Notice of Health and Adult Social Care Overview and Scrutiny Committee

Date: Monday, 2 September 2019 at 6.00 pm

Venue: HMS Phoebe, Town Hall, Bournemouth BH2 6DY

Membership:

Chairman:
Cllr L Northover

Vice Chairman:
Cllr L-J Evans

Cllr H Allen	Cllr C Johnson	Cllr K Rampton
Cllr J Edwards	Cllr L Lewis	Cllr R Rocca
Cllr N C Geary	Cllr C Matthews	Cllr T Trent

All Members of the Health and Adult Social Care Overview and Scrutiny Committee are summoned to attend this meeting to consider the items of business set out on the agenda below.

The press and public are welcome to attend.

If you would like any further information on the items to be considered at the meeting please contact: or email

Press enquiries should be directed to the Press Office: Tel: 01202 454668 or email press.office@bcpcouncil.gov.uk

This notice and all the papers mentioned within it are available at democracy.bcpcouncil.gov.uk

Available online and on the Mod.gov app

GRAHAM FARRANT
CHIEF EXECUTIVE

22 August 2019

AGENDA

Items to be considered while the meeting is open to the public

1. Apologies

To receive any apologies for absence from Councillors.

2. Substitute Members

To receive information on any changes in the membership of the Committee.

Note – When a member of a Committee is unable to attend a meeting of a Committee or Sub-Committee, the relevant Political Group Leader (or their nominated representative) may, by notice to the Monitoring Officer (or their nominated representative) prior to the meeting, appoint a substitute member from within the same Political Group. The contact details on the front of this agenda should be used for notifications.

3. Declarations of Interests

Councillors are required to comply with the requirements of the Localism Act 2011 regarding disclosable pecuniary interests. Declarations received will be reported at the meeting.

4. Confirmation of Minutes 5 - 14

To confirm the minutes of the meetings held on 17th June and 22 July.

a) **Action Sheet** 15 - 16

To note and comment as required on the action sheet which tracks decisions, actions and outcomes arising from previous Committee meetings.

5. Public Issues

To receive any public questions, statements or petitions submitted in accordance with the Constitution. Further information on the requirements for submitting these is available to view at the following link:-

https://democracy.bcpcouncil.gov.uk/documents/s2305/Public%20Items%20-%20Meeting%20Procedure%20Rules.pdf

The deadline for the submission of public questions is 26 August 2019

The deadline for the submission of a statement is 12.00 noon, 1st September 2019

The deadline for the submission of a petition is 12.00 noon, 1st September 2019

6.	**Update on the Outcome of a Judicial Review Process and the Independent Review Panel Process** Update on the Outcome of a Judicial Review process related to changes to local health services proposed by Dorset Clinical Commissioning Group and Up-date on the Independent Review Panel process following referral to the Secretary of State of local health service changes proposed by Dorset CCG.	17 - 108
7.	**Safeguarding Adults Board - Annual Report and Business Plan** The Committee will receive an introduction to the Adult Safeguarding Board and will be able to scrutinise the Annual Report and Business Plan.	109 - 174
8.	**Dorset Clinical Commissioning Group (CCG) - Mental Health Rehabilitation Services** To Committee will receive information from the CCG on a proposed new model of service for mental health rehabilitation services.	175 - 256
9.	**Bournemouth, Christchurch and Poole Council's Safeguarding Strategy** To comment on the BCP Safeguarding Strategy prior to its consideration at Cabinet on 30th September.	257 - 292
10.	**Forward Plan** To consider and amend the Committee's Forward Plan as appropriate.	293 - 300
11.	**Future Meeting Dates** For Councillors to note the meeting dates of the committee, as listed below: Monday 18 November 2019 – Christchurch Civic Centre Monday 20 January 2020 – Bournemouth Town Hall Monday 2 March 2020 – Christchurch Civic Centre	

No other items of business can be considered unless the Chairman decides the matter is urgent for reasons that must be specified and recorded in the Minutes.

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BOURNEMOUTH, CHRISTCHURCH AND POOLE COUNCIL

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the Meeting held on 17 June 2019 at 7.15 pm

Present:-

– Chairman

– Vice-Chairman

Present:	Cllr H Allen, Cllr J Edwards, Cllr L-J Evans, Cllr C Johnson, Cllr L Lewis, Cllr C Matthews, Cllr L Northover, Cllr K Rampton, Cllr R Rocca and Cllr T Trent
Also in attendance:	Cllr L Dedman
Officers in attendance:	Jan Thurgood (Corporate Director for Adult Social Care), Sam Crowe (Director of Public Health) and Phil Hornsby (Service Director of Adult Social Care Commissioning)

Cllr C Matthews in the Chair.

1. Apologies

Apologies for absence were received from Councillor N C Geary.

2. Substitute Members

Councillor P Hilliard substituted for Councillor N C Geary.

3. Declarations of Interest

There were no declarations of interest.

4. Election of Chairman of the Health and Adult Social Care Overview and Scrutiny Committee.

RESOLVED:

That Councillor L Northover be elected Chairman of the Health and Adult Social Care Overview and Scrutiny Committee for the 2019/2020 Municipal Year.

5. Election of Vice-Chairman of the Health and Adult Social Care Overview and Scrutiny Committee

Councillor L Northover in the Chair.

RESOLVED:

That Councillor L-J Evans be elected Vice-Chairman of the Health and Adult Social Care Overview and Scrutiny Committee for the 2019/2020 Municipal Year.

6. Public Speaking

The Democratic Services Officer reported that there was one statement received.
The Committee noted that the following statement did not directly relate to an item of business on the agenda for the meeting but was within the remit of the Overview and Scrutiny Committee.
Statement by David d'Orton-Gibson:
'*When you don't have your health, most other things don't matter. We have lovely beaches, no good if your health won't let you get down there. We encourage employment, of no use if you are not well to get to work. And I could go on. It was this experience that led me to launch "Bournemouth, Health at the heart". What I was pushing for was that in every decision the council makes we should consider the health implications. Does changing the road layout encourage more cars to speed past or does it encourage active travel? I would commend to this panel the idea of adapting BCP Health at the heart*.'

