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Date of issue: Tuesday, 10 November 2015

MEETING:	**HEALTH SCRUTINY PANEL** (Councillors Ajaib (Chair), Strutton (Vice-Chair), Chahal, Chaudhry, Cheema, Chohan, M Holledge, Pantelic and Shah) **NON-VOTING CO-OPTED MEMBER** Healthwatch Representative Buckinghamshire Health and Adult Social Care Select Committee Representative
DATE AND TIME:	WEDNESDAY, 18TH NOVEMBER, 2015 AT 6.30 PM
VENUE:	MEETING ROOM 3, CHALVEY COMMUNITY CENTRE, THE GREEN, CHALVEY, SLOUGH, SL1 2SP
DEMOCRATIC SERVICES OFFICER: **(for all enquiries)**	NICHOLAS PONTONE 01753 875120

NOTICE OF MEETING

You are requested to attend the above Meeting at the time and date indicated to deal with the business set out in the following agenda.

RUTH BAGLEY
Chief Executive

AGENDA

PART I

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	Apologies for absence.		

sustainable forest

AGENDA ITEM	REPORT TITLE	PAGE	WARD
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3.	Member Questions *(An opportunity for Panel Members to ask questions of the relevant Director/ Assistant Director, relating to pertinent, topical issues affecting their Directorate – maximum of 10 minutes allocated).*		
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10.	Date of Next Meeting - 14th January 2016		

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Press and Public

You are welcome to attend this meeting which is open to the press and public, as an observer. You will however be asked to leave before the Committee considers any items in the Part II agenda. Please contact the Democratic Services Officer shown above for further details.

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Health Scrutiny Panel – Meeting held on Thursday, 1st October, 2015.

Present:- Councillors Ajaib (Chair), Strutton (Vice-Chair), Chaudhry, Cheema, Chohan, M Holledge, Pantelic and Shah

Also present:- Councillor Hussain

Apologies for Absence:- Councillor Chahal

PART I

19. Declarations of Interest

No interests were declared.

20. Minutes of the Last Meeting held on 28th July 2015

Resolved – That the minutes of the last meeting held on 28th July 2015 be approved as a correct record.

21. Member Questions

There were no questions from Members.

22. Frimley Park Hospital NHS FT Acquisition of Heatherwood & Wexham Park Hospitals NHS FT: Update

The Panel received an update from Dr Timothy Ho, Medical Director at Frimley Health NHS Foundation Trust, one year on since Frimley Park's acquisition of Heatherwood & Wexham Park Hospitals and integration into the new Trust.

Heatherwood & Wexham Park Hospitals Trust had faced significant financial, operational and clinical challenges at the time of the acquisition and the Panel were informed of the progress made in improving the quality of care and performance on the Wexham Park and Heatherwood sites. The long term aim was to achieve the same high standards of quality, performance and financial efficiency across the combined Trust.

(Councillor Pantelic joined the meeting)

The update can be summarised as follows:

- The acquisition had brought a number of benefits including greater financial stability; the ability to attract and retain high quality staff; and improved clinical outcomes through a larger clinical team and improved access to services for patients.

- The executive team had focused on promoting culture change and management had successfully introduced a single vision and set of principles and values for staff on all three sites.

- Performance was improving and Frimley Health had met all key standards set by Monitor during the first quarter of 2015/16, including the four hour waiting time target for accident and emergency services. Wexham Park Hospital had achieved this target for the first time in several years, underlining the progress that was being made.

- The Trust was seeking to bring a number of new and improved services to Wexham Park including an increased range of chemotherapy and on site radiology services; a new emergency department; renal services; and potentially ophthalmology. Management were committed to delivering a 'seven day NHS'.

- The Care Quality Commission (CQC) would be conducting an inspection of Wexham Park Hospital from 13th October which would provide an opportunity to monitor and review some of the progress that had been made. It was noted that the Panel would be contributing to the inspection.

The Panel welcomed the progress that had been made in stabilising and improving services at Wexham Park since the acquisition. Members asked a number of questions including about the proposed improvements to car parking and the refurbishment of the site. The Trust was progressing plans to significantly increase the number of car parking spaces but it wasn't confirmed when they would be available. A backlog of repairs and maintenance at the site was being addressed including re-roofing and waterproofing in addition to the wider plans to provide a new emergency department and refurbish the maternity unit. A Member asked about the plans to bring standards of maternity care at Wexham Park up to those of the rest of the group, and it was responded that improvements to the fabric of the building and organisational culture, in addition to the recruitment and retention of midwives were important steps in improving services. The template and best practice for high quality maternity services was being introduced at Wexham Park and the services had started to improve.

A Member commented that he had already noticed improvements in the emergency department and asked whether there were metrics to support the anecdotal evidence. The key metric was that the four hour A&E waiting time, which Wexham Park Hospital had consistently failed to meet over the previous three years, was now improving. New ways of working had been introduced which included mirroring the Frimley model by having specialist consultants available for A&E. The target was not only being met but Wexham Park was performing very well against its comparators.

The Panel were impressed about the steps undertaken to improve the culture of the combined Trust, embed the core values and engage staff. It was stated that staff had responded positively and flexibly to the changes and many staff

suggestions had been taken forward in making improvements to processes. Dr Ho was asked what training and support was in place to improve the retention rate of nurses and in response it was confirmed that management had given a high priority to retention with a majority of trainee nurses now staying with the Trust. In respect of the care values, these were central to the recruitment and management culture. It was recognised that staff retention was also crucial in minimising the use of agency staff, which remained a significant financial pressure and was a problem for the NHS nationally.

Members discussed a range of issues relating to existing and new services including specialist stroke and cancer services and bed capacity more generally. In relation to strokes, it was noted that commissioners had decided that outcomes for patients would best be met at a dedicated facility currently provided at High Wycombe which brought together specialism and expertise. There were plans to improve cancer provision at Wexham Park and introduce new chemotherapy and radiotherapy. Bed capacity would always be an issue for the NHS more widely and the Trust was seeking to improve the 'patient pathway' to ensure people did not stay in hospital any longer than was necessary. Members welcomed the new services proposed. Dr Ho was asked whether he expected any services to be moved away from Wexham Park and he responded that he was not aware of any such plans.

The forthcoming CQC inspection was discussed and the Trust expected issues such as safe staffing, accommodation and diagnostics to be identified during the inspection. The Council would be providing input to the inspection and it was agreed that the inspection report would be considered by the Panel as soon as it became available. The Panel welcomed the progress that had been made over the past year and at the conclusion of the discussion, the Chair thanked Dr Ho for his report.

Resolved –

(a) That the update be noted.

(b) That the Panel consider the findings of the forthcoming CQC inspection into Wexham Park Hospital at the earliest opportunity.

23. Slough Caring for Our Carers: Joint Commissioning Strategy 2015-20

The Panel considered a draft version of the Joint Carers Commissioning Strategy for the Council and Clinical Commissioning Group for the period 2015-20.

The Co-Chair of Slough Carers Partnership Board, Jadine Glitzenhirn, and the Assistant Director Adult Social Care updated Members on the key elements of the strategy and invited the Panel to comment on and contribute to the development of the Strategy before it was presented to the Cabinet and Slough Wellbeing Board for approval later in the year. It was estimated that 14% of Slough's population were carers, higher than the national average of 12% and this was likely to be an underestimate given the difficulties

identifying carers. The new strategy updated the interim Joint Carers Strategy 2014-15, which had covered the period including the introduction of the Care Act 2014, and it supported a number of national and local priorities. The four proposed local priorities were identifying and recognising carers; realising and releasing the potential of carers; a life outcome of caring; and supporting carers to help them stay healthy.

Ms Glitzenhirn gave the Panel an insight into her experiences as a carer and explained the role of the Partnership in providing the right support at the right time to Slough's carers. The voice of carers had come through more strongly than before in the new strategy, but it was recognised that more engagement was required in the future. A number of specific priorities and issues were highlighted including raising awareness of the contribution of carers; the challenges in identifying carers; and the particular support required by young carers.

The Panel discussed the potential ways to improve the identification of carers, which could include using the media to tell the stories of carers and improving the GPs register of carers. The Assistant Director explained the work being undertaken by professionals working across social care to identify carers and highlighted the opportunities of working more closely with voluntary and community sector organisations through the new VCS Strategy. It was recognised that many carers would benefit from time and support with other carers and support groups and it was felt that provision in the area could be expanded. Members discussed a range of other issues including carers assessments and support for young carers including the potential implications arising from the transfer of services to Slough Children's Services Trust.

At the conclusion of the discussion the Panel welcomed the work undertaken to prepare the document and agreed to endorse the new strategy. It was also agreed to refer a number of issues to the Cabinet when it considered the strategy for approval. These issues included the further action that could be undertaken by the Council to identify carers and raise public awareness of the vital role they played in the local community; a request to the Commissioner for Health & Wellbeing to raise the effectiveness of the GP register of carers with the CCG and bring a progress report to a future meeting of the Panel; and that the Cabinet direct Council departments to consider and reflect the new strategy in their service areas to ensure they could better meet the needs of carers.

The Chair thanked the Assistant Director and particularly Ms Glitzenhirn for the report.

Resolved –

(a) That the Joint Carers' Commissioning Strategy 2015-2020: 'Slough Caring For Our Carers' be endorsed.

(b) That the following matters be referred to the Cabinet:

1. That the Cabinet considers the further steps the Council can take to identify, support and raise public awareness of the role of carers by widely publicising the Strategy to partners, community organisations, schools and the media.

2. That the Commissioner for Health & Wellbeing discuss with Slough Clinical Commissioning Group how the GP carers register could be improved to better identify carers and improve access to the available support, with the Panel to receive a progress report at a future meeting.

3. That the Cabinet direct Council departments to take the Strategy into account when services are reviewed to ensure all relevant Council services are compliant with the requirements of the Care Act and better support Slough's carers.

24. Adult Social Care Local Account

The Panel received a report on the draft Adult Social Care Local Account for 2014-15 which set out the achievements made during the year and priorities for 2015-16.

Local accounts were used by councils across the country to assess how well adult social care services were performing as part of the commitment to improve the quality of services and transparency. The draft Local Account, as attached as Appendix A to the report, included the progress made against the 22 indicators of the Adult Social Care Outcomes Framework. The Panel noted progress against the indicators including:

<u>Indicators showing significant improvement:</u>

- Adults in contact with secondary mental health services who live independently had improved from 85 to 86.9, well above average.
- Adults with learning disabilities in paid employment had improved from 5.7 to 6.4.
- People who used services who reported that they had as much social contact as they would like had risen from 37.5 to 39.5, although it was below the family group average of 42.8.
- Overall satisfaction of carers with care and support had improved from 34.9 to 43.9 which was now above national and comparator averages.

<u>Indicators showing good performance being maintained:</u>

- Older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services was 100, compared to the England average of 80.7, and reflected the local priority and joint working arrangements.
- Increased people going into reablement

- Permanent admission of older people (aged over 65) to residential and nursing care homes was 570.6 per 100,000 population compared to an average 706.5 across comparator areas.

Indicators requiring further improvement:

- Proportion of adults receiving direct payments was 16.8 compared to a family group average of 24.7. Performance was improving and further steps were being taken to increase the number of direct payments.
- Carer related quality of life had fallen from 8.3 to be 7.9 and this had been identified as a priority area for 2015/16.
- Carers who reported that they had been included or consulted in discussion had fallen from 72.1 to 67.6 which was below average.

The Local Account also outlined the key priorities for the year ahead which were prevention; information & advice; personalised outcomes; building community capacity; workforce development and quality. These priorities also linked to the adult social care transformation programme.

The Panel considered a number of issues including the parity between mental and physical health and the provision of respite care. A Member asked why the number of direct payments remained low and whether the cessation of the previous support service had been a contributory factor. The Assistant Director responded that a support service for direct payments was being put back in place and it was expected that direct payments would increase. It was also asked whether it was considered that complaints were taken seriously enough. It was confirmed that complaints were taken very seriously. The number of complaints had risen from a historically low base, which was welcomed as any issues needed to be reported and dealt with appropriately. Any concerns from Members about the handling of individual cases should be raised separately through the proper process.

At the conclusion of the discussion, the Panel noted that draft Adult Social Care Local Account 2014-15.

Resolved – That the draft Adult Social Care Local Account 2014-15 be noted.

25. Adult Social Care Budget and Reform Programme 2015-19

The Panel received a presentation on the adult social care reform programme and summary of the financial challenges facing the service in the future.

The key points noted by the Panel included the following:

- The adult social care budget for 2015/16 was £34.38m. An overspend of £1.8m was currently reported, however, a recovery plan was in place and the end of year forecast was an overspend of £600k.
- The reason for the overspend was primarily that a careful approach was being taken to implementing agreed savings plans with a staged

approach being taken. There was also emerging evidence that some new clients had more complex needs and work was underway to understand the cost implications of this.

- 1,391 people were supported by Adult Social Care in Slough as at March 2015. 304 people were in care homes which accounted for a substantial proportion of department spending.
- Local government funding had reduced more sharply than other areas of government spending between 2010-2015 with only health spending increasing during this period. The cuts had a significant impact on adult social care service provision across the country.
- The Council was undertaking an outcomes based budgeting process based on 35% funding reductions for SBC. The outcome of the Government's Spending Review would clarify the level of savings required.
- The adult social care efficiency savings between 2015/19 were £7.814m and a strategy had been devised to 2019 to support this reform programme with an emphasis on prevention, personalisation and partnership working.

The Panel were informed that there were significant risks to delivery in implementing the planned reform programme and an even higher level of cuts of up to 35% may be required which would equate to £12m over four years. This would require a different model to be developed and would involve raising the thresholds that would have significant negative impact on services. The Panel was advised that the higher level of cuts may mean services were not compliant with the Care Act and there would also be consequential impacts for other parts of the social care system.

Members expressed concern about the funding position, particularly under the worst case scenario of future funding reductions, and discussed the process being undertaken to develop the budget for 2016/17 and beyond. Decisions would be taken through the usual Council budgeting process and would be informed by the Spending Review to be delivered by the Chancellor on 25th November 2015. The Assistant Director was asked about the level of cooperation between the Council and the Health Priority Delivery Group and other health partners, particularly the Clinical Commissioning Group (CCG). It was responded that the Health PDG was co-chaired by the Assistant Director and the Chair of the CCG and partnership working had improved, however, partners may not fully appreciate of the impacts of the financial challenges to be faced by local authorities.

The Panel recognised that the 1,400 people in receipt of support from adult social were the most vulnerable people in the borough and agreed to support the efficiencies and new ways of working in the reform programme to protect services as far as possible. Members were invited to provide their comments and views on how the reform programme could be delivered and it was also agreed to bring further reports to the Panel on the progress of implementation and financial position of the service following the Spending Review.

Resolved –

(a) That the update on the financial position facing Adult Social Care be noted.

(b) That the Panel support the plans outlined for the Adult Social Care Reform Programme over the next four years to ensure the Council could continue to provide key services to vulnerable adults and meet statutory requirements.

(c) That the Panel receive regular reports on the progress of the future funding position for Adult Social Care and the Reform Programme.

26. Public Health Grant - Funding Cut Implications

The Panel received a report on the level and impact of the impending in year reduction to the Public Health Grant following a Government consultation.

It had been announced that there would be a national in year reduction of 6.2% of the total Public Health Grant which would create a shortfall in Slough of £427k in 2015-16. This was in addition to the £950k savings already made in public health. The Government were consulting on how the reduction should be implemented. The Panel noted Slough's consultation response and were invited to comment on the areas for reducing costs. Members asked whether efficiencies could be made by greater joint working with health partners. It was responded that joint working was already taking place and communication had been made with service providers and partners. A Member asked whether fines generated from illegal tobacco and alcohol could be used the support public health activity. Joint work with the Council's licensing and enforcement activity was recognised as being important, but there were legislative and practical barriers to using fines for public health programmes.

At the conclusion of the discussion, the Panel agreed to note the update and provide any further comments or suggestions directly to the Consultant in Public Health.

Resolved –

(a) That the level and impact of the reductions to the Public Health Grant 2015/16 be noted.

(b) That any further comments and ideas from Panel Members on the funding reductions be provided directly to the Consultant in Public Health.

27. Forward Work Programme

The Panel considered the work programme for 2015/16 and agreed the following additions/amendments:

18th November 2015

- The item on Drug and Alcohol Services would include consideration of the Slough Alcohol Strategy.
- Adult Safeguarding Annual Report to be added to the work programme.

14th January 2016

- Five Year Plan Outcome 6 to be scheduled (from un-programmed).

21st March 2016

- Berkshire Healthcare NHS Foundation Trust Quality Account to be added.
- Transfer of health visitor services to be scheduled (from un-programmed).

It was also agreed that a report on the CQC inspection report into Wexham Park Hospital to be added to the programme at the first available meeting following publication. An additional meeting could be convened if considered appropriate depending on the findings and a copy of the inspection report would be circulated to Panel Members as soon as it's available.

As previously agreed, the Panel to receive future progress updates on the Adult Social Care Budget Update and Reform Programme following the Spending Review.

Resolved – That the Forward Work Programme for 2015/16 be endorsed, subject to the amendments detailed above.

28. Attendance Record

Resolved – That the record of Members' attendance in 2015/16 be noted.

29. Date of Next Meeting - 18th November 2015

The date of the next meeting was confirmed as 18th November 2015.

Chair

(Note: The Meeting opened at 6.31 pm and closed at 8.46 pm)

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SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny Panel **DATE:** 18th November 2015

CONTACT OFFICER: Helen Fisher, Drug and Alcohol Action Team Harm Reduction and Clinical Officer, 01753 477380

(For all Enquiries) (01753) 477380

WARD(S): ALL

PART I
FOR COMMENT & CONSIDERATION

SLOUGH ALCOHOL STRATEGY AND SUBSTANCE MISUSE AND TREATMENT SERVICES IN SLOUGH

1. **Purpose of Report**

- To seek comment from the panel on the Alcohol Strategy

And

- To advise panel members of the progress of Slough's Substance Misuse Services and the ongoing challenges faced in respect of substance misuse in Slough.

2. **Recommendation**

The panel is requested to comment on the draft Slough Alcohol Strategy, proposing recommendations or suggested amendments to the strategy, to be presented to the Slough Wellbeing Board for adoption.

And

The panel is requested to note the report for information on Slough's Substance Misuse Services and provide comments on how services can be improved.

3. **The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan**

The services deliver aspects of the Slough Joint Wellbeing Strategy, JSNA and the Five Year Plan priorities and cross cutting themes including civic responsibility.

3a. **Slough Joint Wellbeing Strategy Priorities**

Priorities:

Health

Slough treatment service contributes to the SJWS aims and priorities;

- Reduce drug and alcohol misuse and their impact on domestic abuse and violent crime
- Ensure good recovery outcomes from drugs and alcohol services

This is achieved by engaging individuals who use substances problematically into treatment, and once engaged, retaining them in the service to enable change. The service works towards successful completions and reducing the number of individuals who re-present to the service.

Safer Slough

Slough treatment services contribute to the SWJS aims and priorities;

- Reduce crime, the fear and perception of crime, anti-social behaviour and substance misuse

This is achieved by partnership working with criminal justice agencies including the police, probation and the prisons. By ensuring the pathways are robust, the service enables substance misusing offender's straightforward access into treatment.

Cross-Cutting themes:

Slough treatment services encourage service users to take ownership for their own health and wellbeing. Through this work, the services reduce inequalities by enabling fair access for a hard to reach group who often do not have positive perceptions of publically provided services. The services that we deliver are of consistently high quality to ensure positive outcomes for substance misusing residents.

Improving the image of the town

The service is commissioned to deliver an outreach service, which often works in partnership with the Police to engage those hard to reach residents who are contributing to negative perceptions of the town. By engaging them in a structured treatment system, they are supported by diversionary activities and thus contributing to reducing their negative impact.

The service is also commissioned to deliver a service, which includes work with service users with complex needs. The service also works in partnership with local pharmacies to engage those hard to reach residents who are contributing to negative perceptions of the town. By engaging them in a structured treatment system (and encouraging them to stay within the services), they are supported by diversionary activities and thus contributing to reducing their negative impact.

3b. **Five Year Plan Outcomes**

The outcomes are:

Slough will be one of the safest places in the Thames Valley
Slough treatment services contribute to the outcomes of the five year plan by;

- Working in partnership with criminal justice agencies such as the police, probation and the prisons to support substance misusing offenders into treatment
- By stabilising substance misusing offenders into treatment, the services reduce the risks around their offending

More people will take responsibility and manage their own health, care and support needs
Slough treatment services contribute to the outcomes of the five year plan by;

- Those accessing treatment, must consent throughout their treatment journey, for example consenting to a referral
- The individual treatment plans are determined in partnership with the service user, their recovery worker and other relevant agencies involved
- Providing service users with information to enable them to gain a holistic understanding of the harm their use causes to their health and wellbeing
- An opportunity to access health clinics within the treatment service around; Blood Borne virus's, vaccinations and testing, sexual health and smoking cessation
- To encourage and facilitate service users to build their own recovery capital to enable them to be responsible and manage their own recovery.

Children and young people in Slough will be healthy, resilient and have positive life chances
Slough treatment services contribute to the outcomes of the five year plan by

- By delivering the Young People's Service to enable this group to address their use of substances and build resilience to reduce the likelihood of them requiring specialist substance misuse services as an adult
- By delivering the 'What About Me' group to children and young people affected by someone else's substance misuse encourages positive lifestyle choices.
- By delivering the Family Intensive Engagement Service
- The service works with families who have substance misuse issues to motivate them and provide opportunities for change

- The intervention has the opportunity to provide resilience to children and young people and contribute to them having positive life chances.

The Council's income and the value of its assets will be maximised

- The DAAT identified and implemented 14.6% of savings in year for 15/16
- Slough Treatment Services have a Performance Related Payment which is 5% of the contract value.

4. **Other Implications**

(a) Financial

The recommendations within the report will be managed within the overall Drug and Alcohol Action Team budget; however the savings that have been implemented in 15/16 have resulted in financial implications for the substance misuse system in year.

(b) Risk Management

The ongoing challenges faced in respect of substance misuse in Slough are around resources (and the reduction in these), and the continued high demand on the services. This will be managed by the DAAT in cooperation with the services, and can be addressed as part of the reconfiguration of the treatment system.

Alcohol has always been an issue in Slough and has never received funding to meet this need. The treatment services are starting to see an increase in alcohol referrals, and the focus for Slough; within the Five Year plan, is around tackling this issue.

The other challenge is the change in drug trends and although Slough has not seen a significant shift currently, there has been a recent increase in the use of synthetic cannabinoids and an increase in the needle exchange provision for Performance Enhancing substances.

Recommendation	*Risk/Threat/Opportunity*	*Mitigation(s)*
The Committee is requested to recommend acceptance or suggest amendments to Slough Alcohol Strategy.	This is an opportunity for the committee to provide amendments to the strategy and for this to be adopted to provide a strategic overview of Slough's strategy to tackle alcohol. There is no funding attached to the strategy therefore implementation would need to be within existing resources.	As part of the Alcohol Misuse Pathways Project the Drug and Alcohol Action Team, with Oxford Academic Health Science Network, Public Health England and other stakeholders are service mapping to gain a cross agency picture of alcohol interventions.

The Committee is requested to note the report for information on Slough's Substance Misuse Services and provide comments on how services can be improved.	There is an opportunity for the panel members to provide comments on the service. No identified risks to this recommendation.	None required.

(c) Human Rights Act and Other Legal Implications

There are no Human Rights implications.

(d) Equalities Impact Assessment

The service is inclusive to all people with substance misuse problems seeking help. The positive impacts are: improved visibility and accessibility, simpler referral and access routes through a single point of entry, and better co-ordination at the tiers of dependency.

There is no identified need for the completion of an Equalities Impact Assessment.

5. Supporting Information

5.1 Slough Alcohol Strategy 2015-2019 (attached as Appendix A)
Slough's Alcohol Strategy 2015-2019 has been presented to stakeholders for consultation and input, prior to being presented to the committee. For a list of stakeholders involved in the consultation day, please refer to page 25 within the strategy.

The strategy was developed to provide an overarching document to address the negative effects of alcohol use. The strategy outlines the priorities and challenges faced by Slough to tackle this issue and have been aligned with the key objectives set out in Slough's Five Year Plan.

The strategy has four themes;

- Working in Partnership
- Responsible Sale and Consumption
- Reducing Harm
- Protecting Families.

A key focus of the strategy is prevention and enabling alcohol users to take control of their own alcohol consumption. The strategy recognises the harm alcohol causes and the importance of working in partnership using a multi agency stakeholder approach.

The strategy will align the stakeholder's response to achieve mutually agreed objectives to address alcohol use in Slough.

5.2 Slough Treatment Services

Slough Treatment Services were reconfigured during a re-commissioning process and in April 2012 the new service was launched.

Slough Treatment Services are an integrated multi agency treatment system. There are three agencies that deliver four broad components of the service; Early Intervention and Harm Minimisation, Psychosocial Recovery, Clinical Provision and Community Re-integration.

All interventions delivered by the service providers have a strong recovery focus, with the objective to support substance users to successfully complete treatment and maintain changes to their use in the long term.

The services are currently co-located and delivered from Maple House in Slough. The Drug and Alcohol Action Team are currently in the process of sourcing alternative accommodation as the lease on our current premise will expire in June 2016.

Turning Point

The agency delivers the Early Intervention and Harm Minimisation Service, and is the first point of contact for all drug and alcohol referrals. The Community Re-integration service is delivered by Turning Point and is responsible for supporting individuals who are substance free to re-integrate into the wider community.

Turning Point is commissioned to deliver an outreach service with their main aim to engage treatment naïve or treatment resistant individuals to access support.

Crime Reduction Initiative (CRI)

The agency provides the medically assisted recovery clinics in partnership with the specialist provider, including alcohol detoxifications. CRI deliver the psychosocial interventions and are responsible for supporting individuals to achieve their treatment goals.

The Family Intensive Engagement Service is delivered by CRI and works with Substance Misusing parents to support them to understand the impact their use has on their parenting.

Farnham Road Practice

Farnham Road is our specialist provider who is responsible for the clinical interventions; this includes prescribing opiate substitute medication and providing specialist medical input. The provider also delivers health clinics, including vaccinating against Hepatitis B.

Young People

Turning Point deliver the Young People's Service and provide interventions to support this group.

This includes a peer education program for young people interested in learning about substance misuse and using their knowledge to support other young people.

Performance indicators

Substance misuse services are nationally monitored on performance by Public Health England's Alcohol and Drugs Team. Slough Treatment Services have local and nationally agreed indicators that they are performance managed against, by Slough Drug and Alcohol Action Team. Further detail of how Slough is performing is provided below.

The contracts for Turning Point and CRI have a Performance Related Payment which is 5% of the contract value, over the last two years the services have achieved at least 3% of this.

5.3 Substance Misuse in Slough

We support approximately seven hundred individuals in treatment within a year across the treatment services.

Drugs

- In 2013/14 the estimated number of Opiate and Crack users in the area verses the number of those in treatment calculates our local 'penetration rates'**.** The penetration for Slough is 43% in comparison to 53% nationally. The rates are slightly lower than previous years; these estimates are due to be refreshed and therefore may change.

- When engaged in treatment, people use less illegal drugs, reduce their offending, and improve their health and well being. All these aspects are beneficial as it reduces the impact drug use and the associated harms have on the wider community. 95% of services users were effectively engaged in treatment for three months or more, which is in line with the national figure of 94%.

- In Slough 21% of drug users completed treatment successfully and 90% did not return to treatment within six months. Nationally these figures were 15% and 89% respectively.

- In Slough 20% of service users in treatment were employed compared to a national figure of 17%. Around a third (33%) of our service users were working ten or more days in the month prior to successfully completing treatment. The national average is 27%.

- Harm reduction including safer injecting practice and blood borne virus interventions are a priority for Slough, and we have been performing well against the national average. For example 63% were no longer injecting at six month review, which is higher than the national figure of 57%.

Alcohol

- Slough has a lower number of alcohol-specific hospital admissions (143.58 per 100,000 nationally; 176.86) and lower alcohol related hospital admissions (492.33 compared to nationally; 567.92). Slough has a higher rate of admission episodes for alcohol-related conditions (2222.83 compared to nationally 2031.76)

- Slough has high levels of alcohol-related recorded crime (9.25 compared to 5.74 nationally). Specifically for alcohol related violent crime (6.15 per 1,000 compared to nationally 3.13)

- In Slough 48% of alcohol users completed treatment successfully, 40% completed and did not return to treatment within six months. Nationally this figure was 38% and 36% respectively.

- In Slough 27% of service users in treatment were in education or employment compared to a national figure of 22%.

- Tackling high risk alcohol use is a priority for Slough as use at these levels increases the risks around alcohol related conditions. Within the treatment system 72% of alcohol users were in this category on entering treatment, compared to 77% nationally.

5.4 Challenges

The ongoing challenges faced in respect of substance misuse in Slough are around resources and the reduction in these and the likelihood of further savings.

The challenge will be to meet the needs of the substance misusing populations within these constraints.

Premises

It is challenging to find appropriate accommodation within Slough to relocate substance misuse services. There have been a number of factors to consider, including location of the service.
The Drug and Alcohol Action Team are working in partnership with Asset Management to identify under utilised council accommodation, in order to secure new premises.

6. Comments of Other Committees

This report has not been presented to other committees.

7. Conclusion

The report provides information on substance misuse in Slough with a particular focus on Slough's Alcohol Strategy 2015-2019.

The key decision for the panel is to make the recommendation to accept Slough's Alcohol Strategy 2015-2019 or to provide comments so that it can be amended.

Despite the aforementioned challenges, Slough Treatment Services have continued to deliver a consistent high quality service to the residents of Slough.

Service users accessing treatment will be assessed within seven days and will be engaged in treatment in no longer than three weeks. The services have adapted to avoid waiting lists.

Slough's successful completion rates remain relatively high when compared to areas of similar substance misuse issues and demographics.

The majority of our service users complete treatment in the community, which has enabled the DAAT to continue to fund complex cases for inpatient placements.

A strategic review of substance misuse services is currently taking place. The aim of this is to determine the scope and configuration of future services. The intention is to maximise outcomes and identify increased value for money in light of the likelihood of reduced resources. We will keep the Health Scrutiny Panel updated of the progress of the review.

8. Appendices Attached

'A' - Slough Alcohol Strategy 2015-2019

9. Background Papers

None

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SLOUGH ALCOHOL STRATEGY 2015-2019

CONTENTS

INTRODUCTION

Slough Borough Council is committed to reducing the negative effects of alcohol whilst supporting a vibrant and diverse economy. This strategy has been developed to provide the strategic overview and priorities for tackling the alcohol challenges within Slough. This builds on Slough's Joint Wellbeing Strategy for 2013-2016 and is based on contemporary data and information derived from the Slough Alcohol Needs Assessment and Joint Strategic Needs Assessment.

The government has highlighted its dedication to tackling alcohol related issues in its 2013 Alcohol Strategy.[1] This includes a commitment to reduce the problems caused by the over-provision of cheap alcohol, whether they are individual, familial or social in nature. Partnership working is put forward as a key tool for driving change, through information sharing and joint working. The government acknowledges the role of the alcohol industry and its responsibility to help reduce these harms and the involvement of retailers, as well as the wider community, is crucial to addressing many of the issues with alcohol misuse in Slough.

In 2015 Slough Borough Council released its Five Year Plan document which replaced the corporate plan and consisted of 8 aims under three themes.[2] The alcohol strategy has been written with reference to the 5 Year Plan, aligning with its key objectives around creating a vibrant, safe and cohesive place for people to live and work. There is a significant focus on young people in the strategy, aiming for a more preventative and proactive approach to reducing harmful alcohol use early on in life and maintaining that through to adulthood. Indeed, prevention is a key focus of the strategy alongside enabling individuals to take control of their alcohol consumption. All of these points must be considered against the wider economic context of Slough, where a vibrant, diverse and responsible economy can be a positive attribute to the area as a whole.

VISION

- **Empowering people to make informed decisions about their alcohol consumption**
- **Working with local communities to prevent alcohol related crime and disorder**
- **Enabling a diverse and responsible local economy**
- **Protecting families from alcohol-related harms**
- **Improving the health of those who struggle with alcohol misuse**

WHAT IS ALCOHOL MIS-USE?

Alcohol has been an important element of many cultures since pre-history. Despite this, its harmful effects have long been recognised and society continues to face many problems attributable to its misuse. These issues range from being individual in nature through to pervasive familial and social effects. Recommendations provided by the government give guidance on what levels of consumption are considered safe. However, it should be recognised that there is no level of consumption which is entirely free from risk and that this risk increases at levels of consumption which fall below those set out by government recommendations.

Drinking behaviour can be broadly divided into two forms: Long term (chronic), heavy drinking, which contributes towards longer term health issues such as liver damage and cardiomyopathy, and short term, binge/episodic drinking which can cause a wide range of issues ranging from alcohol poisoning to violent behaviour.

The links between alcohol and domestic violence are clear. The Crime Survey for England and Wales states that 7.3% of women and 5% of men experienced domestic abuse in 2011/2012.[3] Considering that between 25% and 50% of perpetrators of domestic violence are under the influence of alcohol at the time of assault suggests that a significant proportion of the population are affected by alcohol

related domestic violence.[4] The risk of rape is also affected by alcohol, with this risk being doubled when the perpetrators of violence have been drinking.[4]

The economic impact of alcohol on the health service is also of concern. This cost has been estimated at £3.5 billion per year in England, equating to £120 per taxpayer.[5] On top of this, alcohol-related crime is posited to cost £11 billion per year.[6] Finally, in terms of lost productivity, the UK as a whole faces costs of around £7.3 billion per year.[6]

A 2008 report by the Office of National Statistics reported that nationally 20% of pupils aged 11 to 15 had drunk alcohol in the last seven days.[7] Although the proportion of pupils who have never consumed alcohol has risen recently, the volume of alcohol being consumed by some individuals is a cause of concern. Of the pupils who did drink within the last 7 days, the average number of units consumed was 12.7. This amount is especially concerning when compared to weekly recommendations of 21 units for adult men and 14 for adult women, representing a worrying pattern of alcohol consumption.

