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City of Westminster

Committee Agenda

Title:	**Adults, Health & Public Protection Policy & Scrutiny Committee**
Meeting Date:	**Thursday 24th September, 2015**
Time:	**7.00 pm**
Venue:	**Rooms 5, 6 and 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.

Tel: 020 7641 2802
Email: apalmer@westminster.gov.uk
Corporate Website: www.westminster.gov.uk

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 **(Pages 1 - 2)**

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 AND ACTION TRACKER **(Pages 3 - 12)**

To approve the minutes of the meeting held on 24 June 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 Public Protection and Cabinet Member for Adults & Public Health. The briefings also include responses to any written questions raised by Members in advance of the Committee meeting.

6. STANDING UPDATES **(Pages 25 - 28)**

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

II) **Westminster Healthwatch**
To receive an update on the delivery of current priorities, and on the future Work Programme.

7. ADULTS SOCIAL CARE COMPLAINTS AND PERFORMANCE **(Pages 29 - 44)**

To receive the Tri-Borough Adult Social Care Complaints and Performance Report.

8. POLICING AND MENTAL HEALTH **(Pages 45 - 70)**

To assess the relationship between mental health and police custody.

9. SAFEGUARDING AND SAFER RECRUITMENT **(Pages 71 - 80)**

To examine the work of the Safer Recruitment Panel.

10. WORK PROGRAMME **(Pages 81 - 84)**

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

11. ITEMS ISSUED FOR INFORMATION

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

I) NHS Property Services
– letter sent following the discussion at the last meeting of the Committee on 24 June 2015.

II) Central London Community Healthcare NHS Trust
– letter of support for CLCH to progress to Foundation Trust status.

12. ANY OTHER BUSINESS

To consider any other business which the Chairman considers urgent.

Charlie Parker
Chief Executive
16th September 2015

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CITY OF WESTMINSTER

Standing Declarations of Interest

ADULTS, HEALTH & PUBLIC PROTECTION
POLICY & SCRUTINY COMMITTEE
24 September 2015

The following list details the Committee's standing declarations of interest which shall apply to all relevant items of business considered by the Committee in the course of its work programme.

The list is updated in light of each new standing interest declared and is tabled at each formal meeting of the Committee.

All declarations detailed below are ***personal interests***, unless otherwise stated.

Member/Officer	Declaration of Interest
Councillor Barbara Arzymanow	Councillor Arzymanow and her family have been patients of St. Mary's Hospital.
Councillor Paul Church	Councillor Church declared a non-pecuniary interest as Deputy Cabinet Member for Children & Young People.
Councillor David Harvey	Councillor Harvey's wife, Councillor Angela Harvey, holds the position of Non-Executive Director of the Camden and Islington NHS Foundation Trust.
Councillor Patricia McAllister	Councillor McAllister declared a non-pecuniary interest, as a patient of the Garway Medical Practice at Pickering House, and of St. Mary's Hospital.
Councillor Jan Prendergast	Councillor Prendergast's husband is a long-standing patient of St Mary's Hospital. Councillor Prendergast is also an occasional patient of the hospital and is a member of the Executive Committee of the Friends of St. Mary's Hospital.

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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 **Wednesday 24th June, 2015**, Rooms 6 & 7, 17th Floor, City Hall.

Members Present: Councillors David Harvey (Chairman), Barbara Arzymanow, Paul Church, Audrey Lewis, Patricia McAllister, Guthrie McKie and Ian Rowley.

Also Present: Councillors Nickie Aiken and Rachael Robathan.

1 MEMBERSHIP

1.1 Apologies for absence were received from Councillors Jan Prendergast and Shamim Talukder. Councillors Audrey Lewis and Guthrie McKie attended as their replacements. Apologies for absence were also 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 Guthrie McKie declared a non-pecuniary interest as a Patient Governor of the Royal Brompton and Harefield Hospital.

2.3 Councillor Patricia McAllister declared a non-pecuniary interest, as a patient of the Garway Medical Practice at Pickering House, and of St. Mary's Hospital.

2.4 Councillor Audrey Lewis declared a non-pecuniary interest in that she was a patient of St. Mary's Hospital, Hammersmith Hospital and Western Eye Hospital.

2.5 Councillor Paul Church declared a non-pecuniary interest as Deputy Cabinet Member for Children & Young People.

3 MINUTES

3.1 **RESOLVED:** That the Minutes of the meeting held on 28 April 2015 be approved for signature by the Chairman.

3.2 **Matters Arising**

3.2.1 Rough Sleepers: Minute 8.3

The Committee noted that as part of Westminster's 2013-16 Rough Sleeping Strategy, there was to be a review of the service at the end of the first year. Committee Members sought clarification as to why there had been a £70,000 reduction in funding for St. Mungo's before the end of that period. The Cabinet Member for Public Protection confirmed that outreach services had been restructured when the new services had come into effect in July 2014, and agreed to investigate the issue and update the Committee.

4 CHAIRMAN'S Q&A

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

4.2 **Committee Updates**

4.2.1 Committee Members received 'Safe in the City', which was the final report of the Task Group which had reviewed supported accommodation for 16-25 year olds in Westminster. The Committee endorsed the report and ratified its recommendations.

4.2.2 Committee Members also commented on the findings of the Care Quality Commission's inspection of the Central North West London Foundation Trust, and agreed that the issues raised would be added to the Committee's Work Programme. It was also agreed that Committee Members would undertake a site visit to Redwood Ward at St Charles Hospital.

5 CABINET MEMBER UPDATES

5.1 Cabinet Member for Public Protection

5.1.1 Councillor Nickie Aiken (Cabinet Member for Public Protection) updated the Committee on key issues relating to her portfolio.

5.1.2 The Committee noted that the current count of rough sleepers in Westminster was between 200 and 250, who were mostly foreign nationals with a third coming from Romania for economic reasons. The City Council was continuing to work

with the Romanian Embassy, Home Office, Border Agency and the Police to address the associated street based activities, which were detrimental to local residents and businesses. The Committee noted that the City Council was also preparing a constructive evidence based report, which would support negotiations with the European Union for the current 90 day visa rule to be reviewed.

5.1.3 The Committee discussed the work and priorities of the Safer Neighbourhood Board (SNB) with Anthony Wills, who was the Independent Chairman. The SNB had replaced the Community Policing Engagement Group, and held the performance of the police to account at a local level. Members expressed concern over a possible overlap in the work of the SNB and the Safer Westminster Partnership (SWP), which could lead to conflicting policies. The Cabinet Member confirmed that the two agencies worked well together, as the community representatives within the SNB could highlight community concerns which would support the SWP and inform the City Council's own strategy. Anthony Wills highlighted the positive quality of the SNB in attendance and police commitment, and of the debate which had included discussions on issues such as stop and search, sex-workers and LGBT. The Committee noted that the SNB continued to seek wider community representation, and had submitted a bit for additional funding. Anthony Wills commended the work of Adam Taylor, Westminster's Head of Commissioning for Community Safety, in providing support for the Board. A public meeting of the SNB was to be held in December

5.1.4 The Committee discussed policing in Westminster and the relationship between the City Council and the Police at both officer and senior levels. Members commented on the difficulty of engaging with senior police leadership. The Committee highlighted the importance of effective two-way communication; and considered that changes in senior management may have caused a disconnect between the police and communities, which had been further aggravated by cuts in funding. Committee Members also commented on the Ward impact of relocating police to the West End, and noted that police officers were being brought in to Westminster from other boroughs.

5.1.5 The Cabinet Member updated the Committee on the new Strategy for Violence Against Women and Girls which was to be launched in July, and would include honour violence and forced marriage.

5.1.6 The Cabinet Member also provided an update on the current position following the arrests which had been made over the last year in connection with gang activity in Pimlico. The Committee noted that of the 23 arrests that had been made, 18 offenders had received prison sentences and 5 had received orders for community service. A range of measures had also been put in place, with the involvement of the Probation Service, to ensure against re-offending when the former residents returned to the community.

5.1.7 Other issues discussed with the Cabinet Member included the nuisance caused by unregulated street performers and the forthcoming launch of the Busk in London Programme on 18 July; fixed odds betting machines; and the potential impact of the 24 hour tube service.

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 The Committee discussed Westminster's Public Health role in HIV and sexual health, and noted that the City Council was responsible for the prevention of HIV and for the provision of support and care at home, but not for treatment. The Cabinet Member commented on future budget reductions, and confirmed that a review was to be made of all sexual health services.

5.2.3 Committee Members also discussed the forthcoming devolve of the Independent Living Fund to local authorities in July, and requested details of any possible redundancies which may arise.

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 Mark Platt (Trustee, Healthwatch Central West London) updated the Committee on the current work and priorities of Westminster Healthwatch. Over the forthcoming year, Healthwatch would seek to strengthen their visibility and effectiveness; improve support for their members; and plan for future independence. Other priorities recommended by the Healthwatch Local Committees had included implementation of the new Home Care service; mental health; and the patient experience and outcomes for maternity services. Since being established, the membership of Westminster Healthwatch had risen from 600 to 1,500; with the Tri-Borough Healthwatch groups collectively having 5,000 members. The Committee was invited to attend the forthcoming Annual General Meeting of Westminster Healthwatch, which was to take place in September.

6.2 Mark Platt commented on the effect that the uncertainty of forthcoming independence had on business planning, as Healthwatch moved to a position where it would commission its own providers for services. Healthwatch sought the support of the City Council to make the process clearer and speedier, and the Chairman agreed to raise these issues when he next met with the Chairmen of Tri-Borough Adults & Health Committees at the end of July.

6.3 The Committee discussed the accountability and membership of Healthwatch, as a statutory service. Members noted that as a member of the Westminster Health & Wellbeing Board, Healthwatch was able to provide an insight into how the changes to health services were working for Westminster's residents, as demand and expectation continued to rise and resources were reduced.

6.4 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.

6.5 **RESOLVED:** That the standing update from Westminster Healthwatch be noted.

7 NHS ESTATE IN WESTMINSTER

7.1 The Committee received an overview of the use and availability of NHS estate in Westminster from Tony Griffiths (Regional Director) and Sunita Burke (Strategic Estates Planner) from NHS Property Services, North West London; and from Julie Sands of NHS England. Comments were also received from Matthew Bazeley (Managing Director) and David Cox from Central London CCG; and from Louise Proctor, Managing Director of West London CCG. Approximately 50% of the estate previously owned by Primary Care Trusts had been transferred to NHS Property Services, who sought to ensure that properties were safe and fit for purpose, while also making investments where appropriate. NHS Property Services acknowledged the urgent need for research to establish the demand for health services in 5–10 years' time, and where they would be located.

7.2 The Committee discussed the approach of NHS Property Services and NHS England to the wider healthcare estate in Westminster, and highlighted concerns over pressures facing Westminster's GP practices and on the effective use and management of current property assets. Initial work to determine the need for primary care in Westminster over the next 15 years was being carried out by the Health & Wellbeing Board, which was also considering the number of GPs that would be required, together with the associated need for premises, housing and transport.

7.3 Westminster's CCGs recognised the need for premises for health services, and acknowledged that NHS Property Services had made considerable progress in responding to operational challenges. GP premises could have a range of different owners and landlords, which could include the local authority, and the Committee noted that NHS England was now a co-commissioner linked with NHS Estates and GPs to plan for future needs rather than being reactive.

7.4 The Committee discussed the greater use of the planning process for health premises, and the CCGs suggested securing estate through the D1 property classification, which could prioritise and maintain the future use of property for health purposes. The CCGs also commented on the cost of delivery, and on the possibility of obtaining funding through contributions such as Section 106 agreements

7.5 The Committee commented on the NHS properties in Westminster which were currently empty, and on the apparent incomplete knowledge of the number and nature of empty properties. The Committee highlighted the need for NHS Property Services to have effective audit systems in place to respond to the issue of vacant premises. NHS Property Services and Westminster's CCGs acknowledged the need to identify and respond to void property more rapidly, without compromising existing healthcare services. Committee Members also commented on the Samaritan Hospital site having been empty for a number of years, and noted current proposals for the property to be sold, together with the adjoining Western Eye Hospital, to provide funding for the development of St. Mary's Hospital.

7.6 The Cabinet Member for Adults & Public Health considered that the City Council was entering a new era of collaborative working with health partners, which was focussed on the goal of improved health and care services for Westminster's residents. The Cabinet Member also commented on other significant property issues that needed to be addressed in Westminster, which included improving care homes; providing more supported housing for people with learning difficulties; and ring-fencing housing for care workers.

7.7 Other issues discussed by Committee Members included the difficulties that could arise from groups with divergent interests; the closure of Gobal Road Surgery in North Kensington; areas of deprivation in Westminster; and the need for affordable service charges for health premises.

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

7.9 **RESOLVED:** That NHS Property Services be asked to review how estates were managed and on the audit of vacant NHS property in Westminster; and to report back to the Committee on that process and its findings.

8 NHS ACUTE STAFFING

8.1 In October, the Care Quality Commission's inspection of Chelsea & Westminster Hospital NHS Foundation Trust had questioned the level of staffing, and had considered that the Trust 'required improvement'. In December, the Commission's inspection of Imperial College Healthcare NHS Trust had made a number of comments related to similar issues, and had also reported that

improvement was required. In response to the two inspections, the Committee now heard from Elizabeth McManus (Executive Director) and Vanessa Sloane (Director of Nursing) from the Chelsea & Westminster Hospital; and Steve McManus (Chief Operating Officer & Deputy Chief Executive) and Jayne Mee (Director of People & Organisational Development) from Imperial Healthcare. Comments were also received from Matthew Bazeley (Managing Director of Central London CCG); and Louise Proctor (Managing Director of West London CCG).

8.2 The NHS Trusts had taken the CQCs comments very seriously, and had welcomed the introduction of transparency about safe staffing levels. The Trusts were using flexible bank and agency staffing, which was expensive, to ensure levels were maintained, and it was recognised that continuity was needed. The NHS Trusts acknowledged the high turnover of staff in London and that recruitment could be competitive, and confirmed that they were now working together to offer common packages and incentives. The Committee recognised that a stable workforce helped maintain quality of care

8.3 The NHS Trusts also acknowledged the need to be more innovative about the channels and speed of recruitment, and in staff engagement and retention. The Trusts had increased the number of recruitment campaigns, with greater use of social media, and aimed to offer posts on the day of recruitment. The timescales for placing advertisements and clearing staff had also reduced, which had helped increase the volume of people being recruited. Staff were receiving on-going training to enable them to progress into specialities, and award schemes had been introduced which valued staff and recognised what they were doing. The Committee noted that the vacancy rate at Imperial Healthcare had dropped to 7.68%, and that the momentum was continuing.

8.4 The Committee commented on the need for the NHS to encourage careers in the health service by working more closely with schools, and through more training placements being made available. The NHS Trusts commented that although young people were applying to train as nurses, there were few places which did not need self-funding.

8.5 Although the shortage of nurses and medical staff was a general problem across the UK, the cost of housing had made the issue particularly difficult for hospitals in Westminster and London. Members agreed that the issue needed to be addressed as a pan-London problem, and recognised competition from other major cities could attract staff by offering more affordable accommodation. The Committee noted that interest free loans which had been available for transport were now being extending to accommodation.

8.6 The NHS Trusts highlighted the current difficulty in retaining staff that came to the UK from other countries. Many nurses from Australia, New Zealand and Asia, who may have been trained in the UK, had been affected by changes to immigration rules, which now stated that people who were not earning over £35k

after being in the UK for five years had to return home. Changes to Sponsorship had also made it more difficult for people to come from other countries, and the NHS Trusts commented that they would welcome the support of the City Council in lobbying for change in the sponsorship system.

8.7 The Committee discussed the anticipated devolution of powers to London Councils, and acknowledged that the local authority could not be certain of what impact devolution could have, or of how it could support health services and health education. Members recognised that London was different to other major cities, and that issues needed different answers. The NHS Trusts welcomed the City Council's support on what could be done collaboratively, and in lobbying on issues such as housing.

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

8.9 **RESOLVED**: That consideration be given as to how the City Council can provide support in the on-going debate on devolution, by highlighting the issue of the recruitment and retention of NHS staff.

