability of a high-quality health service, free at the point of use. It is the potential impact of these trends that means that while a new approach is urgently needed, we must take a longer-term view when developing it.

Future pressures on the health service



Ageing society

People are living longer and while this is good news an ageing population also presents a number of serious challenges for the health and social care system:

- Nearly two-thirds of people admitted to hospital are over 65 years old.
- There are more than 2 million unplanned admissions per year for people over 65, accounting for nearly 70% of hospital emergency bed days.[15]
- When they are admitted to hospital, older people stay longer and are more likely to be readmitted.[16]
- Both the proportion and absolute numbers of older people are expected to grow markedly in the coming decades. The greatest growth is expected in the number of people aged 85 or older - the most intensive users of health and social care.[17]

Studies suggest that older patients account for the majority of health expenditure. One analysis found that health and care expenditure on people over 75 was 13-times greater than on the rest of the adult population.[18]

"STUDIES SUGGEST THAT OLDER PATIENTS ACCOUNT FOR THE MAJORITY OF HEALTH EXPENDITURE."

Extra care housing: supporting older people to stay independent

Extra care housing is sometimes referred to as very sheltered housing or housing with care. It is social or private housing that has been modified to suit people with long-term conditions or disabilities that make living in their own home difficult, but who don't want to move into a residential care home.

This 'retirement village' type of housing offers an alternative to traditional nursing homes, providing a range of community and care services on site. Compared with residence in institutional settings, extra care housing is associated with better quality of life and lower levels of hospitalisation, suggesting the potential for overall cost savings.[19]

[15] Candice Imison et al. (2011), "Older people and emergency bed use: exploring variation", King's Fund.
[16] Jocelyn Cornwell et al. (2012), "Continuity of care for older hospital patients: A call for action", King's Fund.
[17] Commission on Funding of Care and Support (2011), "Fairer Care Funding: The Report of the Commission on Funding of Care and Support".
[18] McKinsey & Co. (2013), "Understanding patients' needs and risk: a key to a better NHS".
[19] A Netten et al. (2011), "Improving housing with care choices for older people: an evaluation of extra care housing", Personal Social Services Research Unit.

