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City of Westminster

Committee Agenda

Title:	**Adults, Health & Public Protection Policy & Scrutiny Committee**
Meeting Date:	**Wednesday 25th November, 2015**
Time:	**7.00 pm**
Venue:	**Rooms 5, 6 & 7 – 17th Floor, City Hall, 64 Victoria Street, London SW1E 6QP**
Members:	**Councillors:** David Harvey (Chairman) Barbara Arzymanow Paul Church Patricia McAllister Jan Prendergast Glenys Roberts Tim Roca Ian Rowley

Members of the public are welcome to attend the meeting and listen to the discussion Part 1 of the Agenda

Admission to the public gallery is by ticket, issued from the ground floor reception at City Hall from 6.30pm. If you have a disability and require any special assistance please contact the Committee Officer (details listed below) in advance of the meeting.

An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter. If you require any further information, please contact the Committee Officer, Andrew Palmer.

Email: apalmer@westminster.gov.uk
Tel: 020 76412802
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Note for Members: Members are reminded that Officer contacts are shown at the end of each report and Members are welcome to raise questions in advance of the meeting. With regard to item 2, guidance on declarations of interests is included in the Code of Governance; if Members and Officers have any particular questions they should contact the Head of Legal & Democratic Services in advance of the meeting please.

AGENDA

PART 1 (IN PUBLIC)

1. MEMBERSHIP

To note any changes to the Membership.

2. DECLARATIONS OF INTEREST

To receive declarations by Members and Officers of the existence and nature of any personal or prejudicial interests in matters on this agenda, in addition to the standing declarations previously tabled and included in the agenda.

3. MINUTES **(Pages 1 - 12)**

To approve the Minutes of the meeting held on 24 September 2015 and Action Tracker.

4. CHAIRMAN'S Q&A

To receive any questions from Members of the Committee.

5. CABINET MEMBER UPDATES **(Pages 13 - 24)**

To receive an update on current and forthcoming issues within the portfolios of the Cabinet Member for Adults & Public Health and Cabinet Member for Public Protection. The briefings also include responses to any written questions raised by Members in advance of the Committee meeting.

6. STANDING UPDATES

To receive a verbal update on any significant activity undertaken by the Committee's Task Groups since the Committee's last meeting.

7. POLICING MODEL - MOPAC **(Pages 25 - 80)**

To follow up the assessment of the local policing model in 2014/15 with the Mayor's Office for Policing and Crime (MOPAC).

8. THE PATIENT JOURNEY - MAPPING THE EXPERIENCE OF WESTMINSTER'S RESIDENTS **(Pages 81 - 100)**

To assess how Westminster's residents and patients interact with the health service in the City.

9. WORK PROGRAMME **(Pages 101 - 104)**

To consider the Committee's Work Programme for the remainder of the 2015/16 municipal year.

10. ITEMS ISSUED FOR INFORMATION

To provide Committee Members with the opportunity to comment on items that have been previously circulated for information.

I) Safeguarding Adults Executive Board
SAEB Annual Report 2014-15 – and letter in response sent on behalf of the Committee.

II) Shaping a Healthier Future – Implementation Business Case
Letter sent to CWHHE Clinical Commissioning Groups Collaborative on behalf of the Committee – and letter in response received from the Chief Officer.

11. ANY OTHER BUSINESS

To consider any other business which the Chairman considers urgent.

Charlie Parker
Chief Executive
17 November 2015

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CITY OF WESTMINSTER

DRAFT MINUTES

Adults, Health & Public Protection Policy & Scrutiny Committee

MINUTES OF PROCEEDINGS

Minutes of a meeting of the **Adults, Health & Public Protection Policy & Scrutiny Committee** held on **Thursday 24th September, 2015**, Rooms 5, 6 & 7, 17th Floor, City Hall.

Members Present: Councillors David Harvey (Chairman), Barbara Arzymanow, Paul Church, Patricia McAllister, Jan Prendergast, Tim Roca and Ian Rowley.

Also Present: Councillor Nickie Aiken.

1 MEMBERSHIP

1.1 Apologies for absence were received from Councillor Glenys Roberts.

2 DECLARATIONS OF INTEREST

2.1 The Committee noted the Standing Declarations of Interest tabled in the agenda.

2.2 Councillor Tim Roca declared a non-pecuniary interest, in that he was an employee of the Institute of Pharmaceutical Science at Kings College.

3 MINUTES AND ACTION TRACKER

3.1 **RESOLVED:** That the Minutes of the meeting held on 24 June 2015 be approved for signature by the Chairman.

3.2 Members also noted progress set out the Committee Action Tracker.

4 CHAIRMAN'S Q&A

4.1 The Committee confirmed that it had no questions or comments for the Chairman.

5 CABINET MEMBER UPDATES

5.1 Cabinet Member for Public Protection

5.1.1 Councillor Nickie Aiken updated the Committee on key issues relating to her portfolio, which included Operation Shield, the 24 Hour Tube Service, and community cohesion.

5.1.2 The Committee noted action that had been taken in Westminster under Operation Shield, which had been created by the Mayor's Office for Policing & Crime (MOPAC) as part of the strategy to target gangs. The Cabinet Member highlighted the excellent work that had already been carried out by the City Council's Integrated Gangs Strategy and the Your Choice programme, and acknowledged the need to ensure that Shield did not distract from Westminster's current initiatives. Committee Members commented on the criticism that the Shield project had received, and the Cabinet Member confirmed that the project would continue to be monitored.

5.1.3 The Cabinet Member reported that Westminster's Policy Statement on proposals for a 24 hour tube service had now been published. Although negotiations on implementation were on-going, the Statement had informed residents and the license trade of the City Council's direction of travel. The Cabinet Member acknowledged that the 24 hour service would benefit workers and visitors, but expressed concern that the modelling had focussed on dispersal, with inadequate work being done concerning the potential impact of additional people coming into the West End. To reflect this, the Policy Statement had specified that no applications for variance or new licensing would be approved for at least 12 months after the expanded service had been introduced, in order to determine whether it had any detrimental or positive effect.

5.1.2 The Committee expressed concerns over the work of Community Cohesion and the Prevent initiative, and noted that a cross-party Community Cohesion Commission has been created which would consider how the Prevent Strategy could work better for Westminster and the UK as a whole. The Commission comprised of the Cabinet Member for Public Protection, together with Councillors Adam Hug, Patricia MacAllister and Adnan Mohammed, and had met with officers to scope areas of work. Each Member had taken responsibility for a particular strand and would be reporting back with recommendations. It was recognised that young men who had been attracted by gangs could now be attracted by extremism, and was similarly acknowledged that the Strategy would need to include universities.

5.1.3 The Cabinet Member reported that following the concentrated work carried out under Operation Unite during August, there had been a significant decrease in the number of rough sleepers in Westminster's 'hot spot' areas, which had reduced by 24%. The Cabinet Member had also met with James Brokenshire,

Immigration Minister at the Home Office, who had recognised that new powers were needed relating to rough sleepers who were foreign nationals, and that legislation relating to the current 90 day visa rule needed to be revised. The Cabinet Member commended the work of outreach workers, and agreed to inform Committee Members of how the rough sleeper count was verified.

5.1.4 The Committee acknowledged the need to be realistic on what the provision of policing, particularly in view of the savings of £800million that needed to be made, and noted that progress in the restructure of the Police and MOPAC agenda were to be discussed at the next meeting of the Committee in November.

5.1.5 Other issues discussed with the Cabinet Member included progress in the 8 week pilot for the Busk in London Scheme, and the recruitment of Westminster's Neighbourhood Problem Solving Coordinators.

5.2 Cabinet Member for Adults & Public Health

5.2.1 The Committee received a written briefing from Councillor Rachael Robathan on key issues within her portfolio, which included Adult Social Care, Public Health, and the Westminster Health & Wellbeing Board.

5.2.2 Issues discussed by Committee Members included spot purchase arrangements for the Homecare Service; the Specialist Housing Strategy, and the link between substance abuse and sexual health.

5.3 **RESOLVED:** That the briefings detailing the recent work undertaken within the portfolios of the Cabinet Member for Public Protection and the Cabinet Member for Adults & Public Health be noted.

6 STANDING UPDATES

6.1 Committee Task Groups

6.1.1 The Committee discussed the progress of its current and forthcoming Task Groups, and noted that all of the recommendations made by the Hostels Task Group to improve safeguarding for young people had been accepted by Cabinet Members and stakeholders, and would be implemented.

6.1.2 Committee Members and officers had also met with the Children's Commission and Barnardos to discuss trafficking, which was a pan-London issue outside of the City Council's control. The Committee noted that a set of base information was being complied in order to establish the situation in Westminster.

6.2 Healthwatch

6.2.1 Mark Platt (Trustee, Healthwatch Central West London) updated the Committee on the current work and priorities of Westminster Healthwatch, which included

progress in the procurement process of the bid for tri-borough local Healthwatch; the Healthwatch report on Child & Adolescent Mental Health Services (CAMHS); and the 'Suffering in Silence' report on consumer experiences of the health & social care complaints system.

6.2.2 The Committee discussed the role of Heathwatch in service user complaints, together with the support being offered to GPs by Healthwatch to set up Patient Participation Groups. Committee Members also commented on problems that had occurred in the consultation on proposals to close the Soho Square General Practice.

6.3 **RESOLVED:** That

1) The standing updates from the Committee's Task Groups and from Westminster Healthwatch be noted; and

2) Committee Members meet with Westminster Healthwatch before the next meeting of the Committee, to discuss common areas of working over the forthcoming year.

7. ADULTS SOCIAL CARE COMPLAINTS AND PERFORMANCE

7.1 Mike Rogers (Planning & Performance Manager, Adult Social Care) and Rachel Wigley (Tri-borough Director of Finance, Adult Social Care), presented an overview of statutory complaints made in connection with Adult Social Care, between 1 April 2014 and 31 March 2015. The report also highlighted how various services within Adult Social Care had performed in line with key principles outlined in the complaints regulations, and detailed the learning and service improvements that had been made as a result of responding to complaints. Mike Rogers acknowledged that the scope of the report only gave limited information on the nature of the complaints that had been received; and informed the Committee that although each of the tri-borough partners had different issues, they were seeking to establish a tri-borough gold standard for shared services.

7.2 Mike Rogers reported that the complaints had generally related to the assessment care management process and to the quality of Homecare. Although fewer complaints had related to Homecare than in previous years, many of the complaints were not statutory, and were now being referred directly to providers with responses being monitored as part of the contract management process. Measures put in place to gain reassurance on the quality of services that were being provided included a statutory annual adult social care user survey, a bi-annual carers survey; and networking with carers and Westminster Healthwatch.

7.3 The Committee noted that the City Council worked with providers to encourage customer feedback, which could include complaints. People could find it difficult to complain, and the vast majority of complaints were being made by telephone

or email by carers on service users' behalf. Members acknowledged that dealing with issues at an early stage could avoid them leading to complaints. Committee Members also discussed the effect implementation of new eligibility thresholds arising from the Care Act could have on complaints, and highlighted the importance of quality and consistency in assessments of eligibility.

7.4 The Committee discussed safeguarding issues, and noted that the Safeguarding Board worked closely with Westminster's complaints officers, and that staff were aware of possible safeguarding implications and were constantly assessing risks.

7.5 Committee Members discussed the data given in the report, and expressed concern that the higher percentage of complainants being women could lead to a possible gender bias which could affect decisions and the allocation of resources, and lead to implicit discrimination. Mike Rogers confirmed that the changes made by service departments in response to the complaints had not been gender specific, but had been systemic and had sought to assist everyone.

7.6 Committee Members asked to receive details of the complaints that had been received on a Ward basis, and also requested a briefing note on the measures that were being taken for mediation in response to the Children's Act.

7.7 **RESOLVED:** That the Annual Report on statutory complaints made in connection with Adult Social Care, between 1 April 2014 and 31 March 2015 be noted.

8. SAFEGUARDING AND SAFER RECRUITMENT

8.1 Helen Banham (Strategic Lead, Professional Standards & Safeguarding, Adult Social Care Commissioning) presented the draft Safer Recruitment Principles & Guidance, which had been drawn up by the Safer Recruitment Task Group. The report took account of the legal responsibilities for engagement and hiring, and provided guidelines for checking and screening staff and risk assessments. The report also considered issues relating to overseas workers and agency staff.

8.2 **RESOLVED**: That Committee Members submit any comments they may have on the draft Safer Recruitment Principles & Guidance in writing, in order that they may be taken into account when the paper is presented to the Safeguarding Adults Executive Board at their forthcoming meeting on 8 October.

9. POLICING AND MENTAL HEALTH

9.1 The Committee received a report which considered the issues associated with policing and mental health, and heard from Nicola Hazle (Borough Director, Westminster CNWL); Stephanie Bridger (Divisional Nursing Director, CNWL); and Inspector Paul Ramsey (Westminster Borough Police). The Committee also heard from Adam Taylor (Commissioning Manager, Community Safety), who

outlined the local authority's role in public health commissioning, and the substance misuse service which provided support in a custody environment. Additional papers were tabled at the meeting on the Mental Health Act 1983 Code of Practice; the Government's Care Concordat, which sought to improve outcomes for people experiencing mental health crisis; and on policing issues and the London Street Triage pilot.

9.2 Inspector Ramsey highlighted on-going difficulties in incidents receiving a timely response from the London Ambulance Service (LAS), which led to the majority of cases being transported to places of safety in police vehicles. During 2014, of 167 cases requiring attendance, 111 had been transported in police vehicles, with only 51 being dealt with by the LAS. During 2015, of the 113 that had occurred to date, 65 had been transported by the Police, and 45 by the LAS. The Police were required to call an ambulance in every case and then wait, and the Committee noted that there had been several occasions where the Police had waited a number of hours for an ambulance that did not arrive.

9.3 CNWL agreed that the LAS problem was a challenge to the NHS and to the City Council, as staff had to look after patients until they were taken to a hospital or to a place of safety. CNWL continued to maintain a close relationship with the Police, and met at least bi-monthly with the Police Liaison Forum to review specific cases and incidents, and how they were working together.

9.4 Committee Members highlighted the need for fully staffed places of safety to be available at all times to avoid people being taken into custody, and CNWL confirmed that a reconfigured place of safety which provided two assessment rooms had been open at the Gordon Hospital since June. Although the number of people being removed under Section 136 of the Mental Health Act in Westminster was one of the highest in the country, the Committee noted that of the 19 people who had been taken to police cells across London over the past 12 months, none of these had been in Westminster. The need for children to be detained in Police cells in London was also extremely rare.

9.5 The Committee discussed the person centred safety planning approach which had been adopted by the Police to minimise risk when dealing with people with mental health issues. Members acknowledged that assessing, balancing and managing personal risk was always a challenge, and that health agencies needed to work with an individual to assess and manage the risk to themselves and others, and to avoid risk escalating.

9.6 Committee Members highlighted the need for the medical profession to be the first point of contact for people with mental health issues rather than the Police, who often provided a response to incidents. It was recognised that the Police not always being the best people to deal with mental health situations, and that blame could be transferred to the Police when things went wrong.

9.7 CNWL had been working with the Police and Westminster's Clinical Commissioning Groups (CCGs) to determine how the crisis response could be improved to support the Police and avoid people presenting at A&E. From November, a single point of access into adult mental health services would be introduced across the 5 boroughs within CNWL; and a dedicated telephone line would be available which could be accessed by the LAS and the Police, and enable information to be shared. Additional funding had also been provided by the CCGs for a rapid response function for home treatment teams, which would seek to deliver intensive treatment as an alternative to hospital admission, and keep people within their community.

9.8 Inspector Ramsey commented on progress in the London Street Triage pilot, launched by the Department of Health, in which nurses attended incidents with Police officers. The pilot sought to reduce the use of Section 136 where appropriate; to reduce the time spent by front line police officers responding to those in mental health crisis; and to improve the experience of the people with mental health difficulties. Committee Members noted that Inspector Ramsey did not consider the triage service to be a scalable model that would support London, and suggested that the Metropolitan Police may prefer a 24 hour phone service that was available seven days a week. CNWL also recognised that Westminster was different from other locations, and considered that triage could support the local population by offering advice rather than attendance.

9.9 The Committee discussed the role of the Child & Adolescent Mental Health Services (CAMHS) in supporting the police, and noted the work that was being done in schools through the school nursing service. CNWL acknowledged the need to be more open.

9.10 The Committee highlighted the importance of avoiding people who had been treated for mental health issues becoming institutionalised by being moved back into the community as soon as possible. The Committee also commended Westminster in having an average admission of 9 days for treatment, compared to between 28 and 30 days in other authorities which greatly improved the recovery rate.

9.11 Other issues discussed included the Blue Light programme, which offered support to police officers with mental health issues; the link between substance abuse and mental health; the context of mental health vulnerability across London: and after prison care.

9.12 The Committee commended the co-ordinated work that was taking place between the Police, local authority and health agencies in Westminster, to ensure that people with mental health conditions were given appropriate care and to avoid adults and children being placed in police cells.

9.13 Chairman thanked the witnesses, on behalf of the Committee, for attending the meeting and for their contributions.

9.14 **RESOLVED**: That

1) The Committee would involve the Cabinet Member for Adults & Public Health and write to the London Ambulance Service (LAS) raising general issues, and also supporting the Police in the issues that had been highlighted regarding transport. Consideration would also be given to inviting the LAS to a future meeting.

2) Media coverage should be given to support the work that was being done, and to emphasise that there was no longer any stigma in people suffering from poor mental health and

3) The Committee consider mental health as a more general issue early in the forthcoming year.

10 WORK PROGRAMME 2015/16

10.1 The Committee agreed that Mental Health and the London Ambulance Service would be added to the Committee Work Programme. Consideration would also be given to data security being added as a future agenda item, or as an issue for a separate Task Group.

11 ITEMS ISSUED FOR INFORMATION

11.1 The following papers had been circulated for information separately from the printed Agenda:

- A letter sent on behalf of the Committee to NHS Property Services, following the discussion on NHS estate at the last meeting on 24 June 2015.

- A letter sent on behalf of the Committee to Central London Community Healthcare NHS Trust, in support of their progress towards Foundation Trust status.

12 ANY OTHER BUSINESS

12.1 No further business was reported.

The Meeting ended at 9.10pm.

CHAIRMAN:_____ DATE:_____

ROUND ONE (24 June 2015)		
Agenda Item	**Action**	**Status**
Item 5 – Cabinet Member Updates	That the Committee receive a tailored briefing on the transfer of the Independent Living Fund and its impact in Westminster	Briefing sent on morning of Tuesday 14th July.
Item 6 - Healthwatch	The Committee requested a briefing on the role and function of Westminster Healthwatch, and agreed that a substantive agenda item on Healthwatch would be added to the Committee Work Programme if needed. The Committee also agreed that it would be useful to receive details of the reasons for Healthwatch priorities and the actions they were taking.	Briefing sent to Members on 25th June.
Item 7 – NHS Estate	That NHS Property Services be asked to review how estates were managed; and to report back to the Committee on that process and its findings	Letter sent. Emailed to Members on Tuesday 14th July

HEALTH URGENCY (30th June 2015)		
Agenda Item	**Action**	**Status**
Item X – Imperial College Healthcare NHS Trust	That Imperial meet with Martin Low to discuss transportation issues of the service reconfiguration of stroke services	Complete – Monday 13th July (meeting date) with subsequent one to be arranged

ROUND TWO (24 September 2015)		
Agenda Item	**Action**	**Status**
Item 6 – Healthwatch Westminster	That Committee Members meet with Westminster Healthwatch before the next meeting of the Committee, to discuss common areas of working over the forthcoming year.	Pre-meet prior to 25th November meeting in the diary of Members
Item 7 – ASC Complaints	Members requested a ward breakdown of the complaints in Westminster	Sent via email on 23rd October from Mark Ewbank to Members
Item 7 – ASC Complaints	Members requested a briefing note on the measures that were being taken for mediation in response to the Children's Act.	Sent via email on 23rd October from Mark Ewbank to Members
Item 8 – Safeguarding	That Committee Members submit any comments they may have on the draft Safer Recruitment Principles & Guidance in writing, in order that they may be taken into account when the paper is presented to the Safeguarding Adults Executive Board at their forthcoming meeting on 8 October	Comments invited, none received other than discussion at Committee.
Item 9 – Policing and Mental Health	The Committee would involve the Cabinet Member for Adults & Public Health and write to the London Ambulance Service (LAS) raising general issues, and also supporting the Police in the issues that had been highlighted regarding transport. Consideration would also be given to inviting the LAS to a	To be drafted and amended for Member approval.

	future meeting.	
Item 9 – Policing and Mental Health	The Committee consider mental health as a more general issue early in the forthcoming year.	To be added to work programme going forward (see work programme)

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City of Westminster

Adults, Health & Public Protection Policy & Scrutiny Committee

Date:	**Wednesday, 25th November 2015**
Briefing of:	**Cabinet Member for Adults & Public Health**
Briefing Author and Contact Details:	**Lucy Hoyte** **lhoyte@westminster.gov.uk** **Extension: 5729**

1 Adults

Better Care Fund

1.1 Work continues on key schemes in the Better Care Fund (BCF), including development of the Community Independence Service (CIS) and enhancements to hospital discharge.

1.2 We have further developed the CIS model. Health and care organisations are working together to achieve full rollout. We are prepared for the staff change and consultation on future working arrangements. Roles will commence as soon as 2016-17 funding for the service is agreed between the parties.

1.3 We have also made good progress with the hospital discharge pilot. This has included placing social workers on Chelsea & Westminster's Edgar Horne and David Erskine wards. Early feedback and evaluation supports the case for change. Measures on both staff & patient satisfaction and reduced lengths of stay & re-admissions show encouraging early signs.

1.4 The Department of Health announced on the 16th October that the BCF programme will be extended through 2016/17. Locally we are already planning for the next phase of whole systems development with a high level customer journey, business case and commissioning intentions shared with and supported by Health Partners at the Joint Emergency Team on 5th October.

1.5 The next meeting of the BCF Board is 8th December 2015.

Home Care Procurement

1.6 Contracts have been awarded for a new home care provider for three of the four area patches in Westminster: North East, (Sagecare) Central (London Care) and South Westminster (Vincentian Care Plus).

1.7 The transition of customers to the providers began in September in these three patches. Letters were sent to customers affected and meetings with them arranged if required. Regular meetings are held between Adult Social Care commissioners, contract managers, operational staff and the new providers to ensure a smooth transfer of care.

1.8 This implementation process is expected to continue until March 2016. The safe transfer of customers is the main concern and implementation of the new model of care will be established once this is complete. Contracts will be executed at the end of the implementation period.

1.9 In October, a successful 'meet the providers' event took place between Adult Social Care staff, the new providers and the voluntary sector to start developing the relationships needed to improve the services and to start addressing the areas of work that are key to the new service.

1.10 The implementation team are also working with the outgoing providers to maintain service quality and continuity, particularly as we expect them to continue to be part of the homecare market in the future through Direct Payments and subcontracting arrangements.

1.11 The procurement for the final patch, North West Westminster, started in October. Spot purchase arrangements will continue in the meantime.

Specialist Housing Strategy for Older People (SHSOP)

1.12 We are two months into the contract for Phase One. Progress is being made on the significant recruitment and void position that existed at the point of transfer. One of the key tasks is reconciling the asset issues that Sanctuary raised. Work is progressing on this.

1.13 The CCG are taking the matter of the capital agreement and maintenance costs of the Butterworth forward with relevant parties. This activity will inform mobilisation.

1.14 Stakeholders are discussing resources and methodology to drive Phase Two forward. This phase will focus on the redevelopment/ new development for two of the six homes.

Events

1.15 Silver Sunday took place on Sunday, 4th October. It saw over 1400 people taking part in 40 free events and activities taking place across Westminster. 240 people took part in the tours of Lord's Cricket Ground and a sold out performance of the Pink Champagne Sisters, a 1950's cabaret trio, at the St. James Theatre.

1.16 The Carer Awards took place at the Thistle Marble Arch Hotel on Monday, 2nd November, with over 100 people attending.

1.17 This year's Tea Dance has proved one of the most popular yet, with almost 1100 applicants for the 1000 tickets available to Westminster's older residents. It will take place at The Grosvenor on Sunday, 29th November.

2 Public Health

School Nursing

2.1. Contracts for Health Visiting Services and Family Nurse Partnership transferred to the Local Authority on 1st October from the NHS.

2.2. The transfer of these services marks the final part of the overall public health transfer and will join up commissioning for 0 to 19 year olds to improve continuity for children and their families.

NHS health checks

2.3. In Quarter 2 we have so far delivered 2053 Health Checks.

2.4. If we continue at this rate we will deliver Health Checks to approximately 18% of the eligible population. This is above our target of 15% and a significant improvement on last year.

2.5. From October health checks will be offered to people from BME communities from the age of 35, as opposed to 40, because of the evidence of increased risk from an earlier age.

Childhood Obesity

2.6. The Mayor's office announced the award for the Social Supermarket capital funding at the beginning of November. Unfortunately the competition was very high and we were not successful in our bid.

2.7. The first draft Childhood Obesity JSNA has been completed. A series of workshops and meetings are planned in November to review the evidence,

identify any gaps in evidence and develop recommendations with other departments and partners. The final draft JSNA will be discussed with Cabinet Members in early December. Following this, it is planned to submit the Childhood Obesity JSNA to the Health and Wellbeing Board in January 2016 for approval.

2.8. We are working with Central London CCG (CLCCG) who is keen to commission a 'Beat the Street Westminster' project. This engages a whole community in a physical activity game over a six week period. Evidence shows that by the end of the competition, a significant proportion of participants have changed their behaviour choosing to walk or cycle more often for short journeys, or talking up more activity opportunities in and around their local area. Both the Council and West London CCG have each been asked to support the game through a £20k contribution with CL CCG contributing £126k. It is likely to start in April/May 2016.

Substance Misuse

2.9. The core drug and alcohol services procurement is moving to the award phase. The final decision to award will be in December owing to a slight delay in the process of Tri-borough governance sign-off. We are still on target to implement by April 2016 as planned.

2.10. In the meantime our current providers continue to work with commissioners on making improvements to their services and to improve outcomes. Westminster is in the top quartile for successful completions of drug treatment and alcohol outcomes are on an upward trend.