Young people can also be negatively affected by parental alcohol consumption, 55% of people accessing Turning Point alcohol services stated that their children faced high levels of stress and anxiety as a result of their drinking.[8] Up to 2.6 million children are believed to be living with parents who are hazardous drinkers.[9] The intergeneration cycle of hazardous drinking is highlighted by a report from the Joseph Rowntree Foundation which found that children who experience drunken parents are twice as likely to get drunk themselves. [10]

"Children of parents who drink heavily often feel confused about their role within the family, are isolated from their relatives or other family members and are seriously affected by family conflict, domestic violence, parental separation and divorce."[8]

Nationwide, 4% (4,028) of callers to ChildLine report a problem relating to parental alcohol misuse. Of these, 35% stated that physical abuse was the main problem they were concerned about. This was followed by family relationship problems (20%) and sexual abuse (10%).[11]

"Having to deal with a parent's alcohol or drug misuse can create impossible pressures for a child. Home life can become unpredictable and chaotic, there may be violent rows and a child or young person may be fearful or ashamed of bringing friends home. Children in this situation can become extremely isolated."[11]

DRIVERS OF THE STRATEGY

NATIONAL

- The Government's Alcohol Strategy[1]
- The Licensing Act 2003[12]
- Anti-social Behaviour, Crime and Policing Act 2014[13]
- Public Health and Alcohol Licensing in England[14]

LOCAL

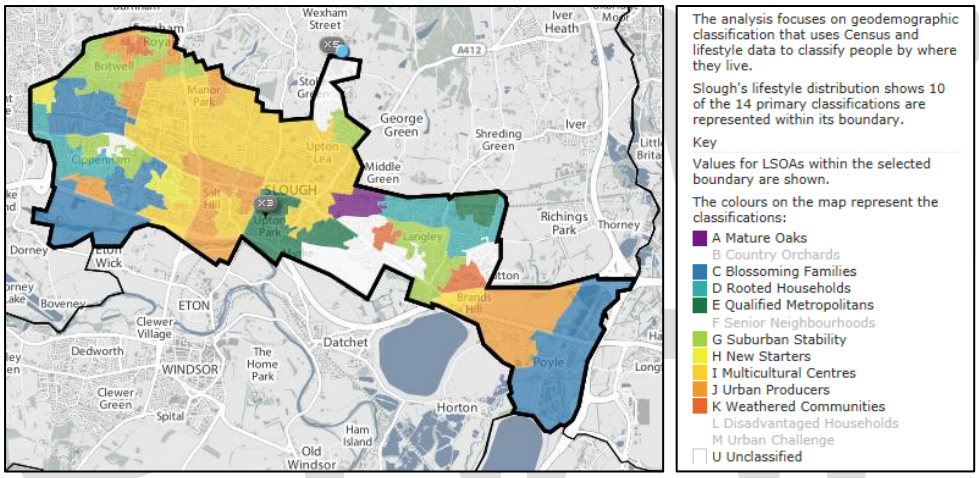
- Slough Joint Wellbeing Strategy 2013-2016[15]
- Slough Statement of Licensing Policy[16]
- Slough Joint Strategic Needs Assessment[17]
- Slough Five Year Plan 2015-2019[2]
- Safer Slough Partnership Strategic Assessment

ALCOHOL ISSUES IN SLOUGH

Slough is home to a highly diverse resident population of 140,205 persons, split evenly between male and female.[18] There is a greater proportion of young children and young adults than is observed in the national population, this being suggestive of Slough being home to many young families. The population of Slough has increased in recent years due to birth rates outweighing death rates and also because of international migration into the area.[17] Slough is a diverse area, with an ethnic profile far different from the country as a whole.[19]

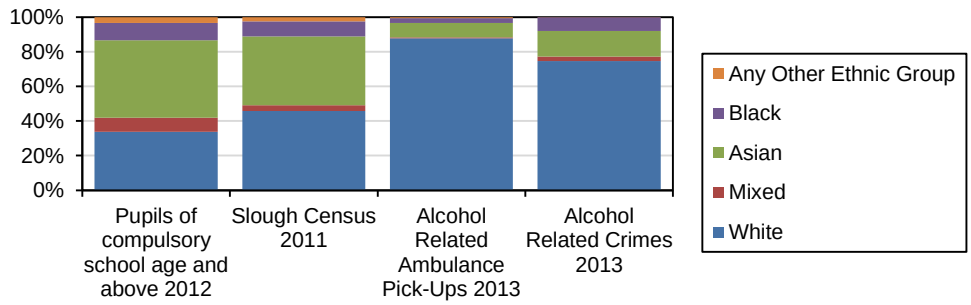
Slough's population exhibits a broad spectrum of different socio-economic backgrounds. Out of 326 local authority districts, Slough is the 93rd most deprived based on the 2010 Indices of Multiple Deprivation.[17] A map of Slough's geodemographic classification can be seen in *Figure 1*. This illustrates the wide range in age, deprivation and ethnicity found across the borough.[20] Further information relating to alcohol and socioeconomic deprivation can be found in *Appendix 3: Alcohol and Socioeconomic Deprivation*.

Figure 1: Geodemographic classification of Slough



Alcohol misuse is disproportionately associated with different subsets of the Slough population. *Figure 2* shows the different ethnicity profiles of the general population and of those individuals dealt with by police and ambulance services for alcohol related issues. This broadly matches referral patterns observed by Slough's Drug And Alcohol Team (DAAT), where 70% of referrals in quarter 4 of 2012/13 were white British. However this will not be fully representative of other forms of alcohol consumption which are less likely to result in police or health interventions. Home drinking, taking place in various communities across the area, is an area of particular concern.

Figure 2: Ethnic category of Slough Compared to Alcohol Related Ambulance Pick-Ups and Crime

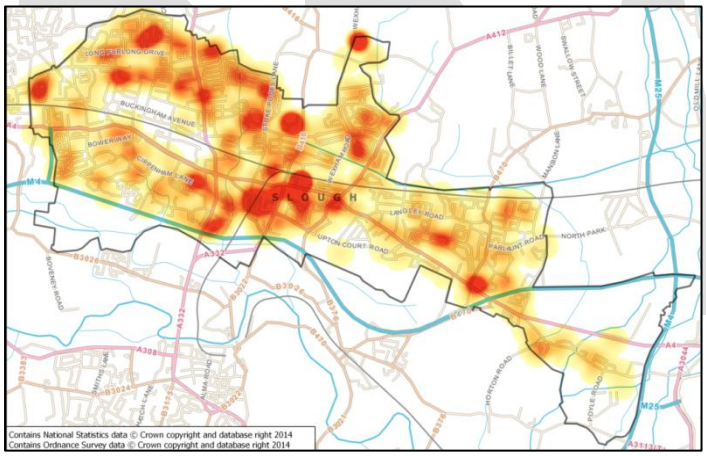


Local alcohol profiles produced by Public Health England allow the impact of alcohol on Slough to be measured quantitatively.[21] Slough performs significantly below average for alcohol-related hospital admissions but performs comparatively well with regards to some other health related indicators such as binge drinking and alcohol-specific hospital admissions for under 18 year olds. See *Appendix 1: LAPE Summary* Statistics for further details.

The Safer Slough Partnership Strategic Assessment 2013/14 states that alcohol is related to instances of littering as well as being associated with drug use. In 2012 1,918 alcohol bottles and 1,412 alcohol cans were recovered and 40% of drug tests completed in local custody centre over a 6 month period showed evidence of alcohol misuse.[22]

Alcohol related crime and anti-social behaviour is a cause of concern within Slough. *Figure 3* shows the concentration of alcohol-related crime across the borough. Data such as this allows for a targeted and evidence based approach to addressing issues faced by the borough. As well as the more obvious issues faced along the high-street, this highlights the issues faced within the healthcare system, with a cluster of alcohol related crime taking place in the immediate vicinity of Wexham Park Hospital.

Figure 3: Heat-Map of Alcohol Related Crime, 2013. Data Provided by Thames Valley Police

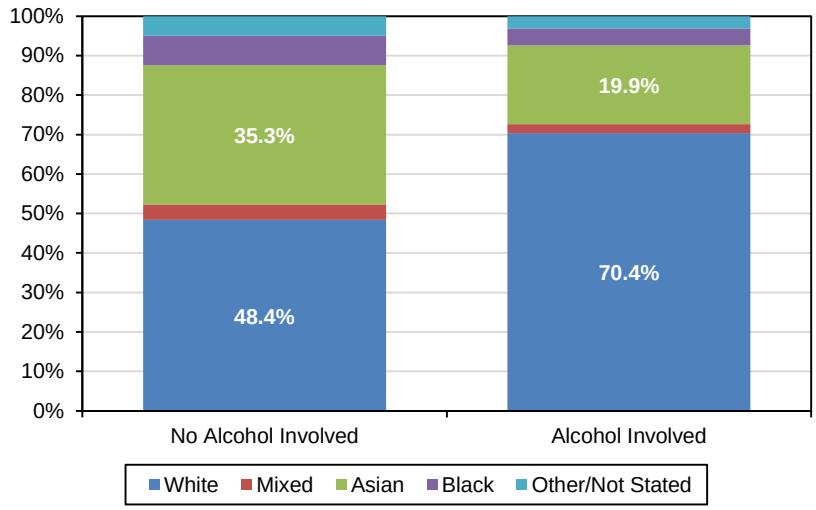


The night-time economy within Slough has reduced in size over the past few years, with most residents looking to neighbouring Windsor and Maidenhead for evenings out. However Slough has a large volume of off-licence premises making alcohol easily accessible across the borough.

In 2010 the Slough Big Drink Debate encouraged residents and practitioners to discuss the impact of alcohol in the borough. The conclusions of this debate were that although the night-time economy in Slough was not particularly large, the opportunity for 24 hour drinking, low pricing and fake IDs meant that alcohol availability was high.

The availability of alcohol in Slough has numerous other implications. Data supplied by Thames Valley Police provides a clear insight into the patterns of alcohol related domestic abuse in Slough. In 2013, 24% of domestic abuse incidents (928 out of 3,817) involved alcohol use. Again, a striking difference in ethnic profile between groups is apparent (see *Figure 4*).

Figure 4: Ethnic profile of domestic abuse (aggrieved party)



THE COST OF ALCOHOL MISUSE

The economic overhead of alcohol misuse in the area cannot be ignored. Accurate quantification of these figures is hampered by the fact that alcohol is indirectly related to a wide variety of health and societal harms. The average cost per ambulance incident ranges from £176 to £251[23] With 1,161 alcohol related ambulance call-outs in 2013, this gives an indicative cost range of between £204,336 and £291,411.

The average cost of an A&E attendance is £114 according to NHS reference costs.[24] Wexham Park Hospital dealt with 506 alcohol related A&E attendances in 2013. Of these, 177 were Slough residents, costing over £20,000 to the service. However this figure is likely understated due to difficulties faced by trusts with coding A&E data.

The average cost per wholly alcohol attributable admission is approximately £1,450.[25] In 2013, Wexham Park Hospital saw 1,896 wholly alcohol attributable admissions, costing approximately £2.75 million. Most of these (1,627, 86%) were admitted from the trusts A&E department. This means that the figure of £20,000 is more likely to be around £185,000. Partially alcohol attributable admissions can cost £1,750 on average and currently present an unknown quantity in Slough.[25]

The Slough Drug And Alcohol Team is budgeted at £1.9 million per year. However, it is not possible to separate the costs of alcohol from drugs due to the large amount of overlap inherent in service provision for this client group.

Thames Valley Police dealt with 2,059 alcohol related crimes in 2013, representing considerable burden on the service. Officers also dealt with 813 domestic abuse incidents where the offender had been drinking, representing over 21% of all recorded domestic abuse incidents in the year. It should be noted that these figures are likely to be understated due to the methodology used in data recording by the police.

INTERVENTIONS TO DATE

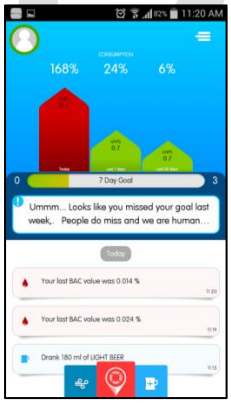
Much has already been done in Slough to combat the influence of alcohol misuse. The borough has taken a pro-active approach to tackling specific issues through the use of retailer engagement and the implementation of various schemes.

SLOUGH DRUG AND ALCOHOL TEAM

Slough's Drug And Alcohol Team (DAAT) provide a partnership based service for those with drug and alcohol related problems. The DAAT commissions several alcohol specific services, including an alcohol liaison team at Wexham Park Hospital and residential rehabilitation services. The DAAT have been heavily involved in a number of projects, including developing a smart-phone application (see *Figure 6*) to allow users to monitor and address their drinking behaviour, peer education sessions aimed at younger people and the distribution of 'What's in my glass?' merchandise in the borough.

Figure 5: 'What's in my glass?' pack and contents

Figure 6: AlcoChange QS Phone Application



COMMUNITY ALCOHOL PARTNERSHIP (CAP)

The Community Alcohol Partnership scheme is a scheme designed to bring together retailers, police, health, local authorities and other local stakeholders to address problems with underage drinking and associated anti-social behaviour. Currently Slough has a CAP scheme in place in the Langley area with plans in place to extend this across the borough. As part of this scheme school and retailer surveys are also being undertaken to assess the perceptions around alcohol use in the area. Retail staff are also receiving training under the scheme to improve their confidence in dealing with underage sales.

Alcohol Exclusion Zones

Slough has several designated alcohol exclusion zones in force across the borough. These give local police the power to confiscate alcohol and intervene directly with problematic drinking.

Pub-Watch

A 'Pubwatch' scheme is in place in Slough, established by licensees and supported by both police and the Council.[26,27] The aim of Pubwatch is to promote best practice and establish a safer drinking environment in licensed premises across the country. There are four Pubwatch areas in the borough, each holding a monthly meeting.

Street Angels

Slough Street Angels is a charity organisation which offers practical help and support to people in the town centre on Friday nights. This service is provided by trained volunteers from Slough's Christian community.

Local Alcohol Action Area

The aim of the Local Alcohol Action Area (LAAA) scheme is to address the effects of irresponsible drinking, specifically crime & disorder and health harms. A third objective is the diversification of the night-time economy. The scheme is government run and involves 20 local authorities across the country.

AIMS AND OBJECTIVES

The aims of this strategy are closely related to the Government's Alcohol Strategy, informed by local issues. Where possible, aims have been developed with reference to available evidence on effectiveness and return on investment from NICE and the World Health Organisation.[28,29] Further information on this can be found in *Appendix 4: NICE Evidence Base For Alcohol ROI*.

Aim	Objective Number	Objective	Measure	Owner
Working in partnership	1	Strengthen networking amongst agencies. Develop and sustain partnership working between the Licensing Authority, responsible authorities, local retailers and bodies such as local schools, MASH and MARAC, including data-sharing where appropriate. Ensure links to members are fostered	Establishment of a local Alcohol Harm Reduction group	Public Health/DAAT (Slough Borough Council)
Working in partnership	2	Ensure the development and implementation of Slough's Licensing Policy is informed by Slough's Alcohol Strategy and national best practice	Assessment of SoLP against Drink Wise's self-assessment framework. Continuous review of the policy in line with changes to strategy.	Licensing (Slough Borough Council)
Working in partnership	3	Work in partnership to develop responses to address the availability and affordability of alcohol	-	Alcohol Harm Reduction Group
Working in partnership	4	Work in partnership with stakeholders to assess need, and plan strategies and programmes for changing behaviour and attitudes in relation to alcohol use and misuse	-	Alcohol Harm Reduction Group
Working in partnership	5	Develop co-ordinated responses to alcohol where it features within situations of domestic abuse, crime and health service use (including mental health services)	Identification of repeat offenders within Slough through data sharing agreements with health and police bodies.	Alcohol Harm Reduction Group, TVP, Slough CCG

Aim	Objective Number	Objective	Measure	Owner
Working in partnership	6	Improve data collection and sharing and use this to inform the development of targeted responses to address individuals, groups or areas contributing disproportionately to alcohol-related crime and disorder in the borough	Establishment of alcohol specific data sharing agreements with key contributors	Alcohol Harm Reduction Group
Working in partnership	7	Review the potential of the 'Reducing the Strength' campaign	Completion of review	Alcohol Harm Reduction Group
Promoting and supporting the responsible sale and consumption of alcohol	1	Ensure retailer compliance with licensing legislation and responsible retail practise. Continue to use available tools and powers to address the illegal and irresponsible sale of alcohol by licensed premises.	Regular feedback on test sales to the Alcohol Harm Reduction Group.	Licensing & Trading Standards (Slough Borough Council)
Promoting and supporting the responsible sale and consumption of alcohol	2	Ensure that licensed premises have information about the law, their responsibilities, and good practice in the sale of alcohol	Information to be distributed to all new and existing license applicants.	Licensing (Slough Borough Council)
Promoting and supporting the responsible sale and consumption of alcohol	3	Ensure that licensed premises have training around selling to those heavily under the influence of alcohol and underage sales	*Can we make this part of the operating schedule and push responsibility to retailers?*	Licensing, CAP, Public Health (Slough Borough Council)
Promoting and supporting the responsible sale and consumption of alcohol	4	Promote and support responsible retailing through initiatives to recognise and reward good practice	Investigate Slough participating in the Best Bar None scheme.	Alcohol Harm Reduction Group

Aim	Objective Number	Objective	Measure	Owner
Promoting and supporting the responsible sale and consumption of alcohol	5	Improve perceptions of safety within the borough	Quantify perceptions of safety both before and after implementation of the strategy via resident surveys.	Community Safety
Promoting and supporting the responsible sale and consumption of alcohol	6	Raise awareness and reduce occurrence of proxy sales in Slough	Reduction in proxy sales recorded by test purchasing schemes	Alcohol Harm Reduction Group and Licensing
Promoting and supporting the responsible sale and consumption of alcohol	7	Evaluate the provision for legal appeal to licensing issues	-	Licensing
Reducing Alcohol-Related Harms	1	Encourage GPs to screen patients and deliver brief interventions when alcohol harms have been identified in GP surgeries.	Appropriate referrals from GP surgeries to specialist provision.	DAAT and Primary Care
Reducing Alcohol-Related Harms	2	Ensure that interventions are available at all stages of the criminal justice system, enabling offenders to address their alcohol misuse and to understand how this is tied to their offending behaviour. These will be linked to interventions to reduce reoffending	Significant increase in the number of referrals coming from within the justice system	TVP, PCC, PHE, YOT and DAAT
Reducing Alcohol-Related Harms	3	Ensure that tools and powers used to address alcohol-related nuisance and disorder in neighbourhoods are linked with access to appropriate interventions for individuals to address their alcohol misuse, whilst recognising that not all issues will pass through the criminal justice system	Significant increase in the number of referrals coming from within the justice system	TVP and Neighbourhood Services

Aim	Objective Number	Objective	Measure	Owner
Reducing Alcohol-Related Harms	4	Ensure that young people involved in crime, disorder and/or antisocial behaviour are supported to access early interventions and treatment services to address substance misuse	Significant increase in the number of referrals of young people from the justice system	TVP, Youth Services, Education and Youth Offending Team
Reducing Alcohol-Related Harms	5	Strengthen links with communities and neighbourhood teams to identify local needs concerning alcohol-related crime and disorder, work together to develop appropriate responses, and communicate about delivery and outcomes of these	Establishment of community engagement meetings, initially in known problematic areas	TVP and Neighbourhood Services
Reducing Alcohol-Related Harms	6	Investigate the provision of alcohol outlets and assess any potential over-provision of licenses. Review the impact of licensed premises in areas with high levels of alcohol-related harm, and explore options for addressing issues	Establishment of a Cumulative Impact Policy based on strong local evidence.	LAAA with Licensing, Community Safety, Public Health, TVP
Reducing Alcohol-Related Harms	7	Ensure that targeting of enforcement activity is intelligence-led, and based on information from a range of sources, including responsible authorities and local communities	Routine GIS based reporting of alcohol related issues, driven by data sharing between stakeholders.	<*Mapping Office/Analyst*>
Reducing Alcohol-Related Harms	8	Ensure that information relating to alcohol misuse resources and support schemes is available to the general public.	-	Alcohol Harm Reduction Group, Public Health
Reducing Alcohol-Related Harms	9	Improve the provision of substance misuse education in schools and other educational settings, ensuring that appropriate alcohol education is available for children, young people and parents. Contribute towards building the preventive capacity of young	Identify successful schemes in use nationally. Adapt these for local use and	DAAT, Youth Services, Youth Offending Team

Aim	Objective Number	Objective	Measure	Owner
		people through the provision of information, advice and support	liaise with schools to provide educational material.	
Reducing Alcohol-Related Harms	10	Ensure that awareness of alcohol misuse harms are communicated effectively to the general public through a variety of settings such as workplaces, leisure facilities and social clubs etc.	-	Alcohol Harm Reduction Group, Public Health
Protecting families from alcohol-related harm	1	Ensure that alcohol services engage with the families of dependent drinkers. Improve the identification, assessment and referral of children and young people affected by parental alcohol misuse. Provide effective services for children affected by alcohol misuse	-	-
Protecting families from alcohol-related harm	2	Develop parents' understanding of the impact of their own alcohol use on themselves and on their children. Provide information and resources to enable schools to help parents understand the role of alcohol in their and their family's lives so they can develop the skills to change behaviours, ensure that this includes non-problematic alcohol use	Identify successful schemes in use nationally. Adapt these for local use and liaise with schools to provide educational material to parents.	DAAT, Youth Services
Protecting families from alcohol-related harm	3	Appraise the use of targeted promotional information in a variety of settings frequented by families.	-	Alcohol Harm Reduction Group, Public Health

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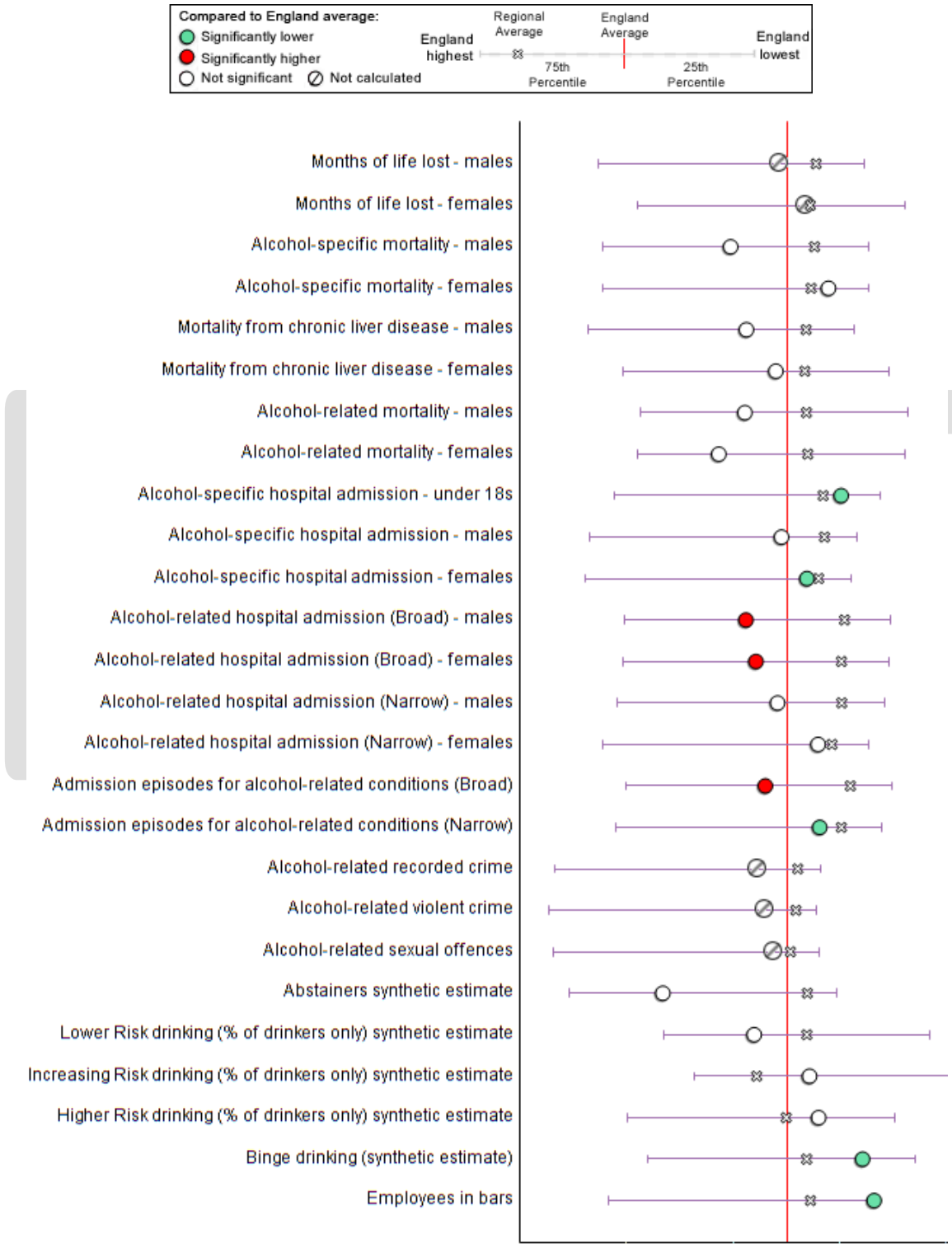
APPENDICES

APPENDIX 1: LAPE SUMMARY STATISTICS FOR SLOUGH 2014



APPENDIX 2: OUTLET DENSITY

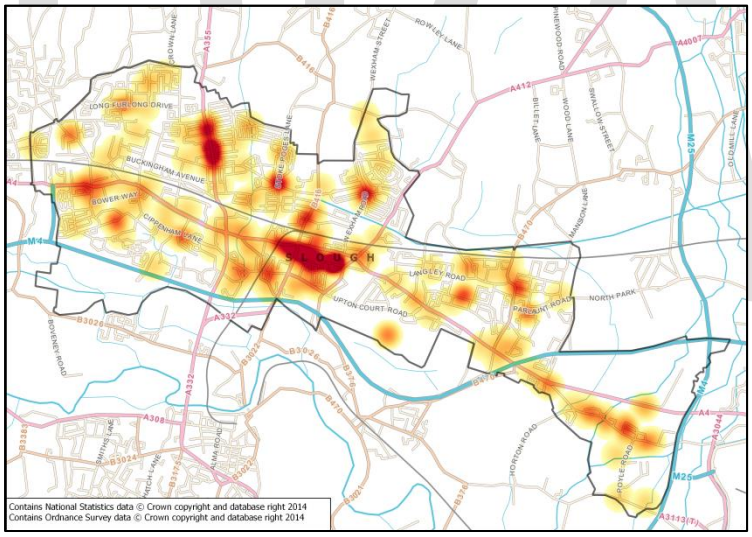
The density of licensed premises has been investigated as a possible causal or exacerbating factor of alcohol-related crime, health harms and domestic abuse.[25]

A systematic review of the available evidence was carried out by Holmes et al in 2014.[30] This review found support for the notion of controlling spatial and temporal availability of alcohol as a means to reduce associated harms. The review highlighted the difficulties faced by licensing authorities with finding strong evidence to support claims of health related harms when health data is frequently available only at population level. The legal challenges which may be faced by authorities in courts is a potential reason many do not want to pursue cumulative impact policies, particularly ones with a pre-dominantly health related evidence base. A weakness of the review was the lack of any deeper critique of the statistical techniques used, particularly those covering spatial relationships. This has been highlighted as an issue which poses considerable challenges.[31]

Outlet density has also been linked specifically to domestic violence. A 2010 study into this relationship concluded that a positive association existed between the density of alcohol outlets and police-recorded rates of domestic violence.[32]

Figure 7 shows the situation in Slough in terms of the clustering of outlet density, with two distinct groups of licensed premises around the high street and Farnham Road.

Figure 7: Density of Licensed Premises in Slough

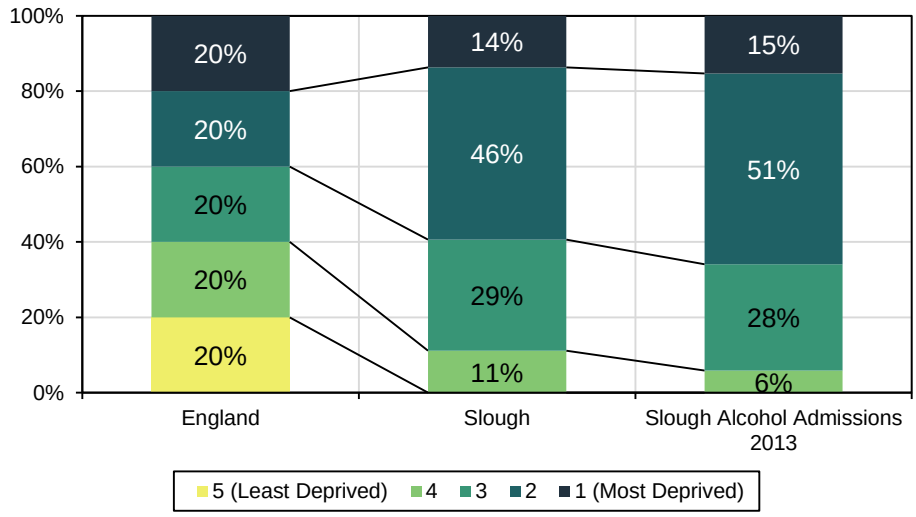


The main tool for addressing high outlet density in the UK is the Cumulative Impact Policy (CIP). This allows an area to be designated as suffering from over provision of alcohol. This must be done through the use of a strong evidence base which ties in to the four licensing objectives of the licensing act. Once in place, any license application must provide evidence supporting why they would not contribute towards the observed problems in the area. This presents obvious problems in regards to using evidence of health harms to support such a policy, these issues are examined in detail by Martineau et al.[33]

APPENDIX 3: ALCOHOL AND SOCIOECONOMIC DEPRIVATION

The negative health effects of socioeconomic deprivation have been covered in depth in recent years.[34] People from more deprived areas are more likely to be heavy drinkers.[35] The complex relationship between alcohol and deprivation is of particular concern and much research has been produced in this area. A study of over 58,000 Welsh adults found a higher risk of binge drinking in those living in deprived areas, with this risk being especially prevalent in young or middle-aged men.[36]

Figure 8: Comparison of IMD Quintiles for Wholly Alcohol Attributable Admissions



APPENDIX 4: NICE EVIDENCE BASE FOR ALCOHOL ROI

Intervention Type	Intervention	Description	% Decrease in Number of People Who Use Alcohol	Unit Cost £2013	Population Associated With Intervention	£ per %
Pricing	50p minimum price per unit of alcohol	An intervention enforcing a 50p minimum price per unit of alcohol in off-licence outlets selling alcohol.	0.40%	£0	General Pop 18+	0.0
Pricing	Ban promotions of more than >20% price discount	An intervention banning promotions that offer a discount of over 20% of the price per unit of alcohol in retail outlets (i.e. supermarkets, off-licenses and corner shops).	0.05%	£0	General Pop 18+	0.0
Advertising	Total ban of advertising	An intervention proposing a complete ban of alcohol advertising	2.19%	£0.27	General Pop 18+	0.1
Availability	10% reduction in licensed hours	An intervention reducing the number of hours per day licensed premises (i.e. pubs, bars and restaurants) can sell alcohol legally	0.20%	£0.27	General Pop 18+	1.4
Availability	10% reduction in outlet density	An intervention reducing the number of retail outlets that sell alcohol off-license (i.e. not pubs, bars or restaurants) in an area by 10%.	0.21%	£0.32	General Pop 18+	1.5

Intervention Type	Intervention	Description	% Decrease in Number of People Who Use Alcohol	Unit Cost £2013	Population Associated With Intervention	£ per %
Advertising	Increase in health message advertising	An intervention to increase the number of positive message health adverts (i.e. advertising that encourages healthy behaviour or highlights the negative sides of drinking to 1/6th of all advertising.	0.13%	£0.45	General Pop 18+	3.5
Screening and Brief Interventions	Brief intervention with family support	Referral for targeted brief intervention with a school nurse and intervention with families to reduce alcohol consumption in children aged 10-15.	4%	£22.58	General Pop 18+	5.6
Alcohol Specific Structured Psychosocial	eCBT	An e-therapy programme based on eCBT with active therapeutic involvement	12%	£75	Needing treatment pop (Adult)	6.3
Screening and Brief Interventions	Brief intervention at next GP registration	5 minute brief advice with GP as part of the registration process when next moving.	2%	£15.13	General Pop 18+	7.6
Screening and Brief Interventions	Screening and Brief intervention at next A&E attendance	5 minute brief advice with A&E staff.	1.44%	£15.95	General Pop 18+	11.1
Advertising	Ban of alcohol television advertising to under 18 year olds	An intervention banning alcohol advertising on television during the hours children may be watching	0.02%	£0.27	General Population 10-17yrs	13.5

Intervention Type	Intervention	Description	% Decrease in Number of People Who Use Alcohol	Unit Cost £2013	Population Associated With Intervention	£ per %
Screening and Brief Interventions	Brief intervention at next GP appointment	5 minute brief advice with GP as part of a patient's next consultation.	2%	£35.40	General Pop 18+	17.7
Alcohol Specific Structured Psychosocial	Behavioural Self Control Training	Behavioural Self Control Training to promote controlled drinking.	8%	£477.47	Needing treatment pop (Adult)	59.7
Alcohol Specific Structured Psychosocial	Marital/Family Therapy	Psychosocial treatment of alcohol abuse where BCT treatment is given to the patient and their spouse or family member to prevent relapse.	8%	£477.47	Needing treatment pop (Adult)	59.7
Alcohol Specific Community Prescribing	Naltrexone to suport relapse-prevention	Naltrexone for relapse-prevention	10%	£678.37	Needing treatment pop (Adult)	67.8
Alcohol Specific Structured Psychosocial	Coping/social skills training	4-10 sessions over 4 weeks of coping/skills training to prevent relapse	7%	£477.47	Needing treatment pop (Adult)	68.2
Alcohol Specific Structured Psychosocial	Motivational interviewing	3-10 sessions over 3 weeks of motivational interviewing to prevent relapse. Evidence found it was best used as an enhancement to a more intensive substance abuse treatment.	7%	£477.47	Needing treatment pop (Adult)	68.2
Alcohol Specific Community Prescribing	Acamprosate to support relapse-prevention	Acamprosate for relapse-prevention	8%	£667.21	Needing treatment pop (Adult)	83.4

Intervention Type	Intervention	Description	% Decrease in Number of People Who Use Alcohol	Unit Cost £2013	Population Associated With Intervention	£ per %
School based	Classroom based alcohol skills activities	Classroom based Skills based activities to reduce alcohol consumption in children aged 10-15	0.34%	£35	General Population 10-15yrs	102.9
Alcohol Specific Structured Day Programme	Acute alcohol withdrawal - hybrid inpatient/outpatient	3-day inpatient detoxification, if required, then an outpatient day programme for 30 days.	4%	£1,309.04	Needing treatment pop (Adult)	327.3
Alcohol Specific Inpatient Detoxification	Acute alcohol withdrawal - direct access/inpatient detoxification	A 10 day direct access detoxification service that can be accessed by people without a referral. Staffed by mental health nurses with GP support.	3%	£1,382.32	Needing treatment pop (Adult)	460.8
School based	Alcohol Education School curriculum	School curriculum designed to educate children and reduce alcohol consumption in children aged 10-15.	0.23%	£170.50	General Population 10-15yrs	741.3

APPENDIX 5: STRATEGY CONSULTATION WORKSHOP

On the 11th May 2015 a workshop took place at Chalvey Community Centre to engage with stakeholders on the structure and content of the strategy. A total of 19 people attended, representing a wide variety of organisations with an interest in alcohol consumption within Slough. These ranged from Thames Valley police and various departments of the council through to retailers and third sector representatives.

