Local Government Association

Community Wellbeing Board

Agenda

Wednesday, 14 October 2020
14.00 am

Virtual Meeting

To: Members of the Community Wellbeing Board
cc: Named officers for briefing purposes

www.local.gov.uk

Local Government Association

LGA Community Wellbeing Board
14 October 2020

There will be a meeting of the Community Wellbeing Board at **14.00 am on Wednesday, 14 October 2020**

Political Group meetings:
The group meetings will take place in advance of the meeting. Please contact your political group as outlined below for further details.

Apologies:
Please notify your political group office (see contact telephone numbers below) if you are unable to attend this meeting.

Conservative:	Group Office:	020 7664 3223	email:	lgaconservatives@local.gov.uk
Labour:	Group Office:	020 7664 3263	email:	Martha.Lauchlan@local.gov.uk
Independent:	Group Office:	020 7664 3224	email:	independent.grouplga@local.gov.uk
Liberal Democrat:	Group Office:	020 7664 3235	email:	libdem@local.gov.uk

LGA Contact:
Amy Haldane
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Carers' Allowance
As part of the LGA Members' Allowances Scheme a Carer's Allowance of £9.00 per hour or £10.55 if receiving London living wage is available to cover the cost of dependants (i.e. children, elderly people or people with disabilities) incurred as a result of attending this meeting.

Social Media
The LGA is committed to using social media in a co-ordinated and sensible way, as part of a strategic approach to communications, to help enhance the reputation of local government, improvement engagement with different elements of the community and drive efficiency. Please feel free to use social media during this meeting. **However, you are requested not to use social media during any confidential items.**

The twitter hashtag for this meeting is #lgacwb

Local Government Association

Community Wellbeing Board – Membership 2020/2021

Councillor	Authority
Conservative (7)	
Cllr Ian Hudspeth (Chairman)	Oxfordshire County Council
Cllr David Fothergill	Somerset County Council
Cllr Adrian Hardman	Worcestershire County Council
Cllr Colin Noble	Suffolk County Council
Cllr Jonathan Owen	East Riding of Yorkshire Council
Cllr Judith Wallace	North Tyneside Council
Cllr Sue Woolley	Lincolnshire County Council
Substitutes	
Cllr David Coppinger	Windsor & Maidenhead Royal Borough
Cllr Wayne Fitzgerald	Peterborough City Council
Cllr Arnold Saunders	Salford City Council
Labour (7)	
Cllr Paulette Hamilton (Vice-Chair)	Birmingham City Council
Cllr Louise Gittins*	Cheshire West and Chester
Cllr Arooj Shah	Oldham MBC
Cllr Shabir Pandor	Kirklees Metropolitan Council
Cllr Natasa Pantelic	Slough Borough Council
Cllr Amy Cross	Blackpool Council
Cllr Denise Scott-McDonald	Royal Borough of Greenwich
Substitutes	
Cllr Mohammed Iqbal	Pendle Borough Council
Cllr Bob Cook	Stockton-on-Tees Borough Council
Cllr Joanne Harding*	Trafford Council
Liberal Democrat (2)	
Cllr Richard Kemp CBE (Deputy Chair)	Liverpool City Council
Cllr Doreen Huddart	Newcastle upon Tyne City Council
Substitutes	
Cllr Rob Rotchell *	Cornwall Council
Independent (2)	
Cllr Claire Wright (Deputy Chair)	Devon County Council
Cllr Neil Burden	Cornwall Council
Substitutes	
Cllr David Beaman	Waverley Borough Council
Cllr Tim Hodgson	Solihull Metropolitan Borough Council
Cllr Rosemary Sexton*	Solihull Metropolitan Borough Council

Local Government Association

Agenda

Community Wellbeing Board

Wednesday 14 October 2020

14.00 pm

	Item	Page
1.	**Welcome and Declarations of interest**	
2.	**Terms of Reference and Board Membership**	1 - 8
3.	**Mental Health and Wellbeing (Andy Bell Guest Speaker)**	
4.	**Community Wellbeing Board Priorities 2020/21**	9 - 20
5.	**Update on other board business**	21 - 362
6.	**Joining up Care - our work with NHSX**	363 - 374
7.	**Notes of the last meeting**	375 - 382

Date of Next Meeting: Wednesday, 2 December 2020, 11.00 am, Virtual Meeting

Local Government Association

Community Wellbeing Board 2020/21: How it works for you, Terms of Reference, and Board Membership

Purpose of report

For information.

Summary

This report sets out how the Community Wellbeing Board operates and how the LGA works to support the objectives and work of its member authorities.

The Community Wellbeing Board are asked to note and agree their Terms of Reference for the 2020/21 year.

Recommendations

That the Community Wellbeing Board:

i. agrees note its Terms of Reference (**Appendix A**);

ii. formally notes the membership for 2020/21 (**Appendix B**); and

iii. note the Board meeting dates for 2020/21 (**Appendix C**);

Action

As directed by Members.

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Local Government Association

Community Wellbeing Board 2020/21: How it works for you, Terms of Reference, and Board Membership

Background

1. The LGA's Boards seek to lead the agenda for local government on the key challenges and issues within their remit and support the overall objectives of the organisation as set out in the LGA's Business Plan.

2. They take an active role in helping to shape the Association's business plan through extensive engagement with councils and oversight of the programmes of work that deliver these strategic priorities.

2020/21 Terms of reference and membership

3. The Community Wellbeing Board's Terms of Reference and Membership are set out at **Appendix A** and **B** for agreement and noting respectively.

4. The Community Wellbeing Boards meeting dates for 2020/21 are also found at **Appendix C** for noting.

Community Wellbeing Board Lead Members

5. The LGA seeks where possible to work on the basis of consensus across all four groups. The Community Wellbeing Board is politically balanced, and led by the Chair and three Vice/Deputy Chairs, drawn from each of the four political groups. This grouping of members – known as Lead Members – meet in between Board meetings, shape future meeting agendas, provide clearance on time sensitive matters, represent the Board at external events, meetings and in the media, as well as engaging with the wider Board to ensure your views are represented.

6. The Lead Members for 2020/21 are:

   6.1 Cllr Ian Hudspeth, Chairman (Conservative)
   6.2 Cllr Paulette Hamilton, Vice-Chair (Labour)
   6.3 Cllr Richard Kemp CBE, Deputy Chair (Liberal Democrat)
   6.4 Cllr Claire Wright, Deputy Chair (Independents)

The Community Wellbeing Board team

7. The Board is supported by a cross cutting team of LGA officers, with Policy colleagues and designated Member Services Officer, being those which you are likely to have regular contact with.

8. The Community Wellbeing Board team supports the LGA's work on the Board's priorities relating to Community Wellbeing, and also a number of other discrete issues which are within the Board's remit. The team works with Board Members, the LGA press office and political groups to maintain local government's reputation on Community Wellbeing issues in the media, directs our lobbying work (according to Members' steer) in conjunction with the Parliamentary affairs team, and works collaboratively with other Boards across relevant cross cutting policy and improvement issues.

9. The team supports Members in person or by briefing when they represent the LGA on external speaking platforms or at Ministerial or Whitehall events. We will provide briefing notes and/or suggested speaking notes as required in advance if each engagement.

10. The team also participate in a number of officer working groups and programme boards, representing the sector's interests and putting forward the LGA's agreed policy positions.

Communications and Events

11. There are a number of internal and external communications channels available to help the Community Wellbeing Board promote the work it is doing and to seek views from our member authorities.

12. In the Autumn the Community Wellbeing Team participates in the National Children and Adult Services conference (NCASC) Organised by the Local Government Association (LGA), Association of Directors of Social Services (ADASS) and Association of Directors of Children's Services (ADCS), the NCASC is regularly attended by more than 1,000 delegates. It is widely recognised as the most important annual event of its kind for councillors, directors, senior officers, policymakers and service managers with responsibilities for children's services, adult care and health in the statutory, voluntary and private sectors. This years NCASC will be held in Manchester from 20 to 22 November.

13. We also have a dedicated section on the LGA website, regular e-bulletins with a personal introduction from the Chair of the Board, outside speaking engagements and interviews, advisory networks, features and news items in First magazine as well as twitter accounts which are used to keep in touch with our members.

Appendix A

Terms of Reference: Community Wellbeing Board

The purpose of the Community Wellbeing Board is to engage and develop a thorough understanding of the issues within their brief and how legislation does or could affect councils and their communities, in particular with regard to the growing integration of health and social care services.

The Board works to support local government in delivery of its public health, social inclusion and equalities responsibilities, as well as issues relating to an ageing society and the reform and funding of adult social care.

It is also responsible for maintaining a close relationship with the work of the Asylum, Refugee and Migration Task Group.

The Community Wellbeing Board's responsibilities include:

1. Representing and lobbying on behalf of the LGA including making public statements on its areas of responsibility.

2. Building and maintaining relationships with key stakeholders.

3. Ensuring the priorities of councils are fed into the business planning process.

4. Developing a work programme to deliver the business plan priorities relevant to their brief, covering lobbying campaigns, research, improvement support in the context of the strategic framework set by the Improvement & Innovation Board and events and linking with other boards where appropriate.

5. Sharing good practice and ideas to stimulate innovation and improvement.

6. Involving representatives from councils in its work, through task groups, Commissions, SIGs, regional networks and mechanisms.

7. Responding to specific issues referred to the Board by one or more member councils or groupings of councils.

8. The Community Wellbeing Board may:

   8.1. Appoint members to relevant outside bodies in accordance with the Political Conventions.

   8.2. Appoint Board holders from the Board to lead on key issues.

Quorum

One third of the members, provided that representatives of at least 2 political groups represented on the body are present.

Political Composition

Conservative group:	7 members
Labour group:	7 members
Independent group:	2 members
Liberal Democrat group:	2 members

Substitute members from each political group may also be appointed.

Frequency per year

Meetings to be held five times per annum.

Reporting Accountabilities

The Executive Advisory Board provides oversight of the Board. The Board may report periodically to the Executive Advisory Board as required, and will submit an annual report to the Executive's July meeting.

Appendix B

Community Wellbeing Board

Councillor	Authority
Conservative (7)	
Cllr Ian Hudspeth (Chairman)	Oxfordshire County Council
Cllr David Fothergill	Somerset County Council
Cllr Adrian Hardman	Worcestershire County Council
Cllr Colin Noble	Suffolk County Council
Cllr Jonathan Owen	East Riding of Yorkshire Council
Cllr Judith Wallace	North Tyneside Council
Cllr Sue Woolley	Lincolnshire County Council
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Cllr David Coppinger	Windsor & Maidenhead Royal Borough
Cllr Wayne Fitzgerald	Peterborough City Council
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Cllr Shabir Pandor	Kirklees Metropolitan Council
Cllr Natasa Pantelic	Slough Borough Council
Cllr Amy Cross	Blackpool Council
Cllr Denise Scott-McDonald	Royal Borough of Greenwich
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Cllr Neil Burden	Cornwall Council
Substitutes	
Cllr David Beaman	Waverley Borough Council
Cllr Tim Hodgson	Solihull Metropolitan Borough Council
Cllr Rosemary Sexton*	Solihull Metropolitan Borough Council

* Newly appointed to this governance structure for 2020/21 meeting year.

Proportionality Figures 2020/21

Members are asked to ensure that appointments for 2020/21 are in broad proportionality with the 19 Member political group makeup of the Board, which is as follows:

7 Conservative, 7 Labour, 2 Independent, 2 Liberal Democrat.

Appendix C

Board Meeting Dates 2020/21

DAY (2020)	**DATE**	**TIME**	**Room at 18 Smith Square**
Wednesday	14 October 2020	Away Day: 11.00 – 14.00 Board Meeting: 14.00 – 16.00	Zoom Meeting Teams Meeting
Wednesday	2 December 2020	11.00 – 13.00	Virtual Meeting
DAY (2021)			
Thursday	4 February 2021	11.00 – 13.00	TBC
Tuesday	11 May 2021	11.00 – 13.00	TBC
Thursday	22 July 2021	11.00 – 13.00	TBC

Community Wellbeing Board

14 October 2020

Community Wellbeing Board Priorities 2020/21

Purpose

For discussion.

Summary

This report outlines proposals for the Board's priorities and key areas of work, set against the available resources for 2020/21. The proposals are based on both corporate LGA priorities and options for broader work based on a combination of areas of interest previously indicated by Board members, ongoing work and recent policy announcements by Government. Subject to members' views, officers will develop a work programme to deliver these priorities.

Recommendation

Board Members are asked to discuss and agree the Board's priorities for 2020/21.

Action

Officers to take forward as directed by members.

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Community Wellbeing Board

14 October 2020

Community Wellbeing Board Priorities 2020/21

Background

1. At this first meeting of the Community Wellbeing Board, members are asked to consider the policy priorities for the work programme for the coming year. In making these decisions, members are asked to consider two issues:

    1.1. The corporate priorities set out in the LGA's business plan.
    1.2. Specific policy priorities based on the remit of this Board.

2. This report sets out a suggested work programme for the Board which will help deliver the LGA's Business Plan priorities, for Members' discussion and decision.

LGA corporate priorities

3. The LGA's business plan for 2019-2022 sets out a range of cross-cutting LGA priorities which Boards are asked to incorporate within their work programmes:

    3.1. Funding for local government
    3.2. Adult social care, health and wellbeing
    3.3. Children, education and schools
    3.4. Places to live and work
    3.5. Strong local democracy
    3.6. Sustainability and climate action

4. The Board's priorities will contribute in the main to the LGA's work around adult social care, health and wellbeing, but will also link in with other areas such as those around places to live and work, and our programme of activity around mental health links in with work to support children and young people. In addition the Board's work to date on supported housing has implications for the wider LGA housing agenda.

Specific work of relevance to this Board's remit

Adult social care – funding

5. Last year's report proposed Board priorities for adult social care on funding and reform. This year, the priorities remain the same but are obviously proposed within the completely unique context created by Covid-19. Many of the challenges facing social care that have been exposed by the pandemic are, of course, not new to those of us in local government. Historic underfunding of adult social care (combined with only incremental and temporary solutions to funding challenges) has impacted on the care workforce, the stability and sustainability of the provider market, quality and access to care, unmet and under-met need, unpaid carers and, most importantly, people using care services. These challenges have been compounded by Covid-19 but have also been placed more firmly in the public spotlight. As with care and support reform (see below), we therefore have an opportunity to try and capitalise on this moment of 'profile' for social care and ensure the service has what it needs over the coming year and beyond.

6. The LGA's recent submission to the Comprehensive Spending Review (CSR) makes clear the scale of the financial challenge facing local government overall. Analysis by the Institute for Fiscal Studies (IFS), and commissioned by the LGA for the CSR, shows an estimate of the funding gap facing councils of £5.3 billion by 2023/24. The IFS estimate this could rise to £9.8 billion due to the uncertainty resulting from the continuing impact of Covid-19.

7. Overall, the LGA is calling on the Government to provide an additional £10.1 billion in core funding by 2023/24, comprising: the £5.3 billion funding gap to sustain 2019/20 service levels; £1.9 billion to deal with other quantifiable pressures to stabilise the sector; and £2.9 billion of other core funding requirements to help councils improve their core offer (which includes funding to increase care worker pay).

8. Given adult social care constitutes such a high proportion of councils' budgets (for those with social care responsibilities), sustainable funding for social care is essential to the sustainability of funding for local government overall. We will therefore continue our policy, public affairs and media work (lobbying and influencing) on this crucial subject, working closely with colleagues in the Care and Health Improvement Programme to ensure our work reflects the issues facing councils on the ground. As we set out in our CSR submission, we want action on three fronts:

   8.1. Additional funding to shore up social care ahead of winter and a likely second wave of the virus, with a look to this continuing in future years;
   8.2. Additional funding for the medium term to help address the long-standing challenges that have faced social care, many of which have been exacerbated by the pandemic; and
   8.3. Use of the above funding as a 'down-payment on reform' and to pave the way for changes that will finally put the funding of social care on a sustainable footing for the long-term.

Adult social care – reform

9. Our work on social care reform remains high profile and well received. Since we launched our green paper, *The Lives We Want To Lead,* in July 2018, we have published:

   9.1. (November 2018) A follow up report to our consultation setting out key findings, implications and recommendations for a way forward, based on the consultation responses we received.
   9.2. (July 2019) A report to mark 'one year on' since our green paper setting out the consequences of further delay from the perspective of experts across the care and support sector
   9.3. (March 2020) A report re-stating the case for change, the issues that need to be addressed and some of the options for action
   9.4. (July 2020) Seven principles for reform that we believe should underpin reform of care and support in light of Covid-19, signed by more than 30 prominent national organisations across the health and care sector

10. As with social care funding, the profile of social care reform has risen over the last few months as the public have seen the essential value of care and support in its own right in

helping people to live the lives they want to lead. We have been clear that, after decades of attempts, the legacy of Covid-19 for social care must be lasting reform so that people are supported to live their best life. Throughout this work, and as with the work to date, we will seek to work with key partners at every opportunity and continue to stress the importance of working nationally on a cross-party basis.