9 WORK PROGRAMME 2015/16

9.1 The Committee noted proposals for the 2015-16 Work Programme.

10 ITEMS ISSUED FOR INFORMATION

10.1 The Committee noted that the following papers had been circulated for information separately from the printed Agenda:

- Minutes of the meeting of the Joint Health Overview & Scrutiny Committee held at Hounslow on Tuesday, 3 March 2015.
- The Committee's response to the Quality Account of Imperial College Healthcare NHS Trust
- Fixed Odds Betting Terminals

11 ANY OTHER BUSINESS

11.1 No further business was reported.

The Meeting ended at 9.36 pm.

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

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City of Westminster

Adults, Health & Public Protection Policy & Scrutiny Committee

Date: **Thursday 24th September 2015**

Briefing of: **Cabinet Member for Public Protection & Licensing**

Contact Details: **Sion Pryse x 2228**
spryse@westminster.gov.uk

1 Public Protection and Licensing Restructure

1.1 The new structure has been operational for five months, and the most recent recruitment round has resulted in all City Inspector posts across the Public Protection and Licensing department being filled. Arrangements are underway to get all officers in post within the next few weeks. These inspectors are spread across Commercial, Residential and City Operations.

1.2 Both the new structure and co-location with other services has meant that City Inspectors have increased their knowledge of a wide range of issues around licensing, waste management, anti-social behaviour and environmental health work. Comprehensive training of all staff continues.

1.3 Demand for services remains high and as concerns emerge, they are assessed and resources deployed to priority issues through the Department's tasking process. This is reducing duplicity in effort and managing expectations.

1.4 Effective outcomes achieved through City Inspector activity are already being seen in dealing with licensed premises, waste hotspots, problematic commercial premises, foreign national street based activity, anti-social behaviour associated with hostels, and rubbish accumulations on private land.

1.5 Neighbourhood Problem Solving Coordinators are working hard to link in to Business Improvement Districts (BIDs) and local community networks in their areas, encouraging communities to work with the Council to resolve issues effectively. Problem solving meetings continue with key partners and the Metropolitan Police Service (MPS) resolving mid to longer term problems associated with anti-social behaviour, enviro-crime, waste, problematic people and premises.

1.6 City Inspectors are engaging with Environmental Health Officers and Neighbourhood Problem Solving Coordinators, through Clean and Safe Street audits, enabling the teams to jointly address entrenched problems identified on the street, and maximise joint enforcement activity. Businesses and residents who place burden on their local communities are beginning to experience increased enforcement. Currently, resources are being targeted towards the 'No Dumping' campaign around dumping hotspots in the North and South of the borough, and proactive work is underway to ensure businesses have appropriate waste disposal arrangements in place.

2 Community Cohesion

2.1 The first meeting of the Westminster Community Cohesion Commission, which I announced in my speech to Full Council in March, took place on 7th September. The Commission is designed to consider practical steps we can take locally to enhance community cohesion and reduce the risk to young people in particular of being lured into dangerous behaviour such as gang activity and radicalisation. The Commission will benefit from input from Councillors Mohammed, Hug and McAllistair who have kindly agreed to support the initiative and drive forward priority strands of work.

2.2 Discussion focused on three main areas.

- First, there was a healthy discussion about our collective understanding of what can make people isolated and marginalised from society and the need to ensure Westminster is a place where that doesn't happen. This is a cross-council challenge touching on everything from housing and employment status to opportunities for open discourse on cultural issues.
- Second, the group considered the processes for identifying risks and the importance of using the eyes and ears not just of council staff, the police or other public services but also communities themselves to do so.
- Third, the group spoke about the importance of empowering communities to ensure they have the tools to challenge disruptive behaviour but also act responsibly in terms of debates between and amongst different groups. Improving how we engage with communities and make them feel part of genuine discussion on the future of their local area and their own lives was flagged as an important issue as part of this.

2.3 There is a significant opportunity presented by the national focus on this area of policy. A new counter-extremism strategy will be published in the autumn and at the same time Louise Casey, former Director of Troubled Families at Department for Communities and Local Government (DCLG) will be leading a review of cohesion policy and practice across the country. We will feed our findings and recommendations into this process and have already contacted Louise Casey with an offer of support.

3 Prevent

3.1 The Prevent and Schools Conference took place on Monday 13th July. The Conference, for Head teachers, Senior Leaders, Safeguarding Leads and Chairs of Governors, was hosted by Children's Services, working alongside the Prevent Teams in London Borough of Hammersmith and Fulham (LBHF), Royal Borough of Kensington and Chelsea (RBKC) and Westminster City Council (WCC). The Conference offered attendees the opportunity to gain an understanding of the local threat and to understand how to respond to this effectively in light of the new Prevent Duty Guidance and the Department of Education (DfE) British Values Guidance. A large part of the morning was given over to schools so that they could present their own unique experiences and approaches to responding to extremism and radicalisation risks.

3.2 The Conference was attended by representatives from 20 schools in Westminster and positive feedback was received from attendees. It also gave the Prevent Team the opportunity to promote the suite of Prevent resources and projects that they have put together for schools' use over the coming academic year. As a result, a number of schools in the borough have requested access to Prevent resources and will be delivering Prevent projects within their schools.

3.3 Confirmation of funding for Prevent projects was received from the Home Office in late June. Alongside the projects to be delivered in schools, a number of other Prevent projects including the Prevent Parenting Programme will be commencing in September. The programme, based on 'Strengthening Families Strengthening Communities' seeks to improve participants' parenting skills and awareness of the risks and vulnerabilities experienced by their children. In addition, it aims to encourage better relationships between parents and children so that parents can fill the space where extremists, gangs and other negative influences try to operate.

4 Street Performing

4.1 Since I last reported in June, we have had a big step forward in joining-up our joint approach with the Greater London Authority (GLA) to managing street performance with the MPS; the GLA launched the programme at National Busking Day and the Busk In London Festival; and, following consultation with local stakeholders, Heart of London Business Alliance (HOLBA) has signed up to trial Busk In London pitches at Leicester Square and Piccadilly Circus.

4.2 The six trial pitches are being managed by the GLA's BID-funded Busker Liaison Team for an initial 8 week period with the aim that over time the performers themselves will form into a self-managing community that works well at Covent Garden and near the Tate Modern in Southwark as the result of an earlier trial. The Busker Liaison Team has provided its duty phone number to the police, Noise Officers, performers, businesses and anyone else

interested, and is logging and responding in real time to complaints and working with the community to help resolve and avoid problems.

4.3 Weekly meetings are being held with HOLBA to review feedback received from its members. This feedback is then provided to representatives of the different groups of performers at fortnightly busker forum meetings where the trial pitch guidance is reviewed and tweaked as necessary.

4.4 So far, a positive impact is being experienced at Piccadilly Circus and the situation is better at Leicester Square when the Busker Liaison Team is on duty. As businesses had been told to expect, after an initial reduction in noise and overcrowding issues, some of the younger and less experienced acts are pushing back and trying to find ways to take advantage of the new system which is causing more problems again. This has been exacerbated by unplanned absences in the Busker Liaison Team which are now expected to be resolved.

4.5 Behind the scenes the agencies involved – WCC, GLA, MPS and HOLBA – are working to tie up our reporting systems and information sharing processes so that our records and processes are watertight when we start moving to the second stage of the trial which will include enforcement, using the new Community Protection Notice route, where needed.

4.6 Once enforcement starts to take place it is expected that there may be some degree of protesting but that the process will be seen to be fair in the long-run and the more rebellious performers will acknowledge that they need to alter their behaviour. The team is working with the UK-wide busking lobby to make sure our joint-approach is proportionate, fair and reasonable.

4.7 The HOLBA trials will be reviewed in late October by which time it is hoped that further trial pitches within the New West End Company and the Northbank BID areas will be in place and helping ease pressure on the initial trial pitches. The latest information can always be found at www.BuskInLondon.com.

5 Rough Sleeping

5.1 A borough wide intelligence street count was held in the last week of August, which is traditionally a month where we see a larger number of rough sleepers in the city due to the weather and high foot traffic from tourists. We will be holding a formal street count in September with partners from Home Office and Met police taking part and all details will be independently verified.

5.2 The month of August saw senior officers from City Management & Communities and Growth, Planning & Housing launch a formal working partnership to provide more inclusive and expanded operational working practices across the city to address both rough sleeping and the anti-social behaviour/street based activity. This enables a three tiered approach to the issue:

- Outreach teams leading on social care and assessment on the streets

- City Management and Hot Spot team carrying out disruption/fixed penalties for low level anti-social behaviour, utilising partnerships between teams to solve localised problems with street based activity/rough sleeping hot spots and sharing intelligence to pursue persistent offenders

- core statutory response to crimes and immigration offences by the police and Home Office

Training has been delivered and operational recording systems and risk assessments have been devised. Both teams will begin measuring the impact of the partnership in the autumn.

5.3 The Rough Sleeping team recently commissioned a small piece of work entitled 'Security for All'. This small service is offering training to private security teams on how to prevent people bedding down on private land, information to sign post to ensure that if an individual wants help they know where to go and finally, to increase confidence of security officers to report people sleeping rough so they can be targeted by outreach teams. There will be regular meetings and/or joint patrols with outreach workers to ensure the issue isn't being dispersed into other areas. This service fits within the strategy of prevention of rough sleeping and enabling private landowners to take action while feeling more confident in WCC supporting them when issues arise.

6 Notting Hill Carnival

6.1 25 officers made up of City Inspectors, Environmental Health Officers and Contingency Planning Officers attended both days.

6.2 Street trading licenses were issued to 34 traders utilising pitches in Talbot Road, Westbourbe Park Road and Maida Hill Market. All traders were compliant of the conditions set on the licenses and adhered to the City Inspectors request for a swift close down at the end of the day. Licensed food traders operated to a good standard in respect of Food Safety and Hygiene.

6.3 The six static sound systems located in Westminster operated at an acceptable noise level. Where necessary Environmental Health Officers worked with operators to reduce noise levels on request.

6.4 Approximately 22 Alcohol warnings were issued by City Inspectors persons having in their possession alcohol with the intent to sell. Two unauthorised food stalls were closed down by officers. Six seizures were carried out by officers these included whistles, horns, necklaces, balloons, alcohol and nitrous oxide.

7 Licensing Consultation

7.1 A small working group of relevant members and officers convened to assess the responses to the consultation proposals and a revised licensing policy is being drafted. Subject to discussions with colleagues and advice from officers I will be presenting this draft for approval at Full Council in November.

8 Fixed Odds Betting Terminals

8.1 Consultation on the first stage of the revision to the Statement of Licensing Principles for Gambling commenced in August 2015 for a period of five weeks. Stage One of the revision to the council's policy relating to gambling incorporates a very minor revision to the current policy. Following the conclusion of the consultation period for this stage it is intended that the revised policy will be put forward for agreement to commence from the 31st January 2016. Stage Two of the review requires a major revision to implement a number of new policies and specific information on the local area to assist applicants completing the new requirement placed upon them by the Gambling Commission to complete local gambling risk assessments. The Stage Two consultation on the completely revised policy will be conducted later this year.

Adults, Health & Public Protection Policy & Scrutiny Committee

Date:	**Thursday, 24th September 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, including development of the Community Independence Service (CIS) and enhancements to hospital discharge.

1.2 The Lead Providers of CIS (Imperial College Healthcare Trust and Tri-borough Adult Social Care) have developed the key elements of service design in line with the joint implementation plan, with oversight by a clinical reference group. Timescales for rollout of Adult Social Care (ASC) staff changes needed to support the design principles are subject to confirmation following further review of funding arrangements for 2016/17.

1.3 The pilot to develop and test improved processes for hospital discharge has informed the development of next steps.

1.4 Implementation of one Tri-borough ASC hospital discharge pathway is commencing.

1.5 The next meeting of the Better Care Fund Board is 13th October 2015.

Home Care Procurement

1.6 The procurement for a new home care provider for three of the four area patches in Westminster has now been completed. The recommendations have been formally approved by the Cabinet Member for Adults & Public Health and the Cabinet Member for Finance & Corporate Services. The decision was not called in and the contracts have been awarded for North East, Central and South Westminster areas.

1.7 The implementation process will start in September in these three patches. It will start with letters and meetings with the customers affected. ASC commissioners, contractors, operational staff and the new providers will have regular meetings to ensure a smooth transfer of care.

1.8 An event will also be set up for ASC and the voluntary sector to meet providers, start developing the relationships needed to improve services and to start addressing the areas of work that are most vital to the new service.

1.9 A values based recruitment workshop will also be held to support the new providers in their recruitment processes. Both of these events are expected to take place in September.

1.10 It was not possible to award the fourth contract covering North West Westminster and a new procurement will be undertaken for this. Spot purchase arrangements will continue in the meantime.

Care Act Implementation

1.11 Part One of the Care Act was successfully implemented from 1st April 2015. National Stocktakes are planned in October 2015 and February 2016 to monitor how local authorities are performing under the new legislation.

1.12 The government has decided to postpone implementation of Part Two of the Care Act until 2020. This is in response to concerns expressed by the Local Government Association and many other stakeholders about the timetable for implementing the cap on care costs in April 2016. The delay will allow time to be taken to ensure that everyone is ready to introduce the new system and to look at what more can be done to support people with the cost of care.

SHSOP

1.13 The Specialist Housing Strategy for Older People (SHSOP) Programme saw the realisation of the key objective in Phase One of the programme. At the end of August, services commenced at Athlone House, Carlton Dene, Garside House, PLK and Westmead with the new service provider Sanctuary Care. This was further to an engagement process with residents, TUPE consultation with staff and the culmination of a challenging lease process with NHS Property Services.

1.14 WCC and its NHS partners continue to address property issues to enable mobilisation of the Butterworth, the sixth and final home in scope for externalisation to Sanctuary Care.

1.15 Work continues on Phase Two of the SHSOP programme, which focuses on redevelopment/new buildings for two of the six homes.

Up-coming Events

1.16 Plans are progressing well for Silver Sunday, the Tea Dance and the Carer Awards. Silver Sunday is on 4th October 2015 and will include a schedule of 40

free events and activities. Such events include a performance at St James Theatre for 140 people, afternoon tea at the Hyatt Regency and a tour of Lord's Cricket Ground. The Carer Awards will take place on 2nd November 2015 at The Thistle Hotel, Marble Arch. 96 nominations have been made this year. A judging panel will consider the candidates and choose the winners on 22nd September 2015. The Tea Dance is on 29th November. So far 700 applications have been made for 1000 tickets.

2 PUBLIC HEALTH

School Nursing

2.1 Working jointly with children's services, schools and other relevant partners, we are developing the service specification and procurement strategy for a new integrated school health service.

2.2 Arrangements are in place to safely transfer the Public Health Services for 0-5 year olds (Health Visiting and Family Nurse Partnership services) from NHS England to the Local Authority by 1st October 2015. 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 1,834 Health Checks were delivered in Westminster between the 1st April 2015 and 30th June 2015. We have therefore exceeded our target for Quarter 1 and are on track to exceed our 15% target for Westminster by year end.

2.4 12,387 patients have been invited for an NHS Health Check between the 1st April 2015 and the 30th June 2015, we have already exceeded our 20% offered target for the year.

2.5 A new service for people identified as being at high risk has been commissioned and will be implemented in October with a launch in January 2016.

2.6 We now have all GP practices within Westminster signed up to the health checks programme.

Childhood Obesity

2.7 The obesity team have submitted a bid to the Mayor's office to help fund a Social Supermarket in Westminster.

2.8 The social supermarket is an entrepreneurial model that considers the social, personal, cultural and environmental issues that surround food poverty and is capable of achieving long term wide ranging economic and health benefits for our communities most in need. It works by creating otherwise unwanted food available cheaply to those on very low incomes.

2.9 Harrow Road will be the main place of focus for the social supermarket if we are successful.

2.10 The bid was submitted on 2nd September 2015 and we have been advised that we will hear back on whether we have been successful by 22nd September 2015.

Substance Misuse

2.11 The core drug and alcohol services procurement is nearing completion and early feedback from the pre-qualification questionnaire stage is positive with three providers invited to tender for Lot 1 and three for Lot 2. We are on target to award contracts at the end of November 2015 and to deliver the new contracts from April 2016. This new model is intended to change the way in which services operate. It will work through an asset based approach which is flexible enough to respond earlier and more effectively to the needs of alcohol users and to changing drug trends.

2.12 In the meantime our current providers continue to work with commissioners on making improvements to their services and to improve outcomes. Westminster is now in the top quartile for successful completions of drug treatment.