7. Future Meeting Dates

The Committee considered a list of future meeting dates and suggested venues.

The Corporate Director of Adult Social Care reported on the latest position regarding the Dorset Clinical Services Review ('CSR') and advised the Committee about latest developments relating to referral to the Secretary of State.

The Committee agreed that this matter should be brought forward for discussion at the next scheduled meeting of the Committee on 22nd July 2019. Because this issue was likely to attract considerable interest within the Poole area, it was also agreed that this meeting should be held at the Poole Civic Centre. There would also be further training for Members of the Committee prior to the meeting.

Cllr Edwards informed the Committee that a question that she had submitted had been answered by Officers ahead of the meeting but sought further assurance that Ward Councillors would be kept informed about service delivery proposals within their respective Wards. The Corporate Director assured Members that this would be done. Members would also be closely involved in the development of new service strategies as they were brought forward for discussion.

The meeting ended at 7.50 pm

CHAIRMAN

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BOURNEMOUTH, CHRISTCHURCH AND POOLE COUNCIL

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the Meeting held on 22 July 2019 at 6.00 pm

Present: -

Cllr L Northover – Chairman

Cllr L-J Evans – Vice-Chairman

Present:	Cllr H Allen, Cllr J Edwards, Cllr C Johnson, Cllr L Lewis, Cllr K Rampton, Cllr R Rocca, Cllr T Trent, Cllr M F Brooke and Cllr P Hilliard
Also in attendance:	Jan Thurgood – Corporate Director for Health and Adult Social Care Tanya Coulter – Service Director Legal and Democratic Sam Crowe – NHS Public Health Dorset Phil Richardson – Dorset CCG Mark Harris – Dorset CCG

8. Apologies

Apologies were received from Councillor N Geary and Councillor C Matthews

9. Substitute Members

Councillor P Hilliard acted as substitute for Councillor N Geary

Councillor M Brooke acted as substitute for Councillor C Matthews

10. Declarations of Interests

There were no declarations of Pecuniary Interest. For Transparency Councillor C Johnson informed the Committee she was a staff nurse at Royal Bournemouth Hospital and For Transparency Councillor L-J Evans informed the Committee she was a bank NHS employee.

11. Public Issues

There were no public questions, statements or petitions submitted for this meeting

12. Independent Reconfiguration Panel - Dorset CCG Clinical Services Review

The Monitoring Officer presented a report, a copy of which has been circulated and appears as Appendix ‘A’ of these minutes in the Minute Book.

Dorset Health Scrutiny Committee sent a referral to the Secretary of State for Health. A letter of support for the referral was also sent from Poole Borough Council. The referral was sent due to concern regarding elements of the Clinical Services Review undertaken by Dorset Clinical Commissioning Group.

The Committee received an update on the progress of the referral which had been sent by the Secretary of State to the Independent Reconfiguration Panel. This Panel would independently review the proposed reconfiguration along with the contents of the referral and any objections.

The Independent Review Panel (IRP) were waiting for a form from NHS England, which would contain detailed information from NHS England and Dorset Clinical Commissioning Group . The IRP would then consider the form and any additional information it might need from the Councils before forming a final opinion to submit to the Secretary of State. There had been no intimation of timescales, but the referral could be considered late summer/autumn. The Appendix to the report contains the associated correspondence.

RESOLVED that: -

(a) The current position be noted;

(b) A further report be provided to the Committee when additional information became available.

13. An overview of the Dorset Integrated Care System

The Committee received a presentation from the BCP Council Corporate Director of Health and Adult Social Care, the Director of Public Health for Dorset and the CCG's Head of Service for Mental Health and Learning Disabilities and Director of Transformation. The presentation provided Councillors with an overview of the Dorset Integrated Care System and the Sustainability and Transformation Plan as well as updates on Primary Care and mental health and learning disabilities services.

The BCP Council Corporate Director of Health and Adult Social Care explained Integrated Care Systems were a collaboration between all local health organisations and Councils to ensure a joined-up approach to the strategic planning and delivery of local services in order to improve the health outcomes of local people and populations; to ensure the integration of services for the benefit of local people and to ensure the best use of public sector funding. The Dorset Integrated Care System included the Dorset Clinical Commissioning Group, which is responsible for commissioning local health services and all local health trusts providing

services, including the three acute hospital trusts in Dorset, the Dorset Healthcare Trust and the South West Ambulance Trust.

A Sustainability and Transformation Plan for Dorset had been agreed by all partners to the Dorset Integrated Care System and approved nationally that set out the system's ambitions for the improvement of residents' health and wellbeing and the efficient use of its resources. The system also sought to ensure services were sustainable and partners were working together effectively in order to provide the best possible quality of care to residents.

The Director of Public Health for Dorset informed the Committee of the achievements of the Sustainability and Transformation Plan and explained that a refresh of the plan would be undertaken over Summer 2019, which would lead to a new plan which was in line with the national NHS Long Term Plan published in January 2019. It was particularly highlighted that the new plan would include greater involvement from the Councils' due to a recognition that the wider deteminants of good health (such as good housing and education) are core to the responsibilities of local authorities.

The CCG Director of Transformation gave an update on plans for primary care. It was explained that national plans had recognized the workforce pressures on GP's and Primary Care Networks had been introduced to improve sustainability by delivering primary care at scale. All of Dorset was covered by a network with each network covering a population of between 20,000 to 50,000 people. The networks included GP's and other professionals who could provide services closer to home.

The Primary Care Network Plan 19/20 was particularly focused on population health. This was a move away from a focus on medical aspects of health to a health and wellbeing approach. This led to greater investment into the community and included greater integration of primary and community services. There was an emphasis on collaboration between professionals and services and an aspiration to consider individuals needs in a way that allowed them to live the life they chose.