Integration

The NHS Long Term Plan

11. In January 2019 NHS England published its 10-year plan to outline how it would improve the quality, safety, sustainability and outcomes of health services. Work to transform health and care systems set out in local implementation plans by the 44 Sustainability and Transformation Partnerships (STPs) was put on hold while the NHS responded to the Covid-19 crisis. However, Phase 3 of the Long Term Plan, published in September 2020, sets out ambitious targets for the NHS getting back on track with system transformation. In particular, by April 2021, all STPs will become Integrated Care Systems (ICS), with the integration of health and social care being a major objective.

12. We will work hard to ensure that local government is recognised and valued as a key planning and delivery partner for the NHS plan, both at national and local level. The LGA will:

    12.1. Work with NHSEI and other national partners to ensure that councils and, in particular, health and wellbeing boards, are meaningfully engaged in the development of integrated care systems and system implementation plans.
    12.2. Work with NHSEI to increase understanding of and commitment to planning and delivery at place level by ICS leadership and to build on existing place-based partnerships and strategies.
    12.3. Support councils to work effectively with their local NHS partners to ensure local delivery plans build on existing priorities to improve population health and wellbeing and are subject to democratic oversight and challenge.

The Future of Integration

13. The Covid-19 pandemic has highlighted even more starkly the importance of joining up care and support to ensure that people get the right care in the right place at the right time. In many areas barriers between health and care have been broken as local health and care leaders have had the flexibility to develop their own solutions. The LGA will work with partners to ensure to build on the positive changes. We will:

    13.1. Identify action that needs to be taken at local, strategic and national level to address barriers to more effective joined up working;
    13.2. Work with the Care and Health Improvement Programme to identify and promote good practice and evidence of how joined up care and support can improve outcomes;
    13.3. Continue to press for greater democratic accountability of the planning and delivery of integrated services, with a stronger role of health and wellbeing boards in leading and overseeing local plans for integration;

13.4. Ensure that local government concerns and priorities are reflected in all stages of the parliamentary process when the NHS Integrated Care Bill is reintroduced to Parliament; and

13.5. Work with partners to press for a single outcomes framework for the health and care system and a system of performance management, which is light touch and locally driven.

The future of the Better Care Fund (BCF)

14. The CWB has continued to support local health and care leaders to ensure that the BCF protects the NHS transfer to support adult social care funding, supports community-based preventative services to improve outcomes for people and reduce pressure on the NHS. The future of BCF, beyond the current spending round, is uncertain. The LGA will continue to press for the continuation of arrangements to incentivise joining up health and care services, but with more local control and less national direction and performance management. We will work to ensure that BCF remains true to its original objectives of local health and political leaders working together to agree shared plans for joined up community and preventative services (including adult social care) to keep people well and independent, and reduce pressure on acute services.

Models of integrated planning and delivery

15. We will continue to work with NHS England and other partners to ensure that integrated care systems and integrated care providers and any other models of joined up planning and provision of care and support are based on the values, principles and evidence in our refresh of the shared vision for integration that the LGA developed in partnership with NHS Confederation, NHS Clinical Commissioners, NHS Providers, ADASS and ADPH. We will provide support for effective system leadership by clinical and political leaders. We will continue to work with colleagues in the Care and Health Improvement Programme (CHIP), the NHS Confederation and other partner organisations to develop and refine our systemwide leadership support offer.

Public Health

Make the case for sustainable prevention funding

16. Councils continue to face significant spending challenges to their public health budgets despite the pandemic having shown that investing more in prevention would have led to better outcomes. We will continue to make the case for a prevention transformation fund and a reversal of the £700 million reduction in the public health grant.

Strengthen the position of councils as public health leaders

17. The pandemic has highlighted the value of local knowledge, supported by national coordination and resources, when responding to a health crisis of this size and scale. This local-first approach should be at the forefront of how we confront the public health challenges ahead. Councils remain best placed to deliver value for money and strong outcomes and this is backed up by The Kings Fund independent assessment in January 2020 which found responsibility for public health within local councils to be the right one.

We will also lobby for increased powers and oversight for councils in the future arrangements for PHE's health improvement functions.

18. We will work with Government and partners to ensure that future arrangements for the Health Improvement functions of Public Health England (PHE), work to support and enhance local systems. PHE have provided vital expertise, guidance and other support to councils. It is the essential that there is a seamless transition to the new system, which builds on existing expertise and partnerships with councils, alongside extra investment to help improve services and keep people healthy. It is essential that this relationship is built upon and strengthened further when the new National Institute for Health Protection comes into force

Reduce health inequalities

19. There is clear evidence that some groups have been disproportionately affected by the virus, with obesity, poor mental health, socio-economic status and ethnicity and disability all increasing the likelihood of COVID-19 being fatal. This is extremely worrying and underlines the need for a strong commitment to tackling health inequalities. We will continue to develop tools which help councils to address health inequalities directly, especially tools to mitigate the ongoing impact of Covid-19 and lockdown on Black, Asian and Minority Ethnic Groups. We will also continue to make the case that local government is best placed to lead on the 'levelling up' and health inequalities agenda if given the right resources. We will continue to make to highlight the impact social and economic factors have on the long-term ill health and premature death rates for the most deprived.

Support councils to evaluate the public health impact of Covid-19 on their communities and respond effectively

20. Emerging data will show the impact of lockdown on everything from rates of problem drinking, exercise, mental health, smoking cessation to breastfeeding. We will work with national partners and councils to support place-based strategies to mitigate the negative public health impacts of Covid-19 as well as capitalising on any positive trends – such as the reduction in smoking levels.

Respond to Covid-19

21. With increasing infection rates it is clear that for the first part of the Board's 2020/21 cycle supporting local authorities in their response to Covid-19 will be a significant strand of work for the Board and the LGA. We will:

21.1. Highlight the constraints in the testing system have on councils' ability to successfully manage local outbreaks, and continue to make the case for a local by default approach to test, trace and outbreak management.
21.2. Lobby government to ensure that councils have the resources and information they need to trace those who might have been exposed to Covid-19 at a local level.
21.3. Assist councils in supporting the clinically extremely vulnerable who need to be shielded from Covid-19.
21.4. Lobby for councils to be given the powers and tools they need to ensure business and communities adhere to social distancing requirements.

Local Government Association

Community Wellbeing Board

14 October 2020

21.5. Work with government and councils to implement the system to financially support those on benefits and low incomes who need to self-isolate.
21.6. Press for greater engagement of local authorities in the planning, development and then delivery of the Covid-19 vaccination campaign.
21.7. Develop and deliver a sector-led improvement support offer to councils to share good practice and help councils respond to local outbreaks.
21.8. Make the case for councils to receive the funding and other resources they need to manage local outbreaks, and to work with Whitehall departments to address the winter capacity issues councils and the social care system face.

Ongoing Priorities

22. Alongside Covid-19 related priorities we will continue our commitment to improve national and local level policy across all public health services, specifically: substance misuse services, sexual and reproductive health services and smoking cessation services. We will also continue to support measures to increase immunisation rates, reduce childhood tooth decay and improve air quality measures.

Child Health Priorities

Develop an integrated early years and child health policy position

23. Develop good practice guidance on integrating educational, social and health services to improve outcomes in 0-5s. This will include commissioning work to evaluate joint commissioning practices and build the evidence-base for effective joint commissioning.

Support Councils to improve outcomes in the Healthy Child Programme

24. Make the case for reform and investment in the Healthy Child Programme to continue whilst the future of Public Health England and oversight for the programme is decided. This will include supporting councils to move towards an integrated 0-19/25 service, improving capability and skill-mix in delivery team and improving outcomes in the high impact areas i.e. breastfeeding and school readiness.

Healthy Child Programme workforce

25. Work with the Government, NHS and partners to rebuild the Healthy Child Programme workforce to ensure children and families are supported, unmet need is identified and work begins to address the adverse impact COVID-19 is predicted to have had on children and health inequalities. Undertake media work to highlight the role of public health nurses during Covid-19, to ensure equal reward and investment in public health nurses working outside of the NHS.

Reduce childhood obesity

26. Ensure learning is shared from the Childhood Obesity Trailblazer Programme and continue to lobby for increased powers for local authorities to tackle issues such as junk-food advertising around schools and nurseries.

Community Wellbeing Board

14 October 2020

People in vulnerable circumstances

Mental Health, mental capacity, wellbeing and suicide prevention

27. Argue for recurrent local funding for children and adult services to invest in mental health services that meet existing, new and unmet demand that has built up during the pandemic; for councils' public health grant to increase so that councils can provide tailored support that promotes wellbeing and prevents the escalation of need; and for the voluntary and community sector to be sustainably funded as an important provider of preventative, advocacy and crisis mental health support.

28. Support councils' mental health and wellbeing response to COVID-19, providing practical support to local leaders and shaping Government advice and resources. Further targeted mental health and wellbeing support will likely be needed as a result of local and/or national restrictions. This will be especially important for people most likely to experience the adverse mental health impacts from COVID-19, including unpaid carers, young people and people with existing mental health challenges.

29. Influence Government's cross-departmental mental health COVID-19 recovery work so that Ministers recognise that the mental health recovery is best led locally by councils with their partners and for government departments to adopt a coordinated approach that complements locally led action.

30. Develop practical support for councillors in their leadership roles that will help to strengthen how the whole council supports the mental wellbeing of young people aged 14 to 25 as part of an all ages / whole household approach to residents' mental health.

31. With the Care and Health Improvement Programme and ADASS, raise the profile of social care mental health with portfolio holders and provide practical support on transforming community mental health services through a webinar with NHSE/I portfolio holders, champions, Directors of Adult of Social Care. Linked to this, continue to strengthen NHSE/I's understanding of local government's roles in relation to mental health and wellbeing.

32. Work with ADASS and DHSC to continue to prepare Mental Health Act reform and implementation of Professor Sir Simon Wessely's independent review, including securing New Burdens funding for councils. We strongly support the reforms, but they will impact upon already stretched Approved Mental Health Professionals and local advocacy services.

33. Work with government and national partners to support transition to, implementation and funding of the Liberty Protection Safeguards to replace the Deprivation of Liberty Safeguards, including working with national partners on proposals for a cross system programme of sector led support.

34. With ADPH deliver year 2 of the suicide prevention sector led improvement programme which will provide further practical support to strengthen local approaches to suicide prevention and share good practice. Seek agreement from DHSC that year 3 (2021/22) covers public mental health rather than to solely focus on suicide prevention. This would bring our national approach to supporting councils on suicide prevention in line with local

approaches that seek to prevent suicide through addressing the wider social, economic and environmental factors that affect people's mental wellbeing and can increase the risk of severe mental illness and suicide.

35. The Community Wellbeing Board actions will be taken forward in partnership with the Children and Young People's Board who leads on children and young people's mental health, the Resources Board who leads on workforce mental health, and the cross-LGA Emotional Wellbeing Steering Group.

Dementia

36. With ADASS, help councils to protect and support people with dementia and their carers during the COVID-19 pandemic. Promote the benefits to councils of dementia friendly communities. Highlight to central government and others how councils support people with dementia and their carers in the community - both at home and in care homes and continue to work as a partner on the Prime Ministers Dementia Challenge 2020 programme. Support councils to promote prevention and risk reduction of dementia, especially vascular dementia, through public health and social care policy.

Carers

37. With ADASS, provide practical advice and examples to councils about supporting carers during the COVID-19 pandemic, for example, access to respite care and day services, employer support and mental health support. Support councils to respond to carers' additional needs, for example carers who are asked to shield or self-isolate. Represent local government's interests on the Ministerial Unpaid Carers' Taskforce that is overseeing the implementation of the Government's Carers' Action Plan. Continue to work with the CYP Board to ensure that the pressures facing young carers, such as mental health stress and boundaries to education, are addressed in our policy and improvement work.

Learning Disability and Autism

38. Together with the CYP Board, feed into the new all ages DHSC national autism strategy and the related action plan that will be launched later this year. Ensure that any new burdens are identified and fully funded. Publicise the plan to councils and identify any support needs arising. Continue to support the Transforming Care Programme which aims to improve health and care services for people with learning disabilities and/or autism who display challenging behaviour so that they can live well and safely in their communities with the right support. Continue to reflect the needs of working age adults with a learning disability and/or autism in our social care reform work.

Loneliness and social isolation

39. With ADPH, support a strong locally led response to loneliness and social isolation, including impacts arising during the pandemic, sharing good practice and positive public health local approaches and messages. Represent local government's interests on the national Let's Talk About Loneliness Coalition, and the Government's National Loneliness Strategy and associated action plan. Promote councils' leadership role in addressing and preventing loneliness and social isolation and the role of public health, social care and

wider council services such as libraries and open spaces. Highlight the importance of tackling loneliness and social isolation as part of a whole-place approach to preventing ill health and inequalities.

End of life Care

40. Continue to promote councils' role and responsibilities in end of life care through the national Ambitions End of Life Partnership and membership of the new NHS Palliative and End of Life Care Programme Board. Share good practice in end of life care and support, including during the pandemic, building upon our forthcoming practical guide joint with ADASS.

Personalisation

41. Personalisation is a theme running throughout the LGA's work. Specifically, we will continue to promote personalised care, coproduction and user/carer engagement to councils. We will continue to be an active member of the Think Local Act Personal Partnership in order to shape policy and practice in self-directed support.

Housing and social care

42. We will work with the Environment, Economy, Housing and Transport Board to:
    - 41.1 Make the case for capital funding to boost supply of supported housing for people in vulnerable circumstances, including older people (extra care housing) and working age adults (specialised supported housing).
    - 41.2 Continue to make the case for the housing and support revenue costs of supported housing to be fully and sustainably funded.
    - 41.3 Argue for a locally led and fully funded approach to improving oversight of support housing as the best way to improve quality and value for money.
    - 41.4 Press for a further increase of the Disabled Facilities Grant to adapt existing housing stock to help older and disabled people live independently in their own homes for longer and prevent escalation of need and hospital admissions.
    - 41.5 Respond to the Government's current consultation on raising the accessibility standards of new homes.

Armed Forces Covenant

43. We will continue to support councils to meet their obligations under the Armed Forces Covenant, which every council has signed, so that serving personnel, veterans and their families receive good quality, co-ordinated and person centred support and advice. Through the LGA's national network of Armed Forces Covenant officers, we will continue to influence the development of the Ministry of Defence's new statutory duty on public authorities to have 'due regard' to the Armed Forces Covenant, and press Government to fully fund the New Burdens on councils.

Sleep-ins in social care

44. At the time of writing, we are still awaiting the Supreme Court decision in the Unison Appeal about whether 'sleep-in time' should be classified as working time, and therefore be subject to the requirements of the National Minimum Wage Regulations 2015. Our

long-standing position is that we support fair pay for care workers, and whatever the outcome of the Unison Appeal, there is a need to ensure that social care staff are paid fairly for their valuable work. We will continue to work with the Children and Young People's Board, the Resources Board, ADASS and ADCS to prepare for the judgment and support councils to understand and respond to the implications.

Asylum, Refugee and Migration

45. The LGA Asylum, Refugee and Migration Task Group also reports to both the Community Wellbeing Board and the Children and Young People's Board. The Task Group will continue to push for clearer alignment between and sustainable funding for all the programmes that resettle asylum seekers and refugee, with regular updates to be provided to the Board.

Financial implications

46. This programme of work will be delivered with existing resources.

Next steps

47. Following the Board's discussion, officers will prepare a detailed work programme to manage the day to day work. The priorities agreed by the Board will also be reported back to the LGA Executive, which oversees the work of the policy Boards and includes the Community Wellbeing Board Chairman as part of its membership.

Local Government Association

Update on other board business

Purpose of report

For information.

Summary

This report sets out other updates relevant to the Board, and not included elsewhere.

Recommendations

Members of the Community Wellbeing Board are asked to:

1. **Provide oral updates** on any other outside bodies / external meetings they may have attended on behalf of the Community Wellbeing Board since the last meeting; and

2. **Note** the updates contained in the report.

Action

As directed by members.

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Local Government Association

Update on other board business

Test, Trace and Outbreak Management

1. The LGA Test, Trace and Outbreak Management Team have facilitated a series of webinars in collaboration with the Department of Health and Social Care (DHSC). The webinars have been a platform for councils to share their learning from their experience responding to local outbreaks. They have also served as an opportunity for Chief Executives, Directors of Public Health, councillors and council officers to directly raise questions with DHSC and their partners. Shared learning from these webinars, Q&A sets produced after, and any other related resources can be found on the Testing, Contact Tracing and Outbreak Management Khub. The webinars facilitated so far, in chronological order are the following:

   1.1 **Outbreak Management: Food Processing - Experiences, Lessons Learned, and the Role of the HSE**
   1.2 **Testing Prototypes, Communications and Engagement**
   1.3 **Data for Local Outbreak Planning**
   1.4 **Local testing and contact tracing systems: local innovation and lessons learnt**
   1.5 **The reopening of universities: supporting councils with the implications for local areas**

The National Institute for Health Protection and other public health functions

2. The Secretary of State for Health and Social Care's announced on 18 August 2020 the creation of a brand-new organisation to extend the existing science-led approach to public health protection – the National Institute for Health Protection (NIHP). The NIHP will bring together the existing health protection responsibilities discharged by Public Health England (PHE) with the new capabilities of NHS Test and Trace, including the Joint Biosecurity Centre, creating a single agency. As the NIHP develops the government will also need to establish the right future system and organisational arrangements for improving the health of individuals and our population. The impact of Covid-19 on key groups of the population has highlighted the importance of levelling up health to support future resilience.