Attendees were asked to identify any gaps and/or weaknesses in the strategy and to discuss which elements might be prioritised.

Name	Organisation
Amy Chapman	DAAT, SBC
Angela Snowling	Public Health, SBC
Chris Morris	Farnham Road Practice
Craig Brewin	Wellbeing, SBC
Ginny de Haan	Consumer Protection & Business Compliance, SBC
Helen Fisher	DAAT, SBC
Jane Rose	Neighbourhood Services, SBC
Jason Mahoney	Public Health England
Ketan Gandhi	Young People's Services, SBC
Louise Cromwell	Crime Reduction Initiative, Slough Treatment Service
Mat Read	Absolutely Leisure
Mick Sims	Licensing, SBC
Nikki Pierce	Thames Valley Police
Odhran Byrne	The Barleycorn
Sián Smith	Children, Young People and Wellbeing, SBC
Simon Hailstone	Public Health, SBC
Tom Starling	Slough Youth Offending Team, SBC
Vikki Lake	Turning Point
Whitney Blunt	Public Health, SBC

After collating and evaluating the results of the workshop, suggestions were incorporated into the strategy document where possible. In some instances it was felt that suggestions covered points which were already acknowledged in the strategy. In these instances the wording of the strategy was altered to make these points clearer.

Particularly important points raised related to how 'Working in Partnership' should be seen as an overarching theme, present throughout the strategy. Also, alignment with the 5 year plan was mentioned in the context of ensuring that the alignment with this document was made more explicitly.

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SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny Panel **DATE:** 18th November 2015

CONTACT OFFICER: Dr Angela Snowling, Assistant Director of Public Health
(For all enquiries). 01753 875142

WARD(S): All

PART I
FOR COMMENT AND CONSIDERATION

CHILD AND ADOLESCENT MENTAL HEALTH STRATEGY 2015-2019 BUILDING RESILIENT COMMUNITIES

1. Purpose of Report

To update the panel on the evidence based content and THRIVE model of CAMHS on which the strategy is based.

To discuss the results of the feasibility programme and engagement work undertaken with respect to the CAMHS strategy and to seek feedback from the panel on the themes and actions

To share the additional actions being considered for the CAMHS transformation grant which NHS England will release to the CCG for immediate effect subject to an assurance process. This funding will be in place for five years (including the current year)

2. Recommendation(s)/Proposed Action

The Panel is requested to review and comment on the strategy and pathways – see link in Section 7.

The Panel is requested to note:

- That additional pathways have also been developed for ASD, ADHD,
- That work is underway with the clinical commissioning group to develop a plan for tackling shared priorities set out in the Five Year Forward view which will be included in the work of the Children and Young Peoples Partnership
- That young people in various vulnerable groups and the youth parliament have been consulted throughout in the design of the THRIVE website
- That the council is the first in England to adopt Mental Health 4 Life themes and staff have been working with the national steering group to launch the materials nationally.
- That the six organisations who deliver the Five Ways to Wellbeing hub service have been fully involved in the design of the strategy.

- That Healthwatch have also been included in the development of the pathways and strategy

- That the final version will be presented to the Wellbeing board in January and will include scrutiny panel comments, the results of the public consultation and a refined action plan in line with the CAMHS transformation fund.

3. The Slough Wellbeing Strategy, the JSNA and the Five Year Plan

3a Slough Wellbeing Strategy priorities

The work on CAMHS and building resilient communities supports the health section of the Slough Wellbeing Strategy in the following ways

Health – the priorities in the CYPP aims to improve children and young people's emotional and physical health.

Safer Communities – the funding supports work with vulnerable children through the children's services improvement programme and early help agenda

3b Five Year Plan Outcomes

The strategy supports Outcome 5 of Slough Borough Council's Five Year Plan i.e.: Children and Young People in Slough will be healthy, resilient and have positive life chances.

There are a series of key actions underneath Outcome 5, which the additional funding from the CAMHS transformation fund will help to deliver:

- Develop more preventative approaches to ensure children, young people and families are safe, independent and responsible.
- Slough Children's Services will be one of the best providers of children's services in the country, providing timely, purposeful support that brings safe, lasting and positive change.
- Ensure vulnerable children and young people are safe and feel safe.
- Ensure children and young people are emotionally and physically healthy.
- Ensure children and young people enjoy life and learning so that they are confident about the future and aspire to achieve to their individual potential.
- Ensure children and young people with SEND and their families receive comprehensive, personalised support from childhood to adulthood.

4. Other Implications

(a) Financial
Funding for the transformation of services into public mental health services has already been provided to the primary CAMHS team from the Public Health grant. This has resulted in revised pathways and improved early detection in school settings. Further funding will be obtained for work on ASD, tackling stigma and a range of interventions to support the most vulnerable

(b) Risk Management

The main risks are staffing related, as staff who deliver the Five Ways to Wellbeing hub are based in five different organisations. Staff work together

collaboratively in Slough and deliver a universal and targeted service. The risk mitigation is through the new CAMHS transformation fund and through the CYP partnership shared priorities.

(c) Human Rights Act and Other Legal Implications

There are no Human Rights Act implications to the proposed action.

(d) Equalities Impact Assessment

An EIA has been conducted for the CAMHS strategy

5. Supporting Information

5.1 The strategy is based on the most up to date information on the costs avoided by a range of early interventions sourced from the Mental Health 4 Life resources, from national policies and a wide range of research to improve outcomes.

5.2 The strategy covers three themes; working with parents, working with children and young people and working with schools. The vision is taken directly from the Mentalhealth4 life recommendations. It also describes the way in which services will support families and children in future under the THRIVE national model of CAMHS. This model removes the need for tiers and describes a way of working that everyone can understand and apply in their work with children or parents.

5.3 Universal, targeted and specialist practitioners should be able to clearly articulate whether they are working to; signpost services or provide one off help (quadrant one of the THRIVE model), providing help of less than 12 weeks such as cognitive behaviour therapy work in schools or online, providing evidence based specialist CAMHS treatment programmes of greater than 12 weeks, or managing risk for the most vulnerable young people for whom interventions are as yet poorly defined, such as those affected by child sexual exploitation, domestic abuse etc.

5.4 The strategy summarises local work to date to improve emotional health and wellbeing outcomes in quadrants 1 and 2. This work has been undertaken by the many agencies acknowledged who collectively deliver; universal, targeted and specialist child and adolescent mental health services.

5.5 The strategy describes the local transformation programme which began in 2014 to; reform eight pathways, develop resources for schools and parents and GPs and to develop an integrated hub called the Five Ways to Wellbeing hub. The hub is a collaborative partnership between the agencies that support young people and families, delivering services across Slough. The hub is an essential feature for system wide improvement enabling; information sharing, joint training and planning and evaluation. The hub members listed in the front of the strategy have been fully consulted in developing the draft strategy and action plan

5.6 As a result of collaboration it was found that high numbers of young people were being referred into primary CAMHS from selected areas of the town and an eight week evidence based Mindfulness programme was piloted within two secondary schools within those areas. The results (published at the PHE conference in September) showed positive reductions in anxiety and depression and increased scores in self awareness in the Mindfulness questionnaire. All pupils have

benefited with the exception of individuals at risk of CSE or DA who require further support. This is what the national THRIVE model of CAMHS predicts and on which the local CAMHS strategy is based.

5.7 Young people who have been involved in building the THRIVE website have also commented on their priorities which are set out in the strategy. The Youth Parliament has also voted improving mental health as one of their top priorities in their manifesto.

5.8 Work with the national steering group for the Mental Health 4 Life programme has enabled the strategy to be built on the most up to date evidence for early intervention. Both national teams have commented on the early draft and their views are incorporated.

5.9 The CAMHS strategy has had the support of Slough Healthwatch and feedback from parents is expected through the online consultation.

5.10 There is early evidence that the strategy is already working well. The pilot in secondary schools focused on the most common mental health conditions i.e. anxiety, depression and self harm and has resulted in the lowest referral rate in the Thames Valley to specialist CAMHS. Early detection also meant that only three young people were stepped up to specialist CAMHS for self harm. Slough's rates of self harm and of admission for other mental health conditions remain the lowest in the Thames Valley and well below the England average.

5.11 More work is however planned in quadrants three and four of the THRIVE model supported by funding from the NHS England and CCG CAMHS Transformation Fund. This work is being finalised through a transparent bidding process and is likely to focus in year 1 on supporting families of children with Autism Spectrum Disorder and Attention Deficit Disorder as long waiting lists remain for diagnosis. Diagnosis for both these conditions is made by specialist CAMHS through observation, questionnaires and tests within school and clinical settings. The aim of the CAMHS Transformation Fund will be to support peer led and voluntary sector support for parents around managing behaviour both pre and post diagnosis. It is important to note that Slough has double the expected number of children and young people with ASD (511 are actually reported on educational psychology registers versus 290 expected) and there are currently a further 142 children awaiting a diagnosis for ASD.

5.12 Further work is likely to be funded too through the CAMHS Transformation Fund to support additional capacity for online counselling for young people, to deliver a local campaign to challenge the stigma of mental illness, to work with vulnerable children. The results of the bids are however not known at the time of preparing this report

5.13 The final version of the action plan will thus be modified to reflect any additional actions funded under the Five Year Forward View themes of

- Promoting resilience, prevention and early intervention (quadrant one of the THRIVE model)
- Improving access to effective support – a system without Tiers (all quadrants of the THRIVE model)
- Care for the most vulnerable (quadrant three of the THRIVE model)
- Developing the workforce (quadrant one of the THRIVE model)

6. Conclusion

6.1 The Slough CAMHS strategy is based on the most up to date national model of CAMHS called THRIVE and uses the evidence base from the new national resources developed under the Mental Health 4 life logo and includes national and local priorities

6.2 Young peoples' priorities are embedded in the strategy and draft action plan.

6.3 The feasibility of the strategy has been tested through the Five Ways to Wellbeing hub and shown to be successful in reducing demand on specialist services (within quadrants 1 and 2 of the THRIVE model)

6.4 The action plan for strategy when finalised will include areas of work yet to be funded which are being proposed through the CAMHS transformation plan. These will strengthen activity in quadrants 3 and 4 of the THRIVE model.

6.5 Members of the panel should note that the strategy is still draft and is out to formal consultation. Views are also being encouraged from the following groups;

- the Health Priority Development group
- the CYP partnership board
- the final version to be signed off by the Wellbeing board

.

6.6 The goal of building community level resilience also involves work with parents and in 2016 NHS England will announce additional funding to develop perinatal mental health services – a local as well as national priority.

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7. Appendices

'A' - Draft CAMHS Strategy, 'Building Resilient Communities'

8. Background Papers

Further information on the pathways is available at
https://www.surveymonkey.com/r/SBCCAMHS2015

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Slough
Children and Young People's
Partnership Board
Getting it right for children

Promoting Mental Health 4 Life
Building Thriving Communities

Slough CAMHS Strategy 2015-2019

Consultation draft
version 30.07.15

www.slough.gov.uk
Slough
Borough Council

ACKNOWLEDGEMENTS

Sincere thanks are acknowledged to the many young people and staff in the organisations listed in listed below who have been consulted in the development of this strategy.

- Anna Freud Centre and the Tavistock and Portman group
- Berkshire Healthcare Foundation Trust (specialist CAMHS and school nursing service)
- Cambridge Education educational psychology and integrated support team
- Healthwatch Slough
- NHS England - Thames Valley Children and Maternity Network
- Public Health England
- SBC's Public Health and primary mental health teams
- SBC's early help, children's social care and youth services team
- Slough Clinical Commissioning group
- Slough schools
- Slough Youth Parliament
- Slough Emotional and Behavioural Outreach Service (SEBDOS)
- The Puffell design team at Creates

CONTENTS

FOREWORD

[To be completed once draft is finalised]

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Councillor Pavitar Mann, Chair of the Slough Children and Young Peoples Partnership

Introduction

This strategy provides the strategic overview and priorities for tackling the drivers of poor emotional resilience and addresses the needs identified by local families and children in the 2014 Thames Valley CAMHS survey[29] and supports the Child and Parental Mental Wellbeing priority in the Slough Children and Young Peoples Plan 2015-16.

It is based on a public mental health approach and on the evidence base for mental health promotion which is cost effective.

The basis for the Mental Health 4 Life approach is set out in the following principles.

Table 1. Core principles for supporting mental health – source Mental Health 4 Life[44]

Know	Believe	Act
Know the nature of mental illness	Understand your own mental health, what influences it, its impact on others and how you can improve it	Communicate effectively with children, young people and adults about mental health
Know the determinants at a structural, community and individual level	Appreciate that there is no health without mental health and the mind and body work as one system	Integrate mental health into your own area of work and address mental and physical health holistically
Know how mental health is a positive asset and resource to society	Commitment to a life course approach and investment in healthy early environments	Consider social inequalities in your work and act to reduce them and empower others to do so
Know what works to improve mental health and prevent mental illness within own area of work	Recognise and act to reduce discrimination against people experiencing mental illness	Support people who disclose lived experience of mental illness

The strategy that follows is built not only on national best evidence but is grounded in powerful local tests of whether the interventions work, from feedback from training offered through the voluntary sector, for schools and young people, for general practices and from co-creation of the wellbeing website with young people.

DEFINITIONS

Early intervention – implementing evidence based programmes and interventions for children and young people which can have a lasting effect on their life long mental wellbeing

Mental health - is a state of wellbeing by which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community.

Prevention – preventing the development of mental illness, preventing suicide and also doing something for people without a mental illness, for examples preventing stigma or discrimination

Promotion – promoting a healthy lifestyle for body and mind, helping people choose activities that are enhancing their wellbeing

Public health - is the art and science of promoting and protecting health and wellbeing, preventing ill health and prolonging life through the organised efforts of society

Public mental health - is the art and science of improving mental health and wellbeing and preventing mental illness through the organised efforts and informed choices of society, organisations, public and private, communities and individuals. Includes promotion, prevention and early intervention. See details in the key themes.

WHY DO WE NEED THE STRATEGY

National figures [2, 3, 4] show that

- Between 10 and 20% of women develop a mental illness during pregnancy or within the first year after having a baby[4]. Examples of illnesses include antenatal and postnatal depression, obsessive compulsive disorder, post-traumatic stress disorder and postpartum psychosis. These conditions often develop suddenly and range from mild to extremely severe, requiring different kinds of care or treatment.
- The average cost to society of one case of perinatal depression is around £74,000, of which £23,000 relates to the mother and £51,000 relates to impacts on the child. Perinatal anxiety (when it exists alone and not with depression) costs about £35,000 per child, of which £21,000 relates to the mother and £14,000 to the child. Perinatal psychosis costs around £53,000 per child, but this is a substantial under-estimate because of lack of evidence about the impact on the child; costs relating to the mother are about £47,000 per case, roughly double the equivalent costs for depression and anxiety
- Half of those with lifetime mental health problems first experience symptoms by the age of 14 and three quarters before their mid 20's
- Nationwide, 4% (4,028) of callers to ChildLine[5] report a problem relating to parental mental health. Of these, 35% stated that physical abuse was the main problem they were concerned about. This was followed by family relationship problems (20%) and sexual abuse (10%). The ACE study[11] estimated that preventing four or more adverse childhood events such as; abuse, neglect and witnessing of domestic violence could reduce heroin/crack use by 59%, violence by 51%, incarceration by 53%, and unplanned teenage pregnancies by 38%.
- WHO[34] estimates child maltreatment is responsible for almost a quarter of the burden of mental disorders. The All Parliamentary report on the first 1001 days of a child's life[2] noted that 80% of maltreated children could be classified as having disorganised attachment which can have lifelong effects on the infant, including high levels of physical and mental illness, high levels of entry into care, disruptive behaviour in preschool and school, low educational and employment

achievement, poor relationship skills, high levels of violence, imprisonment, worklessness and homelessness. Over 25 years the CMO report[1] estimated the total return from parenting programmes, for children with conduct disorder, is between 2.8 and 6.1 times the intervention cost, much of this through reduced crime.

- One in ten young people between 5 and 16 years has a mental health problem[4] young people are estimated to have a mental health condition of which 25% will need to access professional help. (This figure increases to 72% of young people in care and 95% of young people in custody). The majority of mental health conditions include anxiety and depression and conduct disorders and these occur in direct response to what is happening in their lives (Source Mentalhealth4life[4]; Promoting Mental Health in Schools).

- The Chief Medical Officers report[1] identified that in 2000, the service costs associated with childhood psychiatric disorders were 12 times greater for frontline education services than for specialist mental health services. Early intervention services that provide intensive support for young people experiencing a first psychotic episode can help avoid substantial health and social care costs: over 10 years for every £1 invested £15 in costs can be avoided.

- Public Health England[23] have noted that in an average class of 30 15-year-old pupils: three could have a mental disorder, ten are likely to have witnessed their parents separate, one could have experienced the death of a parent, seven are likely to have been bullied, six may be self-harming

- Early intervention is cost effective (for every £1 spent £85 pounds is saved on costs of care)[4]

DRIVERS FOR CHANGE

NATIONAL

- All Parliamentary report into child and adolescent mental health (2015)
- APHO 2015. The Chief Medical Officer's annual report 2012
- NHS England 2015. Five Year Forward View
- NHS England 2014. Model Specification for Child and Adolescent Mental Health Services: Targeted and Specialist levels (Tiers 2/3)
- PHE (2014) Improving Young Peoples Health and Wellbeing -
- Tavistock and Portman 2014. THRIVE model for CAMHS services
- CYP IAPT principles in Child & Adolescent Mental Health services values and standards 2014. Delivering with and delivering well (National standards for operating CAMH services)
- NHS England guidance (awaited) on CAMHS transformation plans

LOCAL

- Thames Valley CAMHS Engagement Programme (2014)
- Slough Joint Strategic Needs Assessment (2013-14 and 2015)
- Slough Five Year Plan 2015-2019
- Slough Children's and Young Peoples Plan (2015-16)
- Slough Alcohol and Domestic Abuse Strategies
- Results of evaluation of the Mindfulness programme
- Results of the Slough public mental health service redesign

LOCAL CONTEXT

The Slough JSNA 201527[27] is based on the same life course sections (Starting well, Developing well, Working well, Aging well) as used in the Mental Health 4 Life materials.

The JSNA has identified that further work is needed to commission an effective parental mental health service which supports parents in pregnancy and immediately after birth continuing through childhood throughout adult life and in older age. The latter two life stages are out of scope for this strategy but will be integrated into the adult mental health framework.

In 2013-2014 Slough was the lowest referrer into specialist CAMHS services and various explanations were proposed i.e;

- that our BME communities were not using services due to the stigma associated with a mental health diagnosis
- there was greater or equivalent need which was being met through schools and other support mechanisms in the community.

In 2014 public health and the CAMHS primary mental health team agreed to lead on the development of a national website and app which required a full review of; pathway improvements, existing tier 1-3 services and resources for schools and GPs. This opportunity has resulted in changes to;

- eight pathways which set out what can be done by the person themselves from taking a self care approach right the way through to accessing local services which can be found in the family services guide under health and wellbeing
- resources for schools which can be found in the Family Services Guide under health and wellbeing /resources and professional guides
- an updated list of local services that fit into the original tier 1-4 model of CAMHS services which can be found in the Family Services Guide under health and wellbeing/resources and professional guides
- professional guides to responding to emotional health and wellbeing issues (GP, social care, school staff etc) can be found in the Family Services Guide under health and wellbeing/resources and guides
- A schools training programme was developed and various hubs established to test the effectiveness of national programmes locally. There are now support hubs running in local schools, within social care (the CAMHS and wellbeing hub for our most vulnerable young people) and for coordination and quality assurance of all our services (the Five Ways to Wellbeing hub). A parental mental health programme has been tested and is providing clients with facilitated self help but as yet the only commissioned parental mental health service is through the CCG IAPT service. Further work is planned through the CAMHS transformation fund[17] to adopt a range of approaches to supporting women prior to and post pregnancy.
- Work undertaken by the Five Ways to Wellbeing hub during the pilot phase has identified new ways of delivering evidence based programmes at a community level. Results show reduced anxiety and depression and increased self awareness and a reduction in self harm in targeted

groups. Those who were unable to benefit (in the minority) required more support due to their additional support needs on a complex care pathway

- Waiting times to discuss childrens and young peoples issues and improve access a range of support to address mental health and wellbeing needs (for anxiety, depression and self harm) in the pilot schools was no longer than two weeks. In addition, since the launch of the pathway changes. the profile of cases managed by the primary mental health and specialist CAMHS teams has changed.

- During the pilot phase the specialist CAMHS team received additional funding to reduce waiting times for diagnosis of Autism Spectrum Disorder and Attention Deficit Disorder and to operate a response for complex trauma cases arriving at hospital. In addition the teams are developing an on line case management programme for young people called Young ShaRon which fits well with young peoples preferences shown in Figure 2.

- The model for a future integrated public mental health service has now been clarified for commissioning through the CAMHS transformation fund.

- The baseline demands on existing services has been determined. The primary mental health team manages over 900 calls for information and face to face consultations per annum and a caseload of which around 65 are open at any one time. Specialist CAMHS manages c 750 referrals into their service which is expected to rise to 850 for 2016-17; of these around 140 are stepped down per year to the primary mental health team (of which half are known to social care) and as a result of the changes to pathways less than 5 have been stepped up to specialist CAMHS. The additional coordinated support from a range of services such as early help advisors, SEBDOS, educational psychology, school nursing and youth services has also informed the pilot and future models of service.

- During the pilot in two secondary schools over 50 young people who were self harming or struggling with low mood/anxiety have all have received an intervention and a proportion have taken part in evidence based Mindfulness programmes. Results show a measurable reduction in anxiety and depression in the majority

- The co-created Slough wellbeing website can be found at www.puffell.com which contains sections for young people and adults

Figure 2. Work with young people identified their desired content for the on line offer

Their must have priorites are shown below and embedded in the website. The ‘should have’ and ‘could have’ sections will be incorprated in later releases.

Table 2. Young peoples views on ‘Must have’, ‘Should have’ and ‘Could have’ topics on the website

Must have topics	Should have	Could have
Self harm	Relationships	Eating problems/disorders
Anxiety/Depression	Domestic Violence	School Life
Anger Management	Drugs	Coping with Parents
Bullying	Parents Section	
How to Help Others		

Key points that the young people noted would help them use this resource are shown below

- Confidentiality is key – must be secure
- Needs to be useful and not just information
- They should be able to personalise it and make it their own
- Has to work across all devices
- Should be a mix of content styles e.g video, text etc
- Should have an interactive place where they can chat with others and with health professionals
- Needs to connect to a service if they need it
- Should have tools that help people manage and improve

- Make it feel like it is ok for young people to struggle with mental wellness – 'it's nothing to be ashamed of'

OUR VISION

That children and young people are able to achieve supportive relationships, a sense of belonging in their families, schools and communities and gain the skills needed to be resilient for life. And for our most vulnerable young people that their needs are identified early and that evidence based support is available as soon as possible.

STRATEGIC AIMS

- Promoting attachment and positive mental health across the life course
- Building resilience and early intervention in early years and school settings
- Empowering people to make informed decisions about their mental wellbeing
- Working with schools and communities to reduce harm at a population level
- Enabling young people and families to obtain access to evidence based support when needed
- Improving the physical health of those who struggle with mental health problems
- Ensuring the standards of commissioned services meet those agreed nationally and locally

Outcomes and expected benefits for health and social care in Slough

- Informed and resourced parents, professionals, children and young people who can support others in their community
- School and community based interventions are effective and support both parental, children's and young people's wellbeing
- Fewer children and young people require specialist CAMHS support
- For those children and young people who do need a diagnosis, shorter waiting times and effective exit pathways reduce the length of stay with specialist CAMHS
- High quality, accessible and cost effective local services reduce demands on education and children's social care

Thematic priorities

THEME 1: Promoting Mental Health 4 Life with parents

- All professionals working with women during the antenatal period need to be aware of the signs of distress and know how to offer help that avoids stigma or fear
- High quality training is offered in infant mental health (e.g. www.1001criticaldays.co.uk and www.chimat.org.uk/pimh)

- All professionals working with families and young children need to know how to respond to a request for help and refer to effective interventions e.g. www.centreformentalhealth.org.uk/parenting, http://bit.ly/FPHgoodstart, http://www.education.gov.uk/commissioning-toolkit,

- The LSCB coordinates and ensures the effectiveness of action to promote the welfare of children e.g. for domestic abuse at www.nice.org.uk/guidance/ph50, for social and emotional wellbeing guidance at www.nice.org.uk/guidance/ph40 and safeguarding at http://bit.ly/LGAsafeguarding

THEME 2: Promoting Mental Health 4 Life with children and young people

- All professionals working with families and young children need to know how to respond to a request for help and refer to effective interventions e.g. www.centreformentalhealth.org.uk/parenting, http://bit.ly/FPHgoodstart http://www.education.gov.uk/commissioning-toolkit, www.triplep.net, www.incredibleyears.com

- Children are enabled to fulfil their potential and are less likely to develop mental health conditions and other problems e.g. in primary schools www.nice.org.uk/guidance/ph12, in secondary schools www.nice.org.uk/guidance/ph20 (for every £1 spent £84 is saved)

- Whole school antibullying approaches save the taxpayer £14 for every £1 invested e.g. on domestic abuse www.nice.org.uk/guidance/ph50

- The LSCB coordinates and ensures the effectiveness of action to promote the welfare of children e.g. for domestic abuse at www.nice.org.uk/guidance/ph50, for social and emotional wellbeing guidance at www.nice.org.uk/guidance/ph40 and safeguarding at http://bit.ly/LGAsafeguarding

THEME 3: Promoting Mental Health 4 Life with schools

- School staff need to know how to respond to a request for help and where to refer to effective interventions e.g. www.centreformentalhealth.org.uk/parenting, http://bit.ly/FPHgoodstart, http://www.education.gov.uk/commissioning-toolkit, www.triplep.net, www.incredibleyears.com

- School based training is compliant with NICE guidance for promoting social and emotional wellbeing; in primary schools www.nice.org.uk/guidance/ph12 or in secondary schools www.nice.org.uk/guidance/ph20

- Whole school, whole community action is taken to tackle bullying e.g. www.nice.org.uk/guidance/ph40

- Schools should work closely in partnership with local authority children's services, the NHS and other services to develop and agree local protocols covering the assessment, referral and definition of the role of schools and other agencies in different interventions e.g. the eight care pathways (insert link here)

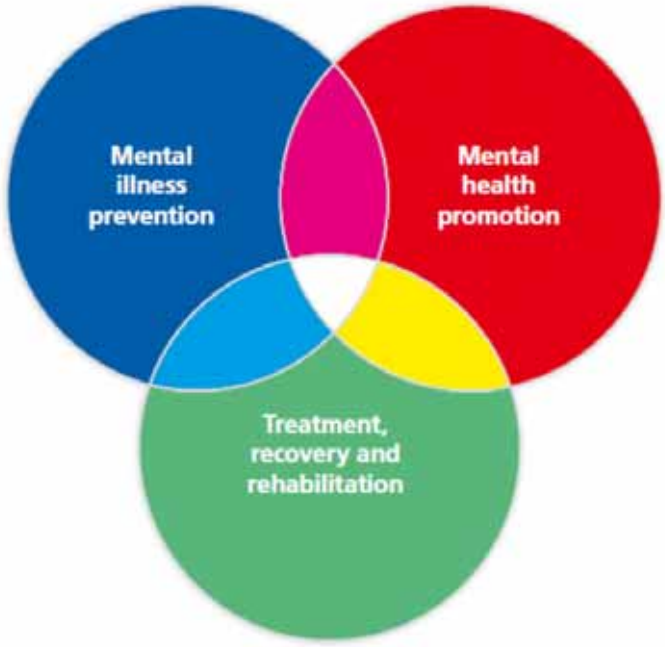
The timescales for achieving the themes are as follows;

- In one year, the goal is for the integrated service to be operating in as many secondary schools that are able to engage in the programme,
- In three years, all primary and secondary schools to have a rolling programme of training and integrated support
- In five years, theme 1 (which is the most challenging to implement in our diverse communities) would be supported through professional development programmes nationally and locally and measurable changes would be available showing long term reduction in harm at a community level.

National context and THRIVE model of CAMHS

The Chief Medical Officers independent report[1] noted that there were three distinct areas of public mental health for which there is a strong evidence base as shown overleaf

Figure 1: The World Health Organisation conceptual model of public mental health



The CMO report made a strong recommendation that the NHS and Public Health England should not commission services under the description of 'supporting well-being', but should focus on commissioning services for which there is evidence according to the WHO model. This is because people with self reported high levels of wellbeing may in fact have mental illness. Until valid measures can be put in place the Chief Medical Officer's (CMO) report recommended a focus on the evidence base for public mental health within the known domains of; mental illness prevention, mental health promotion, treatment, recovery and rehabilitation.

The report therefore recommended that until there was measurable evidence of the psychometric relationships between measures of mental wellbeing and measures of mental disorder/illness councils should not support wellbeing programmes. Further the report recommended that 'well-being' social

marketing campaigns for public mental health should not be rolled out, unless and until there is robust evidence for their effectiveness.

This has led to the generation of new evidence based resources (under the Mentalhealth4life logo)[4] which include the development of public mental health competencies across the life course. Slough Borough Council has made a commitment to incorporate this programme into its work with early year's services, schools, through its services for adults and older adults and through support to roll this out through the voluntary sector. The free resources can be downloaded from our Slough Service Guide *(link to CAREIF national resources[4]).*

Other national and regional reports emerged in the course of 2014 such as; the House of Common CAMHS review (2014), the local Thames Valley Child and Adolescent Engagement survey (2014) the Thames Valley Child and Maternity network report into perinatal mental health service provision (2014) and latterly the development of the THRIVE model of CAMHS provision (Wolpert et al 2014, 2015). All of these pointed towards a review of local services based on a life course and public mental health approach.

The House of Commons report[2] identified that GPs did not feel confident to identify and refer to CAMHS services and requested training to support them in their role

Young peoples and families views were gathered regionally in a very comprehensive engagement exercise, as reported in the Thames Valley Child and Adolescent Mental Health survey (2014). This report[29]29 provided the mandate for redesigning Child and Adolescent Mental Health services (CAMHS) locally, as families and children reported three areas of concern; the timeliness of services, the efficiency and effectiveness of services. The report showed that the language of the tiered model of CAMHS is not well understood by; parents, teachers, social care workers or GPs who; as primary referrers to specialist CAMHS, were seeing rising rates of referrals for autism spectrum disorder, for attention deficit disorder and for self harm in addition to the core work on anxiety and depression and a range of other diagnosable conditions.

Much of the confusion about CAMHS came from the lack of understanding about what services were available and how they worked together to deliver a comprehensive Child and Adolescent Health service. Up to 2014 CAMH services were defined in terms of tiers i.e;

Tier 1: consists of universal, non-specialist services who support children and young people these include; special educational needs coordinators, educational psychologists, behavioural support teams, health visitors working with, for example, common emotional and behavioural problems of childhood such as, sleeping difficulties or feeding problems and school nurses who can provide signposting and support for self management and early emotional needs.