2.11. The Tri-borough service user group has been attended by 40 representatives all current provider services. They are looking at the revised service level of agreements and will be contributing to the implementation of the new model. The current peer mentoring programme is due to complete in December allowing 3 months on placements in current services. These peer mentors will be active in the implementation of the new service.

2.12. The numbers attending education training and employment initiatives for service users continue to increase and the upward trend of people entering paid employment is continuing. The developments between businesses prepared to employ or offer training to those with substance misuse and offending histories and our contracted services is ongoing.

Sexual Health

2.13. Following a review of community sexual health provision, the extended contracts have been agreed and we will be seeking authority to proceed to

procurement of a fully redesigned model for adults community sexual and reproductive health services. We are actively engaging with key stakeholders in preparation for the redesign and procurement. We have identified efficiencies through the review and have a programme in place to increase our focus on prevention initiatives.

2.14. The London wide transformation programme of Genito Urinary Medicine (GUM) services is still on-going. Our current local providers of sexual health mandatory services are working closely with us to achieve improved systems and efficiencies.

2.15. A significant data breach occurred at 56 Dean Street in September impacting on 700 individuals, 57 of whom were Westminster residents. We have been kept informed throughout the resolution of this matter by NHS England (NHSE) and the health trust responsible to ensure that residents could access their treatment. Our understanding is that NHSE are about to close the incident and that our residents have chosen to remain with their treatment provider.

Supported Employment

2.16. An employer engagement event will be held on 19th November with Cllrs Robathan and Bott attending.

2.17. Mapping of local employment services is underway and will inform future commissioning including a tri-borough Supported Employment service.

2.18. The ASC mapping and review exercise of WCC services has reached a critical milestone and the findings and recommendations for future commissioning will be presented to the Cabinet Member in late November.

New Director of Health

2.19. Mike Robinson, the new director of Public Health, started on 16th November.

3. Health & Wellbeing Board

3.1. At the meeting on 1st October, the Board welcomed an initiative on health and wellbeing hubs and a joint project with the CLCC. It expressed an interest in being involved in shaping the Hubs programme. The Board heard updates on the Children and Families Act, the CLCCG business plan themes for 2016/17, the Better Care Fund and Primary Care co-commissioning. The Board also approved a Joint Strategic Needs Assessment (JSNA) on Dementia.

4. Health

Central and North West London NHS Foundation Trust

4.1. Our local Mental Health Trust will be undertaking a reconfiguration of services and bringing their plans to the Health Sub-Committee at Westminster in November. Invitations have gone out to majority and minority party members to join this group.

Imperial College Healthcare NHS Trust

4.2. Imperial are developing a Transport Strategy for the first time, in response to concerns flagged over the last few years. The relocation of inpatient stroke beds to Charing Cross Hospital has now taken place. Dr Batten has given reassurance that she has seen the changes first hand and is very pleased with how the move has gone.

Healthwatch Westminster

4.3. An advert has gone out to source a supplier for local Healthwatch services in Westminster. Westminster is working with RBKC and H&F to procure these services to save the Council the costs of procurement. Westminster will retain a local Healthwatch service as part of these arrangements. Westminster's Healthwatch has gone from strength to strength and now has a membership of over 2,000 local residents from a low of 600 at the start of the contract.

Shaping a Healthier Future

4.4. The CCG Collaborative has recently updated the Council to let us know that they are continuing to work on the Implementation Business Case (ImBC) with an anticipated end in April 2016. The ImBC identifies the level of capital investment required for implementation of the site–based service changes agreed in the 2013 business case. Westminster has been invited to attend a meeting at Portcullis House at the end of November to discuss progress on the ImBC.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact Lucy Hoyte x 5729
lhoyte@westminster.gov.uk

Adults, Health & Public Protection Policy & Scrutiny Committee

Date:	**Wednesday 25th November 2015**
Briefing of:	**Cabinet Member for Public Protection**
Contact Details:	**Sion Pryse x 2228** **spryse@westminster.gov.uk**

1 Community Cohesion

1.1 After a successful initial meeting on 7th September a follow up meeting is expected to take place in December. The discussion emphasised the cross-council cooperation needed to understand and identify the issues that create isolation and marginalisation in society to make sure Westminster is a place where this does not happen. As such the next meeting will include officers from a number of departments ranging from Children Services to City Management and Employment to Housing. I would like to once again thank Councillor Hug, McAllister and Mohammed for their support and expert input.

2 Prevent

2.1 The team have been working alongside Prevent and Children's Services colleagues to host a Prevent and Schools Conference. The Conference outlined to attendees the risks that they face locally and how to respond effectively to the new statutory guidance. For much of the session institutions were given an opportunity to share their own unique experiences and approaches to responding to extremism and radicalisation risks.

2.2 The Creating Stronger Communities project will be completed next week. The project has been delivered alongside the Mosaic Community Trust, in Church Street. It works with Muslim women in order to empower them to overcome a range of social issues that they identified as impacting on their communities. Participants in the project are encouraged to become involved in volunteer work to support their local communities. Topics addressed to date have included gangs, drugs, radicalisation and domestic violence. The feedback received from the women has been very positive, and a number of follow up workshops are being arranged.

2.3 The team have also been providing support to schools across Westminster to assist them with ensuring that they are complying with the Prevent Duty. This has included delivering training to staff, and helping schools with action planning and providing guidance around their safeguarding policies; by making sure that risks around radicalisation are fully reflected.

2.4 The first series of our Prevent Parenting Programme (based on Strengthening Families Strengthening Communities) is being delivered in conjunction with the Abbey Community Association. The project works to support parents and to build and develop their parenting skills. It explores topics including: tools for effective disciplining, internet safety, cultural values and community integration. Two more series of the project will be delivered in Westminster by April 2016.

3 Violence against Women and Girls

3.1 Two new services to support women and their families, who are affected by domestic abuse and other forms of violence against women, were launched at an event at the Yaa centre in Westminster on the 22nd September.

3.2 The Shared VAWG Integrated Support Service is being provided by Angelou, a partnership of local and regional specialist services to tackle VAWG. Angelou is made up of nine organisations ranging from Solace Women's Aid who provide support to victims of sexual violence (and are separately commissioned to deliver the North London Rape Crisis Service), African Women's Centre who specialist in supporting victims of FGM, and Galop who work with LGBT survivors.

3.3 In addition to the integrated support service, we have also commissioned Standing Together, a local charity based in Hammersmith & Fulham, to deliver dedicated domestic violence court at Westminster Magistrates Court, and to run our multi-agency case conference process for high risk victims of domestic abuse.

3.4 The new services have been receiving a lot of positive publicity since they began work in July. The Chief Executive of Advance (the lead partner in Angelou) was interviewed on London lunchtime news, and we were invited to present at a DCLG summit on domestic abuse.

4 Starting Over

4.1 We have extended our contract with Starting Over to continue to provide a custody referral service in police custody until a re-commissioned substance misuse service across the Tri-borough is introduced in April 2016. Instead of working with Short Sentence Prisoners who now receive statutory support we have varied and extended their contract to work with the Integrated Offender Management cohorts with effect from 15th October to provide additional rehabilitation support to the most recidivist offenders with health and social care needs across the Tri-borough.

5 Minerva

5.1 MTC Novo who are the Community Rehabilitation Company (CRC) for London with responsibility for medium and low risk offenders are introducing a cohort model to working with offenders on the 7th December. One of the cohorts is female offenders. They are commissioning a variety of agencies through the London Women's Consortium to deliver some of this work.

5.2 The Deputy Mayor of MOPAC has committed further resources to expand innovative practice for female offenders and the London Reducing Reoffending Board has agreed to deliver upon this pledge. To do this MOPAC are looking to expand upon the provision provided by MTC Novo and to develop a one commissioning approach for London that incorporates a joint funding model between MTC Novo, MOPAC and local authorities.

5.3 The aim is once the basic female offender service is in place across London, boroughs will be available to fund additional support. This should make commissioning in the future easier. In the interim this lack of clarity of what provision will be available to female offenders has resulted in being unable to extend our contract with Minerva, to ensure that there is no duplication in service delivery, in time to meet Tri-borough procurement timeframes.

6 Street Performing

6.1 Over the summer we have trialled our joint approach to managing street performance with the Greater London Authority (GLA) in Leicester Square and Piccadilly Circus. The aim of the trial is to reduce the negative impacts of street performance regularly experienced by businesses and residents.

6.2 The trial began with a period of proactive engagement funded by Heart of London Business Alliance (HOLBA) and backed with Council enforcement.

6.3 The engagement period finished at the end of October. The Busker Liaison Team engaged with performers proactively to respond to complaints and the West End Busker Forums gave all parties the chance to talk openly and receive feedback.

6.4 The feedback from businesses at Piccadilly Circus has been positive and there are now fewer problems as acts stay within their pitches and impact guidelines which mean little Busker Liaison support is now needed. The feedback from businesses at Leicester Square has been mixed. Weekly surveys conducted by HOLBA have focussed on negative impact still felt by businesses. However informal positive comments have been received by businesses and the police.

6.5 Enforcement is beginning to take place and the GLA wrote to four individuals regularly causing problems in Leicester Square noting that their acts were still causing problems despite repeated attempts to engage and so complaints had been passed to the Council and therefore open to enforcement action.

6.6 I have also initiated a Trafalgar and Leicester Square Officer Working Group to find solutions to any outstanding problems in the area that have been highlighted through the Busk In London initiative. The first meeting was held on the 3rd November and was attended by officers from both licensing and planning.

6.7 Further trial pitches in NWEC and the Northbank BIDs' trials are due to start imminently and this will more than double the number of recognised pitches in the West End. The GLA is working to bring in more boroughs, BIDs and landowners into the programme. The Keep Streets Live Campaign and Lord Clement-Jones both continue to lobby against a blanket busking ban in other UK cities instead promoting an approach akin to Busk In London.

7 Rough Sleeping

7.1 September played host to a full street count, all outreach workers were accompanied by a volunteer acting as a verifier and support from Met Police ensured that data was as accurate as possible. Figures continued to rise, a total of 294 were counted. Core UK & Irish accounted for 85; Foreign Nationals accounted for 181 (159 EEA & 22 Rest of the World). Those of unknown nationality accounted for 28. Only around 30% of those encountered were entitled to the benefits required to offer accommodation while the rest can only be offered support into private rented accommodation or a reconnection to their home country. Both offers remain unattractive to those encountered and subsequently refused. This now means that 39% of Westminster's rough sleepers are from Romania.

7.2 Due to the high street count figures and a visible rise in rough sleeping, we continue to work hard with our enforcement partners to address any anti-social behaviour and complaints we may receive. Fortnightly tasking with immigration (Home Office) and weekly co-ordination meetings with the Police ensure we are focused on priorities and working collaboratively to address the problem.

7.3 During this time of year we begin looking to the colder months and a robust Serious Weather Emergency Protocol (SWEP) is compiled. We work closely with our support agencies, City Management and the GLA to ensure that if the weather drops to below freezing, additional actions are undertaken and provision are made available. We will also be meeting with our non-commissioned partners to complement their work with the Winter Churches operation running throughout November to March. This sees a number of spaces made available across a network of faith based buildings to offer shelter to people during the colder months

8 City Inspectors

8.1 On the 7th November I joined our City Inspectors on duty in the West End. Feedback from City Inspectors highlighted that the restructure has benefited the way we manage the city and allows for a more holistic approach. The inspectors fed back that they feel the new role has allowed them to increase their skill base and knowledge. Being out with the team was a real eye opener

and reminder of the excellent work our city inspectors undertake. I have recommended to the West End Partnership Board members and the members on the Licensing Sub-Committee to also join our City Inspectors on a visit to the West End at night.

9 Night Time Economy

9.1 On the 30th November I will be attending a roundtable event titled 'Is Regulation Killing the Night-Time Economy. The discussion will focus on the social and economic conflict associated with the night time economy and the impact of licensing. I will be asserting the difficult decisions local authorities have to make to ensure a balance between opportunities for the night time economy and the needs of residents and communities reminding the attendees that the Licensing Sub Committee will review each case on its individual merits.

10 Licensing Consultation

10.1 Following consideration of the responses to the consultation proposals, a revised licensing policy has being drafted, updating the policy and incorporating revisions. I presented this draft for approval at Full Council on the 11th November where it was approved and so will become effective from January 2016.

11 Stress Zones

11.1 Following the successful revision and updating of our licensing policies, the second phase of the policy review is now underway to verify whether the current boundaries of our cumulative impact areas remain valid, and examine whether it is appropriate to apply special policies to any other areas of the city to address concerns relating to the licensing objectives which may arise.

11.2 Public consultation has already identified resident concerns in Mayfair and the police have highlighted issues in the area south of the current West End Cumulative Impact Area.

11.3 Work is now underway to assess the nature and extent of the problems and to examine how the application of special policies may contribute to resolving them. We recognise of course that all the problems associated with a vibrant night time economy cannot be addressed by licensing measures alone, and the findings of the review will inevitably feed into other areas of work both for the council and our partners.

11.4 We are hopeful that specific proposals can be drafted in the first quarter of the New Year, and, following consultation and scrutiny, any necessary measures can be implemented in the summer. It will be important to engage with all interested parties throughout this process and keep local residents engaged.

12 Fixed Odds Betting Terminals

12.1 The Stage One proposed new Statement of Licensing Principles for Gambling was consulted upon for a period of five weeks ending on the 2nd October 2015. The Council received seven responses to that consultation. After considering these consultation responses and making minor amendments, I presented the draft to for approval Full Council on the 11th November where it was approved and will become effective from the end of January 2016. The consultation for Stage Two will be conducted for a longer period in 2016.

Adults, Health & Public Protection Policy & Scrutiny Committee

Date:	25th November 2015
Classification:	General Release
Title:	**Local Policing Model**
Report of:	Policy & Scrutiny Manager
Cabinet Member Portfolio	External Scrutiny
Wards Involved:	All
Policy Context:	City for Choice
Report Author and Contact Details:	**Mark Ewbank x2636** mewbank@westminster.gov.uk

1. Executive Summary

The Committee have requested an assessment of the introduction of the Local Policing Model (LPM) which was brought in within 2013/ 2014 after consultation. The Mayor's Office for Policing and Crime (MOPAC) will be in attendance to answer questions on the programme and an evaluation of the LPM (from the Metropolitan Police) is attached as an Appendix to this report.

2. Key Matters for the Committee's Consideration

- The Committee may wish to ask MOPAC about the evaluation of the local policing model which was published earlier this year.
- The Committee may wish to make recommendations around the future strategy of policing in London, given the concerns raised by the Chairman in a letter to Chief Superintendent Peter Ayling.

3. Background

The appendix to this report provides an evaluation of the local policing model published earlier this year by the Metropolitan Police.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact Mark Ewbank x2636
mewbank@westminster.gov.uk

APPENDICES:

APPENDIX 1 – Metropolitan Police evaluation of the Local Policing Model

BACKGROUND PAPERS

Nil return

METROPOLITAN POLICE TOTAL POLICING

Freedom of Information Act Publication Scheme	
Protective Marking	**Not Protectively Marked**
Publication Scheme Y/N	Yes
Title	Neighbourhood policing review 2014 phase 1
Summary	Review of neighbourhood policing within the Local Policing Model – 2014
(B)OCU or Unit, Directorate	Territorial Policing
Author	Commander Lucy D'Orsi
Review Date	10 December 2016
Date Issued	23 February 2015

Neighbourhood Policing Review 2014 - Phase 1

Executive Summary

The Local Policing Model (LPM) has undoubtedly realised a safer London through a reduction in crime and anti-social behaviour against a backdrop of improving confidence in policing. The response to emergency calls has improved to 93% within target times and accessibility through appointments and contact points has been established. However, despite this success and an uplift of 2,600 police officers (achieved earlier than the original target date of April 2015), visibility of officers within neighbourhoods remains an issue raised by communities and key stakeholders.

At the Policing and Crime Panel on the 10th of July 2014, the Commissioner advised that Assistant Commissioner Helen King would undertake a two staged review (see Appendix A for terms of reference). This report relates to stage 1.

The key findings of stage 1 are:

- Neighbourhood policing under the LPM is distinctly different to the previous ward based 1:2:3 delivery model which was identical across all London wards irrespective of demand profile or threat, risk and harm indicators.
- Under the LPM, neighbourhood police officer posts have increased by 138% (2,600 officers).
- Neighbourhood officer posts have only recently been filled to full establishment.
- The roles and responsibilities of neighbourhood officers have increased.
- 8% of current neighbourhood officers are on recuperative or restricted duties.
- Neighbourhood officers have undertaken 102,500 tours of aid over a 12 month period.
- The Dedicated Ward Officer shift pattern could be better aligned to their core roles and responsibilities.
- The brand and clarity of neighbourhood policing needs strengthening.
- Secondary investigation of crime to neighbourhood officers exceeds the LPM blueprint.
- 32% of neighbourhood constables are student officers in their first 2 years of service.

This review explores the issues behind the perceived reduction of police visibility by local communities. It makes a number of recommendations for change to enhance police visibility within neighbourhoods, enable effective problem solving and ensure confidence in policing continues to rise.

Recommendations

Immediate Implementation

Number	Recommendation
3(a)	All actual bodily harm (ABH) offences to be investigated by CID. This will reduce an additional area of demand on SN and will allow officers to be more visible in their neighbourhoods.
3(b)	All offences to be allocated as per the LPM blueprint - local circumstances to be considered by Borough Commander in liaison with Area Commander.
6	No reintroduction of Beat Crimes Units
7	30% patrol time for ERPT to be utilised for increased functions.
8	'E' calls to be a function and responsibility of the nearest available unit regardless of portfolio.
9	Appointment cars to be a responsibility of the ERPT.
10	Hospital guards, constant watches and crime scene preservation task primacy to be removed from Neighbourhoods and moved to ERPT (with discretional use of Neighbourhood officers when deemed operationally necessary by BOCU leadership)
12	DWOs to remain ring fenced except for NYE and Notting Hill Carnival operations. This should be subject of audit and performance reporting.
13	Patrol and operational functions within Neighbourhoods should be conducted in uniform, on foot, by cycle or public transport. A governance framework for this to be developed - local circumstances to be considered by Area Commander in liaison with Borough Commander.
16	Neighbourhood shift review to be revisited to consider a separate DWO roster to enhance visibility and deliver on engagement promises such as ward meetings
17	Neighbourhood shift review to reconsider the neighbourhood policing roster against the revised roles and responsibilities maximizing visibility. A new shift pattern to be consulted upon with the intention of implementation by summer 2015.
18	DWO numbers to be reviewed within the top 100 challenged wards.
21	For consistency neighbourhood teams are to be known as Safer Neighbourhood Teams across London.

Medium Term Implementation

Number	Recommendation
1(a)	HR to develop a corporate strategy for the placement of restricted officers through workforce planning based on deployability commencing with neighbourhood officers.
1(b)	HR to review recuperative and restricted PCSOs as front line patrol is core to their employment.
2	Neighbourhood teams to have full establishment of detectives as per blueprint to ensure effective leadership of investigations in light of the student officer numbers.
4	Investigative workloads for neighbourhoods and local CID to be revisited and demand modeled.
5	Demand analysis to be undertaken to consider the 60% secondary investigation rate.
11	E graded incidents and appointment purpose, demand and use to be reviewed using systems analysis, to ensure service users have increased prospect of resolution to an enquiry at time of initial call.
14	Variations to the LPM in Neighbourhood Policing roles as illustrated in figure 26 to be reviewed by Area Commanders.
15	Resource hubs to backfill core posts using officers from across geographic and business group boundaries.
23	Review and reality check Neighbourhood Inspector role, including feasibility and options of ring fencing from Aid and other abstractions

Longer Term Implementation

Number	Recommendation
19	Review of Metropolitan Special Constabulary (MSC) to ensure alignment of resources with neighbourhood policing delivery model to enhance police presence within communities.
20	Public engagement programme to review and develop Volunteer Police Cadet structure to complement neighbourhood policing delivery model.
22	Communication, marketing and branding strategy for Neighbourhood Policing to be further developed in collaboration with the Directorate of Media and Communications (DMC) to reflect the breadth of staff delivering the neighbourhood roles and responsibilities.

Contents

Background

The future of neighbourhood policing in the Metropolitan Police Service has been the subject of wide ranging operational, political, academic and media debate. Neighbourhood Policing has evolved with much success over two decades culminating in 2013 with the implementation of the Local Policing Model (LPM).

Upon appointment the Commissioner publicly confirmed his support for a strong Neighbourhood Policing delivery model within the MPS with an uplift of frontline staff which was supported by the Mayors Office for Policing and Crime;

"My vision of total policing begins in the neighbourhoods.

We need dedicated officers in every ward in London.

We can only succeed if we work with and for local people

to tackle the crimes that matter most to them,

with a promise to improve, not reduce the neighbourhood policing model,

finding an additional 2,000 officers for such duties"

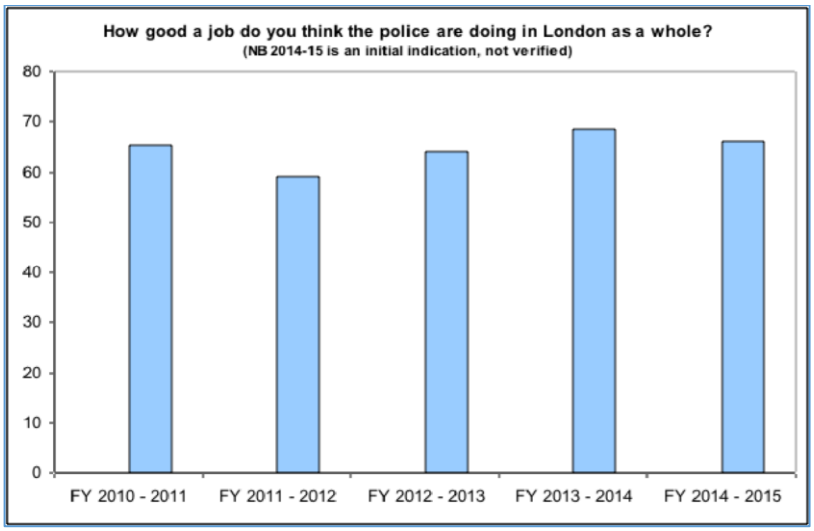
Sir Bernard Hogan-Howe,

Commissioner of the Metropolis

This vision and commitment has been realised with pre LPM Neighbourhood Officer numbers of c.1900 rising to 4000 after the launch of the LPM in 2013, rising again to 4500 in August 2014. Although the increase was not immediate and a large number of vacancies were initially carried, officer numbers now surpass the increased commitment promised.

Notwithstanding the 12 months of challenges to reach full establishment within Neighbourhood Policing during transition to the Local Policing Model, indices show improvements in MPS performance which are making London safer. Crime and anti-social behaviour (ASB) has reduced, response to calls from the public have improved and all against a backdrop of improving confidence and satisfaction. These are illustrated at figures 1, 2 and 3.

Figure 1: Confidence



(Source: PAS Quarterly Report)

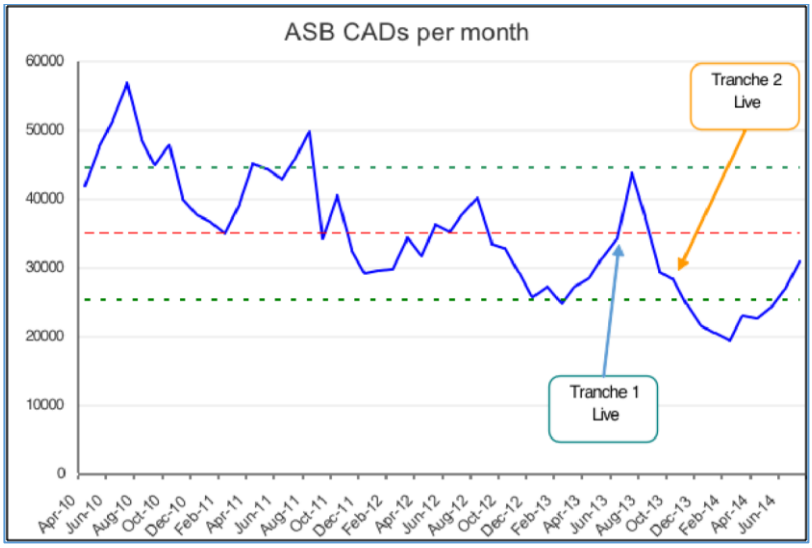
An increase of 4% in 2012/13 to 2013/14.

Figure 2: Satisfaction

(Source: USS Monthly Report)

Satisfaction with the overall service provided by the MPS has increased by 4% 2013/14 against 2012/13.

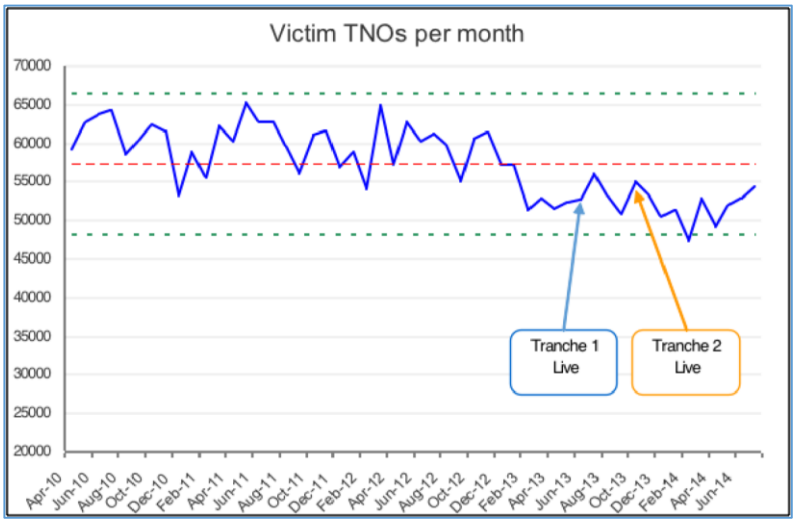
Figure 3: ASB



(Source: CAD via DARIS)

ASB calls have continued to fall (following a 4 year trend) with 69,587 fewer calls in the current rolling 12 months compared to the previous 12 months. A -28.3% reduction.