3. The DHSC have established a new Population Health Improvement Stakeholder Advisory Group to provide expert advice to Ministers on this aspect of the Improvement work from representatives from public health, local government and health care. This Group will input into a high-level options paper to be published in October. Cllr James Jameison, represents the LGA on this group along with local government colleagues from SOLACE and the Association Directors of Public Health.

4. The reform of public health agencies in the middle of a pandemic is not with risk. Board members can read an article by the Chair setting out the LGA's views on the public health reforms here https://www.lgafirst.co.uk/features/public-health-reforms/

Local Government Association

Roll out of HIV Prevention Drug (PrEP)

5. The Government has announced the PrEP grant determination for 2020-21, which means councils in England can finally provide uncapped access to the game-changing HIV prevention drug. This was delayed due to the COVID-19 epidemic but the roll-out of PrEP (pre-exposure prophylaxis) will begin from 1 October.

6. LGA fully supports using PrEP as part of an effective HIV prevention strategy. Local authorities have invested hundreds of millions in providing sexual health services since taking over responsibility for public health seven years ago, and we firmly believe that PrEP could significantly reduce levels of HIV in the community. This is a potentially life-saving drug which can help us achieve the Government's ambition of getting us closer to zero transmission by 2030.

7. In 2016, the LGA were 'Interested Parties' in a High Court and subsequently Appeal Court action between the National AIDS Trust and NHS England.

People in vulnerable circumstances

8. **Mental health, wellbeing and suicide prevention** – our focus since the last Board has been on supporting the mental health and wellbeing COVID-19 response:

   8.1. Produced briefings, practical support and shared good practice on public mental health and tackling loneliness and social isolation in partnership with the Association of Directors of Public Health (ADPH). We have also fed into the Ministry of Housing, Communities and Local Government's (MHCLG) 'Tackling Loneliness' work.

   8.2. Worked with the Department of Health and Social Care (DHSC), the Department for Education (DfE), Public Health England, NHSE/I, NHSX and the voluntary sector to help ensure that national guidance and tools complement and reflect locally led activity, that local government's voice was represented on various national mental health and wellbeing 'cells' and linked to the mental health subgroup of the Adult Social Care Taskforce.

   8.3. Joint meeting CWB Lead Members, CYP Lead Members and the Emotional Wellbeing Steering Group to give a steer on mental health and wellbeing priorities. Members identified particular concern about the impacts on 14 to 25-year olds, which has been taken forward in our policy work and forthcoming practical resources for councillors.

   8.4. With the Centre for Mental Health, published Our Place, substantial new research that examined how nine councils are promoting good mental health and preventing poor mental health in communities, including early learning from COVID-19.

8.5. Worked with partners to produce advice, guidance and support to help councils to respond to and manage the different wellbeing needs of staff, including those staff working remotely at home; keyworkers and other frontline council staff who remain at work in our communities; social care staff; and schools/teaching staff who remain at work or who are providing more remote/online teaching.

8.6. Emphasised the need for a continued focus on safeguarding vulnerable people's human rights as Government considered the impact of the pandemic on mental health legislation.

8.7. Continued to make the case for a locally led all ages and whole family / household approach to mental health and wellbeing, including to the Inter-Ministerial Mental Health COVID-19 recovery group. Highlighted how much universal services, such as playgrounds, open spaces, libraries and general opportunities for play and social interaction are necessary for good mental wellbeing for all ages. Also highlighted the importance of a locally led approach in recognition that some people are at greater risk of the mental health impacts of COVID-19 than others, and that targeted support was (and continues to be) needed.

8.8. Cllr Richard Kemp represented the LGA at the National Suicide Prevention Strategy Advisory Group and the Suicide Prevention and Self Harm APPG, highlighting the need for DHSC to swiftly release funding for the 2020/21 LGA/ADPH sector led improvement programme.

9. **Armed Forces Covenant** – the Government's manifesto includes a commitment to further enshrine into law the Armed Forces Covenant in order to address Ministerial concern that members of the armed forces are still suffering disadvantage in accessing public services. A 'duty to have due regard' to the Armed Forces Covenant will be placed on housing, education and health services. Over the summer we worked with our network of Armed Forces Covenant Officers and the Ministry of Defence to ensure that councils have a genuine opportunity to shape the plans and to understand potential New Burdens. This work is ongoing.

10. **Housing** – supported housing providers and commissioners have been on the frontline of the COVID-19 response. We have worked with our network of supported housing advisers to identify operational concerns and feed them into Government. Due to civil service re-deployment, we have been unable to progress policy work, but this is now re-starting. We understand the Government's Supported Housing National Statement of Expectation will shortly be published. Councils are increasingly concerned about the interface between supported housing and the benefit system. Technicalities in the Housing Benefit regulations mean that some councils are picking-up a significant shortfall in housing benefit subsidy. We will shortly publish a joint LGA/ADASS/NHSE advice note for local commissioners in response to the Social Housing Regulator's concerns about specialised supported housing funded by the lease-based model and are raising councils' concerns about artificially inflated rents and quality concerns for some properties.

Local Government Association

11. We have updated, and will shortly re-publish, the joint LGA/ADASS/Age UK/Care and Repair England guide to accessible housing in response to COVID-19.

12. **Sleep-ins** – while awaiting the Supreme Court decision in the Unison Appeal about whether 'sleep-in time' should be classified as working time, and therefore be subject to the requirements of the National Minimum Wage Regulations 2015, we have continued to work with councils, ADASS, DHSC, ADCS, DfE and providers to plan for the possible outcomes. We have continued to emphasise Members' position that we support fair pay for care workers, whatever the outcome of the Unison Appeal.

13. **National Autism Strategy** – The government are aiming to publish the national autism strategy by the end of 2020. The strategy will be for adults and children. We have continued to work with the DHSC to feed into the national autism strategy. We have submitted a response to the DHSC proposed priorities based on the key priorities for social care identified by the LGA and ADASS. We will continue to feed into the strategy as it is developed, and we will identify any new burdens or sector support needs arising from its implementation.

14. **End of Life Care** – In September, we published our guide for councils on end of life care in partnership with ADASS. This guide was begun in early 2020 and was nearing completion in March 2020. It has been revised to reflect the new challenges posed by the COVID-19 pandemic. The guide seeks to help councils play a leading role in how people in their local areas experience end of life care, including during the pandemic.

15. **Healthy ageing** – In September, Cllr Hudspeth chaired a Webinar on Healthy Ageing with Sir Muir Grey, Director of the Optimal Ageing Programme and Alison Giles, Associate Director of the Centre for Ageing Better. The Webinar looked at the challenges and opportunities of an ageing society, with preference to the impact of COVID-19, and how councils can contribute to healthy ageing.

Asylum, Refugee and Migration

16. The LGA Asylum, Refugee and Migration Task Group met with Chris Philps MP, Minister with responsibility for immigration, on 22 September to discuss joint work across local and central government on supporting adult and child asylum seekers. The Task Group reports to the Community Wellbeing and Children and Young People's Board, is chaired by Cllr Nick Forbes, and is attended by LGA lead members and regional representatives from across the UK.

Local Government Association

COVID-19 Adult Safeguarding Insight Project: Findings and Discussion (September 2020)

17. The Insight project was developed to create a national picture regarding safeguarding adults' activity during the Covid-19 pandemic. Local insight and data on safeguarding activity was requested on a voluntary basis and 92 (over 60%) of local authorities participated. A report has been drafted from the collated data and commentaries and is attached at **Appendix A** in the private report pack. The report has been discussed at the ADASS Safeguarding Adults policy Network meeting, Adult Social Care Hub Safeguarding workstream meeting, verbally reported to the National Network of SAB Chairs meeting and the work has been both welcomed and supported.

18. The report covers the period up until the end of June 2020. Feedback from participants and consultees was that this was inadequate to ascertain the impact, particularly Section 42 enquiries. A proposal to extend this project for a further 3 months, or longer, was broadly supported. Proposals have been agreed by the Adult Social Care Data and Outcomes Board for NHS Digital to undertake a non-statutory half year collection regarding the first six months of 2020/21, which would include some Safeguarding Adult Collection items. The data would be less detailed than that collected through the Insight project. The LGA's Care and Health Improvement Programme (CHIP) and NHS Digital are working closely together to ensure the two approaches are aligned and do not unnecessarily duplicate work for local authorities.

19. CHIP senior management team has agreed to:

    19.1. co-badge the report, using both LGA and ADASS logos (subject to agreement by ADASS Trustees);
    19.2. publication of the report on the LGA website;
    19.3. dissemination through relevant bulletins;
    19.4. development of presentations for webinars etc based on the content;
    19.5. circulation as a word document pending design (due to potential delays);
    19.6. to sharing anonymised comparative regional data with regions (through regional safeguarding leads); and
    19.7. supporting continued voluntary data collection with a follow up report following further collation and analysis.

National Report on Safeguarding Adults Reviews (SARs) and Executive Summary

20. The CHIP safeguarding workstream commissioned Suzy Braye, Michael Preston-Shoot and Research in Practice to undertake a review of SARs published in 2018/18 and 2918/19 to inform future priorities for sector led improvement in safeguarding adults' practice. This is a 'once in a decade' opportunity to identify learning from SARs at a national level, as there is no regular reporting mechanism.

Local Government Association

21. The draft full report was discussed at the ADASS Safeguarding Policy Network and Adult Social Care Hub meetings mentioned above, as well as circulated to the Chief Social Worker for Adults (and is attached as **Appendix B** in the private report pack). The findings have been verbally reported to the National Network of SAB Chairs meeting and the work has been both welcomed and supported. The full report is lengthy and academic, reflecting the considerable work that has been undertaken, the range and depth of analysis. The 6-page Executive Summary has been developed and is also attached as **Appendix C**. It is planned to provide targeted briefings (for members, practitioners, Safeguarding Adults Boards, etc) with an offer of webinars for a range of audiences, including the ADASS regions, to disseminate the findings. This will also provide opportunities for engagement and consultation on the sector led improvement priorities.

22. The priorities for improvement will subsequently be developed into a plan, which will inform the work of the CHIP adult safeguarding workstream in 2021/22 and beyond.

23. CHIP senior management team agreed to:

    23.1. co-badge the report and summary, using both LGA and ADASS logos (subject to agreement by ADASS Trustees);
    23.2. publication of the report and summary on the LGA website and dissemination through the relevant bulletins, and development of targeted briefings and presentations for webinars etc based on the content; and
    23.3. circulation as Word documents pending design (due to potential delays) due to the level of sector interest in the detailed report.

Making Safeguarding Personal (MSP) Outcomes Framework 2019/20

24. The MSP Outcomes Framework project continued during 2019/20, with project management support from NHS Digital. The report on the work comprises of a summary covering paper (**Appendix D**) and a power point slide presentation from the project manager (**Appendix E**). This project is currently paused for 2020/21 due to Covid-19.

Annual Report of National Safeguarding Adults Board Chairs Network 2018/19

25. The previous annual reports of the Network have been published on the LGA website as the Network does not have its own website. The 2018/19 report (see **Appendix F**) was delayed due to changes in the Network Co-ordination role and has not been presented previously.

Document is Restricted

Document is Restricted

Analysis of Safeguarding Adult Reviews April 2017 – March 2019
Findings for Sector Led Improvement

Michael Preston-Shoot, Suzy Braye, Oli Preston, Karen Allen and Kate Spreadbury

Executive summary

Introduction: This first national analysis of SARs in England has been funded by the Care and Health Improvement Programme, supported by the Local Government Association and the Association of Directors of Adult Social Services. Its purpose is to identify priorities for sector-led improvement. This short summary identifies the headline findings and provides an outline of the eleven sections of the main report, to which readers can turn for further detail. Building on published regional thematic reviews and analyses focusing on specific types of abuse and neglect, the analysis fills a significant gap in the knowledge base about adult safeguarding across all types of abuse and neglect.

Methodology: Material for analysis was collected from SABs, 98% of which (129/132) responded to requests for published and unpublished reviews completed between 1st April 2017 and 31st March 2019. This material was triangulated with SARs available in the national repository held by the Social Care Institute for Excellence, and from SAB and other web sites. In total 231 SARs are included in the analysis[1]. A data collection framework tool[2] was used to gather structured and unstructured data, which were subject to quantitative[3] and qualitative thematic analysis[4].

SAB Governance of SAR Decision-Making: Findings relating to SABs' management of the complete SAR process are compared and contrasted with their powers and duties codified in Section 44, Care Act 2014 and amplified in statutory guidance[5]. Findings are also analysed against the standards outlined in quality markers[6]. The result is a set of key questions to guide SABs and SAR authors in their decision-making from referral through commissioning, choice of methodology and approach to family involvement, to quality assurance, publication, action on recommendations and reporting.

Key Questions for SABs and SAR Authors

1. Has decision-making about SAR referrals clearly distinguished between mandatory and discretionary reviews?
2. How timely has decision-making been regarding responses to referrals?
3. What types of abuse and/or neglect are the main and secondary focus in each SAR?
4. What methodology has been chosen and why?
5. What methods for gathering and exploring information have been chosen and why?
6. What positive and negative reasons for delay have impacted on the SAR process?
7. Have services and agencies cooperated as required[7]?
8. What approach has been taken to subject and family involvement?
9. Do annual reports provide information about SARs in progress and completed, their findings and the actions taken in response to those findings, as required in statute?
10. How has SAR quality been assured?

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[1] Representing the work of 103 SABs. 22% of SABs (29/132) did not complete a SAR during this period.
[2] Managed using Smart Survey.
[3] Using the R programming language and Microsoft Excel.
[4] In the main report the quantitative analysis is presented both nationally and by region.
[5] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office.
[6] Social Care Institute for Excellence and Research in Practice for Adults (2018) *Safeguarding Adult Review Quality Markers Checklist*. London: SCIE.
[7] Section 44(5) Care Act 2014.

11. How has the SAB captured the outcomes of action taken to implement SAR recommendations?
12. Have the reasons for decisions at all stages of the SAR process been recorded?

The 231 reviews in the sample investigated a range of types of abuse and neglect, sometimes including multiple types per case[8], the most common being self-neglect.

Type of abuse/neglect	Reviews n	%	Type of abuse/neglect	Reviews n	%
Self-neglect	104	45.02%	Sexual abuse	12	5.19%
Neglect/omission	85	36.80%	Sexual exploitation	5	2.16%
Physical abuse	45	19.48%	Modern slavery	2	0.87%
Organisational abuse	33	14.29%	Discriminatory abuse	2	0.87%
Financial abuse	30	12.99%	Other	11	4.76%
Domestic abuse	22	9.52%	Not specified	29	12.55%
Psychological abuse	19	8.23%			

Modern slavery, sexual abuse, and sexual exploitation occurred more prevalently in younger subjects, whereas neglect and abuse by omission occurred more in older subjects. Psychological/ emotional abuse and modern slavery are more prevalent for females, whereas financial, physical abuse and self-neglect are slightly more prevalent for males.

No direct correlations were found between the types of abuse and neglect that become the focus of SARs and those referred for adult safeguarding enquiries[9], but there were regional variations in the prevalence of section 42 enquiries and the prevalence of SARs. Some types of abuse and neglect are positively associated with one another. For example, domestic, financial, physical and emotional abuse consistently occur together. Conversely, some types of abuse, such as self-neglect and neglect/omission, appear unrelated to all other types.

Cases: There were 263 SAR subjects[10] [11], 81% of whom had died, a finding much in line with previous thematic reviews[12]. There were slightly more male subjects (129) than female (109) with regional variations. The average age was 55, varying significantly by region. Comparison with Section 42 data shows that the subjects of SARs are more likely to be younger and male, Section 42 subjects older and female. Few SARs provide information about, or analyse, the impact of sexuality and ethnicity.