Tier 2: consists of specialised Primary Mental Health Workers (PMHW's) offering support to other professionals around child development; assessment and treatment in problems in primary care, such as family work, bereavement, parenting groups etc. This also includes Substance Misuse & Counselling Services. Counselling services such as Cognitive Behaviour therapy, Mindfulness and nurture groups can be offered on an individual basis or in groups by primary mental health workers and educational psychologists. DfE guidance sets out the quality standards required when schools commission counselling services as up to 80% of schools use the pupil premium to do so.

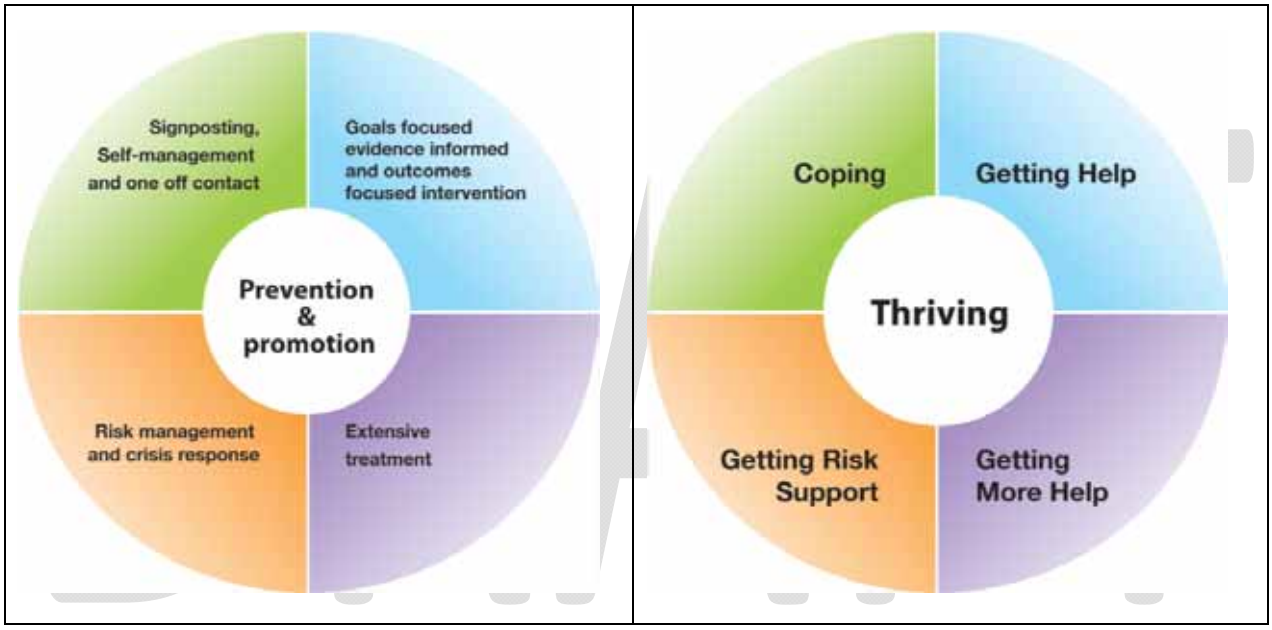
Tier 3: consist of specialist multidisciplinary teams such as Child & Adolescent Mental Health Teams based in a local clinic. Problems dealt with here would be problems that are too complicated to be dealt

with at tier 2 e.g. assessment of development problems, autism, hyperactivity, depression, early onset psychosis.

Tier 4: consists of specialised day and inpatient units, where patients with more severe mental health problems can be assessed and treated.

CAMHS tier 2 and 3 service staff have worked nationally to design a much more understandable and comprehensive model for CAMHS (THRIVE, Wolpert et al, 2014, 2015). The model shown in Figure 2 encourages staff at any stage to reflect on; whether they are offering evidence based interventions to help young people and to consider what they are doing under the four categories of; coping, getting help, getting more help or getting risk support. It is underpinned by a strong evidence base.

Figure 2; The THRIVE model of CAMHS (Wolpert et al 2015)



Caring for young minds
Anna Freud Centre
The Tavistock and Portman NHS
NHS Foundation Trust

The THRIVE model above sets out four clusters (or groupings) for young people with mental health issues and their families, as part of the wider group of young people who are supported to thrive by a variety of prevention and promotion initiatives in the community. It is in essence a discussion tool for practitioners to use in shared decision making with young people and their families and moves away from a diagnosis based grouping,

Wolpert et al 2015 note that currencies are classifications that aim to group together episodes of health care (or advice/help) with broadly similar resource use, in a manner that is compatible with need. In the national guidance produced by the NHS pricing team these should

- be clinically meaningful,
- identify health care provision of broadly similar resource usage, reflecting patient need and
- group units of care consistently (i.e. be reliable).

Wolpert et al noted was that the national costing model did not find any measurable relationship between the need for resources and the complexity of cases which is a common misperception. The categories examined included whether young people were in employment, education or training and other contextual factors such

as; looked after children, serious health issues, autism, Aspergers, neurological problems (Tics and Tourettes), on a child protection plan, children in need, refugee or asylum seeker, previous experience of war, torture or trafficking, abuse or neglect, parental ill health, contact with youth justice system, living in poverty.

The national payment system will undergo further revisions to inform future commissioning for tier 2 and 3 services and the national tariff will apply to specialist CAMHS when reporting goes direct to the Health and Social Care Information Centre through the Mental Health Services dataset. The latter is a combination of the Children and Young Peoples Introducing Access to Psychological therapies and the adult mental health datasets.

Specialist CAMHS in Berkshire are accessed by the common point of entry and they are contracted to lead on the following pathways; autism spectrum disorder (for a diagnosis), attention deficit disorder (for a diagnosis and treatment), anxiety and depression, eating disorders, crisis response for early psychosis and trauma or self harm.

By contrast the work of the primary mental health services covers the sections of the model that relate to coping and getting help with some group treatment programmes that can be offered in school or community settings and last for less than 12 weeks. National agreed tariffs are being launched as part of the CAMHS transformation plans which will allow the work of the integrated support services that collectively deliver the Five Ways to Wellbeing service to be commissioned. This public mental health and CAMHS service is coordinated by the primary mental health team and lead on; promoting information and support direct to schools through; the Slough Services Guide, training for school staff and GPs, evidence based interventions for self harm, anxiety and depression for secondary school pupils. This service supports young people who have been 'stepped down' from the common point of entry at specialist CAMHS. See the full service guide in the Slough Services Guide.

Slough's emotional, behavioural difficulties outreach service (SEBDOS) supports children in early years and primary school settings after a diagnosis has been made and supports specialist schools and resource centres. The service also offers support to schools to challenge sexting and cyber bullying as young people have reported these as continuing issues.

Interviews with young people reflect other factors that help them to cope; the importance of good relationships is at the centre of the model for young people's health and wellbeing shown in Figure 3.

Figure 3 Model for promoting young people's health and wellbeing (PHE, 2015)

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Evidence on what works in enabling young people to build strong relationships to enable them to cope[21] starts from birth by enhancing the bond between the mother and child (based on Attachment Theory[12]) examples of programmes that incorporate attachment based interventions include the Family Nurse Partnership, baby massage[17,21] nurture programmes[26,28] as well as a range of DfE approved parenting support and parenting programmes cited in the conduct disorders and attachment pathways.

NICE guidance and PHE guidance for schools on emotional health and wellbeing cites examples of what works in building social and emotional and life skills for school aged children and young people[19,20,23]

There is a clear message that life skills can be learned and enable young people to cope and become resilient to both internal and external stressors. Ungar (2014)[26] noted that *"In the context of exposure to significant adversity, resilience is both the capacity of individuals to **navigate** their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to **negotiate** for these resources to be provided in culturally meaningful ways."*

In terms of interventions in school settings;

- Mindfulness training is a well evaluated intervention for symptoms of depression and anxiety disorders in in young people as well as adults as reported in a metanalysis published by Zoogman et al 2014[35]. Further evaluations of Mindfulness are planned nationally. The learning from local pilots has also been captured and is awaiting publication

- CBT based approaches for youth and adult counselling are evidence based as cited in NICE guidance and form the basis of the CYPIAPT offer nationally which all specialist CAMHS services should report to the Health and Social Care Information Centre in future.

- Systemic Family Practice is evidence based and cost effective[28]
- Nurture groups can be effective in supporting those with behavioural difficulties at key transition stages, with supervision and peer support[322.]

In summary therefore the THRIVE categories provide a useful bridge between the language of 'wellbeing' and 'building resilience' used by staff and pupils in schools, and that used by professionals who work in specialist treatment services.

JOINT ACTION PLAN

The joint action plan shown in Appendix 3 is owned by the Children and Young Peoples Partnership subgroup for health.

The objectives are based on the four categories of the THRIVE model (Wolpert M. et al 2014) which fit with the emergent themes from young people obtained during the design and testing of the web based service, from engagement with young people and school staff during the service redesign phase and with engagement with specialist CAMHS services and the national team leading on the development of the Mentalhealth4 life resources.

- signposting and information
- getting help and early intervention
- timely access to evidence based care
- risk management for vulnerable young people
- service quality standards.

COMMUNICATIONS

Effective communication is vital to the successful implementation of this strategy and the joint action plan. There is a duty for all statutory bodies to consult and include the people they serve in the development of their services. This is known as the 'Duty to Involve' and influences all the councils and NHS engagement and communication activities. It is therefore important that all stakeholders are aware of this strategy and what it is intended to achieve. The joint communication plan with the youth council will set out how this strategy is to be communicated. This will be done using a variety of methods and media to encourage participation and ownership of the strategy by all stakeholders.

IMPLEMENTATION AND GOVERNANCE

Responsibility for the implementation of this strategy rests with the Slough Children's and Young Peoples board and the health subgroup. Decision making in relation to the commitment of statutory funding rests with Slough Borough Council's Cabinet and Slough CC Governing body

REVIEW

This strategy and its joint action plan will be in place from 2015-19 and will be reviewed annually to;

- Review the effectiveness of the actions and programmes

- Respond to local, regional and national changes
- Identify new priorities that have emerged since the implementation of the strategy
- Reassess priorities, actions and initiatives
- Plan for future development and or/amendment

The detailed action plans shown in Appendix 4 are already aligned to the THRIVE headings which support a payment schedule for the interface between primary and specialist CAMHS services. The detailed planning templates of the CAMHS transformation funding will be announced in the summer of 2015 during the consultation period. The final plans are required to cover five priority areas; all of which are mentioned in the action plans attached i.e; building capacity and capability across the system, rolling out the CYPIAPT programme, developing evidence based eating disorder services, improving perinatal care, bringing schools and local children and young peoples services together around the needs of the individual child.

Further local testing within further schools in the Autumn term will also inform the plans for the eating disorder service.

The continuing funding of the delivery organisations will be dependent on effective delivery of the targets and outcomes. Consistent monitoring arrangements will be in place across all agencies to assess performance against these outcomes.

Equality impact assessment

The full EIA can be found at Appendix 1. We aim to promote and deliver healthcare services that are equitable and are appropriate to each service user's needs regardless of age, disability, race, ethnic or national origin, gender, religion, belief, sexual orientation or domestic circumstances. Some groups are more likely to be affected by mental health disorders as shown below;

- Conduct disorders disproportionately affect males compared to females
- Self harm disproportionately affects females compared to males. There are multiple causes of self harm with rates of self harm reported as between 6-20% generally and more common in young people who are; lesbian, gay, bisexual transgender or questioning
- Eating disorders affect females disproportionately to males
- The PHE wellbeing report identified those who are most vulnerable i.e.; living in poverty, with special educational needs, Not in Education, Employment of Training, providing targeted support for those in care, those in youth custody (up to 40% having emotional and mental health needs where rates of mental illness are higher), asylum seekers, those excluded from school, teenage parents and young people in the Troubled Families programme.

CONTACT INFORMATION

For queries relating to this document contact the author on 01753 875142 or email publichealth@slough.gov.uk. The full consultation will take place from August-October 2015 and can be found at (insert link on SBC site when ready)

Appendix 1: Equality impact assessment

	Positive impact (Y or N)	**Negative Impact** (Y or N)	**Reasoning / evidence**

Age			
Older people(60 +)		✓	Separate services exist for adults with mental health problems. Families will however be encouraged to engage with this new service.
Younger people(17-25)	✓		Higher risks of suicide are reported among children in care or leaving care 4-5 fold increased risk of attempted suicide 7.5 fold increased risk if in long term foster care Young offenders are at increased risk of self harm and suicide with increased risk of severe mental health problems in later life and in association with solitary confinement. Alcohol misuse can lead to: psychosis . Self harm and suicide are more common in people who misuse alcohol. (RCP 2014). Alcohol affects the chemistry of the brain, increasing the risk of depression. Peer victimization has been associated with lower levels of personal wellbeing (Wolke and Skew 2011). 86% of children and young people report that they are members of social networking sites (ONS 2014) Although positive connections can form it has also been associated with increased rates of depression. Social media increases the risk of cyber bullying, sexting and exposure to risky situation but as yet there is no quantitative survey data on the impact of cyberbullying.
Gender			
Men	✓		More than half of all adults with mental health problems were diagnosed in childhood. (Young Minds 2015) Males members of social class V are at greater risk of committing suicide than females (National Institute of Mental Health 2003)
Women	✓		Between 10 and 20% of women develop a mental illness during pregnancy or within the first year after having a baby. Examples of these illnesses include antenatal and postnatal depression, obsessive compulsive disorder, post-traumatic stress disorder (PTSD) and postpartum psychosis. Symptoms range from mild to severe. Anxiety is more common in women than men (RCP 2014)

Ethnicity			
Asian or Asian British people	✓		The Mental Health Foundation notes that In general, people from black and minority ethnic groups living in the UK are: • more likely to be diagnosed with mental health problems • more likely to be diagnosed and admitted to hospital • more likely to experience a poor outcome from treatment • more likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health Bhui and McKenzie 2008 noted that South Asian females aged 25–39 are at increased risk of suicide and self harm (OR 2.8)
Black or Black British people	✓		The Mental Health Foundation noted that African Caribbean people living in the UK have lower rates of common mental disorders than other ethnic groups but are more likely to be diagnosed with severe mental illness. African Caribbean people are three to five times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia. Bhui and Mckenzie 2008 noted that rates of suicide and self harm were higher in black males i.e Black African (OR 2.5) and Black Caribbean (OR 2.9) aged 13–24 And among females the rates were increased in Black African (OR 3.2) and Black Caribbean (OR 2.7) groups

Ethnicity continued			
Chinese people	✓		The Mental Health Foundation notes there is very little information about the incidence of mental health problems in this category
Gypsy, Roma and Traveller People	✓		Evidence from a number of studies (Parry et al, 2004; Goward et al, 2006; MIND Bristol, 2008) shows that Gypsies and Travellers have greatly raised rates of depression and anxiety, the two factors most highly associated with suicide, with relative risks 20 and 8.5 times higher than in the general population (Harris & Barraclough, 1997).
Irish People	✓		Irish people living in the UK have much higher hospital admission rates for mental health problems than other ethnic groups. In particular they have higher rates of depression and alcohol problems and are at greater risk of suicide. Mind 2015.

People of Mixed Heritage	✓		See other categories
White People	✓		The Mental Health Foundation report that one in four people will experience a mental health problem in their lifetime. Mixed anxiety & depression is the most common mental disorder in Britain, with almost 9% of people meeting criteria for diagnosis. (The Office for National Statistics Psychiatric Morbidity report, 2001) Between 8-12% of the population experience depression in any year. (The Office for National Statistics Psychiatric Morbidity report, 2001) Rates among children are reported in the various pathways
People of other ethnic backgrounds	✓		See other categories
Asylum Seekers and Refugees	✓		Robjant et al 2009 noted that among those in detention centres. Anxiety, depression and post-traumatic stress disorder were commonly reported, as were self-harm and suicidal ideation. Time in detention was positively associated with severity of distress. There is evidence for an initial improvement in mental health occurring subsequent to release, although longitudinal results have shown that the negative impact of detention persists. Homeless people have an increased risk of suicide 61% reported suicidal ideation 34% attempted suicide
Disability			
People with physical or sensory difficulties	✓		Physical health and life expectancy are severely compromised in individuals who self-harm compared with the general population (Bergen et al 2012)
Deaf People who use British Sign Language.	✓		Children with early onset, severe to profound deafness are more vulnerable to mental health problems than their hearing peers. The key risk factors are developmental delays associated with early communication deprivation, CNS disorders associated with specific causes of deafness and abuse. Early psychological support to families and a wide range of communication options are crucial components in preventing mental health problems. Clinicians working with deaf children need to be sensitive to their communication needs and if necessary use British Sign Language (BSL) interpreters. Deaf children can benefit from a wide range of mental health interventions provided by generic and specialist services. (Hindley 2006)
People with mental health issues	✓		Suicide and self harm rates are reportedly 7% among 11-16 year olds (Green et al, 2005). Among those with existing mental health problems increased rates are suggested according to the condition.

People with learning disabilities	✓		The National Autistic Society note that people with autism or Asperger syndrome are particularly vulnerable to mental health problems such as anxiety and depression, especially in late adolescence and early adult life (Tantam & Prestwood, 1999). Young people with other learning disabilities in this age group will not be excluded and pathways for autism have been developed and included

Appendix 2 Needs and estimated demand for CAMHS in Slough

Automated CAMHS needs assessments are produced nationally on the Child and Maternal Health Intelligence Network (CHIMAT) website and these are being updated. The latest was reproduced in the JSNA CAMHS section available at http://www.slough.gov.uk/council/strategies-plans-and-policies/child-and-adolescent-mental-health.aspx

The extract that follows is for Slough CCG which is coterminous to Slough UA and is awaiting update by CHIMAT which has produced a series of prevalence estimates for mental health disorders in children. These combine the findings from different national and international studies to provide modelled estimates at a local level. Slough Clinical Commissioning Group's (CCG's) CAMHS Needs Assessment has been summarised below and is based on the 2012 registered population information. The full report can be found on the Slough JSNA website[27].

Pre School children

1,900 children aged 2-5 have the potential to develop a mental health disorder (based on a modelled prevalence of 19.6%)

School-age children

The prevalence of mental health disorders in school-age children vary by age and sex, with boys more likely (11.4%) to have experienced or be experiencing mental health problems than girls (7.8%). Children aged 11 to 16 years olds are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems.

In 2012, 2,170 children aged 5-16 were estimated to have a mental health disorder in the CCG.

Table 3. Estimated number of children with mental health disorders in Slough CCG by age group and sex

All mental health disorders	6 to 10 year olds	11 to 16 year olds	Total number
Boys	655	680	1335
Girls	305	530	835
Total	960	1210	2170

Table 4 Estimated number of children with specific mental health disorders in Slough CCG by age group and sex

Conduct disorders	6 to 10 year olds	11 to 16 year olds	Total number	Emotional disorders	6 to 10 year olds	11 to 16 year olds	Total number
Boys	445	440	885	Boys	145	220	365
Girls	170	265	435	Girls	150	315	465
Total	615	705	1,320	Total	295	535	830

Table 5 Hyperkinetic and less common disorders

Hyperkinetic disorders	6 to 10 year olds	11 to 16 year olds	Total number	Less common disorders	6 to 10 year olds	11 to 16 year olds	Total number
Boys	175	130	305	**Boys**	145	90	235
Girls	25	25	50	**Girls**	25	60	85
Total	200	155	355	**Total**	170	150	320

Young people aged 16-19

The prevalence of neurotic disorders in young people aged 16-19 is shown below

Table 6: Estimated number of young people aged 16-19 with neurotic disorders in Slough CCG

	Mixed anxiety and depressive disorder	Generalised anxiety disorder	Depressive episode	All phobias	Obsessive compulsive disorder	Panic disorder	Any neuroti disorder
Males (aged 16-19)	185	60	35	25	35	20	310
Females (aged 16-19)	420	40	95	75	115	25	650
Total	605	100	130	100	150	45	960

Local child health and wellbeing profiles are produced by Public Health England[24] and the 2015 report shows that in comparison with the 2008/09-2010/11 period, the rate of young people aged 10 to 24 years who are admitted to hospital as a result of self-harm was below the England average in the 2011/12-2013/14 period.

Although the admission rate in the 2011/12-2013/14 period is lower than the England average, nationally and locally our work shows that, levels of self-harm are higher among young women than young men.

Estimated need for CAMHS services

CAMHS Tier 1: 5,580 children and young people. Service provided by professionals whose main role and training is not in mental health. These include GPs, health visitors, school nurses, social services, voluntary agencies, teachers, residential social workers and juvenile justice workers.

CAMHS Tier 2: 2,605 children and young people. Provided by specialist trained mental health professionals. They work primarily on their own but may provide specialist input to multiagency teams. Roles include clinical child psychologists, paediatricians, educational psychologists, child psychiatrists and community child psychiatric nurses. **I think this describes teir three? Teir two are the ed psyches, school nurse,PMHW's,specialist TA's, youth service,YOT ect**

CAMHS Tier 3: 690 children and young people. Aimed at young people with more complex mental health problems than those seen in Tier 2. This service is provided by a multidisciplinary team, including child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists and art, drama and music therapists)

CAMHS Tier 4: 30 children and young people. Aimed at children and adolescents with severe and/or complex problems. These specialised services may be offered in residential, day patient or out-patient settings. These services include in-patient units, secure forensic adolescent units, eating disorder units, specialised teams for sexual abuse and specialist teams for neuropsychiatric problems

Children with a learning disability

Approximately 555 children aged 5 to 19 are estimated to have a learning disability in Slough CCG. This figure increases by age group:

- 5 to 9 year olds: 125
- 10 to 14 year olds: 200
- 15 to 19 year olds: 235

Approximately 225 children aged 5 to 19 are estimated have a learning disability with mental health problems in Slough CCG. This figure also increases by age group:

- 5 to 9 year olds: 50
- 10 to 14 year olds: 80
- 15 to 19 year olds: 95

The JSNA[27]26 provides estimates of the numbers of young people with learning disability and within other protected groups.

Appendix 3 Joint action plans

Theme	Objective Number	Objective	Measure	Owner
Signposting, information, peer support and training	1	Ensure young people are aware of what they can do to help others, can promote a range of self help resources, can tackle stigma and ensure confidentiality is maintained	Use of Puffell wellbeing deck Nos of young people trained in Youth MHFA and in anxiety and depression and self harm Feedback from courses	Youth Parliament, app champions, young peoples services. The Five Ways to Wellbeing team
Signposting, information, peer support and training	1	Ensure school staff are competent to understand their own response to promoting wellbeing and can assess and detect health problems early	No's of staff accessing MHFA, self harm training or training in using the pathways or resources Feedback from courses	Head teachers, SENCOS and pastoral staff supported by the Five Ways to Wellbeing hub partnership (including PMHWs, SEBDOS, SN, EHAs, Family support and educational psychologists)
Signposting, information, peer support and training	1	Ensure that early years and schools settings have information to promote Mentalhealth4life and pathway related resources, know their responsibilities and can get support to improve their practice in engaging the help of others	Information to be distributed to all new and existing schools on a termly basis	Slough Services Guide, Five Ways to Wellbeing hub partnership. and Gateway school distribution team
Signposting, information, peer support and training	1	Ensure that voluntary and community services have introductory training around Mental Health First Aid	No's of courses and feedback	Slough Council for Voluntary Services and SBC young peoples services
Signposting, information, peer support and training	1	Encourage GPS and other primary care professionals to promote Mentalhealth4life resources	No's accessing from the Slough Services guide	Practice managers and patient navigators
Signposting, information, peer support and training	1	Promote and support awareness of the SBC website and Puffell website	No's accessing per quarter	Slough services guide and public health

Theme	Objective Number	Objective	Measure	Owner
Signposting, information, peer support and training	1	Ensure that family courts and magistrates are trained to recognise mental health conditions and self help options	No's trained per quarter	BHFT specialist CAMHS

Theme	Objective Number	Objective	Measure	Owner
Getting early help and building resilience	2	Schools and services in other educational settings, ensure that effective social and emotional education is available for children, young people and parents.	Use of evidence based PSHE programmes Use of Mindfulness or THRIVE interventions Use of pupil premium to fund CBT and behaviour support interventions	Five Ways to Wellbeing Hub, schools and Young Peoples Services
Getting early help and building resilience	2	Develop parents' understanding of the impact of their own mental health on themselves and on their children. Develop professionals understanding of postnatal depression Provide Mentalhealth4life resources to enable schools to help parents understand the role of mental ill health plays in their and their family's lives so they can develop the skills to change behaviours	No's accessing supported parental self help groups through the voluntary sector No's accessing Institute of Health Visiting resources for fathers and mothers No's using e-learning for post natal depression No's of CCs offering in reach services for post natal depression	Perinatal support groups, CAMHS and Wellbeing hub, schools
Getting early help and building resilience	2	Encourage GPs to signpost to CPE where necessary and based on the pathways	% of appropriate referrals from GP surgeries to CPE No's stepped down from CPE to Five Ways to Wellbeing hub	Specialist CAMHS and Five Ways to Wellbeing hub
Getting early help and building resilience	2	More young people get access to help early	Nos of early help assessments completed	All agencies and settings
Getting early help and building resilience	2	Ensure that interventions are available at all stages of the criminal justice system, enabling young offenders to address their mental health or developmental delays and to understand how this is tied to their offending behaviour.	Significant decrease in the number of referrals to CAMHS coming from within the justice system	Young peoples services, TVP, YOS, specialist CAMHS, social care

Theme	Objective Number	Objective	Measure	Owner
Timely access to evidence based interventions	3	Improve the provision of evidence based mental wellbeing education in antenatal settings to promote maternal health and attachment	No's of referrals to Introducing Access to Psychological Therapies, baseline 89 in 2014-15	Slough GPs and CCG, BHFT perinatal mental health services, midwives and health visitors
Timely access to evidence based interventions	3	Improve the provision of evidence based mental wellbeing education in early years settings to promote attachment	No's of mothers attending peer led support programmes to reduce post natal depression	Health visitors, voluntary sector providers
Timely access to evidence based interventions	3	Ensure that young people are supported to access early interventions within all school settings	No's of referrals and cases held in school settings No's of Mindfulness and nurture group sessions No's of CBT sessions	School hubs, Five Ways to Wellbeing hub and CAMHS and wellbeing hub, and educational psychology services
Timely access to evidence based interventions	3	Promote and support awareness of the Young Sharon website and app	No's of specialist CAMHS users supported on line quarterly figures	Specialist CAMHS
Timely access to evidence based interventions	3	Ensure staff and peer leaders have access to a rolling programme of training to ensure high quality implementation of agreed programmes	No's of staff taking part in training	Learning and development team, Slough Council for Voluntary Services, specialist CAMHS and MHFA providers
Timely access to evidence based interventions	3	Ensure consistent quality standards are met across all agencies providing specialist counselling or family services	No's of schools that have had training in accessing key resources and guidance provided via the Five Ways hub	Training offered through the Five Ways to Wellbeing hub supported by specialist CAMHS
Timely access to evidence based interventions	3	Improve data collection and sharing for the Troubled Families programme and reduce anxiety and depression using a range of techniques in areas disproportionately affected by domestic abuse and related crime and disorder in the borough	Hub metrics and routine GIS based reporting of domestic abuse issues, driven by data sharing between stakeholders.	Troubled Families coordinator

Theme	Objective Number	Objective	Measure	Owner
Risk management of complex and vulnerable cases	4	Ensure that mental health services engage as early as possible with the families of complex cases. Improve capacity and capability for the identification, assessment and referral of children and young people affected by parental mental health problems.	Training of CSC staff in FST. Waiting times to access FST. Changes to CYP global scores Changes in parental and carers ability to cope	Integrated support service, CAMHS Wellbeing service, Troubled Families support partners
Risk management of complex and vulnerable cases	4	Assertive outreach is provided by BHFT working with local accident and emergency/hospital services	Crisis response rates for early psychosis and self harm	Frimley Park Hospital and Slough CCG, specialist CAMHS
Risk management of complex and vulnerable cases	4	Provide effective family based therapeutic services for children placed in care	LAC and foster carer reports. SDQ changes at reviews. Corporate parenting panel reviews	Children's Trust CSC, family services and Specialist CAMHS
Risk management of complex and vulnerable cases	4	Integrate motivational interviewing and mental health interventions into CSE action plans	No's of young people and families supported No's of plans with a mental health action	CSE coordinator and CAMHS wellbeing hub
Risk management of complex and vulnerable cases	4	Provide effective interventions to address attachment and understanding of behaviour for foster carers (NICE guidance)	No's of families accessing training	Children's Trust
Risk management of complex and vulnerable cases	4	Coordination of post ASD and ADHD diagnosis support is reviewed annually	No's of cases supported per quarter	SEBDOS, educational psychology and specialist CAMHS

Theme	Objective Number	Objective	Measure	Owner
Risk management of complex and vulnerable cases	4	Mainstream OOH and crisis support services into core services	No's of cases supported per quarter	Specialist CAMHS
Risk management of complex and vulnerable cases	4	Enhance the early intervention in psychosis service and 24/7 inpatient services	No's of cases supported per quarter	Specialist CAMHS
Risk management of complex and vulnerable cases	4	Drugs and alcohol services for young people are integrated with mental health services	No's of cases supported per quarter	DAAT commissioned services Specialist CAMHS

Theme	Objective Number	Objective	Measure	Owner
Service quality standards	5	Waiting times for consultation and action plans in the school based hubs are no longer than 2 weeks (for those screened and where a need has been identified or if there is a programme in school running) or 24 hrs in a crisis (a CPE role for the crisis response team) for the CAMHS and wellbeing hub.	Waiting times for those stepped up to and down from specialist CAMHS and for direct referrals. Bank Holiday and OOH reports from A and E	Five Ways to Wellbeing and specialist CAMHS metrics
Service quality standards	5	Young people are included in annual reviews of the service	Engagement reports through the youth parliament	Youth Parliament, app champions, youth engagement services
Service quality standards	5	Information on what each service does is freely available and updated regularly	Service guide and dates of updates	Slough Services Guide, Five Ways to Wellbeing hub partnership
Service quality standards	5	Children and young people friendly environments are available at specialist services e.g. magazines, websites, leaflets, apps, stress balls in waiting areas, posters which focus on positive mental health	*Mystery shopper reports from Youth Parliament*	Berkshire Healthcare Foundation Trust specialist CAMHS
Service quality standards	5	Electronic apps, tablets and Smartphone accessible services are monitored	Service metrics	Young SHARON and Slough CAMHS website
Service quality standards	5	Service letters and referrals are clear and enable improved case management		GPs, SENCOS and pastoral staff supported by the Five Ways to Wellbeing hub partnership
Service quality standards	5	Care plans include physical and emotional health measures	All statutory care plans for YOS, LAC, CP, CIN, and on the edge of care include measures such as SDQ, BAI, BDI and self harm metrics and health assessments for LAC	CAMHS and wellbeing hub, Five Ways to Wellbeing partnership, specialist CAMHS and LAC school nurse
Service quality standards	5	Staff are trained to national competencies appropriate to their role	No's trained per quarter by category; GPs, school staff social workers, PMHWS, family workers, other hub staff	CAMHS and wellbeing hub, Five Ways to wellbeing partnership and specialist CAMHS
Service quality standards	5	Trauma and specialist DAAT support can be accessed when needed	No's of cases requiring family support	DAAT family services reports

Theme	Objective Number	Objective	Measure	Owner
Service quality standards	5	Learning disability services are trained to provide appropriate mental health support	No's of outreach sessions by location and type of LD	Specialist CAMHS

APPENDIX 4 STATUTORY DUTIES IN RELATION TO ASSESSING AND IMPROVING CHILD AND ADOLESCENT MENTAL HEALTH

Legislation of particular relevance (identified in the statutory guidance) includes:

- The Crime and Disorder Act 1998
- The Children Act 1989 and associated regulations
- The Children Act 2004
- The Health and Social Care Act 2012
- The Care Act 2014
- The Children and Families Act 2014.

The Crime and Disorder Act 1998 requires the council and its partners to set up a youth offending service. The YOS duties include for the assessment of the health needs (including emotional and mental health) needs of young people. The initial screening is accomplished with a number of nationally determined tools. Of particular relevance here are "SQIFA" (the mental health screening questionnaire for adolescents) and "SIFA" (the mental health screening interview for adolescents). These are only completed if a more general assessment (Asset) shows a need for this more detailed assessment

Under **Section 10 of the Children Act 2004**, the Children's Services authority is required to promote co-operation with its partners and others with a view to improving the physical, mental health and emotional well-being of children in its area.

The Children Act 1989: Section 1(3) establishes a set of principles which must guide any decision made in relation to a child. The overriding principle is the welfare of the child and further considerations include (at sub-section 1(3)(b)) the child's physical, emotional and educational needs).

Section 17 deals with Children in Need and establishes the LA's duty to provide a "range and level of services appropriate to those children's needs".

Section 11 establishes that disabled children (who are established to be "Children in Need" in section 10) includes children with poor mental health

Section 23 (3) (a) of the Children Act 1989 establishes the key duty for a local authority to be "to safeguard and promote the welfare of the children they look after, including eligible children and those placed for adoption". Health Care Assessments include the requirement for the completion of a "Strength and Difficulties Questionnaire" (initially and as part of the normal review process). This is an important tool for identifying those individuals in need of specialist (Tier 3) support and is (in aggregate) a measure of the performance of the emotional health and wellbeing arrangements across a local authority area.

The Health and Social Care Act 2012 established local health and wellbeing boards, charged with "preparing the joint strategic needs assessment, the joint health and wellbeing strategy and in promoting integrated working between NHS, public health and social care commissioners (Chapter 2)."