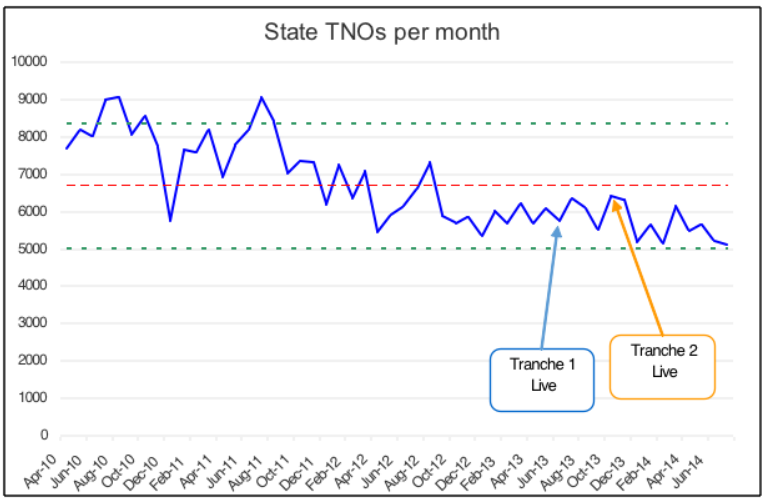
Figure 4: Victim based Crime



(Source: CRIS via MetStats)

44,670 fewer victim Total Notifiable Offences (TNOs) in the current rolling 12 months against the previous 12 months. A -6.7% reduction.

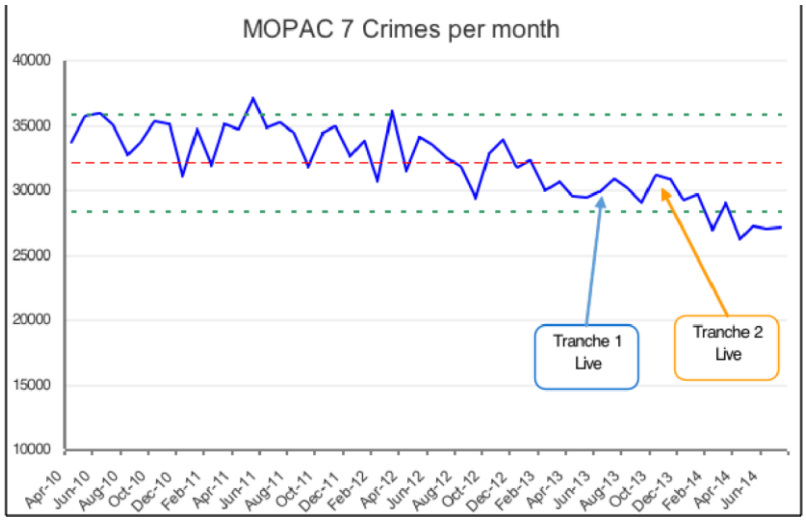
Figure 5: State/Regina based crime



(Source: CRIS via MetStats)

Since the LPM went live there have been 3,949 fewer state TNOs, a fall of 5.5%. These crimes are predominantly police generated such as drugs possession, going equipped etc. They are often referred to as police proactivity. These reductions question whether such proactivity is required to reduce crime as crime has reduced against a backdrop of reduced proactivity but increased problem solving and prevention activity under the LPM.

Figure 6: MOPAC 7 Crimes per month



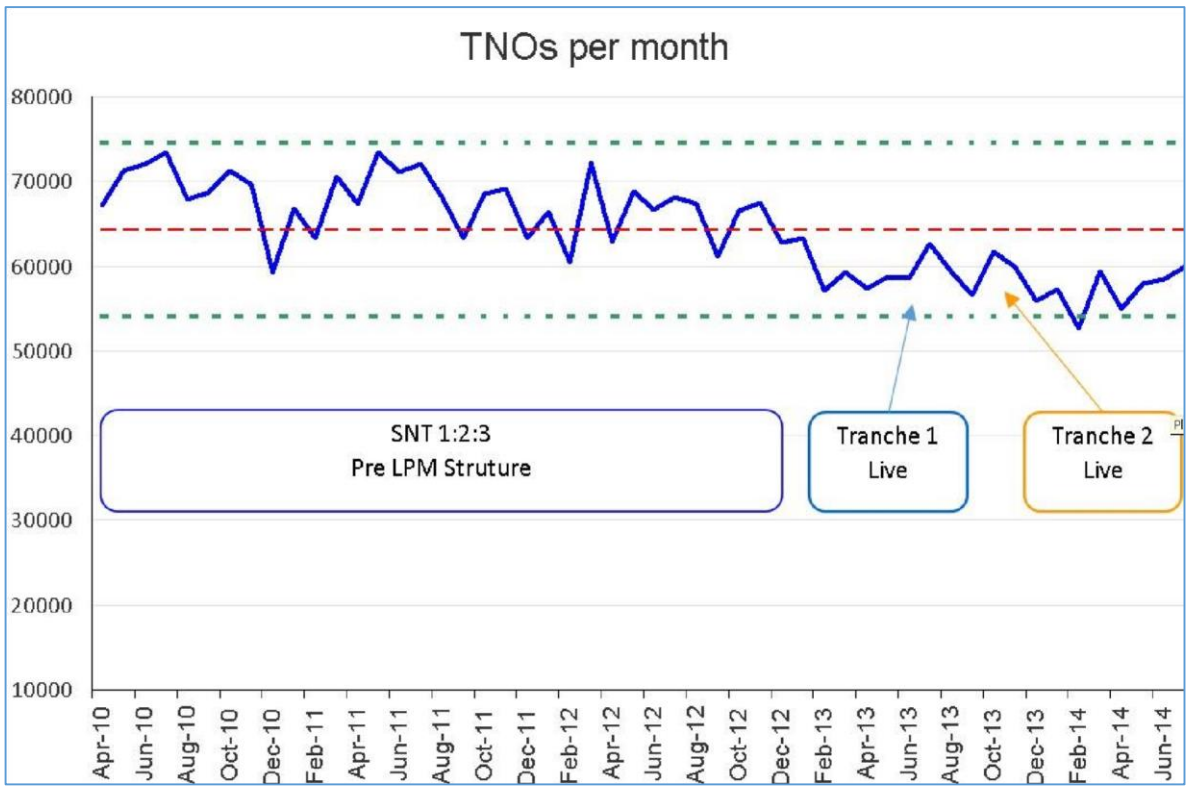
(Source: CRIS via MetStats)

Since the LPM came in, there have been 28,361 fewer MOPAC 7 crimes. A reduction of -7.6%.

Despite these successes there has been growing concern from local and pan-London community and political stakeholders that neighbourhood policing is less engaged and present in neighbourhoods than under the previous Safer Neighbourhood Team structure of 1 sergeant, 2 constables and 3 PCSOs per London ward, commonly referred to nationally as the 1:2:3 model.

The 1:2:3 model was developed at a time of national prosperity within policing and the primary focus was community and stakeholder engagement. Stakeholder management was delivered well under the 1:2:3 model with teams receiving strong community and political support however, crime reduction was varied with ASB and crime rates significantly higher than post implementation of Neighbourhood Policing. See Figure 7.

Figure 7: TNOs shown against Neighbourhood Delivery Models between April 2010 and June 2014



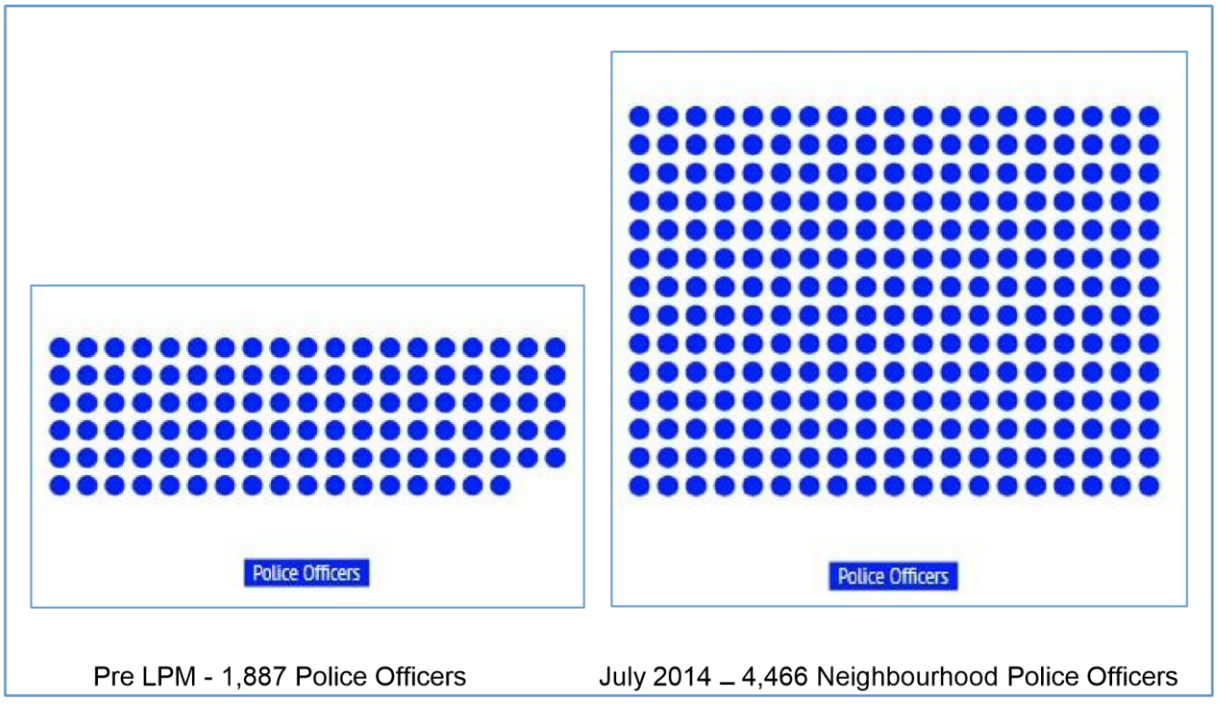
(Source: CRIS via MetStats)

Historical Context of Neighbourhoods Visibility

Public feedback indicates concern about police visibility within neighbourhoods. In order to understand this it is important to look at the context of visibility and the difference between the traditional, well known and recognised, 1:2:3 Safer Neighbourhood model operated by the MPS for 9 years between 2004 and 2013 and the current LPM structure of Neighbourhood Policing.

Despite the 138% uplift of officers into neighbourhood policing, the move to a single Dedicated Ward Officer (DWO) with a single dedicated ward PCSO represents a 77% reduction in ward based neighbourhood policing when compared to the 1:2:3 model. Currently there are 1258 personnel, 629 constables and 629 PCSOs, who are ring-fenced and dedicated to ward based policing across the metropolis. Under the 1:2:3 model there was a total of 3774 personnel, comprising of 629 sergeants, 1258 constables and 1887 PCSOs who were all ring-fenced

There has been a significant increase in the number of police officers within Neighbourhood Policing. Before the LPM came into being there were 1,887 police officers within the Safer Neighbourhood environment. Following implementation of the LPM this number has risen to 4,466 police officers with 4,500 being the establishment figure, a significant increase in warranted officers, which is illustrated in figure 9 below;

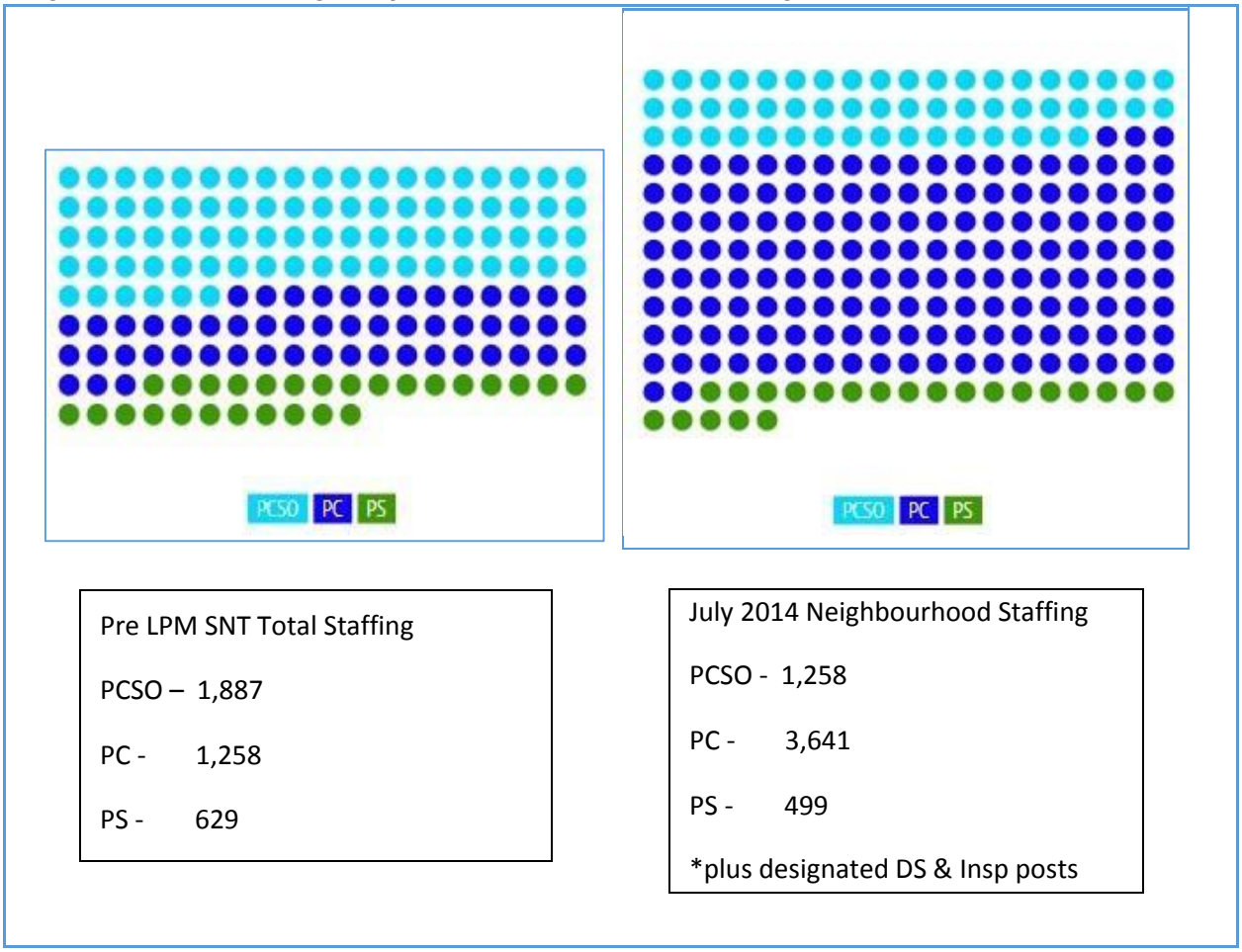


(Source: Metchange)

Figure 9: Police Officer numbers

In terms of overall resources allocated to Neighbourhood Policing, this is higher than it has ever been with July 2014 showing just over 6,000 personnel in neighbourhood policing exceeding the 5,724 establishment figure. Figure 10 disaggregates Neighbourhood Policing staffing numbers pre LPM and currently. A healthy growth can clearly be seen.

Figure 10: Total staffing comparison – Pre LPM SNTs vs Neighbourhoods 2014



(Source: Metchange)

The 1:2:3 model was well branded and was well supported by community and political stakeholders alike. It was fundamentally designed to deliver engagement across London's communities and the roles and responsibilities were distinctly different. Enhanced Performance in the Community (EPIC) data, at Figure 11 & 12 illustrates that the primary roles expected under the 1:2:3 model were engagement activities such as ward meetings, surgeries and leaflet drops. Activity reflective of crime fighting principles such as crime investigation and problem solving were limited, and despite its external popularity, crime was higher (see Figure 7)

Figure 11: Safer Neighbourhood Team EPIC Data - Action Tracker

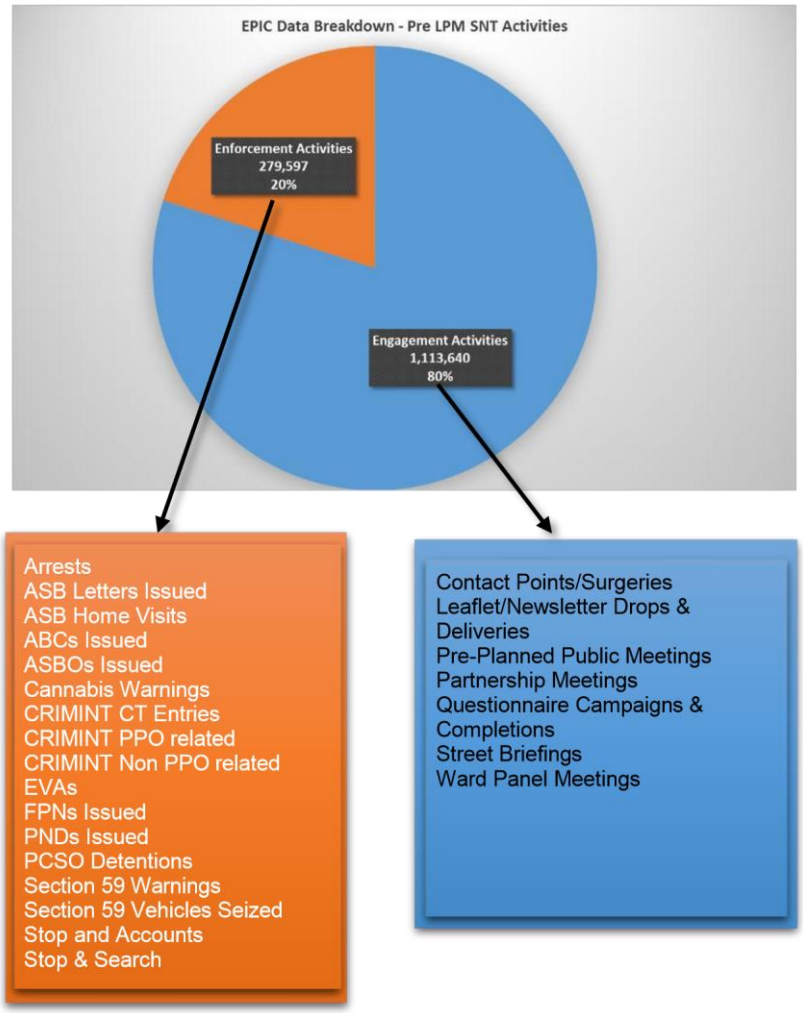
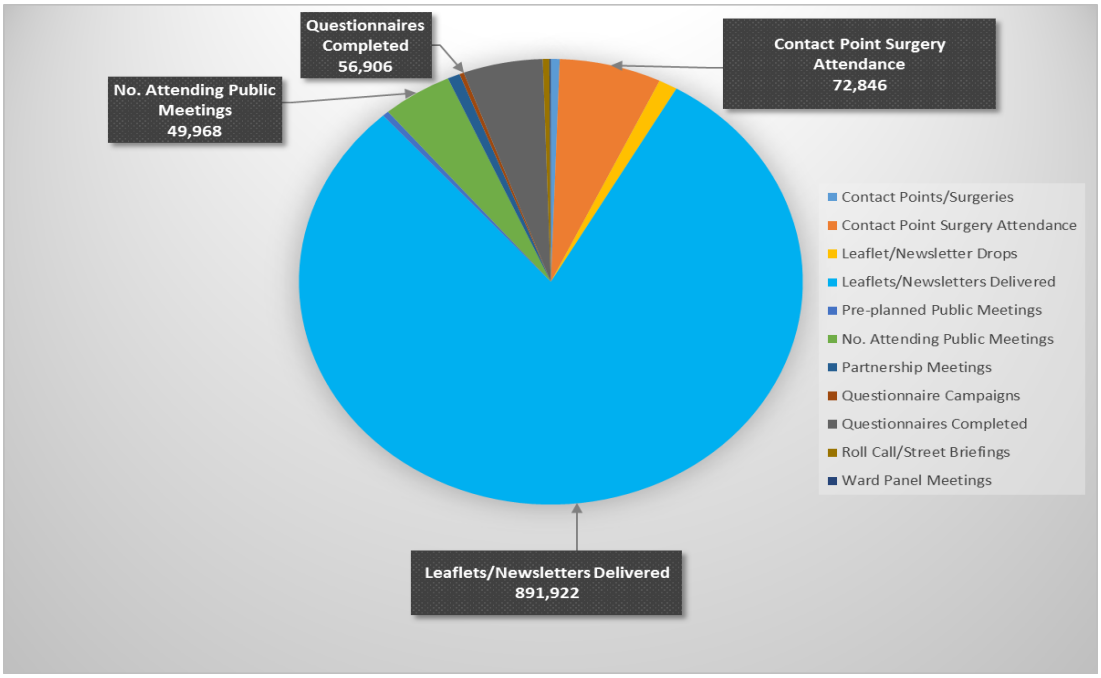


Figure 12: Safer Neighbourhood Team EPIC Data Action Tracker (Detail of Non-Core Policing - Blue Area from Fig 11)



(Source: EPIC Data)

Although the LPM has allocated 2,600 additional police officers to Neighbourhood Policing, with a greater ability to flex resources, to realise the crime and ASB reduction, and respond effectively to community concerns, it has at the same time allocated additional functionality previously undertaken elsewhere. Figure 13 illustrates the additional policing activity which is now being undertaken by neighbourhood officers which was not a function of resources under the 1:2:3 model.

The LPM Detailed Design Document version 6.8.2 outlines the development of the LPM modelling process from conception to implementation. The key design principles which underpinned the uplift in roles and responsibilities are at Appendix B.

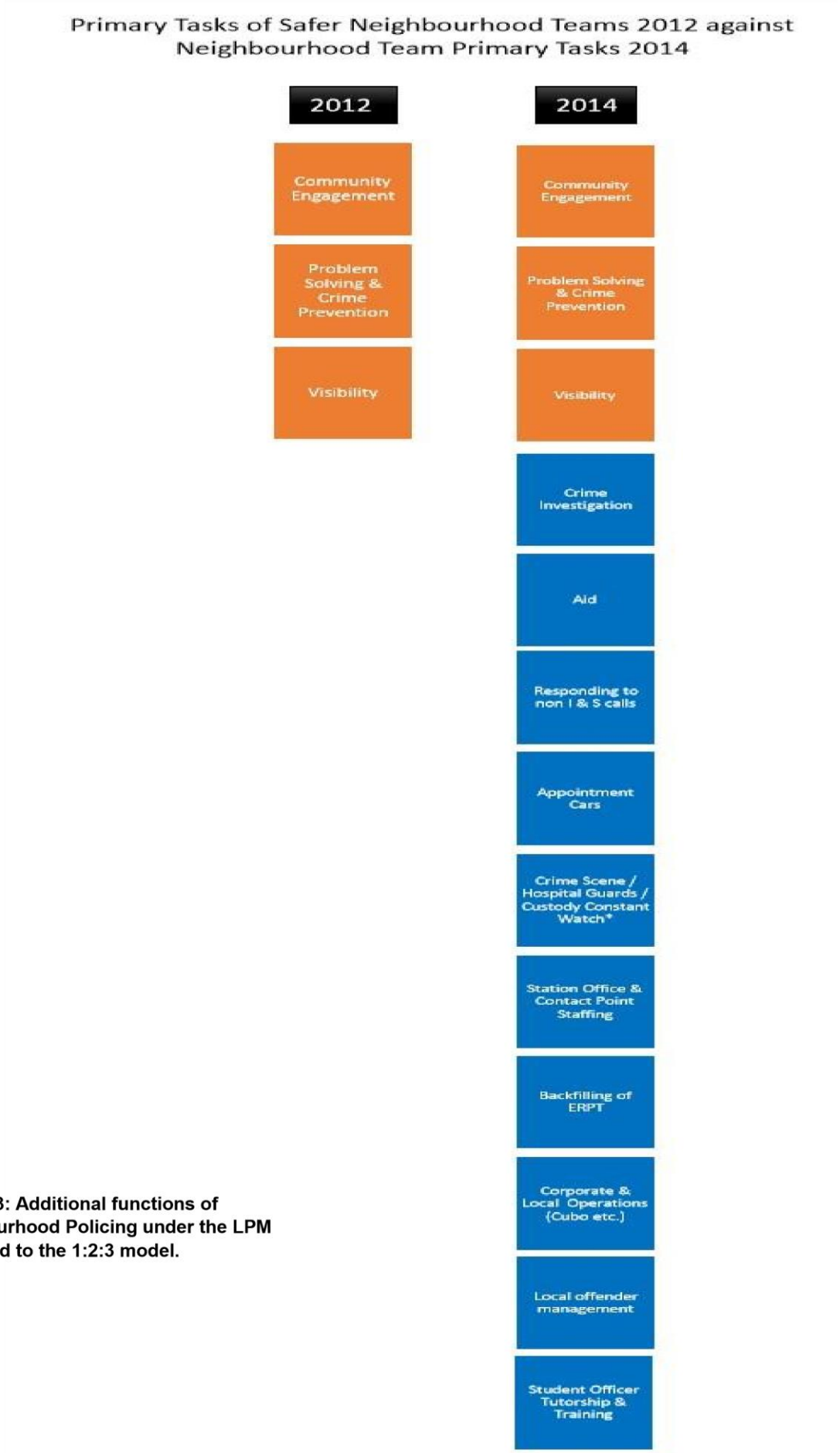


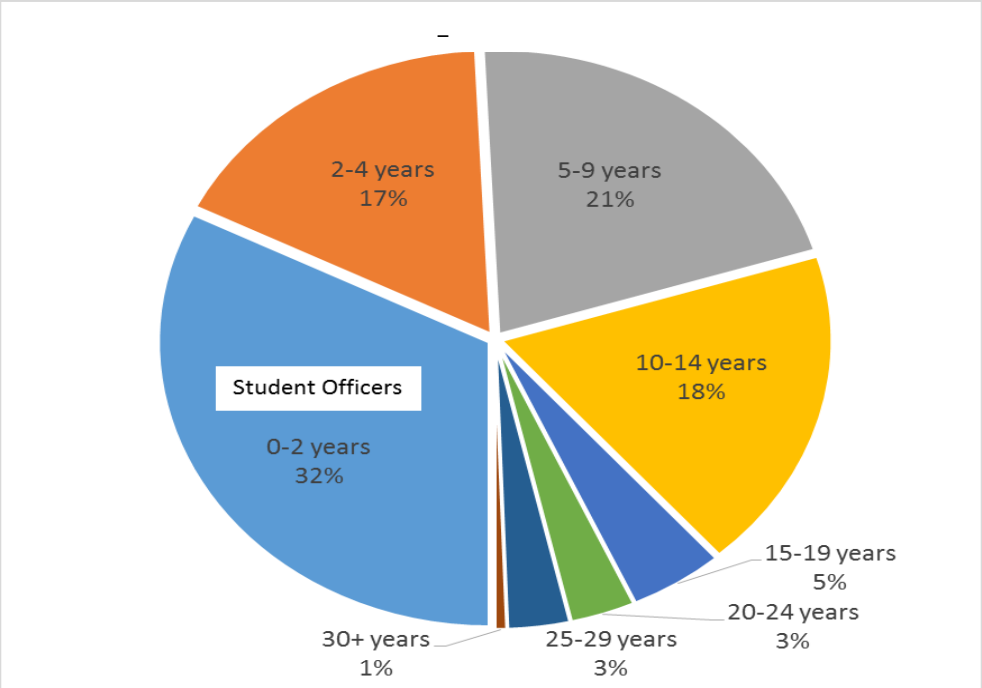
Figure 13: Additional functions of Neighbourhood Policing under the LPM compared to the 1:2:3 model.