A range of health concerns are reported, the most common being mental health and chronic physical conditions; there is complex interplay between physical comorbidities and between physical and mental ill-health, sometimes related to significant life events. The most common living situations were living alone and in group care; the most common location for the abuse/neglect was the person's own home (48%), followed by residential/nursing care (18%). The most common perpetrator of abuse was 'self' (48%)[13], followed by care providers (30%). Noteworthy here, because of Government criticism[14] that SARs have paid too little attention to the deaths of people sleeping on the streets, is the inclusion in the sample of 25 cases (11%) where adults were or had been homeless. In relation to whether criminal prosecutions had been pursued, in the majority of cases (54%) they had not, and a further 29% of the reports did not specify. However, in 37 cases (16.2%)

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[8] The total is therefore higher than the number of SARs.
[9] Section 42 Care Act 2014.
[10] Some SARs had multiple subjects.
[11] 129 men, 109 women, 1 transgender, 24 other/not stated.
[12] For example, Braye, S. and Preston-Shoot, M. (2017) *Learning from SARs: A Report for the London Safeguarding Adults Board*. London: ADASS.
[13] Due to the high proportion of self-neglect cases in the analysis.
[14] https://www.gov.uk/government/publications/the-rough-sleeping-strategy

prosecution had concluded, with custodial sentence being the most common outcome, and in a further 4 cases no conclusion had yet been reached. The theme of imprecision is noted again, with reports omitting details of outcomes or of the reasons for investigations being discontinued, but the analysis also highlights the importance of collaboration between those investigating abuse and neglect to ensure a clear focus on how to achieve best evidence.

Themes and Recommendations: This section of the main report presents quantitative data on SARs' observations on good and poor practice and the recommendations they make for service improvement[15]. These are categorised across four domains: direct practice with the individual, interagency working, organisational features, and SAB governance, with each domain containing a number of themes. Extracts from the tables are given below to show, for each domain, the most prominent good practice and poor practice themes[16 17].

Top good practice themes Direct work		**Top poor practice themes Direct work**		**Top recommendation themes: Direct work**	
Responding to health	56	Mental capacity	138	Risk assessment	72
Personalisation	53	Risk assessment	134	Mental capacity	64
Continuity	37	Safeguarding	115	Working with caregivers	62
Care/support assessment	36	Working with caregivers	111	Care/support assessment	56
Safeguarding	32	Care/support assessment	110	Personalisation	47
Mental capacity	32	Responding to health	99	Responding to health	45

Top good practice themes Interagency work		**Top poor practice themes Interagency work**		**Top recommendation themes: Interagency work**	
Information-sharing	53	Case coordination	168	Case coordination	126
Case coordination	45	Information-sharing	162	Information-sharing	96
Safeguarding	37	Safeguarding	115	Safeguarding	76
Legal literacy	5	Procedures	53	Procedures	54
Record sharing	3	Legal literacy	44	Record sharing	27

Top good practice themes Organisational features		**Top poor practice themes Organisational features**		**Top recommendation themes: Organisational**	
Management oversight	10	Staffing/workloads	64	Training	90
Commissioning	6	Management oversight	63	Commissioning	65
Access to specialist advice	4	Training	54	Quality assurance	48
Staff support	4	Resources	49	Policy/procedures	42
Quality assurance	4	Commissioning	49	Records/recording	38

Top good practice themes SAB governance		**Top poor practice themes SAB governance**		**Top recommendation themes: SAB governance**	
SAR management	3	Self-neglect policy	15	Dissemination of learning	75
SAB policy/procedures	2	Escalation policy	14	Quality assurance	50
Dissemination of learning	1	Risk assessment policy	9	Training	39
Membership	1	SAR management	9	Self-neglect policy	34
Training	1	Mental capacity policy	8	Other policy/procedures	33

Three further sections of the main report, namely **Good Practice**, **Poor Practice**, and **Recommendations**, provide the findings of the qualitative thematic analysis across the four domains to accompany the quantitative analysis above, drawing on examples and evidence from specific

[15] The data are also available by region.
[16] Note that SARs can make recommendations relating to one domain based on practice identified in another (for example poor practice in direct work can result in an organisational recommendation).
[17] The main report shows the full range of different themes within each domain.

SARs. The concerns that are highlighted across the four domains, and the recommendations made in response, are not new and have been raised in previous thematic reviews[18]. The findings pose two questions for SABs, their partners and SAR authors, namely:

- Are we making sufficient use of the available evidence from SARs and from research when analysing the facilitators that enhance and the barriers that impede good practice?
- Are we learning what still needs to be achieved locally and nationally to provide the best context for preventing and protecting individuals from different types of abuse and neglect?

SABs should reflect individually, regionally and nationally on what makes adult safeguarding so challenging and change so apparently difficult to achieve. Strategic business plans should be informed by the outcomes of this reflection.

There is a trend towards all recommendations being addressed to the SAB, giving it the responsibility for determining which (combination of) agencies should lead on implementing particular findings. The theme of imprecision is noticeable here. There were 10 SARs where recommendations were directed to "partner agencies" without specificity as to which services were included in this phrase. There were also occasions when recommendations were directed to "health". It is more helpful for SABs when report authors are clear about which agencies they believe should lead on implementing particular recommendations.

The analysis of the recommendations concerned with direct practice are analysed partly through the lens of the six adult safeguarding principles outlined in the statutory guidance. The recommendations that are directed specifically at SABs are analysed through the lens of the roles and responsibilities that have been articulated for Boards in the same statutory guidance. The SAR process does not end, however, with the recommendations. Some SARs explicitly acknowledged this by listing the changes that had already been made to local policies, procedures and practices as a result of emergent learning from the review process. Annual reports should be capturing improvements and enhancements arising from SAR outcomes. When further cases of types of abuse and neglect are referred for review, these present an opportunity to review what changes have been achieved and what further work remains to be done.

National Legal and Policy Context: All adult safeguarding is situated in this context. The Quality Markers[19] advise SABs to consider which SAR findings would be better addressed in national, regional or other forums, yet there is concern that SARs have given insufficient attention to this domain, even though practice and policy locally are profoundly shaped and influenced by the national legal, policy and financial context within which they are situated[20]. Less than one quarter of SARs in this analysis make reference to this context, for example the impact of financial austerity on the range of services available and on the increasing number and complexity of cases referred to practitioners. SARs miss opportunities to highlight both where other reviews have focused on similar concerns, such as abuse in closed institutions, and where revisions to the legal rules and/or national policy could strengthen adult safeguarding provision.

Conclusions and Reflections: The concluding reflections signpost further research and analysis that would sustain the work begun in this national report. It highlights again the importance of analysing

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[18] For example, see Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews.' *Journal of Adult Protection*, 17, 1, 3-18.

[19] Social Care Institute for Excellence and Research in Practice for Adults (2018) *Safeguarding Adult Review Quality Markers Checklist*. London: SCIE.

[20] Preston-Shoot, M. (2017) 'On self-neglect and safeguarding adult reviews: diminishing returns or adding value?' *Journal of Adult Protection*, 19(2), 53-66.

cases through the lens of an available evidence-base, this time drawing on “seminal” reviews to pose and begin to answer the question of what else adult safeguarding needs to learn about, for example hate crime, organisational abuse or self-neglect when creating a national and local context in which best practice can thrive. However, it is important to remember that SARs do also comment on good practice and to recognise that much adult safeguarding practice is unheralded, person-centred and committed to empowerment, prevention and protection. This analysis has taken place in the midst of the Covid-19 pandemic which, in many respects, has shown the very best of health and social care staff, emergency services and other practitioners on whom people at risk of abuse, neglect and significant harm rely.

Sector-Led Improvement Priorities: The findings of this analysis give rise to priorities for sector-led improvement. They are clustered below within five main categories and numbered in the order in which they arise in the main report, for ease of cross reference. Some are priorities that should already be standard good practice and therefore require reinforcement. For others, additional resources will be required[21].

1. SAB practice on the commissioning and conduct of SARs (priorities 2, 4, 5, 6, 7, 8, 10, 14, 18, 20)

2: SABs should review their record-keeping to ensure that completed SARs remain in the collective memory and available as a baseline against which to measure subsequent policy and practice change.
4: The SAR quality markers should be reviewed and completed, informed by the findings of this national analysis. After dissemination of the revised quality markers, SABs should be asked to report on how they have been used to enhance the SAR process.
5: SABs should be asked to provide reassurance that partner agencies understand the relevant legislation regarding referral and commissioning of SARs.
6: Regional and national SAB networks to be used to review approaches to the interpretation and application of section 44 Care Act 2014 in decision-making about SAR referrals.
7: SABs should review their governance procedures for SARs and ensure that referrals and decision-making are timely, with meeting minutes and reviews clearly noting the reasons for positive or negative delay.
8: SABs must ensure that SARs identify the types of abuse and neglect within cases being reviewed.
10: SARs should give a full account and offer a reflective analysis of the methodology used. The quality markers should be revised to emphasise the importance of methodological rigour.
15: SAB should review their reporting of SARs in annual reports to ensure compliance with the requirements of statutory guidance and the imperatives that learning is embedded, and the impact and outcomes of reviews evaluated.
18: SABs should review their approach to ensuring the quality of reports.
20: This research highlights the need for better recording of ethnicity in SARs. Terms of reference for all SARs must include consideration of how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management.

2. Supporting sector-wide learning from SARs (priorities 1, 3, 11, 13, 19, 29)

1: The future of the national library of SARs should be secured, with SABs committed to depositing completed reviews therein, and technology developed to enable searching by types of abuse and neglect.
3: SABs locally and regionally adopt the data collection tool as the basis for learning from SARs.
11: Regional and national networks provide a space where SABs can discuss learning regarding a proportional and change-oriented approach to cases involving types of abuse and neglect that have previously been the subject of local reviews.
13: Regional and national networks provide a space where SABs can discuss and disseminate learning from experiences of subject and family involvement in SARs.
19: Sector-led improvement to engage with SABs to capture the impact of review activity.

[21] The report’s authors believe that improvement priorities that are new resource-dependent are: 1, 4, 12, 17, 19, 21, 22 and 28.

29: SABs locally, regionally and nationally should be leading a continuing conversation that seeks to address the questions that arise out of the poor practice reported by SARs.

3. Support for adult safeguarding practice improvement[22] (priorities 16, 17, 21, 22, 23, 24, 25, 26)

16: The national SAB network should engage with DHSC, ADASS, NHS England and Improvement and other national bodies responsible for services whose roles include adult safeguarding to reinforce agency and service compliance with their duties to cooperate and share information.
17: Sector-led improvement to explore further work on the interface between section 42 and section 44 Care Act 2014: (a) to inform understanding of routes that provide best learning in cases involving people who have survived abuse and neglect, and (b) to inform initiatives to strengthen practice in the category of abuse and neglect most over-represented in section 44 statistics (i.e. self-neglect).
21: Consideration should be given to the dissemination of briefings on good practice regarding all forms of abuse and neglect but especially those newly highlighted by the Care Act 2014 within adult safeguarding, such as domestic abuse, modern slavery and discriminatory abuse (hate and mate crime).
22: Briefings should be published for practitioners and managers on the implications for best practice in adult safeguarding of the requirements of the Equality Act 2010.
23: In light of the reporting by SARs of poor practice in direct work with adults at risk, SABs should review (in local, regional and national discussion) how they seek assurance on practice standards and contribute to improvement across their partnerships, working to the priorities set out in the main report.
24: In light of the reporting by SARs of poor interagency working, SABs should review (in local, regional and national discussion) how they seek assurance on standards of interagency practice and contribute to improvement across their partnership, working to the priorities set out in the main report.
25: In light of the reporting by SARs of concerns about how organisations support safeguarding practice, SABs should review (in local, regional and national discussion) how they seek assurance on organisational systems, culture and resources, and contribute to improvement across their partnership, working to the priorities set out in the main report.
26: In light of the consistency of recommendations in SARs across all four domains of analysis, appearing to replicate those made in earlier reviews, SABs should review (in local, regional and national discussion) how they seek assurance on practice standards and contribute to service and policy improvement and enhancement across their partnerships.

4. Revision to national policy/guidance (priorities 9, 14, 27)

9: In light of the findings from this national analysis, the statutory definitions of types of abuse and neglect should be revisited and, if necessary, revised to ensure that they fully capture the developing understanding of the contexts in which adult safeguarding concerns and risks emerge.
14: Statutory guidance should be revised to indicate when the time period for a SAR commences.
27: SABs, regionally and nationally should discuss the role of SARs in sharing learning with and holding central government departments and national regulatory bodies to account when findings require a response that is beyond the scope of SABs locally to implement.

5. Further research (for example through the NIHR research programme) to inform sector-led improvement initiatives (priorities 12, 28)

12: Comparative research should be commissioned to highlight the effectiveness of different review methodologies.
28: Projects should be commissioned to develop the evidence-base for good practice with respect to preventing, and protecting people from, particular types of abuse and neglect, working to the priorities set out in the main report.

[22] Drawing also on the roles of designated named professionals in healthcare and safeguarding leads such as Principal Social Workers in local authorities, as set out chapter 14 of the statutory guidance.

Local Government Association

Appendix D

Making Safeguarding Personal Outcomes Framework Project Summary 2019/20

The Making Safeguarding Personal Outcomes Framework (MSPOF) was developed to provide a means of promoting and measuring practice that supports an outcomes focus and person led approach to safeguarding adults. The framework aims to inform practitioners, teams, councils, Safeguarding Adults Boards (SABs) and their partners regarding the extent to which they are making a difference to the safety of people who are at risk of, or who have suffered, abuse or neglect in their area. It is hoped that the framework will enable councils and SABs to better identify how practice is impacting on outcomes, indicate areas for improvement, enable bench marking and share best practice and learning.

The slides attached provide a summary of the activity undertaken during 2019/20, along with the output from 2 workshops that focused on the qualitative aspects of the MSPOF (see below)

The MSPOF framework itself consists of seven questions, including the MSP voluntary return that is part of the annual data collection process undertaken by NHS Digital. The framework was endorsed by the Association if Directors of Adult Social Services (ADASS) Executive and Local Government Association (LGA) in June 2018 and publicised in the ADASS Bulletin in July 2018. (see https://www.adass.org.uk/media/6526/msp-outcomes-framework-may-2018-framework.pdf)

During 2018/19 Councils were invited to join the pilot implementation phase and the focus of the project was on supporting them to use the framework and develop a national reporting mechanism using the LG Inform system as a vehicle for sharing data. The key deliverables for 2018/19 in summary were: implement the MSPOF; developing a national mechanism for collecting and collating data, using LG Inform; and identifying which IT systems can support the MSPOF and which cannot.(see https://www.local.gov.uk/making-safeguarding-personal-outcomes-framework-project-summary-report-201819).

Due to Covid-19 the MSPOF project was paused. Participants were asked what they wanted to achieve in 2020/21 and what support might be helpful in changed circumstances. Those that responded said that they did not have the capacity to participate at present. However, there continues to be occasional enquiries regarding the project and interest in participation.

Update report on Making Safeguarding Personal (MSP) outcomes framework workshops 2019

Two workshops have been held, one in London and one in Manchester c.60 delegates across both, the majority had not attended the March 2019 workshops.

An emerging theme from both workshops was about how information gets cascaded to the correct people, when using the Safeguarding Adult Board (SAB) managers, or SAB Chairs

networks it was felt important to clearly mark who the information is aimed at. Regional safeguarding leads were felt to be a good conduit for information also.

At the London event all the delegates signed up to become pilot sites- those details will be forwarded to the project lead. Delegates at the Manchester event were more circumspect, with most wanting to check back in their organisation before committing. Delegates remained unaware that they could complete partial returns for the MSP Outcome Framework.

In asking what would support the programme moving forward, opportunities to share and discuss were again highlighted. A key way to do this was felt to be the reinvigoration of the LGA Knowledge Hub, and for that to be "the" place to host information. Face to face workshops and conferences were also felt to be of value, with perhaps this being broadly about the implementation of MSP, rather than a focus on the framework.

There was a request for a briefing to boards that "sells" the value of the MSP outcomes framework, what it is for, and how they can use it.

Practice is still not felt to be reflecting true MSP, and part of the issue is with language, and organisations still using "old" safeguarding language, while this is happening there was a view that we will struggle to change the culture. Articulating that MSP reflects the core values of social work and the embedding of Human Rights in practice would support the development of practice.

There was a request for clarity on the programme, what is the intended length of Phase Two, and what will happen after that.

In asking what enables using the framework (or makes it of value) delegates said:

- Can compare to see in moving in the right direction (this was not shared in the Manchester workshop where the value of using the framework for comparison purposes was questioned)
- Can network with other areas to see what doing differently (this was not shared in the Manchester workshop where the value of using the framework for comparison purposes was questioned)
- Mandatory questions within the forms
- Relevance of question (seeing the value)
- Using the information from audits to inform responses
- Effective uses of the information by the boards
- Incentives for completion
- Working with independent organisations to gather feedback
- Opportunities to network with others

- Events and conferences

Barriers to completing the framework that were identified included:

- IT systems which don't support the framework, or that don't communicate with each other
- Framework fatigue
- Understanding of MSP
- Time and resource to gather the information
- Lack of engagement of partner agencies
- Professional nervousness about gathering feedback.
- Recording processes which then become data drive rather than person-led
- Subjectivity and interpretation of feedback from people
- Lack of knowledge of MSP at the practice level
- The way in which the board may use the framework

Local Government Association

directors of adass adult social services

Making Safeguarding Personal Outcomes Framework (MSPOF)

Review of 2019/20 Expansion and Development Project

Author
Dominic Gair, Secondee with the Local Government Association (LGA)

Care and Health Improvement Programme

Background

Making Safeguarding Personal (MSP) is a sector led initiative which aims to develop a personalised and outcomes focused approach to adult safeguarding work, and a range of responses to support people to improve or resolve their circumstances. Additional information on MSP maybe found here.