Other acts establish specific duties for Local Authorities. In particular there are specific duties relating to emotional health and wellbeing for Children in Care Children and Young People involved with the Youth Justice System (under the Youth Offending Team) and Children in Need.

The Care Act 2014 requires A local authority must establish and maintain a service for providing people in its area with information and advice relating to care and support for adults and support for carers (including young carers)

The Children and Families Act 2014 requires the integration of educational provision and training provision with health care provision and social care provision and the preparation and maintenance of an education, health and care plan to promote the well-being of children or young people in its area who have special educational needs or a disability

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ACRONYMS

BAI	Becks anxiety inventory
BDI	Becks Depression Inventory
BHFT	Berkshire Healthcare Foundation Trust
BP	Boxall profile
CAMHS	Child and adolescent health services
CBT	Cognitive behaviour therapy
CCG	Clinical commissioning group
CGAS	Child global assessment score
CORC	Child outcomes research consortium
CSE	Child sexual exploitation
CYPIAPT	Children and young peoples improving access to psychological therapies
EPDS	Edinburgh Postnatal Depression Score
GP	General Practitioner
HV	Health visitor
IAPT	Improving access to psychological therapies
MH	Mental health
MMQ5	Mindfulness Questionnaire
PIMH	Parental and infant mental health
PND	Post natal depression
SEBDOS	Slough Emotional and Behavioural Outreach Service
SDQ	Strengths and difficulties questionnaire
SN	School nurse

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SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board **DATE:** 18th November 2015

CONTACT OFFICER: Nadia Barakat, Head of Mental Health and Learning Disabilities Commissioning, NHS Slough CCG

(For all Enquiries) (01753) 636031

WARD(S): All

PART I
FOR INFORMATION

MENTAL HEALTH CRISIS CARE CONCORDAT ACTION PLAN UPDATE

1. Purpose of Report

1.1 The purpose of this report is to update the Panel on the development of a Mental Health Crisis Concordat for Slough.

2. Recommendation(s)/Proposed Action

2.1 The Panel is requested to note the contents of this report and the action plan at appendix A.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

3a. Slough Joint Wellbeing Strategy Priorities

Providing joined up and appropriate responses for people who are experiencing a mental health crisis through organisations that are well trained will ensure support the delivery of the following Slough Joint Wellbeing Strategy (SJWS) priorities:

- **Health** - Slough will be healthier with reduced inequalities, improved wellbeing and opportunities for our residents to live positive, active and independent lives
- **Safer Slough** - Slough will have levels of crime and disorder that are not significantly higher than any other town in the Thames Valley.

3b. Five Year Plan Outcomes

Reducing inequality, supporting the most vulnerable and enabling people to help themselves are threads that run through each of the challenges and opportunities identified in the council's Five Year Plan (2015 – 2019). The Concordat supports specific delivery against each of the following Five Year Plan outcomes:
4 - Slough will be one of the safest places in the Thames Valley
5 - Children and young people in Slough will be healthy, resilient and have positive life chances

6 - More people will take responsibility and manage their own health, care and support needs

4. **Other Implications**

(a) Financial - There are no financial implications of proposed action.

(b) Risk Management - There are no risks associated with the proposed action.

(c) Human Rights Act and Other Legal Implications -There are no Human Rights Act implications.

(d) Equalities Impact Assessment - There are no equality impacts associated with the proposed action.

5. **Supporting Information**

5.1 The Mental Health Crisis Care Concordat is a national agreement between local services and agencies involved in the care and support of people in mental health crisis. It sets out how organisations will work together better to make sure people get the help they need when they need it.

5.2 The Concordat focuses on four main areas:

1) Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
2) Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
3) Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.
4) Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.

5.3 Across Berkshire 24 organisations have committed to delivering the Crisis Care Concordat, including all six Local Authorities, seven Clinical Commissioning Groups (CCGs), Thames Valley Police, the Ambulance Trust, local hospitals, the Mental Health Trust, the DAATs, NHS England and Berkshire Mind.

5.4 In order to deliver this Concordat an action plan has been developed and is appended to this report. It highlights the progress made to date.

5.5 This action plan is reviewed on a quarterly basis and was last updated in June. The most recent quarterly review meeting took place on 9th September and an updated action plan reflecting recent progress made to date will be produced shortly and is available on request.

5.6 Two areas of activity in the action plan at appendix A currently have a red RAG status:

1) The emergency duty service will respond within four hours so that patients will receive appropriate care in a timely basis (page 6 refers).
2) To maintain a high return on investment in the prevention of drug and alcohol related hospital admissions (page 8 refers).

5.7 These issues are being raised with the relevant Local Authorities in order to identify possible remedial/mitigating actions.

6. Comments of Other Committees

6.1 There are no comments from other Committees.

7. Conclusion

7.1 The Committee is requested to note the action plan appended to this report.

8. Appendices Attached

'A' - Crisis Care Concordat Action Plan

9. Background Papers

None

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Crisis Care Concordat
Mental Health

BERKSHIRE ACTION PLAN

Updated June 2015

1. Commissioning to allow earlier intervention and responsive crisis services					
No.	**Action**	**Timescale**	**Led By**	**Outcomes**	**Progress/RAG Rating**
Matching Local Need with a suitable Range of Services - Commissioners					
1.	Frimley Health Care NHS Trust and BHFT to produce a joint business case for investment to improve access to Liaison Psychiatry Service for all ages at Wexham Park Hospital in Berkshire East.	June 2015	Frimley Health NHS Foundation Trust/BHFT/East Berkshire CCGs	All referrals at A&E will be assessed within 4 hours, subject to their referral within 2 hours of attendance and the patient being medically fit for assessment.	£400k Parity of Esteem funding has been agreed by Berkshire East CCGs. BHFT is now recruiting staff. Regular meetings established between CRHTT and A&E Consultant Mental Health Lead.
2.	Evaluate CAMHS Psychological Medicine service pilot at Royal Berkshire and Wexham Park Hospital, this will enable rapid response and assessment to those aged under18 years presenting at A&E with self-harm. Any Lessons learned will shape future commissioning intentions and service configuration.	May 2015	East Berkshire Clinical Commissioning Groups	Children and Young People access multi agency assessment and CAMHs help in a timely manner. Fewer admissions, reduced length of stay. Information gathered from the pilot will help understand how the service has helped and supported children and young person.	BE CCGs have reported there had been recruitment issues which had delayed this pilot project and therefore to date there has not been enough operational time to evaluate the service, which is funded with winter resilience monies. Berkshire West CCG will share the RBH pilot

					evaluation report when this is complete
3.	Parity of Esteem Business Cases is being developed by both East Berkshire & Berkshire West CCGs for investment in 2015/16.	June 2015	East Berkshire and Berkshire West CCGs	Improve capacity of the MH urgent care services to deal well with crises. This will meet the parity of esteem investment plan and improve mental health service across Berkshire.	Parity of Esteem funding have been approved by both Berkshire East & West CCGs in EIP, CRHTT, CAMHS & A&E Liaison Service(East Berkshire only)
4.	A mental health specialist will work jointly with the police in the West of Berkshire to assess individuals who come to their attention as presenting with possible mental health issues	June 2015	Berkshire Healthcare Trust	Fewer individuals will be detained by the police, in the West of Berkshire, under the mental health act and taken to a place of safety. The most appropriate response to the situation will be made at the first point of contact and consequently individuals will have a better experience when they are seen by the Police in a crisis.	Berkshire West Street Triage is due to go 'live' from 24th July 2015; most preparatory work has been completed, one staff has been appointed awaiting police clearance. Operational Group will meet monthly to monitor progress; Street Triage Steering Group will meet quarterly.
5.	Ensure that same day access to primary care is available for patients needing this in crisis.	Autumn 2015	CCG West & East Primary Care Programme Board	Timely assessment, de-escalation or referral for all those in crisis.	BE CCGs will include this as part of their MH Strategies; BW have invested additional resources to increase capacity in primary care
Mental Health Crisis Services Response Times					
6.	All patients referred urgently to our Berkshire Crisis Response Home Treatment Team [CRHTT] from the Trusts Common Point of Entry [CPE] service (our referral service) are contacted within 4 hours.	On-going	Berkshire Healthcare Trust	Patients will be contacted within four hours improving patient and relative satisfaction.	Implemented and on-going, reported on quarterly to CCGs with one month data as part of [Quality Schedule 15/16]
7.	Crisis calls received directly by CRHTT from	On-going	Berkshire Healthcare	Patients and carers will feel supported	Implemented and on-going,

	patients or relatives will be responded to within 1 hour by the service and where a visit is clinically required this will happen in 2 hours.		Trust	by the service because they know what service they can expect to receive.	reported quarterly to CCGs with one month data as part of [Quality Schedule 2015/16]
8.	Royal Berkshire Hospital A&E - referrals from A/E staff to the Mental Health A/E Liaison team will be assessed within two hours of referral providing the patient is well enough to undertake the assessment	1 April 2015	Berkshire Healthcare Trust	All patients presenting with mental health problems at RBH are receiving timely and appropriate care for their mental health need whilst in A&E.	Fully 'RAID' compliant Psychological Medicine Service is now operational at RBH
Responsive Ambulance Times					
9.	The current South Central Ambulance Services (SCAS) contract is being reviewed to agree on data sets in transporting mental health patient to a place of safety	April 2015	SCAS Contract Lead CSU	There is now an establish process in place to monitor compliance with the commissioned service specification for SCAS.	SCAS Clinical Lead have confirmed that there is now a facility to produce data on response time which is then submitted to SCAS contract lead as part of the 2015/16 contract agreement
10.	To review current demands and arrangements in place to support mental health patients under section 136, (urgent) 135 (planned) to be taken to a place of safety by Ambulance Services within the Thames Valley Region SCAS to work with Thames Valley Police and Mental Health Trusts via the Protocol In Partnership Group to agree a joint protocol on the above	April 2015	South Central Ambulance Service - Chief Operating Officer	An agreed protocol between SCAS & TVP is now in place.	Leads from SCAS & TVP have confirmed that there is a joint protocol in place to manage demand to convey patient to PoS (Place of Safety)
11.	Review and update contracts as appropriate when they are renewed to include specific standards on	commenced August 2014 the	South Central Ambulance Service -	Patients will receive appropriate and timely transport to support their mental	Compliant and is monitored monthly during contract

	mental health responses based on the national guidance, this will ensure that there is specific reference to the standards and measures recorded formally in any relevant contracts that SCAS is party to	action is ongoing	Chief Operating Officer	health needs as outlined in the NHS Standard Contract	performance monitoring meeting
12.	SCAS to review and agree with Berkshire Healthcare the demand and capacity required to enable SCAS to plan sufficient and appropriate resources. SCAS to agree a local protocol for response to different situations i.e. protocol for non-emergency transfers and, emergency transfers, HCP response	January – March 2015	South Central Ambulance Service - Regional Operations Director North	Patients will receive mental health services which are appropriately resourced with a joined up service approach	SCAS Clinical Lead advised that a mental health protocol has been introduced; there have been difficulties with recruitment and sourcing a suitable wheelchair accessible vehicle. Further work needs to be done to reduce unnecessary police call-out to convey mental health patient to hospital. SCAS are rolling out mental health training to all their front line staff

No.	Action	Timescale	Led By	Outcomes	
Improve Access to Support via Primary Care					
13.	Develop a comprehensive training package for General Practitioners in Mental Health.	Autumn 2015	Health Commissioners	GPs will be better equipped to understand patient's mental health condition so that they can support and sign-post patients to most appropriate	Berkshire East & West GPs have received core MH awareness training at different level, this is being rolled-out to

				services.	receptionists, practice nurses etc.
14.	A specialist training programme will be provided to GP's and teachers which will help them spot emerging mental health issues in children and young people and give them the confidence to know how best to manage the situation.	April 2015	Berkshire Healthcare Trust and Commissioners	Mental Health issues in children and young people are more likely to be identified at an early stage in education and primary care settings and be dealt with appropriately.	2 day week PPEP Care Lead appointed to roll-out the PPEP Care Training Programme to primary care and schools across Berkshire. The first train the trainer programme has been held to train CAMHS Staff who will act as the core training team. On-going train the trainer training is being developed for relevant Tier s and other colleagues who do not have a CAMHS core profession/CYP IAPT training who need some input to skill them up in CBT to become trainers. BHFT have a number of training events booked and the project lead is making contact with relevant colleagues in all localities to raise awareness of the training. This is being worked around clinical work capacity to reduce waiting lists and waiting times.

					Roll-out of this programme is in phase 2 of the CAMHS parity of esteem programme
Social Services Contribution to Improved Emergency Duty response Times					
15.	The emergency duty service will respond within 4 hours in line with the Joint Working Protocol. Response times will be monitored. During the working week, any social care response would come from the relevant community mental health team for the locality.	On-going	Bracknell local authority on behalf of all six unitary authorities	Patients will receive appropriate care in a timely basis. If response times exceed four hours then appropriate actions will be taken to ensure that it is reduced.	This is currently being reviewed by the Unitary Authorities across Berkshire.
3. Urgent and emergency access to crisis care					
No.	**Action**	**Timescale**	**Led By**	**Outcomes**	
Improve CAMHs Alternatives to Admission and Access to Tier 4 Beds					
16.	Clinical Commissioning Groups to work with NHS England and BHFT to disaggregate the Berkshire Adolescent Service block contract into Tier 3 and Tier 4 activity NHSE to seek additional investment to enable Berkshire Adolescent Unit (BAU) to open 24/7 NHSE seek additional investment to increase the	May 2015 By summer 2015 By March 2017	Clinical Commissioning Groups/Local Authority & Education Department NHS England NHS England	Children and young person who are very unwell are placed in Berkshire and do not have to be in hospital long way from home.	Disaggregate Berkshire Adolescent Service Contract into Tier 3 & 4 activity Additional investment for Berkshire Adolescent Unit (BAU) to open 24/7 – funding have been approved This is included as part of Parity of Esteem work for Berkshire

	number of Tier 4 beds in Berkshire				East & West and will be implemented
	CCGs to consider options for enhancing crisis care at Tier 3	March 2015			On-going discussion between parties
	CCGs and BHFT to evaluate the pilot projects funded by NHSE over the winter, additional CAMHs duty clinics at weekends and bank holidays, enhanced Early Intervention in Psychosis Service and a psychological medicines service for under 18's at Wexham Park Hospital	April 2015	Clinical Commissioning Groups Clinical Commissioning Groups	Every Acute Hospital in Berkshire will have an NHS Mental Health Worker who will be able to assess and triage children in crisis to appropriate management and care.	Awaiting evaluation report

Improved quality of response when people are detained under Section 135 and 136 of the Mental Health Act 1983					
Improved Ambulance Response Times for S135 & S136 Detentions					
Improved Training and Guidance for Police Officers					
17.	Thames Valley Police will ensure that all frontline officers and staff, who may deal with people with mental health problems, receive updated training by Autumn 2015.	Autumn 2015	Thames Valley Police	5,000 Thames Valley Police officers and staff will receive training to improve their ability to support persons suffering a mental health crisis.	Bespoke training for different roles is underway for around 6,000 TVP Staff including police officers, PCSOs, station and duty staff, special constables; this will be on-

					going in 2015/16
Response from Community Substance Misuse Service Providers					
18.	To continue to work with partners to reduce the likelihood of crisis interventions being required for individuals who use drugs and alcohol.	April 2015	Public Health DAAT Leads/Local Authority	To maintain a high return on investment in the prevention of drug and alcohol related hospital admissions.	This is work in progress based on funding allocation for DAAT in each Local Authorities in Berkshire

4. Quality of treatment and care when in crisis					
No.	**Action**	**Timescale**	**Led By**	**Outcomes**	
Review Police use of Places of Safety under the Mental Health Act 1983 and Results of Local Monitoring					
19.	Thames Valley Police will work with partners to ensure that custody is only used as a place of safety on an exceptional basis (below 5%)	Summer 2015	Thames Valley Police	The use of police cells as places of safety falling to below 5% of Section 136 detainees ensuring patients are accommodated in an appropriate health facility.	TVP confirmed that numbers have reduced to 8.8% against a target of 5% but this is an improvement over the last twelve months; there are 3 places of safety assessment rooms across Berkshire, it is anticipated that street triage will support further reduction.
Develop further Alternatives to Admission (NHS & Local Authority)					
20.	We have established three crisis beds at Yew Tree Lodge in Reading run by Care UK as alternative to hospital admission.	September 2014	Berkshire Healthcare Trust	The facility will offer residents of the West of Berkshire a more personal, less institutional alternative to hospital admission when in crisis.	Remains in place, this service are managed by Partnership in Care with full compliments of staff.
Use of Restraint					
21.	Our staff at Prospect Park Hospital who has direct contact with patients will receive Promoting Safer & Therapeutic Services (PSTS) training.	September 2015	Berkshire Healthcare Trust	The training will mean that our staff will use different techniques to reduce the use of restraint in the wards. This will improve patient experience.	Standards achieved – all staff facing mental health patient receive PSTS training and bi-monthly annual update. Those working in inpatient settings receive this via SMART week, PMVA or standalone courses; community staff will

					receive this via standalone bespoke courses
22.	Calming (de-escalation) areas will be introduced to all mental health ward environments.	June 2015	Berkshire Healthcare Trust	Patients who are very agitated and who potentially might be violent and aggressive will have a dedicated area on each ward to receive individual care. This will promote privacy and dignity, reduced the use of restraint and an overall improved patient experience.	All de-escalation areas open and in use
23.	All mental health inpatient and crisis response home treatment team staff will be trained in Breakaway techniques so that they are able to safely manage situations where an acutely unwell patient may be a risk to staff and others.	December 2015	Berkshire Healthcare Trust	Staffs are supported to maintain both their own personal safety and that of their patients.	Ongoing training; CRHTT Staff are also allocated a lone worker device for their protection.
24.	On the rare occasions when restraint is used, our staff will only use techniques and interventions that are designed not to cause pain or injury and maintain the principles of dignity and respect for patients. All patients will receive a de brief following such an event.	April 2014	Berkshire Healthcare Trust	Patients will be helped to understand the reasons why restraint was used. Patients will also tell staff how it felt to be restrained and together they will agree a joint plan of what to do should another incident occur to try and avoid the use of restraint in the future.	All patients are offered a post-incident review following a restraint event, either with ward staff or through SEAP
25.	Clinical Staff at the Royal Berkshire Hospital in A&E department and other relevant wards and departments will receive Conflict Resolution Training using a scenario based approach relevant to the patient cared for.	September 2015	Royal Berkshire Health Care Foundation Trust	The training will mean that our staff will use de-escalation techniques to minimise the need for restraint. This will improve patient experience.	80% of nurses in ED have undertaken a 5 hour conflict resolution training in the last year; an additional training for ED Consultants has been designed and will be delivered during Aug/Sept and the 5 hour training for ED Consultants will be

					scheduled over the following year.
26.	Security Staff do not restrain patients unless there is a serious risk of them harming themselves or other people. They are trained in techniques and interventions that are designed not to cause pain, to maintain privacy and dignity and they work with clinical staff to ensure patient safety. Where ever possible the patient or their family is given an opportunity to discuss the reasons for using restraint and there is a team debrief to learn lessons.	September 2014	Royal Berkshire Health Care FT	Patients will only be restrained when it is absolutely necessary and when they are episode of restraint this will be looked at by the security, clinical and safeguarding team to learn lessons about avoiding using restraint whenever possible.	All security staff provided to the RBFT by Keyline Security Services are trained in techniques to restrain that are designed not to cause pain and to maintain privacy and dignity, however patient are only restrained when it is absolutely necessary.
27.	Police officers should not be deployed to restrain persons suffering mental illness unless there is a serious and imminent risk of harm to any person or serious damage to any property.	Spring 2015	Thames Valley Police	The use of police to restrain persons in mental health crisis, both in a health care setting and in the community, is significantly reduced.	TVP reported that there is a National Working Group looking at whether police should ever have to do this and if yes, how and if not, who should do it? It was noted that Police Officers are not trained to restrain MH patients
Primary care response					
28.	Improve Primary Care response to Mental Health Crisis by providing education to GPs in all 7 CCGs in Berkshire so that each GP knows who it is appropriate to refer and to phone for urgent referrals Establish DXS system in Primary Care Computer IT systems to guide GPs in Berkshire West to better signpost to appropriate mental health services.	January 2016 November 2015	Clinical Commissioning Groups (CCGs)	Improved timeliness and quality of referrals to CPE Better training are available for GPs in primary care to support clinicians to manage mental health patients who present in crisis Deliver an enhanced level of IT software system to support access to patient records	GP education programme is now fully rolled-out across Berkshire Currently under review

	Better GP signposting i.e. to Access to debt/welfare advisors in Primary Care Settings and support.	September 2015		Primary Care Clinicians can make direct referrals to debt/welfare advisors for those with finance problems	BW Clinical Lead advised that BW are working with RVA as CAB have capacity issues
	Explore increased use of Peer mentors & peer navigators to support access to services and decrease DNA rates.	June 2015		Mental Health patients have access to peer mentoring in the community via voluntary sector providers	BW are working with Reading Your Way and BE are working with Depression Alliance
	Sharing of patient records with NHS Providers and Emergency Services so that when patients contact in crisis, their primary care records can be accessed easily.	November 2015		Better record sharing system are in place to allow emergency services to access patients records both for primary care and secondary care	This is being progressed through Programme Board

5. Partnership Working					
No.	**Action**	**Timescale**	**Led By**	**Outcomes**	
Monitoring Progress and Planning Future System Improvements					
29.	Expand the Emergency Department of the Royal Berkshire Hospital to provide a new Observation Unit. This will be made up of 8 beds (2 bays of 4 beds) to provide single sex accommodation and 5 ambulatory chairs. The facility will have a mental health assessment room that is compliant with National Standards, a side room with shower facilities	November 2014	Royal Berkshire Foundation NHS Trust	To provide a ward environment for those patients requiring treatment within the Emergency Department post 4 hours with the expectation that they will be discharged home. Promoting privacy and dignity and an improved patient experience. A significant number of patients attending ED with mental health problems fall into this category.	○ ED Observation Bay is fully operational since November 2014 which has a mental health assessment room with appropriate furnishings
	Provide office accommodation for the new Acute Mental Health Liaison Service based at the Royal Berkshire Hospital	October 2014	Royal Berkshire Health Care FT	The Observatory Unit and Mental Health Assessment Room will improve the working conditions for both ED staff and the Acute Mental Health Liaison Team and support better care for their patients.	○ Office accommodation for PMS achieved
	Joint Clinical Governance arrangements for the ED and newly commissioned Psychological Medicine Service at Royal Berkshire Health Care FT	October 2014	Royal Berkshire Health Care FT	A working environment, adjacent to Emergency Department colleagues and the Older Peoples Mental Health Liaison Team that will promote multidisciplinary, and partnership working and lead to improved holistic care of patients with mental health problems who attend the Emergency	○ ED & PMS clinical governance meeting fully established since Oct 2014
	A comprehensive safeguarding training strategy that includes mental capacity assessment and mental health act training and addresses the knowledge and competencies of the work force in relation to care of mental health patients	April 2015	Royal Berkshire NHS FT	Provide a forum for close partnership working where key performance indicators, clinical incidents, complaints and patient experience in relation to the care of mental health patients can be	○ Safeguarding training strategy approved by the Strategic Safeguarding Committee since

	who have acute and chronic physical health needs requiring admission to hospital. Royal Berkshire FT will be able to 'flag' individual crisis care plans shared by Berkshire Health Care FT on the A&E electronic patient record system. The Crisis Care Concordat should be placed on the agenda of Local Safeguarding Adults Boards, which have a statutory basis under the Care Act 2014 from 1st April 2015. Mental capacity awareness needs to be supplemented by consideration of the potential for Deprivation of Liberty Safeguards to be applied, for example, in certain cases of informal admission. The Concordat will be of interest and relevance to the work of our Health and Wellbeing Boards, some of which may wish to endorse the concordat individually for their area.	April 2015 April 2015 April 2015 April 2015		monitored and a culture of continuous improvement fostered. There is patient representation on the ED Clinical Governance Committee. A work force that has the knowledge and skills to support mental health patients with acute physical health needs, respecting their rights and recognising when and how to make reasonable adjustments to ensure they have access to appropriate care. Staff at A&E will be able to understand what the most appropriate care is for an individual when they are in crisis. Concordat to be circulated to DASS in Berkshire for the attention of the Safeguarding Co-ordinator. All Unitary Authorities in Berkshire Concordat to be circulated to Health and Wellbeing Board Chairs in each of the 6 areas.	April 2015 ○ Individual patient crisis management plans can be flagged as a safeguarding concern on First Net, ED EPR before
30.	We will share individual crisis care plans with the police, ambulance service and acute hospitals regarding patients who are frequently in contact with our mental health and	September 2015	Berkshire Healthcare Trust	The police and ambulance service will be able to understand what the most appropriate care for an individual is when they are in crisis.	Being implemented; patient being identified through the Berkshire PIP (Protocol In Practice) as well as more

	emergency services.				locally amongst partner organisation

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SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny Panel **DATE:** 18th November 2015

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PART I
FOR INFORMATION

SLOUGH SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2014/15

1. Purpose of Report

To make the Slough Health Scrutiny Panel aware of the work of the Slough Safeguarding Adults Board (SSAB) during 2014/15 and to present the main areas of common concern to the board.

2. Recommendation(s)/Proposed Action

The Panel is requested to note and comment on the report.

3. The Slough Safeguarding Adults Board Annual Report

Although the annual report has been presented to the HSP in previous years, with the introduction of the Care Act in April 2015 this is the first time that the SSAB has had a statutory responsibility to prepare and present the annual report.

As part of putting Adult Safeguarding on a statutory footing the Care Act also identified the local authority as the lead authority with both the local police force and CCG sharing responsibility for local safeguarding arrangements as core board members.

The six key safeguarding principles outlined in the Care Act underpin all our adult safeguarding work; they are consistent with the Slough Wellbeing Board priorities, particularly in regard to Health, Housing and Safer Communities. These principles are:

- Empowerment
- Prevention
- Proportionality
- Protection
- Partnership
- Accountability

They are described more fully in the introduction to the Annual Report.

As well as describing both national and local developments through the year, this annual report is a retrospective that reflects the work carried out in 2014/15. The report is presented in a different way from previous annual reports focusing on the issues and work carried through in relation to the objectives in the Board's

strategic business plan. By taking this approach our intention is to generate a more readable and coherent picture of the work undertaken, the shared objectives of this work across the partner agencies and their respective contributions.

3a. **Issues in the annual report of specific relevance to the HSP**

As will be expected there are significant areas of common interest and overlap in the priorities of the Slough Wellbeing Board and SSAB. This is also the case between the SSAB and the Safer Slough Partnership (SSP), and this was reinforced in the Care Act with the introduction of three new categories of abuse, two of which are directly relevant to the SSP: Modern Slavery and Domestic Violence. This has been drawn out in the report of this annual report to the SSP in November 2015. The third category of Self Neglect will be of significance to this board and has been a consideration in Serious Case Reviews (now referred to as Safeguarding Adult Reviews) and is often a factor in mental capacity assessments.

Two of the SSAB's strategic objectives referred to in the annual report are emphasised here:

Strategic Objective 3: Making Safeguarding Personal
This work has been referred to in last year's annual report but the initiative has been advanced both at the national and local level. This is the national direction for safeguarding work with a lesser emphasis on the safeguarding process and stronger focus on achieving, with the individual, what they would like to see as an outcome from the safeguarding involvement. This is not always easy to progress but contains the potential for a much more effective and relevant service to people at risk. This approach is endorsed and promoted in the Care Act and both the borough council, as the lead safeguarding agency, and the SSAB seek to embed this way of working in all adult safeguarding work, the majority of which is multiagency work with partners.

Strategic Objective 4: All agencies will ensure that there is consistent compliance with the Mental Capacity Act, including Deprivation of Liberty Safeguards where relevant
Working within the mental capacity framework is an important aspect of Making Safeguarding Personal. It is a counter to any tendency to want to make risk averse decisions for people rather than the agency working with the person and their families and friends to make positive decisions that may generate greater risk as the outcome of consideration by that person of their own situation and what they want for themselves. There is no doubt that this does require a changed working model that professionals across the agencies have struggled with since the introduction of the Mental Capacity Act in 2007. This view is reflected nationally, and Slough is active in the Berkshire Mental Capacity Implementation Group and awareness raising training underway locally.

There are however, very difficult resource and practice implications in regard to the Deprivation of Liberty Safeguards (DOLS) as the definition of those subject to DOLS has been extended following judgements in the Supreme Court in 2014. This has led to a significant increase in the numbers of DOLS applications, from 28 in 2013/14 to 391 in 2014/15. It is anticipated that the number in the current year will exceed 400. Each application requires assessment by a limited pool of qualified Best Interest Assessors (BIA).

This is a major national issue with all local authority areas affected, some more than others depending on their demographic and the resources in the area. Slough is working with neighbouring local authorities to share BIA capacity as necessary, and while there is significant local pressure and an unavoidable budget overspend, by careful prioritisation the pressure is being managed though with extended waiting times for assessment where the situation is not urgent.

3b. **Five Year Plan Outcomes**

The work of the SSAB directly contributes to the following outcomes in the Councils Five Year Plan:

- Slough will be one of the safest places in the Thames Valley
- More people will take responsibility and manage their own health, care and support needs

4. **Other Implications**

(a) Financial

The Care Act identified the local authority police authority and Clinical Commissioning Group for each area as core members of the statutory Adult Safeguarding Board. As part of their core membership an expectation of funding for the board was set out with each agency making a contribution to the costs incurred in delivering the board's responsibilities. Each agency does make a contribution; for the current year, 2015/16 Thames Valley Police has contributed £5,000, the CCG £5,000 and the borough council as the lead authority meeting the costs of staff members with specific safeguarding responsibilities.

There are clearly significant financial and resource strains for all the partners of the SSAB . While it is not possible to quantify a specific and direct impact on safeguarding work, as agencies continue to make savings it is probable that the risk will be increased if support resources decrease and pressures on staff increases. While the SSAB is aware of this, it's responsibility to seek assurance of the quality of safeguarding within and between local agencies remains of primary importance to the SSAB.

There is a specific financial pressure faced by the borough council from the increased DOLS work referred to above with an overspend in 2014/15 of £15,000. This has been recognised by central government who have agreed a one off increase in the DoLS grant to local authorities this year resulting in an on target budget projection.

(b) Risk Management

In large measure all safeguarding work is about risk management, and as identified above there is a concern that further savings and continuing pressure on resources, for all agencies, will increase safeguarding risks.

Risk/Threat/Opportunity	Mitigation(s)
Increase in safeguarding activity following addition of new categories set out in the Care Act 2014.	Ensure triaging system for receiving safeguarding concerns is thorough with clear management oversight.
Responding to DoLS in a timely fashion	Train more BIAs and develop retention strategies.
Increase in Safeguarding Adult	Further embed risk management

Reviews for Self Neglect cases	training and tools for operational staff.
Increase in costs in relation to Serious Case Reviews	This would be an additional cost pressure to SBC unless partners increased their financial contribution.

(c) Human Rights Act and Other Legal Implications

The working principle of the Board is that:

"people's human and civil rights should be protected, and they have a right to be able to live their lives without fear of abuse or intimidation, in an environment where individuality, independence, privacy and personal dignity are respected"

(d) Equalities Impact Assessment

Equalities Impact Assessment will be undertaken for as and when required for specific programmes of work as directed by the SSAB.

5. Comments of Other Committees

The SSAB has considered and endorsed this Annual Report which will also be presented to the Safer Slough Partnership and the Slough Wellbeing Board at the end of November. Partner agencies of the SSAB will also be presenting to their respective Boards over the next few weeks.