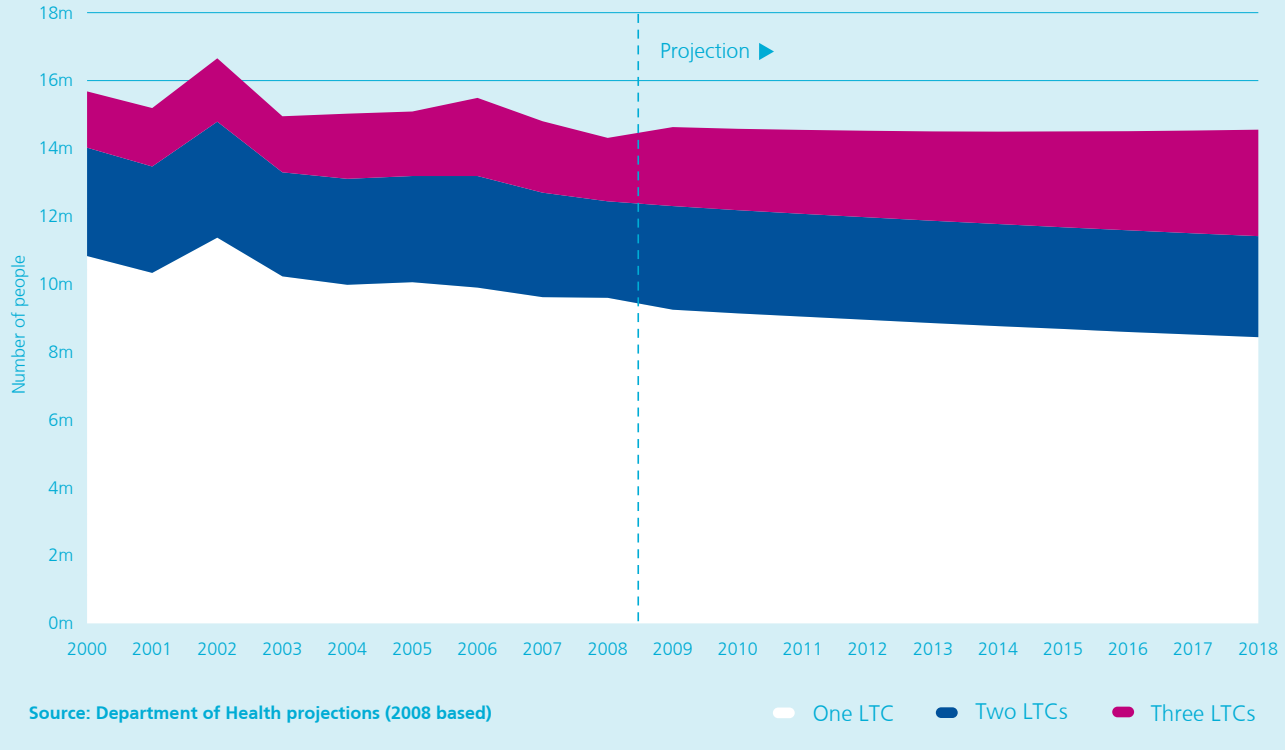
Changing burden of disease

People with one or more long-term conditions are already the most important source of demand for NHS services: the 30% who have one or more of these conditions account for £7 out of every £10 spent on health and care in England. Those with more than one long-term condition have the greatest needs and absorb more healthcare resources; for example, patients with a single long-term condition cost about £3,000 per year whilst those with three or more conditions cost nearly £8,000 per year. These multi-morbid, high-cost patients are projected to grow from 1.9 million in 2008 to 2.9 million in 2018.[20]

Patients with multiple long-term conditions must be managed differently. A hospital-centred delivery system made sense for the diseases of the 20th century, but today patients could be providing much more of their own care, facilitated by technology, and supported by a range of professionals including clinicians, dieticians, pharmacists and lifestyle coaches. They also need close coordination amongst these different professionals.

> "THE 30% WHO HAVE ONE OR MORE LONG-TERM CONDITION ACCOUNT FOR £7 OUT OF EVERY £10 SPENT ON HEALTH AND CARE IN ENGLAND"

Actual/projected numbers with one or more long-term conditions by year and number of conditions



Source: Department of Health projections (2008 based)

[20] Department of Health (2012), "Long Term Conditions Compendium" (3rd edition).

Meeting the dementia challenge: rapid diagnosis and referral

There are now 800,000 people living with dementia in the UK. By 2021, the number of sufferers is projected to exceed one million and dementia is estimated to cost the NHS, local authorities and families £23 billion a year. As the Prime Minister's 2012 Challenge on Dementia noted, diagnosis comes too late for many dementia patients and they and their families don't always get the care and support they need. This is in part because too little is known about the causes of this disease and how to prevent it, but some areas are leading the way in offering better care. In Stockport, Greater Manchester, local GPs are working with the Alzheimer's Society to increase diagnosis rates and provide post-diagnosis support. GPs have agreed a 'fast-track' referral process for suspected dementia patients that will also trigger support from Alzheimer's Society staff and volunteers. The scheme also sets out to improve the skills of clinicians to better recognise the early signs of dementia and increase early detection.[21]

Lifestyle risk factors in the young

We know that the risk of developing debilitating diseases is greatly increased by personal circumstances and unhealthy behaviours such as drinking, smoking, poor diet and lack of exercise, all of which contribute to premature mortality. If predictions are correct, and 46% of men and 40% of women are obese by 2035, the result is likely to be 550,000 additional cases of diabetes, and 400,000 additional cases of stroke and heart disease.[22] Although we understand the problem, we do not yet have enough evidence to be sure about what will facilitate sustainable weight loss and other associated behaviours. Working together with individuals, their families, employers and communities to develop effective approaches will be an extremely important task for the next generation NHS.

Rising expectations

Patients and the public rightly have high expectations for the standards of care they receive - increasingly demanding access to the latest therapies, more information and more involvement in decisions about their care.[23] If the convenience and quality of NHS services is compared to those in other sectors, many people will wonder why the NHS cannot offer more services online or enable patients to receive more information on their mobile telephones. Patients want seven-day access to primary care provided near their homes, places of work, or even their local shop or pharmacy. They also want co-ordinated health and social care services, tailored to their own needs. To provide this level of convenience and access, we need to rethink where and how services are provided.

[21] Alzheimer's Society (2012), "Dementia 2012".
[22] Y.C. Wang et al (August 2011), "Health and economic burden of the projected obesity trends in the USA and the UK," The Lancet.
[23] See for example Economist Intelligence Unit (2009), "Fixing Healthcare: The Professionals Perspective".

Increasing costs

The cost of providing care is getting more expensive. The NHS now provides a much more extensive and sophisticated range of treatments and procedures than could ever have been envisaged at its inception. New drugs, technologies and therapies have made a major contribution to curing disease and extending the length and quality of people's lives. The NHS can now treat conditions that previously went undiagnosed or were simply untreatable. It is of course a good thing that the NHS has more therapies at its disposal and can now diagnose and treat previously neglected illnesses. However, many healthcare innovations are more expensive than the old technologies they replace - for example, the latest cancer therapies[24] - which raises affordability questions. We must ensure that we invest in the technology and drugs that demonstrate the best value and this rigour must be extended throughout the system, evaluating not just therapies and technologies, but also different models of delivering health and care services.