2.13 The recently established tri-borough service user group has been focusing on gaps in services and on opportunities to influence service improvements. Some providers have used the group to consult on plans and redesign work. Peer-led initiatives continue to grow and the momentum to contribute to the workforce via peer mentoring and volunteering continues to increase.

2.14 It is an on-going priority to provide education training and employment initiatives for service users. The work is progressing well, with an improvement in the numbers entering the various schemes to increase skills. There is now a significant increase in people entering paid employment.

2.15 We are also continuing to encourage providers to work directly with organisations where there are opportunities to access apprenticeships or trainee roles that accept people with substance misuse and offending histories.

Sexual Health

2.16 Following a review of community sexual health provision, we are proposing to award contracts for a further year, to a reduced number of providers, to allow for a full redesign and procurement. We are continuing to engage with service users and providers in preparation for the redesign of community based sexual health services. We have identified efficiencies through the review and have a programme in place to redesign and remodel the community-based sexual health services to focus more on prevention.

2.17 We have slowed the re-procurement to ensure we fully accommodate the impact of revised levels of financial constraints.

2.18 The London wide transformation programme of Genito Urinary Medicine (GUM) services is still on-going with the programme progressing with Phase Two.

Providers have registered interest through the PIN notice process and the majority of interest has come from current providers of sexual health mandatory services within London.

2.19 The changing financial landscape is impacting on the progress of the collaborative and the full business case has been delayed. The approvals to proceed with the strategy will now begin fully from the end of September.

Supported Employment

2.20 A full time Specialist Employment Broker has been appointed by Cross River Partnership. The Broker will support local services and charities and assist residents with specialist needs into work related opportunities. The Broker will also integrate with the Recruit London service.

2.21 Mapping of local employment services is underway and will inform future commissioning including a tri-borough Supported Employment service and with input from officers across the Council including Growth Planning and Housing, Public Health, Policy and Tri-borough Adults.

Funding

2.22 A response to a DoH's consultation on how the £200 million Public Health funding cuts should be implemented was submitted at the end of August 2015. The submission agreed with the DoH's proposal to spread the cuts evenly across local authorities. This would result in a £2.1 million share of cuts for Westminster. It was highlighted in the submission that any further cuts will directly affect front line services in the long run.

New Director of Health

2.23 The new Director of Health, Mike Robinson will start in mid-November.

3. HEALTH & WELLBEING BOARD

3.1 The Health and Wellbeing Board has not met since the last Policy and Scrutiny Committee. The next meeting is on 1st October 2015.

4. HEALTH

Bayswater Medical Centre

4.1 The Care Quality Commission (CQC) carried out an announced comprehensive inspection at Bayswater Medical Centre in June 2015. They inspected the main practice and their branch practice located at 7 Golborne Road. Overall the practices were rated as inadequate.

4.2 As a result, the provider has been placed under special measures. Bayswater Medical Centre may not register any new patients at the main practice, except

for family members of existing patients, for a period of six months. It also may not carry out activities at the branch site.

Central & North West London NHS Foundation Trust – Redwood Ward

4.3 Central and North West London NHS Foundation Trust (CNWLFT) received a 'requires improvement' overall from the CQC but behind this top figure they actually received 'outstanding' for whether the services are caring. The most concerning comments for Westminster residents related to Redwood Ward, an older people's at St Charles Hospital.

4.4 Members from the Adults, Health and Public Protection Committee have since visited Redwood Ward and noted that actions required improvements requested by the CQC had been undertaken.

Victoria Medical Centre

4.5 The CQC has found the quality of care provided by the Victoria Medical Centre to be outstanding. Inspectors found that the surgery was providing a safe, caring, effective and well-led service that was particularly responsive to the needs of the local community.

4.6 Victoria Medical Centre provides a primary medical service to patients living in and around South Westminster. The Adults, Health & Public Protection Committee wrote to the Practice to congratulate the team on their success.

Adults, Health & Public Protection Policy & Scrutiny Committee

Date:	**24th September 2015**
Classification:	**General Release**
Title:	**HEALTHWATCH WESTMINSTER**
Report of:	**Healtwatch Central West London**
Cabinet Member Portfolio	**Adults & Public Health**
Wards Involved:	**All**
Policy Context:	**Health and Social Care Act 2012**
Financial Summary:	**N/A**
Report Author and Contact Details:	**Paula Murphy, Director, Healthwatch CWL** Paula.murphy@hestia.org

1.1 The procurement process for the local Healthwatch in 2016 has now begun. The current Healthwatch Central West London Board of Trustees are planning to bid for this contract with support from Hestia.

1.2 Healthwatch CWL is pleased to announce the appointment of our interim director Anne Green. Anne joins us with experience as operations director for a national charity and in international consultancy. Our current Director, Paula will support us through the procurement process and then move to a new role in our parent charity, Hestia. The Board wishes to express appreciation of Paula's contribution over the past 5 years in establishing Healthwatch and its predecessor the LINk.

1.3 In June, Healthwatch CWL held its first three borough patient and public forum on district nursing and on assistive technologies. Members expressed concern about the impact of district nursing shortages on holistic care provision and safeguarding. Attendees were generally very supportive of the roll-out of assistive technologies. Comments were made on:

- The need for a transparent, person-centred multi-disciplinary assessment to include health and care needs

- The need for a clear information offer for customers wishing to purchase assistive technology (not eligible for Adult Social Care funded provision)
- The importance of integrating with health and self-management to enable access to assistive technology through social prescribing
- The need to ensure assistive technology does not replace human contact for many already isolated individuals.

The next Forum will be on October 21st, from 2pm to 4.30pm, in Committee Room 1, Kensington Town Hall and will focus on community mental health services.

1.4 Our dignity champions have recently assessed one local care home and two CNWL sites

- Penfold hub dementia unit (report now published)
- The Butterworth centre, (report available mid-October)
- The Gordon hospital (CNWL) the report will be available at the end of October.

1.5 Following the recent CQC inspections, we joined the visit by Councillors (Westminster and RBKC) to Redwood ward in the St Charles Mental Health Unit. We were pleased to note improvements to privacy, the reduction in sleeps out/ sleep-overs and the provision of psychiatric consultancy on each ward. We still have concerns about staffing levels and delayed discharge.

1.6 Our final report on Child and Adolescent Mental Health Services is now available. Our report analysed the lived experiences of people using, caring for and/or working with young people who have been referred to mental health services. Key recommendations include:

- Clarity is needed about the role of Tier 1 early intervention support services
- The need for a young adults mental health service to lessen the impact of transitioning should be explored further
- The need for improved understanding of the 'Think Family' approach with greater clarity on the parental role in recovery, especially in Tier 1 is needed
- Optimising school services as a gateway to CAMHS
- Ensuring mental health is part of a wrap-around offer of wider well-being services coordinated across schools, health and voluntary organisations.

1.7 Healthwatch England has recently published a new report 'Suffering in silence: Listening to consumer experiences of the health and social care complaints system.'

1.8 Healthwatch CWL is delighted to have supported and celebrated a number of local upcoming community events:

- Silver Sunday
- The Carers Awards.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact: paula.murphy@hestia.org

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Adults, Health & Public Protection Policy & Scrutiny Committee

Date:	Thursday 24th September
Classification:	General Release
Title:	**ANNUAL COMPLAINTS REPORT 1ST APRIL 2014 - 31ST MARCH 2015**
Report of:	Tri-Borough ASC
Cabinet Member Portfolio	Cabinet Member for Adults & Public Health
Wards Involved:	All
Policy Context:	City of Choice
Report Author and Contact Details:	**Nadia Husain** (RBKC x2552) Nadia.Husain@rbkc.gov.uk

1. Executive Summary

1.1 The report contained within the Appendix is the Adult Social Care Annual Complaints Report - 1st April 2014 to 31st March 2015.

2. Key Matters for the Committee's Consideration

2.1 What are the Committee's views and recommendations in relation to the complaints data as presented in the report?

If you have any queries about this Report or wish to inspect any of the Background Papers please contact Nadia Husain, TB ASC, Nadia.Husain@rbkc.gov.uk (RBKC x2552)

APPENDICES

Appendix A: Annual Complaints Report - 1st April 2014 to 31st March 2015

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WESTMINSTER CITY COUNCIL

ANNUAL COMPLAINTS REPORT

1ST APRIL 2014 TO 31ST MARCH 2015

DRAFT – Pending approval from ALT and Cabinet Lead

Westminster City Council
Westminster City Hall
64 Victoria Street
London SW1E 6QP
020 7641 6000
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City of Westminster

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Introduction

This report provides information about statutory complaints made between 1 April 2014 and 31 March 2015 under the Adult Social Care Services and NHS Complaints regulations, 2009.

The report highlights how various services within Adult Social Care (ASC) services have performed in line with key principles outlined in the complaints regulations. Learning and service improvements that have been made as a result of responding to complaints are also discussed, as are plans for further service developments.

The Customer Feedback Team (CF Team) is responsible for recording, managing and analysing all statutory complaints and feedback in ASC as well as comments and compliments for the Westminster City Council (WCC).

The Customer Feedback Team

All statutory complaints, compliments and any feedback are managed within the CF Team. The team works closely with the ASC executive support staff and the Corporate Complaints Teams for the Council in order to ensure that any crossover complaints (complaints across different organisations) and all Local Government Ombudsman (LGO) investigations are handled appropriately. The CF Team mostly works with the operational teams to ensure, where possible, responses provided to complaints are delivered on time, are factual and answer the complainants concerns or provide an explanation around service delivery. The CF Team consists of three full time staff members, working across three partner boroughs, (LBHF, RBKC and WCC).

The complaints process

The Department of Health (DoH) defines a complaint as, “an expression of dissatisfaction or disquiet about the actions, decisions or apparent failings of a councils adult social care provision which requires a response”- The Council definition.

Anyone who has received a service, is currently receiving a service or is seeking a service from us can make a complaint. This includes anyone who is affected by decisions we may make about providing social care, including a service provided by an external provider acting on behalf of the Council. In such a case you can complain directly to the provider or to the CF Team. External providers are required to have their own complaints procedures and must comply with them. They are also required to share information on complaints and outcomes with the Council. The CF team or person handling your complaint should try to resolve your concerns in the first instance, If you are still unhappy and we are not able to resolve your concerns to your satisfaction, you can ask the LGO to review the way we have dealt with your complaint. When we receive your complaint it is logged and acknowledged in writing within three working days. A plan of how the complaint will be dealt with will be agreed with the complainant including the time-scales for providing a response. The CF Team conducts a risk assessment for each complaint to determine how it should be handled. Complaints are graded into four risk categories:

- low
- moderate
- high
- extreme

Complaints that fall between low and moderate risk are dealt with by the service manager concerned and is usually resolved through meeting with the complainant and a paper review or an internal investigation followed by a written response. Those that are deemed to be high or extreme risk are usually investigated by independent investigating officers who submit their findings to the Council, followed by a letter along with the report to the complainant from the Adjudicating Officer - usually a Director. In other cases, some complaints may need to be passed on to the Safeguarding Leads as appropriate, where the complaints process may be suspended, in order to allow the safeguarding process to be completed.

The Council will try to resolve the complaint as soon as possible, and no later than within 10 working days. If delays are expected, the complainant is consulted and informed appropriately. All responses, whether or not the timescale has been agreed with the complainant, must be made within six months of receiving the complaint. In exceptional circumstances, an investigation may take longer and this will be discussed with the complainant.

In cases where the complaint is across several organisations, one organisation will act as the lead and co-ordinate a joint response to the complainant. The Council has one opportunity to provide a formal response which must set out the right to approach the LGO should the complainant remain dissatisfied.

Summary of activity and demand

The total number of people that received an adult social care service during the year was 6,373. The table below highlights key ASC activity;

Table 1 – Breakdown in ASC activity

Category	Number in 2014/15
New referrals	4,592
New assessments	3,024
Reviews	3,774
Customers	6,373

When looking at the total numbers of residents receiving support from the department, approximately 1% of these customers or someone acting on their behalf raised a complaint about a service that they received.

Compliments

Customers and their representatives are encouraged to tell us if they are happy with their care or would like to highlight a good service. People can complete the feedback form as well as contact the relevant social care team or the CF Team to express their praise. There has been a drop in this number this year and the CF Team will remind staff and managers to make sure that all compliments are passed to the CF Team so that good practice can be recorded and reported across the department.

Table 2 – Compliments over last three periods

Year	No of compliments
2012/13	8
2013/14	21
2014/15	11

Some examples of the compliments received this year are;

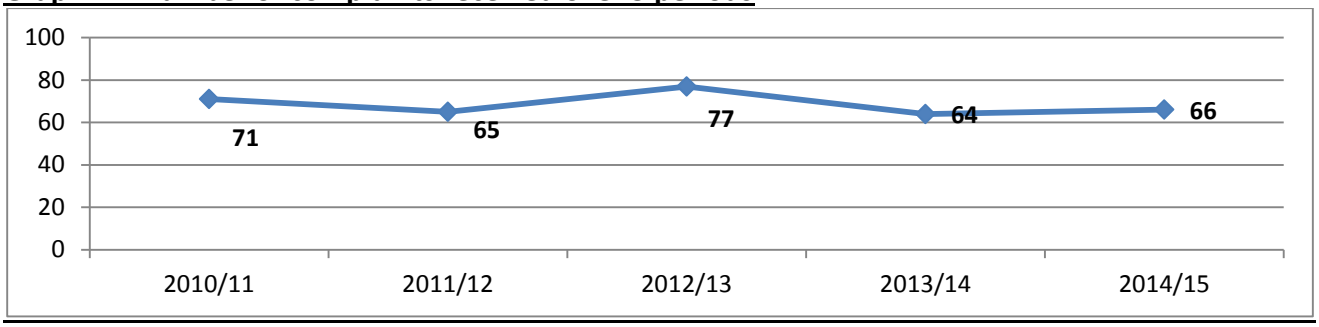
"I wanted to take this opportunity to commend the team for the excellent care and attention for our mother. We are particularly impressed with the various safety measures (pressure mattress, flood and fire alarms). Plus of course daily care visitors and meals on wheels. The relentless and inexorable deterioration that occurs in this tragic condition touches so many who are involved in the sufferer's care. Their dedication and commitment is truly remarkable. I would sincerely like to thank you for attending to my mother. I really appreciate the care, compassion and peace of mind you and your team provide"

"All my carers were absolutely excellent! They were most appreciated and necessary. Their approach and effort was first class. It was so good to see the organisation working so well!.

Detailed complaints activity for 2014/15

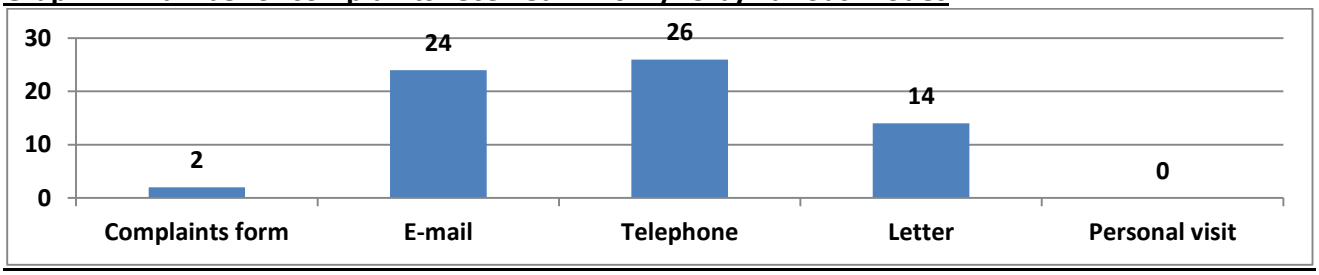
While we appreciate positive feedback we also understand that sometimes things go wrong where customers become unhappy with the support they have been provided. In this case, they and/or their relatives/carers/advocates are encouraged and advised to raise concerns with the CF Team. The CF Team recorded 66 formal complaints in 2014/15. This number shows a 3% increase on the previous year.

Graph 1 – Number of complaints received over 5 periods



There is not much difference in the numbers compared to last year, however it can be reported that majority (68%) of the 66 complaints were received during quarters 3 and 4. The CF Team continues to actively work with providers, community organisations and care management teams to encourage customers to talk to us about any aspect of their care and support.