An exercise known as the MSP Temperature check was undertaken in 2016 by the Association of Directors of Adult Social Services (ADASS), to examine local authority progress in implementing MSP. A number of recommendations were made from this exercise, which included the development of a MSP outcomes framework (MSPOF). Research into Practice for Adults (RiPfA) and the Institute of Public Care (IPC) were commissioned by ADASS, on behalf of the Local Government Association (LGA) Care and Health Improvement Programme, to work with stakeholders to create the framework which was endorsed and publicised by LGA and ADASS in June 2018 found here

In 2018/19 a pilot was undertaken to test the implementation of a voluntary national MSPOF data collection and reporting framework that would provide timely information to health and care practitioners and Safeguarding Adults Boards (SABs) to:

- Improve outcomes for vulnerable adults with care and support needs at risk of abuse or neglect
- Indicate areas for improvement in safeguarding practice
- Enable a robust mechanism for benchmarking and comparing results across in a consistent and standardised way
- Share good practice from local areas

A report on the voluntary activity of the MSPOF project 2018/19 is available here

2019/20 Expansion and Development Project

Following the successful pilot project in 2018/19, which established the viability of a national MSPOF voluntary data collection, feedback was received highlighting the potential for operational benefits locally. A business case was drafted to continue the project beyond the pilot phase. However this recognised further work was needed to increase the benefits and reduce the barriers to participation.

In July 2019 a new phase of the wider project titled Expansion & Development of the MSPOF was proposed and accepted by the MSPOF project Task and Finish Group.

This presentation provides a review of the progress that has been made during 2019/20 period and how these relate to the specified project deliverables.

Project Deliverables

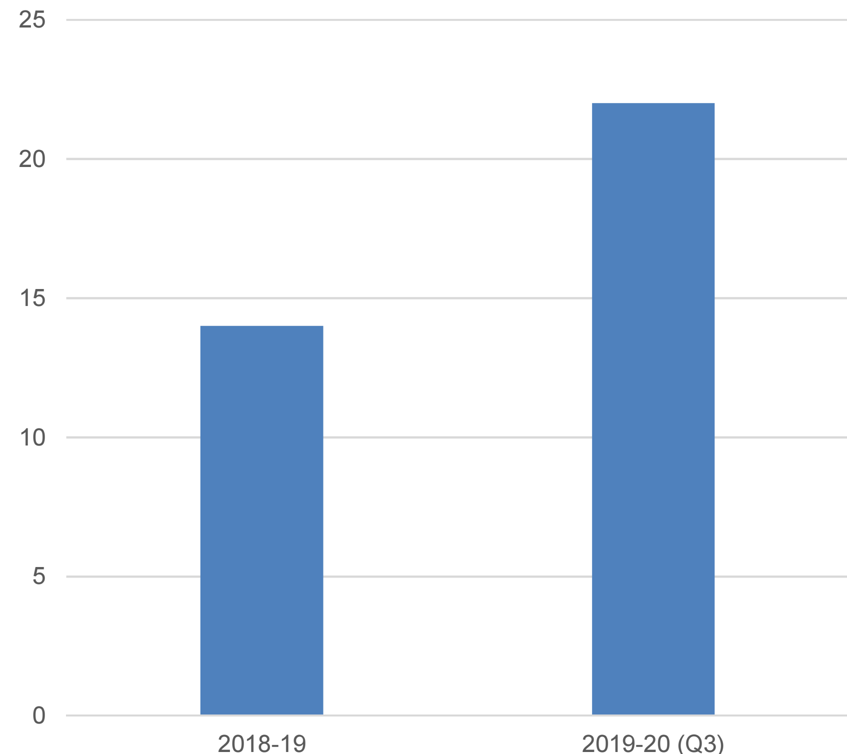
	EXPAND	Promote adoption of the MSP outcomes framework. Improve coverage in reporting best practice by encouraging voluntary participation in the data collection
	REPORT	Produce tailored outputs promoting voluntary participation in the MSPOF and demonstrate the value it can bring through sharing best practice
	ACCESS	Improving access to the existing learning enabling best practice to be shared and other useful materials to be signposted.
	COMMUNICATE	Engage with stakeholders through national and regional events and networks to promote the benefits of voluntary participation in the MSPOF
	IDENTIFY	Identify and understand the barriers to adoption and explore and share solutions.
	LINK	Develop links with IT system suppliers to understand and promote the role they can play in encouraging the MSPOF.
	SUPPORT	Encourage and support participating and other interested organisations.

Expand

Over a 50% increase in participation in MSPOF to date.

More scheduled to join in quarter 4 prior to Covid-19 collection pause.

First examples of participants able to capture and report data across all MSPOF metrics occurred.



Report

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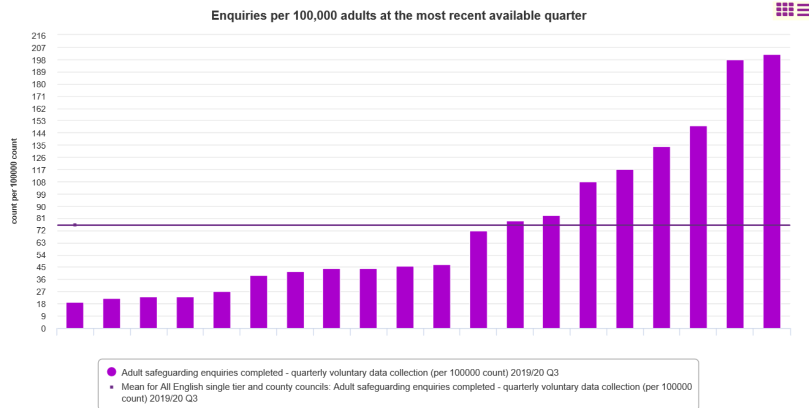
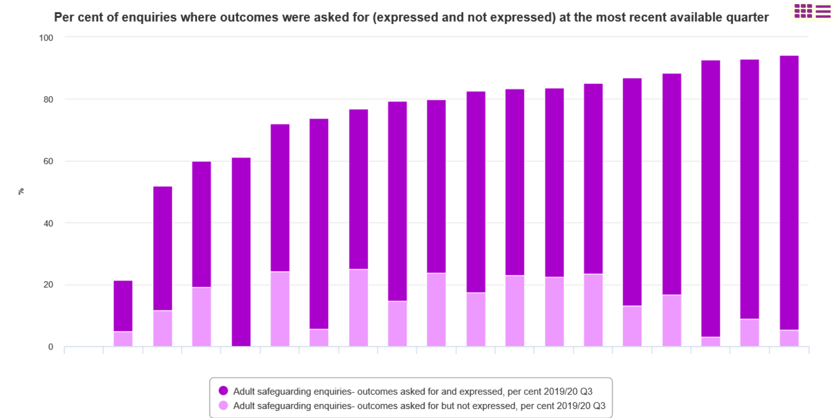
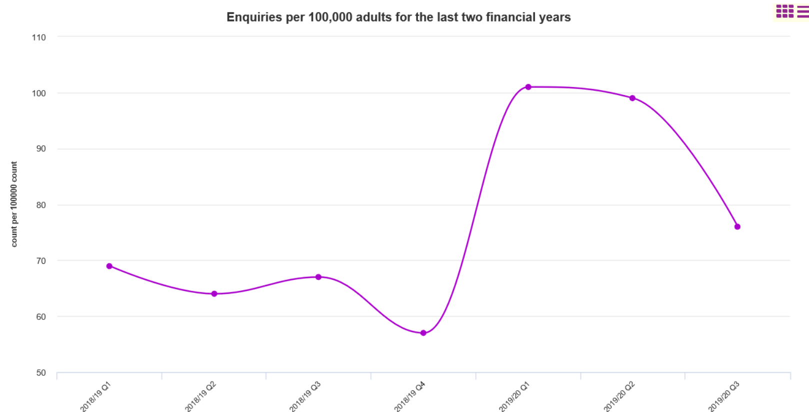
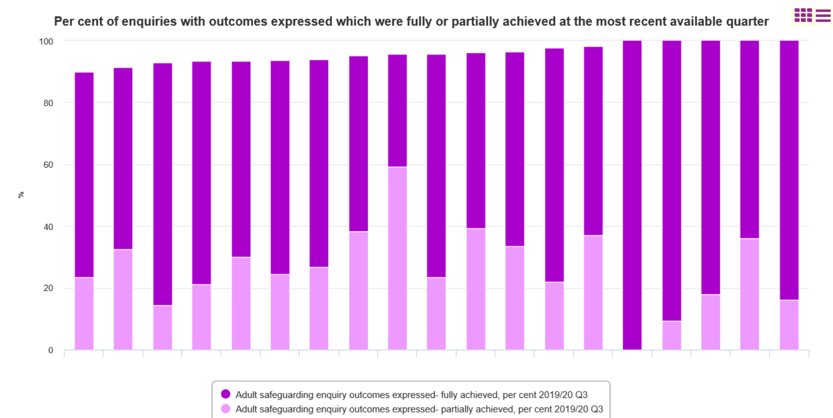
Making Safeguarding Personal Outcomes Framework - Quarterly Voluntary Data Collection

MSPOF Reports Developed in LG Inform providing an online resource for MSPOF to explore and discuss different service models and best practice.









LG Inform

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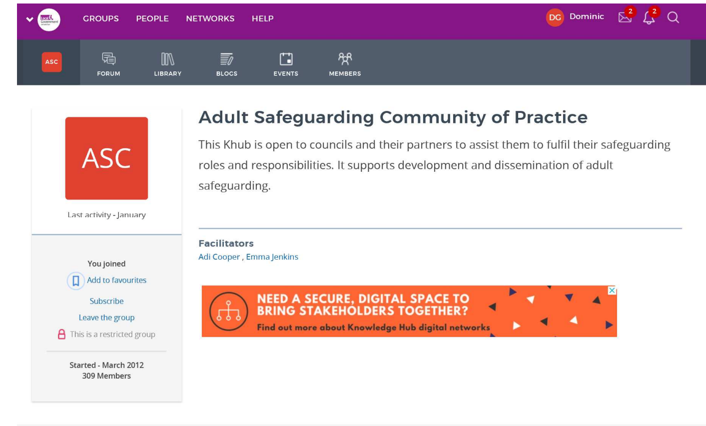
Access

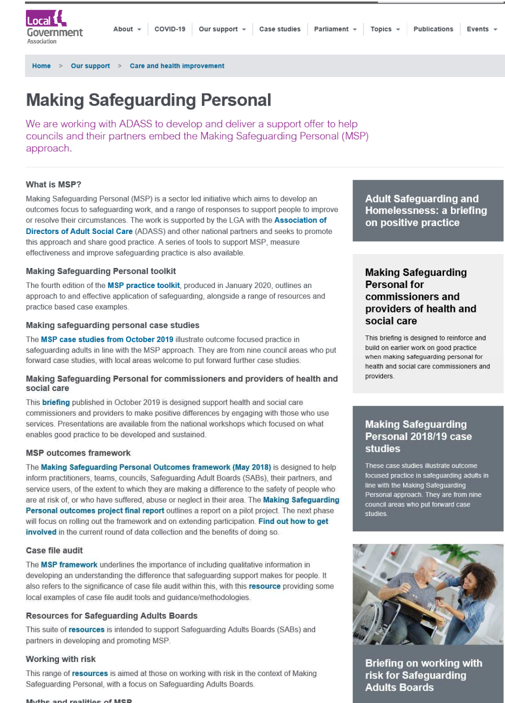
Facilitation of quarterly MSPOF Task and Finish Group meetings acting as a forum where identification of best practice and signposting of developments and supporting materials can occur.

National workshops held facilitating national discussions of MSP providing reassurance that organisations are moving in the right direction.

Promotion of the “Knowledge Hub” in stakeholder events and in external communications.

Increased utilisation of Making Safeguarding Personal Local Government Association web page to bring together historic and more recent developments of the MSPOF and how it sits in wider work regarding MSP approach.





COMMUNICATE

Co-hosted with Research in Practice for Adults (RiPFA) national workshops: one in London and one in Manchester; c.60 delegates across both, the majority of whom had not attended previous workshops.

National workshops facilitating a broader dialogue around MSP and how the outcome framework can act as a mechanism to maintain ongoing discussions on this locally/ nationally. A note on the workshops is attached.

Arranged promotion of MSPOF to national Directors of Adult Social Services and senior social care data collection colleagues highlighting the benefits and synergies of the MSPOF with existing mandated national collections through NHS Digital national “September letter”

Making Safeguarding Personal
Making Safeguarding Personal (MSP) is a sector led initiative which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances. The work is supported by the LGA with the Association of Directors of Adult Social Care (ADASS) and other national partners and seeks to promote this approach and share good practice.

Further opportunities to review the data quality of elements of the SAC return are possible through participation of the voluntary Making Safeguarding Personal Outcomes Framework (MSPOF) quarterly benchmarking exercise run by the LGA and ADASS. This has been designed to be integrated with the MSP elements of the SAC. Participant local authorities will have opportunity for early review of findings and identification of data quality issues during the year, and prior to the opening of the annual SAC submission window. The data collection will be supplemented with two workshops during the year which will provide opportunities to share practice. Further details can be found on the LGA website[8].

IDENTIFY

Communication with stakeholders through the quarterly MSPOF Task & Finish group and also the national workshops helped identified new barriers to participation but also helped explore barriers identified in the project pilot in more detail which then informed action:

Barrier	Action/s
IT systems which don't support the framework, or that don't communicate with each other	See project Link Objective
Understanding of MSP	Produced targeted briefing documents and communications to Safeguarding Adult Boards and other audiences. Clear points of contact for additional information to arrange calls / site visits.
Time and resource to gather the information	Be clear in communication that partial submissions are okay. Highlight where this information is already flowing in areas through the Safeguarding Adult Collection synergies
Professional nervousness about gathering feedback	Tailored sessions provided around this at the national workshop events. Resource from event signposted on Knowledge Hub.
The way in which the board may use the framework	Demonstrate how such feedback is been used and show how collective ownership and influence in this via the MSPOF task and finish group.

Link

To promote greater voluntary participation an objective existed to develop links with IT system suppliers to understand and promote the role they can play in encouraging the MSPOF.

Due to emerging developments surrounding a review of the national Adult Social Care Outcomes Frameworks (ASCOF), discussions amongst the project steering group (endorsed by the project SRO) agreed to park this objective, mindful that we did not wish to propose changes in IT system configurations, which were very likely to be changed again in the near future.

However links have been made between the MSPOF and the ASCOF review work project to identify areas of alignment and support in the future.

Support

Quarterly MSPOF Task and Finish Group meetings continued to be held as a forum for participants to support each other collectively and promote best practice and learning.

Support provided via email or telephone calls both for people:

- Looking to participate and requiring support for the collections portal
- Those with a more general interest in MSPOF throughout the project.

Site visits to organisations supporting how MSPOF might be utilised and aligned to support their local service provision.

Attended and presented at Safeguarding Adults Board meetings, promoting knowledge of MSPOF amongst partner agencies.

Summary

Progress has been achieved against all active deliverables in 2019-20 despite the Covid-19 lockdown late in the year.

Participation has increased during the year. Alongside this developments in reporting outputs have increased opportunities for additional insights to be ascertained relating to best practice in the delivery of MSP.

The well attended national workshops added to the ongoing discussions around successful MSPOF developments going forward.

Continued progress of the MSPOF and its work means that it is able to help support in future discussions and shape of the ASCOF in the future, if it is called upon to do so.

National Network for Chairs of Safeguarding Adults Boards

Annual Report
2018 - 2019

National Network for Chairs of Safeguarding Adult Boards

CONTENTS **Page**

1. INTRODUCTION **2**

2. ABOUT THE NETWORK **2**

3. ABOUT SAFEGUARDING ADULTS BOARDS **4**

4. NATIONAL SURVEY CHAIRS OF SAFEGUARDING ADULT BOARDS **5**

5. PROGRESS AND PRIORITIES **7**

1. INTRODUCTION

Welcome to the National Network for Chairs of Safeguarding Adults Boards (the National Network) Annual Report 2017-18. The National Network was established in 2009 to support the new roles of Independent Chairs of Safeguarding Adults Boards (SABs). In 2016 membership was extended to all Chairs of SABs. Since it was formed the membership has expanded considerably. There are currently over 100 members chairing 117 SABs. This report brings together the work of the National Network over the past year.