The BCP Corporate Director of Health and Adult Social Care explained that there were 18 networks across Dorset and BCP. The networks worked within local areas which allowed the Primary Care Networks membership to be tailored to meet local need. Additionally, GP networks would receive a sum of almost £1.5 miliion over the coming 5 years and the networks needed to develop plans to meet their local community's needs by developing a range of services such as social prescribing and recruiting professionals, including paramedics and pharmacists.

The CCG Head of Service for Mental Health and Learning Disabilities provided an update on mental health and learning disabilities. The importance of affording the same value to mental health as physical health was expressed to the Committee and a desire to work together to achieve the best outcomes for the person. Key Pieces of work were highlighted

including work on the Mental Health Acute Care Pathway, the new Retreat facilities and community front rooms, recovery beds and Safe Stop.

It was explained that important work around the mental health of children and young people was underway, particularly in regard to their access to services. A Joint Steering Group, that included Public Health and the Council's Children's Services professionals, had developed a Transformation Plan in order to improve the offer and services available to this group. Successes included Kooth online counseling and the provision of mental health support teams in schools. A business case had been provided to NHS England for a crisis and home treatment team specifically for young people.

Additional initiatives included annual physical health checks and follow up treatment for people with a serious mental illness, 24/7 Psychiatric liaison around acute hospitals, a mental health rehabilitation and a dementia service review and the improvement of access to psychological therapies. Additionally, there was a Transforming Care Program that sought to bring people receiving care outside of the area back into their own accommodation where appropriate.

It was explained to the Committee that the work set the background and context of the Sustainability and Transformation Plan and the Integrated Care Plan. The Committee were then asked to consider the NHS Long Term Plan and the plans key emerging themes. It was highlighted that the NHS Long Term Plan should include collaboration across services, care across the life course and a personalized care approach.

It was highlighted that to deliver the ambitions of the plan there needed to be a focus on doing things differently, tackling prevention and understanding health inequalities, backing the workforce, making better use of data and digital technology and getting the most out of taxpayers' investment in the NHS Investment. The emerging themes for the ICS Plan were around individuals, communities, living well, wellbeing, the workforce and digital innovation.

The Plan was out for public consultation and could be accessed through the Our Dorset website. It was also highlighted that the engagement team were out talking to members of the public. The 1st draft off the plan would be signed off in September by local Health Trust Boards and the BCP and Dorset Health and Well-Being Boards. The Final submission would be in November.

A number of questions were raised and discussed by members including

- The Integrated Care System and the integration of budgets and ensuring there were no excluded population groups;
- The need for future presentations to have BCP specific information;

- The use of the word 'system' and reassurance that individual needs are not lost in the jargon;
- Reassurance that professionals have the right training to ensure individuals get the right treatment and there isn't a global approach to health and wellbeing;
- A recognition that Healthwatch is a key stakeholder and the importance of being fully engaged with them;
- That it was too early to tell whether the available services were decreasing the number of people with mental health issues in crisis;
- That no particular age group was presenting in crisis and that children, young people, adults and elderly people's needs were being considered;
- That the retreat is a café style partnership between the statutory and voluntary sector where people can come if they're in crisis;
- That a report would be preferred in the future so the committee could have time to digest the information and ask more detailed questions;
- Details of the number of people with mental health and learning disabilities who are currently out of area and some considerations related to moving them back into the area;
- The impact of additional house building on health and social care services and the importance of working collaboratively to ensure sustainability;
- That personal health budgets were available and publicized on the NHS and CCG websites;
- That the survey for The Dementia Review would be circulated to the Committee after the meeting;
- The importance of being proactive in order to engage hard to reach groups;
- Reassurance that Dorset Integrated Care System isn't a cost cutting exercise and its focus is on the quality of outcomes;
- The challenge for the integrated care system of bringing together providers of homelessness services. An expression of interest had been submitted to Public Health England's Rough Sleepers Grant Scheme.

14. Forward Plan

The Overview and Scrutiny Specialist introduced the Committees Forward Plan, a copy of which had been circulated and appears as Appendix 'C' to these minutes in the minute book. The Overview and Scrutiny Specialist also introduced a scoping report that recommended the establishment of a focus group to consider the new Charging Policy for Adult Social Care for BCP Council. A copy of the report had been circulated and appears as an Appendix to the Forward Plan in the minute book.

RESOLVED that: -

(a) The Committee agreed the items on the Forward Plan at Appendix 'C' subject to the inclusion of an additional item on the Councils Safeguarding Strategy

(b) The Committee agreed to establish a working group to focus on the Charging Policy Project. It was agreed that the working group would consist of three Alliance Group members, 2 Conservative members and a representative from Healthwatch.

Voting: 7/4

Note: A vote for the membership to include three Alliance Group members and three conservative members was lost via casting vote 5/5. There was one abstention.

15. Future Meeting Dates

For Councillors to note the meeting dates of the committee, as listed below:

Monday 18 November 2019 – Christchurch Civic Centre
Monday 20 January 2020 – Bournemouth Town Hall
Monday 2 March 2020 – Christchurch Civic Centre

The meeting ended at 8.08pm

CHAIRMAN

ACTION SHEET – BOURNEMOUTH, CHRISTCHURCH AND POOLE ADULT HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Minute number	**Item**	**Action*** *Items remain until action completed.	**Benefit**	**Outcome** (where recommendations are made to other bodies)
Actions arising from Board meeting: 22 July 2019				
12	**Independent Reconfiguration Panel – Dorset CCG Clinical Services Review**	Decision Made: That the Health and Adult Social Care Overview and Scrutiny Committee Receive an update on the Outcome of the Independent Reconfiguration Panel ✓**Actioned – Request captured on Committee Forward Plan**	To enable the Committee to maintain oversight of this issue.	N/A
13	**NHS Dorset Clinical Commissioning Group - An Overview of the Dorset Integrated Care System**	Decision Made: The Panel to receive BCP specific information from the CCG on the Dorset Integrated Care System That a link to the Dementia Services Review be provided to members ✓ **Actioned – Link circulated to Councillors by email 23 July 2019**	To enable O&S to sufficiently consider The integrated Care System information relevant to BCP To allow Committee members the opportunity to contribute to the consultation on Dementia Care	N/A N/A