Graph 2 – Number of complaints received in 2014/15 by various modes

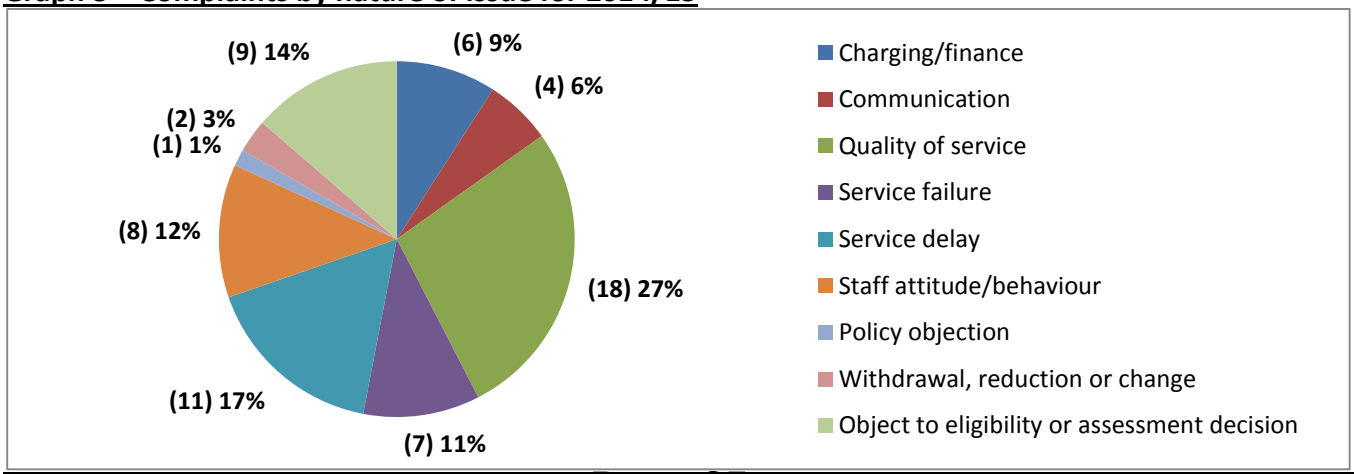


Most complainants prefer contact by e-mail and telephone, as it allows people to impart as much information as possible. The telephone contact is an easy access route, especially with the free phone number, which is advertised heavily, and allows people to get their concerns across sooner. The complaints forms remain the least favourite route for people, however they do get picked up by customers as they have valuable information about the process and access to the CF Team.

Nature of issue

Graph 3 shows a breakdown of the complaint received by nature of issue. If you would like to see a detailed breakdown by team of this information, please see Appendix 1.

Graph 3 – Complaints by nature of issue for 2014/15



As can be seen the majority of complaints have been about the quality of the service or service delay.

Complaints activity by team

The table below shows a detailed look in the complaints activity by all the teams. The care and assessment teams collectively have received the highest (40%) number of complaints. These teams see the most number of customers, therefore this should be considered when looking at the percentage distribution. 12% of complaints received were against external homecare providers, this is less than half of those received last year.

Table 3 – Complaints activity by team for 2014/15

Teams	Complaints received	Percentage	Outcome				Ongoing
			Upheld	Not upheld	Partially upheld	w/drawn	
Access	6	9%	0	4	2	-	-
Adults North East	9	14%	1	4	4	-	-
Adults North West	5	8%	1	3	0	1	-
Adults South	12	18%	0	7	4	1	-
Hospital Discharge Team	3	5%	2	0	1	-	-
Older People's Mental Health Team	2	3%	0	0	2	-	-
Re-ablement & OT Service	8	12%	3	4	1	-	-
LD Partnerships	4	6%	1	3	0	-	-
Homecare	8	12%	2	3	3	-	-
Commissioned services	4	6%	0	0	4	-	-
Substance use	1	1%	0	1	0	-	-
EDT	1	1%	1	0	0	-	-
Finance	3	5%	0	2	1	-	-
TOTAL	**66**	**100%**	**11**	**31**	**22**	**2**	**0**

The Council and the agencies work in partnership to handle these complaints and ensure that action is taken to ensure complete resolution of the complaint, improvement in service and prevention of recurrence of the issue.

Complaints activity by demographics

This section captures data on demographics for all customers who have made a complaint themselves or had a representative raise a complaint on their behalf. We have tried to compare the data presented last year with this year and work is ongoing to ensure the complaints process is accessible to all and that under-represented groups can be targeted. Table 5 shows the number of complaints received by WCC against different demographic categories.

Table 5 – Complaints by age, gender, ethnicity and disability

(a)

Age	WCC (2013/14)	WCC (2014/15)
18-64	23 (36%)	24 (36%)
65-74	13 (20%)	7 (11%)
75-84	15 (24%)	15 (23%)

Over 85	13 (20%)	20 (30%)
TOTAL	**64 (100%)**	**66 (100%)**

In Westminster, the age of majority of the customers, 57% are 65 or over. The number of complaints made by or on behalf of services users from this age group is recorded at 64%, which is in line with the customer population. Further analysis shows that only 1% of total customers over the age of 65 have complained to the Council about a social care service they receive.

(b)

Gender	WCC (2013/14)	WCC (2014/15)
Male	21 (33%)	19 (15%)
Female	43 (67%)	47 (85%)
TOTAL	**64 (100%)**	**66 (100%)**

The majority of the customers in WCC are female (55%), however 85% of complainants in WCC have been women.

(c)

Ethnicity	WCC (2013/14)	WCC (2014/15)
White – British	27 (42%)	42 (64%)
White – Irish	4 (6%)	0
White – Other	5 (8%)	3 (4%)
Black or Black British – Caribbean	1 (2%)	6 (8%)
Black or Black British – African	2 (3%)	2 (3%)
Black or Black British – Other	0	-
Asian or Asian British – Bangladeshi	0	1 (2%)
Asian or Asian British – Indian	0	1 (2%)
Asian or Asian British – Other	4 (6%)	1 (2%)
Mixed - White and Black Caribbean	1 (2%)	1 (2%)
Arab	0	5 (6%)
Not stated	9 (14%)	4 (6%)
Other	11 (17%)	-
TOTAL	**64 (100%)**	**66 (100%)**

The majority of the customers in WCC describe their ethnicity as White British. The percentage of this group is 45% and the complaints received 64%, which is significantly higher than the 42% of last year. However, we recognise that there may be a need to engage with Black Minority Ethnic (BME) groups and community groups to ensure they are aware of how to feedback any concerns they may have about services they receive by making links with community groups and attending any relevant events.

(d)

Disability	WCC (2013/14)	WCC (2014/15)
Physical disability, frailty & sensory impairment	43 (67%)	46 (70%)
Social support	n/a	6 (9%)
Learning disability	4 (6%)	4 (6%)
Mental health	10 (16%)	6 (9%)

Other vulnerability	4 (6%)	-
Substance use	0	-
Not recorded	3 (5%)	4 (6%)
TOTAL	**64 (100%)**	**66 (100%)**

54% of customers in the borough are recorded to have a physical disability this year, which is very slightly lower than last year. In relation to complaints 70% customers that have had a complaint logged about their care fall under this category. However, this year a new category "social support" has been added to the social care system which accounts for 9% of total complaints in WCC. Statistics also show that only 1% of customers with a physical disability have made a complaint. This could suggest that more support is required for clients in this group to access the complaints process. Our statistics show that 8% of our customers this year have a learning disability (LD). In terms of complaints only 6% of the 66 complaints fall under this category. The new LD customer feedback form that will be in circulation later this year will help to raise awareness and access to people who may want to raise concerns.

This analysis will inform the way the CF team will engage and promote the work they do amongst all customers and their representatives. The CF team will work closely with commissioning, procurement, voluntary organisations and community groups to ensure all customers understand the process and can ultimately inform service provision decisions.

Outcomes

There are three main categories for classifying the outcome of a complaint;

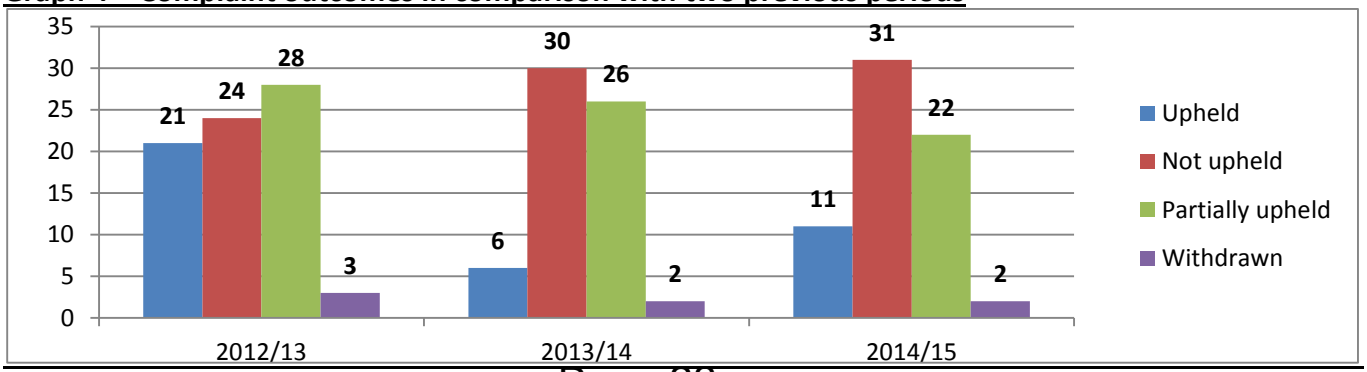
"Upheld" – This is where the Council has accepted responsibility for the matter arising. This is followed up with a detailed letter of apology and clarification with reasons and remedies and actions to ensure such a complaint does not recur.

"Partially upheld" – This is where the Council accepts some responsibility for part of the complaint. A response outlining the part that is upheld is sent, stating any reasons and proposed remedies.

"Not upheld" – This usually means that the investigation into the complaint has not found the Council at fault. This is explained carefully and thoroughly in writing with appropriate reasons for this conclusion.

Graph 4 shows the outcome of all complaints that were made to ASC, and comparisons with previous two years. Exactly half of the complaints received have been either fully or partly upheld which is consistent with last year. The teams ensure that they learn from complaints to ensure that the problem does not recur with other customers.

Graph 4 – Complaint outcomes in comparison with two previous periods



Local Government Ombudsman activity

Table 4 shows the number and type of correspondence received from the LGO in relation to the Adult Social Care complaints.

Table 4 – LGO investigations and outcome for 2014/15

Type	No of complaints	Outcome		
		Upheld/ Partial upheld	Not upheld	Still active
Premature complaints	0	-	-	-
Complaints investigated by the LGO	4	1	3	-
TOTAL	**4**	**1**	**3**	**0**

There were no premature complaints. There were four cases investigated by the LGO. These cases were about Occupational Therapy Services, Care and Assessment Services, Access Team and Financial Assessment Team respectively.

The investigations have been completed and the cases have been closed. One was partially upheld and the recommendations for the case have been implemented including financial recompense.

The number of complaints investigated by the LGO in 2014/15 has decreased by 1 compared to last year. The trend pattern is difficult to evaluate as the number of cases are very low and the LGO exercises its discretion, as to whether or not a complaint they receive will be subject to a full investigation. All complainants are referred to the LGO at the end of the Council's complaints process so they ate aware of their option to escalate the complaint if unhappy with the outcome.

Customer feedback

The role of the CF Team extends to recording general enquiries and feedback about services within Adult Social Care. In 2014/15 the CF Team has dealt with 18 such cases.

These have been about a variety of issues. Some of these are service requests, requests for information, suggestion for improvement to services and/or informal complaints. These can be about social care assessments, homecare, external providers and mental health services.

The CF Team responds to these within 10 working days and where appropriate will write to the person raising this feedback with a response.

To quote an example, the CF Team received written correspondence from a customer about a support plan that had been sent to him to check, sign and send back. The customer raised concerns about the social work team as they incorrectly referred to a friend as his carer in the support plan. The customer did not want to formalise the relationship and the records were amended and resent immediately.

Independent investigations

An independent investigation may be initiated for very high risk or complex complaints. There have been no independent investigations for WCC this year.

Members enquiries

All Member enquiries are managed and recorded by the executive support staff. In 2014/15 the number of member enquiries for the Westminster City Council was 149. The CF Team liaise with the executive support staff to ensure that if a Member enquiry raises concerns about an ongoing or new complaint the correct process can be applied and all parties are informed.

Corporate complaints

The Council recorded 3 corporate complaints. These are complaints that are received by the service; however the issues being raised are outside the jurisdiction of the ASC complaints regulations. The complaints were against a mixture of the teams and were about low risk issues. They were all responded to within 10 working days and closed.

Financial recompense

In this financial year in recognition of inconvenience and distress, a payment was made to a customer amounting to £150.

Learning from complaints

Learning from complaints provides opportunities for services to be shaped by customer experience. 'Learning from complaints' is an increasingly important part of the ethos within adult social care and managers responding to complaints/representations are encouraged to identify any shortcomings within the service and to inform the customer of any actions which will be taken to prevent a recurrence of the event which led to the complaint. The role of the CF Team is to ensure that service managers transform learning from complaints into service improvements. Below are some examples of lessons that have been learnt and some service improvements that have been made as a result.

- A complaint about an assessment outcome led to review and although the outcome of the assessment could not be altered a carer's assessment was offered to further support the family.

- A complaint against commissioned services was raised where the customers' expectations had been raised by ASC staff about home care providing domestic tasks at 9 am. The matter was clarified and staff were reminded that homecare agencies cannot provide domestic support during the morning slots.

- A joint complaint against Adult Social Care and Children's Social Care Services led to a situation where two separate complaint responses were sent out due to difference in level of service being sought. Although this was unavoidable at the time a protocol has been agreed in principle with the Children's Complaints Team to ensure all joint complaints receive a joint response by a mutually agreed timescale.

- A homecare complaint identified issues with care staff in recording care task details. This was reported back to the agency and the agency has been monitoring this and has not received any further complaints on this issue.

- Contact with a front line ASC team identified some communication issues, which were dealt with by manager in a team meeting to ensure correct and appropriate information is recorded.

- Following a complaint the manager raised it with the front line staff concerned as part of their work plan. The advisor was given further coaching and training and was monitored for a period of two weeks following the complaint (in which time, there were no further issues of this nature reported). All process documents and scripts used were reviewed and some amendments to these were made to make sure they were clear to follow. The incident was also communicated to all advisors as an example of what can happen if systems are not properly checked.

In addition the CF team is conducting work in the following areas in line with the priorities for 2014/15;

- Customer Satisfaction Survey – The CF Team started sending these surveys out to all complainants this year. Based on the completed forms we are receiving, which is a low number for now, we know that some people remain worried about repercussions to making a complaint and are daunted by the process. As the numbers for complaints are going up for the Council we will continue to promote accessibility to the service and ensure we speak to our customers especially vulnerable groups to encourage them to raise their dissatisfaction with any service in confidence.

- Care Act 2014 – The Care Act 2014, emphasises the role of carers; this may result in more feedback from carers. To encourage this and provide increased opportunity and accessibility the CF team has revised all information in the public domain. The material will also have up-to-date information about advocacy services available to our customers and encourage people to contact us in confidence to raise concerns whether positive or negative about a service they receive. The Team is developing links with all advocacy agencies working within the borough to ensure we have good working arrangements in place.

- Barriers to complaints – As stated above, we also often hear from operational staff and partner organisations that our customers do not feel comfortable in raising complaints for a variety of reasons. We have conducted a short survey with partner agencies form across health and voluntary sector to find out what these may be and how we can improve access to complaints and encourage people to contact us to share their feedback and trust that we will ensure that if it can, it does lead to a service improvement.

- Mediation – in light of changes to the Children's Act that came into effect in September 2014, there is a role for this team to provide assistance to young adults between 16 and 25. To this end, we have participated in developing a set of roles and responsibilities for our team within this process and making sure that young adults and/or their parents/carers still have access to statutory complaints process.

Priorities

2014/15 has proved to be another busy year for the CF Team. The team was able to work on most of the priorities set for the year. They have also continued to handle statutory complaints, feedback, LGO investigations and any other correspondence. In doing so, it has ensured that deadlines are met and that the quality of the response has consistently improved. This year, the team has seen more complaints, experienced more contact from customers and their representatives and noted that the issues being raised have been more complex. The team has tried to ensure services make informed changes to deliver improved services for our customers. The team will continue to fulfil this role and in addition, it has set itself the following priorities for the current financial year;

- Continue to promote the CF Team across all services as well as Adult Social Care operational teams, ensuring that staff are familiar with the procedures and are fully equipped with effective complaints handling skills.