Neighbourhood Resourcing

Student Officers

One of the earliest challenges to the success of the LPM was achieving the 2015 police officer modelled figures of 4,500. Tranche 1 went live with a c.5-10% vacancy factor and Tranche 2 with a c.10% vacancy factor. Full establishment has only very recently been achieved. However, this in itself has proved complex to manage as large pockets of vacancies within Neighbourhood Policing have now been filled with student officers who require training and support through coached patrols. As of July 2014 student constable numbers within Neighbourhoods ranged from 18% - 48% across individual boroughs, with 32% being the MPS average. The overall MPS service mix within Neighbourhoods is illustrated at figure 14 which although showing a balance across service bands reflects the inexperience of the officer workforce with just under 50% having up to 4 years' service. TP has recently undertaken a review of coached patrol and currently there is no evidence to require alterations to it.

Figure 14: Service bands of officers within neighbourhoods

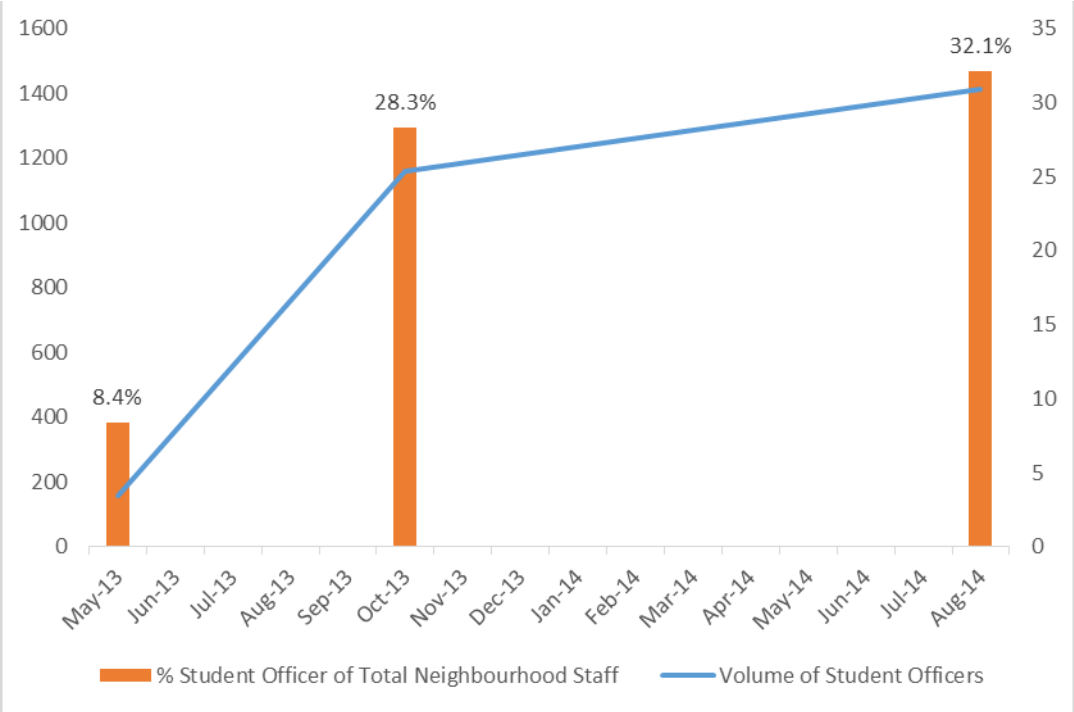


(Source: Metchange/HR)

Figure 15 below illustrates the increase in student constable numbers in Neighbourhoods since Tranche 1 implementation in June 2013. It highlights a steady increase in PC numbers in Neighbourhoods, provided by the increase in recruit numbers. There is no target strength for probationers in Neighbourhoods as they are all posted into Neighbourhoods directly from initial training as per the Local Policing Model. Conversely, there has been a decrease in the number of PCSOs in Neighbourhoods. This can be attributed to the requirement for a reduction in

PCSO posts to the current neighbourhood policing model - an approximate 33% reduction in PCSOs (c.1900-1260 respectively.)

Figure 15: Volume and ratio of student officers within neighbourhoods



(Source: Metchange/HR)

Restricted and Recuperative Officers

Restricted and recuperative figures vary considerably across the seven business groups with the current average for TP being 3.5% for restricted officers and 3.1% for recuperative officers. This ranks TP, 2/7 and 3/7 respectively despite the fact that changes under Metchange mean that its ability to deploy such staff have diminished as a higher proportion of roles require operational front line deployment. As of July 2014, there were 131 restricted police officers and 244 police officers on recuperative duties posted to Neighbourhood teams. This equates to 8% of the Neighbourhood workforce. There were also 60 PCSOs within Neighbourhoods that are on recuperative duties.

Recommendation 1

(a) HR to develop a corporate strategy for the placement of restricted officers through workforce planning based on deployability commencing with neighbourhood officers

(b) HR to review recuperative and restricted PCSOs as front line patrol is core to their employment.

Demand/Abstractions

There are a number of functions within the neighbourhood policing strand of the LPM which are required but which impact on the opportunities for officers to be visible within the 108 MPS Neighbourhoods. These are;

- Investigation of neighbourhood crime
- Appointment Cars
- E graded calls
- Hospital guards, crime scene management, custody constant watches.
- Aid

The above are all additional functions which were not previously undertaken within neighbourhoods under the 1:2:3 model. A 30% patrol factor has been modelled into ERPT. Despite pre-LPM demand modelling being undertaken and resources being reallocated to neighbourhoods from ERPT and CID, it is clear that the additional functions are placing considerable pressure on resources, impacting on community visibility.

The movement of these areas of responsibility into the Neighbourhood portfolio has brought with it a greater demand than anticipated but it has enabled a 30% patrol factor for ERPTs to be maintained.

In order to understand the impact of these additional responsibilities on the ability of neighbourhood officers to be visible it is relevant to consider the history, context and volumetrics.

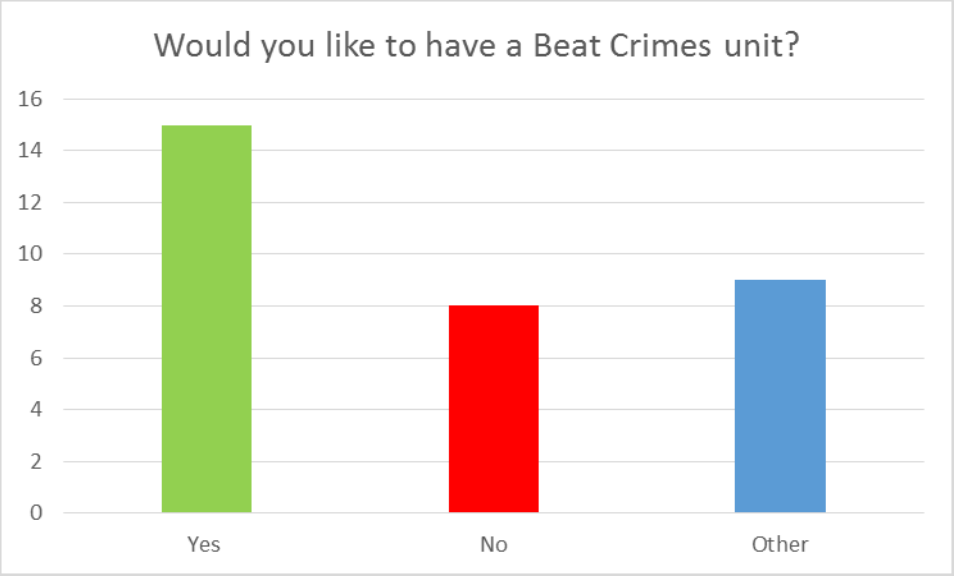
Investigation of Neighbourhood Crime

A change to Neighbourhood policing has been the responsibility for managing all Neighbourhood crime. These crime types were previously referred to as Beat crimes and are low level, high volume crimes that require investigation but do not require the additional skill of a detective.

The LPM was predicated on a desire for neighbourhood officers to have greater ownership of the end to end process for investigating neighbourhood crime, contact with local victims and knowledge of local offenders. Recent analysis of the Victims Code of Practice indices shows that performance in this area has not changed however detections have reduced slightly from 18% in 2012 to 17% in 2014. Work is ongoing regarding improving investigations skills and processes.

Prior to the current model Beat crimes were dealt with by a Beat Crimes Unit managed by the CID portfolio. These units were staffed by uniform officers and carried high caseloads and provided an entry point into the CID as a career pathway. With the current pressures on neighbourhood officers borough commanders were consulted with regard to their views as to whether re-establishing these units would be a preference. Feedback was varied as illustrated at figure 16.

Figure 16: Beat Crime Unit research



(Source: E-mail survey of BOCU Commanders – September 2014)

Those against felt that such a move would be regressive as the current model has led to a fundamental shift in the responsibility and accountability of neighbourhood crimes which should be a fundamental principle of Neighbourhood Policing. That said most felt that the roles and responsibilities of neighbourhood policing needed to be rationalised in order to create time to ensure prompt and effective investigations are undertaken. Many felt that officers are getting greater investigative experience and that there is greater accountability to the communities they serve. Retaining investigations is also aiding a greater understanding of the local crime picture which facilitates more effective problem solving and greater contact locally.

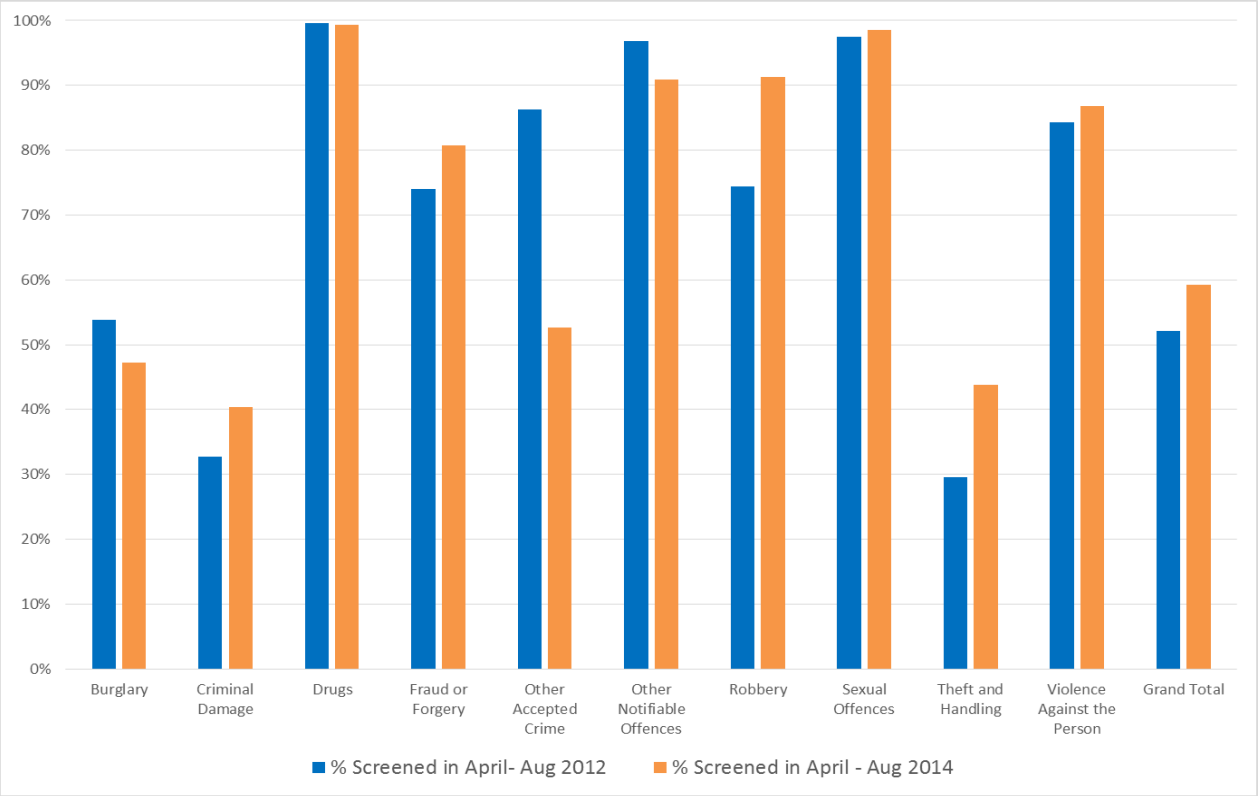
Those against felt neighbourhoods were struggling to keep abreast of investigations despite the Detective Sergeant and Detective Constable support within the model mainly due to shortages in those roles.

The investigation of neighbourhood crime by neighbourhood officers is a cultural shift but one which uplifts the investigative skills of officers. This model is still relatively new and there is clear evidence from Borough Commanders that performance in this area is improving. The most significant challenge inhibiting neighbourhood officers' ability to investigate crime in a timely manner is the varied abstractions which this paper addresses. The case is not made to reintroduce a beat crimes unit.

The LPM detailed design model was predicated on 40% of crime being allocated for secondary investigation. Figure 17 illustrates that over 59% of crime is currently allocated for secondary investigation. What is also significant is that theft and violence offences (the two biggest volume contributor offence categories to crime levels) are now allocated for secondary investigation at a greater rate than pre LPM. This is in contradiction to a projected reduction in allocation as envisaged by LPM system modelling with the resultant impact being a reduction in Neighbourhood visibility and resources.

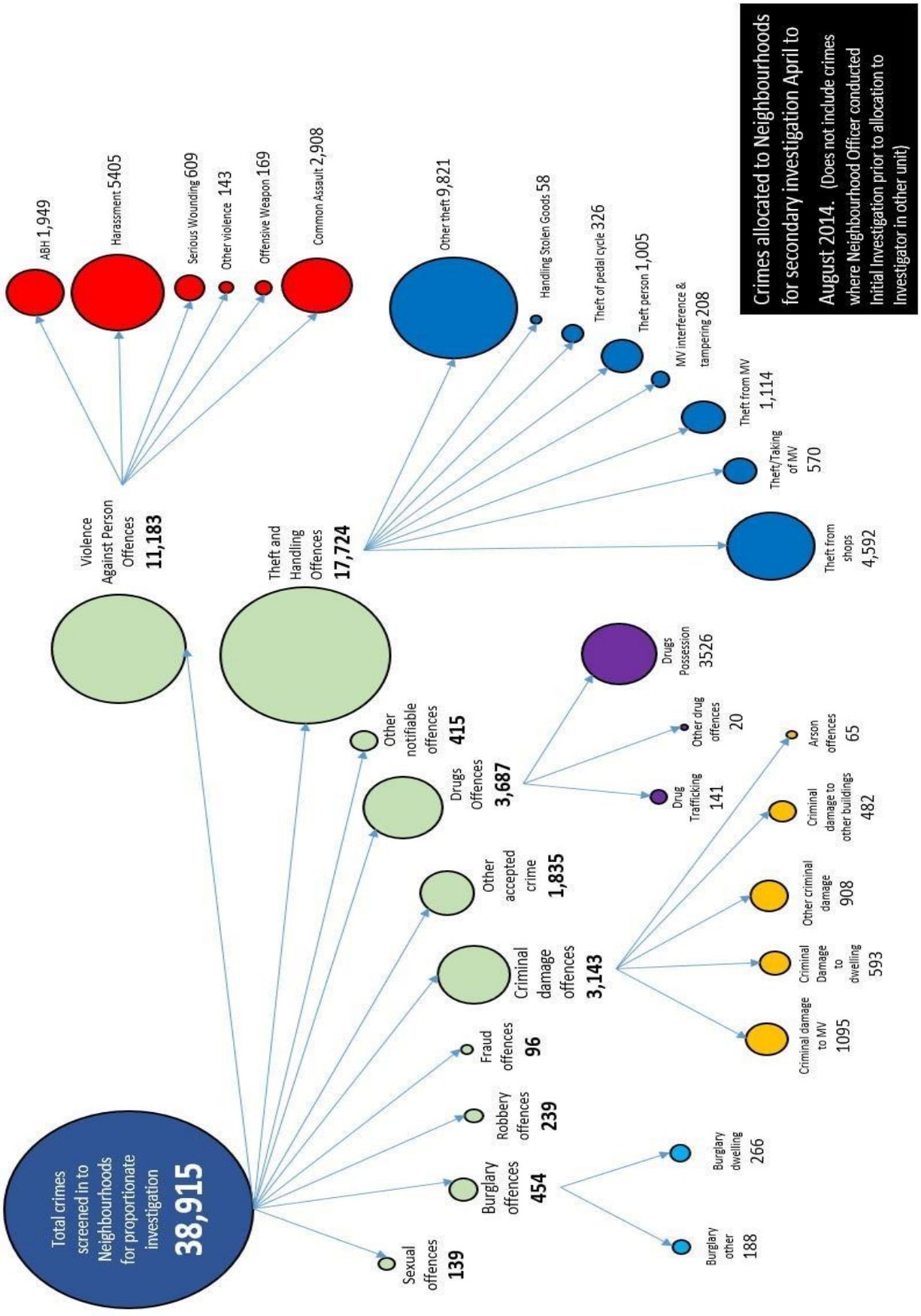
The growth of crime investigations within neighbourhoods is significant when balanced against abstractions and additional functions. The types and volume of their investigations are illustrated at figure 18. What is immediately apparent is the number of serious wounding, ABH and burglary investigations being investigated by neighbourhoods. This is outside of the LPM blueprint and not something which neighbourhood policing teams were resourced for.

Figure 17: Crimes allocated for secondary investigation April – August 2013 against April – August 2014. Note, theft & handling offence and violence against person offence categories are the largest volume contributors. Both showing an increases in allocation. Total offence allocation has risen from 52.1% in 2012 to 59.2% in 2014. NB: More serious/complex crime are allocated to CID for secondary investigation.



(Source: CRIS data by MetHQ Portfolio & Planning)

Figure 18 (Source: CRIS data by MetHQ Portfolio & Planning)



Recommendation 2

Neighbourhood teams to have full establishment of detectives as per blueprint to ensure effective leadership of investigations in light of the student officer numbers.

Recommendation 3(a)

All actual bodily harm (ABH) offences to be investigated by CID. This will reduce an additional area of demand on SN and will allow officers to be more visible in their Neighbourhoods.

Recommendation 3(b)

All offences to be allocated as per the LPM blueprint - local circumstances to be considered by Borough Commander in liaison with Area Commander.

Recommendation 4

Investigative workloads for neighbourhoods and local CID to be revisited and demand modeled.

Recommendation 5

Demand analysis to be undertaken to consider the 60% secondary investigation rate.

Recommendation 6

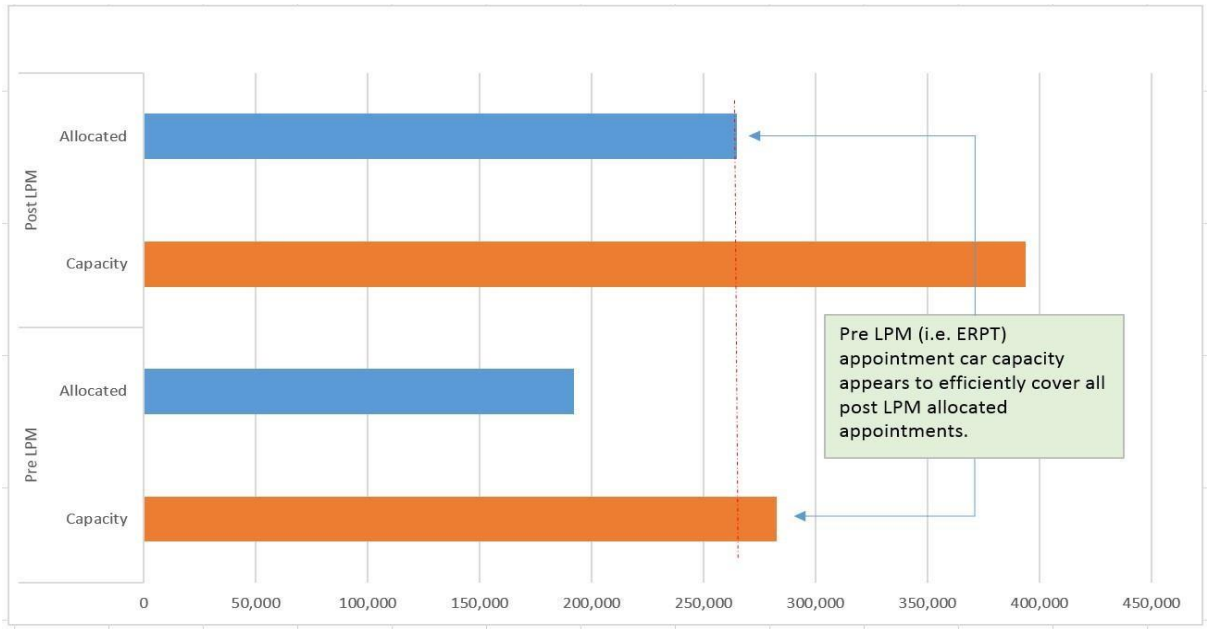
No reintroduction of Beat Crimes Units.

Appointment cars and E graded calls

Appointment cars were historically developed to improve the service delivery to callers by offering a scheduled appointment time to attend outside of charter times, they are categorized as ‘Extended’ or ‘E’ calls. This formed part of the corporate strategy to improve customer satisfaction. Pre-LPM appointment cars were staffed by ERPT officers and an early and late car was deployed requiring 64 officers a day pan-London. Post-LPM implementation, deployment has grown to cover two shifts for each of the 108 Neighbourhoods. This required 216 staff, an uplift of 237%. Officers undertaking this role must be drivers and therefore due to the high volumes of student constables within neighbourhoods this has virtually become a regular posting for experienced staff in some areas.

The volume of allocated appointments has significantly grown across all Boroughs post-LPM implementation by 38% as illustrated in figure 19. However only around 68% of available appointment capacity is utilised, plus with Neighbourhood Officers now used to crew appointment cars there is an impact on community engagement and visibility. There is no clear explanation to account for this growth in appointment volume although what is evident is that ’S’ graded response calls have equally increased by 16% as illustrated in Figure 21.

Figure 19: Appointment car capacity and allocation pre and post-LPM implementation (9 month period)

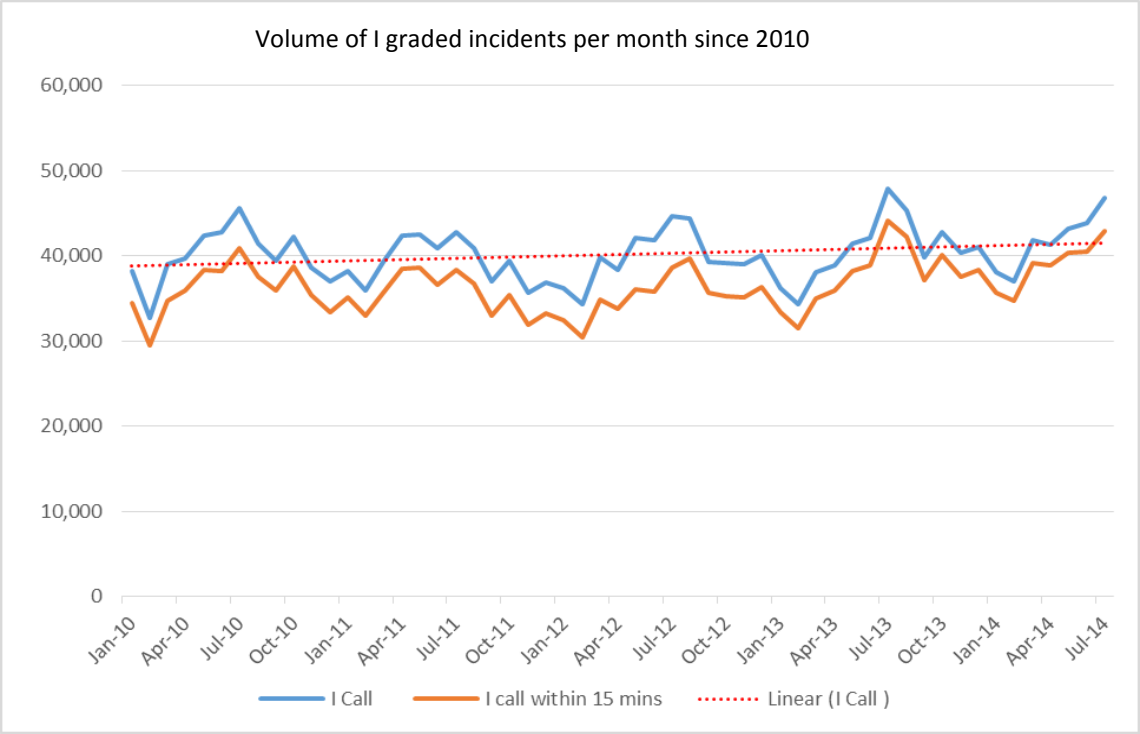


(Source: Met CCC data via Metchange)

There is no evidence base available that demonstrates a benefit of transferring appointment cars to a neighbourhood policing delivery model from the ERPT or indeed to demonstrate that the ERPT delivery model was ineffective.