Minute number	Item	Action* *Items remain until action completed.	Benefit	Outcome (where recommendations are made to other bodies)
		That a link to the consultation on health priorities be circulated to members **Actioned – Link circulated to Councillors by email 25 July 2019**	To allow Committee members the opportunity to contribute to the consultation on health priorities	N/A
14	**Forward Plan**	The Committee agreed to establish a working group to focus on the Charging Policy Project	To act as a test and challenge function in the development of the new Charging Policy for ASC for the Council	N/A

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Report subject	**Up-date on the Outcome of a Judicial Review process related to changes to local health services proposed by Dorset Clinical Commissioning Group and Up-date on the Independent Reconfiguration Panel process following referral to the Secretary of State of local health service changes proposed by Dorset CCG**
Meeting date	2 September 2019
Status	Public Report
Executive summary	This Report provides an update for the Committee on the outcome of a Judicial Review relating to the proposed changes to the delivery of health services in Dorset. It also provides a further update following the one to the last meeting of the Committee about the referral to the Secretary of State and the work of the Independent Reconfiguration Panel (IRP).
Recommendations	**It is RECOMMENDED that:** **(a) The Committee notes the current position, and** **(b) Requests a further report be provided to the Committee when additional information is available**
Reason for recommendations	To ensure that the Committee is kept up to date about the progress of the referral and related legal proceedings.

Portfolio Holder(s):	Councillor Lesley Dedman, Portfolio Holder for Adults & Health
Corporate Director	Jan Thurgood, Corporate Director, Adult Social Care
Contributors	Tanya Coulter, Director, Law & Governance
Wards	All wards
Classification	For Update and Information

Background

1. The Committee received a Report at its meeting on 22 July 2019 which set out the background to this matter and the legislative framework which is applied to a referral made to the Secretary of State.
2. In addition, and separately to the referral made to the Secretary of State, a challenge to the proposed re-organisation of health services in Dorset was made by way of Judicial Review by a local resident and this application was initially refused by the High Court. An appeal against this refusal was heard by the Court of Appeal on the 24 July 2019.

Update on Current Position

3. The Court of Appeal considered the appeal and refused permission to appeal against the judgement of the High Court. The Judgement of the Court and the Order are attached for information so that members of the Committee can be fully appraised of the issues considered by the Court in this matter. They are attached as Appendix A and B respectively.
4. The challenge by way of Judicial Review is a separate process to the referral to the Secretary of State. The Independent Reconfiguration Panel will consider the matters raised with the Secretary of State, as set out in the previous Report.
5. As at the date of the previous Committee meeting, the IRP were awaiting information from the CCG as part of the standard process. This information is provided on a pro-form used for this purpose in each case by the IRP. This information has been sent to the IRP and is attached for information at Appendix C. This is to ensure members of the Committee have all available information which has been presented to the IRP and are kept fully informed of the process.
6. At the time of preparing this Report no further information about the timescale for completion of this Review has been received by the Council. Officers will endeavour to find out further information in this respect before the date of the Committee meeting and will update members of the Committee verbally in this regard.

Summary of financial implications

7. There are no financial implications arising from this report.

Summary of legal implications

8. The referral was made pursuant to the relevant Regulations and statutory process. The Secretary of State has to consider the referral and will do so taking account of the independent advice of the Independent Reconfiguration Panel. The Council may be asked to provide further information pursuant to the referral and the Committee will be advised should this be the case.

Summary of human resources implications

9. There are no human resources implications arising from this report.

Summary of environmental impact

10. There are no environmental implications arising from this report.

Summary of public health implications

11. There are no public health implications arising from this report.

Summary of equality implications

12. There are no equality implications arising from this report.

Summary of risk assessment

13. The referral has been made by a predecessor Council and the Council is obliged to engage and provide information in line with the statutory process which applies. There is a potential risk of delay in the process which could cause uncertainty in regard to future arrangements, however the Council is not in a position to mitigate this risk other than to ensure that it provides information if requested to do so in a timely manner.

Background papers

None

Appendices

Appendix 1: Court of Appeal judgement
Appendix 2: Court Order
Appendix 3: Submission of information to IRP by CCG

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Appendix 1

Neutral Citation Number: [2019] EWCA Civ 1412

Case No: C1/2018/2334

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE,
ADMINISTRATIVE COURT
SIR STEPHEN SILBER SITTING AS A DEPUTY HIGH COURT JUDGE
CO/5867/2017

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 07/08/2019

Before :

THE SENIOR PRESIDENT OF TRIBUNALS
LORD JUSTICE BEAN
and
LADY JUSTICE SIMLER

- -

Between :

ANNA HINSULL	**Appellant**
- and -	
NHS DORSET CLINICAL COMMISSIONING GROUP	**Respondent**

- -
- -

Jason Coppel QC and **Hannah Slarks** (instructed by **Leigh Day**) for the **Appellant**
Fenella Morris QC and **Annabel Lee** (instructed by **Capsticks LLP**) for the **Respondent**

Hearing date: 24 July 2019

- -

Approved Judgment

Lady Justice Simler:

Introduction

1. Having heard this application for permission to appeal (on 24 July 2019) from the order of Sir Stephen Silber dismissing a judicial review challenge to a series of decisions (that followed a Clinical Services Review, "the CSR", and a lengthy formal consultation process) made by the Dorset Clinical Commissioning Group ("the CCG") on 20 September 2017 ("the Decisions"), the Court announced that permission to appeal is refused, indicating that reasons would follow later. These are my reasons for having agreed to that decision.