6. Conclusion

The Health Scrutiny Panel is asked to consider and note the Annual Report of the SSAB

7. Appendices Attached

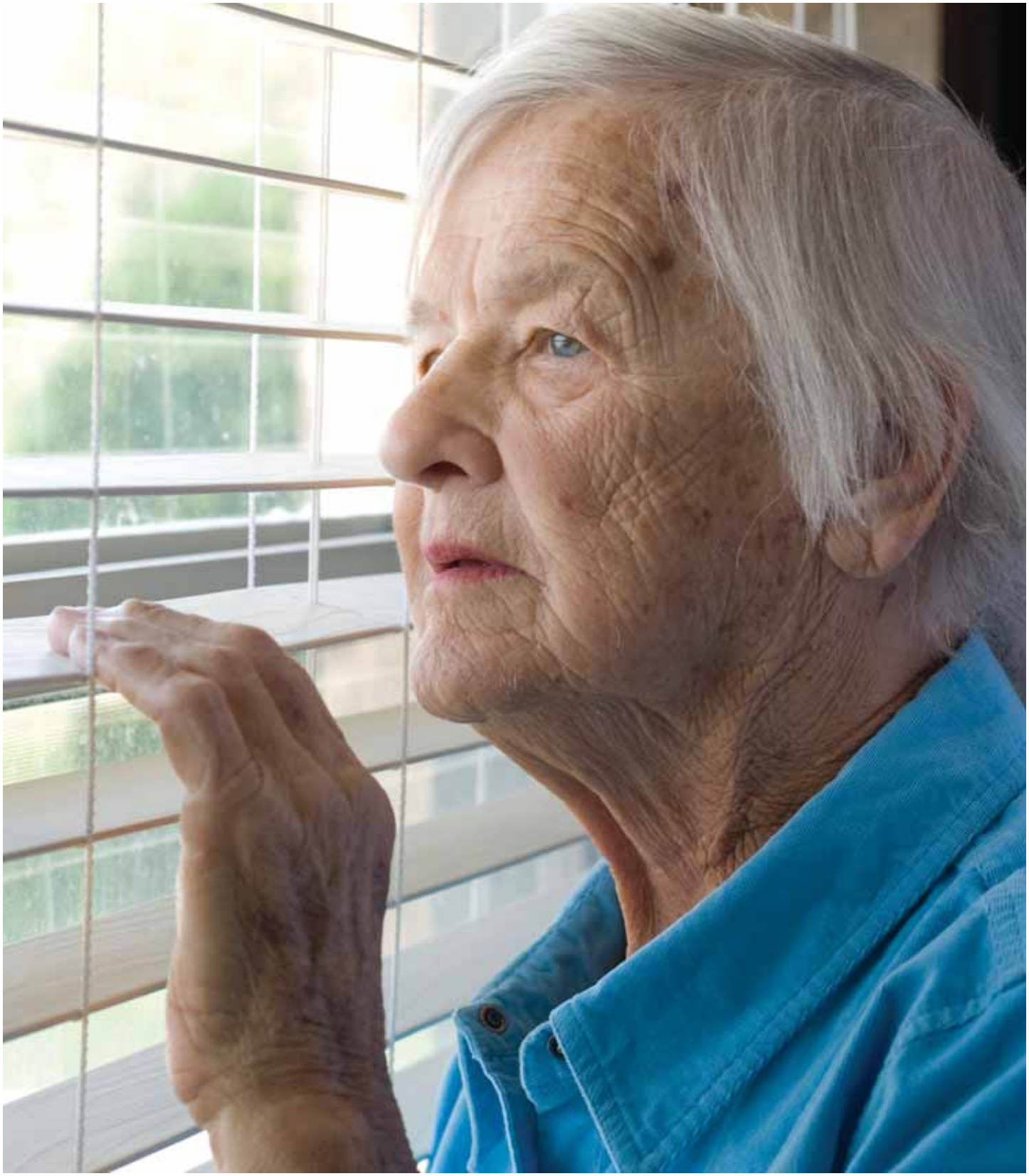
A - Slough Safeguarding Adults Board Annual Report April 2014 to March 2015

8. Background Papers

None

Annual Report

Slough Safeguarding Adults Partnership Board
April 2014 to March 2015



Slough
Safeguarding Adults Partnership Board
preventing abuse, protecting people

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Foreword

Although this report relates to the year before the introduction of the Care Act in April 2015, our anticipation, planning and introducing changes prior to its introduction have been major features of the Board's work, and that of all the partners working in Slough.

There is a changed focus to the objectives in safeguarding with our stronger focus on involving the person in the process and seeking to achieve the outcomes they want from the protective intervention and involvement with statutory services. I hope this is reflected in this annual report, and also that the report drafted to show progress against our strategic objectives conveys the breadth of local safeguarding work and the Board's collective response and drive to tackle the range of local challenges.

The commitment of staff working across the agencies, statutory and voluntary, is as impressive as ever as they work in ever more challenging financial circumstances and with higher levels of expectation placed on them.

We know that there is always a lot more to do to ensure that the service is as positive and inclusive as possible. With the new demands and possibilities in the Care Act we look forward to rising to this challenge.

Nick Georgiou
Independent Chair
Slough Safeguarding Adults Board

Introduction

This is an exciting time for Adult Social Care and for Adult Safeguarding with the introduction of the Care Act 2014 (implemented 2015). For the first time the Care Act puts Adult Safeguarding on a legal footing, making requirements of the local authority and its partner agencies to protect our most vulnerable citizens. The Act re-enforces the principles developed in the ADASS guidance 2005 and reaffirms that they are central to adult safeguarding:

Six key principles underpin all adult safeguarding work

1. **Empowerment** - People being supported and encouraged to make their own decisions and informed consent. *"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."*
2. **Prevention** - It is better to take action before harm occurs. *"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."*
3. **Proportionality** - The least intrusive response appropriate to the risk presented. *"I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."*
4. **Protection** - Support and representation for those in greatest need. *"I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."*
5. **Partnership** - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse. *"I know that staff treats any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."*
6. **Accountability** - Accountability and transparency in delivering safeguarding. *"I understand the role of everyone involved in my life and so do they."*

(Care Act 2014, Section 14.13)

The Act then goes onto describe the context of Adult Safeguarding and provides a new definition of whom these safeguards relate to.

The aims of adult safeguarding are to:

- stop abuse or neglect wherever possible; prevent harm and reduce the risk of abuse or neglect to adults with care and support needs;
- safeguard adults in a way that supports them in making choices and having control about how they want to live;
- promote an approach that concentrates on improving life for the adults concerned;
- raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect;
- provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult; and address what has caused the abuse or neglect.

(Care Act 2014, section 14.11)

The safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of, abuse or neglect;
- and as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

(Care Act 2014, section 14.2)

The definition is interesting in that it replaces the one described in "No Secrets" (2000) which talks about different service user groups and widens the scope of the people whom locally authorities now have a duty to protect. The Act further widens this again with the types of abuse that are now covered by the Act and these include:

- *Physical abuse - including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.*
- *Sexual abuse - including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.*
- *Psychological abuse - including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.*
- *Financial or material abuse - including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.*
- *Discriminatory abuse - including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.*
- *Organisational abuse - including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.*
- *Neglect and acts of omission - including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating*

(Care Act 2014, 14.17)

The Care Act also introduces three new categories of abuse:

1. *Self-neglect - this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.*
2. *Modern slavery - encompasses slavery, human trafficking, and forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.*
3. *Domestic violence - including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence.*

(Care Act 2014, 14.17)

Slough Safeguarding Team together with Slough Safeguarding Adults Board are looking at how we adapt our services to meet these new categories of abuse, in particular the issues related to self-neglect which has always sat outside of Adult Safeguarding. This will be referred to again later on in the Annual Report in terms of future work for the Board.

3) National developments 2014/15

The Care Act 2014

The Care Act 2014 is an historic piece of legislation, not only because it includes the first overhaul of social care statute in England for more than 60 years, but also because of the collaborative nature of its passage through parliament.

Local councils' new duty to promote people's wellbeing will now apply not just to users of services, but also to carers. And not only to carers of adults: a corresponding duty in respect of parent carers of disabled under-18s has been included in the Children and Families Act 2014, which was proceeding in parallel.

People receiving care and support from a regulated provider and arranged by their council, whether in a residential setting or at home, will now be covered by the Human Rights Act.

The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect.

Local authorities have new safeguarding duties. They must:

- **lead a multi-agency local adult safeguarding system** that seeks to prevent abuse and neglect and stop it quickly when it happens
- **make enquiries, or request others to make them,** when they think an adult with care and support needs may be at risk of abuse or neglect and they need to find out what action may be needed
- **establish Safeguarding Adults Boards,** including the local authority, NHS and police, which will develop, share and implement a joint safeguarding strategy
- **carry out Safeguarding Adults Reviews** when someone with care and support needs dies as a result of neglect or abuse and there is a concern that the local authority or its partners could have done more to protect them
- **arrange for an independent advocate** to represent and support a person who is the subject of a safeguarding enquiry or review, if required.

Any relevant person or organisation must provide information to Safeguarding Adults Boards as requested.

Orchid View Serious Case Review

Orchid View was a care home in West Sussex that was registered with the Care Quality Commission (CQC) from September 2009 to October 2011. The home, run by Southern Cross, provided care and nursing for up to 87 people who were elderly, frail, had nursing, or dementia care needs. The home closed in October 2011 following a number of serious safeguarding concerns over the two years that it was open.

In October 2013 a coroner's report ruled that neglect had contributed to five resident deaths, with other residents suffering 'sub-optimal' care. The report said that the home was mismanaged and understaffed. The coroner also criticised CQC for failing to identify the failings at the home prior to its inspection in September 2011 and not taking action to close the home prior to its voluntary application to cancel its registration resulting in closure in October 2011.

Following the coroner's report, a Serious Case Review (SCR) commenced to consider the practices of all the agencies that had a role in safeguarding residents at the nursing home and to ensure that the lessons learned are being auctioned by all the agencies involved. CQC submitted an Individual Management Review to support the SCR in December 2013. The overall report from the SCR published in June 2014 and the further recommendations for CQC arising from the SCR are being taken into account.

This Serious Case Review had many recommendations which could apply to all local authorities and many of the recommendations have been taken on board by Slough Adult Safeguarding Board.

Operation Yewtree

This was a police investigation into sexual abuse allegations, predominantly the abuse of children, against the British media personality Jimmy Saville and others. The investigation, led by the Metropolitan Police Service, started in October 2012. After a period of assessment it became a full criminal investigation, involving inquiries into living people as well as Saville.

On 19 October 2012 the Metropolitan Police reported that more than 400 lines of enquiry had been assessed and over 200 potential victims had been identified. By 19 December, eight people had been questioned; the total number of alleged victims was 589, of who 450 alleged abuse by Saville. The report of the investigations into the activities of Saville himself was published, as Giving Victims a Voice, in January 2013. Operation Yewtree continued as an investigation into others, some but not all linked with Saville.

Although this investigation related to child sexual allegations it does have implications for Adult Safeguarding in that it shows how organisations allowed people access to vulnerable children without supervision or monitoring and this has been known to happen to adults. Secondly a lot of the victims of Saville are now adults and the abuse will obviously have an impact on their adult lives.

Oxfordshire Children's Serious Case Review - Bullfinch

The independent Serious Case Review into Child Sexual Exploitation in Oxfordshire was published on Tuesday 3 March 2015 by the Oxfordshire Safeguarding Children Board. The serious case review followed a trial in 2013 in which seven men were imprisoned for a total of 95 years for their crimes which took place from 2005-2011.

Again although this is a report around Child abuse, the lessons learnt which are important for adult safeguarding especially with the widening of the definition of Adult Safeguarding to include Slavery, Domestic abuse and Self-Harm.

In Slough like other authorities we are working closely with our colleagues in Children's services to devise plans to ensure that our children and young adults are protected from such exploitation and grooming. This form of grooming is as likely to happen to young children to some of our most vulnerable adults, in particular those who have a learning disability or a mental health problem.

4) Local developments 2014/15

Multi-Agency Safeguarding Hub (MASH)

The protection of our most vulnerable children or adults, is a fundamental responsibility of all public agencies whether statutory, non-statutory or from the third sector. There is a key acknowledgement that services engaged in the safeguarding of children and adults should work together in a structured way to keep them safe.

In 2014/15 it was decided that there should be a Multi-Agency Safeguarding Hub (MASH) in Slough. Working with our partners at Slough Borough Council, Health and Thames Valley Police a plan has been put in place to have their key safeguarding teams together to physically work in the same place. It is anticipated that this service will go live in April 2015 for Children's service with Adult service coming on line in 2015/16.

The MASH takes a 'whole family' approach to safeguarding. Our partners share and analyse key information about each family to inform safeguarding decisions. This enhanced data sharing across the partnership joins up all the available information to support vulnerable people, and may inform interventions to protect them.

5) Strategic Business Plan 2014-15

Strategic objective 1

All agencies individually and collectively will have a process for identifying and managing risk.

Quality recording will enable details of concerns and actions taken to be seen clearly. All agencies will have an audit process which will identify areas of good practice and areas for improvement.

The governing principle behind good approaches to choice and risk is that people have the right to live their lives to the full as long as that does not stop others from doing the same:

By taking account of the benefits in terms of independence, well-being and choice, it should be possible for a person to have a support plan which enables them to manage identified risks and to live their lives in ways which best suit them." Independence, choice and risk: a guide to best practice in supported decision making - DOH 2007

Slough Safeguarding Adults Board recognised the importance of good risk assessments in all areas of work with vulnerable adults, but particularly in relation to Safeguarding Work. The importance of good risk assessments was highlighted to the Board from a Serious Case Review commissioned by the Board in 2012/13. The Board decided that risk would form an area of work for the Board and its members.

What have we achieved?

1. **Slough Safeguarding Adults Board - Multi-Agency Risk Framework**
   The first piece of work that was undertaken was a refreshing of the Boards Multi-Agency Audit Framework. This Framework had been in place for several years but it was felt that this needed to be updated in line with the forthcoming Care Act and to ensure it took into account the philosophy and values of "Making Safeguarding Personal".
   This Framework was updated and ratified by the Board in February 2015 and compliance with the Framework will form part of the work of the Board over the following year.
2. **Slough Adult Social Care Risk Tool and Guidance**
   It was decided that this Guidance also needed to be updated in line with the Care Act and "Making Safeguarding Personal", (see MSP Section below). The Board also wanted to re assure itself that this Guidance was now part of everyday practice and not just in Safeguarding work of all Adult Social Care staff. A training plan has been devised which will ensure that all staff will receive this training relevant to their role, but due to the implementation of the Care Act this training will be delivered between May and July 2015.
3. **Multi-Agency Audit**
   The Safeguarding Board wanted to reassure itself that risk assessments were part of all Safeguarding cases and therefore two multi-agency audits were undertaken to by Board members looking at over 20 Safeguarding Cases with the main focus being on the quality of risk assessments in individual cases, one in March and one in October 2014/15. These audits used a particular audit tool that had been recently developed looking at an outcome focused approach. A report regarding the outcome of the first audit was available to Board members and Adult Social Care staff (January 2014) and highlighted the need for further work in this area. A report for the second audit is due out for the Board in June 2015.
4. **Internal Safeguarding Audits**
   Slough Borough Council carries out internal audits of Adult Safeguarding cases. This year we moved away from our old audit tool which focused primarily on timescales and moved towards a tool which looked at the outcomes for the Adult involved and what change it made to their lives.

This means that our staff will be asking people at the beginning of their safeguarding enquiries what they want out of the case and how we can work with them to achieve these goals. These outcomes will be continually updated as the case progresses and at the end of the case the Adult will be asked if they feel their outcomes have been met and if not what else could or should be done to help them to achieve them. This work may need to be done outside of safeguarding as it could relate to housing, counselling etc.

These audits are carried out on a one to one basis, with a member of the Safeguarding Team meeting with a Designated Safeguarding Manager (DSM) to audit a case and the feedback from these audits are then given to the DSM and Level Two worker involved in the case. Any general patterns regarding practice that arise from the audits are fed into the training strategy.

5. **Fire Safety Checks**
Royal Berkshire Fire and Rescue Service (RBFRS) are members of the Safeguarding Board and were keen for the Board to look at one specific area of risk, fire deaths. The key aim of Royal Berkshire Fire and Rescue Service is to reduce deaths and injuries from fires and other emergencies. RBFRS have a free fire safety check service which is available to all clients. In order to try and address this issue the RBFRS are offering free Home Fire Safety Checks to all vulnerable adults in Berkshire and they have produced a leaflet to promote this service. The Board agreed to distribute this leaflet to all of the agencies involved in the Board to forward to their front line staff.

The leaflet was distributed to all users of Adult Social Services and now forms part of the pack of information pack that Slough Adult Social Care sends out to all people who contact the service. A fire safety check is also offered to all adults where there is a risk of fire due to the condition of their property, such as in cases of hoarding or neglect of property.

It is hoped that this approach will help to reduce the risk of fire deaths within Slough.

Way forward

Management of risk will continue to remain high on the Boards Strategic Objective's for 2015/16 and this will be taken forward again into the Board's Business plan for the coming year.

Slough Safeguarding Adults Board Member Gavin Wong, Deputy Commander for Slough local police area

My role is to support the Commander who has responsibility for front line policing and this means that I will deputise in his absence and take on that responsibility when required. In addition to a significant administrative role, I also work closely with partner agencies which reflects the need for all agencies to work together to achieve their own goals.

Policing has changed significantly over the last 20 years since I joined the Service, and safeguarding is now a significant aspect. We have always tried to protect people but it used to be very much about catching criminals. It is now clear that the Police Service has a responsibility for ensuring that our communities are protected from the dangers from many different types of harm.

Because we recognise the importance of protecting the vulnerable that is why 'Protecting Our Communities from the Most Serious harm' is one of our core objectives.

Thames Valley Police has itself changed over the years to reflect this need and there are a number of specialist roles to provide support which has been created. This includes the Protecting Vulnerable Persons department, development of Specially Trained Officers to support victims and the creation of Multi Agency Safeguarding Hubs (MASH). All officers receive specific training in relation to safeguarding. We certainly didn't have this level of focus when I joined and I feel that the Police are much better placed for it.

Safeguarding Adults is now a statutory responsibility and as with children, it is an opportunity to hold all agencies to account. I hope that it will encourage agencies to work together which will mean we are all in a better position to identify and safeguard the most vulnerable in our community.

Strategic objective 2

All agencies will have a clear process for managing safeguarding cases. All agencies will have a working knowledge of safeguarding adults.

Slough Safeguarding Adults Board has signed up to the Berkshire Safeguarding Policies and Procedures which are available on the internet http://berksadultsg.proceduresonline.com/index.htm. These provide clear guidance on the Safeguarding process in regard to Adults who are/or at risk of abuse or neglect. All board members and partner agencies have agreed to follow these procedures.

What have we achieved?

The Board decided this year to focus on looking at agencies and their trigger processes for Safeguarding. This was done through a variety of processes including training, leaflet and information sharing as well as auditing and monitoring individual cases.

A new Performance Subgroup of the Board was set up with the remit to provide a more effective performance report which would enable the Board to reassure itself that agencies were correctly identifying and reporting allegations of abuse and neglect.

The Performance Subgroup is made up of a range of agencies and it was decided by the group that the report that was produced needed to include a range of information including:

- Safeguarding information - numbers of reports, location of abuse, type of abuse etc.
- Training Statistics - numbers of staff trained in relevant positions.
- Incidents of Hate Crime
- Numbers of prosecutions and outcomes of criminal and civil investigations
- Details of any Serious Case Reviews, Adults Reviews, Domestic Homicide Reviews, Children's Serious Case Reviews in area.
- Details of any serious untoward incidents or other agencies serious incidents involving adults in need of care and support.

Due to the complexity of obtaining the data from various sources the first copy of this report will be available for the September Board in 2015. The report will be available on a quarterly basis and will direct the forward planning to the Board and targeting its resources.

Way forward

- Performance report to be collated and disseminated to board
- Report to be used to determine board priorities for 2015/16
- Re-evaluation of report to ensure that it meets the working needs of the Board.

Slough Safeguarding Adults Board Member Jo Barnett, Named Nurse for Safeguarding Adults at Frimley Health NHS Foundation Trust

As Named Nurse for Safeguarding Adults at Frimley Health NHS Foundation Trust, I provide a point of contact for staff, patients and external agencies, identifying and supporting adults at risk and supporting patients with a learning disability. I ensure that the best interests of patients are upheld and that the Mental Capacity Act is implemented were necessary and regulatory standards are met. Training our staff in the different aspects of safeguarding adults is key to the success of keeping people safe in hospital

I really hope that adult safeguarding will continue to attract more attention as child protection does, to empower our patients to be confident about reporting abuse and not 'putting up' with a situation because they have little support or are too frightened to report it. I look forward to new statutory powers to safeguard adults, and to protect the most vulnerable using existing law, which will facilitate this.

Strategic objective 3

Making Safeguarding Personal

This objective is mentioned specifically within safeguarding elements within the Care Act 2015.

The LGA/ADASS Making Safeguarding Personal development project was drawn up in response to feedback from people using safeguarding services, stakeholders and practitioners that the focus of safeguarding work was on process and procedure.

People using safeguarding services wanted a focus on a resolution of their circumstances, with more engagement and control. Practitioners and safeguarding adult's board members want to know what difference they are making, but find it difficult to get this information from national indicators and data, which measure inputs, processes and outputs.

In 2009 the Improvement and Development Agency (IDeA, now LGA), SCIE, British Association of Social Workers (BASW) and Women's Aid worked together to form a body of knowledge, to assist empowerment and support for people making difficult decisions.

This initial work resulted in, 'Review of literature on safeguarding adults supporting 'vulnerable people' who have experienced abuse with difficult decision making' (Deborah Klèe, LGA 2009). The literature review found that there was very little evidence in this field, so we neither know what works best nor have evaluations of methods used. Following this literature review the LGA developed a toolkit with ADASS and academics, 'Making Safeguarding Personal - a tool kit of responses' (Ogilvie and Williams, LGA 2010), which identified a range of interventions that could be appropriate for adult safeguarding practice.

"Making Safeguarding Personal" in Slough

What did we do? In Slough we first entered the "Making Safeguarding Project" MSP in 2013 at Bronze level and as part of this we worked with a small group of staff, who represented all the Adult Services teams to look at embedding outcome focused work in Safeguarding. We completed this pilot project in March 2014. The outcomes of which was a resounding success from those staff and service users involved. As a consequence of this we decided to take part in the next stage of the Programme, and entered at Silver Level. In 2014/15 we decided to focus on three areas and these are recorded below. Slough Safeguarding Adult's Board endorsed the three areas above and have monitored progress of MSP in Slough.

What have we achieved?

1) **Embedding current good practice**
Slough like most authorities had set the Safeguarding service up in line with the requirements of the Department of Health, in terms of outcomes, so that we were deciding whether an allegation of abuse was substantiated or not, rather than deeming whether it was meeting the needs or outcomes of the service user. This did not mean that work we were doing was not client focused but that our recording systems were not outcome focused. Therefore one of the first pieces of work that needed to be undertaken was updating our client recording system "IAS" to ensure that it was able to record outcomes.

It must be remembered that not all outcomes will be achievable or are in the Best interest of the client, or in the power of the local authority to achieve but it is anticipated that through the Safeguarding process the Level 2 worker, who will work alongside the Adult at Risk will be able to help them to identify more realistic and achievable outcomes.

It is still early days in terms of being able to report on Outcomes and we are at present looking at setting up electronic reporting systems in order that we will be able to report outcomes to the Safeguarding Board on a quarterly basis.

The second part of embedding outcome focused work was undertaken through awareness raising and we have done this in several ways. Firstly, we have updated our materials on the intranet (our internal website for practitioners) with guidance and a range of support tools to assist workers in working alongside Adults at Risk of abuse and neglect. We have also produced three newsletters for our staff informing them of the changes in systems in relation to Safeguarding and how they can get involved in MSP.

We have also undertaken two Multi-Agency Audits on Safeguarding cases with a focus on Outcome focused work.

Reports have been made available to the Safeguarding Adults Board regarding the findings of these audits. The findings from the above audits have been taken into account and have been fed into the work streams in Adult Safeguarding as well as informing training programmes for staff.

Case Study - Making Safeguarding Personal

Mary is a 79 year old female who has a mild learning disability, she is a sociable lady and she likes telling jokes, she is affectionate to her soft toys namely her large rag doll and monkeys. Her family share a close relationship with her.

Mary is an insulin dependent diabetic; she has diabetic retinopathy, suffers with depression and has poor mobility. Concerns were raised in relation to recurrent pressure sores that were not identified by care workers and their failure to take appropriate actions by care staff. Concern was also raised by the family that the care workers could not identify when Mary's blood glucose levels dropped significantly leaving her drowsy. Mary was left for a few hours whilst she deteriorated without help which led to a hospital admission. Family raised concerns about the poor quality of care that Mary received by the care workers and their failure to react promptly. Mary stated that care workers did not respond to her calls for toileting which led to her becoming incontinent and at other times she attempted to mobilise to the toilet which resulted in numerous falls and hospital admissions. Mary disclosed allegations to her family during a hospital admission and stated that she did not want to return to her flat.

Social worker met with Mary to inform Mary that a safeguarding alert was raised by the Hospital team and shared information on the allegations which were disclosed by her daughters. Mary listened carefully to the information, nodding her head and agreeing with the content of the allegation, she also cried and described incidents of poor care.

The safeguarding process was explained to Mary requesting whether she wanted the allegations to be investigated. Mary agreed that the allegations should be investigated. The Social worker presented information to Mary in simple language to enable her to understand the information and make a decision about her engagement with the safeguarding process.

Mary was deemed to have mental capacity to make a decision regarding the safeguarding; she was encouraged to share information which also included her views on what she wanted out of the process. The aim of determining Mary's outcomes were to improve Mary's circumstances rather than being process driven to find a conclusion without making a difference in Mary's life. The engagement with Mary reflected a person centred approach; decisions were being taken with her and not for her.

Mary stated that she is now happy in the nursing home; she also commented that she likes the residential care workers, they respect her and most importantly they listen to her. Mary shared that she feels safe. The outcome of this safeguarding case has improved the life of Mary.

2) **Implementing the Positive Risk Tool. This is reported on in Strategic Objective One of this Report**

3) **Working with our statutory partners to influence their approach to positive risk taking**

   This involved developing a Safeguarding Board Multi-Agency Risk guidance document which was signed off and ratified by the Board in 2014/5. The Board recognises that it needs to do more work in this area and is looking to undertake a Multi-Agency file audit focusing on Risk and Outcomes in 2015/16.

Way forward

- Making Safeguarding Personal is now no longer a project but is firmly embedded in the Care Act, and Slough's Safeguarding Adult's Board will be reviewing the impact of these changes throughout 2015/16 both within Safeguarding investigations but also within the work of partner agencies.
- The Board will be looking at the preventative work done by all agencies and to try and form closer working relationships i.e. Berkshire Fire Safety Checks and Housing/Adult Social Care.
- Slough Safeguarding Adult's Team will be focusing on the MSP tool kit to see what tools they can bring into practice to support people suffering from abuse and neglect.

Anthony Heselton - South Central Ambulance NHS Foundation Trust

1) Tell us about yourself and your role.

I'm Tony Heselton the Head of Safeguarding for South Central Ambulance service (SCAS). My role in SCAS is to ensure that we have safeguarding at the heart of our business and that our policies and procedures are relevant in all parts of 4.6 million square miles population of just over 4 million in the SCAS area.

2) Why is safeguarding important to you and what have you achieved?

Safeguarding is core in all of our daily work life. We come across some of the most vulnerable persons daily and frequently as they are the ones in most need of our service. The biggest achievement for SCAS over the last year is we are now vertical members of number of MASH and as such we are now contributing far more to safeguarding the most vulnerable of those million persons we cover. I now have a safeguarding manager who is responsible for the day to day running of the small but effective safeguarding team and this has improved our ability to support Local Authorities safeguarding teams across the Trust in any way needed.

During the end of last year we developed and delivered a train the trainer course for the Trusts education department which has now enabled level 2 children and safeguarding adults to be delivered face to face to all of our 4000 staff that needs it. This training will be rolled out during 2015.

3) What do you hope to achieve with Slough Safeguarding Adults Board in the future?

Raise awareness of the importance of safeguarding and the vital role the ambulance service play in this to all partner agencies

Utilise some of the good practises championed by the board like the SAR template

To be a useful partner in safeguarding sloughs vulnerable persons and bring good practise from other areas for the board to consider.

Strategic objective 4

All agencies will ensure that there is consistent compliance with the Mental Capacity Act, including Deprivation of Liberty Safeguards where relevant.

Mental Capacity Act

The Mental Capacity Act came into force in 2007 and sets out the processes by which an assessment of capacity must be undertaken to be legally valid. The associated code of practice sets out guidance for professionals who support people who lack capacity. The Mental Capacity Act also introduced the role of independent mental capacity advocates (IMCA).

In March 2014 the House of Lords post-legislative scrutiny committee met and reported on the implementation of the Mental Capacity Act. The committee found that the Act was held in high regard. However, its implementation had not met the expectations that it had raised. They found that the Act had suffered from a lack of awareness and a lack of understanding. They found that it had been seen as an add on and found that instead there still existed a culture of paternalism and risk aversion amongst professionals. They had many recommendations to make which including tasking local authorities and other organisations to make sure that the Act became embedded in practice. They also recommended that they set up a central body to manage this process and at the same times requested a review of the Deprivation of Liberty Safeguards.

What have we achieved?

Slough is part of the Berkshire Mental Capacity Implementation group which continues to meet on a quarterly basis to manage the implementation of the Mental Capacity Act, with specific relation to the Deprivation of Liberty Safeguards.

As a direct consequence of the House of Lords a new Mental Capacity Steering group has been set up and is hosted by the Clinical Commissioning group (CCG) looking at how the Mental Capacity Act can be further embedded into practice. The CCG had been successful in obtaining a grant from the government to provide training for health staff and the steering group will look at how to spend this money to provide the most effective training.

Over 2014/2015 Slough Borough Council has continued to provide training on the Mental Capacity Act and Deprivation of Liberty Safeguards in line with the Berkshire Training Strategy http://www.slough.gov.uk/council/strategies-plans-and-policies/slough-multi-agency-workforce-development-strategy.aspx.

We continue to hold an annual Deprivation of Liberty Briefing for Care Homes and other providers which also encompasses the Mental Capacity Act. In 2014 the event was held on 7th August 2015 and over 40 people attended, these included representatives from hospitals, care homes and care agencies within Slough.

A Mental Capacity Audit was undertaken by Slough Borough Council of cases held by Adult Social Care. A report on the findings of the Audit will be presented to the Safeguarding Board in June 2014. The findings will be taken into account when designing training plans for 2015/16.

Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards are part of the Mental Capacity Act and were added to the Act in 2009. Since their inception there have been concerns about how they have been implemented as this has varied widely around the country. When the impact of the Safeguards was first scoped it was thought that thousands of people in England and Wales would fall under this Act, however the reality was that only a very small of number of people were ever placed on a Deprivation of Liberty authorisation this was in part due to the lack of a definition for what constituted a deprivation but also due to the involving case law which had suggested that there was a very high threshold for what constituted a deprivation.

In 2009 it was also anticipated that the Deprivation of Liberty Safeguards would only apply to people over 18 years of age in Care Homes and Hospitals. In Slough there were only 28 people on a Deprivation of Liberty Authorisation in 2012/13. This was consistent with applications across the south east in relation to the number of people in care homes in those areas.

In March 2014 this all changed with two landmark cases from the Supreme Court:-

MIG and MEG (2010) EWHC 785 (Fam) Cheshire West and Chester Council v P (2011) EWCA Civ 1257

These cases provided what have now become known as the "acid test" which provides a much lower threshold of what constitutes a deprivation of. That is "someone free to leave" and are they "under constant supervision and control". This has led to a significant increase across the country in the number of successful authorisations under these safeguards.

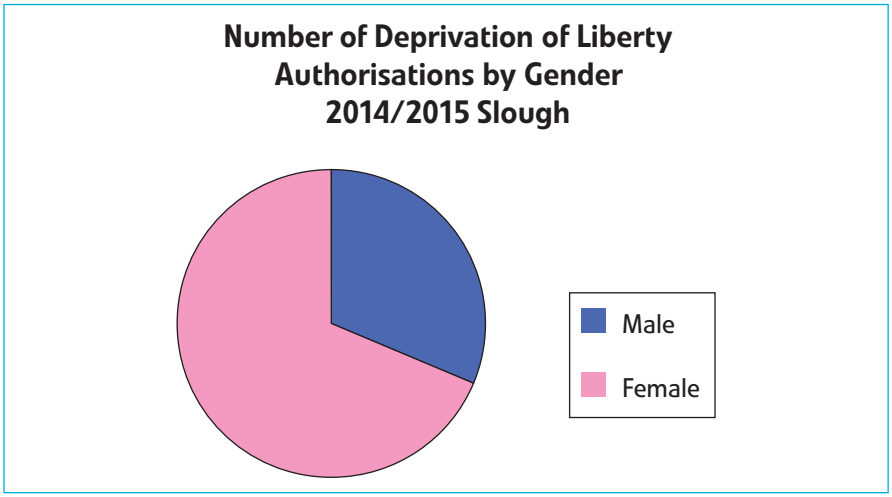
Deprivation of Liberty in Care Homes and Hospitals

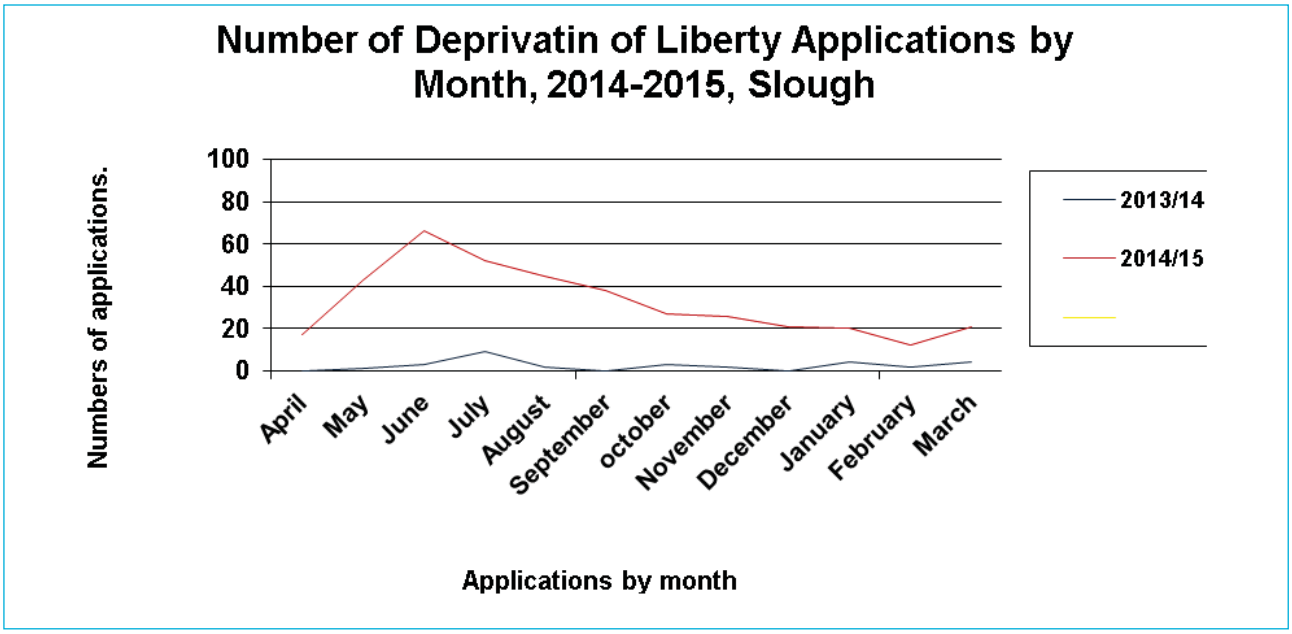
In January 2015 the Care Quality Commission produced its fifth report on the Deprivation of Liberty Safeguards. This report highlighted the impact of House of Lords post-legislative scrutiny committee report on the MCA and the Supreme Court Judgment on the number of Deprivation of Liberty Authorisations around the country which have increased from under 15,000 applications for the whole of 2013/14 to over 20,000 up to January 2015 which represents an eight fold increase. It is interesting to note that although all local authorities are reporting an increase some of these are at a much lower rate than others, still therefore illustrating a discrepancy in the way in which the legislation is implemented in each area. There appears to be no correlation between population numbers and the numbers of Deprivation of Liberty applications in an area.