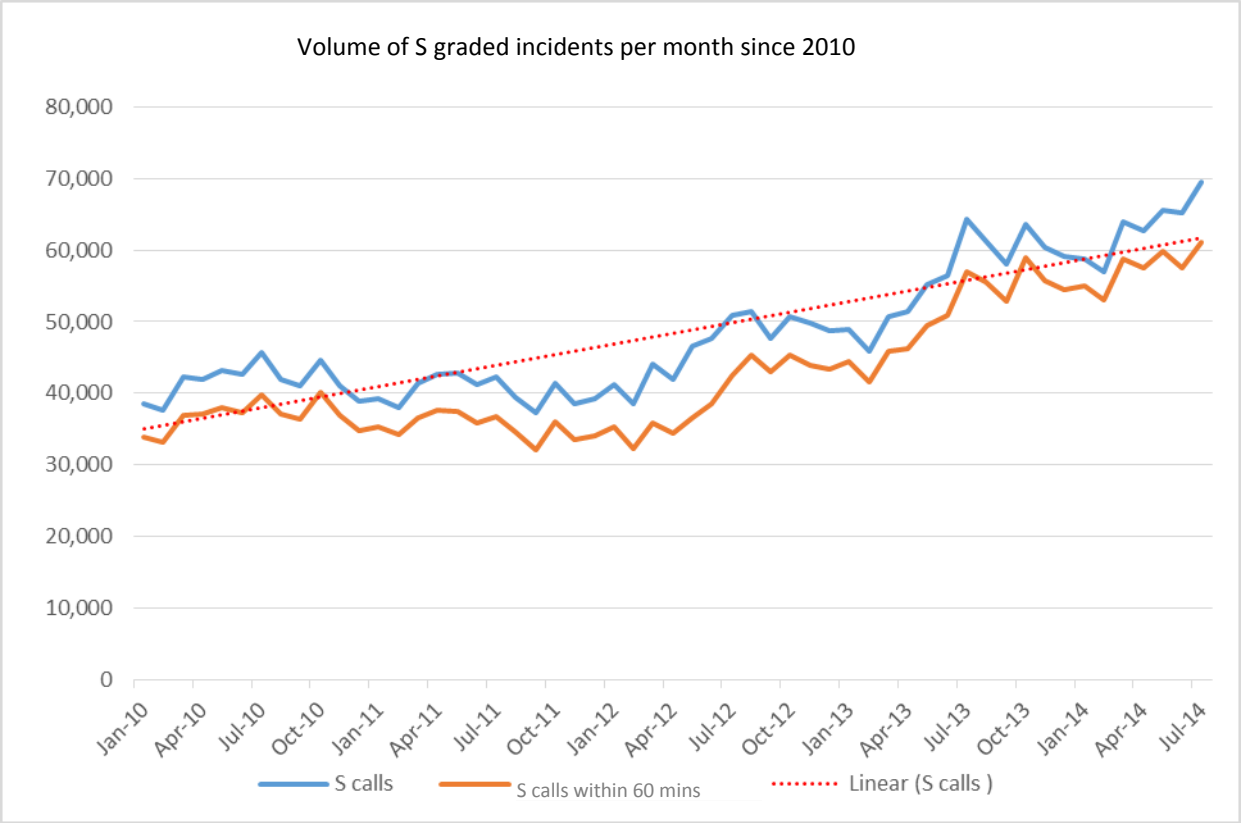
In considering where best to site the responsibility of appointments an option is to use the 30% patrol capacity of ERPT (data at figures 4&5 questions any direct correlation between proactivity and crime reduction) and return the appointment car function and responsibility to ERPT. Data from figure 19 suggests that ERPTs could return to pre LPM resourcing levels for appointment cars and efficiently cover the post LPM volume of allocated appointments – a 94% capacity to allocation efficiency against the current 68%. ERPTs performance for response to I & S call incidents exceeds charter expectations as illustrated in figures 20 & 21.

Figure 20: Number of I incidents per month against incidents attended within 15 minutes since 2010. Very gradual rising trend.



(Source: CAD via MetStats)

Figure 21: Number of S incidents per month against incidents attended within 60 minutes since 2010. Significant increasing trend.



(Source: CAD via MetStats)

Hospital Guards, Crime Scene Guarding & Custody Constant Watch

As part of the Local Policing Model structure, Neighbourhood Officers were given the responsibility to resource hospital guards, crime scenes & constant watches in custody in an effort to release ERPT officers from incidents following the initial first hour. This has had an operational impact on the visibility of neighbourhood officers. Current command and control systems do not permit comprehensive quantitative analysis of the impact of such duties, or other similar duties such as assisting other agencies with mental health assessments (another task allocated primarily to Neighbourhoods).

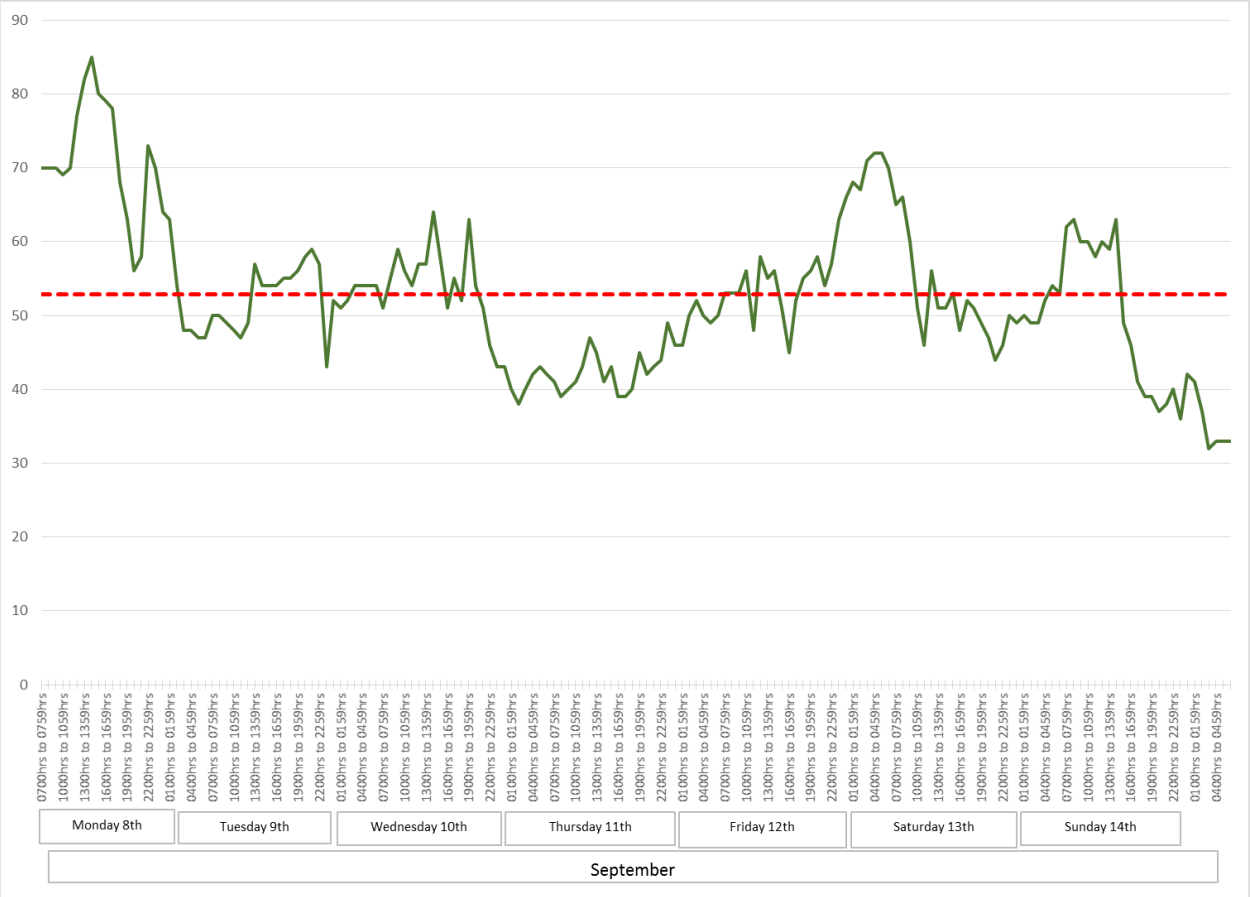
Bespoke research undertaken during the week commencing Monday 8th September has established an hourly average of 52.8 officers tasked with guarding prisoners in hospital, crime scene preservation and custody constant watches across the MPS during the week analysed. This is a conservative figure and the reality is probably higher due to data collection challenges.

Figure 22 tracks the number of officers assigned to such duties each hour as the week progresses with the average displayed in red. It is clear from the data that such duties are a

constant requirement of operational policing and common feature on every BOCU. There does not appear to be any evidence base or demand modelling as to why such tasks were allocated exclusively to Neighbourhoods Policing under the LPM. This has caused an undesirable silo effect.

The individual decisions around deployment of officers to such tasks should be left to borough leadership on an hour by hour basis to make best use of resources. Primacy for hospital guards, crime scene preservation and constant watches in custody should not primarily be a task for Neighbourhoods. Many boroughs have already deviated from the blueprint and are tasking ERPTs when deemed appropriate to these tasks.

Figure 22: Number of officers tasked with hospital guard, crime scene preservation or custody constant watches across the MPS over week commencing 8th September.



(Source: Survey of BOCU GPCs conducted week commencing 8th September)

Recommendation 7

30% patrol time for ERPT to be utilised for increased functions.

Recommendation 8

'E' calls to be a function and responsibility of the nearest available unit regardless of portfolio.

Recommendation 9

Appointment cars to be a responsibility of the ERPT.

Recommendation 10

Hospital guards, constant watches and crime scene preservation task primacy to be removed from Neighbourhoods and moved to ERPT (with discretional use of Neighbourhood officers when deemed operationally necessary by BOCU leadership)

Recommendation 11

E graded incidents & appointment purpose, demand and use to be reviewed using systems analysis, to ensure service users have increased prospect of resolution to an enquiry at time of initial call.

Aid

Historically neighbourhood officers under the 1:2:3 model were ring fenced from aid. DWOs are ring fenced under the LPM albeit there have been anecdotal examples where they have been utilised for central aid or to backfill skills and to maintain minimum strengths on ERPTs. Regrettably this has led to broken promises to attend community meetings and functions which has raised concern in some areas amongst key stakeholders. This position is subject of scrutiny by all Boroughs and TP COG. Steps have already been implemented to prevent abstractions of DWOs.

Recommendation 12

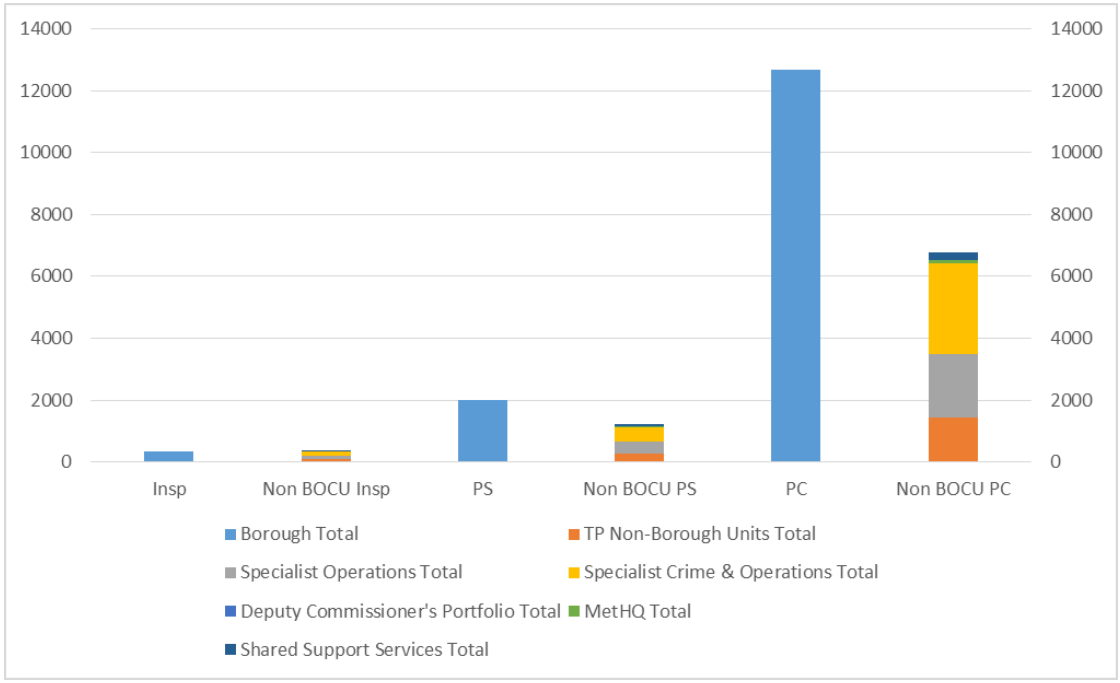
DWOs to remain ring fenced except for NYE and Notting Hill Carnival operations. This should be subject of audit and performance reporting.

Aid remains a significant challenge for TP and in particular for Neighbourhood policing and it will be considered in greater detail within phase 2. TP complete the majority of aid with the exception of units such as TSG, mounted etc. whose requirement is predicated on skillset.

Figure 23 shows the spread of uniformed officers at constable, sergeant and Inspector level across business groups. Many of the uniformed officers within other business groups are not used for aid and although it is recognised that some are on restricted or recuperative duties there are those who are fully fit for operational duties. The impact of aid, particularly on neighbourhood policing, would be less within TP if the entire pool of available uniformed officers were considered for aid warnings, pan London.

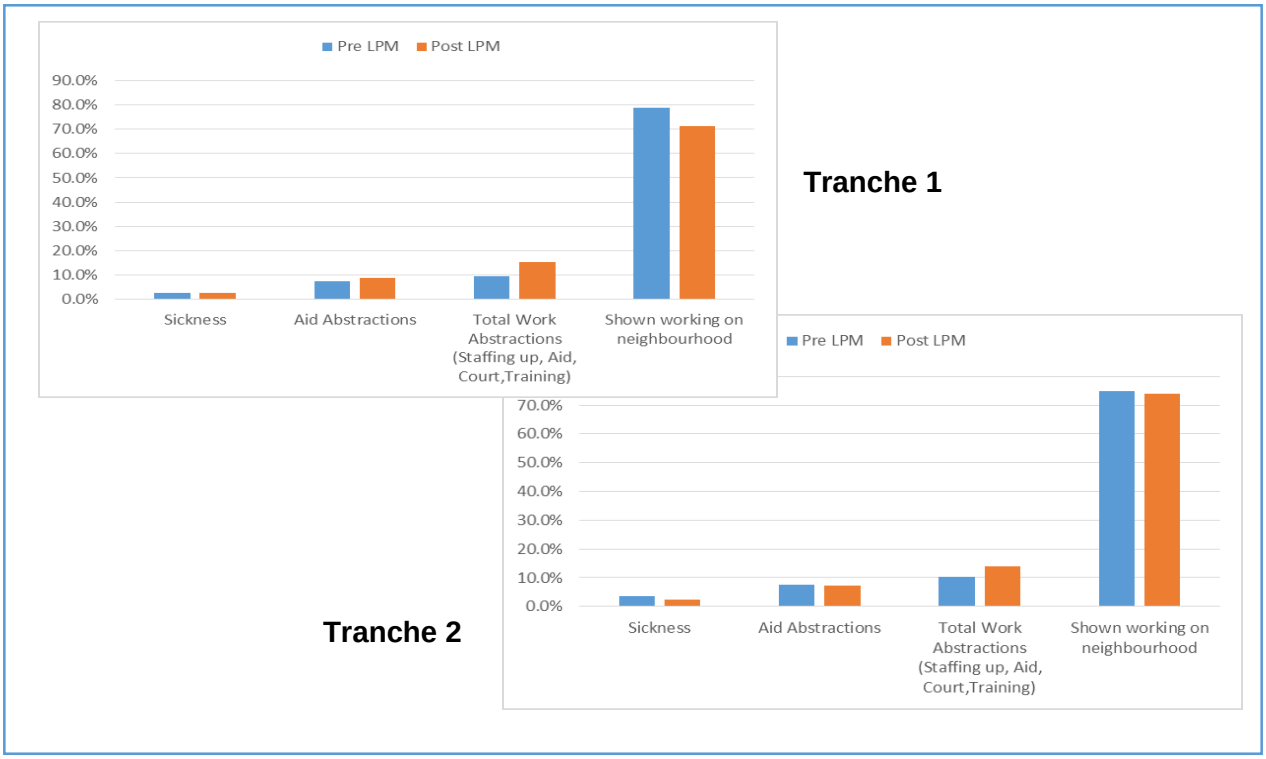
In addition, as corporate structural change continues and functions are transferred away from TP and into other business groups, TP naturally lose the associated officers, many of whom undertook aid duties previously. The impact of this should be considered within change programmes. The use of uniformed officers across business groups for corporate aid demands through cross business group resource management must be reconsidered. Good practice of this was delivered during the 2011 disorder when 6,000 non TP officers were mobilised for front line duties.

Figure 23: Spread of Uniformed PC, PS & Inspector ranks across the MPS. Blue shaded are BOCU based uniformed officers.



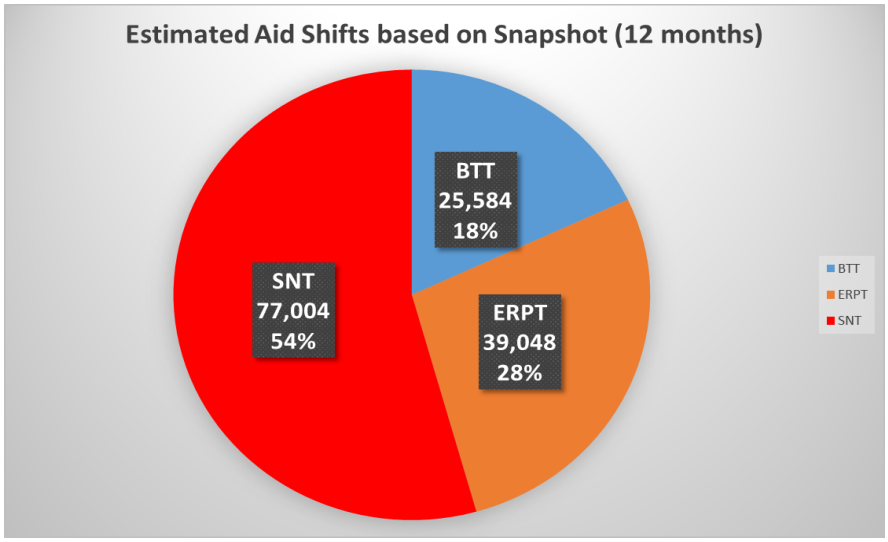
(Source: MetHR)

Figure 24: Tranche 1 & Tranche 2 Aid, Sickness and total abstractions pre and post LPM – CARMS data



(Source: MetHR via Metchange)

Figure 25: TP distribution of Aid on BOCUs

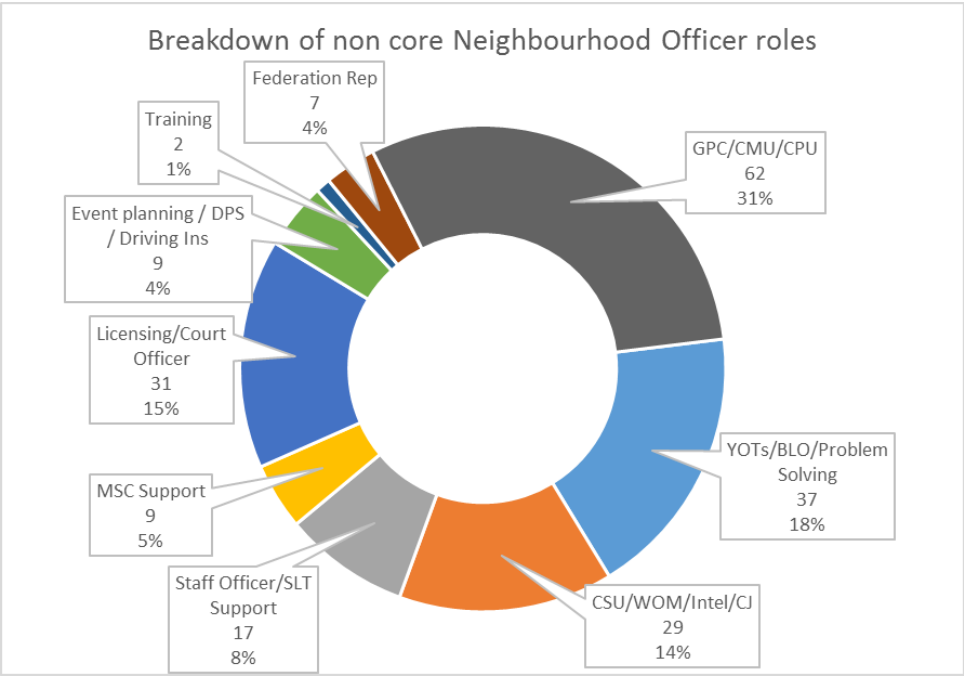


(Source: CARMS via Metchange)

Abstractions

A small number of neighbourhood officers in some Boroughs have been allocated specific responsibilities that were outside the original model. Borough Commanders were given a 3% "flex" under LPM to meet particular local needs. Whilst many of the roles in fig 26 clearly directly support and enhance the work of neighbourhoods these should now be reviewed by Area Commanders to ensure appropriate resource usage.

Figure 26: Breakdown of the 203 Neighbourhood Officers outside of core role



(Source: Metchange research)

A further abstraction for neighbourhood officers is the requirement to backfill core functions in other areas such as ERPT & GPC. During August 2014 there were 2,430 tours of duty by Neighbourhood PC's to backfill ERPTs. Currently the planning of this is undertaken by resourcing hubs and is undertaken on a geographic basis. In practice this means that if a borough ERPT is under minimum strength neighbourhood officers will be abstracted to fulfil this posting even though the neighbouring Borough ERPT may be exceeding its minimum strengths. There would be a significant benefit of a more holistic approach to resource management.

Recommendation 13

Patrol and operational functions within Neighbourhoods should be conducted in uniform, on foot, by cycle or public transport. A governance framework for this to be developed - local circumstances to be considered by Area Commander in liaison with Borough Commander.

Recommendation 14

Variations to the LPM in Neighbourhood policing roles as illustrated in figure 26 to be reviewed by Area Commanders.

Recommendation 15

Resource hubs to backfill core posts using officers from across geographic & business group boundaries.

Shift Pattern

Following concerns from borough command teams, officers and the Police Federation around the neighbourhood shift pattern TP commissioned a review. The purpose of this review was to establish whether the shift pattern is fit for purpose in meeting demand and whether adjustments to the pattern could be made to promote a better work/life balance. The review was not primarily commissioned to consider the functions of staff deployed within neighbourhood policing.

Neighbourhood officers do not work the 2x2x2 shift pattern which is operated by ERPT but one which provides core coverage between 0800-midnight Sunday to Wednesday and 08000200 Thursday to Saturday to reflect operational demand. Boroughs were provided with flexibility to extend shifts to reflect night time economy, alcohol and VWI issues which some elected to do.

In many ways the current Neighbourhood shift pattern was the first time the MPS has implemented an intelligent shift pattern which reflects demand and places officers on duty at an optimal time to reduce and detect crime and ASB and be visible within the night time economy.

Demand modelling for the Neighbourhood shift pattern was based on CAD data and did not take into consideration the totality of roles and responsibilities expected from neighbourhood officers, some previously the responsibility of ERPTs and more suited to a 24/7 response structure. In addition it did not consider the volumetrics for community visibility and engagement, completed well under the 1:2:3 model on an 8-4pm shift pattern.

The recent shift review considered current neighbourhood demand from CAD ‘E’ calls, the appointment car, ASB and crime demand and aid requirements and held extensive workshops with staff employed within neighbourhoods.

The recent shift review did not consider a change in roles and responsibilities for Neighbourhood officers or placing the Dedicated Ward Officers on a separate shift pattern as this was not in scope. The review considered moving neighbourhood officers onto a 2x2x2 shift pattern of earlies, days and lates. This would be a popular pattern with staff as it would provide a much better work/life balance. However, this pattern is predicated on equitable work demand 24/7 which figure 16 clearly illustrates is not the case and reduces the late coverage albeit variants could be included to reflect night and daytime economy issues. It could however deliver efficiency savings c£794k-£1.95m from the reduction in unsociable hour payments. However, it is questionable whether this option deals with neighbourhood demand in terms of

the spectrum of roles and responsibilities. A variant of the 2,2,2 might be capable of development that better balances needs.

The current shift pattern is clearly challenging to officers and impacts significantly on their work/life balance and a change should not be ruled out. However, in order to ensure effective change the shift review should be revisited to consider a separate DWO roster, as a separate DWO shift pattern would enable greater community visibility and enable promises of attendance at key community meetings to be delivered. The review should also reconsider the neighbourhood shift pattern against demand analysis once the roles and responsibilities of neighbourhoods are confirmed.

Recommendation 16

Neighbourhood shift review to be revisited to consider a separate DWO roster to enhance visibility and deliver on engagement promises such as ward meetings.