2. The appellant, Ms Anna Hinsull, has the misfortune to suffer from a large number of different health conditions and is heavily dependent on safe access to emergency health care, hitherto provided at Poole General Hospital ("Poole Hospital") which is close to her home.

3. She challenged the Decisions which made significant changes to the configuration of health services in the Dorset area as a result (among other things) of a significant shortfall in funding and increasing demand on health care and social care services. Her particular concern is that the Decisions reduce acute hospital provision at a time when demand for acute hospital beds is increasing, by closing the Accident and Emergency ("A&E") unit at Poole Hospital, leaving only two acute units in Dorset: one at the Royal Bournemouth Hospital ("RBH") (which is 8.5 miles from Poole) and the other at Dorset County Hospital ("Dorset Hospital") in Dorchester. She also challenges the proposed closure of Poole Hospital's Specialist Maternity Unit, with its consultant-led maternity and paediatric services proposed to be delivered only from RBH and Dorset Hospital.

4. The grounds of challenge were many and varied and overlapped to a substantial extent. All were rejected by the Judge in a detailed judgment that deals comprehensively with the background and process leading to the Decisions (see paragraphs 7 to 29) and the legal and factual issues arising from each ground of challenge.

5. Three of the grounds advanced below are raised on this appeal. They and the Judge's answer to them in summary, are as follows:

i) **The sufficiency of social care workforce issue.** The appellant contends (and contended below) that the Decisions should be quashed because the CCG failed to have regard to the relevant consideration of whether there would be a sufficient social care workforce to deliver its new integrated model of community provision.

The Judge dealt with this issue at paragraphs 42 to 91 of the judgment. He concluded, in summary, that the CCG appreciated the significance of the need for a sufficient social care workforce (paragraph 78) and its Governing Body was aware that this question was subject to continuing work after the Decisions were taken. That was an approach the CCG was entitled to take. It considered all material factors and developed a clear strategy that it would "continue to work on workforce development alongside partner organisations" as Dorset County Council recommended it should do

(paragraph 91). This approach was neither *Wednesbury* unreasonable nor in breach of the CCG's public law obligations.

ii) **The alternative community provision issue.** The appellant contends (and contended below) that the Decisions should be quashed because the CCG failed adequately to investigate and reach a conclusion on whether alternative community provision could be put in place, before deciding to close hospital beds, contrary to the *Tameside* duty of careful enquiry, with its duty to make further enquiries as to what alternative community provision would need to be put in place to achieve the reduction in demand for acute hospital care; how the workforce for this community provision would be recruited; and how it would be paid for.

The Judge dealt with this issue at paragraphs 92 to 102 of his judgment. He accepted the evidence and arguments that the CCG was entitled to act as it did. In other words, in the context of a decision to reconfigure health service arrangements in Dorset, comprising a large number of interrelated decisions concerning community services, acute hospital services, and maternity and paediatric services across the area, the judge was satisfied that the CCG took reasonable steps to acquaint itself with the relevant information and was entitled to act as it did. He therefore rejected the contention that the CCG acted unlawfully by failing adequately to investigate and reach a conclusion on whether alternative community provision could be put in place before deciding to close hospital beds.

I note in this context that there was a separate ground of appeal relating to the CCG's alleged failure to take account of the requirements of the new "bed closure test". This ground failed below and is no longer pursued on this appeal.

iii) **The travel time issue**. The appellant contends (and contended below) that the Decisions should be quashed because the CCG failed to consider adequately the impact of increased travel times in emergency cases to RBH, which was the major emergency hospital rather than Poole Hospital which was the more centrally located hospital.

The judge dealt with this issue at paragraphs 126 to 157 of his judgment. In summary, the judge concluded that contrary to the appellant's case, the CCG in fact equipped itself with the appropriate information required to apply the accessibility criterion. The CCG reached conclusions open to it on the information available and considered appropriately the issue of access to services for those in the more remote and isolated areas of Dorset. Moreover, it was open to the CCG to conclude that the advantages of improved health services under the proposed reconfiguration outweighed any problems caused by increased journey times (see, in particular, paragraph 157).

The CCG obtained a number of specific reports on this issue, including a report by South Western Ambulance Service NHS Trust ("SWAST") "to establish the potential impact of the proposed CSR reconfiguration on the emergency ambulance services". The judge held that the CCG was entitled to conclude that the statistics and analysis in that detailed report analysed a total of 21,994 patient records covering all incidents where an ambulance attended and conveyed a patient to hospital during the period 1 January 2017 to 30 April 2017. The judge found that the CCG was entitled to rely on that report to conclude that the additional clinical risk caused by the increased travel times as a result of implementing the proposed reconfiguration was minimal.

6. In summary, Mr Jason Coppel QC, who appears with Ms Hannah Slarks on behalf of the appellant, contends that Sir Stephen Silber's judgment on these grounds is "replete with significant errors on key issues and glosses over and fails to grapple with the most problematic aspects of the CCG's defence to the claim". He maintains this is not a merits challenge, but a process challenge to the decision-making in the context of very significant changes to the delivery of healthcare services, against a background of a crisis in both health and social care, and giving rise to what he described as questions of life and death for residents of Dorset.

7. Mr Coppel accepts nonetheless that the approach to be adopted by this court on appeal is the standard approach to appeals of this kind: if, after reviewing the judge's judgment and any relevant evidence, the appellate court considers that the judge approached the questions raised on judicial review correctly as a matter of law and reached decisions which he or she was entitled to reach on the evidence and findings made, then the appellate court will not interfere. If, on the other hand, after such a review, the appellate court considers that the judge made a significant error of principle in reaching a conclusion or reached a conclusion that should not have been reached, then, and only then, will the appellate court reconsider the issue for itself if it can properly do so.