- Helping stakeholders and partners understand the complaints process including what a complaint is, consent issues, deadlines and what to expect from a response.

- Continue to encourage residents to report positive feedback and record and respond to compliments from customers and/or their representatives.

- Attending more customer events. This gives us a chance to engage with customers as well as promote our service. It also allows our main stakeholders to understand our work so that they can effectively support the customer, in the event of a complaint.

- Developing an appeals process as part of the Care Act implementation in line with any government guidance for the year 2016/17. The CF Team will be working with partners in the London Complaints Managers Group and participating in workshops with the Department of Health to develop a workable scheme.

- Working with colleagues on the new arrangements for Advocacy under the Care Act, which will widen the role of advocates to make representations for customers.

- Strengthening links with commissioning and procurement services in order to capture and share customer insight by developing a reciprocal arrangement with these teams to inform service development.

- Developing a clear protocol for handling feedback that needs to be handled jointly by Health and Adult Social Care.

- Developing a quality audit tool to ensure complaints are resolved to satisfaction and more can be learnt from something that goes wrong in the organisation.

- Analysing data from customer satisfaction surveys to improve customer experience.

- Liaising with the homecare implementation group to ensure homecare arrangements are well understood and where customers know how they can report dissatisfaction, especially in terms of the upcoming changes to homecare delivery this year.

- Continuing to push forward a learning culture throughout the organisation. We will continue to do this by ensuring learning is followed up by simple action plans with the service managers at the time the complaint is closed and that this information is appropriately recorded.

Appendix 1 – Breakdown of complaints issues by team

Teams	Complaints categories	Charging/finance	Communication	Quality of service	Service failure	Service delay	Staff attitude/behaviour	Withdrawal, reduction or change in service	Policy objection	Object to eligibility or assessment decision	TOTAL
Access		-	-	1	-	1	1	1	1	1	6
Adults North East		1	1	2	1	2	1	-	-	1	9
Adults North West		-	1	1	-	-	1	-	-	2	5
Adults South		1	2	1	-	1	3	-	-	4	12
Hospital Discharge Team		1	-	-	2	-	-	-	-	-	3
Older People's Mental Health Team		-	-	1	-	1			-	-	2
Re-ablement & OT Service		-	-	-	1	5	1	-	-	1	8
LD Partnerships		-	-	3	-	-	1		-	-	4
Homecare		-	-	6	2	-	-	-	-	-	8
Commissioned services		-	-	2	-	1		1	-	-	4
Substance use		-	-	1	-	-	-	-	-	-	1
EDT		-	-	-	1	-	-	-	-	-	1
Finance		3	-	-	-	-	-	-	-	-	3
TOTAL		**6**	**4**	**18**	**7**	**11**	**8**	**2**	**1**	**9**	**66**

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Adults, Health & Public Protection Policy & Scrutiny Committee

Date:	Thursday 24th September
Classification:	General Release
Title:	**POLICING AND MENTAL HEALTH**
Report of:	Policy & Scrutiny Manager
Cabinet Member Portfolio	Cabinet Member for Adults & Public Health Cabinet Member for Public Protection
Wards Involved:	All
Policy Context:	City of Choice
Report Author and Contact Details:	**Mark Ewbank x2636** **mewbank@westminster.gov.uk**

1. Executive Summary

Members requested consideration of the issues associated with policing and mental health at the Adults, Health and Public Protection Committee. As responsibility for these issues falls across a range of stakeholders, representations have been sought from the local Borough police, MOPAC and our local acute mental health trust (CNWLFT). The following covering report explores some of these issues but the operational detail lies in the Appendices to this report from Westminster City Council, MOPAC and Central and North West London NHS Foundation Trust. The Police have agreed to provide a verbal contribution at the meeting itself.

Key Matters for the Committee's Consideration

- How well do stakeholders in Westminster work together to ensure that those with mental health conditions are given appropriate care?
- How well do the local Borough Police manage these issues?
- How can the local authority contribute to some the issues raised in the reports?

2. Background

2.1 There is no universally agreed definition of mental health and what constitutes mental wellbeing and mental illness. There are official definitions from both the Mental Health Act and the World Health Organisation (WHO) however. The Mental Health Act defines mental ill health as '*any disorder or disability of the mind'*, while the WHO describe mental ill health as the inability of an individual to realise their own abilities, cope with the normal stresses of life and work productively.

2.2 Mental ill health includes mental disorders and mental health needs. For clinical purposes, the term mental disorder is a broad category for all mental illness to match patients to clinically recognisable sets of symptoms and behaviours, for treatment. These mental health disorders are diagnosed using the 'International System for Classification of Disease' provided by the WHO. This system involves classifying mental illness into two broad categories of 'psychotic' and 'neurotic' illness.

- *Psychotic symptoms* occur when a patient's perceptions of reality are distorted. *Psychotic disorders* have medically defined phases referred to as 'the 'at risk' phase', 'the acute phase' and 'the recovery phase'. Disorders within the psychotic category include schizophrenia, schizoaffective disorders and borderline personality disorders; while

- *Neurotic disorders* refer to most 'normal' emotional symptoms such as depression and anxiety. Disorders within this category are referred to as 'common mental health disorders and include depression and anxiety.

2.3 It is important to note however there is often an overlap of symptoms and mental illness rarely fits neatly into one single category. In addition to this there may be a dual diagnosis of mental illness and substance abuse. In this case it can be difficult to distinguish between which symptoms are the effects of illness and which are the effects of being under the influence.

2.4 Particular social and environmental factors such as loud noises and bright lights can trigger reactions of stress that can increase the severity of symptoms associated with a particular mental illness. Without proper control and methods of coping this can lead to mental crises in which an individual can become at risk of harming themselves or others. In this case the police have legal power under the Mental Health Act 1983 to make a decision as to whether they should detain an individual under **Section 136** in the interests of safety for both the individual and the public.

2.5 Mental Health Need within Westminster:

2.6 There is a significant demand for mental health resources within Westminster with 17% of 18-64 year olds estimated to have a common mental health disorder. The level of child mental health need is lower than national average but still prevalent with 89 admissions between 2009 and 2010 for deliberate

and intentional injuries for under 18's, this is lower than the national average of 123 admissions.

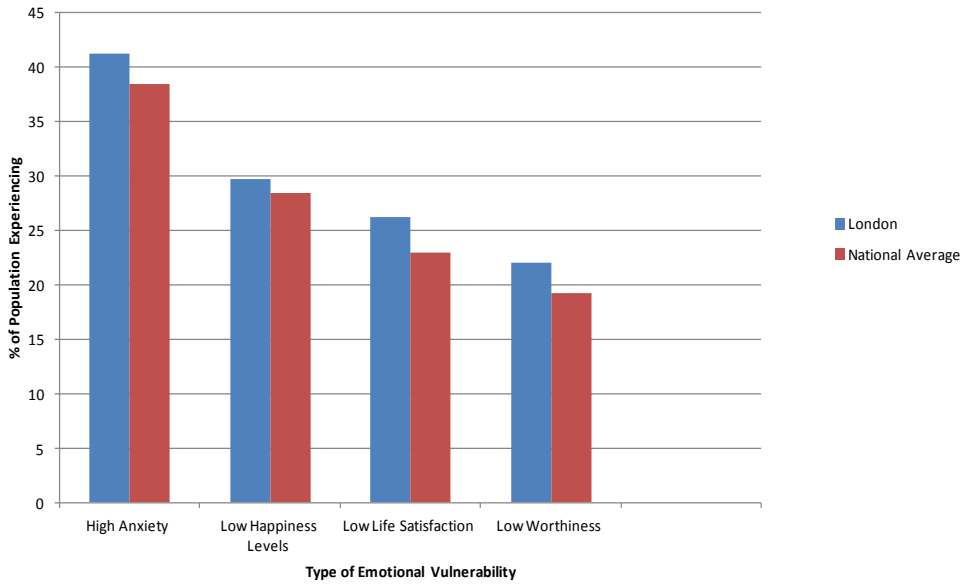
2.7 This need is reflected in the higher than average level of spending per head for mental health services. However there is indication of strain on resources with significantly lower than average contacts with psychiatric nurses.

2.8 **Mental Health Need in London**

2.9 There is a significant mental health need across London. Based on population statistics it was estimated that there were a total of 2,100,050 people experiencing clinical levels of mental illness across London. Of this figure 111,000 were children. It was further discovered that 3.3% of children suffer from anxiety disorders, a total of 38,000 people and at least 1 in 5 of the population aged 11-25 self-harm[1].

2.10 In addition to this a survey conducted by the Mayor of London revealed current levels of mental health vulnerability which are displayed in the Figure below. London has higher levels of all forms of emotional vulnerability than the national average. There is particular concern surrounding high anxiety levels and low life satisfaction. This suggests that there may be an increased demand for mental health care in the future.

Mental Health Vulnerability Across London Versus National Average for 2012-2013



Factors of Vulnerability

2.11 Mental vulnerability refers to the lack of ability to think logically and coherently which exposes the individual to increased risk of emotional or physical trauma.

[1] Mayor of London (2014) *The invisible costs of mental ill health* [Online] Available from: https://www.london.gov.uk/sites/default/files/FINAL%20-%20LMH%20-Full%20Report.pdf

There are multiple factors contributing to increased vulnerability which can be classified as follows:

Social Factors:

- **Homelessness -** a number of London's rough sleepers are located in Westminster.
- **Social isolation -** Westminster has one of the highest proportions of older people living alone
- **Poverty -** Westminster is the 15th most deprived borough in London with 14% of its neighbourhoods classified as being in severe deprivation.
- **Relative deprivation** - For the year of 2010 the % of the population living in the 20% most deprived areas lay at 21.7 per 1,000 people compared to the national average of 19.8.
- **High population turnover**
- **Unemployment**
- **'Troubled Families'**- 20% of troubled families experience domestic abuse, 85% of children from troubled families experience attendance and behavioural issues at school.
- **High crime rates**

Physical Factors:

- **Alcohol and drug abuse / Poor physical health / Physical inactivity**

3. Current Police Involvement and Powers under Section 136:

3.1 Section 136 is a set of current policies and procedures under the Mental Health Act 1983 that issues the police with a duty of care towards persons suffering from mental ill health by granting them the power to remove them from a public place to a 'place of safety' via detainment. Once an individual has been detained under Section 136 they are subject to arrest.

3.2 The power of arrest under Section 136 is a preserved power under Section 26 of the Police and Criminal Evidence Act 1984. Section 54 of the same act allows the power to search upon arrest.

3.3 The guidelines written within Section 136 were designed to take account of all the provisions of the law and Home Office, Department of Health and Mental Health Act Commission guidelines. They reflect a certain level of commitment

of all agencies working together to ensure the availability of appropriate care levels with the available resources[2].

3.4 The roles and obligations of each authority before, during and after detainment are outlined in Section 136. The main purpose of the Act is to ensure a place of safety is provided to reduce factors of vulnerability until a medical assessment can be conducted.

3.5 The Act was designed with the aim to optimise service user experience with the available resources at the time. However both population structures, cultures and resource availability change leading to the need for innovation to match a more diverse range of service users and meet a greater range of needs.

3.6 It could be said that nationally there is a lack of police training in mental health awareness and how to deal with mental health crises. Officer's such as Inspector Brown who delivers a blog called 'Mental Health Cop'[3] have recognised this issue themselves and raised concerns over the lack of resources available to them. Although they have the legal duty to care for people in mental health crisis they may not be able to deliver the correct standards of care.

3.7 **Legal Responsibility of Police Under Section 136:**

Deciding to use Section 136:

3.8 In order to use legal powers under Section 136:

- The person must appear to the officer to be suffering from a mental disorder;
- They must appear to the officer to be in immediate need for care and control; and
- The officer must think they need removing in their own interests or in the protection of others.

3.9 There are currently a number of issues with the legal powers under Section 136. Firstly an officer with no or minimal mental health training does not have sufficient knowledge to recognise the symptoms of mental illness. With this being the case it is extremely difficult for them to decide when the individual poses a risk to themselves and others. Nor is there a clear criterion for when a person has reached a point of crisis and instead it remains subjective. This can create inconsistencies in care across the board and poses a risk to officers, the community and individuals.

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[2] Metropolitan Police (2011) *Freedom of Information Act Publication Scheme: Mental Health Policy* [Online] Available at: http://www.met.police.uk/foi/pdfs/policies/mental_health_policy.pdf
Mind (2014) *Parliamentary Briefing from Mind: Mental health and the police* [Online] Available at: http://www.mind.org.uk/media/553151/mind-briefing-on-police-and-mental-health.pdf

[3] https://mentalhealthcop.wordpress.com/

Effects of detaining someone under Section 136:

- The person is considered to be under arrest;
- Section 136 does not used the word *arrest* but is the preserved power of arrest under the Police and Criminal Evidence Act 1984 under which reasonable force may be used;
- The person can be detained at a place of safety for up to 72 hours in order to be examined by a registered medical practitioner;
- The detainee is entitled to legal advice, regardless of what place of safety they are located in; and
- The detainee is allowed to request that one person to be informed of their whereabouts.

3.10 Although police custody is currently defined as a 'place of safety' under Section 136, in reality it is not a therapeutic location for someone suffering from a mental crisis. The loud noises, bright lights and social isolation can cause further distress and risk of harm to the individual. In addition to this, 72 hours can be a long time to detain someone who may be unlikely to have committed a crime. Mental recovery varies between individuals and some may recover more quickly than others. There is no set criterion for when a patient can be released from detainment and can be subjective, leading to inconsistencies in care standards.

Police Action following detention under Section 136:

- There is a code of practice that requires that the officer responsible for the detainment to pre-notify the chosen place of safety in advance and also to notify the Local Social Services Authority (ASW).
- In rare cases of extreme violence then no such agreements are necessary and the appropriate person must be taken immediately to a place of safety.
- For reasons of risk to the patient and avoiding stigma ambulances should be used where available for transfers.

3.11 This multi-agency approach to care allows the sharing of information between the police and the local services authority. However there could be a need for clearer guidelines in terms of the exact information that needs to be relayed to ensure records for all patients are consistent across the board. The transfer of a patient from one place of safety to another can be distressing, so a policy to transfer in ambulances, where available, provides a therapeutic environment with expertise and the resources for care. In addition to this the patient may already be familiar with some of the care staff which makes for an easier transition. However this may create care inequalities in which some patients are being transferred in ambulances whilst others in police vehicles.

Emergencies involving violent patients in psychiatric wards:

- Officers are often called to assist hospital staff when patients become violent.

- Although it is the responsibility of the hospital to ensure there is sufficient security and ability to safely restrain patients were necessary, it is often left to police officers in more dangerous situations.
- Every effort is made to ensure a police supervisor attends the scene in a timely manner.
- Police can take patients into custody if necessary and then returned when deemed appropriate.

3.12 Although it is recognised that there will always be a certain level of need for police involvement in detaining violent patients within care, it can damage police perceptions creating resentment and mistrust. This may then prevent them co-operating in the future. Removing patients from an appropriate health care based place of safety to custody suite will disrupt care plans and prolong recovery time. A police custody suite does not offer the necessary therapeutic environment for recovery and can cause further deterioration of the individual.

Transporting patients: Including dangerous and violent patients:

In transporting psychiatric patients and persons suffering from mental ill health, there needs to be a dedicated officer responsible for:

- Carrying out a dynamic risk assessment ;
- The deployment and actions of police resources; and
- Ensuring that any action taken by the police is proportionate, legal and necessary.

In the case of an NHS trust or health care provider requesting a transfer between hospitals:

- The police are qualified under law to conduct these transfers however the responsibility of the transfer lies solely with the hospital and not the police; and
- Any agreement for such a request must be authorised by the duty officer. The Duty Officer is responsible for carrying out a risk assessment, deciding how to deploy police resources and ensuring that any action taken by the police is proportionate, legal and necessary. [4]

3.13 There could be multiple issues with this; firstly communication between certain multi-agency partners particularly the NHS may be weak due to the strain on staff and resources. Therefore officers may not have the necessary information to conduct a full risk assessment. Without being fully aware of the level of care need of the patient they cannot provide optimum levels of care. Further to this the transportation of patients in labelled police cars can cause

[4] Open Government Licence (2015) *Mental Health Act 1983* [Online] Available at: http://www.legislation.gov.uk/ukpga/1983/20/section/136
ImROC (2014) *Person Centred Safety Planning can help manage risk and support recovery* [Online] Available at: http://www.imroc.org/risk-safety-recovery-launch/

further distress due to perceptions. This added stress may increase the severity of their symptoms.