Recommendation 17

Neighbourhood shift review to reconsider the neighbourhood policing roster against the revised roles and responsibilities maximizing visibility. A new shift pattern to be consulted upon with the intention of implementation by summer 2015

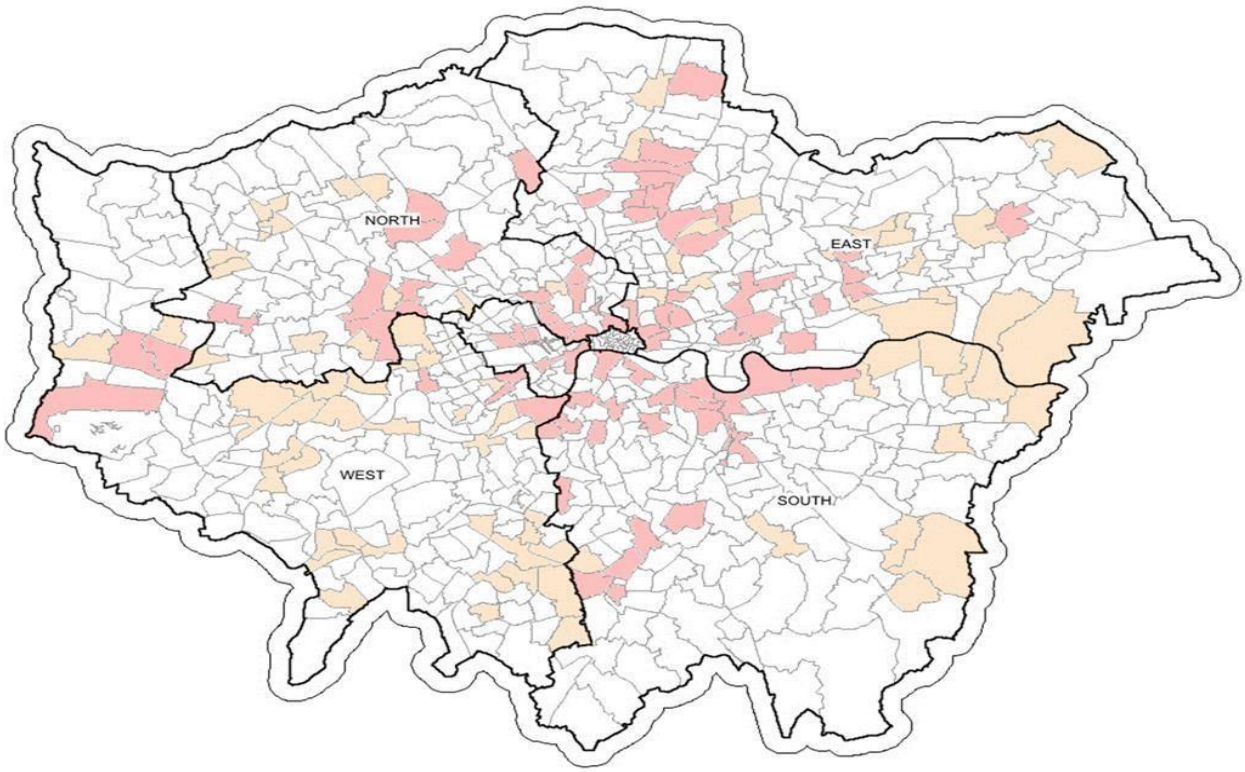
Ward Demand

Prior to the introduction of the LPM some Boroughs developed an operating model to enhance policing of some wards that received an additional three PCSOs. These wards were not identified through a threat, risk, harm matrix but were identified as having a population above 14,000 residents.

In assessing whether visibility could be achieved through an up lift in DWO's to achieve an enhanced delivery model, analysis was undertaken to establish the top 100 challenged wards across the MPS. The parameters used were ASB and MOPAC 7 offences. This data was unweighted and each ward was then afforded an individual position within each measured area and an overall position having combined all results. Unlike the historical enhanced model population was not a factor.

Figure 27 illustrates the MPS top 100 wards in red whilst the orange denotes the top 5 within each Borough.

Figure 27: MPS Area map of Top 100 challenged wards (red) compared to borough Top 5 (orange)



(Source: CAD and CRIS)

There are a number of Top 100 wards that abut at least one other top 100 ward. A number of these wards also sit within the same Neighbourhood. The current neighbourhood delivery model is designed to enable neighbourhood Inspectors to flex resources and therefore these wards would already receive enhanced neighbourhood policing, presence and problem solving. Enhancing police numbers within these wards too far could be inflexible and undermine the neighbourhood inspector's ability to direct resources to the location/issue of highest priority in a dynamic and intelligence led manner. However the accessibility of the public to their DWO in these particularly high demand wards should be considered.

Recommendation 18

DWO numbers to be reviewed within the top 100 challenged wards.

Engagement & Presence

Engagement across London's communities is led by a dedicated ACPO officer. Commander Chishty is leading the public engagement programme. The strategic intentions of this programme are:

- To improve public confidence and community engagement
- To focus activity on the emerging themes from the listening campaign to improve community engagement that is integrated into the borough confidence plans
- To focus activity on the clusters with the lowest confidence
- To empower boroughs to take ownership and responsibility to develop their confidence plans based on the drivers to improve public confidence
- To maximise partnership and community engagement, leading to sustainable relationships to empower and conduct joint problem solving
- To maximise the local media to ensure that the community are involved and informed of the response to the themes
- Ward profiles are regularly updated to ensure that the identification of new communities and engagement with a purpose is a continuous process, and they are available for all the MPS

There are opportunities to enhance police presence within communities using the broader policing family in particular volunteers such as the Met Special Constabulary (MSC) and Volunteer Police Cadets (VPC) and Mounted Police.

Mounted Police

Academic research by Oxford University, commissioned by the national ACPO lead for Mounted policing, suggests that the presence of police horses within communities provides significant police visibility. The MPS was part of the academic study and SCO22 are keen to progress this by identifying named horses for specific London wards and a neighbourhood patrol strategy.

Metropolitan Special Constabulary

TP recently commissioned a review of the operational strategy of the MSC. The MSC structure was changed during 2013 and now has an independent operating structure overseen by a Chief Officer who reports directly to ACTP. The ongoing pressure to restructure to an affordable delivery model presents an opportunity to reconsider the delivery model of the MSC

and make a stronger link to neighbourhood policing with resources being aligned to wards and schools to complement and enhance the neighbourhood police structure.

Volunteer Police Cadets

Police cadets are a valuable asset in terms of the engagement and prevention work they currently undertake which is exceptionally productive. As with the MSC there is an opportunity to reconsider the delivery model of the cadets to align them with the neighbourhood policing model and enhancing their visibility within schools and communities.

Recommendation 19

Review of the Metropolitan Special Constabulary (MSC) to ensure alignment of resources with neighbourhood policing delivery model to enhance police presence within communities.

Recommendation 20

Public engagement programme review and develop Volunteer Police Cadet structure to complement neighbourhood policing delivery model.

Neighbourhood Policing Brand

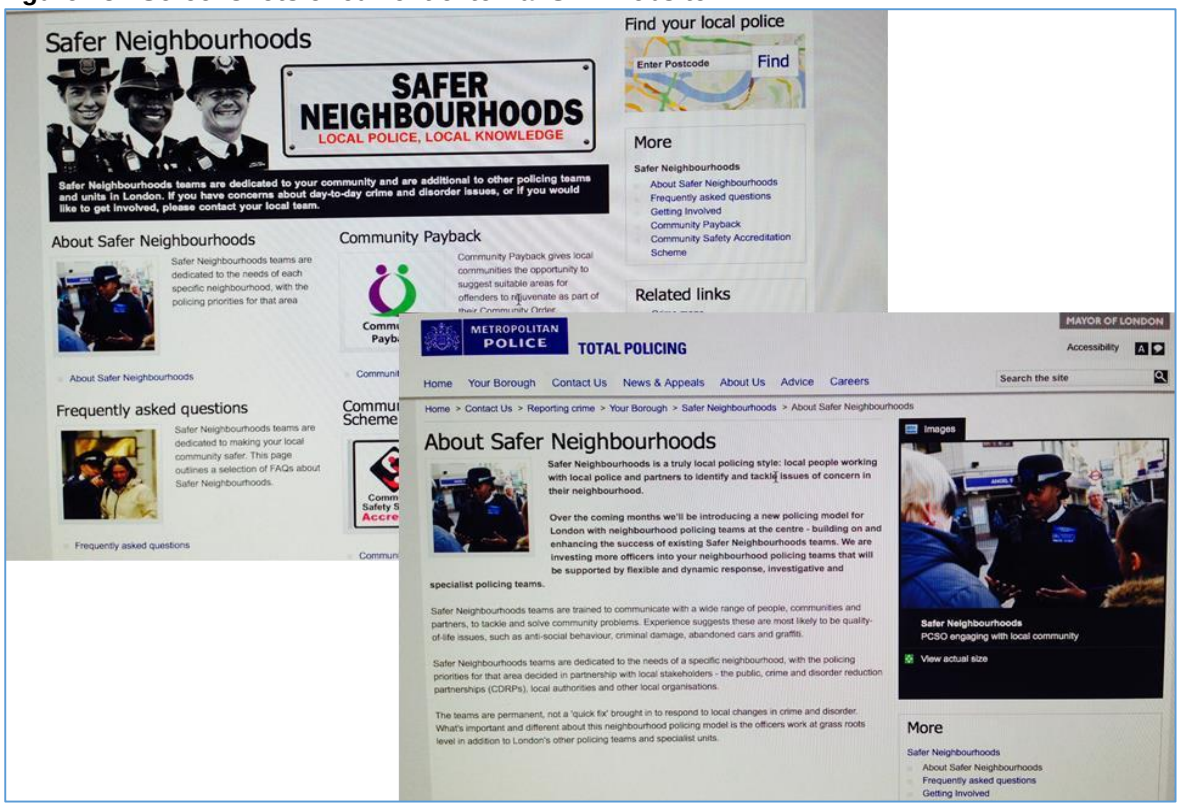
The neighbourhood delivery model remains branded as ‘Safer Neighbourhoods’ on the MPS website but internally the Neighbourhood Policing brand is confusing with it being referred to as neighbourhood policing, safer neighbourhoods, local policing teams to name a few listed on internal publications.

Academic research demonstrates that branding is critical and goes way beyond just a logo or graphic. Branding is about the customer experience, the logo, the website, social media experiences and to the way contact is experienced by people. It could be argued that the brand is the way you are perceived which is intrinsically linked to confidence. A brand should cascade a clear message in order that people, communities, know what to expect.

Neighbourhood Policing is at the core policing yet our brand, when viewed externally, is unclear and a hybrid of the old and new neighbourhood policing models with outdated information.

Figure 28 is reflective of the Neighbourhood Policing brand currently on the MPS website.

Figure 28: Screenshots of current external SNT website.



(Source: MPS website September 2014)

Neighbourhood Inspectors were a key part of the LPM design with a view to make them a visible local commander who communities would know. There is evidence that abstractions amount to well over 10% of Neighbourhood Inspector duties, with 1,061 Duty Officer shifts and over 500 Aid shifts performed by these Inspectors between 1st June and 31st August this year. This will have affected the abilities of these Inspectors to fulfil visible leadership as designed by the LPM. A review should be conducted to look at the workload and abstractions of the 108 Neighbourhood Inspectors including the feasibility of ring fencing them from Aid and reducing the impact of other abstractions

Recommendation 21

For consistency neighbourhood teams are to be known as Safer Neighbourhood Teams across London.

Recommendation 22

Communication, marketing and branding strategy for Neighbourhood Policing to be further developed in collaboration with the Directorate of Media and Communications (DMC) to reflect the breadth of staff delivering the neighbourhood roles and responsibilities.

Recommendation 23

Review and reality check Neighbourhood Inspector role, including feasibility and options of ring fencing from Aid and other abstractions.

Neighbourhood Policing Commitments

Feedback at both MOPAC and Commissioner led roadshows has consistently been focused on the visibility of dedicated ward officers and their presence at community venues, events and ward panel meetings. Earlier chapters illustrate the impact of the shift pattern in relation to dedicated ward officers and recommendations have been made to address this.

The roles and responsibilities of both dedicated ward officers and neighbourhood officers are outlined within the detailed design document. However, it is clear that visibility, trust and confidence and presence within communities could be improved through clear neighbourhood commitments which are outlined below.

Communities can contact and develop relationships and trust through a named officer at key community locations, therefore:

- Every school in London will have a named Neighbourhood Officer who will attend at least twice a month and be known and engage with staff and students.
- Every faith premises will have a named Neighbourhood Officer who will attend monthly and be known and engage with faith communities.
- Every hospital will have a named Neighbourhood Officer who will attend twice a month. They will be known to staff and assist with problem solving and crime reduction.
- Metropolitan Special Constabulary Officers will be aligned to Neighbourhood Policing. They will be members of the community working within the community.
- Probationary constables will serve a minimum of six months of their probation within a Neighbourhood to understand the needs of local communities.

Neighbourhood Inspectors are police leaders within their neighbourhood. They engage with community leaders and local service providers to develop strong working relationships to build trust and increase confidence and satisfaction in neighbourhood policing. They are committed to:

- Attending a meeting with every primary and secondary school head each term.
- Attending faith forum meetings as required.
- A minimum tenure of 2 years.

- Attending Safer Neighbourhood Board meetings.
- Ensuring quarterly newsletters from all wards and neighbourhoods.
- Maintaining and growing KINs (Key individual networks).
- Delivering weekly street briefings.

Dedicated Ward Officers and Dedicated Police Community Support Officers are the primary contact for ward communities. They develop strong community relationships to build trust and increase confidence and satisfaction in local policing and provide feedback to communities on police activity. We will ensure that this happens through the following:

- Every ward will have a named dedicated ward constable and community support officer who are easy to identify and contact via the internet, email and telephone. They will be the access point into policing services (other than 999 and 101).
- They will acknowledge non-emergency community contact with neighbourhood officers (not 999 and 101) within 24 hours, and provide an update within 5 working days around police action.
- Attending ward panel meetings and agreeing and reviewing local promises.
- Staffing local contact points.
- DWO's will serve a minimum tenure of 2 years.
- DWO's will not be abstracted to fulfill other policing functions outside of their ward except for significant annual events such as Trooping the Colour, Notting Hill Carnival and New Year's Eve celebrations.

Future Implications

In considering the recommendations in this paper, Change Board members should be cognisant of a number of ongoing areas of development that may potentially affect Neighbourhood policing. Whilst it is difficult at this time to quantify the full impact of implementation of any of these, they are highlighted as an indicative selection.

Target Operating Model (TOM)

The TOM is looking to design future organisation within future budget constraints, including a projected reduction in funding to 2019/20. The TOM is also considering how services will be delivered including a potential BCU model. It is envisaged that Neighbourhoods remain the foundation of local policing but other services may well be delivered very differently.

Police Community Support Officers (PCSO) 2014/15

The MPS total PCSO strength at the end of July was 1,920, slightly below current target of 2,095. Work to re-distribute existing PCSO's across the organisation continues. This will allow the organisation to ensure that any vacancies are more evenly distributed, pending recruitment to backfill the remaining vacancies subject to current discussions on our budget position this year and into 2015/16 Recruitment activity is currently being scoped and would require circa 250 to 300 new starters to reach the target, but a decision will not be taken on whether to activate recruitment until the conclusion of the current budget discussions.

Mobile Technology

Current pilots of tablets and body worn video are likely to change ways of working and engaging with the public.

Summary

Neighbourhood policing is fundamentally different today and therefore the debate surrounding visibility is complex. To compare historical structures against the new in terms of visibility would be an unequal and oversimplified debate.

Neighbourhood Policing has seen an increase of 2,600 police officers and their role has expanded as shown in appendix C. The uplift in roles and responsibilities of neighbourhood officers has created pressures which are impacting on workloads, officer availability and policing presence and the recommendations in this paper seek to address these and should be implemented through a strong governance framework.

Appendix D illustrates the hours required to deliver these additional roles and responsibilities by neighbourhood officers. Although approximate data it estimates that these functions require the equivalent of 1,199 full time officers to deliver.

Today's enhanced neighbourhood policing is contributing to the significant crime and ASB reductions that London is experiencing and as a result communities are much safer. Neighbourhood Policing is more than the dedicated ward officers who are the face of neighbourhoods. It is a team of people as illustrated below who are working in collaboration to realise Safer Neighbourhoods, with DWOs & Neighbourhood Officers being those closest and most visible to the public.

Appendix A

Neighbourhood Policing Review 2014 Terms of Reference - AC King and Cmdr D'Orsi.

Aims

1. To identify actions that will address the public concern that SNTs are less available, visible and responsive since the implementation of LPM
2. To maintain service standards to incidents.
3. To maintain MPS resilience to resource and respond to significant events and threats appropriately and proportionately investigating crime.

Phase 1 – The data collection and review being undertaken during phase 1 will conclude at the end of August. The focus is on:

• Officer numbers against blueprint

• Neighbourhood Policing remit and structure, with particular focus on DWO

• Causes of abstractions from neighbourhood policing and shift review

• Opportunities to increase visibility.

It is anticipated that Phase 1 will enable quick time recommendations for swift implementation to ensure that:

• Neighbourhood posts are filled as intended.

• DWOs are enabled through effective resource management providing more visible dedicated resource to local communities.

• The structure of DWOs meets the demand.

Phase 2 – This phase is dependent upon the findings from Phase 1. An anticipated completion date is the end of October.

This phase will require collaboration with SC&O and will deliver recommendations to:

a) Review AID levels and processes.

b) Identify opportunities to further enhance impact of SNTs and DWOs for local communities.

c) Review resource, skills and work demands on ERPTs and CID.

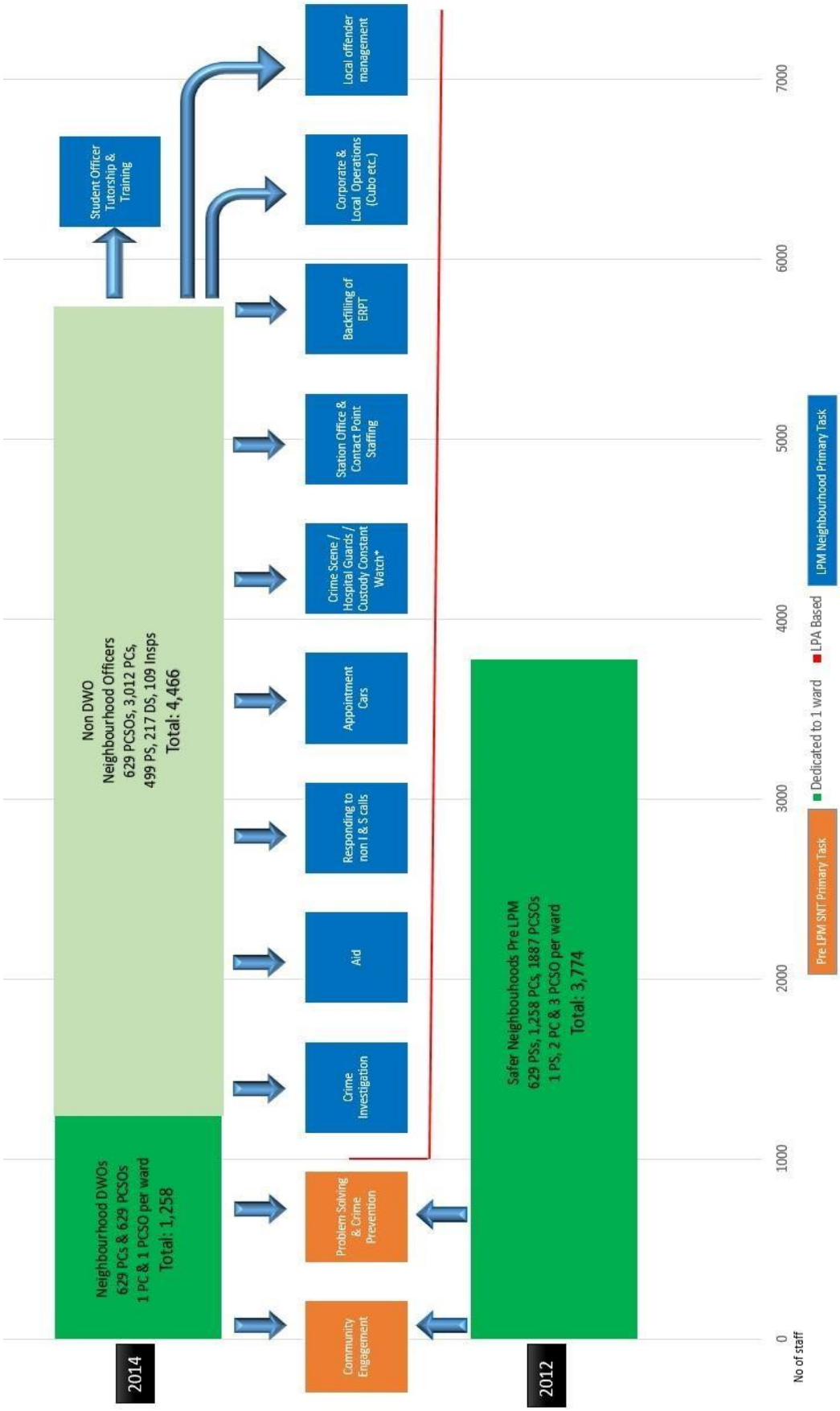
Appendix B

LPM Programme Design Principles for Neighbourhood Policing

Programme design principle	SN specific design principles
Services will be improved and standardised.	• Improve standards of primary and secondary investigation. • Student Officers and MSC will be posted to SNTs.
Services will deliver improved victim and witness care.	• Victims and witnesses will be able to agree a suitable time to be seen by police. • Vulnerable victims and witnesses will be HOT assessed at first point of contact, prioritising police actions.
Services will provide maximum flexibility of resource use both within and across boroughs.	• SNT Officers will respond to demand across their entire Neighbourhood. • A corporate five-week shift pattern will be worked to match core demand providing resilience to ERPT, service mobilisation and borough demand.
Service delivery will be demand led.	• SNT Inspectors will be responsible for all ASB and crime in their Neighbourhood. SNTs will target offenders and co-ordinate activity through the GPC and local tasking process.
Proactive deployment will be intelligence led.	• SNTs will link with communities, partners, ward panel and Key Individual Networks to problem solve against local priorities.
Services will be delivered with enhanced grip and supervision.	• SNTs will ensure visibility and availability to GPC who will assign HOT desk tasking.
There will be increased police visibility.	• SNTs will be resourced to balance reassurance and enforcement activities. • Shifts will provide increased coverage and engagement opportunities during evenings and weekends 365 days a year. • Police will respond to public contact within 24hrs. • Ward and public meetings will be pre-planned, advertised and minuted.
Services will be informed by and delivered through a partnership and community focused approach wherever possible.	• SNTs will make and record action on three ward based 'SMART' promises to their community.
Services will be delivered at a reduced operating cost.	• SNT resource will be co-located centrally within their Neighbourhood wherever possible to achieve estate savings.

Source: LPM Detailed Design Document (DDD) v6.8.2

Appendix C


2014
Neighbourhood DWOs
629 PCs & 629 PCSOs
1 PC & 1 PCSO per ward
Total: 1,258
Non DWO
Neighbourhood Officers
629 PCSOs, 3,012 PCs,
499 PS, 217 DS, 109 Insps
Total: 4,466
Community Engagement
Problem Solving & Crime Prevention
Crime Investigation
Aid
Responding to non I & S calls
Appointment Cars
Crime Scene / Hospital Guards / Custody Constant Watch*
Station Office & Contact Point Staffing
Backfilling of ERPT
Corporate & Local Operations (Cubo etc.)
Local offender management
Student Officer Tutorship & Training
2012
Safer Neighbouhoods Pre LPM
629 PSs, 1,258 PCs, 1887 PCSOs
1 PS, 2 PC & 3 PCSO per ward
Total: 3,774
0
1000
2000
3000
4000
5000
6000
7000
No of staff
Pre LPM SNT Primary Task
Dedicated to 1 ward
LPA Based
LPM Neighbourhood Primary Task

Appendix D

To understand the scale of the resourcing implications of the various tasks allocated to Neighbourhoods, as prescribed by the LPM, the following information has been extrapolated utilising staff hours based around a constables 2,024 hour work year. It should be understood that these are approximations to understand the scale of the issue. Shifts of eight hours have been used (which is shorter than many actual shifts) and overtime has not been considered. It is estimated that these are conservative figures.

Crime Investigation

93,396 neighbourhood crimes allocated to Neighbourhoods per year. If 3 hours are allocated to each crime for investigation this equates to 280,188 staff hours. This is the equivalent of **138.4** officers a year working permanently and solely on criminal investigations (does not include annual leave, training or other abstractions).

Aid

102,558 tours of aid per year. If 8 hours is allocated to each tour of duty this equates to 820,464 staff hours. This is the equivalent of **405.4** officers per year permanently and solely performing Aid duty (does not include annual leave, training or other abstractions).

Backfilling ERPT

19,440 tours of duty per year backfilling ERPT. If 8 hours is allocated to each tour this equates to 155,520 hours a year. This is the equivalent of **76.83** officers per year permanently and solely performing backfilling duties for ERPT (does not include annual leave, training or other abstractions).

Appointment Cars

216 officers crewing appointment cars each day or 1,728 staff hours. This equates to 630,720 staff hours per year. This is the equivalent of **311.6** officers per year permanently and solely crewing appointment cars (does not include annual leave, training and other abstractions).

Hospital Guards, Crime Scene & Custody Constant Watches

53 officers on average per hour performing guard duties. This equates to 8,904 hours per week or 463,008 hours per year. This is the equivalent of **228.8** officers per year permanently and solely performing guard duties (does not include annual leave, training and other abstractions).

In summary the 5 tasks listed above require a resource level equivalent to 1,161 officers each year.

Glossary

2x2x2 – Shift pattern currently worked by Emergency Response & Patrol Officers. 2 early shifts, the 2 late shifts then 2 night shifts followed by 4 rest days.

ABH - Actual Bodily Harm. An assault defined by section 47 of the Offences against the Person Act 1861.

Aid - When an officer is deployed away from his usual location of work to resource events, operations or as part of a London wide response to an issue. Examples include Notting Hill Carnival, football matches, policing of protests, central London New Years Eve celebrations, response to large scale disturbances, Trooping the Colour and so on.

CAD - Computer Aided Despatch. Nearly every operational incident dealt with by the MPS is entered into the CAD system resulting in a unique electronic record with a unique reference number.

CID – Criminal Investigation Department. The overarching term describing the investigative units that deal with more serious and complex crime. Mainly staffed by detectives.

COG - Chief Officer Group. Meeting of senior officers at and above the rank of Commander.

CRIS – Crime Recording Information System. The electronic crime recording system used to record notifiable offences and a few other types of miscellaneous incidents.

Duty Officer - Normally an Inspector who is responsible for overseeing live operational policing on a borough 24 hours every day through shifts.

DWO – Dedicated Ward Officer. Each London Borough has a PC and PCSO who are dedicated and ring fenced to policing that ward.

E grade incident - Extended response. A CAD which does not require an emergency response (I grade), or response within the hour (S grade). Appointments are E grades, but not all E grades are appointments.

ERPT – Emergency Response & Patrol Teams. Team of officers who cover response policing 24 hours every day through shifts. Responsible for responding to and dealing with emergencies (I grades) and calls requiring a response within the hour (S grades).