The statutory framework and applicable legal principles

8. The judge set out the relevant statutory framework created by the Health and Social Care Act 2012 which amended the National Health Service Act 2006, establishing CCGs as bodies corporate, responsible for commissioning, that is arranging for the provision of various services to the extent they consider necessary to meet the reasonable requirements of people for whom they have responsibility (see s.3 (1) of the 2006 Act). No criticism is made of this part of the judgment, and it is not repeated here.

9. Further, the approach of the courts to a judicial review challenge of this kind is well established and not in dispute. The judge dealt with the applicable legal principles at paragraphs 40 and 41. Again, I do not repeat them here.

The factual background leading to the Decisions

10. The factual background is comprehensively described by the judge. I summarise it below based on the judge's findings, which are gratefully adopted.

11. Prior to the Decisions, Dorset, a mainly rural county, had three acute hospitals, each with A&E departments and maternity units, (though Bournemouth Hospital's maternity unit was only midwife-led and delivered 350 babies compared to over 4,500 babies at Poole Hospital in the same year). Each hospital offered planned services, although there was some degree of specialisation between the hospitals. For example, cardiac cases went to Bournemouth Hospital, while trauma and emergency maternity cases were dealt with at Poole Hospital. Poole Hospital was the busiest county maternity unit, delivering two-thirds of the county's babies born in hospital and providing Dorset's only neonatal unit offering high-dependency and intensive care.

12. By 2012, Dorset, like the rest of England, had been facing, and was continuing to face, a crisis. The judge set out the six main causes of the crisis. They included a

population older than the national average which placed particular demands on the health and social care system; and the fact that the CCG was spending more money than it received and was facing a shortfall of £158 million each year by 2020/2021.

13. The Governing Body of the CCG recognised the future challenges facing the healthcare of Dorset in 2013 and approved the initiation of the CSR programme in March 2014. The purpose of the CSR was to establish a clear commissioning plan for Dorset by looking at the areas where there was a need for change, including changing health needs, variation in quality of care, specialist treatments, clinical unsustainability, workforce unsustainability and financial pressures.

14. The CSR's in-depth review programme was launched in October 2014. The overriding approach of the CSR was to ensure that the design of healthcare in Dorset was clinically led and evidence-based. Throughout the process, primary stakeholder partners and reference groups were engaged to inform the development of options for consultation. In particular, the NHS Commissioning Board ("NHS England") was involved in the CSR from the beginning and made a significant input in the development of potential options. In accordance with best practice guidelines, NHS England undertook an assurance process of the plans for consultation and models of care for the future, and continued to do so.

15. The CSR was led by frontline workers from Dorset's health and care organisations. These professionals, in a number of Clinical Working Groups, looked in depth at options for how services could be organised. They considered current services, best practice care pathways and potential models of care for their service area and options for delivering these in Dorset. A strategic Clinical Reference Group was established to be the main clinical advisory group of the review.

16. In January 2015, the CCG published its “Case for Change”. Through the CSR, Dorset CCG aimed to deliver five key ambitions which were:

    i) Services organised around people;

    ii) Supporting people to stay well and take better care of themselves;

    iii) Delivering more care closer to home;

    iv) Integrated teams of professionals working together;

    v) Centralised hospital services.

17. On 10 April 2015, NHS England completed the first stage of the assurance process, "the Strategic Sense Check". This meant that the CSR programme could be entered onto the NHS England reconfiguration grid, and became subject to the full assurance framework.

18. As was explained in the consultation document, the CCG originally hoped to go to public consultation in August 2015. Extensive stakeholder and professional feedback, however, made clear that more work was needed to be done in a number of areas – in particular around community services, where 90% of services were provided, and with joint working between health and care providers. As a result, since August 2015,

the CCG has placed significant focus on community health and care services as well as continuing to work on the options for acute hospital services.

19. Following considerable engagement with stakeholders and others, the CCG identified six criteria drawn up by doctors and other health professionals in conjunction with the Patient (Carer) and Public Engagement Group by which to evaluate the different options:

    i) The quality of care and patient safety;

    ii) Access to services (travel);

    iii) Cost and affordability;

    iv) The impact on staff (workforce);

    v) Whether the changes would be delivered within the required timescale (deliverability); and

    vi) Other factors such as research and education.

20. The CCG proposed that Poole and Bournemouth Hospitals (both located in the east of the county) should have their own distinctive roles. One would be a hospital for major planned care, allowing for continuous delivery of treatment away from the disruption that urgent and emergency care can create. The other would be a major emergency hospital with more consultants available more of the time to deal with urgent and emergency care. By specialising in this way, the evidence showed that outcomes for patients could be improved and more lives could be saved. In both scenarios, Dorset Hospital would remain a district general hospital serving the west of the county and providing planned and emergency care.

21. In November 2016, NHS England gave confirmation of Stage 2 Assurance which approved the proposals against the Government's "Four Tests of Reconfiguration". This meant that the proposals could proceed to formal public consultation. This assurance incorporated inputs from the Wessex Clinical Senate, which provided independent clinical advice on the proposals.

22. The CCG launched its formal consultation on 1 December 2016, which lasted for 12 weeks, closing on 28 February 2017. Two options were put forward in respect of acute hospital services. Option A had Poole Hospital as the major emergency hospital with Dorset Hospital as a planned and emergency care hospital and RBH as the major planned care hospital. Under Option B, Poole Hospital was to be the planned care hospital with Dorset Hospital as a planned and emergency care hospital and RBH as the major emergency hospital.

23. The CCG preferred Option B. In most areas of evaluation, both options rated the same and so ultimately the decision between the two came down to access and affordability. In both areas, Option B was rated more highly than Option A.

24. The consultation responses were independently analysed and reported on by Opinion Research Services and quality assured by the Consultation Institute. The Consultation Institute awarded the CCG "best practice" accreditation for the CSR consultation.