Returning patients who are still under psychiatric care:

- If the location of the patient is known, the role of the police is simply to assist mental health professionals; they do not hold the main responsibility.
- It should be noted however that it should not be necessary to involve the police unless there is a case of violence or the whereabouts of the patient is unknown.

4. Person Centred Safety Planning Approach:

4.1 The current approach to risk management across all care, including the police force, is negative. This means that it is risk adverse and aims to minimise all potential harm to zero. This is an issue because minimising risk is not always in the best interests of the individual but rather of the care agency. In addition to this there is an imbalance in responsibility. All responsibility lies with the agency in immediate care of the person when it could be recognised that a multi-agency responsibility approach is required.

4.2 Best practise guidelines for risk management under Section 136 include the *person-centred safety planning approach*. This approach involves minimising risk while considering the best outcomes for the individual. It takes a more positive approach and believes that the main aim is to improve the care of the individual rather than hinder it through negative risk management. It accepts that risk can never be reduced to zero and full reduction of risk would compromise the care of the individual. There are a 3 main steps to this approach, as outlined below :

- Risk Inventory: Identifying Past Experiences of Risk
- Risk History: Understanding past risk experiences from different perspectives
- Personal Risk and Safety Plan

4.3 The *person-centred safety planning approach* ensures that the individual is involved in all aspects of their care and that there is consistency in the information recorded across all agencies. In addition, it also ensures that the minimisation of risk is in the best interests of the individual and not the agent of care. This model could be adopted by police agencies when assessing the risk an individual poses to both themselves and the community before detainment. Coupled with correct mental health training this could be the way forward.

5. Should the police be involved in mental health care?

5.1 There is much debate as to whether the police should be involved in the care of persons suffering from mental ill health.

5.2 Between 2014 and 2015 funding for the NHS increased by 0.1%, which has required the NHS to become more innovative in their use of resources under increased strain. In the case of a psychiatric bed not being available it could be in the best interests of individual to be detained in police custody where the majority of factors of vulnerability are reduced. With this in the mind the role of the police is fundamental in filling a care gap and ensuring the protection of the individual.

5.3 Others agree with this approach but believe that in order for it to be effective solution; the multi-agency approach needs to be improved. By working with the NHS the police can improve mental health care and reduce detainment statistics. For example, the 'Street Triage Scheme' in Oxfordshire' which involves mental health nurses attending police call outs has seen a reduction of 40% in people being detained under the Mental Health Act and a 73% reduction in police cell detention numbers.

5.4 A third argument is that police involvement could be effective if amendments were made to Section 136 under the Mental Health Act 1983. Some of the suggested amendments include *reducing the maximum time for detainment to below 72 hours* and *removing a police custody cell as a defined 'place of safety'*

5.5 Others think tanks argue that the role of the police is to deal with criminals and victims; not mental health patients. Mental health should be treated with the same value as physical health. Police involvement in mental health care could be seen as criminalising victims. Further to this issue the police may not have received adequate training on how to deal with mental health issues which can result in injury and violence during detainment. According to the Human Rights Commission between 2010 and 2013, 367 adults with mental health conditions died of 'non-natural causes while in state detention and psychiatric wards'. A further element to this argument is that as of current there are no age limits regarding minimum or maximum age of detainment. There are a number of safe guarding issues around the detainment of children and the elderly in police cells[5]. In 2011 children as young as 11 were held in police cells. For this year 35 out of 42 forces in England and Wales held children under 18 in custody under the Mental Health Act. There are a number of issues around this including the exploitation of children's rights under Article 19 and 37. This view is supported by Health Secretary Theresa May who proposed, under the last coalition government, that £15 million would be invested into the mental health care system to ensure that police cells were only used as a last resort and in the rare case of a patient's behaviour requiring that level of isolation. She also proposed plans to reform the use of Section 135 and Section 136 of the Mental Health Act 1983. These plans included amending legislation so those under 18 were never sent to police custody and reducing the 72 hour period for maximum custody.

[5] Metropolitan Police Authority (2005) *Joint Review: Policing and Mental Health* [Online] Available at: http://policeauthority.org/metropolitan/downloads/committees/mpa/051027-11-appendix01.pdf

6. Examples of Policing Practice:

6.1 There are a multiple examples of positive police practice across the UK regarding mental health. These tend to involve strengthening multi agency communications and improving awareness of mental health in the police service. Examples include;

- Police working in collaboration with charity volunteers. For example **Hillingdon MIND** provides appropriate adult volunteers who respond to calls every day of the week whenever an adult experiencing mental health issues is arrested or detained. They currently have 35 volunteers working closely with the police. In 2012-2013 they responded to over 260 calls and spent over 600 hours in police custody suites.

- The 'E Card' scheme has been adopted by **Lancashire Constabulary**. This is an emergency information card scheme which involves the NHS handing out free cards containing personal details for mental health patients to carry in case of an emergency. The card contains emergency contacts and care needs information. It has solved communication and patience issues between the police and clients. It has also reduced immediate contact time and allowed for more effective use of police resources.

- **Leicestershire Police** improved their multi agency approach and community contact with Leicestershire community through a once a month beat surgery called 'Cuppa with a Copper' in local psychiatric unit.

- The adoption of the 'Triage Car' scheme **Leicestershire**. An innovative partnership between Leicestershire Partnership NHS trust and Leicestershire Police. It involves mental health nurses accompanying police officers to mental health crisis incidents. It also acts as an on the job training scheme for police officers.

- The **Dyfed Powys Police** and **Hywel Dda Health Board** collaboration in training for mental health awareness. Student officers complete a day's training at a local acute psychiatric ward. After this they attend a placement with a local mental health charity. In addition to training it also provides officers with the opportunity to interact with service users and develop closer professional relationships with care service providers.

- **Essex Police** have developed a one day mental health awareness training course that is compulsory to all officers. The aim of the training is to raise awareness of mental health needs and improve expertise. It teaches background knowledge to mental illness, common symptoms and behavioural patterns for identification. It also teaches how to deal with crisis situations.

7. Examples of Negative Practice

7.1 It is recognised that the aim of the police is to provide the highest standards of care in terms of protection to the community. However due to a potential lack

of training and strain on resources there are circumstances in which examples of poor practice may exist;

- Unnecessary use of restraint;
- Poor communication skills with detainee, for example, not explaining what their role of an officer is and how they can help. Not informing the individual of their rights and involving them in their care plan
- Focusing on negative language and lack of responsibility
- When confronted with anger from the detainee officers attempt to defend rather than acknowledging the situation and attempting to diffuse it.

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

APPENDICES

Appendix A: Westminster City Council – Community Safety Commissioning
Appendix B: MOPAC – MAST Briefing Note
Appendix C: Central and North West London NHS Foundation Trust

BACKGROUND PAPERS

As referenced throughout.

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Community Safety Commissioning

Briefing Note

City of Westminster

Purpose: Policing & Mental Health: Commissioned Services in Police Custody

To: Adult Services, Health, Public Protection Policy & Scrutiny Committee

From: Adam Taylor, Commissioning Manager

Date: 16th September 2015

Action required: For Information

Summary

1. Responsibility for Mental Health provision in Police Custody and the wider criminal justice system rests with NHS England through their Liaison & Diversion services
2. Westminster City Council has traditionally been responsible purely for equivalent substance misuse services in court and custody;
3. However, recent changes to both have blurred the boundaries between services and this is being addressed through re-commissioning in the coming months

Background

Traditionally, Local Authorities have had very little involvement in the mental health side of policing outside of appropriate adult provision, and direct work with clients accessing social care services.

However, in 2012 Westminster, in partnership with our Tri-borough partners in Hammersmith & Fulham, and the Royal Borough of Kensington & Chelsea we re-commissioned what was previously the Drug Intervention Programme in police custody.

In doing so we refocused the new service so that it was part of a wider reducing reoffending service offer and thus the new custody referral element began to assess for more than just substance misuse needs, but also mental health amongst others. This assessment would then follow the offender into community support either directly from police custody, or after criminal justice proceedings had completed.

The combination of a more general assessment and support offer in police custody, together with through the gate services in Wandsworth and Wormwood Scrubs Prisons, and key worker support in the community, has so far proved successful in reducing reoffending of the 240 or so offenders who have been referred to the service, with provisional figures showing a 40% reduction in rearrests and reconvictions.

Alongside this general support offer were services commissioned by NHS England under their Liaison & Diversion banner that focussed more specifically on mental health needs. Custody referral teams, and substance misuse teams that continued to operate in magistrates courts, worked closely with these services to provide a seamless offer of support.

The role of all of this provision was to identify offenders in police custody who may be diverted away from the criminal justice system, or at the very least have more specific sentence requirements to address their underlying criminogenic needs and therefore more effectively prevent future offending

However, in 2014 changes to the probation landscape through the offender rehabilitation act, and to the way NHS England commissioned Liaison & Diversion meant that changes needed to be made.

In the context of mental health the most significant of these was the creation of a pilot in West London for Liaison & Diversion that positioned this as a general health and care support intervention for offenders in police custody and the criminal justice system, rather than specifically a mental health Liaison & Diversion service.

This created potential duplication with our custody referral provision. Whilst in an ideal world we would have liked to co-commission with NHS England to create a single service spanning criminal justice, the reality of our different governance arrangements and the requirement for NHS England to seek HM Treasury approval for continuation made this impossible to achieve.

Consequently, officers from Westminster Community Safety and Tri-borough Public Health have been working over the last 6-months to improve alignment between the respective provision with the result that council commissioned services in police custody and courts will now be commissioned as part of the wider substance misuse contracts and provide specialist provision working alongside NHS Liaison & Diversion.

Next Steps

Tri-Borough Public Health is in the process of recommissioning substance misuse and offender health services, with new service due to start in April 2016.

NHS England is currently waiting for HM Treasury approval to roll-out the Liaison and Diversion model being piloted in West London and elsewhere.

MOPAC | MAYOR OF LONDON
OFFICE FOR POLICING AND CRIME

Mental Health Awareness & Safeguarding Training (MAST)

Top Lines

- Mayor's £1.4m boost for mental health training to help young Londoners
- Around 8,000 of London's frontline professionals working with young people are being offered training in mental health support and safeguarding.
- The Mental Health and Safeguarding training (MAST) will give frontline professionals including teachers, police officers, council workers and health and social care workers unprecedented specialised training in understanding gang culture, identifying young people who are gang affiliated, providing them with support services, and knowing the right steps to take when they encounter a young person that may be an easy target for gang recruitment.
- Part of the Mayor's commitment to reducing gang-related crime and preventing young people from becoming involved in gang activity, MAST will be delivered by mental health practitioners, experts in safeguarding and Met Police professionals who deal with gang-related crime.
- The programme builds on the comprehensive measures MOPAC has already taken to fight gang-related crime in London. This includes setting up the Trident Gang Crime Command which, since February 2012, has made almost 1,300 arrests, seized 87 firearms and over £900,000 in cash, and funding 25 core gangs projects at a value of over £3m.
- MOPAC has also helped to fund a range of e-resources for professionals who complete the MAST programme including a discussion forum, advice from safeguarding experts, as well as real life case studies, academic papers, and useful tips.
- From next month, there will be a specialist safeguarding referral guide for every borough which has been developed with the help of Multi-Agency Safeguarding Hubs (MASH) across London. The e-hub can be viewed at http://benjamintoddclients.co.uk/mastdev1/
- MOPAC is working closely with the Met and a range of partners on this project which has been partly funded with £839,100 through a successful Home Office Innovation Fund bid.
- The programme consists of two days of training and will run until March 2016. It is available to anyone within the London Metropolitan area who has a role in dealing with young people.
- For more information and to register for the free training, visit www.masttraining.co.uk

Quotes

Deputy Mayor for Policing and Crime, Stephen Greenhalgh said: "This programme is a key part of the Mayor's commitment to protect vulnerable young Londoners from having their lives damaged and derailed by gang crime. With specialised training for teachers, police officers, healthcare and social workers, we can empower frontline staff to identify and act on the signs of emotional trauma or mental health issues in the young people they come into contact with. Whether they are already involved in gangs or are at risk of victimisation by

gangs, we can ensure young people receive the support they need. I strongly encourage everyone who works with London's youngsters to take full advantage of this important opportunity."

Strategic Director at Catch22, Frances Flaxington said: "This training should have a real impact on how we understand and address gang and youth violence. This flexible and responsive new approach has the potential to address complex challenges before they escalate. The reality is that these are exceptionally vulnerable children and young people. They need specialist support services including strong relationships with people they trust. The MAST training will go a long way towards creating the multi-skilled frontline workforce we need to address gang involvement in our communities."

Chair of the Ealing Custody Panel, Jeannine Andre said: "The training was very interactive and proactive. It opened my eyes to the meaning of mental health and the importance of early diagnosis, especially in the young. Although there is a high number of young people who go through police custody, the percentage that we, as custody visitors, meet and talk to is small. The big benefit I feel overall in my role is that ninety per cent of detainees in custody are believed to have mental health issues and this training has helped me to understand mental health and to be more sensitive to the needs of detainees. It has also given me the knowledge to ask correct questions of the police."

Assistant Psychologist at HMYOI Feltham, Mental Health Team, Kumar Birch said: "The MAST training was well structured and engaging. Although many attendees had good working knowledge of mental health, it was extremely helpful to focus on the specific impact of gang dynamics. The discussions were useful in getting everyone to think about the number of factors that can increase young people's vulnerability to gang involvement. Overall the training raised awareness, inspired reflection on the ways to improve professional practice and provided a great opportunity to connect with others working within the young people network."

Background

What is MAST training?

MAST Training is about promoting the safety of young people in London, by making it easier for practitioners to take action to support young people when there are signs that they are suffering from mental health (MH) issues and emotional trauma (ET). The programme is funded by the Home Office Innovation Fund and funding finishes in March 2016

A particular focus is on the link between mental health, safeguarding, and the harm caused by gangs - both to gang members themselves and to vulnerable victims. Mental Health is core business for many organisations and a key goal is about reducing workload through effective action.

How long will the training take?

The training consists of two days of training, starting from March 2015 and to be completed by March 2016. The second day of training will take place approximately six months after the first day of training.

What are the benefits of this?
The training workshops will provide an opportunity for practitioners to network with staff in other agencies, promoting more effective working across organisations. In addition to promoting more effective safeguarding we intend to reduce levels of gang activity and decrease the risks to agencies of missing safeguarding opportunities, with the associated loss in public confidence.

The outcomes from this training will include:

- Ability to Identify MH/ET issues
- Understanding of Referral Pathways and key Contacts within the borough
- Ability to support a person with MH/ET
- Understanding the Referral Guide
- Understanding the relationship between MH, offending, safeguarding and gangs

Who can take part in the training?
MAST will provide joint agency training for front line practitioners working with young people, including Police, School Staff (primary, secondary and alternative provision), gang workers, YOS, secure estate, Health and third sector organisations. Training will be delivered by a training supplier, working with agencies that will benefit from the training. Within Schools we are asking for the release specifically of the School Designated Safeguarding lead and Safer Schools Officer

How will the training help?
A key element of the work is providing practitioners with additional resources, pathways and strategies to manage mental health issues when they have been identified. The intention is not to turn practitioners into clinicians, but to give them sufficient knowledge and confidence to act on the underlying problem, rather than the presenting problem.

A young person presenting as difficult, unreasonable or disruptive may actually be suffering from MH issues. Through MAST training staff will be better equipped to identify MH issues at an early stage, and provide an effective response. The result will be a safer environment, better safeguarded young people, and an improved learning environment for pupils. A preventative approach will ensure that young people are better supported before a crisis point is reached.

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CNWL Westminster Borough OSC Briefing: Working with the Police

Nicola Hazle - Borough Director of Westminster CNWL September 2015

Background:

In January 2015 CNWL implemented an organisational restructure from service lines into three divisions with borough or service line structures underneath. A Westminster borough structure was established for adult and older adult mental health services (where other services such as CAMHS, Forensics, Addictions, Inpatient Rehab and IAPT remained in service lines in other divisions).