I grade incident - Immediate response. A CAD that requires an emergency response. Officers should arrive at the incident as soon as possible, and no later than 15 minutes after the call to police is connected to the MPS control room.

MOPAC 7 - The basket of 7 crime types which is the focus of MOPAC performance measurement of the MPS and part of the 20:20:20 challenge. Consists of Burglary, Robbery, Criminal Damage, Theft from Person, Theft of Motor Vehicle, Theft from Motor Vehicle and Violence with Injury offences.

PAS - Public Attitude Survey. A quarterly survey of a sample of residents from all London Boroughs tracking various attitudes towards the police or the work and performance of the police.

S grade incident - Significant response. A CAD that requires a response by a police officer within the hour.

TNO - Total Notifiable Offences. All criminal offences which police forces are required to report to the Home Office as part of the national crime statistics. For example, theft is a notifiable offence, whereas drunk and disorderly is not.

USS - User Satisfaction Survey. A survey of people who have used the services of the MPS, generally as a result of being a victim of crime.

City of Westminster

Adults, Health & Public Protection Policy & Scrutiny Committee

Date:	25th November 2015
Classification:	General Release
Title:	**ASC Customer Journey Programme**
Report of:	Stella Baillie, Tri-borough Director, Integrated Care
Cabinet Member Portfolio	Cabinet Member for Adults & Public Health, Councillor Rachael Robathan
Wards Involved:	All
Policy Context:	City of Choice
Report Author and Contact Details:	**Martin Calleja** martin.calleja@lbhf.gov.uk

1. Executive Summary

1.1 This report provides a brief overview of the scope and progress of the Tri-Borough ASC Customer Journey Programme.

2. Key Matters for the Committee's Consideration

2.1 The report is for information and to support the Committee's ongoing consideration of its 2016 work programme.

3. Background

3.1 Business case and scope of the programme

3.1.1 The Customer Journey Programme is a major Tri-borough ASC programme that was initiated in June 2014. This followed a consultancy led piece of work undertaken in 2013. This work concluded there was substantial scope to simplify and improve case and pathway management through a range of measures including improved use of technology, self service, new ways of working with health (both in and out of hospital) and by simplifying key

processes The programme aims to deliver a better customer experience and substantial savings through the cumulative impact of these changes.

3.1.2 The programme has four component projects covering front door information and advice, hospital discharge, Community Independence Service (CIS) and complex care management. The overarching programme approach ensures that the design of the future service system is appropriately joined up and customer focused.

3.1.3 Savings of up to 25% to social care operations through the programme are expected to be delivered for each borough between the two years 2015 – 2017, subject to agreement of viable plans. Westminster is on track to deliver the first £500k by the end of 2015/16.

3.1.4 The saving ambition for all boroughs in 16/17 is £1.33m for each borough. The complete service re-design, which will set out associated further savings options, is due to be completed by the end of 2015.

3.1.5 The hospital discharge and CIS aspects of the programme are also within the scope of the associated Better Care Fund (BCF) programme. These two areas of service and associated pathways are being driven by an ambition for an accelerated level of multi-disciplinary working and integration with health in these areas. A saving of £1.743m for 2015/16 was committed within the BCF programme for work in these areas. This was associated with improved recovery and reablement targets and reduced care costs. The current out-turn projection for delivery against this target is £1.660m.

3.2 **Progress and achievements**

3.2.1 Front door: arrangements and costs for enquiry handling, providing information and advice and initial screening are currently provided on a single borough basis and have been mapped. Options for improving self servicing on the web, developing the information advice and preventative service offer and a tri-borough solution in readiness for a future integrated front door with health are now being set out.

3.2.2 Hospital Discharge: Integrated pathway and case management has been developed and piloted over all 4 tri-borough hospital sites over the last 6 months. Initial evaluation of the 8 ward pilot and recommendations for rollout have been agreed by the Adults Leadership Team. The aim is to achieve a three borough harmonised service that maximises efficiencies by early 2016. West London Alliance are supporting the development of the business case for sub-regional development. This is an area where the three boroughs are taking a leadership role across health and care.

3.2.3 CIS: An integrated approach to assessing and meeting short term needs to avoid hospital admission and provide better recovery and reablement has been in operation since April 2015. An independent review of front line re-eablement functions across the boroughs was completed in September 2015 and future options are now being considered and wrapped into the customer journey programme. A full evaluation of CIS is now taking place

which will inform the finalisation of the future service design. A consultation on future working arrangements and roles will commence as soon as 2016-17 funding for the service is agreed between the local authorities and CCGs which is expected shortly.

3.2.4 Complex Care: year 1 savings are expected to be delivered through the application of the general principles for service re-design. Detailed work is now taking place and has been completed in the area of carers assessments where the process has been substantially simplified.

3.2.5 The programmes overall service re-design work including savings options will be will be completed by the end of the year, including savings options for discussion with Cabinet Members.

3.2.6 A high level approach to the next phase of whole systems development, that aligns the customer journey and commissioning intentions with health, has been developed and has the support of the Joint Executive Team (JET). Cabinet Members are being briefed on this currently. There will be an increasing focus on Health and Wellbeing Boards as we move forward.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact the Report Author
martin.calleja@lbhf.gov.uk

APPENDICES:

- Improving the patient journey across Central & West London

BACKGROUND PAPERS

- Customer Journey November 2015 Programme Highlight Report

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NHS
Central London
Clinical Commissioning Group

NHS
West London
Clinical Commissioning Group

Improving the patient journey across Central & West London

Introduction

We are working together across the NHS to improve the patient journey across the boroughs of Westminster, Kensington and Chelsea to deliver care that is *personalised; localised; integrated;* and *specialised.*

The work we are doing to improve the patient journey is based on our vision of transformed services. Our transformation of services includes five elements: prevention and self management; primary care transformation; Integrated care; Improving hospital care; and transforming mental health.

The **out of hospital** strategy across Central and West London CCGs increases the amount of care delivered closer to the patient's home, enabling better co-ordination of that care, ensuring the patient has access to the right help in the right setting, and an improved patient journey.

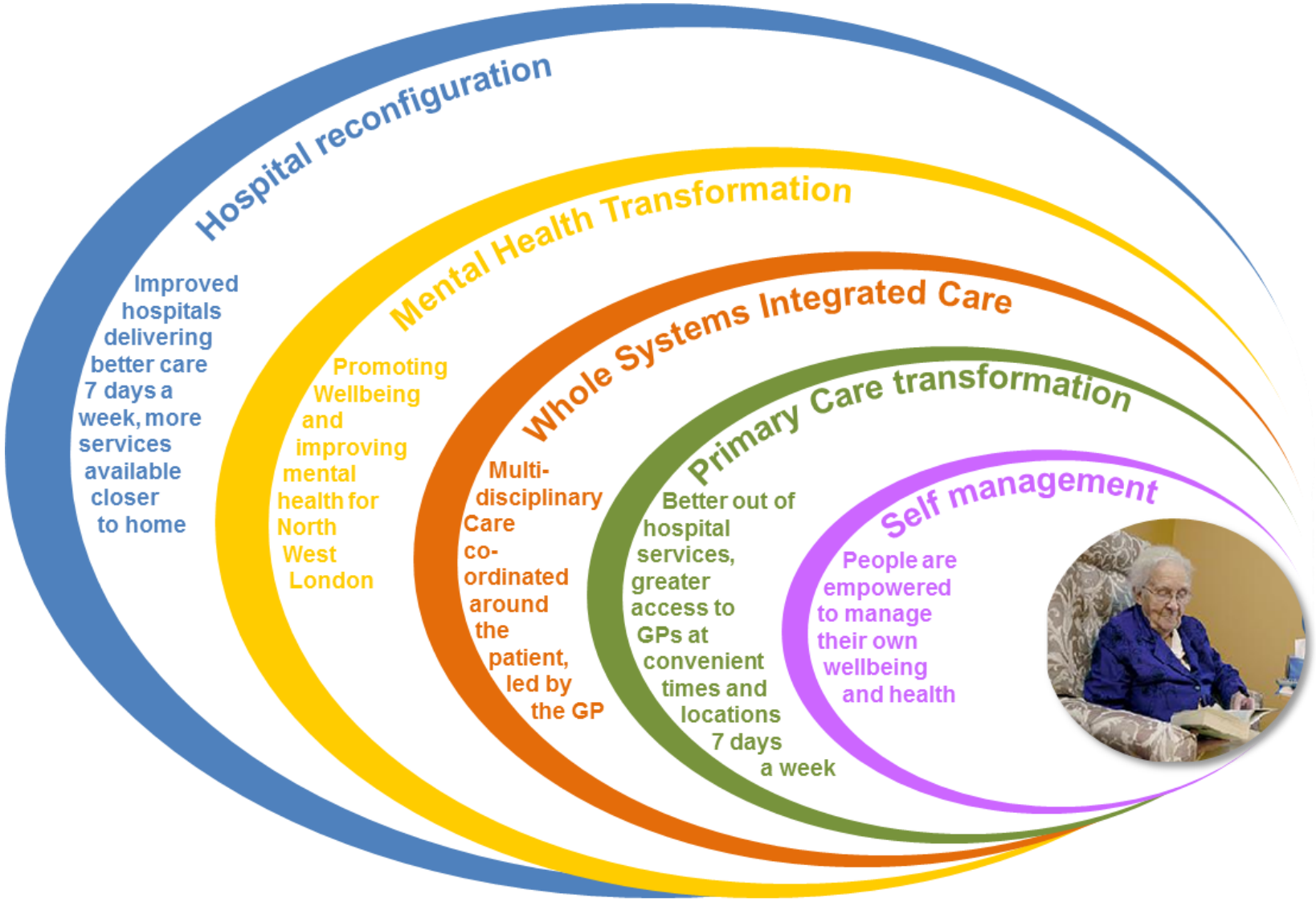
The **Whole Systems Integrated Care (WSIC)** programme in these boroughs is based around giving people more say over their care; when and where they receive it, so that care is planned jointly between patients, their carers and the teams that support them. By involving patients and carers on the journey from day one, we have a much better chance of achieving our vision: care that enables each person to help themselves. By widening access to services that aren't necessarily provided by the NHS, such as local social services or buddying schemes and exercise groups run by third sector parties, we can better support people to maintain independence and lead full lives as active participants in their communities.

The WSIC model is designed to improve the patient journey in various ways: it can mean increased access to GP appointments and specialist doctors; considering mental health at the same time as physical health; and a single, coordinated approach by health, local authority and voluntary sector organisations; so that when patients need longer term care from different people, it is joined up and they don't need to keep repeating their story.

By working together with CCGs across North West London, we can achieve our vision of patient-centred care in all our care settings, ensuring a better, more joined up experience at every point along the patient journey: from self care, through primary care; integrated multi-disciplinary care, mental health transformation, through better, reconfigured out of hospital and in hospital services.

We have provided more detail on this from existing content in the following pages. These begin with our overall strategy in the first two following pages, followed by further detail on specific programmes projects across Central and West London.

The patient journey ..



Our joined-up vision for North West London healthcare

NW London are delivering care that will be…

…this will mean….

Personalised

*Care is to be personalised, enabling people to manage their own care themselves and to offer the best treatment to them. This ensures care is **unique**.*

"I know how to lead a healthy lifestyle and can manage my own care"

- More information, advice and support available online and over the phone. The public are able to easily find out whether they need care, and if so, where to get it, as well as knowing how to get support for existing conditions.
- People can use technology to understand their own health and wellbeing at home. People who need to monitor their conditions will be able to do so through convenient methods to ensure it minimally impacts their lifestyles.

"I feel in control over my care because decisions are taken with me"

- People, not the provider, are at the centre of the design of their own care and of the services available within their community. This is true for the most vulnerable groups in society, too – reducing inequality in health outcomes.
- Wellbeing is seen in its widest sense - it is not only about seeing a doctor and getting medical support – people are able to explore other routes, such as through community support and alternative treatment, where appropriate. Treatment is appropriate for not only the condition, but also for the person.

Localised

*Care is to be localised where possible, allowing for a wider variety of services closer to home. This ensures care is **convenient**.*

"My care is now more convenient because the services closer to my home are more accessible"

- Consultations are more accessible and flexible through the use of telephone, email and video consultations available for all local services, allowing for people to have better access to medical advice.
- People are able to access their GP at more suitable times for them through the availability of appointments seven days a week. There is more availability of GP services offered in other community settings, too.

"I know I will be provided with a wider range of high quality care within my community for all of my health and wellbeing needs"

- Support to prevent people getting ill or to enable them to take care of themselves if they have a mental or physical health condition is consistently available across NWL community care settings.
- A variety of services are provided within the community in buildings that are modern and fit-for-purpose (including minor surgeries, simple tests and outpatient appointments).

Integrated

*Delivering care that considers all the aspects of a person's health and wellbeing and is coordinated across all the services involved. This ensures care is **efficient**.*

"I'm not treated 'in parts', but as a whole person in a coordinated way"

- Mental and physical care are given equal importance in all care settings, ensuring that the person's health care and wellbeing are considered in a more complete way, resulting in the best outcomes for the person. This is true for children as much as for any other population segment.
- Care isn't just limited to hospitals and GP surgeries; services provided within the community are considered to help prevent illness and support wellbeing.

"Whoever I see, knows me and my preferences, and I no longer have to repeat my details each time"

- All those involved in a person's care work jointly with them and/or their carer, and each other. People aren't left on their own to coordinate the care they receive and can't see the joins between different services.
- Care is delivered through structured planning with the patients, their carer and all providers involved – coordination through a single-point. Staff are trained to deliver joined up working.

Specialised

*Centralising services where necessary for specific conditions ensuring greater access to specialist support. This ensures care is **better**.*

"I have a positive experience and a successful outcome in a great hospital environment which helps me feel confident in the quality of care provided to me"

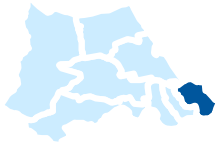
- People are treated in modern facilities with the latest technology available, dealt by compassionate staff across all hospital sites, giving them confidence in their care.
- People are directed to centres for specialised care, whether that's within hospitals or in out-of-hospital settings, relevant to their condition, considering the patient's choice at all times.

"I receive timely and effective care every time; when at hospital, I am home sooner rather than later"

- People are treated at the right time, by the right person, in the right care setting, appropriate for the person and their condition, regardless of the day of the week.
- Higher quality care is available through more expert consultants, delivering more personalised care.

INTRODUCTION TO CENTRAL LONDON CCG

Central London CCG covers the majority of Westminster , a densely populated and vibrant Central London borough, with a daytime population three times the size of the resident population.



Population demographics

- The age profile in Westminster is common to other inner city areas in that it has a very large working age population and smaller proportions of children in particular (the smallest in London).
- The proportion of the total population aged 65+ is similar to London, but not as large as England.

- Four in 10 (38%) of the population is from Black, Asian and minority ethnic (BAME) groups.
- Westminster has a smaller Black population and Asian population than the London average, but the largest proportion nationally from the 'Arab' group (e.g. Middle East & North Africa) and the 14th highest from 'Mixed' groups.

- There are significant differences within and between electoral wards as a result of varied levels of social and economic deprivation. For example, men living in the least deprived areas are expected to live 16.9 years longer than their counterparts in the most deprived areas. Pockets of deprivation are particularly focused in the northwest of the borough, Church St, and parts of Pimlico. Over a third of children under 16 (35%) live in poverty according to official definitions, which is higher than London and England.

Overview

230,000* **(est)**
Local borough population

£249m
2014/15 health commissioning budget

£7m invested in community and integrated services

*based on 2013 ONS figures for Westminster borough

Care provision

- **Imperial College Healthcare NHS Trust** and **Chelsea & Westminster NHS Foundation Trust** are the main providers of acute and specialist care. However patients do use hospitals outside NW London due to proximity.
- **Central London Community Healthcare NHS Trust (CLCH)** provides community nursing and therapies.
- **Central and North West London NHS Foundation Trust** provides mental health services.

- 35 **GP** practices
- 62 **dental** practices
- 94 **pharmacies**
- 17 **care homes**

Health challenges

- The principal cause of premature (<75) death in Westminster is cancer, followed by cardiovascular disease (which includes heart disease and stroke). A significant number of people also die from Chronic Obstructive Pulmonary Disease (COPD).
- Children in Westminster attend A&E and other urgent care much more frequently than is typical for London or England.
- In 2012, Westminster had the 7th highest reported acute Sexually Transmitted Infections (STI) rate in England.
- Westminster also has one of the highest rates of homelessness and rough sleeping in the country; this vulnerable population increases the prevalence of drug and alcohol-related conditions, as well significantly increasing the need for mental health services.

CURRENT SERVICES

Central London CCG has invested £7m[1] in 13/14 and 14/15 on increasing the number of community services and joining up health and social care.

Whole systems integrated care

The ambition of CLCCG is to improve the quality of care for individuals, carers and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their communities.

1. To enable patients to have an improved quality of life by increasing or maintaining their levels of independence

2. To reduce time spent in hospital for the defined cohort, including a reduction in unplanned visits to A&E, unplanned hospital admissions and admissions to residential and nursing care

3. To enable patients to know how to get their needs reviewed if their circumstances change and that patients' carers know how to access support

4. To reduce unplanned / inappropriate visits to the GP amongst the defined cohort through improved care co-ordination and increased self-care / self-management

5. To enable patients to have the proactive/preventative support they need to live independently, including an appropriate range of choice and empowerment

EXAMPLE: Connecting Care for Children: Integrated clinics, bringing together primary and secondary care for children, have been set up in primary care hubs. These provide an alternative to going to hospital for children's health services, in locations that are closer to people's homes. There are now four hubs and so far 52 patients have benefitted.

Community Out of Hospital services

- **Cardiology & Respiratory:** The contract for a new, integrated cardiology and respiratory community service in was awarded in February 2015, and the new service will commence in April 2015.
- **Musculoskeletal & Ophthalmology:** Musculoskeletal and ophthalmology services will be procured in 2015/16.
- **Gynaecology & urology:** A joint gynaecology/uro-gynaecology service and a urology service will be procured in 2015/16.
- **Expert patient programme:** Investment continues in the expansion of the programme which empowers patients by providing training in areas such as coping with depression and planning for the future.
- **Urgent Care Centres:** A national review of the urgent care system and the role of Urgent Care Centres within it is underway. We will make changes to ensure that primary care services, urgent care centres are used appropriately to peoples' needs and cost-effectively.

Mental health and wellbeing

- **The Primary Care Plus Mental Health** service is now operational across Central London, supporting patients with non-urgent mental health conditions to access the support services they need in community settings as an alternative to secondary care.
- **Improving Access to Psychological Therapies (IAPT):** Central London CCG is working to achieve its 15% access target for patients in need of psychological therapies. Significant investment has been made in secondary care, primary care, and the voluntary sector to ensure that people with mild anxiety and depression can access services to keep them well.
- North West London was the 2nd area nationally to have its action plan approved for the ground-breaking **Mental Health Crisis Care Concordat**, ensuring better, joined up, care for people experiencing mental health crisis.
- Central London will be contributing to the development of a mental health and wellbeing strategy across North West London. This will involve partnership working across health and social care and other partners.
- Since April 2015 we have had a **Child and Adolescent Mental Health Services (CAMHS)** professional available 24 hours to respond to crisis.

Primary care transformation

- **Prime Ministers Challenge Fund (PMCF)**: 35 practices are taking part in PMCF, which supports practices in providing patients with more convenient access to primary care through investment in key services.
- **Extended access to GPs:** Four practices provide walk-in clinics with same-day GP and nurse appointments on weekends for eight hours. Two practices offer appointments from 8am-4pm, and two from 10am-6pm.
- **Efficient appointments:** 19 practices provide phone consultations,17 practices offer online appointment booking and 21 practices offer longer appointments where needed. Building on the learning from the Skype consultation pilot in 2014, more practices will be offering online access.
- **Improved estates:** The CCG is investing in the buildings and space needed to bring more services out of hospital in to locations that are closer to patients' homes.

1. Note: Additional expenditure on 'out of hospital' services and infrastructure, spent since the start of SaHF. This is expenditure on primary and community care services, provided outside of acute, intended to reduce demand on the acute sector, i.e. to reduce non-elective or elective admissions, in-hospital outpatient appointments, and A&E attendances. Also includes investment in supporting infrastructure. Project costs are excluded.

FUTURE PLANS (1)

Whole systems integrated care

- **The shared vision of the North West London Whole Systems integrated care programme** is "to improve the quality of care for individuals, carers and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their community". We are in year 2 of a 5 year programme. As set out in the recent commissioning intentions of the 8 North West London Clinical Commissioning Groups, and building on an international evidence base, our ambition is that by 2018 care will be commissioned from 'Accountable Care Partnerships'. These are groups of providers who will be collectively accountable for improving outcomes for patients across the whole spectrum of their needs. To deliver this we are transforming models of care across North West London, and working to improve the ability of our workforce, IT, and other systems to deliver across organisational boundaries.
- **Triborough* Integrated Community Independence Service (CIS).** This new service will by provided by health and social care services working together, seven days a week, to provide **rapid response** services to help patients avoid hospital admissions, **in-reach** services to bring people home sooner from hospital admissions, **rehabilitation and reablement** services to help people return to independent living as soon as possible.
- Increase investment in **neuro-rehabilitation community support** and bed based intermediate care in the community to support recovery and return to independence.
- **Extend Personal Health Budgets** to adults with long-term conditions to give people more choice and control over how they are supported.
- Working with public health team to develop supportive and resilient neighbourhoods and communities across Tri-borough, reducing demand for health and social care services and improving individual outcomes, e.g. Community Champions
- *Central London, West London, and Hammersmith and Fulham CCGs with Westminster City Council, RB Kensington and Chelsea, and LB Hammersmith and Fulham*

Mental health and wellbeing

- **Increasing investment to increase the size and scope of the Primary Care Plus mental health service,** to enable more people to receive mental health services in primary care, complemented by new services being provided by GPs.
- **Continued support for Improving Access to Psychological Therapies (IAPT):** Central London CCG is working to achieve its 15 per cent access target for patients in need of psychological therapies. This is an essential part of increasing access to therapies like Cognitive Behavioural Therapy (CBT) so that more people can stay well and e.g. return employment.
- Working with our local mental health trust, we will be improving access to **urgent mental health services** through changing the pathway and interfaces between services. This is likely to include implementing a single point of access and reconfiguring teams to deliver a service which is able to respond to the needs to patients in crisis.

FUTURE PLANS (2)

Primary care / out of hospital services

- **Improving primary care and access to it -** the CCG will make primary care more convenient and easier to access for patients by extending the opening hours of a number of local GP practices to twelve hours per day on weekdays, and twelve hours at weekends.
- Our review of the **urgent care system** is indicating that urgent care services need to be more closely aligned to primary care services. We will make changes to ensure that primary care services, urgent care centres are used appropriately to peoples' needs and cost-effectively.
- **Improved buildings**: Central London is investing in the primary care estate needed to deliver more services in an out of hospital setting. Two practices will receive a share of £45,000 to improve their buildings. In addition, we will be developing three new out of hospital hubs to deliver further services in the community
- **Increasing Outpatient and elective services in the community**: we will be replacing our existing musculoskeletal services, expanding the scope to include pain management and rheumatology. We will be also re-commissioning our community gynaecology to include uro-gynaecology. We will also be commissioning new ophthalmology and urology services in 2015/16. These services will provide c.20,000 appointments in the community instead of hospital.
- **Community transport services**: we are reviewing, with input from patients, the benefits of investing in improving community transport services, especially for those with mobility or social isolation issues.
- **Additional investment in homelessness services**: the CCG is currently working on a number of initiatives related to improving our homeless population's experience of healthcare, keeping them well and reducing demand on healthcare services. This will include continuing to invest in Hepatitis C clinics, and improving care planning, GP input nursing input into existing services.
- **Integrated Home Care services**: the CCG and the local council are working together to specify a new home care service model and pathway, with a focus on regaining independence following a stay in hospital.