2. ABOUT THE NATIONAL NETWORK FOR CHAIRS OF SAFEGUARDING ADULTS BOARDS

The National Network is a community of practice that aims to support and strengthen Chairs and Safeguarding Adults Board partnerships in order to improve their effectiveness in safeguarding adults and to influence and promote best practice for safeguarding adults nationally and locally through effective working. The purpose of the Network is to coordinate and provide support to the Chairs of Safeguarding Adults Boards in order to:

- Share best practice and good examples with regards to the implementation of the Care Act 2014
- Support the implementation of SABs becoming statutory bodies under the Care Act 2014 in a coherent and consistent way;
- Share and disseminate knowledge and learning between Boards;
- To work with partners in respect of information sharing agreements, budgets and performance
- Improve consistency of approaches to safeguarding and contribute to the raising of overall standards of adult safeguarding;
- Continue to develop a national voice and resource for consultations and advice on safeguarding matters; and
- Provide peer support and networking opportunities.

Attendance at National Network meetings is often in excess of 30 Chairs with all regions represented; a member produces minutes and these contain links to documents tabled and referenced during the meeting. Feedback is arranged through regional networks and their meetings where they occur.

Network Coordinator: The Network was coordinated and Chaired by Robert Templeton who is Chair of Portsmouth, Southampton and Hampshire SABs. In March 2019 Robert stepped-down handing over to Fran Pearson independent Chair of Newham and Luton SABs. The responsibilities of the coordinator are as follows:

- Chairing National Network meetings;
- Establishing and maintaining the national database of SAB Chairs;
- Keeping the network up to date in policy and practice;
- Supporting the collation of views of members in response to national consultations;
- Attending and providing regular updates to the Local Government Association (LGA)/Association of Directors of Adult Social Services (ADASS) Adult Safeguarding Policy Network;
- Attending and providing regular updates to the Department of Health and Social Care (DHSC) Safeguarding Adults Leadership group;
- Attending and providing regular updates to Making Safeguarding Personal Advisory Group; and
- Drafting the National Network Annual Report.

Executive Group: The work of the Network Coordinator is supported by an executive group who provide their time on a voluntary basis, members are:

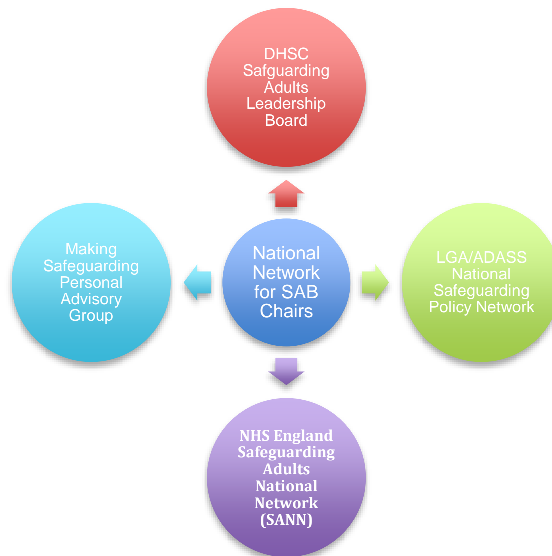
- Michael Preston -Shoot- Independent Chair of Brent SAB
- Mark Godferry - Independent Chair of The Royal Borough of Greenwich SAB
- Simon Turpitt - Independent Chair of Surrey SAB
- Sian Walker - Independent Chair of Devon, Kingston and Lambeth SABs
- Paul Kingston - Independent Chair of Wigan SAB
- Robert Templeton - Independent Chair of Hampshire, Southampton and Portsmouth SABs

The Network would like to express gratitude to the following outgoing members of the Executive Group: Deborah Klee, Julia Stephens-Row and Mike Taylor whose wise counsel and patient advice has been essential in supporting both the Network and the Chair of the Network.

Funding: Members conduct the majority of the work of the National Network on a voluntary basis. Network meetings are hosted free of charge by the City of London and Birmingham City Council. The Network Co-ordinator is funded for a specified number of days a year by the Care and Health Improvement Programme (CHIP) of the LGA/ADASS as part of the sector led improvement work on safeguarding adults. The expenditure of the Network in 2018/19 is outlined below:

Item	Cost £
Coordinator Time	£ 3,000.00
Expenses	£ 94.00
Total	£ 3,094.00

Representation: The diagram below illustrates the groups that the SAB Network is represented on:



Department of Health and Social Care (DHSC) Safeguarding Adults Leadership Group: This group provides DHSC national leadership and an opportunity for the department to listen to key stakeholders contributing to the national agenda and related topics to support safeguarding adults.

LGA/ ADASS National Safeguarding Adults Policy Network: Maintains close links with relevant bodies, policymakers and provides strategic direction for the Association of Directors of Adult Social Services/Local Government Association policy development on Safeguarding Adults and supports policy developments as required.

Making Safeguarding Personal Advisory Group: The aim of this group is to ensure that person-centred adult safeguarding practice is embedded and delivers The Care Act 2014 guidance, through developing and implementing the Making Safeguarding Personal programmes.

NHS England Safeguarding Adults National Network: The Safeguarding Adults National Network (SANN) is chaired by Paul Kingston and aims to provide a national voice to adult safeguarding leads representing Clinical Commissioning Groups (CCGs) across England and acts as a clinical reference group to the National Safeguarding Steering Group (NSSG). The NSSG leads the assurance of the NHS safeguarding system and offers strategic leadership for safeguarding and quality improvement across NHS England and the health economy.

3. ABOUT SAFEGUARDING ADULTS BOARDS (SABs)

Safeguarding Adult Boards: SABs are statutory, multi-organisational partnerships coordinated by the local authority, which oversee and lead adult safeguarding across a local authority area(s). The main objective of the SAB is to gain assurance of safeguarding arrangements locally, assurance that its partner organisations work effectively individually and together to support and safeguard adults in its area who are at risk of abuse and neglect.

SABs also have an interest in a range of matters that contribute to the prevention of abuse and neglect. This includes the safety of patients in its local health services, quality of local care and support services, effectiveness of prisons and approved premises in safeguarding offenders and awareness and responsiveness of further education services. The SAB does this by:

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

Chairing arrangements: Most, but not all, Boards employ an Independent Chair who is responsible for ensuring that all organisations contribute effectively to the work of the Board. The Chair provides accountability for the work undertaken by the Board by way of reports to relevant strategic committees and Boards.

Membership: The SABs are made up of a wide range of statutory, community and voluntary organisations which includes representatives from Local Authority, Police, Clinical Commissioning Groups, NHS providers, emergency services, district and borough councils, independent care providers, housing, advocacy, service users and carers etc.

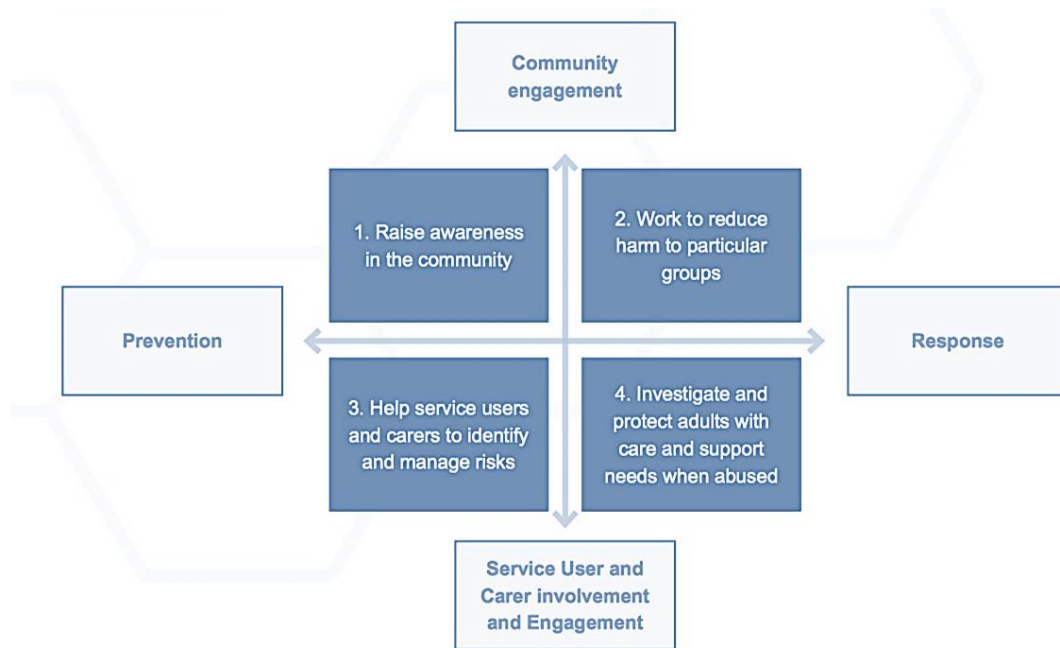
Duties under the Care Act (2014): The Care Act gives SABs three specific duties- they must:

I. Publish a strategic plan for each financial year that sets out how it will meet its main objective and how each member is to implement that strategy. In developing the plan it must consult the Local Healthwatch organisation and involve the community.

II. Publish an annual report detailing what the SAB has done during the year to achieve its objective and what it and each member has done to implement its strategy as well as reporting the findings of any Safeguarding Adults Reviews (SAR) including any ongoing reviews.

III. Decide when a SAR is necessary, arrange for its conduct and if it so decides, to implement the findings. Where the SAB decides not to implement an action from the findings it must state the reason for that decision in the Annual Report.

The Care Act 2014 statutory guidance sets out a range of areas of interest for Safeguarding Adults Boards which is illustrated below:



Source: Braye, S., Orr, D; Preston-Shoot, M,(2011) in ADASS / LGA Making Safeguarding Personal Support for safeguarding adults boards:
https://www.local.gov.uk/sites/default/files/documents/25.25%20-%20Chip_MSP%20safeguarding_WEB.PDF

4. NATIONAL SURVEY OF SAB CHAIRS

One of the major pieces of work the Network undertook in October 2018 was a survey which was sent to all Chairs of Safeguarding Adults Boards in England. This work builds upon the network's first survey of undertaken in 2017 (National Network for Chairs of Safeguarding Adults Boards, 2017) that reviewed the impact of the implementation of The Care Act 2014. (see https://www.adass.org.uk/media/6015/the-national-network-of-safeguarding-adult-board-chairs-annual-report-final.pdf.

The aim of the survey was to report upon the progress made by Safeguarding Adults Boards, the key challenges faced by Boards and Chairs, and to support the further development of Safeguarding Adults Boards. This report will inform discussions about policy and practice within and between Safeguarding Adults Boards, the Department of Health and Social Care (DHSC), Association of Directors of Adult Social Services (ADASS), NHS England and other stakeholders. Both surveys inform the Network priorities outlined in section 5 and 6 of this report.

A total of 85 Independent Chairs responded to the survey in 2018. There are 132 Safeguarding Adults Boards in England. As some respondents have responsibility for more than one Board, the responses represented 89 SABs, and over two thirds of local authority areas.

The survey found the main strengths reported by Safeguarding Adults Boards Chairs were:

- There is strong partnership working across organisations and 94% of SABs hold development/mutual challenge days.
- 78% reported that their Safeguarding Adults Board measures its effectiveness of impact.
- Generally good representation of senior leaders on Safeguarding Adults Boards with 96% Directors of Adult Services, 81% Superintendent or Chief Superintendent, although Clinical Commissioning Group representation is more variable with 58% Director of Nursing.
- 90% reported that their local Healthwatch is represented on the SAB.
- 53% reported Safeguarding Adult Reviews as accounting for the highest proportion of Board business.
- 94% of SABs have a Board Manager, with 26% of these shared with Local Safeguarding Children Boards, and 93% have access to admin staff.
- 65% of SABs are leading on taking action on local provider concerns.
- Nine out of 10 SAB Chairs are meeting regularly with the Council's Chief Executive and 64% meet every six-months or more frequently.

The main challenges for Safeguarding Adults Boards Chairs are: receiving information from Quality Surveillance Groups; local performance information; and assurance about managing the market/market failure. Other challenges were:

- Safeguarding Adults Boards face membership challenges regarding continuity, seniority and participation;
- Low levels of service user engagement. Only 9% report that service users are represented on the Board, and less than a third (28%) say they are represented on sub-groups. Less than half (42%) say they are measuring the impact of service user involvement and responding to the learning found;
- Further assurance and focus is needed regarding local provider concerns;
- Partner agency workloads, capacity and diminishing resources are having an impact on sub-group engagement and delivery; and
- Legal liability issues for Safeguarding Adults Boards need clarification and potential action.

The main safeguarding practice concerns for Boards were:

- All organisations adopting the Making Safeguarding Personal approach (see LGA/ADASS, 2017 https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal/resources)
- Prevention responses;
- Frontline staff undertaking mental capacity assessments;
- Data on Making Safeguarding Personal reported to the Safeguarding Adults Board;
- Thresholds for Section 42 Enquiries.

Other Issues identified were:

- The impact of the changes to children's safeguarding partnership arrangements;
- Developing better mechanisms for assurance following Safeguarding Adults Reviews;
- Board Member succession planning;
- Working effectively with diminishing resources and uncertainty regarding Safeguarding Adults Boards' budget year on year;
- Managing the backlog and responding to delivering the new requirements regarding Deprivation of Liberty Safeguards;
- Improving carer engagement;

- Working with contemporary safeguarding challenges e.g. domestic abuse, online threats, homelessness, suicide and social isolation;
- Improving transitions from children's services to adult services;
- Addressing prevention and early help;
- Improving safeguarding awareness and support for third sector organisations; and
- Adults at risk who do not meet the thresholds for statutory services.

The survey highlighted that although good progress has been made in many areas there is more work to do. In response the Chairs Network has worked with the ADASS, LGA and Skills for Care to produce resources to support development in the areas where there is a need for improvement, These resources are referenced throughout this report and bibliography. This includes the forthcoming briefing on core ingredients and principles for SABs in making decisions about whether a Section 42 enquiry (Care Act, 2014) is needed. This will be available in summer 2019: see https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal

The network would like to thank Mark Godfrey, Adi Cooper OBE, Jane Lawson, Robert Templeton and Professor Michael Preston-Shoot for the development of the survey and Philippa Lynch and Rose Pycock at the Local Government Association for completing the analysis.

5. PROGRESS AND PRIORITIES

Progress on Priorities 2016-2019: The table below outlines the Networks progress on its priorities described in the Annual Report 2017/18 and the work still to do.

Priority	Progress	Work still to do
1. Improving Performance and Data: Network will work with NHS Digital, LGA and others to ensure adult safeguarding performance data is developed to enable SABs to evaluate and benchmark performance.	The Network has worked with NHS Digital in the following areas -Influencing National Safeguarding Adults Collection (SAC); How Boards use the NHS Digital Safeguarding Adults collection data and reports; Identifying gaps in the current collection. The information from the Network fed into NHS Digital's review of the data collection.	Address issues raised by Action on Elder Abuse 'A Patchwork of Practice' paper, already begun with the Local Government Association on decision-making regarding Section 42 enquiries
2. SAB Broadened Remit: The Network will continue to work both nationally and regionally to ensure SABs work with other partnerships and contribute to cross cutting areas such as Modern Day Slavery and Human Trafficking; PREVENT; CSE; Harmful Cultural Practices; Domestic Abuse; Suicides and Self Harm; Cyber Crime – Desk Top and Door Step Crime; Self-Neglect and Hoarding; Homelessness;	The Network has worked with the following agencies: DHSC in all areas - Home Office - Modern Day Slavery and Human Trafficking and PREVENT - Office of the Public Guardian - Self-Neglect and Hoarding - National Trading Standards - Cyber Crime – Desk Top and Door Step Crime; - NHS England - All areas - Norah Fry Centre for Disability Studies - LD Mortality Reviews	Clarify SAB roles, remit, and engagement in these areas; gain assurance in these areas etc. Gather evidence of SABs and SAB Chairs' Network of impact in these areas

social isolation, elder abuse; and LD Mortality Reviews.	The Association of Independent LSCB Chairs - CSE; Harmful Cultural Practices	
3. Safeguarding Adult Reviews: The Network will promote a consistent approach to SAR's; supporting the new National SAR Library, and explore how SARs can impact on practice and promote culture change	The Network has played a key role in supporting a national project to establish a SAR Library and quality standards.	Continue to Promote SAR quality standards Continue to Continue to Promote National SAR Library SAR impact assessment mechanisms - seek good practice examples via SAB Chairs survey
4. Making Safeguarding Personal: Ensure that SABs play a key role in implementing Making Safeguarding Personal across partnerships; and improve engagement of service users with the SABs.	The Network has helped in the development of the LGA/ADASS MSP programme, including promoting and disseminating a suite of resources to support SABs and partners.	Continue to Promote LGA/ADASS resources for engaging with service users Continue to Promote MSP adoption across partners (using the LGA/ADASS resources) Use SAB Chairs survey to assess progress on implementing MSP and service user engagement
5. Develop SAB work on quality including prevention of provider failure and stronger relationships with Quality Surveillance Groups: The Network will support SAB Chairs to seek assurance of local arrangements for working with poor providers; will work with NHS England to explore opportunities to achieve ways of strengthening relationships between SABs and QSGs; including disseminating learning from SARs regarding poor quality service provision.	The Network fed into the development of the 3rd edition of the National Guidance to Quality Surveillance Groups published in July 2017.	Collate and promote examples of local and regional best practice in quality assurance panels, linked to 'Quality Matters' priorities Collate and promote local and regional best practice regarding links between SABs and QSGs
6. Greater Collaborations on a National Level: The Network will work with the ADASS / LGA Safeguarding Adults Policy Network and the DH Adult Safeguarding Leadership Group to develop	The Network continues to be represented and works closely with ADASS Safeguarding Adults National Policy Group and DH Adult Safeguarding Leadership Group. The Network has made strong links with Rebecca Brown	Develop links with Home Office and NPCC