There was much strategic, Trustwide and local partnership working with the police already underway across all services prior to this change and the new borough structure has sought to maintain, build upon and develop further these existing arrangements. Locally, there have been historical (special measure arrangements for the Gordon Hospital in March 2008- February 2009) and more recent events (changes to police station provision in the borough, CQC inspection in February 2015) which form the foundation for on-going and close working relationships between our integrated mental health services and the police.

Trust wide Partnership Working:

Community Services Redesign Programme:
There has been much discussion as to how CNWL can deliver the expectations of the Mental Health Crisis Concordat which sets out an agreement between agencies of how they will respond and work together better to make sure that people get access to the help that they need when in a crisis. The Trustwide programme of redesign to community mental health services is resulting in the development of a Trustwide Single Point of Access (SPA) for all referrers. Work on implementation has included discussions with senior Police and LAS (London Ambulance Service) colleagues to explore how a dedicated telephone line could be set up for them to the SPA team to access information that may inform how they respond when they are called to someone experiencing a mental health crisis (with the intention of avoiding A&E or detention via the section 136 process). New investment from the CCGs will see the development of a rapid response team (RRT) function to the Home Treatment Team enabling a 24 hour response to all emergency (within 4 hours) and urgent (within 24 hours) referrals.

The development of an in-hours centralised AMHP service in Westminster is envisaged to improve the coordination of mental health act assessments in the borough and the pathway with the out-of-hours EDT service. There is an expectation that the RRT function will operationally develop close working relationship with both AMHP teams to support the response and management of people presenting to services in a crisis.

Pan London Mental Health Partnership Arrangements:
Central and North West London NHS Foundation Trust is part of a Pan London Mental Health Partnership Board that is working to provide a consistent and collaborative

approach to partnership working between the three London police forces, London Ambulance Service (LAS) and the nine Mental Health Trusts across London. The Board and its working group has now incorporated the Government's Crisis Care Concordat which was launched on 18 February 2014 setting out expectations on agencies to ensure the quality of response in crisis situations when people with mental health problems urgently need help. Through its work, the Board plans to improve the patient experience by:

1. **Reviewing Places of safety** - The Trust review in February 2015 found sufficient 'Places of Safety' S136 suites across the Trust which can be easily accessed and have sufficient rooms to meet the local need most of the time, noting that this will fluctuate. S136 suites now have dedicated staff to ensure that a high standard of care can be provided by healthcare staff, without reliance on police support to safely assess and care for acutely disturbed individuals.
2. **Examining data on S136** -The data used is that collected by the Trust's Mental Health Act Team in partnership with the borough's Approved Mental Health Professional (AMHP) Service. There has been a 30% increase in the number of S136 patients detained this year when compared with the same period last year. The data also looks at response times for AMHP and Section 12 doctors. The Trust has introduced a S12 rota from 9am-5pm from Monday to Friday and this has greatly improved response times. There are still concerns about access to AMHP availability after 5pm.
3. **The management of absconding patients from inpatients services** - This is essentially a partnership function between the police and the Trust. There is an action plan to reduce the number of people that abscond which is beginning to see the numbers reduce. Actions have included review of inpatient ward layout with introduction of swipe care entry and greater usage of CCTV facilities in some areas. There has also been a review of risk assessment and management plans and use of S17 leave under the Mental Health Act.
4. **Conveyance of Patients -** The majority of S136 patients are still transported in a police vehicle rather than in an ambulance. The long term aim (although challenging to achieve) is that the London Ambulance Service would convey all S136 cases. There is Task and Finish group reporting into the London Mental Health Board and this is addressing this issue.
5. **Escalation Process -** When the police are called inappropriately to an incident involving the Trust there is an 'escalation process' to ensure appropriate action.
6. **24 hour helpline -** The Trust's 24-hour telephone line for professionals is enabling professional's access information to make informed decisions. This is been used by the police and feedback suggests that it is giving them vital extra information about a person.
7. **The use of S135 (1) warrants** - The principal purpose of a S135 warrant is to overcome a refusal to enter someone's property. The numbers of warrants have increased due to concerns police officers have for the legal basis for their attendance at assessments. The London AMHP Network has identified a Lead who is chairing a Task and Finish group reporting into the Pan London Board and this is addressing AMHP issues with the Police and Magistrates.

8. **Working to never use a police cell as a Place of Safety-** The number of people on S136 in London was over 6,000 in 2013 and only about 87 of these were held in custody. In 2014, 19 people were held in custody and none of these patients were from the Trust. This is felt to be very good especially when compared with figures elsewhere in the country.

There is no doubt with greater focus on partnerships, the role of this partnership in supporting people experiencing mental health crisis and their families/carers has never been more important. Forging a working partnership for when things are going well and learning together when things have gone wrong has never been more crucial.

Trustwide AWOL/ Absconsion Programme:

Whilst the AWOL Policy and Board oversight of AWOL issues has clearly been in place for many years, a review of arrangements to support a reduction in the number of patients who go (AWOL from acute in-patient units was completed after the serious incident at the Gordon and subsequent CQC inspection. A report and its recommendations were agreed at the Operations Board in April 2015. The report clarified that AWOLs of detained patients include both those who abscond from the ward and those on Section 17 Leave who fail to return.

A target to reduce absconsion of detained patients from Wards by 50% by 1 April 2016 has been agreed. Progress is being monitored by Divisional Governance Teams, as well as at the weekly Bed Management Meetings. Implementation of the actions has been overseen by the CQC group which meets weekly. Board oversight is undertaken by the Quality and Performance Committee.

The Trust is also reducing the cohort of patients who fail to return from leave in a project with the Thames Valley Academic Health Science Network (AHSN). The project employs an evidence-based methodology from the Institute of Healthcare Improvement to test a range of interventions.

In addition to this, work is on-going with inpatient staff to ensure that where a risk of absconsion for a patient is identified that the risk management plan is reflected in the patient's care plan. Monitoring is via local Quality Governance Groups and Team Meetings. Care plans are regularly audited by Ward Managers and Clinical Team Leaders. Therapeutic engagement between service users and staff is being emphasised as part of the Observation and Engagement training as well as at ward level to improve relational security. Assurance of the effectiveness these actions are via peer reviews and learning walks that are planned in each Division.

Westminster Borough Partnership Working:

Borough Partnership Arrangements:

Collectively senior members from key mental health partner organisations (CNWL, Central London CCG, WCC, the Metropolitan Police, Healthwatch, Joint Commissioning) have been coming together since June 2015 to look at how we are working together across the system locally; holding influencing wider strategic direction to meet local n The meetings are held quarterly with plans currently to expand out to include Kensington & Chelsea and West London CCG colleagues given the interdependencies for many services across the

two boroughs. The draft work plan has been agreed against the following topics with key priorities identified:

Prevention *Priorities: IAPT, public health prevention, addressing complex needs in housing support, GP education)*
Access to routine care *(Priorities: linking social care in to the MHA, access to IAPT, deep dive of patient pathway and provision available)*
Access to crisis care support *(Priorities: Single Point of Access (SPA) implementation, carers support, services directory, Joint Strategic Needs Assessment (JSNA), crisis houses, ensuring SPA is compliant with Care Act 2015, availability of AMHPs for timely MHA assessments)*
Emergency and urgent access to crisis care *(Priorities: Understanding bed pressures)*
Quality and treatment in crisis care *(Priorities: Coordinated response to SPA)*
Recovery and staying well *(Priorities: Carers support, Personalisation, JSNA)*

At the last meeting in June members were asked to vote on the key priority project area for the year with the majority votes cast for carers support.

Westminster Borough Police Liaison Meeting:
This meeting is held bi-monthly and chaired by the Westminster Social Care and AMHP Lead. It is attended by representatives from the Metropolitan Police, British Transport Police, Fixated Threats Team, St Mary's Liaison Psychiatry team, AMHPs in the borough and colleagues from inpatient and community mental health services. The meeting strengthens partnership working and is a forum for monitoring how we work together with the Police. This meeting allows us to look at s136 activity over the preceding two month period in line with requirements under the Code of Practice to the Mental Health Act 1983.

Community Services:
The local MARAC (Multi Agency Risk Assessment Conference) meetings are attended by one of our Community Recovery Team Managers who acts as a link between mental health and the MARAC. Similarly the Team Manager of our community forensic service (Focus) represents the borough at the local MAPPA (Multi Agency Public Protection Arrangements). We have worked with our Police Liaison Officer to be clear about how to request Police input into safeguarding strategy meetings when appropriate.

AMHPs (Approved Mental Health Practitioners) will apply to our Magistrate Courts for s135 warrants when following a risk assessment it is deemed necessary to request that Police attend with the AMHP and assessing doctors.

We have a dedicated AMHP who is part of the Westminster Magistrates Court Diversion service working in partnership with the court, probation and nurses and psychiatrists from West London NHS Trust. This service ensures that where appropriate people with mental health problems are diverted from custody into psychiatric hospital for assessment and treatment.

All the police custody suites in Westminster have a police liaison psychiatric nurse attached to them which again allows for the identification of people detained in custody who are mentally unwell and where it is felt that an assessment under the Mental Health Act is required.

Acute/Inpatient Services:
The acute and in patient Service for Westminster have being working proactively with the police and have met several times with representative of Westminster Metropolitan and British Transport Police Services and with the Fixated Threat Assessment Centre (FTAC).

The focus of the work has been to improve:

1. **Improved Section 135/136 assessment Suite -** Mental Health Act 1983 / 2005 (http://www.legislation.gov.uk/ukpga/1983/20/contents)

CNWL identified that the Place of Safety for people requiring assessment under Sections 135 and 136 did not meet the requirement under the Code of Practice for the Act (https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983) or the Recommended Guidance from The Royal College of Psychiatry (https://www.rcpsych.ac.uk/pdf/PS02_2013.pdf), The Care Quality Commission (CQC) (http://www.cqc.org.uk/sites/default/files/20141021%20CQC_SaferPlace_2014_07_FINAL%20for%20WEB.pdf) also highlight this as an area for improvement in their report to CNWL this year.

CNWL had already identified this on the annual estates work programme and had allocated capital funds to improve the suite. The local Gordon Hospital Management Team and estates colleagues worked with representatives from The Metropolitan Police and British Transport Police on the design plans to ensure the space created would work for both the CNWL and police services.

The refurbished suite now conforms to the recommendations of the Code of Practice and the Royal College of Psychiatry guidance. This includes a separate entrance into the suite (from Vincent Square), one of the two assessment rooms having an en suite toilet for people who require assistance, CCTV cover, two doors into each assessment room and an improved waiting area for friend and relatives.

2. **Reduction of patients who are Absent Without Leave (AWOL) from the Hospital**

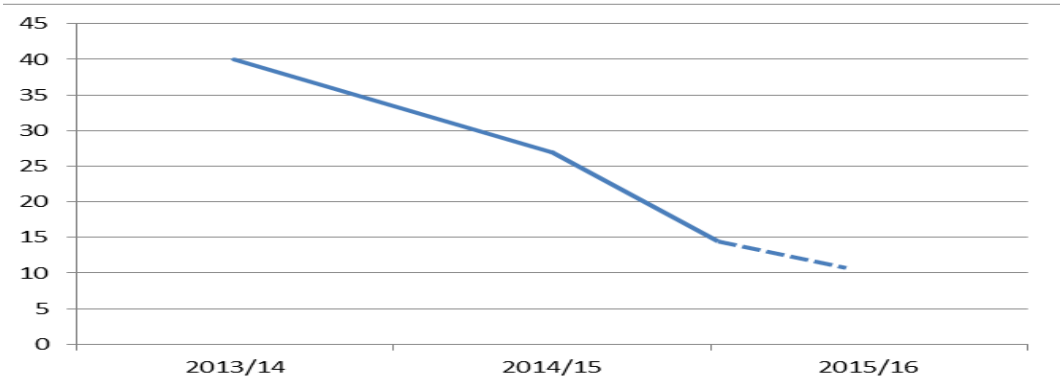
An AWOL, for the purposes of this paper is defined as people, detained under the Mental Health Act, who do not have authority to be outside the hospital grounds from their Responsible Clinician i.e. the provisions of Section 17 leave.

The Gordon Hospital Management Team has work with the local Metropolitan Police, the Mental Health Lead Sargent for Westminster and local Sargent in Belgravia to consider the environment of the hospital in response to AWOL's. The work included so far has been the removal of push buttons for main doors to the ward; increased strength of locks, replacement of break glass fire points with turn key points (these opened doors that exited the ward and were abused by some patients), increased staffing and installation of internal doors to improve security.

The work done so far has shown and significant decline in the number of AWOL's as demonstrated in table 1 (below). Extrapolation of the data for 2015/16 indicates that the Gordon Hospital is on target to reduce the number of incidents within the year, to 15 as illustrated in the graph 1 below:

Locations in the Gordon Hospital where AWOLs can occur	2013/14	2014/15	April – August 2015/16
136 Suite	8	1	1
Ebury Ward	8	4	1
Gerrard Ward	12	10	2
Vincent Ward	12	12	2
Total	**40**	**27**	**6**

Table 1: AWOLs from the Gordon Hospital Wards 2013/14 to August 2015



Graph 1: Line Graph of AWOLs from the Gordon Ward and Trajectory for 2015/16

3. **Reduce the reported crimes from The Gordon Hospital**

The meetings with Belgravia Police Station early this year highlighted that The Gordon Hospital generated a high numbers of call that the police had to attend. Working with the police and CNWL Health and Safety Team the Gordon Hospital Management Team have used existing patient forums and staff meetings to manage incidents that had previously been reported to the police. Through this work and regular bi-monthly meetings with the local Sargent, The Gordon Hospital is reported to have significantly reduced its call levels to the Police. In June 2015 the local Sargent informed The Gordon that there was a significant reduction in activity. He went on to conclude:

"This is an outstanding result for the month. What pleases me most is the complete absence of MOPAC 7 crimes (Violence with injury, robbery, theft from person, criminal damage, burglary, theft of motor vehicle and theft from motor vehicle) I'm particularly impressed by the massive reduction in violent crime. Please accept and pass on my thanks and congratulations to your team."

Further meeting has confirmed that the level is activity has significantly reduced with the Sargent reporting the Police are attending calls two to three times a week down from at least daily.

4. **Develop closer working relationships**

In line with good practice The Gordon Hospital Management Team now meets bi-monthly with the local Metropolitan Police service for Westminster. This meeting is in addition to the bi-monthly Westminster Borough Police Liaison Meeting and is a forum to discuss specific issues for The Gordon Hospital. The meeting have been successful in identifying areas that require joint working and have been used to focus on strategies for managing the environment in the Hospital to reduce AWOLs and reduce crime reports.

There are now clear lines of communications outside set meeting times and frequent ad hoc discussions in response to specific incidents that may raise concerns.

In addition to the work with the Metropolitan Police the service has also met with the Fixated Threat Assessment Centre (FTAC) as they have regular contact with the service. The teams have now agreed to have regular meeting with the nursing representatives of FTAC with the Matrons in The Gordon Hospital. This is in the planning stage and there is also a possibility for joint training / support.

5. **Joint Training**

As part of the work done to improve services in The Gordon Hospital all senior nursing staff at this site completed training in June 2015 in the management of Section 135/136 Suite. This included a training session with the Metropolitan Police service as well as an opportunity for CNWL staff to shadow the police service. As previously mentioned the CNWL service are currently working to identify work/ training that can be developed with FTAC.

6. **Improve escalation procedures for areas of concern to senior staff for both Police and CNWL staff**

The police and CNWL now have agreed escalation procedures within normal working hours and outside this time. This was identified as a weakness in the system by the police. In hours any issues are escalated to the Acute Service Manager and local Inspector out of Hours it is done through CNWL's on call system for Senior Nurses / Managers. This system will support resolution of blockages in system and dispute thought the full day.