Investment in GP practice buildings

Practice	CCG	Year of planned completion	£'000s *
FITZROVIA MEDICAL CENTRE	NHS CENTRAL LONDON CCG	15-16	45
NEWTON MEDICAL CENTRE	NHS CENTRAL LONDON CCG	16-17	TBC
			45

Out of hospital hub development

	Central London Hubs	Anticipated investment	Expected completion
1	St Mary's Hospital Hub	*tbc*	2019/20
2	Church Street Hub	£14.3m	2019
3	Central Westminster Hub	£6.3m	*tbc*
4	South Westminster	-	Open

FUTURE PLANS (3)

NW London hospital services post-reconfiguration

Core services	Local Hospital			Major Hospital									Elective hospital		Other		
	24/7 Local hospital A&E[2]	24/7 Urgent Care Centre	Outpatients and Diagnostics	24/7 A&E	Emergency surgery	Emergency medicine	Elective medicine	Elective surgery	L3 Intensive Care	Psychiatric liaison	Inpatient Paediatrics	Obstetrics and maternity unit	Non-complex elective surgery and/or medicine	High Dependency	Heart attack	HASU	Major Trauma
Central Middlesex		◆	◆										◆	◆			
Chelsea & Westminster		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆					
Hammersmith[1]		◆	◆		S	S	S	S	◆			◆			◆		
Hillingdon		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆					
Northwick Park		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆				◆	
St Mary's		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆				◆	◆
West Middlesex		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆					
Harefield															◆		
Charing Cross	◆	◆	◆	The redevelopment of local hospitals will lead the way for a new type of hospital, providing dedicated access to a wide range of specialist planned care on an outpatient or ambulatory basis. This will facilitate the more rapid development of ambulatory services as part of a much more integrated approach across secondary, community and primary care. Emergency care services will also be provided													
Ealing	◆	◆	◆														

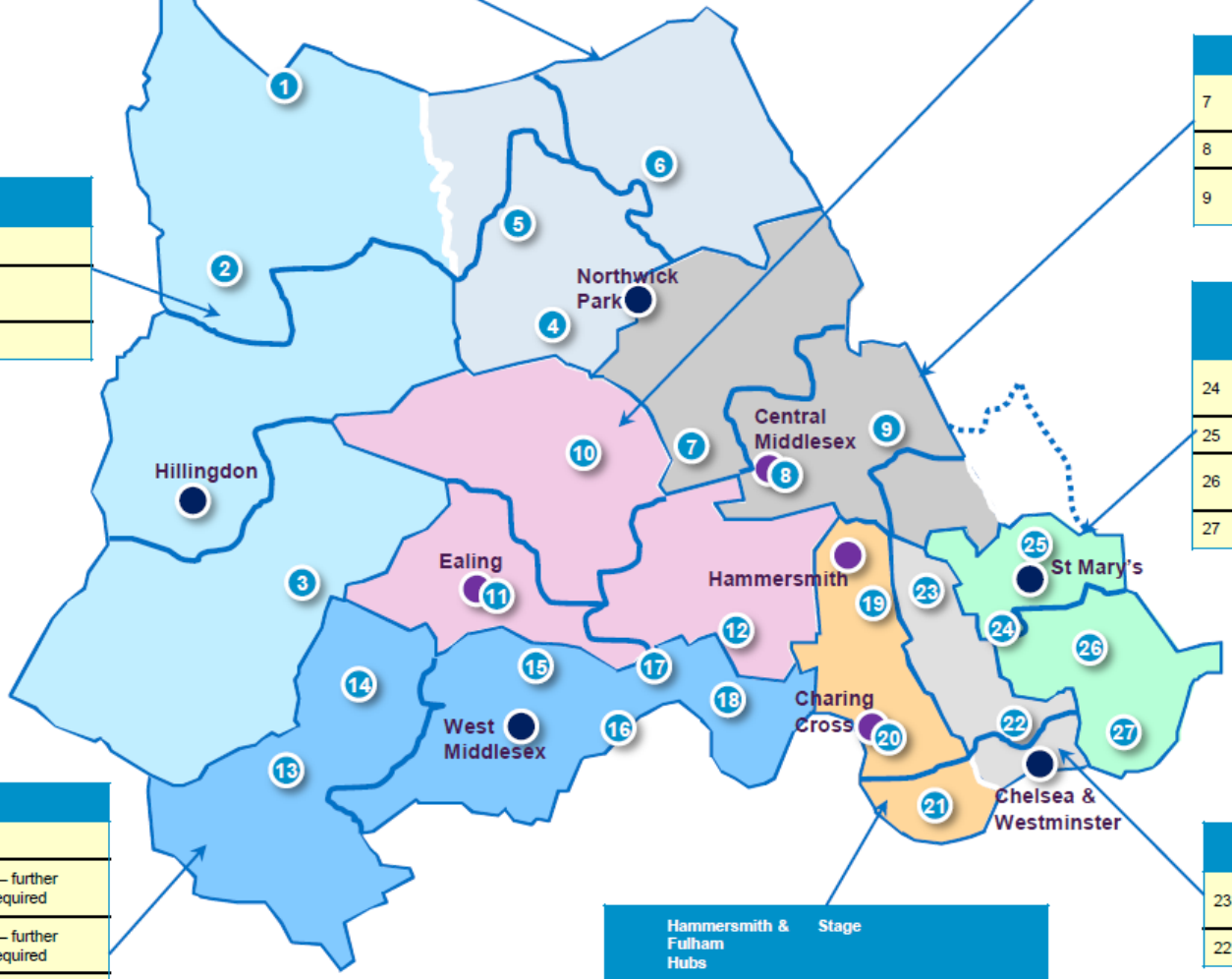
1 Including Queen Charlotte's

2 Including support as defined by the Keogh review

S = specialist services on site

Hubs in North West London

[Map shows boroughs in block colours overlaid with indicative Parliamentary boundaries]



	Harrow Hubs	Stage
4	The Pinn Medical Centre	Operational – further investment required
5	Alexandra Avenue Health and Social Care Centre	Operational – further investment required
6	NE Harrow	OBC in development

	Ealing Hubs	Stage
10	Ealing North Hub	OBC in development
11	Ealing Local Hospital Hub	OBC in development
12	Ealing East Hub	OBC in development

	Hillingdon Hubs	Stage
1	North Hillingdon Hub	Strategic stage
2	Uxbridge and West Drayton Hub	Strategic stage
3	Hesa Primary Care Centre	Operational

	Brent Hubs	Stage
7	Wembley Centre for Health and Care	Operational – further investment required
8	Central Middlesex Hospital 'Hub Plus'	OBC in development
9	Willesden Centre for Health and Care	Operational – further investment required

	Central London Hubs	Stage
24	St Mary's Hospital Hub	OBC in development
25	Church Street Hub	OBC in development
26	Central Westminster Hub	Strategic stage
27	South Westminster	Operational

	Hounslow Hubs	Stage
13	Feltham Health Centre	Operational
14	Heston Health Centre	Operational – further investment required
15	Heart of Hounslow Centre for Health	Operational – further investment required
16	West Middlesex Hub	Strategic stage
17	Brentford Health Centre	Operational – further investment required
18	Chiswick Health Centre	Operational – further investment required

	Hammersmith & Fulham Hubs	Stage
19	Park View (formerly known as White City)	Operational
20	Charing Cross Hospital Hub	OBC in development
21	Parsons Green	Operational – further investment required

	West London Hubs	Stage
23	St Charles Centre	Operational – further investment required
22	South Locality Hub	OBC in development

Major hospitals

Local, specialist & elective hospitals

INTRODUCTION TO WEST LONDON CCG

West London CCG covers the Royal Borough of Kensington and Chelsea and also the Queen's Park and Paddington area of Westminster.

Population demographics

- The age profile of the area is common to other inner city areas in that it has a very large working age population and smaller proportions of children in particular, (the 2nd smallest in London).
- Those aged 65+ form a slightly larger proportion of the total population than London, but smaller than England.

- Half the area's population were born abroad.
- Four in 10 (38%) of the population in Westminster and nearly a third (29%) of the population in Kensington and Chelsea (K&C) is from Black, Asian and minority ethnic (BAME) groups
- Over a quarter of people in K&C and just under a third of people in Westminster state that English is not their main language

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- Life expectancy for men and women living in the area covered by West London CCG is higher than London and England averages.
- However, the north of the area covered by West London CCG has worse health outcomes. The wards falling into the worst 20% in London for self-reported bad/very bad health, self-reported limiting long-term illness (LLTI) and self-reported working age LLTI are Golborne, St Charles, Notting Barns and Cremorne.

Overview

240,000* (est)
Local population

£378m
2015/16 health commissioning budget

*based on 2013 ONS figures

Care provision

- **Chelsea & Westminster NHS FT** and **Imperial College Healthcare NHS Trust are** the main providers of acute and specialist care.
- **Central London Community Healthcare (CLCH)** provides community nursing and therapies.
- **Central and North West London NHS Foundation Trust** is the acute mental health NHS provider with most treatment taking place in General Practice and also a diverse range of voluntary sector services

- 52 **GP** practices
- 24 **dental** practices in K&C and 62 in Westminster
- 42 **pharmacies**
- 15 **care homes**

Health challenges

- The principle cause of premature (<75) death in our area is cancer, followed by cardiovascular disease (which includes heart disease and stroke). A significant number of people also die from COPD.
- There are very high rates of people with severe and enduring mental illness in the area. In 2013/14, 16,000 people received treatment for a mental health problem.
- Priority areas for the CCG include people with long term conditions, older people and homeless people.

CURRENT PLANS (1)

West London CCG has invested £16m[1] in 13/14 and 14/15 on increasing the number of community services and joining up health and social care.

Whole systems integrated care

- **Community Independence Service (CIS):** The service is made up of health and social care professionals with a joint aim of keeping people at home for longer. CIS achieves its aims through discharge support and rapid response support clinicians in the community. West London CCG have further enhanced the rapid response element by commissioning GP medical cover and more recently launching the Older Adults Support Team in December. The team provides elderly consultant support to home visits by the team as well as a rapid access clinic.
- **Primary Care Navigators (PCNs):** There are PCNs working in GP practices to help patients who are 55+ with physical and/or mental health needs. They achieve this by providing one on one support to patients in the community or local practices, informing them of NHS, Voluntary and Local Authority services that are available to them.
- **Child Health GP Practice Hubs** – provide an environment in which health and social care professionals can work together in multi-disciplinary teams to provide integrated care for children most in need

Mental health and wellbeing

- **Urgent Care:** The urgent care pathway has been redesigned to ensure that access to crisis and urgent mental health assessment and care is delivered at home, 24/7/365, and away from A&E departments and in-patient acute wards as far as possible.
- We are **improving dementia diagnosis and support in general practice**, and have initiated an integrated pathway review under the mental health programme board.
- We are continuing our work to **better integrate physical and mental health services**, for example by putting specialist mental health liaison services into A&E departments and supporting ward earlier discharge for dementia, by implementing a new out of hospital payment scheme to guarantee that mental health patients under GP-only care get increased appointment time and that GPs are remunerated for this.
- We are working hard to develop an **integrated primary mental health service**, including the third sector, so we can deliver nationally required access and recovery targets for Improving Access to Psychological Therapies (IAPT) and support increased, high quality out of hospital mental health care.
- Innovating with service users and clinicians to design a new approach to **supporting long-term recovery and wellbeing** for the 16,000+ people with mental ill health in our area.
- North West London was the 2nd area nationally to have its action plan approved for the ground-breaking **Mental Health Crisis Care Concordat**, ensuring better, joined up, care for people experiencing mental health crisis.

1. Note: Additional expenditure on 'out of hospital' services and infrastructure, spent since the start of SaHF. This is expenditure on primary and community care services, provided outside of acute, intended to reduce demand on the acute sector, i.e. to reduce non-elective or elective admissions, in-hospital outpatient appointments, and A&E attendances. Also includes investment in supporting infrastructure.

CURRENT PLANS (1)

West London CCG has invested £16m in 13/14 and 14/15 on increasing the number of community services and joining up health and social care.

Community Out of Hospital services

- **Musculoskeletal, dermatology, diabetes and respiratory** services have been redesigned, bringing care out of hospital and closer to home.
  - **Community Diabetes Service:** increased provision
  - **Community Cardiology Service:** extension to K&C
- **Case management:** we have 15 band 7 Case Managers which we commission from CLCH (as part of the contract with CLCH) - these case managers support and case manage complex patients and coordinated their care.
- **Putting Patients First:** We have invested in building relationships between the different sectors such as the local authority, mental health, community nursing and pharmacists who provide care planning support at monthly practice meetings. This is achieved by incentivising integrated working and supporting with an organisational development programme.

Additional one off investments

SystmOne: All practices and all newly-commissioned community health services in West London are now using one IT system, SystmOne, leading to continuity of care for patients between services, ensuring clinical information is real time and delivering safer patient care.

St Charles – the development of 'community health and social care' hub at St Charles supports the promotion of integrated working across health and social care.

Primary care transformation (including OOH hubs)

- **Prime Ministers Challenge Fund (PMCF)**: all 50 GP practices in West London are taking part to help make it easier for patients to see a GP at a time convenient to them.
- **GP Federation:** as part of the Federation development process, all practices in WLCCG have agreed to work as a single federation, ensuring 100% population coverage across the CCG, and enabling further network development amongst GPs.
- **Extended access to GPs:** patients can access weekend GP services at 4 practices offering a walk-in and booked appointments and referrals from 111 open to all West London patients. Two walk-in services also available.
- **Enhanced access:** we have invested in 28 practices which offer telephone consultations as an alternative to face to face appointments, 5 offering email consultations, 22 practices offer online appointment booking.
- **Improved estates**: West London is investing in the buildings needed to deliver more services outside hospitals and closer to patients' homes. The St Charles Centre health hub is open to patients and another hub is planned to offer integrated care across the area.
- **Urgent phone advice to GPs from Chelsea and Westminster Hospital consultants**: A new dedicated phone line for GPs to deal with urgent patients enquiries for medicine, surgery, paediatrics, maternity and genecology. Sixty calls are made monthly providing urgent advice to GPs and improving patient care.

FUTURE PLANS (1)

Whole systems integrated care

- Embedding the Community Independence Service (CIS) reference earlier into our Whole Systems model will ensure the full impact of CIS is achieved in terms of ensuring patients are seen by the right clinician closer to home.
- **Integrated adult social care and GP IT systems** enabling seamless transfer of patient records between hospital, community services and GP practices improving the quality of patient care.
- The model will include a **new model of primary care** where the GP is central to caring for older people and offers extended care planning appointments with rapid access to a number of other providers including social care and the third sector. In quarter 4 we will launch our model in the South.
- We have launched **our Whole System model for Older People -** initially in the North - focusing on **creating a dynamic, multi professional hub at St Charles.** St Charles Integrated Care Centre opened on 21 September. Small numbers of practices are currently operating from it, and we aim to expand the roll-out across additional practices in coming months. The centre has social workers present 5 days a week and this allows holistic care planning discussions. There is also medicines management support available at the hub and we are building up the additional services present there, to include mental health
- We are working towards launching our hub in the south (at Violet Melchett clinic) in Q4. We are also launching a self-care pilot in January, which will fund additional capacity in the voluntary sector to allow patients to take up activities to support their wellbeing

Mental health and wellbeing

- Implement out of hospital mental health access standards, single point of access, and our integrated Crisis Mental Health Care Action Plan.
- Deliver our commitment to increase community **dementia diagnosis** services, and **increase access** to psychological therapies and specialist early intervention in psychosis services
- Implement new integrated community pathways for **urgent care, perinatal, dementia and learning disabilities.**
- Continue our pioneering work, under *Whole Systems* to develop a recovery-based, preventative **Community Living Well** service to help maintain health and well-being and prevent future crises occurring – which will be integrated into our 'Hubs'. The model will be implemented during 2015/16.
- Review Liaison Psychiatry Services at Chelsea and Westminster Hospital & St Mary's Hospital to ensure they are delivering efficient, high quality services.

FUTURE PLANS (2)

Primary care and Out of Hospital services

- **Improving primary care and access:** we will continue to ensure access to good quality primary care through extended evening and weekend opening.
- **GP Federation:** as part of the Federation development process, all practices in WLCCG have agreed to work as a single federation, ensuring 100% population coverage across the CCG, and enabling further network development with the Federation.
- Increasing **Outpatient and elective services** in the community: we will establish a new gynaecology and urology service and further develop our musculoskeletal service. We will also provide our new and enhanced cardiology and respiratory services.
- Increased investment in **neuro-rehabilitation** and intermediate bed based capacity, ensuring the appropriate provision is delivered as well as extending the community rehabilitation period up to 12 weeks in the community including support at home.
- Develop **self-management** and peer support programmes/interventions, with a focus on those with Chronic Obstructive Pulmonary Disease, cancer, diabetes and/or dementia.
- Create a single **care home placement** contracting team across health and social care in order to develop patient focused outcomes-based specifications and ensure appropriate and timely provision reducing pressure on hospitals.
- **Improved buildings**: West London is investing in the primary care estate needed to deliver more services in an out of hospital setting. Six practices will receive a share of £623,000 to improve their buildings. In addition, we will be investing further in St Charles Centre and developing a new out of hospital hub in the South of the borough to deliver further services in the community

Investment in GP practice buildings

Practice	CCG	Year of planned completion	£'000s *
EARLS COURT MEDICAL CENTRE	NHS WEST LONDON CCG	15-16	35
LANCASTER GATE MEDICAL CENTRE	NHS WEST LONDON CCG	15-16	146
NORTH KENSINGTON MEDICAL CENTRE	NHS WEST LONDON CCG	15-16	153
THE REDCLIFFE SURGERY	NHS WEST LONDON CCG	15-16	53
THE SURGERY	NHS WEST LONDON CCG	15-16	155
THE SURGERY	NHS WEST LONDON CCG	15-16	81
			623

Out of hospital hub development

	West London Hubs	Stage	Expected completion
1	St Charles Centre	Operational – further investment required	2017
2	South Locality Hub	OBC in development	2017

FUTURE PLANS (3)

NW London hospital services post-reconfiguration

Core services	Local Hospital			Major Hospital									Elective hospital		Other		
	24/7 Local hospital A&E[2]	24/7 Urgent Care Centre	Outpatients and Diagnostics	24/7 A&E	Emergency surgery	Emergency medicine	Elective medicine	Elective surgery	L3 Intensive Care	Psychiatric liaison	Inpatient Paediatrics	Obstetrics and maternity unit	Non-complex elective surgery and/or medicine	High Dependency	Heart attack	HASU	Major Trauma
Central Middlesex		◆	◆										◆	◆			
Charing Cross	◆	◆	◆														
Chelsea & Westminster		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆					
Ealing	◆	◆	◆														
Hammersmith[1]		◆	◆		S	S	S	S	◆			◆			◆		
Hillingdon		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆					
Northwick Park		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆				◆	
St Mary's		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆				◆	◆
West Middlesex		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆					
Harefield															◆		

[1] Including Queen Charlotte's

[2] Including support as defined by the Keogh review

S = specialist services on site

Hubs in North West London

[Map shows boroughs in block colours overlaid with indicative Parliamentary boundaries]

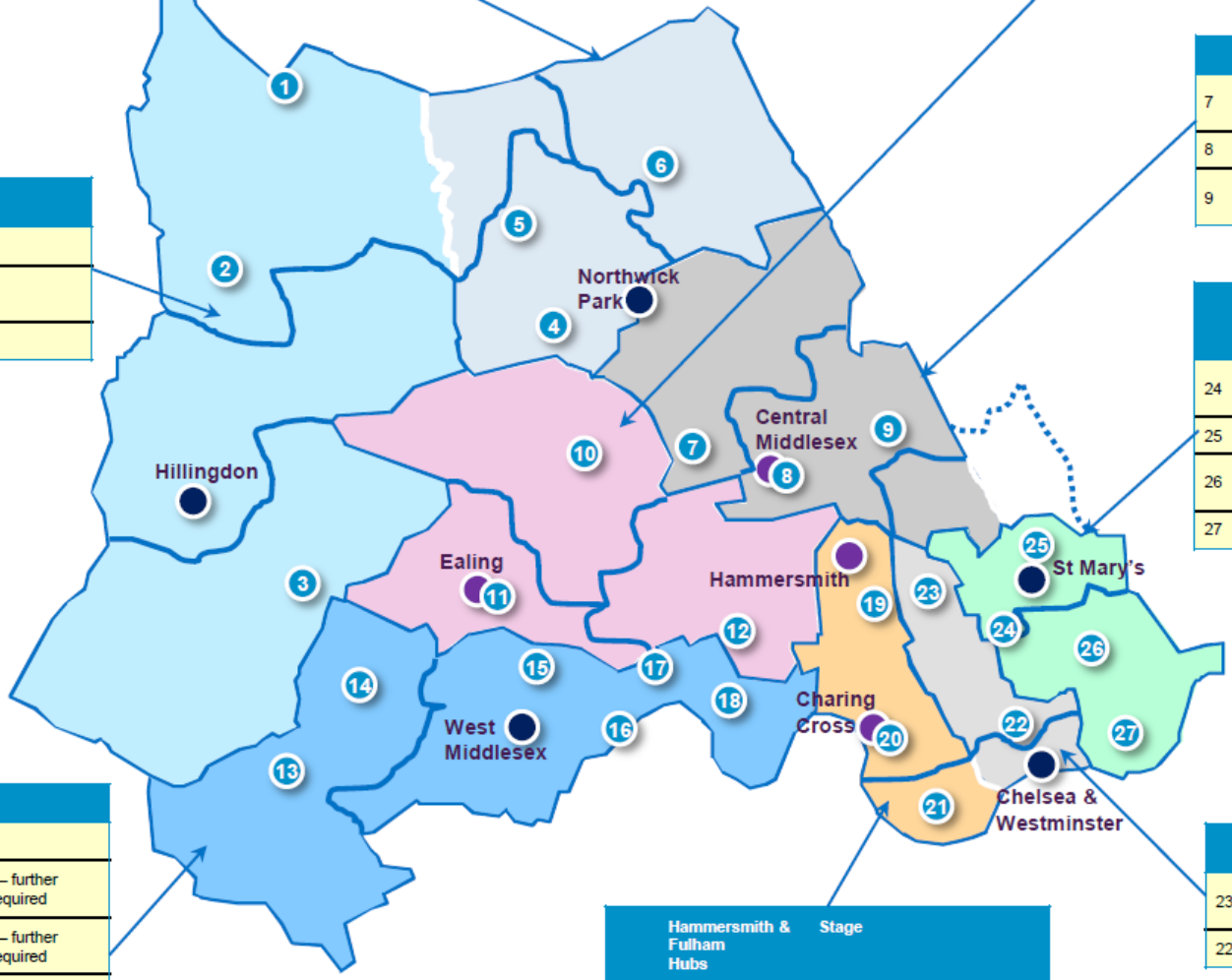
	Harrow Hubs	Stage
4	The Pinn Medical Centre	Operational – further investment required
5	Alexandra Avenue Health and Social Care Centre	Operational – further investment required
6	NE Harrow	OBC in development

	Ealing Hubs	Stage
10	Ealing North Hub	OBC in development
11	Ealing Local Hospital Hub	OBC in development
12	Ealing East Hub	OBC in development

	Brent Hubs	Stage
7	Wembley Centre for Health and Care	Operational – further investment required
8	Central Middlesex Hospital 'Hub Plus'	OBC in development
9	Willesden Centre for Health and Care	Operational – further investment required

	Hillingdon Hubs	Stage
1	North Hillingdon Hub	Strategic stage
2	Uxbridge and West Drayton Hub	Strategic stage
3	Hesa Primary Care Centre	Operational

	Central London Hubs	Stage
24	St Mary's Hospital Hub	OBC in development
25	Church Street Hub	OBC in development
26	Central Westminster Hub	Strategic stage
27	South Westminster	Operational



	Hounslow Hubs	Stage
13	Feltham Health Centre	Operational
14	Heston Health Centre	Operational – further investment required
15	Heart of Hounslow Centre for Health	Operational – further investment required
16	West Middlesex Hub	Strategic stage
17	Brentford Health Centre	Operational – further investment required
18	Chiswick Health Centre	Operational – further investment required

	Hammersmith & Fulham Hubs	Stage
19	Park View (formerly known as White City)	Operational
20	Charing Cross Hospital Hub	OBC in development
21	Parsons Green	Operational – further investment required

	West London Hubs	Stage
23	St Charles Centre	Operational – further investment required
22	South Locality Hub	OBC in development

Major hospitals

Local, specialist & elective hospitals

ROUND ONE (24 June 2015)		
Agenda Item	**Reasons & objective for item**	**Represented by:**
The NHS estate in Westminster	To review the strategy relating to NHS estates in Westminster	• NHS Property Services • NHS England • CCGs • LA
NHS Staffing in the Acute Sector	To examine the impact of current staffing levels on the operation of our local acute Trusts	• Imperial • Chelsea and Westminster

HEALTH URGENCY (30th June 2015)		
Agenda Item	**Reasons & objective for item**	**Represented by:**
Imperial College Healthcare NHS Trust – Reconfiguration of stroke services	Imperial College Healthcare NHS Trust are consulting the Committee under Section 244 of the NHS Act 2006 on plans to reconfigure stroke services	• Dr Batten, CEX, Imperial

ROUND TWO (24 September 2015)		
Agenda Item	**Reasons & objective for item**	**Represented by:**
Policing and Mental Health	To assess the relationship between mental health and Police custody	• Borough Police
Adult Social Care Complaints and Performance	To receive the TB ASC Complaints and Performance report	• Liz Bruce • Nadia Husain
Safeguarding – Employment Checks	To consider the work of the Safeguarding Task Group looking into recruitment checks	• Safeguarding

HEALTH URGENCY (17th November 2015)		
Agenda Item	**Reasons & objective for item**	**Represented by:**
CCG Plans relating to Urgent and Emergency Care	To assess developments at the CCG in relation to provision of urgent and emergency care in Westminster	• CLCCG
Central and North West London NHS Foundation Trust	To review a Section 244 notice of reconfiguration at our local mental health provider.	• CNWLFT

ROUND THREE (25 November 2015)		
Agenda Item	**Reasons & objective for item**	**Represented by:**
Policing Model – MOPAC	To follow up the assessment of the local policing model in 14 / 15 with MOPAC	• MOPAC
***The Patient Journey* – Journey mapping the experience of Westminster residents**	To assess how Westminster residents and patients interact with the health and social care services in the City – and how this will develop under *Shaping a Healthier Future*	• CCG • ASC

ROUND FOUR (27 January 2016)		
Agenda Item	**Reasons & objective for item**	**Represented by:**
Finding and Supporting Carers	To assess and review the work of ASC in finding and supporting carers in the Westminster population	• ASC
Strategic approaches to Mental Health	To assess community provision of mental health and what agencies are doing to ensure out-of-hospital / community strategies are effective.	• CNWLFT • CCGs • LA

ROUND FIVE (21 March 2016)		
Agenda Item	**Reasons & objective for item**	**Represented by:**
Childhood Obesity	To **assess** and **input into** Cllr Robathan's programme for addressing Childhood Obesity	• Public Health
HWB Project - Needs-modelling Westminster population	To assess the work of the Health and Wellbeing Board on needs modelling the future population and health need of Westminster residents	• Health and Wellbeing Board • Damian Highwood

OFFLINE ITEM		
Agenda Item	**Reasons & objective for item**	**Represented by:**
Joint Strategic Needs Assessments – the Implementation of Recommendations	To review recent JSNA reports and ensure recommendations have been acted upon and if not, why not.	• Public Health

ROUND SIX (18 April 2016)		
Agenda Item	**Reasons & objective for item**	**Represented by:**
The Implementation of Shaping a Healthier Future	To examine progress of implementing the *Shaping a Healthier Future* reconfiguration	• CCG Collaborative (Claire Parker)
The Implementation of Shaping a Healthier Future - Imperial Specific	To assess the specifics, with our local Borough-based Trust, about their site development and proposals.	• Imperial College Healthcare NHS Trust

Other Committee Events & Task Groups		
Briefings	**Reason**	**Type**
Safer Westminster Partnership	To assess the work of the Safer Westminster Partnership. Please note that this is one of the statutory **duties** of the Committee.	**On-going**
NHS Provider Complaints	To assess complaints from local Provider Trusts as a result of the Francis Inquiry and new Health Scrutiny powers.	**Briefing**

Healthwatch Westminster Updates
Round 1
Round 2
Round 4
Round 6

Visits	
S136 Suite Visit (The Gordon)	Tuesday 3rd November
Rough Sleeper Count	Thursday 26th November