greater collaboration at a national level between statutory partners.	(DHSC) with responsibility for Adult Safeguarding. The Network has also made strong links with Ian Pilling Deputy Chief Constable, Greater Manchester Police NPCC Lead for Vulnerable Adults.	
7. Supporting Integration: The Network will work with regional groups and partners to link the role of the SAB to health and social care integration work and share good practice.	A number of regional groups have fed back regularly to the Network on this area.	Identify areas where links have been made between SABs and STP governance systems Share models of good practice
8. SAB Peer Review: Look for options to apply national SAB peer review methodology (LGA) and investigate how local outputs can evidence improving Board effectiveness and good practice.	Members of the Network have participated in the LGA Peer Review Pilot and 2 SAB peer reviews were undertaken. The methodology was finalised and published.	Promote the use of Peer Reviews among the Network
9. Review Care Act 2014 implementation: Highlighting areas of strength and weakness in implementation, including service user engagement, impact of SARs and culture change. Develop a national picture of key SAB priorities. Include seeking evidence of impact of the SABs	During 2018-9 The network conducted a survey of SAB chairs to assess the impact of the implementation of The Care Act 2014 on SABs and to capture the effects of making SABs statutory partnerships.	Complete
10. Implement SAB Chairs workforce plan: work with Skills for Care to develop and implement a workforce plan for SAB Chairs	The Network has worked with *Skills for Care* to develop a Safeguarding Adults Chair Workforce Framework focusing on the role of the Safeguarding Adults Board Chair. It supports adult social care employers and other agencies represented on Safeguarding Adults Boards with developing the chair's role, job description, continuing professional development and learning requirements.	To be tested out
11. Develop and strengthen regional SAB Chair Networks	The network has worked closely with regional Chairs Networks. There are currently active networks in the following areas: • North West • North East	Continue to maintain robust links with Chairs the of regional networks

	• Yorkshire and Humber • West Midlands • East Midlands • East Anglia • South West • South East • London	

Progress on Priorities 2019-2021:

The table above highlights that although the Network has made progress in many areas there is more work to do. Based on the survey of SAB Chairs the Network has revised its priories, which are listed in the table below, together with proposed actions.

Priority	Proposed Action
1. Membership challenges: continuity, seniority and participation and Board member succession planning	The SAB Chairs Network to emphasise the importance of continuity, seniority and participation of partners by working with national bodies representing police and health partners and highlighting the impact of SABs locally.
2. Low levels of service user engagement.	The SAB Chairs Network to work to ensure Boards are using and embedding the MSP resource of the MSP supporting increased involvement of service users: https://www.local.gov.uk/sites/default/files/documents/25%2026%20-%20Chip_MSP%20Safeguarding%20Adults%20Boards_WEB.PDF The network to work with service user and carer groups to identify good examples of service user engagement with SABs and to make links with those cited in the resource as having made good progress on this.
3. Assurance on local provider concerns	The SAB Chairs Network to work with the LGA/ADASS Care and Health Improvement Programme (CHIP) and ADASS policy network to explore examples of good practice. The SAB Chairs Network will also work with NHS England's Safeguarding Adults National Network to identify opportunities to achieve ways of strengthening relationships between SABs and QSGs.
4. Partner agency workloads, capacity, diminishing resources and impact on sub-group engagement and delivery	The SAB Chairs Network to highlight these pressures to the DHSC through the DHSC leadership group.
5. Legal liability issues for Safeguarding Adults Boards and Chairs	The SAB Chairs Network to seek support and advice from the DHSC, NHS England and the LGA.
6. All organisations adopting the Making Safeguarding Personal approach.	The SAB Chairs Network to work to support Boards using and embedding MSP resources and encourage sharing of good practice.
7. Data and other information and insights on Making Safeguarding Personal reported to the SABs	The SAB Chairs Network to work with SABs locally and NHS Digital to see how to improve collection of MSP data, encouraging use of the MSP Outcomes Framework https://www.local.gov.uk/sites/default/files/documents/msp-
8. Prevention responses including addressing prevention and early help	The SAB Chairs Network to put out a call for good practice in this area.
9. Frontline staff undertaking mental capacity assessments;	The SAB Chairs Network to put out a call for good practice in the area.

10.	Thresholds for Section 42 Enquiries.	The SAB Chairs Network to explore ways of enabling greater consistency with the ADASS policy group/LGA/ ADASS CHIP.
11.	The impact of the changes to children's safeguarding arrangements	The SAB Chairs Network to work with the Association of LSCB Chairs to monitor the impact of the changes to children's safeguarding arrangements.
12.	Developing better mechanisms for assurance following Safeguarding Adult Reviews (SARs) action plans and evidencing that changes to practice/systems are embedded	The SAB Chairs Network to work with the LGA/ADASS CHIP to explore ways of developing better mechanisms for assurance following a SAR.
13.	Working effectively with diminishing resources and uncertainty regarding Safeguarding Adult Boards budget year on year	The SAB Chairs Network to highlight the impact of this issue to ADASS, LGA, NHS England and the DHSC
14.	Managing the backlog and responding to delivering the new requirements regarding Deprivation of Liberty Safeguards	The SAB Chairs Network to highlight this issue to the LGA, ADASS and DHSC.
15.	Improving carer engagement with Carers	The SAB Chairs Network to work with carer's organisations such as 'Carers UK' and to identify and disseminate good practice in this area.
16.	Working with contemporary safeguarding challenges e.g. domestic abuse, online threats, homelessness, suicide and social isolation;	The SAB Chairs Network to work with organisations such as Women's Aid, St Mungos, Crisis, Shelter, Carers UK and others to identify and disseminate good practice in these areas.
17.	Improving safeguarding of adolescents and young adults transitions from children's services to adulthood	The SAB Chairs Network to work with the Association of LSCB Chairs ADASS and Association of Directors of Children's Services to establish our respective roles in supporting work on "Transitional Safeguarding"
18.	Improving safeguarding awareness and support for third sector organisations	The Network to recognise and encourage SABs to underline the important role of this sector in safeguarding adults.
19.	Adults at risk who do not meet thresholds for statutory services	The SAB Chairs Network to work with ADASS policy network and LGA CHIP to develop a shared understanding of the particular risks for this group

Robert Templeton

April 2019

Local Government Association

Joining Up Care Programme - NHSX

Purpose of report

For direction.

Summary

This report introduces Members of the Community Wellbeing Board to the new joint programme between NHSX, the LGA and ADASS called Joining Up Care. It explains the background to the programme, and advises upon the key issues, opportunities and considerations for Members.

Recommendations

Member of the board are asked to consider and approve the following:

1.1. to approve, in principle, the co-branding and partnership between the LGA and NHSX for the JUC programme. Further information will be provided for individual elements

1.2. receive JUC programme updates to the board on a regular basis ensuring the board are sighted on key programmes and progress

1.3. update paper at next board which outlines the LGA plans to ensure local government views are embedded into the JUC approach and governance

1.4. This work also fits under the portfolio of the LGA's Innovation and Improvement Board (IIB). CWB take ownership of this work with IIB to receive updates for note where relevant

Action

Officers to report back to the Board in line with their decisions and recommendations.

Contact officer: Jamie Cross / Hannah Gill

Position: Programme Lead Advisor / Programme Manager

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Joining Up Care Programme - NHSX

Background

1. NHSX were created in April 2019 to hold responsibility for setting national policy and developing best practice for National Health Service technology, digital and data, including data sharing and transparency.

2. Prior to COVID-19, we have been working relentlessly to engage with NHSX and influence their work. NHSX is a key partner and as such there has been significant time investing in nurturing this relationship.

3. The COVID pandemic has brought the need to improve digital technology across health and care services into sharp focus. Since March we have been working closely with NHSX on their offer. This soon developed into a new agenda called Joining Up Care (JUC) which incorporates existing programmes, as well as new ones due to COVID, to further move towards digitally enabled and integrated frontline health and care services.

4. In May, a joint letter from Mark Lloyd, Cllr Hudspeth and James Bullion (ADASS) was sent to Matthew Gould, the Chief Executive of NHSX to officially suggest that the LGA co-partner JUC, with the agreement to ensure resource was available from the LGA digital CHIP team. This letter was well received and secured commitment that JUC will be delivered in partnership with the LGA and the Association of Directors of Adult Social Services (ADASS).

5. JUC has the dual aim of reducing the impact of winter pressures and a second COVID wave, whilst also accelerating and reinvigorating existing pre-COVID long term priorities. Whilst the last five months has naturally seen a focus on the short-term winter and second wave aims, it will be important to keep strategic momentum for the benefits that the longer-term elements of JUC will bring.

    5.1. The benefits to residents of joined up care and health which is supported through better digital technology have been brought into sharper focus as a result of the pandemic, particularly with the forced lockdown which saw many face-to-face interactions stopped. More health, social care and community health is taking place in people's homes using digital tools. In the short-term, this is reducing the risk of face-to-face infection transmission whilst maintaining social connections and whilst still meeting health and care outcomes for individuals.

    5.2. Society has seen the benefits of digital tools in all walks of life, with the pandemic increasingly highlighting the benefits and therefore accelerating cultural change. There is now a greater appetite for digital transformation and skills development.

6. However, this initiative, whilst welcome, is not without its challenges and it will be key that local government co-designs and delivers this work in partnership, with local political involvement and oversight. The focus nationally has typically been on the NHS and despite excellent examples of digital transformation in social care, it has not seen that same focus on investment in infrastructure and training.

Joining Up Care Overview

7. Joining Up Care is an initial three-year plan, with most objectives looking to be reached by FY2023/24, however this is a much longer-term agenda than that with many of the projects looking at developing the evidence for further change. Its three interdependent workstreams are described in the graphic below.

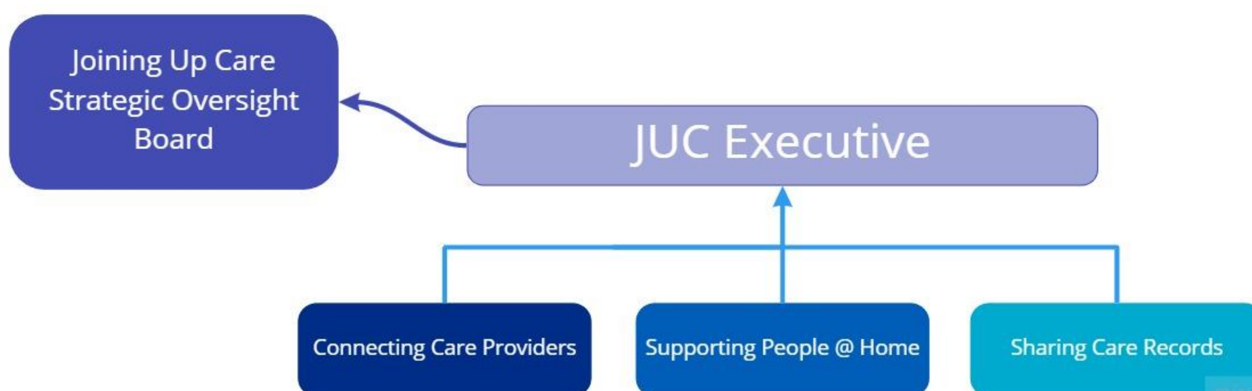
Connecting care providers	Improve the health and wellbeing of service users and care home residents through better connectivity and the delivery of remote health and care services
Supporting people at home	Supporting people to stay well and to help them access and receive health and care services from home
Sharing care records	Implementing records across care providers and accelerating sharing of care records and plans as needed by the health and care frontline; creating a platform for digital service models and insights that drive population health management.

These three workstreams contain several projects, full detail of all the projects can be found in **Annex A**. The workstreams are also underpinned by critical enablers such as essential culture and skills work, clarification on policy and funding, standards and guidance, and support for the development of digital transformation capabilities in culture and skills.

8. The programme is governed by an internal JUC Operational Executive, and an external JUC Strategic Oversight Board. The Digital arm of the LGA's Care and Health Improvement Programme have been co-ordinating and engaging at a programme, workstream and project level. Ian James is the LGA's primary strategic lead and is the deputy chair of the Joining Up Care Strategic Oversight Board (governance structure in image below). The LGA have also invested in a full-time joint programme adviser lead role at tactical level.

9. The LGA's role in the programme is to ensure adult social care is an equitable partner to health, to build strong strategic relationships, and to engage local government and care sectors to make sure the delivery of JUC works locally.

10. It will also be vital that we embed the right people with the right strategic and front-line experiences across care and local government systematically across at the project level to properly represent local government and care at all levels of this programme.



Issues, Opportunities and Considerations

11. Whilst there is support from national politicians for this work, NHSX have not yet settled on their Joining Up Care narrative, nor do they have funding committed post March 2021. Funding post-March has been included in several Comprehensive Spending Review bids. The programme contains risks and it is critical for its success that we get this right in terms of communication and engagement with local government and social care.

12. We are therefore beginning our internal LGA engagement now to prevent the risks associated with waiting for an agreed NHSX narrative. We will begin external engagement with our local government and care provider partners following our internal engagement.

13. Although there is still work being done at a strategic level by NHSX on JUC there are several operational projects which NHSX have progressed quickly. The first major project was launched on 27th September 2020, which is the gifting of up to 11,000 iPads to care homes in need. This was to enable:

    13.1. Video consultations with medical and social care professionals.
    13.2. Use of NHS mail (secure email) and MS Teams.
    13.3. Access to residents' health information.
    13.4. Residents to connect with loved ones remotely.
    13.5. 4G connectivity to care homes if required.

14. This project was a ministerial priority, directly funded by HM Treasury, and the LGA have been heavily involved in simplifying the application process for local government and care, advising on language and co-drafting outputs. Cllr Hudspeth and lead members were briefed and approved the co-branding the offer letter whilst colleagues worked quickly to help distribute it through Local Government channels and develop a press release.

15. As we are a key partner in JUC, it is critical that we support CWB members to engage in risk/opportunity management and provide oversight over key decisions. Several of the other projects in **Annex A** are progressing quickly and therefore we will increasingly be needing to update members to evolve this engagement.

16. We are exploring opportunities for how members of the CWB can be engaged in the wider governance of JUC.

17. Members of the board are asked to consider and approve the following:
    17.1. to approve, in principle, the co-branding and partnership between the LGA and NHSX for the JUC programme. Further information will be provided for individual elements;
    17.2. to receive JUC programme updates to the board on a regular basis ensuring the board are sighted on key programmes and progress;
    17.3. for an update paper at next board which outlines the LGA plans to ensure local government views are embedded into the JUC approach and governance; and
    17.4. for CWB take ownership of this work with the Innovation and Improvement Board to receive updates for note where relevant.

18. JUC will only succeed if it is truly delivered in partnership with local government and care. Engagement with members is an essential element of that and therefore the team are very keen to work quickly to ensure members have the tools they need. The team welcomes a two-way conversation and members' experiences as community leaders and residents is crucial. A key role the LGA must hold is to speak up, influence and say when things won't work locally.

Implications for Wales

19. No specific implications for Wales.

Financial Implications

20. Joining Up Care is primarily being funded by NHSX. c£125m has been committed to in FY 2020-21. NHSX have submitted Comprehensive Spending Review bids totalling c£940m for FY 2021-24.

21. The LGA have committed to a joint Grade 6 resource for six months, with the longer-term plan that this will be funded via NHSX or DHSC separately

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Next steps

22. Members of the board are asked to consider and approve the following:
    22.1. to approve, in principle, the co-branding and partnership between the LGA and NHSX for the JUC programme. Further information will be provided for individual elements;
    22.2. to receive JUC programme updates to the board on a regular basis ensuring the board are sighted on key programmes and progress;
    22.3. for an update paper at next board which outlines the LGA plans to ensure local government views are embedded into the JUC approach and governance; and
    22.4. for CWB take ownership of this work with the Innovation and Improvement Board to receive updates for note where relevant.