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Adults, Health & Public Protection Policy & Scrutiny Committee

Date:	Thursday 24th September 2015
Classification:	General Release
Title:	**SAFEGUARDING RECRUITMENT**
Report of:	Tri-Borough Safeguarding
Cabinet Member Portfolio	Cabinet Member for Adults & Public Health
Wards Involved:	All
Policy Context:	City of Choice
Report Author and Contact Details:	**Louise Butler x5201** lbutler@westminster.gov.uk

1. Executive Summary

1.1 The report in the Appendix is the report of the Safer Recruitment Task Group which will be presented at the next Safeguarding Board which is on the 8th October

2. Key Matters for the Committee's Consideration

2.1 What are the Committee's thoughts on the ***implementation*** of the safer recruitment principles and guidance?

If you have any queries about this Report or wish to inspect any of the Background Papers please contact Louise Butler, Safeguarding, lbutler@westminster.gov.uk x5201

APPENDICES

Appendix A: Safer recruitment principles and guidance

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Safer recruitment principles and guidance

Key Points

This guide applies to **all people** working with children and vulnerable adults whether employed directly, or engaged as agency workers, volunteers, contractors etc. It does not provide comprehensive processes across the whole range of recruitment and selection but rather emphasises important principles and activities to be put in place to satisfy safeguarding expectations.

It is applicable to **all agencies**, whether within the statutory or voluntary sector, but it is recognised that most larger organisations have dedicated HR departments responsible for the recruitment of staff. Some of the HR mangers from such organisations working across the three boroughs have helped to agree these recommendations, accepting that there are learning points and areas of good practice which they can use in their processes. It is hoped that these guidelines will be most beneficial to smaller agencies recruiting staff.

This guidance is about reducing risk by putting in place clear standards and robust practices to protect vulnerable people of whatever age. This means deterring and preventing unsuitable people being put in positions where they can cause harm. Recent national cases have also highlighted the damage to the reputations of organisations caused by placing unsuitable staff in caring roles, commonly known as 'corporate risk'. Whilst it is accepted that robust recruitment procedures can be seen to be expensive and bureaucratic, serious consideration needs to be given to the cost of 'getting it wrong'.

At the heart of the guidance is the role of an Appointing Manager and their specific responsibilities for managing the process, risk assessment and 'sign off' of all appointments / placements.

The Disclosure and Barring Service (DBS) is responsible for processing the checks on candidates to regulated posts. It manages the police check process and the two lists of barred people. It is a requirement that those recruited to regulated posts have a DBS check. Specifically:

• All job descriptions, person specifications and selection criteria must be reviewed by the Appointing Manager prior to advertisement. This will include ensuring that documentation clearly states whether it is a regulated post.

• Appropriate selection and testing methods should be drawn up that cover all criteria relevant for the job. This should form the basis of the selection decision. Selection panel members must be suitably trained.

• A range of specific and detailed checks must be undertaken before appointment begins: DBS, barring list, references, qualifications verification, identity verification, medical fitness. All checks must be signed off by the Appointing Manager.

The appendices detail model checklists; these can be adopted / adapted by organisations for their own use.

1. Legal Responsibilities for Engagement & Hiring

The Protection of Freedoms Act 2012, created the **Disclosure and Barring Service** (DBS). This is a public body, sponsored by the Home Office, which acts in respect of decisions to bar certain people from working with children or adults requiring medical or social care. It maintains the two barred lists which relate to work with adults and work with children whist managing the process for police checks. Checks of these lists are made as part of an Enhanced DBS disclosure **for regulated posts only.**

Classification of Posts

Posts are classified according to the type of work or where this is undertaken. Classifications apply to employees, agency workers and some volunteers and contractors. All posts or roles classified as "Regulated." under the Protection of Freedoms Act will require both an enhanced DBS disclosure and a check against the DBS barred lists (adults and children's).

Regulated activity – Broad definitions

Regulated activity is any activity which involves contact with children or adults; this could be paid or voluntary work. There is a real emphasis on employers making their own judgements about which posts are regulated and about the nature of supervision. An initial review of all posts in the organisation will be necessary to recategorise roles and to ensure that appropriate checks are made when a post becomes vacant. Categorisation should be reconsidered at regular intervals.

For Adults' services

- All health care professionals providing health care to adults or provider of health care under supervision of a professional
- Providers of personal care
- Those instructing or advising giving guidance in personal care to adults
- Providers of Social Work
- Assisting with cash, bills or shopping
- Assisting in conducting personal affairs
- Transporting adults to places where they receive health care, personal care or social care
- Those who supervise all the above

No "frequency" test applies to the above so there is no need to determine how often the individual is undertaking such duties.

https://www.gov.uk/government/publications/disclosure-and-barring-service

2. Safer Selection – Guidelines for Checking / Screening Staff

Unsafe selection can have serious implications for the safety and security of vulnerable adults and children and potentially be extremely damaging to the child or adult. It can prove costly in real terms and extremely damaging to the employer's reputation and standing.

It is relatively easy for an organisation to make clear to applicants in its policy statements and staff selection procedures that the organisation has robust processes to research offending history where relevant to the application. This actively discourages offenders. The best safeguard is a high standard of management practice and quality control consistently applied at recruitment and selection and subsequently through induction, performance management, appraisal, supervision and monitoring.

All job descriptions, person specifications and selection criteria must be reviewed by the Appointing Manager prior to advertisement. This will include ensuring that documentation clearly states that it is a regulated post and if so, the requirement for a DBS check and any professional registration requirements. Applicants should be required to make a self-declaration whether they are on a barred list. Any disclosures should be considered at interview stage or through a separate discussion.

Appropriate selection and testing methods should be drawn up that cover all criteria. The aim of the selection process is to obtain key relevant and comprehensive information on all candidates by applying consistent procedures. Suitable probing during interview questioning is essential in order to elicit complete responses but this must be concerning the criteria specified. Probing applicants regarding their motivation to do the work, how they deal with difficult issues and how they maintain safe and appropriate boundaries through professional working relationships will be part of the interview for all regulated posts.

Selection panel members should be suitably competent. Ideally at least one member should have received safer recruitment training or at least attended an awareness course. It is recognised that in smaller organisations such training may not be readily available but the onus is on the panel chair to ensure that at least one member has these skills.

Relevant information for candidates

Applicants for regulated posts should be advised that:

• We will ask whether they are a barred person as per the DBS requirements and we will conduct a DBS check.

• We reserve the right to approach any current or previous employer for a reference.

• We will ask about disciplinary offences, including those that have expired.

• The Rehabilitation of Offenders Exceptions Order applies so we will ask about 'spent' convictions.

• We will ask you why did you leave your last employment?

• Providing false information will lead to no appointment or dismissal.

• Failing to declare conviction, caution or pending police action **could** disqualify the applicant for employment.

• They may be required to participate in appropriate testing e.g. group exercise, competency interview, verbal and numerical reasoning tests, Occupational/ Personality Questionnaire etc. as relevant to the post.

• Offers but not appointments are 'subject to satisfactory checks' i.e. no waivers and no unsupervised access to children until all appropriate checks carried out.

Recruitment and Selection Checks Overview

To increase the threshold of protection, a combination of positive selection steps should be implemented. Key ones are:

I. All candidates must complete a written declaration on whether they are a barred person, (normally as part of the application form).

II. Reserve the right to approach any previous employer (take up all relevant care and other references over the last 3 to 5 years). It is essential to cover gaps in CV / employment history (and check dates against references, pensions, reasons previous employment ended, continuous service etc. information) so there is a complete history on file. The Appointing Manager to identify who should be approached for references and identify any extra questions.

III. Ensure that references are read and cleared by the Appointing Manager.

IV. Do not commence staff without references or any other essential check. If there is an urgent need to put staff in place before all checks are made, first conduct a written risk assessment and only employ on the basis that the applicant knows that their employment will cease if the safeguarding checks are not satisfactory in any way once they are received.

V. Confirm person's identity through official documents (birth certificate, passport etc.). **Make sure the person who starts work is the same person who attended for interview and assessments**.

V1. Employers are required by law to satisfy themselves as to the applicant's right to work in the UK. Best practice from the NHS is the use of scanners to examine the documents presented by the applicants to ensure their authenticity.

VII. When working in an off-site unit, ensure that identity is verified; a photograph ID card is the best method. Managers should ask for evidence of photo identity for agency workers to ensure they are the same person hired for placement. More advice on identity checks is available on the DBS web site

http://www.homeoffice.gov.uk/agencies-public-bodies/dbs/

VIII. Verify the authenticity of qualifications and references directly (e.g. telephone contact, website information, check referee is legitimate, headed paper etc.). Insist on original documents (check registration details online). HR/support staff must scan / photocopy for file and record who saw the original and when.

IX. The Appointing Manager is the key decision-maker who 'signs off' the documentation and clears the appointment. Where there are gaps in employment history or matters of judgement the Appointing Manager will undertake a risk assessment and identify follow-up action, e.g. more references, further interviewing, temporary restrictions on duties etc. Any such risk management decision must be written and properly and fully recorded by the Appointing Manager.

X. Rigorous management of all appointments to work with children and vulnerable adults is essential. This must include internal transfers and promotions.

Risk Assessment

Where there are gaps in information, concerns or matters of judgement, the Appointing Manager will undertake a risk assessment to determine whether the appointment should proceed or the offer is withdrawn. The Appointing Manager will weigh up the information available and consider whether further information / advice is required, whether the safety risk is small or can be mitigated by temporary work restrictions. Advice from HR should be sought on potential employment rights matters (for example if a temporary contract is envisaged).

As a rule of thumb, any risk must be judged by a sense of reasonable action to avoid the risk arising and should be mitigated so it becomes negligible. Generally risks should be avoided, and never be unmanaged.

All risk assessments should clearly identify necessary actions, be time-bound and reviewed by the Appointing Manager within the period identified.

The Appointing Manager must 'sign off' the documentation and clear the appointment for processing. The Appointing Manager will be held accountable for this decision.

References; extra advice

The minimum requirement is for at least two relevant references (not friends or relatives). Key reference to be from the last employer or one most relevant for position (as a general rule, check for regulated posts working with young people or adults over the last 3 to 5 years). If there are concerns about past employment record, any number of previous employers should be contacted for reference. Notes of any telephone discussions should be kept and filed / scanned on relevant personal/recruitment files.

Care should always be exercised in reading references – some of which may be 'agreed' following Employment Tribunal decisions or as "Compromise Agreements"; some may be evasive and not addressing contentious issues; and some may not be from authorised sources. Always seek further information if it is felt questions have not been answered.

Important points to bear in mind when receiving or giving references:

• The Appointing Manager should agree (with HR/support staff) who should be approached for references having regard to any gaps in employment or issues arising from interview, that need further enquiry

• Personal references are of limited value and should be treated with caution. They should not substitute for minimum two work references.

• Managers are entitled to make appropriate enquiries about anything in a reference that requires investigation (e.g. ambiguities or unguarded comments) and to take this into account when making decisions on employment. If necessary, customise reference requests to deal with particular issues.

•. No inhibition exists to restrain the employer from making further and appropriate enquiries of the provider of a reference, the applicant for the job or anyone else deemed relevant.

• A key lesson from experience (Bichard Inquiry) is that Managers should not accept open or 'To whom it may concern' references.

• All contacts should be documented and held on file, to which the employee or prospective employee has access.

• References should be checked against application forms to verify dates of employment.

• The reference request should clearly identify that the applicant is to work with children or adults in a regulated capacity and should ask directly if the referee knows of any reason why they should not do so.

• References must be signed by the author. E-mail references may be accepted but sender e-mail address must tie up with the person providing the reference and be from a verifiable source, e.g. from a local authority /company e-mail address not a personal e-mail account.

3. Other considerations

Overseas workers

Extra care needs to be taken where candidates are from overseas as detailed verification may be difficult to obtain and where they are new arrivals they have no track record of relevant employment.

These workers must still be checked in accordance with DBS requirements and utilise all available avenues to check candidate's background: the DBS website details the availability of criminal records from overseas.

The DBS also provides an Overseas Information Service, which will provide employers with details of the information that applicants may be able to obtain from their country of origin. This may involve obtaining a translation of the information that comes back.

The Health Care Professional Council (HCPC) www.hpc-**uk**.org has an international application pack to consider applications for registration for social care and health workers.

Special efforts need to be made to ensure that reference sources are reliable, employment history is break-free or explained, and supplementary references should be obtained in order to produce a proper historical work, training, etc.

For potential appointments the Appointing Officer must take care to ensure sufficient breadth and depth of information is available to make a safe decision.

Agency Workers / Contractors

Recruitment processes should be rigorous for all who work with children and adults for health or social care purposes; this includes all agency and temporary staff, volunteers, escort and transport agencies, students on placement. Other people who may be on the premises and who have access to children e.g. consultants, independent visitors, contractors and Councillors, may require a DBS disclosure, but only where they meet the criteria for regulated posts (See section 1).

In using agency staff, managers are relying on the agencies to apply the proper selection and checking arrangements on their behalf. Passing responsibility on in this way, entails risk and organisations need to ensure they use agencies who have rigorous processes in place and that these are audited to ensure compliance in all cases.

Best practice from the three boroughs and the NHS has minimised this risk by using the approved agency service providers who is contractually responsible for vetting candidates to high-risk positions and auditing vendor agencies. This will include ensuring that agencies check whether an agency worker is a barred person under DBS requirements. All vendor agencies providing social care, and other staff with access to children and vulnerable adults, will have a specific service agreement, which outlines their responsibilities and the expectations placed upon them when proposing workers for placement.

Failure to reach quality standards will result in removal from the approved list of suppliers. The service provider will monitor / audit these agencies quarterly to ensure quality standards are maintained. Corporate HR will review and periodically check the audit reports for agency screening / checking arrangements.

Some job types will be identified as 'high risk' posts (i.e. those with direct care responsibilities). In those cases the Service Provider will undertake sight of documentation before workers will be put forward for selection. Documents include:

- Professional references – two minimum (not 'To Whom It May Concern')
- Identity checks
- Professional registration checks
- Qualification checks necessary for the job
- Enhanced DBS check
- Overseas police check where appropriate
- Medical clearance

The Service Provider will hold documents and supply them as requested. Normally this will include uploading documents for hiring managers to scrutinise and the hiring manager is responsible for ensuring that they have satisfied themselves that the documentation meets requirements. Where necessary hiring managers must undertake a risk assessment where there is an urgent need to secure agency staff before all checks are in place. The risk assessment should be kept regularly under review at minimum monthly.

Through procurement rules, all contractors who provide services which would fall under the safeguarding umbrella must be required to follow appropriate checking procedures. As contracts are renewed, these requirements need to be written into contract documentation. Where services are being subcontracted, managers need to be confident that safeguarding principles are being upheld throughout the provided service.

Post recruitment responsibilities

Employers retain responsibility post recruitment to ensure that people are eligible to practice and that periodic checks are made via DBS routes. Checks on professional registration and the frequency of DBS re-checks will be determined in accordance with the relevant professional body.

Staff should be told that any police or criminal law related activity that occurs during employment should be reported to their manager at the earliest opportunity so that the potential risk posed can be assessed and any management action which may be necessary considered. This will include police arrest, charge, caution, conviction or bind over.

Details of discussions with staff about criminal or other declarations must be retained on personal files confidentially.

All other applicant related documents should be retained on personal files.

Sources of additional information

Home office
http://www.homeoffice.gov.uk/agencies-public-bodies/dbs/

Department of Health
http://www.nhsemployers.org/your-workforce/recruit/employment-checks/nhs-employment-check-standards

Department for Education
http://www.education.gov.uk/childrenandyoungpeople/safeguardingchildren/a00209802/disclosure-barring

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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 – indicative only)		
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
Secondary Item **Safeguarding (Safer Recruitment)**	To examine the work of Mike Howard's Safer Recruitment Panel	• Helen Banham • Louise Butler

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 • Mick Smith • Adam Taylor
The Patient Journey – Journey mapping the experience of Westminster residents	To assess how Westminster residents and patients interact with the health service in the City	• CCG

ROUND FOUR (27 January 2016)		
Agenda Item	**Reasons & objective for item**	**Represented by:**
Finding Carers	To assess how the Council can find carers in the community	• Liz Bruce
Supported Employment	To examine the programme and commitments going forward	• Liz Bruce

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
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	• Major Acute Trusts (Imperial) • CCG Collaborative

Other Committee Events & Task Groups		
Briefings	**Reason**	**Type**
Safer Westminster Partnership	To assess the work of the Safer Westminster Partnership;	**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**
Outpatients at Imperial College Healthcare NHS Trust	To assess the improvement of outpatient services following the review of Imperial by the Care Quality Commission	**Task Group**

Healthwatch Westminster Updates

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Round 2
Round 4
Round 6

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