What have we achieved?

The number of Deprivation of Liberty applications in Slough over the last twelve months is as follows:

Deprivation of Liberty Applications - Slough Borough Council 2014/5	
Number of standard applications received	320
Number of standard applications granted	213
Number of urgent applications	71
Number of urgent applications granted	45
Total number of applications received	391
Total number of applications granted	258
Average length of order	10 months





Case Study - Deprivation of Liberty Safeguards

Jane is a 45 year old Caribbean woman who has lived in care for most of her adult life. She has a learning disability and experiences mental health problems, schizophrenia she is also blind. She currently lives in a care home outside of Slough and has no contact from her family.

The Care Home manager was aware of that Jane lacks the mental capacity to make decisions around her care and treatment and that she would not be free to leave the care home and she is under continuous supervision and control. She therefore put in for an application for a Deprivation of Liberty Authorisation.

On receipt of the applicant the local authority appointed a Section 12 Doctor, IMCA (Independent Mental Capacity Advocate) and a Best Interest Assessor.

The IMCA's report stated that although they felt that the placement was in Jane's best interest they were concerned by the lack of activities that were on offer to Jane and felt that she needed more opportunities to engage with the community. This recommendation was then included in the Best Interest Assessors report and was put forward to the care home as part of the conditions of the order that the care home needed to comply with.

An authorisation was put in place for three months in order to enable the home to put the necessary changes in place. At the three month period it was clear that the home had put some changes in place but it was clear that Jane could still become more independent and therefore a further short order was put in place.

Jane remains under a Deprivation of Liberty Authorisation at the care home but there are plans to move Jane to supported living were it is hoped that she will have more independence.

The increase in requests for authorisations has had a major impact both in terms of finances and staff for the local authority. In Slough like other local authorities because of the low take up of the scheme in previous years there were only 10 people who were trained as Best Interest Assessors, many of these having other significant roles, which meant that there were not enough assessor around to meet the legal deadlines for authorisations. The impact on the budget was also significant, with an increase of over £70,000 over the original budget, which has had to come out of other funds. It is anticipated that if the numbers to continue as they are the budget for 2015/16 will be over £100,000, with some possible additional one off findings.

Deprivation of Liberty in the Community

In 2014 the courts also ruled that Deprivation of Liberty Safeguards should apply to people in their own homes and in supported living. In November 2014 the Court of Protection provided a system known as parte X process were applications could be made to the Court of Protection for people who were being deprived of their liberty in their own homes. It is obviously difficult to ascertain how many people are being deprived of their liberty in their own homes and one of the difficulties relates to the fact that the deprivation can only relate to people who are being deprived of their liberty by the state but what that means in practice is difficult to determine, as it could apply to people who have home care or those have district nurses etc.

What have we achieved?

In Slough like many local authorities we have started to apply for authorisations related to people living in supported living as these represent people who are being deprived of their liberty often with extensive control and supervision. These applications are currently being made to the Court of Protection and we are awaiting outcomes.

In 2014/15 we made one application to the Court of Protection for Deprivation of Liberty in the Community using the parte X process and we are still awaiting the outcome of this application. We anticipate in 2015/16 we will make around 40 applications using this process.

In order to help families with understanding what a Deprivation of Liberty is in the community, Slough Borough Council have devised a leaflet which is available on our website

Further information on Deprivation of Liberty Safeguards can be found on Slough Website. http://www.slough.gov.uk/council/strategies-plans-and-policies/deprivation-of-liberty-safeguards.aspx.

Way forward

In 2015/16 we anticipate a continued increase in the number of requests for Deprivation of Liberty Authorisations so we will as a Board is looking at how it can reassure itself that the Local Authority and its partner agencies are able to meet the increased needs. As well as looking across Berkshire at developing effective training in regard to both Deprivation of Liberty Safeguards and the Mental Capacity Act.

Slough Safeguarding Adult's Board Member Carol Clegg, Business Continuity and Response Manager (Slough Borough Council, Housing)

1) Tell us about yourself and your role.

I am Carol Clegg, Business Continuity and Response Manager. I have corporate responsibility for emergency planning and business continuity. I am based in the housing and neighbourhood services teams where I have responsibility for safeguarding lone workers in the team and safeguarding of the services' children and adults in need of care and support.

2) Why is safeguarding important to you and what have you achieved?

Part of my role as Business Continuity and Response Manager is to monitor the housing and neighbourhood services team's safeguarding of the services' children and adults in need of care and support. Customers of our services often have vulnerability issues and our frontline staff are in a position to identify people who need help.

I have acted as the lead officer in housing and neighbourhood services in raising awareness of the need to ensure that those in need of care and support are given the early attention required to help resolve their issues.

3) What do you hope to achieve with Slough Safeguarding Adults Board in the future?

Raise awareness of the importance of safeguarding with housing and neighbourhood service staff so they are aware of their responsibilities.

Monitor a programme of mandatory training for housing and neighbourhood service to include:

- *Safeguarding for children and adults*
- *Understanding mental capacity*
- *Domestic abuse*
- *Hoarding*
- *Self-neglect*

Ensure that with housing and neighbourhood service staff are aware of and able to recognise the unseen factors that might indicate that an individual is experiencing or vulnerable to abuse.

Develop and implement processes to safeguard the business and reputation of SBC as well as the wellbeing of the services' residents

Keep and monitor a Safeguarding Register detailing cases that have been referred to relevant safeguarding teams and in partnership with safeguarding teams - ensuring that they are appropriately followed up and actioned.

Strategic objective 5

All relevant staff have safeguarding appropriate training and the effectiveness of that training is evidenced. This will include learning from Serious Case Reviews.

Safeguarding Adults Training 2014-15

Safeguarding Adults training during 2014-15 included the following topics:

Safeguarding Adults Level 2 (Investigations & Assessments)

Member Development

Management of Challenging Behaviours/Positive Behaviour Support

Safeguarding Adults Level 1 Generic and Bespoke programmes

ELearning

Domestic Abuse | Parental Drug Misuse | Honour Based Violence Female Genital Mutilation

DOLs Forums

MARAC and DASH

Safe Moving of People

RIPfA Safeguarding Conferences

Loan Shark Awareness

Administration of Medication

Court of Protection

Safeguarding Seminars

Safeguarding Adults Level 3 (Designated Safeguarding Managers)

MCA/DoIs Introduction and MCA Practical Implications

Safeguarding Adults Minute Taking

What have we achieved?

1) **Safeguarding Adults Level 1: Generic training:**
All Safeguarding courses at Slough Borough Council follow the National Competency Framework for Safeguarding Adults[1]. SBC provided 9 generic sessions at Level 1 last year, which were aimed at all services, and not just those within adult social care.

   - 180 places offered with 153 places taken (85% attendance rate).

   Services attending generic training included children's services, CCTV control operators, customer services and more. Attendance from external services included many of the same provider services as in previous years, although there was attendance from some new organisations such as the Arts Class group for older people in Slough.

2) **Bespoke training:**
A total of 25 bespoke sessions were delivered, accessed by 271 people.

   The Bespoke safeguarding courses were accessed by 18 services, listed in Table 1, with 5 new services this year: Building Control, Property Services, and Unpaid Carer Groups, Martin Conway Bed and Breakfast and CID officers from Thames Valley Police.

3) **Safeguarding Adults Level 2:**
Safeguarding Adults Level 2 is targeted at social workers and similar qualified roles in health services that are required to investigate and risk assess safeguarding enquiries.

   - Two courses were needed at Foundation level, and 19 staff attended from both SBC and Berkshire Health Foundation Trust. The majority of these staff went on to the Safeguarding Rota.

[1] Bournemouth and Learn to Care production

4) **Safeguarding Adults Level 3:**
There was a need to increase the availability of Designated Safeguarding Managers at SBC.

- Eight staff were trained, which included our internal Provider Manager's.
- Safeguarding Adults Minute Taking
- Two refresher courses were required for staff within SBC and BHFT who carried out both a minute taking and SA administrative role.
- 20 staff attended training.

5) **Safeguarding Adults Member Development:**
14 Members attended refresher training this year. An eLearning programme for Members is also available.

6) **Additional training to support Safeguarding Adults (shown below).**

Course	Attendance
Administration of Medication	Attendance from both internal and external care services. 160 places offered with 92 places taken (58%)
Best Practice Seminars related to Safeguarding: Do Not Resuscitate Deprivation of Liberty Safeguards Update for Social Workers Forced Marriage Update Human Rights Assessment x 2 sessions No Resource to Public Funds	6 sessions, 113 adult social care staff attended:
Court of Protection	32 Social workers
Dols Provider Forum	15 Provider Managers and Health staff
Introduction to Dols (Deprivation of Liberty Safeguards)	2 courses offered to internal and external services. 28 people attended.
Introduction to Domestic Abuse	25 staff from Adults and Children's social care services
Introduction to the Mental Capacity Act (MCA)	2 courses offered to all, 32 people attended.
Loan Shark Awareness	4 staff from SBC Drug and Alcohol, Licensing and Adult Social Services, 1 external from Citizens Advice Bureau
MARAC and DASH	Attendance from adults and children's social services and Thames Valley Police. 32 places available. (complete attendance figures unavailable)
MCA - Practical Implications for Care Homes	24 people from internal and external services.
Positive Behaviours/Managing Challenging Behaviour	63 staff attended from internal provider services.
Safe Moving of Clients	Attendance from both internal and external care services. 156 places offered with 111 places taken (71%)

The following sessions led by Children's Social Care training were open to SBC adult services:

- Domestic Abuse and Violence: Honour based killing, FGM and Forced Marriage
- Advanced Domestic Abuse
- Parental Drug Misuse
- Honour Based Violence

Research in Practice for Adults (RIPfA)

Seven representatives from SBC attended the following RIPfA seminars, to share information with colleagues on the following topics:

- Supporting people who self-neglect research messages workshop
- Working preventatively in adult social care
- Putting people at the heart of services; making outcomes meaningful Partnership Conference

ELearning

Log on to care: Slough's usage of eLearning on Log on to Care more than doubled compared to the year before, from 633 completions in 2013-14 to 1826 in 2014-15. Courses in Log on to Care (www.logontocare.org.uk) are adult social care focused and range from Induction courses such as the Care Certificate, Dementia, Communication Skills, Loss and Bereavement, Mental Capacity Act, Parental Substance Misuse, Safeguarding and more.

Learning Pool: Learning Pool is an eLearning platform for internal staff. Last year 51 staff completed Safeguarding Adults eLearning training from across all council departments.

Additional eLearning courses are also available on learning pool, including the Mental Capacity Act, Deprivation of Liberty Safeguards, Carer Awareness and Autism Awareness.

Best Interest Assessors (BIA's)

To meet the DoIs requirements in 2014 SBC required an increase in the number of available BIA's. An additional 7 staff were trained during the year. There are plans for a further 13 staff to complete the qualification during 2015-16 in order to continue to meet the demand for DoIs applications and reviews.

Impact of Training and Workforce Development

There have been some examples of were training has made an impact on workforce development and the services provided. There are some examples of referrals made following training, for example, after briefing groups of unpaid carers, two alerts were raised, which were then investigated. It is not however, easy to determine the effectiveness of training and work will be done in 2015/16 to look at how we can evidence the impact of training in relation to concerns being raised and quality of investigations and outcomes for service users.

External care provider services

A survey was sent to external provider services requesting information about the impact of their workforce development activities. Six care homes responded.

"Staff have confidence in the raising and reporting of safeguarding. Staff are more confident and are challenging practices that they feel can lead to abuse or neglect"

"Knowledge of procedures has improved greatly and safeguarding is regularly discussed at team meetings and in supervision sessions. The low number of referrals seems to suggest that staff are preventing abuse and keeping people safe"

"Staff feel able to openly report any concerns to the manager they openly make suggestions for improvements. Staff are more aware how to record things factually and with detail"

Way forward

With Making Safeguarding Personal now a key theme for safeguarding within the Care Act, the social care workforce needs to continue reviewing their safeguarding work with the person as the centre of their work and the decisions that they make.

All development activities will need to have an emphasis on person centred working, and within SBC there needs to be a particular emphasis on joint training with children's services. Training themes for joint working are:

- Neglect
- Think Family
- Drug/Alcohol
- Forced Marriage/FGM/Honour Based Violence
- Independent Management Reviews
- All Safeguarding Adults courses will continue to incorporate the Care Act duties and new terminology. SA Level 2 training in SBC will include the Adult Social Care Risk Tool, and learning from Serious Case Reviews.
- Children's services will receive Mental Capacity Act and DoIs training
- The need for Best Interest Assessors will continue.
- Bespoke training will need to be driven and increased in particular to care provider services.

These themes will be explored by the East Berkshire Training subgroup and delivered during 2015/16.

Slough Safeguarding Adults Board Member Slough Clinical Commissioning Group Partner (CCG) Deputy Director of Nursing - Safeguarding and Infection Control

Why is safeguarding important to you?

The CCG are committed to protecting and safeguarding vulnerable people from abuse and harm and are committed to work in partnership to achieve this aim. The CCG is an active partner in the Slough Safeguarding Adult board.

The CCG has continued to work with its providers to enable it to undertake its responsibility for ensuring that the organisations from which they commission services provide a safe system that safeguards vulnerable adults. Slough CCG has done this through strengthening contractual requirements and working closely with the Safeguarding leads.

Development of the safeguarding dashboard in anticipation of the Care Act implementation has assisted in analysis of safeguarding activity and provider status of safeguarding adult assurance; particularly for training, DOLs, Mental Capacity Act training, prevent and alert notifications. This has resulted in increasing awareness of the need to detect abuse as early as possible and encourages multiagency collaboration.

Close liaison between the deputy director of nursing (safeguarding) and provider safeguarding leads has established specialised supervision pathways and support for innovation in safeguarding as a firm part of provider planning. Swift notifications and liaison regarding concerns between the CCG and providers have meant timely interventions to keep people safer.

Primary care has an increased awareness of adult safeguarding responsibilities which will be further supported 2015/16.

The continuing healthcare team has undertaken specialised prevent training and MCA training updates. The deputy director of nursing (safeguarding) offers safeguarding supervision on a regular basis which has resulted in more consideration of a potential safeguarding issue and resulting actions.

Successfully winning a bid for funds to develop an MCA train the trainers programme across Berkshire and a Berkshire wide MCA conference will further assist in awareness of adult safeguarding across the health economy.

What are your organisations planned development during 2014-2015?

- *New safeguarding lead to work with Deputy Director of Nursing (safeguarding) April 2015.*
- *Commitment to remain a key and active member of the board and appropriate subgroups.*
- *Chair the Safeguarding Adult Review Panel.*
- *Self-assessment tool adult safeguarding tool will be developed and rolled out to providers and analysed by the CCG safeguarding team for gap analysis/improvement planning.*
- *Led by the Deputy Director of Nursing, development of MCA train the trainers programme for health and social care providers; including ongoing support for the trainer pool.*
- *Working with West Berkshire CCG's plan and implement a MCA cross Berkshire conference.*
- *Ongoing monitoring of provider safeguarding activity at the CCG Quality Committee.*
- *Primary care safeguarding STEPs training with emphasis on the Care Act implications prevent training, MCA/DOLs and lessons from national and Berkshire serious case reviews.*

How will the success of the project or development be measured?

1. *Minutes of board minutes demonstrating active CCG involvement of board and sub committees.*
2. *Self-assessment will be rolled out to providers to complete as part of contracting arrangements and analysed for progress by the CCG*
3. *Two train the trainer courses will be rolled out and evaluated and a trainer pool will be established and reported to the Board.*
4. *A cross Berkshire MCA conference will be held and evaluation analysis presented to the Safeguarding Adult Board.*
5. *The CCG quality committee will continue to have safeguarding as a standing agenda item were provider safeguarding data and reports will be analysed.*
6. *Primary care safeguarding adult training assisted by partner agencies will be carried out, evaluated and reported to the Board.*

Strategic objective 6

The Board will promote safeguarding messages and public awareness with regard to preventing abuse and how to report abuse.

Slough's Safeguarding Adult's Board is aware of the importance of raising awareness around safeguarding both amongst professionals and members of the public and in order to facilitate this the board has established a subgroup of the board, "Communication Subgroup" whose function is to develop a communication strategy for the board.

The Communication Subgroup is made up of staff from the various partner agencies that have a communication function within their organisation. The partners currently taking part in the subgroup are as follows:

- Slough Borough Council
- Thames Valley Police
- Women's Aid
- Voluntary Sector

There are now terms of reference for the subgroup which are available on the Board's website page. The group has met twice since being formed and it is planned that the group will meet four times a year, to coincide with the work of the board.

What have we achieved?

The first piece of work that the subgroup carried out was to ensure that all leaflets and material produced by the board was available on the website and that the website was updated. This was to ensure that all the current contact numbers were on the leaflets and that the material was compliant with the Care Act 2014.

One area of work that the group was particularly concerned about came out of a recent Serious Case Review in Mid Sussex, "Orchid View". The board wanted to re assure itself that public and professionals in Slough were aware of how to report concerns about both poor practice and abuse. It was agreed that one way to do this was by raising awareness. The Communications subgroup was tasked into looking into how this could be achieved.

The group met and looked at how they could raise awareness and agreed that a new leaflet needed to be developed to give to service users and their families when they were looking to receive care either at home, or in a care home. Slough Borough Council had already got a leaflet entitled "What good care looks like" and it was decided to refresh this leaflet and then use this as a starting point for a local campaign. Due to the implementation of the Care Act the production of the leaflet had to be delayed to ensure that it was compliant with the requirements of the Care Act and it is hoped that this will be ready to be launched by December 2015.

Outside of the work of the Communications subgroup the Adult Safeguarding Team within Slough Borough Council, organised events to mark "World Elder Abuse Day" on 15.6.2015. Their event focused on raising awareness of abuse and neglect within care homes in the area. Each care home within Slough was issued with a pack of information and leaflets so that they could set up display boards within their care homes and provide leaflets to residents and family members. This event was a great success and one home even managed to have cakes and balloons.

"World Elder Abuse Awareness Day" is now an international event and is marked around the world. The event is organised and co-ordinated through Action on Elder Abuse who are a charity who have been instrumental in raising issues around abuse of vulnerable adults, in particular older people for many years and this event has now grown in stature is celebrated around the world.

With the introduction of the Care Act the Board produced a Fact Sheet on the impact of the Care Act on the role of the Safeguarding Board and Safeguarding which was shared with all partner agencies and all service providers within Slough, to ensure that everyone was now aware of the new statutory responsibilities around Adult Safeguarding in particular the new duty to make enquiries and the new roles of the Safeguarding Adults Board.

Way forward

To widen the membership of the Communication subgroup

- To develop a communication strategy
- To complete the campaign about encouraging people to report poor care and abuse using the newly designed leaflet.

Slough Safeguarding Adults Board Member Helen Buckland - Safeguarding Co-ordinator Slough Borough Council Safeguarding Team

1) Tell us about yourself and your role

I originally trained as a learning disability nurse and then moved on to manage services for people who have learning disabilities, both as a registered manager and a service manager. I have worked for SBC for 5 years as Safeguarding Co-ordinator. My role was initially to work with external providers to increase their knowledge and practice around safeguarding issues. Over the time that I have been in this role, it has diversified significantly. I still work with providers; I provide training on safeguarding and associated issues to a wide range of agencies; I give advice to colleagues both internally and externally on safeguarding and preventative measures; I attend a variety of multi-agency meetings to give advice; I have supported a Peer Review of Safeguarding arrangements as well as three Safeguarding Adult Reviews; I am also a Best Interest Assessor.

2) Why is safeguarding important to you and what have you achieved?

I believe that everyone has the right to live a life safely and free of fear. I also firmly believe in "doing the right thing" and ensuring that as professionals that is what we do. I enjoy watching a multi-agency response in action, with each agency playing its' part in supporting someone to live their lives safely, and one of my favourite parts of my role is to encourage multi-agency working and communication. I particularly enjoy working in Slough as it is a diverse area with a range of issues, and its' small geographical area means that you can build really effective working relationships with other agencies.

3) What do you hope to achieve with Slough Safeguarding Adults Board in the future?

I would like to see the multi-agency working arrangements strengthened even further, and I feel that we have a good base for this already. I am keen to see processes in place via the board for addressing some of the newer areas covered in the Care Act, such as Domestic Abuse and Self-neglect, and effective responses to the recommendations from Safeguarding Adults Reviews.

Strategic objective 7

Governance arrangements are in place to ensure that the quality of services is thorough and effective.

The monitoring of the quality and safety of Care services (both residential and home care providers) within Slough is undertaken by a range of agencies including the Care Quality Commission, contract and commissioning teams from Local Authorities and Clinical Commissioning Group who contract with these providers. In order to pull this work together Slough has a Care Governance Board which ensures that these agencies share any concerns and good practice. The governance framework for monitoring the quality of commissioned and contracted services was reviewed during 2014/15 and proposals for future monitoring activity arrangements to be undertaken by Care Group Commissioning and Contracts Team staff considered at the Care Governance Board. The new framework provides a range of quality monitoring recording tools that can be used during monitoring and sets out the framework of planned and reactive measures to monitor and report on the quality of service provision from contracted providers.

What have we achieved?

During the year, planned onsite monitoring visits have taken place with contracted providers and annual contract monitoring meetings have been held. Reactive onsite visits and contract review meetings are also undertaken where information has been passed from safeguarding or social work teams which indicate that there may be contractual compliance, safeguarding or quality concerns.

The highlight reports from concerns raised, quality monitoring visits and contract review meetings held throughout the year are discussed at monthly Care Governance Board meetings and services allocated to either Green, Amber or Red status. Amber and Red status providers concerns are reported to internal team managers for circulation to team members and reported externally to other Berkshire area commissioning or contracting teams.

- Green status represents organisations with no significant concerns raised and no restrictions on the commissioning of placements.
- Amber status represents that concerns raised warranted increased monitoring until action plans to resolve issues have been addressed and placements made with caution or restricted numbers of placements to be authorised, and
- Red status represents providers were there have been serious concerns raised and have been embargoed until such time as the concerns have been addressed.

The status of providers is reviewed monthly at Care Governance Board Meetings.

Concerns have been identified in relation to a range of matters including but not limited to:

- Poor staff practice and response times
- Staff understanding of the principles of the Mental Capacity Act 2005
- Deprivation of Liberties and Safeguarding concerns
- Staffing ratios

- Building compliance issues
- Safe storage and administration of medicines
- Risk assessments and falls prevention
- Tissue viability and weight monitoring
- Business continuity issues
- Financial processes

During the year April 14 to March 15 the following number of planned visits, unplanned visits and contract review meetings were held with contracted providers.

	Planned Visits	Reactive Visits	Contract Review Meetings
Residential and Nursing Home Providers	12	88	
Supported Living Providers	10		3
Domiciliary Care Providers	49	5	6

At the end of 2014/15 a total of 9 providers (6 domiciliary care and 2 residential and nursing home providers) have been permanently removed from the list of authorised providers and the following number of providers are on Amber or Red status at the end of March 2015.

	AMBER	RED
Residential and Nursing Home Providers	3	1
Supported Living Providers	0	1
Domiciliary Care Providers	1	0

Contract monitoring visits continue to be provided to monitor the progress of service improvement action plans.

Commissioning and Contracts staff have worked in conjunction with representatives of the Procurement Team to procure supporting services to allow the Council to meet its duties to provide Direct Payments under the Care Act 2015. Such services include, Independent Financial Advice, Advocacy, Personal Assistant Register and Matching Service, Prepayment Cards, Payroll and Managed Account services.

Way forward

The Contracts Team is required to carry out procurement, contract management and quality monitoring functions. Allocated staffing roles and responsibilities are being considered under the current Care Group Commissioning and Contracts Team review. The functions of staff will be defined and the teams will be reconfigured to ensure adequate resources are available. This may include the use of temporary secondments to meet peak activity alongside core team staffing arrangements.

A number of frameworks used by contracting and commissioning will expire in 2015/16 and arrangements are required to re-procure services using methods appropriate to the new public procurement regulations that came into effect on 26th February 2015. This exercise will provide an opportunity to review existing procurement and commissioning methods as well as introducing more flexible procurement systems that enable the Market Shaping required under The Care Act 2015 and underpin Market Failure strategies.

As departmental strategies to increase the use of supported living rather than residential care placements are implemented, there is an identified need for formal monitoring processes to be extended to include the growing number of supported living providers within the area. Similarly with the strategies to move from traditional day care to more flexible day opportunities a range of new providers will be entering the local marketplace.

In response, Care Group Commissioning and Contract Team staff will be jointly developing new purchasing systems with the Procurement Team that provide more flexibility and allow an extended range of services and providers to become authorised suppliers throughout the year and enable the quality of providers to be assessed through a formal process.

Slough Safeguarding Adults Board Member Malcolm Rigg - Health watch

My role

My role is solely to represent patient and public safeguarding on the board. This includes highlighting aspects of safeguarding that appear to be inadequate. Another dimension to be a critical friend. All board members are of course concerned about the public and patients but they are also responsible and accountable for policy and delivery.

Why safeguarding is important to me and what have I achieved?

The scale of abuse appears to be rising in the UK which makes it all the more important to detect signs of problems. I now have a better holistic understanding of safeguarding and how to engage more effectively with those responsible for addressing safeguarding.

Strategic objective 8

There will be a clear understanding about the scope of safeguarding activity and agency responsibilities specific to Slough's diverse population and demographic.

Slough Local Context

Slough is a predominantly urban area situated in the east of Berkshire which developed as a result of the Old London Road (now the A4), connecting Bath to London. The town now straddles the Great West Road and the Great Western Mainline, 35 kilometres (22 miles), west of Central London and covers an area of 32.5 square kilometres (or 12.6 square miles).

From the Census 2011, Slough is estimated to have a total population estimate of 140, 2003, an increase of 17.7% from 2001 (the population of Slough was 119,070). At the time of the 2001 Census, the borough area was the most ethnically diverse local authority area outside of London in the United Kingdom, with the highest proportion of religious adherents in England.

Gender is split evenly between men and women (50%). The borough has a younger than average population structure, with the highest proportion of 0-4 year olds, 5-9 year olds, 30-34 and 35-39 year olds amongst any of the South East local authorities.

As a result of having a smaller older population in comparison to our neighbouring authorities this has resulted in there only being a few care homes within Slough which affects the number of safeguarding referrals that we have regarding abuse in care homes and also explains why we have very few large scale investigations in comparison to our neighbours.

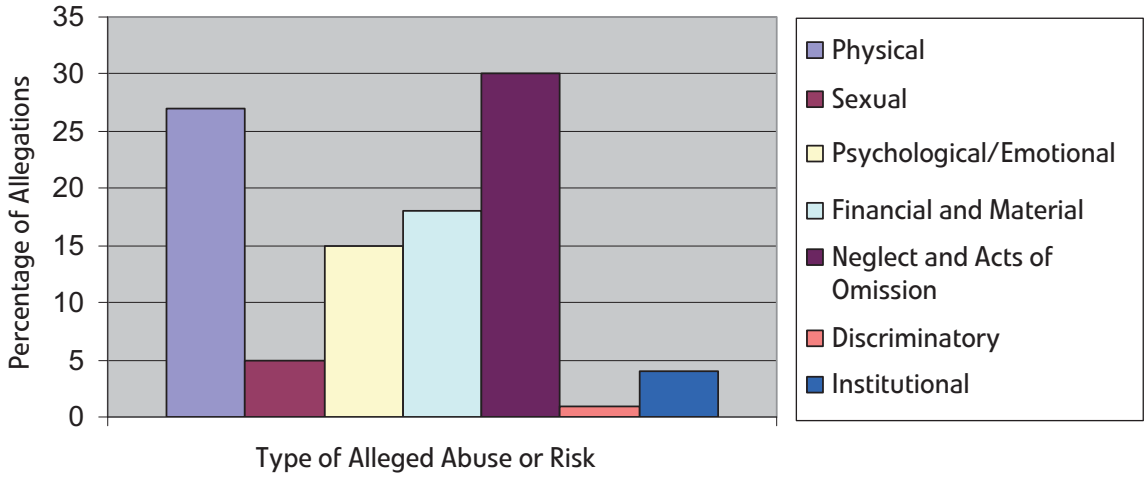
Safeguarding Performance Data

Slough Borough Council maintains a Safeguarding Database which records all the Safeguarding Activity regarding Adults in Slough. This database is used to provide statistical information for the Health and Social Care Information Centre as well as providing the Safeguarding Adult's Board with information to use to inform their work.

National Comparison

Every year each local authority has to provide data relating to Adult Safeguarding to the Health and Social Care Information Centre (HSCIC) and they then produce a report which attempts to make comparisons across the country regarding safeguarding activity. In March 2014 the HSCIC produced key findings from the Abuse of Vulnerable Adults data collection for the period 1 April 2013 to 31 March 2014 this is a comprehensive national analysis of adult safeguarding based on returns from 152 councils. This is the latest set of data that is currently available we are still awaiting the publication of 2014/15 data.

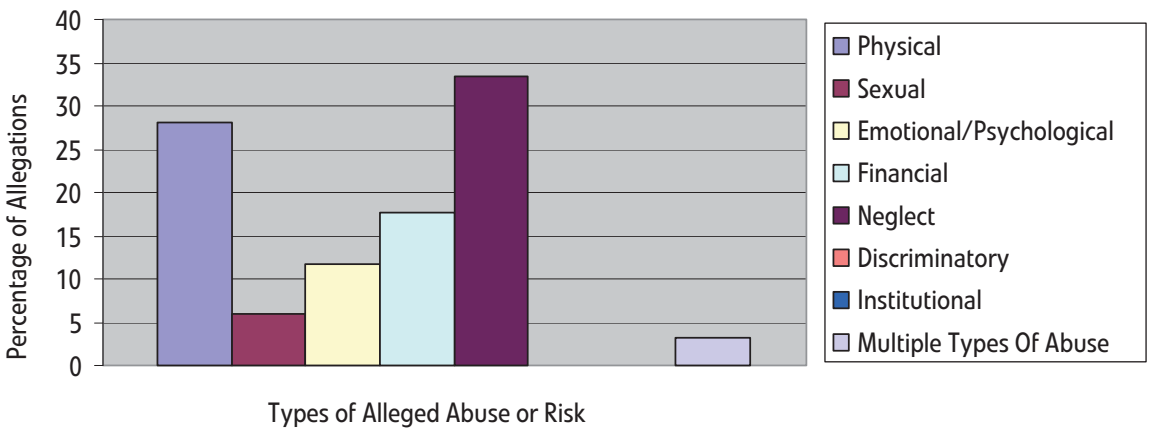
Percentage distribution of allegations by type of risk, 2013-14 England



The headline information from that report is used here to assess how Slough compares with the wider national picture for the same period. Using the same national baseline we can compare our 2014-15 data to see how trends are developing in Slough.

The national figures published for 2013-14 are almost identical to those published in 2013-14. The table below outlines the proportions of alleged abuse reported nationally during 2013-14 and in Slough during 2013-14 and 2014-15:

Percentage distribution of allegations by type of risk, 2014-2015 Slough



Slough's statistics appear in relation to types of abuse appear to mirror the national picture. In Slough we have around 400 allegations of abuse reported to the Safeguarding Team. The one area that appears to be slightly different relates to institutional abuse which is relatively low nationally but lower in Slough, this may relate to the fact that we have very few care homes in Slough in comparison to other authorities.

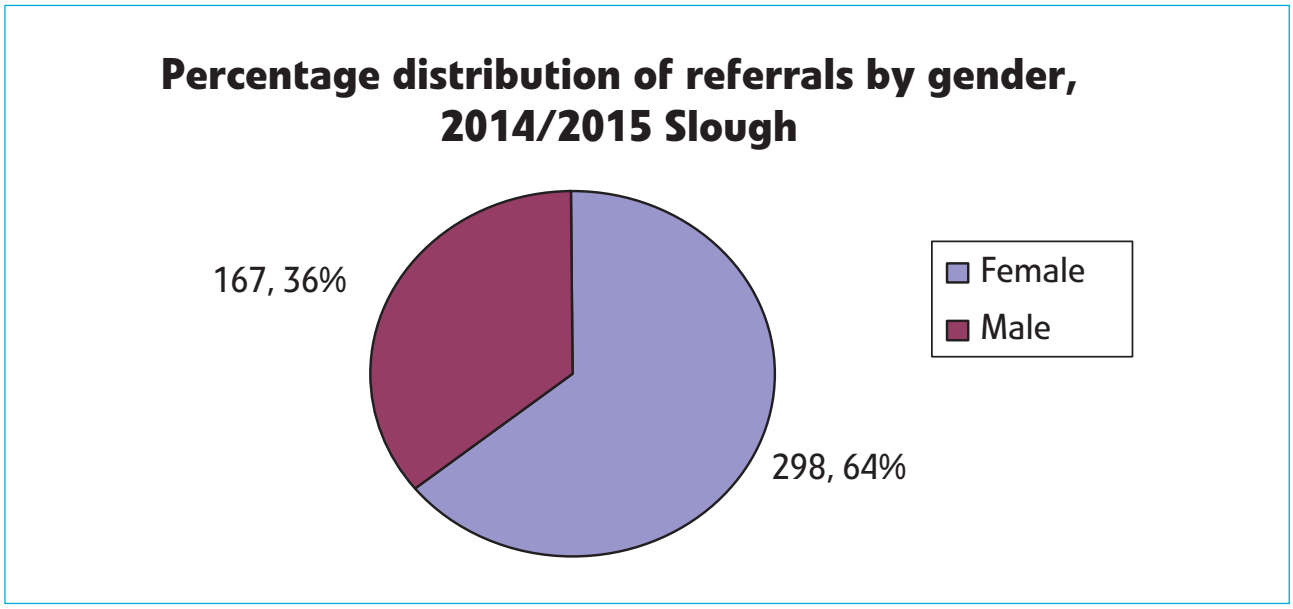
In regard to the alleged victim of adult safeguarding the national figures break down as follows:

Nationally it is reported that females are more likely to have a safeguarding referral than males, with 285 and 204 individuals per 100,000 populations respectively. This compares to Slough where there were 2014/15 Female - 298, 64% and Male - 167, 36%.