Limited financial resources

The NHS is facing these challenges at the same time that the UK is experiencing the most challenging economic crisis since the 1930s and adjusting to an era of much tighter public finances. The broad consensus is that for the next decade, the NHS can expect its budget to remain flat in real terms, or to increase with overall GDP growth at best. This represents a dramatic slow-down in spending growth.

Since it began in 1948, the share of national income that the NHS receives has more than doubled, an average rise of about 4% a year in real terms. As part of its deficit reduction programme the Government has severely constrained funding growth.

In addition, recent spending settlements for local government have not kept pace with demand for social care services. Unlike healthcare funding, social care funding is not ring-fenced; councils decide how much of their budget to spend on services based on local need. As a result, financially challenged local authorities have, in some locations, reduced spend on social care to shore up their finances. Reduced social care funding can drive up demand for health services, with cost implications for the NHS.[26] We therefore need to consider how health and care spending is best allocated in the round rather than separately in order to provide integrated services.

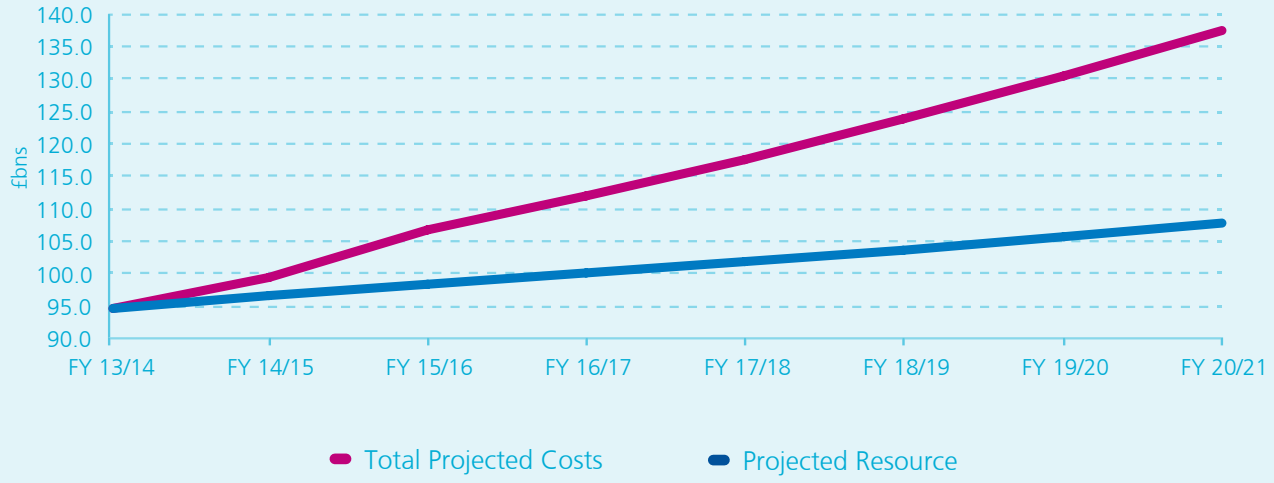
In England, continuing with the current model of care will result in the NHS facing a funding gap between projected spending requirements and resources available of around £30bn between 2013/14 and 2020/21 (approximately 22% of projected costs in 2020/21). This estimate is before taking into account any productivity improvements and assumes that the health budget will remain protected in real terms.[25]

[24] Richard Sullivan et al (September 2011), "Delivering affordable cancer care in high-income countries", The Lancet Oncology.

[25] NHS England analysis.

[26] Research has found that spending on social care could generate savings in both primary and secondary healthcare and that increased social care provision is related to reductions in delayed hospital discharges and readmission rates. See Richard Humphries (2011), "Social Care Funding and the NHS: An Impending Crisis?," King's Fund and J Forder and JL Fernández (2010), "The Impact of a Tightening Fiscal Situation on Social Care for Older People", PSSRU Discussion Paper 2723, London, Kent and Manchester, Personal Social Services Research Unit.

Projected resource vs. Projected spending requirements



Source: NHS England

Limited productivity improvements

Measuring the productivity[27] of the NHS is methodologically difficult and hotly debated. The Office of National Statistics suggests that between 1995 and 2010 average productivity in the NHS grew at 0.4%, whilst in the economy as a whole it grew at a much faster rate of 2% over the same period.[28] Beneath this, NHS labour productivity levels have increased faster than equivalent rates in the wider economy by an average of 2.5% per year between 2007 and 2010.[29] This suggests that the NHS may not be using its capacity as efficiently as it could.