25. Initial feedback from the public consultation highlighted some areas where the CCG felt further work was needed to enable the Governing Body to make their decision. These areas were:

    i) Transport / travel times (emergency and non-emergency);

    ii) Clinical risk;

    iii) Equality Impact Assessment;

    iv) Health and wellbeing.

26. As a result, the CCG commissioned additional work (a) on emergency transport from SWAST, (b) on non-emergency transport from Dorset County Council, (c) a review of clinical risk by the CCG Deputy Director of Nursing and Quality, (d) a robust review of the Equality Impact Assessment; and (e) a review by Public Health Dorset (a partnership of Bournemouth, Poole and Dorset Councils) of concerns about health and wellbeing from a prevention perspective.

27. In addition, a detailed programme of events and workshops was organised between July and September 2017 to ensure that the consultation responses were shared with and considered by members of the CCG's Governing Body and key partner organisations during their detailed deliberations in preparation for the decision-making meeting on 20 September 2017.

28. The CSR set out the information required by the Governing Body to make their decisions on the configuration of healthcare services for Dorset in its document entitled, Decision-Making Business Case (September 2017) (referred to as "the DMBC") and made its recommendations. As a result of the feedback from public consultation, some of the recommendations for integrated community services changed from the proposals set out in the Consultation Document. In respect of acute hospital services, the recommendation for Option B remained the same.

29. At a meeting on 20 September 2017, the Governing Body approved the recommendations and the Decisions were made. This meant that instead of the three main hospitals each providing many of the same services, under the new regime, they would each have different roles. RBH, as the major emergency hospital would provide what was described in the DMBC as "the most rapid access and high-quality treatment across Dorset" and there would be more consultants available than under the existing regime. Poole and Dorset Hospitals would have significant roles as respectively "the major planned hospital" and the "planned and emergency hospital". Further there was to be a new regime to provide care closer to people's homes using teams based at local community hubs; this would enable many people to be treated without going to hospital, while many of those who were admitted hospital would be released earlier than under the previous arrangements because more treatment and care can be provided outside hospitals. Following the Governing Body's decision on 20 September 2017, the CSR moved towards the implementation phase, with some implementation having now taken place.

30. The judicial review challenge to the Decisions was heard on 17 and 18 July 2018. On 5 September 2018 Sir Stephen Silber handed down his judgment dismissing all grounds of judicial review.

The application for permission to appeal

31. As indicated above, there were five contested areas of challenge below, but only three are pursued on this appeal. Although Mr Coppel reversed the order in which he took these issues, I take them in the order set out in the Notice of Appeal (which follows the scheme of the judgment below).

Issue 1: Sufficiency of Social Care Workforce Issue

32. In advancing this ground, Mr Coppel emphasised that the need for a social care workforce was accepted as a relevant consideration by the CCG and should therefore have been front and centre of their considerations, but in the result it was deliberately excluded. He relies on the letter of 17 March 2017 from Dorset County Council responding to the CCG's public consultation on the CSR, which agreed in principle with the case for change but raised concerns about a number of areas and in particular, shortages in the social care workforce and concerns about the care market capacity in Dorset, suggesting that further consideration of these (and other) issues was necessary. Thus the CCG was expressly warned about this important deficiency, but, he submits, deliberately and consciously excluded the sufficiency or capacity of the social care workforce from its considerations.

33. To demonstrate that there was no evidence that the CCG undertook any kind of workforce modelling to understand the future demand for the social care workforce, Mr Coppel relies on the fact that out of many hundreds, or thousands, of documents produced in the course of the process leading to the Decisions, there was only a single document (headed "Assumptions for ideal activity levels and staffing mix" that formed part of a document called "Supporting people in Dorset to lead healthier lives") that referred in terms to a social care workforce. However, even this document included no assessment of current activity or future activity in this area and/or of the numbers of social care staff consequently required. This was all left "to be determined" (as the entry "tbd" in each column shows).

34. Likewise, the DMBC recognised that delivery of the integrated community and primary care services would require staff employed in social care services in Dorset. It also recognised the existence of shortages of staff in key social care roles (including domiciliary care workers). Yet it described the future clinical workforce required to deliver services in the community (identifying the potential gaps in current versus future workforce numbers and the assumptions made for addressing the gap) but social care was expressly "excluded as workforce assumptions for relevant activity".

35. Mr Coppel submits that this was powerful evidence of the failure of the CCG to inform themselves, by modelling or otherwise, as to what increased numbers of social care staff would be needed and how they would be recruited in order to achieve the integrated care model proposed. Even after the Decisions were taken, in December 2017, in a document produced by the CCG called 'Integrated Community Services Review and Design, Outline Business Case', social care was expressly excluded "due to the difficulty in establishing current input" (paragraph 3.30). This demonstrates, he

submits, the CCG was even then, failing to make inroads into this important consideration.

36. Mr Coppel criticises the judge's reasons for rejecting his case on this issue, summarised at paragraph 89, as irrelevant or surprising or both.

37. I do not regard this ground of appeal as arguable. It seems to me that, contrary to Mr Coppel's protestations, this is a merits challenge dressed up as a process challenge. In any event, the judge made no error and reached conclusions that were supported by the evidence. This ground is simply an attempt to reargue the merits of the challenge advanced below.

38. There was in fact an ample evidence base entitling the judge to conclude the CCG appreciated the significance of the need for a sufficient social care work force and had developed a clear strategy to "continue to work on workforce development alongside partner organisations" as Dorset County Council recommended that it should do.

39. First, the DMBC made clear on the face of the document the challenges that existed in relation to workforce capacity and in particular social care. It explained that the aims of the "Workforce and Capability Plan" were to (i) ensure there were the "right staff in the right places to deliver services across Dorset"; (ii) identify and address the workforce challenges, both existing gaps and shortages as well as areas where there is likely to be a future challenge in workforce supply; and (iii) "work in partnership to address these challenges together, through recruitment, networking and development of skills".