Nationally 51% of safeguarding referrals were for adults with a physical disability, frail or temporary illness. In Slough for 2014/15 the figure is 42%

Nationally 24% of safeguarding referrals were for adults with a mental health diagnosis. In Slough for 2014/15 the figure is 30%

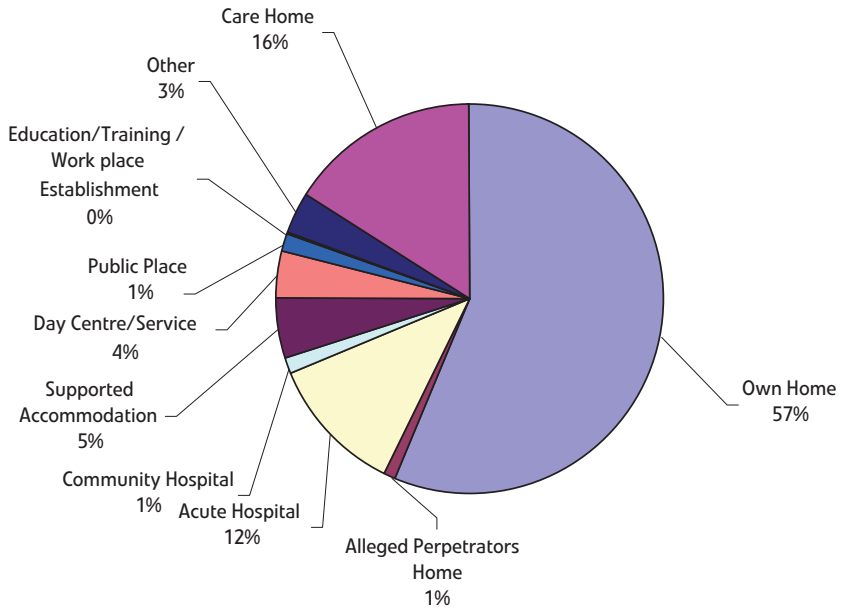
Nationally 18% of safeguarding referrals were for adults with a learning disability. In Slough for 2014/15 the figure is 15%. Nationally 1% of safeguarding referrals were for adults with a substance misuse. In Slough for 2015/16 the figure is 1%.So again there is a similar picture in Slough to the national picture.



Location of abuse

In regard to the location of abuse it was found nationally that 42% were abused in their own homes, 36% in care homes, 6% in hospitals, 5% in community services and 11% in other settings. In Slough we had the following figures for 2014/15:

Percentage distribution of allegations by location of abuse, 2014-2015 Slough

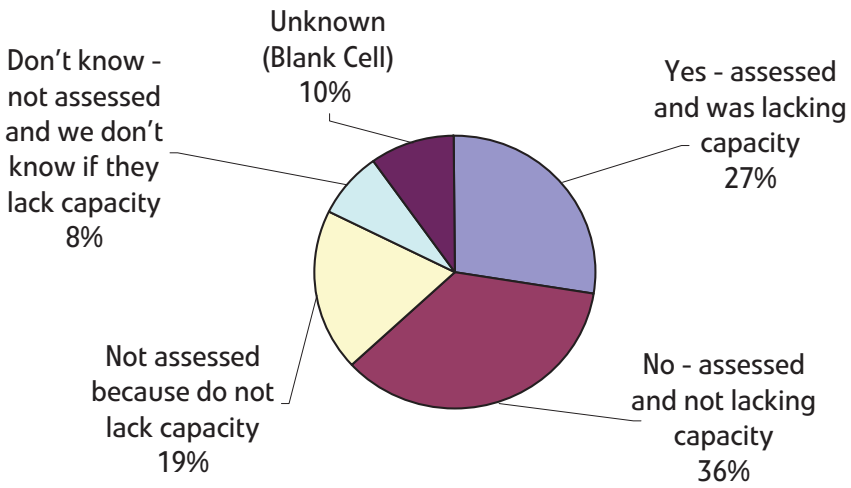


So in Slough as nationally the most likely setting for abuse to take place is in a person's own home. Isolation and social exclusion have been identified as risk factors for abuse. What is interesting perhaps is that there's still thought to be a massive under reporting of abuse and as people are more likely to be abused in their own homes it is interesting that although people are isolated in their homes that these cases still manage to get reported which suggests that there are many people out there who are being abused in their own homes that we never hear about. What is also reassuring is that although we have had some high profile cases of abuse in care homes that actually abuse in care settings is much less than being at home so it is a relatively safe environment. In Slough we work with our contracts and commissioning team to ensure that our providers are supported to provide safe and good quality care for our service users.

Mental Capacity

One new area that was reported on last year was mental capacity and how this related to safeguarding. Research has shown, such as that carried out by Action on Elder Abuse that those people who lack mental capacity in protecting themselves are more likely to be abused than those people who have the mental capacity to protect themselves. Therefore it is interesting to look at the first tranche of statistics on this subject. The HSCIC data set looks at the mental capacity of those involved in cases which went through the whole safeguarding process. This shows that 28% of people who were abused lacked mental capacity, 44% had capacity and more worryingly 29% it was not known whether someone had capacity. There are no national figures to use to compare Slough with at present.

Percentage distribution of cases were mental capacity was assessed, 2014-2015 Slough

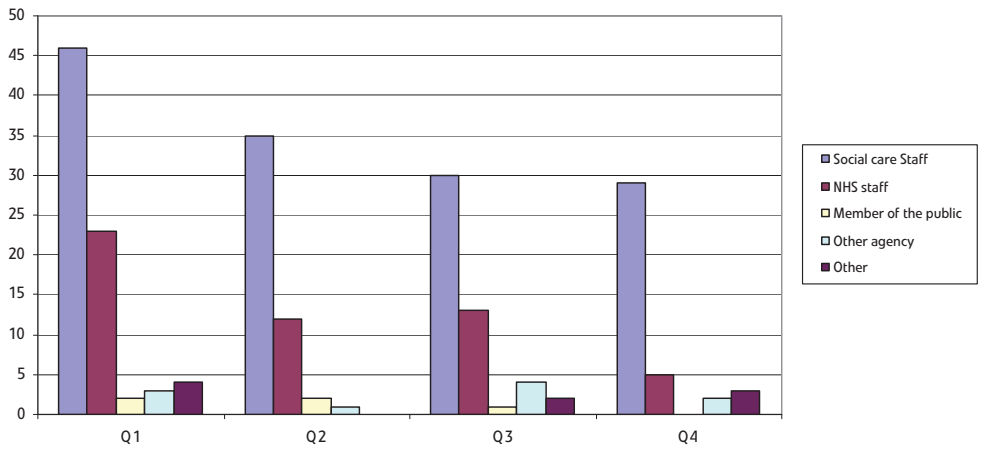


In Slough the following figures were recorded:

Referral Source

A lot of work has been done in Slough in regard to making sure that staff in various partner agencies are trained in Safeguarding so that they know how to make referrals. As well as formal training a newsletter is circulated internally to all social care staff to assist to keep up to date with regard to safeguarding and the changes. A guidance sheet was sent out earlier this year prior to the Care Act informing our partner agencies of the new categories of abuse and the new responsibilities both on the local authority and partner agencies regarding safeguarding and this was circulated to staff within those agencies. It is therefore anticipated that this should increase the number of referrals from different agencies.

Percentage distribution of allegations by referral source, 2014-15



Ethnicity of victim of abuse

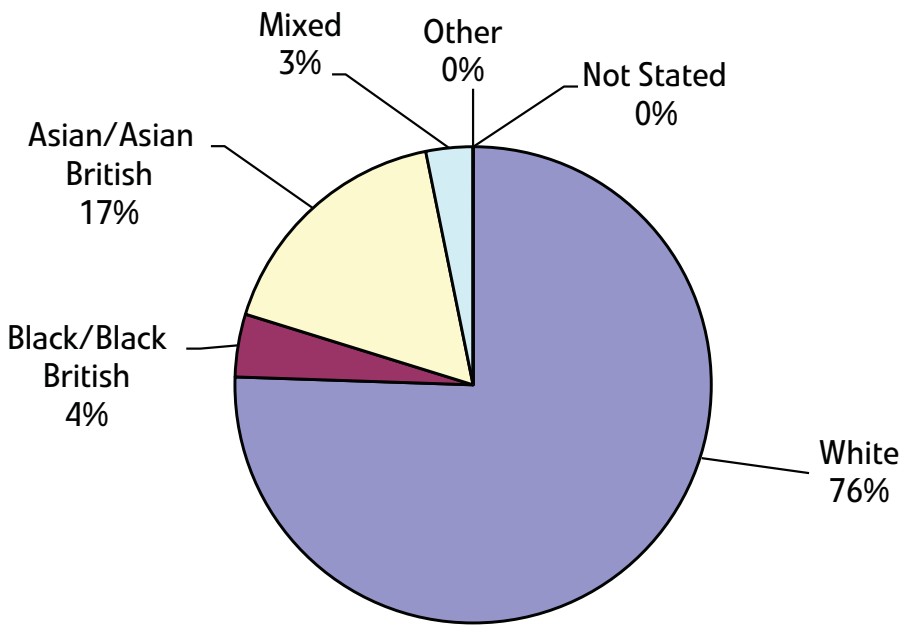
When looking at the ethnicity of alleged victims both nationally and locally, there is an obvious gap between national and local figures:

- Nationally 85% of alleged victims were white, in Slough for 2014/15 the figure is 72% Nationally this in not broken down into different white groups, but in Slough we have a high number of referrals from the Polish community.
- Nationally 1% of alleged victims were from mixed ethnic minority groups, 3% from Asian groups 3% from Black Caribbean groups; in Slough for 2014/15 the figures are 22%. Slough does however have a higher than average population of residents from ethnic minority groups compared to the number of people referred to Adult Safeguarding.
- In Slough 3% of alleged victims declined to state their ethnicity.

The figures for Slough in 2014-15 show no variation to those for 2012-13. The engagement of minority communities in safeguarding is a national issue, not one that is specific to Slough; however local work is being planned to engage minority ethnic groups in a whole range of Adult Social Care work not just in Safeguarding.

Slough is unique in not having one dominate ethnic group and has a translate population due to being so close to London and having two major airports nearby. This creates interesting issues within Safeguarding particularly regarding working with families and the communities themselves.

Percentage distribution of allegations by ethnicity of abuse, 2014-15 Slough



Way forward

1) The board is always concerned about the source of referrals and has focused its attention on this area at several board meetings, in particular trying to understand why there is a large number of referrals from social care staff compared to other staff groups. One reason for this is that the referral may have been made to the social care member of staff but as they are putting it on the system then they made record it as coming from social care staff. But clearly this is not the reason for the low referrals from some groups and work will need to be done to try and re assure the board that all agencies are aware of how to report and this may be a task for the communication group in conjunction with the performance subgroup.
2) The Board wants to engage with different ethnic groups and this has always been an issue for the Adult Safeguarding board not only in Slough but across the country, various different methods have been tried in the past with little evidence of success. Due to the complexity and the different ways in which different communities operate there is not one size fits all solution to this problem. The communications subgroups have started to look at this issue and will hope to start to look at how to address these issues over the coming year.
3) The Board will be monitoring how the new categories of abuse and the new wider definition of abuse will affect the people who report abuse to adult safeguarding. One area of work that the board is looking at is how we may have to deal with more people with substance misuse under safeguarding particularly in the area of self-neglect and how this will be dealt with through community teams.

Slough Safeguarding Adults Board Member David Philips - Head of prevention and protection Berkshire Fire and Rescue Service

I am the head of prevention and protection for Royal Berkshire Fire and Rescue Service. Responding to incidents of fire or other emergencies such as road traffic collisions remains a very important part of the fire and rescue service's work. However the service has transformed itself, placing prevention and protection as its primary consideration. Fire-fighters and specialist staff now perform a wider range of educational, technical and regulatory roles than ever before. The fire and rescue service is also having a much greater impact on wider social outcomes, such as anti-social behaviour, health and wellbeing and community cohesion. Building upon our popularity with the public and particularly young people, we've been able to help partners in meeting their aims which also results in us achieving our own

RBFRS carries out activities such home fire safety checks for residents who are deemed to be most at risk of experiencing a fire in the home. The visit includes the provision of advice on how prevent fires occurring, the installation of smoke alarms and guidance on how to escape if a fire actually occurred. Whilst in the home RBFRS staff are able to identify additional risk factors and have an impact on the wider health and wellbeing of vulnerable people in our communities by for example referring residents for falls prevention advice. At political level, we are also lobbying hard on the issue of domestic sprinkler systems and sprinkler systems for care homes

RBFRS uses predictive geographical data to target its work in areas where residents may be at greater risk from fire. However in order to continuously improve the impact of its work, RBFRS is working with partners whose staff also visit people in their homes in order to raise awareness of the home fire risk check offer to increase the number of referrals received for the home fie safety check to be provided for those most in need. RBFRS staff are working with

partners through the work of the safeguarding adult partnership board to further develop its work to support the 'make every visit count' approach, to reinforce a robust programme of joint social intervention and safeguarding of vulnerable individuals.

Strategic objective 9

The Board will ensure that the safeguarding elements of the Care Act 2014 are fully implemented.

The Care Act 2014 (implemented 2015) makes radical changes to Adult Safeguarding particularly in relation to the way in which Safeguarding investigations are carried out and to the work of the board. In order to ensure the implementation of these new requirements Slough's Safeguarding Adult's Board directed the Safeguarding Adults Manager to develop a Care Act implementation plan in relation to Adult Safeguarding.

The Care Act has a specific section relating to Adult Safeguarding, chapter 14,which looks at ten areas relating to safeguarding and these are listed below:

1. **Overall safeguarding issues**
2. **Information sharing**
3. **Policies and Procedures**
4. **Advocacy**
5. **Abuse in Provider settings**
6. **Information and record keeping**
7. **Roles and Responsibilities**
8. **Recruitment and training of staff and volunteers**
9. **Setting up of Safeguarding Board**
10. **Communication of Care Act changes**

Each of the above areas have been worked on by the Board and the Safeguarding Adults Team, as the Act is still relatively new some of these areas are still in progress and should be completed within the 2015/16.

What have we achieved?

1) Overall Safeguarding Issues

This area is broken down into several areas including ensuring that staff in all agencies are aware of their roles within Safeguarding and this is embedded in the Local Berkshire Safeguarding Adults Policies and Procedures which makes clear that Safeguarding is everyone's business and also outlines the roles of agencies and their staff within safeguarding.

This part of the Act also states which agencies are mandatory members of safeguarding boards including Local Authority, Police and Health, but it also recommends other agencies such as fire, ambulance, housing, voluntary sector and the private sector etc. The Act also suggests that the Board needs to have the involvement of service users and carers and this is something that the Board in Slough is very keen to progress on and will be looking at this further in 2015/16.

The Act also suggests that the remit of Adult Safeguarding is far wider than just those who are being abused but should include looking at developing the local community in order to make people feel safer and increase social inclusion. This is an area that the Board again will be focusing on in 2015/16 with its partner agencies and other Boards in Slough such as the "Wellbeing Board" and "Safer Slough Partnership".

2) Information Sharing

As part of Berkshire, Slough has signed up to the Berkshire Safeguarding Adults Policy and Procedures these cover all the six unitary authorities. There is one policy and procedure for Adults and one for children. As part of the Adult Safeguarding policy there is an information sharing protocol which relates to adult safeguarding and it is in operation across the whole of Berkshire which is particularly useful for those agencies that go across council boundaries, such as the Thames Valley Police etc.

These policies are in the process of being updated and as part of this update the information sharing protocol will be updated. Once the policy and procedures have been updated they will be taken to the Slough Safeguarding Adults Board for sign off in September 2015.

3) **Policy and Procedures**
As mentioned in section 2 above, Slough has signed up to the Berkshire Safeguarding Policy and Procedures and these are currently being updated. At the same time each local authority has its own internal procedures which provide more detailed advice to staff on how to carry out investigations etc. In Slough these are stored on our intranet and accessible by all staff. These have been updated in line with the Care Act as has the data recording system that is used by Slough Adult Care staff. These changes were ratified by the Adult Safeguarding Board in March 2015.

4) **Advocacy**
Advocacy is central to the Care Act and the requirement for the local authority and its partner agencies to provide access to advocates is a core requirement of the Care Act. In Slough we already have advocates available to people accessing Social Care, this includes safeguarding investigations. At present there is a very low take up of this service and this might be because the service is not well prompted or easily accessible to service users and staff. A working group has been set up to look at re commissioning the advocacy service to make sure it is fit for purpose and Safeguarding is integral to their delivery. The outcome of this group will be reported in 2015/16.

5) **Abuse in Provider settings**
In Slough there is a Care Governance group which is made of health, social care inspectorate. The group meets on a 6 weekly basis and looks at the quality and safety of services within Slough, particularly focusing on care homes and home care agencies.

6) **Information sharing and record keeping**
The Care Act is clear that staff in all agencies need to be aware of the requirements around record keeping and information sharing. As mentioned above we have a Berkshire wide information sharing protocol which all staff is made of aware of during either their induction or training.

The Care Act makes a requirement of local authorities and partner agencies to provide information to the public and this is includes Safeguarding The Safeguarding team in Slough Borough Council have developed a range of leaflets which area available to the public in hard format as well as available on line from the Safeguarding internet web pages. These leaflets include:

- Safeguarding Adults from abuse and neglect
- What are the Deprivation of Liberty Safeguards?
- What is safeguarding adults?
- What is the Mental Capacity Act?
- Don't suffer in Silence

We also have a range of contacts such as Action on Elder Abuse and Age Concern phone numbers and web contacts on our web page which provide further advice re adult safeguarding.

7) **Roles and Responsibilities**

The Care Act makes it clear that each agency should have clearly prescribed roles in relation to Adult Safeguarding. In order to ensure that this is happening within Adult Social Care the internal Safeguarding procedures have been updated and are now in line with the Care Act. A new section on supervision has been added to ensure that when people have supervision that any safeguarding cases are now formally recorded and discussed.

8) **Recruitment and Training of staff and volunteers**
Slough has signed up to the Berkshire Training strategy which sets out levels of training for all staff groups, in line with the training levels from the "Bournemouth competencies". This lays down what training each staff group should have and how frequently the training should be repeated. All board members have agreed that their staff will be trained in line with the strategy.

9) **Each Local Authority MUST set up a Safeguarding Adults Board (SAB)**
Slough like many authorities has had a Safeguarding Board in place for many years and the board had decided to use the Care Act as a way to refresh its membership to ensure that all the key players are part of the board and at the right level in their agencies.

The Board decided to update the terms of reference relating to the Board and its role in line with the Care Act and these have been ratified by their Board and are available on the website www.slough.gov.uk/council/strategies-plans-and-policies/slough-safeguarding-adults-board.aspx.

10) **Communication of the Care Act and changes in relation to Safeguarding**
Although the Care Act won't formally come into place until April 2015, the Safeguarding Adults Board decided that it was essential that agencies working in Slough with vulnerable adults were aware of the Act prior to implementation so that they could prepare for the Act.

The Safeguarding Adults Team devised a briefing for Board members to disseminate to their staff outlining the major changes in relation to Adult Safeguarding and their responsibilities. This went out to all members in January 2015 and was discussed at the March 2014 Board.

At the same time as communicating with partners the Board recognised the importance of informing the public around the changes to the Care Act. Though there will be a National launch of the Care Act with its associated publicising in the next financial year. The Board decided to update all its publications in relation to Adult Safeguarding and to task the Communications subgroup with looking at how best to disseminate this information to the vulnerable adults within Slough.

This is obviously an area which will be picked up and developed further in the next financial year.

Way forward

The Board recognised that although a lot of hard work had gone into making the Board and the Safeguarding Services in Slough Care Act compliant there is still work to do to enable the Board to meet all the objectives of the Care Act. Some of the areas that the Board will be focusing on in 2015/16 are as follows:

- Developing the relationship between Adult Safeguarding and other areas of work within Slough.
- Widening the membership of the Safeguarding Board to include representatives from service users and their carers.
- To look at how the Board is holding members to account and looking at more examples of collaborative working.
- Looking at how to most effectively spread the message regarding safeguarding to the communities within Slough.
- Looking at moving away from a paternalistic approach in regard to safeguarding to one which is person centred and enables the person to safeguard themselves with the support of agencies.

Slough Safeguarding Adults Board Member Simon Broad - Head of Safeguarding and Learning Disabilities, Slough Borough Council Safeguarding Team

1. Tell us about yourself and your role.

My name is Simon Broad and I am employed by Slough Borough Council as the Head of Safeguarding and Learning Disabilities. My role is to be part of a team that makes sure that safeguarding arrangements in Slough are thorough and understood by people who live and work in Slough. I started work in Adult Social Care in 1989 as a day centre worker for people with learning disabilities. During that time I witnessed verbal abuse being directed at some people with learning disabilities and that had a lasting effect on the sense of unfairness within society and strengthened my determination to challenge these prejudices and abuses.

2) Why is safeguarding important to you and what have you achieved?

Safeguarding is important to me as I believe that no person should be subject to abuse or poor care as a result of their vulnerabilities. Some abuse is deliberate and I make sure that the Council works hard with the Police and other partner agencies to respond appropriately when this has been disclosed or noticed. This could mean seeking convictions through the courts when a crime has been committed or where abuse is not deliberate making sure that staff are trained properly and treat people with dignity and respect.

3) What do you hope to achieve with Slough Safeguarding Adults Board in the future?

I would like the Board to be passionate about safeguarding and be effective leaders in ensuring that people who work for the organisations they represent are made fully aware of issues effecting safeguarding and clear pathways for reporting abuse.

Strategic objective 10

The Board will monitor the effectiveness and quality of arrangements for transfers of care. This will include people going into and out of an acute hospital setting as well as transfers of care from their own home to care home.

The Transfer of Care Policy Implementation Group has been established and being led by East Berkshire commissioners. Frimley Health NHS Foundation Trust is a member of this group and its purpose is to develop, agree and approve a single common transfer of care policy that clearly defines the processes that will transfer a patient to their home or other care provider from the acute hospital setting.

Key responsibilities of this group include:

- Agreeing clear, efficient and safe pathways that show the pathway from Frimley North to the patient's home or receiving organisation.
- The definition of clear roles and responsibilities for each organisation involved in complex and simple discharges.
- Recommending and implementing changes to partner organisations' current discharge policies and processes.
- The creation of an agreed "directory of services" that will support patients on transfer to and from any environment.
- The incorporation of a clear communications plan into the process to ensure that patients are kept informed and involved at all times.

The Trust will also be re-establishing its own Discharge Steering group. This is a multi-disciplinary group that will coordinate improvement activity with the Trust discharge process; facilitating the improvement of patient flow and consistent safe transfers of care.

Throughout the year issues relating to the transfer of care that have been investigated within the safeguarding adults framework, are reported to the Trust's Safeguarding Adults and Paediatric Group, chaired by the Deputy Director of Nursing. This group meets bi-monthly to oversee the development, implementation and monitoring of systems, processes and policies to ensure Adults that are subject to safeguarding and Children are safeguarded whilst in Wexham Park and Heatherwood hospitals.

Slough Safeguarding Adults Board Member Becky Spiller - Head of Service, Dash Charity

1. Tell us about yourself and your role.

I'm Becky Spiller and I'm Head of Services at the Dash Charity, a local charity providing specialist support, advice and advocacy to men, women and children experiencing domestic abuse. I'm a qualified Independent Domestic Violence Advocate and have worked in the field of domestic abuse for over 10 years. I started life in the sector as a volunteer in our refuges in 2005 and have had significant experience on the 'frontline' working directly with families, as well as delivering specialist training to a variety of multi-agency professionals and managing services. As Head of Services, I sit on the senior management team of the Dash Charity and oversee our three main service departments, those being refuge provision, outreach and advocacy and children's services. My role is to ensure that we are delivering quality and continually developing services in response to local need and changing landscapes. I'm proud to work with a very passionate and dedicated team who are committed to changing lives for the better.

2) Why is safeguarding important to you and what have you achieved?

Working with clients experiencing domestic abuse, many of which are still at a high risk of continued harm, safety is at the very core of our work and as such safeguarding plays an integral part in our day to day roles.

We believe that everyone has the right to live their lives free from maltreatment and abuse and should be empowered to live lives that are fulfilling and safe. We work hard to ensure that the rights and voices of our clients are heard and work within a supportive network of multi-agency partners to ensure a co-ordinated approach to support and safeguarding. We recognise that some of our clients will have additional vulnerabilities requiring statutory intervention and have recently received funding for a specialist complex needs IDVA to work with clients who may have multiple additional needs, including issues with substance misuse, mental health and sex working.

3) What do you hope to achieve with Slough Safeguarding Adults Board in the future?

Slough Safeguarding Adults Board is a great platform for developing networks, sharing information and ensuring safeguarding remains a priority in the agendas of key partners. As part of the voluntary sector, its great be involved, have a voice and work alongside our statutory partners. Moving forward, we hope to work with the Board members to proactively engage a greater proportion of hidden victims with additional barriers to disclosure in order to offer our specialist support.

Strategic objective 11

Board Development

Slough has a well-established Safeguarding Board with a wide ranging membership from the main statutory agencies including representation from health, fire service, ambulance service and the police. The Board also has representation from voluntary organisations including DASH and Health Watch.

What have we achieved?

A review of the terms of reference of the board has led to a widening of the membership to include representation from the private sector in particular from care providers. The terms also suggest that there should be representation from service users and carers and this work is still in progress and will remain an objective for the Board in 2015/16.

The second objective set by the Board was around developing the Boards' subgroups. These have now been refreshed and have been given work streams for the next twelve months. The subgroups that are now in place are:

1) Executive Subgroup
2) Communications Subgroup
3) Performance and Quality Subgroup
4) Workforce Development Subgroup (East Berkshire)
5) Safeguarding Adults Review Panel
6) Care Act Implementation Group (This is a task and finish group and will be disbanded in April 2015 with the implementation of the Act)

Each of the subgroup will report to the Board on a quarterly basis their progress on their various work streams.

The third and final objective of the Board in regards to its development was to ensure that it has a robust strategy that addressed all the current issues regarding Safeguarding within Slough and that this was available to the public. The Strategy is updated on a quarterly basis following each Board meetings is available on the Slough Safeguarding Adults web page www.slough.gov.uk/council/strategies-plans-and-policies/slough-safeguarding-adults-board.aspx.

Way forward

There are various areas of work that the Board still needs to develop and these will form the Strategic Business Plan for 2015/16. However, one of the main challenges has to be how to involve service users and carers in the work of the board and in designing and approving board strategies.

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- House of Lords (2014) "The Mental Capacity Act 2005 post legislative scrutiny"
- Local Government Association (2013) "Making Safeguarding Personal", LGA, London.
- Local Government Association (2013) "Making Safeguarding Toolkit"
- Metropolitan Police (2015) "Operation Yewtree"
- Ogilvie and Williams (2010) "Making Safeguarding Personal - a tool kit of responses"
- Office of National Statistics (2011)"Census 2011"
- Thames Valley Police (2015) "Operation Bullfinch"

Legislation

- Care Act 2014
- Children and Family's Act 2014
- Mental Capacity Act 2005

This document can be made available on audio tape, braille or in large print, and is also available on the website where it can easily be viewed in large print.

www.slough.gov.uk
Slough
Borough Council

Slough Safeguarding Adults Partnership Board Annual Report

If you would like assistance with the translation of the information in this document, please ask an English speaking person to request this by calling 01753 475111.

यदि आप इस दस्तावेज में दी गई जानकारी के अनुवाद किए जाने की सहायता चाहते हैं तो कृपया किसी अंग्रेजी भाषी व्यक्ति से यह अनुरोध करने के लिए 01753 475111 पर बात करके कहें.

ਜੇ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਵਿਚਲੀ ਜਾਣਕਾਰੀ ਦਾ ਅਨੁਵਾਦ ਕਰਨ ਲਈ ਸਹਾਇਤਾ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਸੇ ਅੰਗਰੇਜ਼ੀ ਬੋਲਣ ਵਾਲੇ ਵਿਅਕਤੀ ਨੂੰ 01753 475111 ਉੱਤੇ ਕਾਲ ਕਰਕੇ ਇਸ ਬਾਰੇ ਬੇਨਤੀ ਕਰਨ ਲਈ ਕਹੋ।

Aby uzyskać pomoc odnośnie tłumaczenia instrukcji zawartych w niniejszym dokumencie, należy zwrócić się do osoby mówiącej po angielsku, aby zadzwoniła w tej sprawie pod numer 01753 475111.

Haddii aad doonayso caawinaad ah in lagu turjibaano warbixinta dukumeentigaan ku qoran, fadlan weydiiso in qof ku hadla Inriis uu ku Waco 01753 475111 si uu kugu codsado.

اگر آپ کو اس دستاویز میں دی گئی معلومات کے ترجمے کے سلسلے میں مدد چاہئے تو، براہ کرم ایک انگریزی بولنے والے شخص سے 01753 475111 پر کال کرکے اس کی درخواست کرنے کے لئے کہیں۔

Designed and printed by Slough Borough Council | SS/5896/21-10-15

SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny Panel **DATE:** 18th November 2015

CONTACT OFFICER: Dave Gordon – Scrutiny Officer
(For all Enquiries) (01753) 875411

WARDS: All

PART I
TO NOTE

HEALTH SCRUTINY PANEL – 2015/16 WORK PROGRAMME

1. Purpose of Report

1.1 For the Health Scrutiny Panel (HSP) to discuss its current work programme.

2. Recommendations/Proposed Action

2.1 That the Panel note the current work programme for the 2015/16 municipal year.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

3.1 The Council's decision-making and the effective scrutiny of it underpins the delivery of all the Joint Slough Wellbeing Strategy priorities. The HSP, along with the Overview & Scrutiny Committee and other Scrutiny Panels combine to meet the local authority's statutory requirement to provide public transparency and accountability, ensuring the best outcomes for the residents of Slough.

3.2 The work of the HSP also reflects the priorities of the Five Year Plan, in particular the following:

- More people will take responsibility and manage their own health, care and support needs
- Children and young people in Slough will be healthy, resilient and have positive life chances

4. Supporting Information

4.1 The current work programme is based on the discussions of the HSP at previous meetings, looking at requests for consideration of issues from officers and issues that have been brought to the attention of Members outside of the Panel's meetings.

4.2 The work programme is a flexible document which will be continually open to review throughout the municipal year.

5. Conclusion

5.1 This report is intended to provide the HSP with the opportunity to review its upcoming work programme and make any amendments it feels are required.

6. Appendices Attached

A - Work Programme for 2015/16 Municipal Year

7. Background Papers

None.

HEALTH SCRUTINY PANEL
WORK PROGRAMME 2015 – 2016

Meeting Date
18 November 2015
• Drug and alcohol services • Mental Health Crisis Care Concordat Action Plan • Adult Safeguarding Report • Child and Adult Mental Health Services (CAMHS tier 2) Engagement Update
14 January 2016
• Care Act 2014: Update on Performance and Outcomes • Leisure Strategy: Get Active Slough – Commissioner for Community & Leisure • Five Year Plan outcome: More people will take responsibility and manage their own health, care and support needs • Adult Social Care budget • Slough walk in centre
21 March 2016
• Measurable outcomes from formal co-operation between Slough Borough Council and CCGs (Forum?) • Berkshire Healthcare NHS Foundation Trust Quality Account 2014/15 • Transfer of health visitor services

Currently Un-programmed:

Issue	Directorate	Date
CQC inspection of Wexham Park Hospital		ASAP
Slough Caring for Our Carers: Joint Commissioning Strategy 2015-20 update	C&WB	
Thames Valley Cancer Strategic Clinical Network review of the provision of specialist surgery		
Access to extended hours primary care appointments	C&WB	14th January?

MEMBERS' ATTENDANCE RECORD 2015/16

HEALTH SCRUTINY PANEL

COUNCILLOR	02/07	28/07	01/10	18/11	14/01	21/03
Ajaib	P	P	P			
Chahal	P	P	Ap			
Chaudhry	P	P	P			
Cheema	P	P	P			
Chohan	P	P	P			
M Holledge	P	P	P			
Pantelic	P	P*	P*			
Shah	Ab	P*	P			
Strutton	P	P	P			

P = Present for whole meeting
P* = Present for part of meeting
Ap = Apologies given
Ab = Absent, no apologies given

(Ext*- Extraordinary)

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