NHS productivity remains an unresolved debate. However, traditional productivity improvements will not be enough to plug the future funding gap. NHS England's analysis suggests that the overall efficiency challenge could be as high as 5-6% in 2015/16 compared to the current 4% required efficiency in 2013/14.[30] Improvements such as better performance management, reducing length of stay, wage freezes or better procurement practices all have a role to play in keeping health spending at affordable levels. However, these measures have been employed to deliver the so-called "Nicholson Challenge" of 4% productivity improvements each year, amounting to some £20bn in savings, and there is a limit to how much more can be achieved without damaging quality or safety. A fundamentally more productive health service is now needed, one capable of meeting modern health needs with broadly the same resources.

> "THE OVERALL EFFICIENCY CHALLENGE COULD BE AS HIGH AS 5-6% IN 2015/16 COMPARED TO THE CURRENT 4% REQUIRED EFFICIENCY IN 2013/14."

[27] At its most basic productivity is the rate at which inputs (like labour, capital and supplies), are converted into outputs (like consultations or operations) and outcomes (such as good health) in order to improve quality of life.

[28] Office for National Statistics (2010), "Public Service Productivity Estimates: Healthcare, 2010".

[29] Office for National Statistics (2010), "Public Service Productivity Estimates: Healthcare, 2010".

[30] This is the challenge for the NHS after national action to constrain wages and other input costs. In recent years these have typically delivered c.1% per annum in savings which over the period modelled would equate to c.£8bn.

Seizing future opportunities

The future doesn't just pose challenges, it also presents opportunities. Technological, social and other innovations – many of which are already at work in other industries or sectors – can and should be harnessed to transform the NHS. These exciting opportunities have the potential to deliver better patient care more efficiently to achieve the transformation that is required, some of which are discussed below. These are not exhaustive and it is crucial that as a service we become better able to spot other trends and innovations with the potential to reshape health services.

A health service, not just an illness service

We must get better at preventing disease. In the future this means working increasingly closely with partners such as Public Health England, health and wellbeing boards and local authorities to identify effective ways of influencing people's behaviours and encouraging healthier lifestyles. The NHS has helped many people quit smoking (although there are still about 8m smokers in England), but has yet to develop similarly sophisticated methods for assisting people to improve their diet, take more exercise or drink less alcohol.

About 4% of the total health budget in England is spent on prevention and public health, which is above the Organisation for Economic Co-operation and Development (OECD) average,[31] but this will strike many as too little. We need to look at our health spending and how investment in prevention may be scaled up over time. It is not just about investment; partnering with Public Health England, working with health and wellbeing boards and local authorities and refocusing the NHS workforce on prevention will shape a service that is better prepared to support individuals in primary and community care settings.

[31] Department of Health (2009), "Public Health and Prevention Expenditure in England".

Giving patients greater control over their health

Developing effective preventative approaches means helping people take more control of their own health, particularly the 15 million people with long-term conditions. The evidence shows that support for self-management, personalised care planning and shared decision making are highly effective ways that the health system can give patients greater control of their health. When patients are involved in managing and deciding about their own care and treatment, they have better outcomes, are less likely to be hospitalised,[32] follow appropriate drug treatments[33] and avoid over-treatment.[34] Personalised care planning is also highly effective.[35] A major trial of Personal Health Budgets, a tool for personalised care planning, has shown improved quality of life and cost-effectiveness, particularly for higher needs patients and mental health service users.[36]

Manchester Royal Infirmary: home dialysis

Manchester Royal Infirmary has developed an innovative dialysis provision pathway, which allows patients to perform extended haemodialysis at home, rather than in hospital. This has delivered improved health and longevity, empowering patients through greater involvement, freedom and flexibility, and offers wider benefits of fewer medications and hospital visits resulting in substantial reductions in healthcare costs.[37]

Harnessing transformational technologies

The digital revolution can give patients control over their own care. Patients should have the same level of access, information and control over their healthcare matters as they do in the rest of their lives. The NHS must learn from the way online services help people to take control over other important parts of their lives, whether financial or social, such as online banking or travel services. First introduced to the UK in 1998, now more than 55% of internet users use online banking services.[38] A comparable model in health would offer online access to individual medical records, online test results and appointment booking, and email consultations with individual clinicians. Some of the best international providers already do this.[39] This approach could extend to keeping people healthy and independent through at-home monitoring, for example. These innovations would not only give patients more control, they would also make the NHS more efficient and effective in the way that it serves the public.

[32] JH Hibbard and J Green (February 2013), "What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs," Health Affairs.

[33] Expert Patients Programme (2010), "Self-care reduces costs and improves health: the evidence".