23. Officers will engage with the Board in line with their decisions and recommendations.

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Annex A – Description of Projects which make up Joining Up Care

	Project Title	Project Outcome Ambition
Connecting Care Providers	Devices for Care Homes (short-term for winter)	Care homes will have access to tablet devices to support remote health consultations and enable contacts with friends and families.
	Care Provider Connectivity (strategic, longer-term)	Care homes who want to upgrade broadband/ Wi-Fi do so with co-ordinated discounted deals.
	Care Provider IG & Cyber Compliance (strategic, longer-term)	There are increased levels of compliance with data security and IG, following simplification of guidance.
	NHS Mail and Care365 (short-term for winter)	NHSmail / secure email in use by 80% of care homes, with increased uptake of MS teams and Microsoft Tools.
	Access to Information Carer proxy access (strategic, longer-term) GP Connect and Summary Care Record (short-term for winter)	 Care staff have proxy access to medication re-ordering, and GP record access. Local health and care teams have national support to establish data sharing agreements for direct care. Care providers can access GP records (read only) for the people in their care, via the Summary Care Record mobile application and GP Connect website.
	Virtual Clinical Support for Care Homes (short-term for winter)	Rolled out new service model for GPs to provide virtual clinical support for care home residents.
	Digital Social Care Records	Care providers in deprived areas will have access to reduced rates for implementation of digital care management systems. A list of common interoperability standards for Digital Social Care Records published. An assured list of digital care management systems suppliers will be available for care providers to use and have access to buyers guidance to support care providers' decisions.
	Clinical Communications (strategic, longer-term)	Easier access to instant message platforms across health and care settings for urgent advice and guidance.

Supporting People at Home		
	Remote monitoring (short-term for winter)	Remote monitoring of health in homes and care settings, tested across all regions and covering people with particular long-term conditions.
	Outpatient transformation (medium-term)	Outpatient transformation for ophthalmology and other digital pathways implemented regionally for particular conditions.
	Scaling Social Care Tech (strategic, longer-term)	A national strategy for scaling the use of technology in social care. A taxonomy to identify tech that solves particular problems. A procurement framework that supports local authority investment in care tech. Sharing local guidance and good practice.
	Covid-19 symptom monitoring in care homes (short-term for winter)	COVID-19 symptom monitoring software solutions deployed to residents via apps on care home devices within a number of homes and evaluate impact.
	Digitally Connected Households (strategic, longer-term)	The needs of housebound population and ways to support them digitally are understood, with local exemplars leading innovation in home settings for health and care. Plus, associated maturity model. Digital innovations that support self-care for different health and care issues are categorised by the type of tech platform, the level of evidence of benefit to resident, and evidence of reducing health and care inequalities.

Sharing Care Records	Shared Care Record roll out	Each Integrated Care System area and Sustainability and Transformation Partnership area has a plan for sharing care records which is aligned with a strategy and accompanied by architecture. Clear guidance and support for building or buying sharing solutions with associated delivery plan and support for unblocking local procurement issues.
	Strategic use of linked health & care data	Strategic delivery plans for Shared Care Records which include how data can be used strategically for health and care outcomes, and for population health management and research.
	Standards (medium-term)	Mapped standards for sharing records with analysis for any changes that need to be made.
	Simplified Information Governance (short-term for winter)	Legislative environment reviewed with simplified information governance across health and social care.
	Digital Community Services Interoperability	Digital transformation challenges for community services and providers, and options for solutions.

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Enablers	Procurement and standards	Simple selection of remote monitoring tools locally available. Advice and guidance for digital social care records and management software for care providers. Guidance and support for commissioners. Frameworks to assisting in scaling for evidence-based innovations. Suppliers vetted against required cyber security standards.
	Policy	Funding and support to social care sector is compliant with legal functions. Funding agreements with social care providers align with incentives around using the deployed tech, but without adding undue burden. Data collection policy and data strategies are aligned. Requirements options for quality and safety in social care have been explored to reflect digital maturity.
	Sharing good practice	Clarity over the funding of local investments. A clear vision for digital maturity.
	Digital Leadership	Digital leadership requirements are clear. Learning is designed and there is a deliver plan across care sector. Creation of ASC digital network to engage digital audience, share best practice and implementation. The Digital Nurse Network brings together nurses (and other practice staff like HCAs) together to learn more about the national and digital initiatives being implemented and provides support to develop their digital skills.

	Skills	There’s a shared understanding of skills and digital maturity levels across the sector, following a published independent review. The HEE digital readiness programme includes a wide-ranging social care training and skills development offer. There’s a model for digital champions to encourage peer to peer learning. Providers have access to a wide range of digitisation support materials, provided by sector-led Digital Social Care website. Continued funding committed for Digital Social Care helpline.
	Career Pathways	Digital skills to be embedded professional career pathway. Extension of National Clinical Entrepreneur Programme to include care workers.
	Levers and incentives	Incentives & levers for compliance with standards are understood.

Local Government Association

Note of the last Community Wellbeing Board

Title: Community Wellbeing Board

Date and time: Tuesday 9 June 2020

Attendance
An attendance list is attached as **Appendix A** to this note.

Item	Decisions and actions

1. Declarations of interest

Chairman welcomed members to the Board

Apologies were received from Cllr Claire Wright and there were no declarations of interest.

2. Sir Muir Gray

Cllr Ian Hudspeth welcomed Sir Muir Gray CBE, Optimal Ageing, to the meeting and invited him to introduce his presentation on LIVE LONGER BETTER.

In his presentation Sir Muir set out;

- His diagnosis of the ageing challenge facing society, which he summarised as: a future increase in the number of older people (in particular a doubling of the number of people aged over eighty in the next fifteen years); the implications of this for both local authorities and the NHS; and the absence of a similar increase in the numbers of young people employed in health and social care facilities. Sir Muir asserted that this creates both absolute and relative population ageing.

- The improved understanding of ageing, including recognition that problems previously assumed to be due to ageing are now known to be attributable to three other processes:

    - loss of fitness, usually starting from the early twenties and including mental fitness as well as physical fitness;
    - disease, much of it preventable, including dementia and frailty, and often complicated by accelerated loss of fitness.
    - wrong beliefs and attitudes.

- The impact of COVID-19 in heightening some of aforementioned challenges, particularly those linked to increased inactivity and isolation.

- Why the key to tackling isolation and inactivity must not simply be to provide 'more of the same', but to change the culture and societal mindset associated with ageing to help reduce the need for traditional social care by improving physical, cognitive and emotional activity.

Members made general comments about the importance and helpfulness of Sir Muir's presentation, particularly in highlighting the need for developing local communities that are geared towards, and support, positive ageing. This helped frame the debate in terms of building resilient communities in which different networks (eg social care, primary care, acute sector, voluntary sector) linked appropriately to provide the means for improving physical, cognitive and social wellbeing. Members made the following specific comments:

- A view was expressed that the effects of the current pandemic on vulnerable people encouraged them to stay at home, thereby reducing physical outdoor exercise. Sir Muir responded that vulnerable people can, and should, still be doing physical exercise at home and that emotional stimulation helps motivate people to continue exercising.
- That a notable part of the response to the current pandemic has been high numbers of people volunteering to provide appropriate support and assistance, and that this needs to be harnessed for the future. Sir Muir responded that altruistic volunteering can have huge benefits for people's health and wellbeing. He added that maybe consideration should be given to giving the older people objectives such as volunteering to help protect the environment or starting a business.
- A concern was raised that where councils were trying to reduce the use of care homes so older people could remain at home, thus could be difficult to achieve because acute hospitals discharged people to care homes as their first reaction, so there needed to be a change in the culture of the NHS. Sir Muir agreed there needed to be a change in approach given the loss of condition people experienced in hospital, and there needed to be a greater focus on prevention.
- A concern was raised that engagement and involvement in community or social networks is a struggle, particularly during the current pandemic, for those residents who do not have the internet and who are therefore unable to access materials online. Sir Muir responded that a specific focus was needed on deprived communities without technology and access to the internet. He added that age distribution shows rural areas are highly populated by older people and there is a challenge around deprivation in both rural and urban areas.
- Personal trainers often focussed on services for young people and there was a need to look at gentler exercise classes for older adults. More affordable services and physical activities need to be introduced, encouraging social interaction and physical activity. Sir Muir responded that "wellness" centres, rather than leisure centres, needed to be provided and this would need more leadership and funding from local authorities.
- Government advice on shielding of vulnerable people had resulted in some people being worried to leave their home and go out into the community. There was a task to help people feel confident about going out and decrease anxiety levels. Sir Muir responded that an unfortunate consequence of taking steps to minimise risk of infection has been, in some cases, a reduction in

the physical activity and resilience of some older people. He said any approach must be about the relative balance of of risks and that people generally underestimate the risks associated with inactivity.
- Care homes are unaffordable for many and the crisis has proved they are not the safe places they should be. Sir Muir said that the health and social care system should therefore be moving away from the traditional care home model.
- Levels of anxiety and depression during lockdown had increased due to people missing human contact and social communication. Sir Muir responded that isolation, depression and anxiety were a major risk factor for dementia, in addition to sleep, diet and other health conditions.

Sir Muir thanked the Board for the opportunity to present and offered to run similar presentations for Members who thought this would be beneficial for their council and council colleagues. The Chairman thanked Sir Muir for his stimulating presentation and for taking the time to address the Board.

Decision

Members of the Community Wellbeing Board noted the presentation.

3. COVID-19 Update

The Chairman invited Mark Norris, Principal Policy Adviser, to introduce the report.

Mark informed the Board that the report covered the LGA's activity undertaken since the last Board meeting in response to COVID-19. The focus had predominantly been around supporting people in the shielded and clinically vulnerable groups during the period of lockdown, working closely with the Department of Health and Social Care, MHCLG and DEFRA. Alongside that there had been volunteering links between local authorities and NHS responders. The LGA had also been looking at those people who were self-isolating and had difficulty accessing food, were in financial hardship and suffering from mental health problems.

Ian James, Care and Health Improvement Adviser, highlighted a key part of the LGA's role had been working with the Department of Health and Social Care (DHSC) and the Ministry of Housing, Communities and Local Government (MHCLG) alongside national partners, particularly the Association of Directors of Adult Social Services (ADASS), NHS bodies and the care provider associations, to ensure that government policy is informed by what can best support councils and local partners to help keep residents and staff safe and supported. A new social care taskforce had been set up with all local government associations, headed by David Pierson, with further details to follow in the coming weeks.

Paul Ogden, Senior Adviser, updated Members on the latest public health statistics which included:

- Overall the trend in number of deaths is reducing, within care homes and hospitals. Although, 57 per cent of deaths have occurred in care settings.
- Expected to see varied mix in local outbreaks, the disease is different from flu

Local Government Association

and seems to cluster in specific places.
- Projection of a further 18 months to see a significant improvement in the overall situation, with the intention of pushing for vaccinations and testing.
- We are now well beyond the peak and are starting to see the number of new cases fall.
- The number of tests is increasing with over 200,000 tests per day. In total 288,000 have tested positive for COVID-19.
- R value is below 1 but is there are a high level of incidents around the country.
- To date 40,597 people have sadly lost their lives in hospitals, care homes and within the wider community, but is starting to slow with 55 deaths recorded yesterday.
- BAME community are 4 times more likely to die from COVID-19.

Following the discussion, Members made the following comments:
- A concern was raised that some young people were not listening to government advice around social distancing and were putting themselves and others at risk. Paul agreed that some young people were getting bored of lockdown which poses a risk. He emphasised that the virus must be contained before the winter months, as we are still far off developing a viable vaccine.
- In response to queries around the Governments Test, Track and Trace system Paul confirmed that it needed accurate granular data to make it work and this wasn't currently available to local authorities. He added that it was difficult to provide an accurate localised R rate as it can take 1 death to skew the figure. The LGA had been lobbying for additional powers with Test, Track and Trace so we can know where the outbreaks are and help contain them.
- A concern was expressed about people having to care for family members with disabilities as with day centres being closed, many relatives were having to occupy family members who were in need of support and care.

Decision

Members of the Community Wellbeing Board noted the COVID -19 update.

4. End of Year Report and 2020/21 Priorities

The Chairman invited Mark Norris to introduce the report.

Mark explained that the report set out the Community Wellbeing Board's achievements during the year and some immediate priorities across the Board's responsibilities as the UK transitions out of lockdown.

Mark highlighted that some areas of the LGA's work around COVID-19, such as death management, had seen a reduction in support needed although others, such as adult social care, public health and supporting vulnerable people would most likely continue to be priorities for the next cycle of the Board.

As there were no comments raised by members, the Chairman stated that he was happy with the direction of travel set out in the report.

Decision

Members of the Community Wellbeing Board noted the End of Year Report and 2020/21 Priorities.

5. HWB Covid-19 Reset: rapid research with HWBs

The Chairman invited Caroline Bosdet, Senior Adviser, to introduce the report.

Caroline began by thanking the Health & Wellbeing Board (HWB) Chairs who participated in the rapid research commissioned by the LGA's Care and Health Improvement Programme.

Caroline highlighted that since the last Board meeting, continued engagement with Chairs provided opportunities to look at the role of the Board, steer the support offer and gain feedback. The HWB reset tool designed to support HWB Chairs move into the next stage of COVID-19, would incorporate a link to Local Outbreak Plans and offer bespoke facilitated virtual peer support for members.

Following the introduction, Members made the following comments:

- The Mental Health Partnership Boards could be really effective if properly supported. However, the dynamics of the Boards is different in each local authority and strategic support from HWBs would help moving forward as would gaining feedback from partners and those that use and support the service would.
- There were growing concerns around maintaining air quality moving out of lockdown need to be considered on HWB strategy.

Decision

Members of the Community Wellbeing Board noted the report and agreed the revised support offer set out in paragraph 7.

6. Update on other board business

The Chairman invited Laura Caton, Senior Advisor, to provide an update on the LGA's Armed Forces Covenant work.

Laura updated the Board on the Ministry of Defence's (MoD) plans to introduce a statutory duty for public authorities to have due regard to the armed forces covenant, across health and social care, housing and education, but not employment. The current proposal considered by Lead Members and Improvement and Innovation Board set out fairly minimal requirements. Laura added that any new duties must be accompanied by new funding due to differences in local authority capacity around covenant implementation. Overall, capacity is reducing as local government funding from the armed forces covenant trust continues to decrease. A new statutory duty

Local Government Association

proposal should also be subject to a formal 12-week consultation.

Laura said that she would update Lead Members when further information on the new duty was available from the MoD.

Members made the following comments on the report:

- There was a danger that the issue of low uptake of routine childhood immunisations would fall off the radar as a result of Covid-19 but the pandemic also gives a strong opportunity to promote the importance of vaccination to parents. Paul followed up the comment to stress the importance of childhood immunisation and the concerns parents have taking their children to the GP during the pandemic. The LGA continues to work closely with PHE and Institute of Health Visiting.
- What work is being done about GP registrations for the armed forces community, as it causes many problems for families and individuals who have to move around the country for work. Laura said that there are challenges around some GP practices and more needed to be done to raise awareness of the covenant.

Decision

Members of the Community Wellbeing Board noted the update.

7. Note of the last meeting

Members agreed minutes of the previous meeting held on Thursday 26 March 2020.

Appendix A – Attendance

Position/Role	Councillor	Authority
Chairman	Cllr Ian Hudspeth	Oxfordshire County Council
Vice-Chair	Cllr Paulette Hamilton	Birmingham City Council
Deputy-chair	Cllr Richard Kemp CBE	Liverpool City Council
Committee Member	Cllr David Fothergill	Somerset County Council
Committee Member	Cllr Adrian Hardman	Worcestershire County Council
Committee Member	Cllr Colin Noble	Suffolk County Council
Committee Member	Cllr Judith Wallace	North Tyneside Council
Committee Member	Cllr Sue Woolley	Lincolnshire County Council
Committee Member	Cllr David Coppinger	The Royal Borough of Windsor and Maidenhead
Committee Member	Cllr Wayne Fitzgerald	Peterborough City Council
Committee Member	Cllr Arnold Saunders	Salford City Council
Committee Member	Cllr Helen Holland	Bristol City Council
Committee Member	Cllr Arooj Shah	Oldham MBC
Committee Member	Cllr Shabir Pandor	Kirklees Metropolitan Council

Local Government Association

Committee Member	Cllr Natasa Pantelic	Slough Borough Counci
Committee Member	Cllr Amy Cross	Blackpool Council
Committee Member	Cllr Denise Scott-McDonald	Royal Borough of Greenwich
Committee Member	Cllr Bob Cook	Stockton-on-Tees Borough Council
Committee Member	Cllr Doreen Huddart	Newcastle upon Tyne City Council
Committee Member	Cllr Neil Burden	Cornwall Council
Committee Member	Cllr Tim Hodgson	Solihull Metropolitan Borough Council
In attendance	Sir Muir Gray	Optimal Ageing
LGA Officers	Mark Norris Alyson Morley Paul Ogden Laura Caton Matthew Hibberd Naomi Cooke Jonathan Bryant Tahmina Akther	
Apologies	Cllr Claire Wright	Devon County Council