[34] D Stacey et al. (May 2011), "Decision aids to help people who are facing health treatment or screening decisions", Cochrane Summaries and Department of Health (2011), "NHS Atlas of Variation in Healthcare: Reducing unwarranted variation to increase value an improve quality".

[35] "RCGP Clinical Innovation and Research Centre (2011), "Care Planning: improving the lives of people with long term conditions".

[36] https://www.phbe.org.uk/

[37] NHS England (2013), "Catalogue of Potential Innovation".

[38] Office for National Statistics (2009), "e-society" (Social Trends 41).

[39] For example Kaiser Permanente and the Veterans Administration, both in the USA

e-Intensive Care: a second pair of eyes

Guy's and St Thomas' NHS Foundation Trust, in London, has recently deployed a new e-Intensive Care Unit (ICU) to keep a 'second pair of eyes' on critically ill patients. Used in about 300 hospitals in the US, where studies have shown the system has reduced mortality rates and hospital stays, the eICU allows critical care specialists to remotely monitor patients using high-definition cameras, two-way audio and other instruments that keep track of vital signs. Not only does the system facilitate provision of 24/7 care, it also enables the most experienced specialists to spread their skills more widely and to help more patients with the greatest need.[40]

"THE NEW FRIENDS AND FAMILY TEST ASKS PATIENTS WHETHER THEY WOULD RECOMMEND THEIR HOSPITAL TO THEIR FRIENDS & FAMILY AND THE FIRST RESULTS WILL BE PUBLISHED ON NHS CHOICES IN JULY 2013"

Digital inclusion will have a direct impact on the health of the nation, and so innovation must be accessible to all, not just the fortunate. From April 2013, 50 existing UK online centres in local settings, such as libraries, community centres, cafes and pubs, are receiving additional funding to develop as digital health hubs where people will be able to find support to go online for the first time and use technology and information services such as NHS Choices to improve their health and wellbeing.

Exploiting the potential of transparent data

To support active patients the best quality data must be collected and made available. Dramatic improvements need to be made in the supply of timely and accurate information to citizens, clinicians and commissioners. Commissioners can use improved data to better understand how effectively money is being invested. For patients, more and better data will enable them to make informed decisions about their health and healthcare.

The new Friends and Family Test asks patients whether they would recommend their hospital wards or A&E department to their friends and family should they need similar care or treatment. Beginning in July 2013, the results will be published on the NHS Choices website. This is just one example of transparency which will for the first time allow citizens to compare NHS performance based on the opinions of the patients.

[40] Guy's and St. Thomas' NHS Foundation Trust, www.guysandstthomas.nhs.uk/news-and-events/2013-news/20130703-eICU.aspx

Moving away from a 'one-size fits all' model of care

A relatively small minority of patients accounts for a high proportion of health service utilisation and expenditure. This suggests an opportunity to manage patients, and help them manage themselves, more intelligently, based on an understanding of individual risk.

Healthcare is becoming more personal in other ways too. Recent biomedical advances suggest a revolution in medicine itself may be afoot that could enable clinicians to tailor treatment to individuals' specific characteristics. For instance, it has been proven that mutations in two genes called BRCA1 and BRCA2 significantly increase a person's risk of developing breast cancer. Individuals can now be tested for these mutations, allowing early detection and targeted use of therapeutic interventions. Similar progress is being made in understanding the biological basis of other common diseases. The health service needs to consider how to invest in this work and how it can most effectively be translated into everyday practice.

Risk-stratification in North West London

As part of the Inner North West London Integrated Care Pilot, patient information was combined across primary, secondary and social care providers to understand the impact of high-risk patients on services and expenditure. The data showed that the 20% of the population most at risk of an emergency admission to hospital accounted for 86% of hospital and 87% of social care expenditure. Yet despite this high concentration in expensive downstream services, only 36% of primary care resources were expended on these same patients.[41] This suggests that through better management of these patients in primary care many hospital admissions could be prevented and intensive social care support reduced, resulting in improved care with reduced costs.

Unlocking healthcare as a key source of future economic growth

All too often we think of health expenditure as solely a cost, but investment in individuals' wellbeing and productivity delivers vast benefits to society and the economy. Conversely, illness costs the UK economy dearly: in 2011, 131 million work days were lost due to sickness.[42] This translates into an annual economic cost estimated to be over £100bn whilst the cost to the taxpayer, including benefits, additional health costs and forgone taxes, is estimated to be over £60bn.[43]

In addition to preventing and relieving illness, the NHS has a central role in contributing to economic growth. The NHS is the largest single customer for the UK health and life sciences industries including pharmaceutical, biotechnology, medical devices and other sectors,[44] and Britain is recognised as a leader in biomedical research. We must consider how the NHS can work with industry partners to make sure that the health and life sciences continue to be a growing part of the UK economy.

[41] McKinsey & Co. (2013), "Understanding patients' needs and risk: a key to a better NHS".
[42] Office of National Statistics (2012), "Sickness absence in the labour market".
[43] Department of Health (2011), "Innovation, Health and Wealth".
[44] Department of Health (2011), "Innovation, Health and Wealth"

What's next?

This document discusses the key problems and opportunities that a renewed vision for the health service must address. In the next phase of work, we will analyse, with our key partners, the causes of these trends and challenges and share these more widely in order to begin to generate potential solutions. Some of these solutions may come from reviews that are already underway such as the Urgent and Emergency Care Review and the Berwick Review on improving safety in the NHS. Some solutions may be adapted from small-scale pilots or international models that can demonstrate success, but there is no doubt that new ideas are needed.

We cannot generate these new ideas alone. NHS England is committed to working collectively to improve services. This is why Monitor, the NHS Trust Development Authority, Public Health England, NICE, the Health and Social Care Information Centre, the Local Government Association,the steering group of the NHS Commissioning Assembly, Health Education England and the Care Quality Commission want to work in partnership with NHS England to understand the pressures that the NHS faces and to work together alongside patients, the public and other stakeholders to identify new and better ways to deliver health and care.

The NHS constitution stipulates that the NHS belongs to the people and so does its future. In keeping with this principle we will be working together with staff, patients and the public to develop new local approaches for the NHS. We need your help to ensure that the ideas identified are sustainable and respect the values that underpin the health service. To enlist your help, we are launching a nationwide campaign called *'The NHS belongs to the people: a Call to Action'*.

A call to action

A call to action is a programme of engagement that will allow everyone to contribute to the debate about the future of health and care provision in England. This programme will be the broadest, deepest and most meaningful public discussion that the service has ever undertaken. The engagement will be patient - and public-centred through hundreds of local, regional and national events, as well as through online and digital resources. It will produce meaningful views, data and information that CCGs can use to develop 3-5 year commissioning plans setting out their commitments to patients and how services will improve.

The call to action aims to:

- Build a common understanding about the need to renew our vision of the health and care service, particularly to meet the challenges of the future.
- Give people an opportunity to tell us how the values that underpin the health service can be maintained in the face of future pressures.
- Gather ideas and potential solutions that inform and enable CCGs to develop 3-5 year commissioning plans.
- Gather ideas and potential solutions to inform and develop national plans, including levers and incentives, for the next 5 – 10 years.

What will happen with the data and views that are collected?

All data, views and information will be collected by CCGs and NHS England. This information will then be used by CCGs to develop 3-5 year commissioning plans, setting out commitments to patients about how services will be improved.

This information will also be used by NHS England to shape its direct commissioning responsibilities in primary care and specialised commissioning.

Information gathered in this way will drive real future decision making. This will be evident in the business plans submitted for both 2014/15 and 2015/16. These plans will signal service transformation intentions at both local and national level.

There is no set of predetermined solutions or options about which we are consulting. Bold, new thinking is needed and we will consider a wide range of potential options. However, there are three options that we will not be considering:

1. **Do nothing.** The evidence is clear that doing nothing is not a realistic option nor one that is consistent with our duties. We cannot meet future challenges, seize potential opportunities and keep the NHS on a sustainable path without change.

2. **Assume increased NHS funding.** In the 2010 spending review, the Government reduced spending on almost all most public services, although health spending was maintained. We do not believe it would be realistic or responsible to expect anything more than flat funding (adjusting for inflation) in the coming years.

3. **Cut or charge for fundamental services, or 'privatise' the NHS.** We firmly believe that fundamentally reducing the scope of services the NHS offers would be unconstitutional, contravene the values that underpin the NHS and - most importantly - harm the interests of patients. Similarly, we do not think more charges for users or co-payments are consistent with NHS principles.

How will the call to action engage people?

The call to action will offer a number of ways for everyone to engage with the development of a renewed vision for the health service including:

A digital call to action

Staff, patients and the public will be able contribute via an online platform hosted by NHS Choices. This platform will enable people to submit their ideas, hold their own local conversations about the future of the NHS and search for engagement events and other interactive forums.

'Future of the NHS' surgeries with NHS staff, patients and the public

Local engagement events will be led by clinical commissioning groups, health and wellbeing boards, local authorities and other local partners such as charities and patient groups. These workshop-style meetings will be designed to gather views from patients and carers, local partner groups and the public. We will also be holding events designed to capture the views of NHS staff, for instance, through clinical senates.

Town hall meetings

Held in major cities across the NHS, these events will engage local government, regional partners, business and the public. These regional events will give people who have not contributed locally a chance to participate in regional discussions.

National engagement events

A number of national events focusing on national level partner organisations to the NHS will be held. These will include Royal Colleges, patient groups and charities, the private sector and other stakeholders.

Conclusion

The NHS is one of our most precious institutions. We need to cherish it, but we also need to transform it. Future trends threaten its sustainability, and that means taking some tough decisions now to ensure that its future is guaranteed. We believe that by working together as a nation, we have a unique opportunity to transform the NHS into a health service that is both safe and fit for the future.

The NHS needs your help. Have your say.

Agenda Item No.13

DUDLEY HEALTH AND WELL-BEING BOARD 26TH SEPTEMBER 2013

Report of the Chief Officer of Healthwatch Dudley

Update on Healthwatch Dudley progress

Purpose of Report

1. To update the Board on Healthwatch Dudley (HWD) progress.

Background

2. All Councils were required to establish a Local Healthwatch organisation (LHW) by April 1st 2013. Local Healthwatch is the consumer champion for health and social care. The establishment of LHW is of particular relevance to the Health and Wellbeing Board, how the Board and Local Healthwatch interact with each other will have a direct influence on improving outcomes for local communities and people who use services.

Healthwatch Dudley

3. Dudley Council for Voluntary Service (DCVS) commenced delivery of Healthwatch Dudley (HWD) on 1st April. The following outlines key areas of progress made by HWD up to the end of August 2013:

Launch Event

4. A HWD launch event, where participants were asked 'How can we work together to build the best Healthwatch?' was held on 8th May 2013. We brought together over seventy people from forty local stakeholder organisations develop ideas for discussion as part of an un-conferenced approach where participants are able to steer the agenda for the meeting. Thirty discussion topics were suggested and grouped together into a smaller number of representative categories. Then there were eleven workshop sessions with lots of vibrant debate. There were lots of questions, some of which were answered on the day and others which have been used to start a 'questions and answers page' on the HWD website (www.healthwatchdudley.co.uk).

Staff Recruitment

5. HWD has a full staffing complement in place that comprises:
   - Chief Officer
   - Participatory Research Officer
   - Communications Development Officer

- Administration Officer.

Customer Relationship Management (CRM)

6. HWD are investing time identifying the most appropriate platform to record, track and analyse data collected via an online CRM system with interactive dashboards and reports. This will allow HWD to filter and share real-time information to identify problems and opportunities. While also providing invaluable support for surveys, user incentive schemes and training for users of the website and CRM system, leaving HWD time to co-ordinate activity.

Board Recruitment

7. HWD are currently recruiting board members who have interests in health, social care, children's services and a passion for making local services the best they can be. Board members are being asked to commit to supporting one or more areas of interest in:
   - Primary Health Care
   - Secondary Health Care
   - Adult Social Care
   - Mental Health Care
   - Public Health
   - Children and Young People's Services.

8. The HWD team have adopted an innovative recruitment approach to select board members. People interested in the board member role were invited to meet with the HWD team for an informal chat and some tea and cake. They could also get answers to any questions that they had about HWD and the board member role prior to submitting their application form. Applications have been reviewed. Shortlisted candidates have been invited to take part in an assessed interactive workshop on the evening of Wednesday 11th September.

New Economics Foundation (nef)

9. The nef held a health inequalities workshop on Wednesday 24th July at Dudley Conference Centre. It was an important ground breaking event that involved HWD bringing together different people with an interest in health and health inequalities. They included representatives from organisations working with older people, people with alcohol and substance misuse problems, people with mental health problems, and people with learning disabilities. There was an in-depth conversation about the extent of health inequalities across Dudley borough and action that could be taken to deal with them. A blog and summary of information and insights gathered from the participants at the workshop can be found at *http://healthwatchdudley.co.uk/research-reports/*

Information Points

10. Information Points are going to be opened in a number of locations in order to provide an accessible Healthwatch service to all residents of the Dudley borough. Meetings have taken place with Libraries who are willing to have an Information Point in all 13 libraries. They will be taking enquires and using an online referral form to submit them to HWD staff for processing. HWD has been working in partnership with the Council and Clinical Commissioning Group (CCG) who also

have plans to have public access points in different localities or ratings systems for services to avoid duplication of effort and service provision.

11. In conjunction with colleagues from the Directorate of Adult, Community and Housing Services, visits are being made to the forty-three different voluntary and community organisations that have Service Level Agreements' (SLA) to raise the profile of HWD and talk about potential for the development of Information Points and the use of existing volunteers in organisations to act as trained HWD Champions.

Adult Social Care Local Account

12. As part of Dudley's Making It Real programme, local people have been invited to help to produce the 2012/2013 Adult Social Care Local Account. It lists the differences made to people's lives as a result of the provision of adult social care services by Dudley Council and priorities for future improvements to future services. HWD are leading a series of workshops to ensure that a diverse range of stakeholder views are gathered to inform the production of a final Local Account that is a fair and balanced account of what is really happening in Dudley borough. The first workshop was held on Wednesday 31st July and a further two workshops are planned for Tuesday 24th September and Tuesday 22nd October to view proofs and to sign off the 2012/2013 Local Account.

Networking and Board Representation

13. The HWD team have spent much time building relationships with strategic partners within the Dudley borough promoting the importance and value of HWD.

    Networking – National

    - Community Participation and Research Conference
    - CQC National Conference
    - Embedding Children and Young People's Participation Conference
    - HW England National Conference

    Networking – Regional

    - West Midlands Strategic Clinical Network and Clinic Senate
    - HW England Regional Launch Event
    - HW Region Network Meetings
    - NHS England Patient Voice and Insight Day
    - Responding To Francis Regional Response
    - West Midlands Academic Health Science Network
    - West Midlands Ambulance Service NHS Foundation Trust
    - Worcestershire Association of Carers

    Networking – Local

    - Building Health Partnerships
    - Dementia Friendly Communities Halesowen
    - Dudley Health and Well Being Board Annual Conference
    - Healthcare Forums
    - Integration Bid

- Mental Health Personalisation
- Patient Experience
- Patient Opportunity Panel
- Planning For Personalisation Meetings
- Primary Care Strategy
- Urgent Care Strategy

Representation

- Clinical Commission Group
- Dudley Safeguarding Adults Board
- Health and Well Being Board
- Health Scrutiny Committee
- Healthcare Forum
- Making It Real

Professor Sir Bruce Keogh Review

14. As part of this overarching review of fourteen hospital trusts in England selected on the basis that they have been outliers for the last two consecutive years on mortality indicators HWD were invited to contribute to the work undertaken with the Dudley Group NHS Foundation Trust. HWD attended a patient listening event and the Risk Summit in Cambridge. The Risk Summit considered a report from the Rapid Response Review team alongside other hard and soft intelligence, in order to make judgements about the quality of care being provided by the Trust and agree any necessary actions, including offers of support. The key urgent actions identified that HWD are especially concerned about include:
    - the shortfalls in learning from serious incidents and complaints
    - the complaints process not being fit for purpose
    - adequately responding to the patients needs.

15. As local consumer champion for health and social care, HWD has a very important role to play. In the coming months we will be listening to the experiences of patients, their families and carers, to ensure that their views are fully taken into account. Our findings will inform key decisions that are made as new systems are introduced. HWD are committed to representing the views of local people and are looking forward to working with colleagues from Trust to support everyone through a challenging journey.

Patient-Led Assessments

16. HWD identified volunteers to help both Russells Hall Hospital and the West Midlands Hospital in Halesowen undertake their annual Patient Led Assessment of the Care Environment (PLACE) focussing on non-clinical services and buildings. The assessments are ‘patient-led’ in order to ensure that the patient voice is given the highest priority and patient assessors make up at least 50% of the assessment team. Results of the assessments are due to be announced later this month.

Enter and View

17. HWD can send authorised representatives (trained staff, board members and volunteers) into health and social care premises to listen to people’s experiences of services and observe what is going on around them. The views of patients,

residents, carers and relatives are collected and evidence based feedback is reported to relevant organisations including:

- Care Quality Commission
- Dudley Council
- NHS commissioners
- Healthwatch England

18. Legislation allows Enter and View activity to be undertaken in a number of organisations including:

- NHS Trusts
- Local Authorities
- General Practitioners
- Dentists
- Opticians
- Community Pharmacists
- Adult Social Care Homes
- Day Centres.

HWD are undertaking Enter and View training delivered by Healthwatch England and a recruitment drive for volunteers to undertake Enter and View training is due to commence shortly. Relationships have been established with a number of partners including local inspectors from the CQC, members of the Dudley Safeguarding Adults Board and West Midlands Care Association to consider how this function can be undertaken most appropriately.

Finance

19. Local Healthwatch is funded by the Government and primarily through Department of Health.

The contract runs for a 3 year period subject to the Governments on-going funding of the Healthwatch programme.

Law

20. As outlined within the Health & Social Care Act 2012, Local Authorities have a statutory duty to support and establish local Healthwatch in their area.

Recommendation

21. It is recommended that the Dudley Health and Well-being Board note the work being progressed by Healthwatch Dudley.

Jayne Emery
Chief Officer of Healthwatch Dudley

Contact Officer: Jayne Emery
Chief Officer, Healthwatch Dudley
Telephone: 03000 111 001
Email: jayne@healthwatchdudley.co.uk