40. The DMBC explained (at appendix E, and elsewhere) that the recommendations in relation to workforce capacity and capability planning were iterative and developing; they would be developed in relation to each service area over the following 12 to 24 months; the pace of those developments would be dependent on the readiness of the services and the timescales for changes set out in the CSR implementation plan. That demonstrated, as the judge found, that consideration of the sufficiency of the social care workforce would have to be considered after the decisions were taken in the light of what the DMBC described as "a risk that they may not be available staff and resources in the system to deliver the future service models". These statements in the "implementation of recommendations" sections of the DMBC show clearly that the sufficiency of the workforce was to be the subject of continuing work after the decisions were taken. In the meantime, the DMBC made clear that work would continue to develop the recommendations set out in the plan and in Dorset's "Leading and working differently" strategy.

41. That was consistent with the recommendation of Dorset County Council "that the CCG continues workforce development, alongside partner organisations." As the judge found, the use of the word 'continuous' demonstrated that this was ongoing work and that Dorset County Council was content with the CCG's work on workforce development as it wanted the CCG to continue with its work "alongside partner developments". The judge found that this is what happened.

42. Furthermore, it was an inevitable inference, based on this material that consideration of the sufficiency of the social care workforce would continue to be considered after the Decisions were taken. As the DMBC described it, there was "a risk that there may

not be available staff and resources in the system to deliver the future service models". The Governing Body was on notice of this and could have pursued these issues in whatever manner they thought appropriate, but accepted the CCG's approach that the sufficiency of the workforce would be subject to continuing work after the Decisions were taken; and made the Decisions with full knowledge of this approach, as the judge found.

43. Secondly, the second witness statement of Mr Goodson, the CCG's Chief Officer, explained that a critical feature of the CSR was more collaborative working between health and social care (also a feature of the Sustainability and Transformation Plan "STP") and in order to develop proposals, local social care professionals were therefore involved throughout the lengthy process. He described one of the five enabling portfolios within the STP, the "Leading and Working Differently" portfolio and that the work streams within that portfolio included

> "recruitment and retention of staff: the vision is to develop a system-wide approach to attract new staff and retain existing staff within the health and social care sector in Dorset".

It also included workforce planning, with a vision to

> "ensure that a workforce with the required skills and competencies to deliver new models of care is available".

To achieve these aims, the CCG developed a partnership known as the "Better Together" programme with the three local authorities in Dorset (as well as Poole Hospital, RBH and Dorset Hospital and Dorset Healthcare). It was supported by the Dorset and Bournemouth and Poole Health and Well-being boards. This partnership was used to "sense check" the CCG's vision for community-based services and to implement some initial changes to introduce jointly delivered services. Mr Goodson explained that the importance of the involvement of the three local authorities was that as they were responsible for the social care, they would have had a strong incentive to ensure that there would be a sufficient social care workforce able to deliver the services required by the CCG's proposals, especially as these were replacing certain hospital services.

44. There was also substantial involvement of the three local authorities in the programme for developing "Integrated Community Services" and the development of "Better Care Fund" plans. The latter was informed by and aligned with the STP and the CSR. Both the STP and the Better Care Fund plan were formally signed off by the local authority Health and Well-being Board, while the STP was also signed off by all of the NHS providers in Dorset. Moreover, during the CSR process, the local authorities were identified as key stakeholders in the programme and an extensive programme of engagement with the local authorities was undertaken during the CSR. There was also evidence that the CSR programme included a "Leading and Working Differently" portfolio which included social care professionals, and reviewed what would be the workforce requirements of the proposed new regime as well as the skill mix that would be required within the workforce, including the social care workforce. There was detailed analysis of workforce considerations which formed one of the six criteria for decision-making. The analysis included specific consideration of "workforce capacity" for "care services".

45. The judge set out in detail the collaboration between the CCG and the local authorities at paragraph 61 to 70 of his judgment, some of which is highlighted above. He noted the letter from Dorset County Council, which was before the CCG Governing Body when they made their decision, and drew attention to concerns over the capacity of the social care workforce, relied on by Mr Coppel. At paragraph 83 of his judgment the judge held:

> "These statements in the "Implementation of Recommendations" sections of the DMBC show clearly that the sufficiency of the workforce was to be the subject of continuing work after the Decisions were taken. The Governing Body was put on notice and it could have decided to pursue it in any way they wished, but they accepted the approach which I have explained and then made the Decisions with full knowledge of this approach. I cannot accept the criticism of Ms Monkhouse that this policy amounts to "closing the door after the horse has bolted" as there is nothing to suggest that the decisions relating to the workforce required would not be taken in advance of and in the light of proposed changes."

46. Accordingly, these and other materials were relied on by the judge as supporting his conclusion that the CCG was entitled to take the approach it adopted to delivering the proposed new integrated model of community service. The judge stated that his conclusion that the CCG were entitled to take the approach it did was supported by the confidence the main healthcare providers, the NHS Trusts, had in the proposals. There was also no suggestion from any of the local authorities that the CCG had failed to give adequate consideration to the sufficiency of the social care workforce. I see nothing wrong in that approach.

47. Equally, the judge drew support for his conclusion from the fact the relevant local authorities had not exercised their power under rule 23(9) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 to make a reference to the Secretary of State. The judge said it was highly likely they would have at least complained to the CCG or made a reference to the Secretary of State if they thought a sufficient social care service could not be provided. That was true at the time of his judgment, but is no longer the case. I do not accept Mr Coppel's criticism of the judge for relying on this factor, but in any event, the fact that it no longer applies does not begin to invalidate his decision, given the other evidence and findings he made.

48. Similarly, Mr Coppel criticises the judge's rejection of his submission that the CCG had not had regard to the relevant consideration of whether there would be a sufficient social care workforce because social care costs were excluded from all the workforce calculations and/or because no document was produced showing that the CCG had considered the capacity of the workforce. Again, I can see no error of principle in the judge's approach. The social care sector is a market that responds to need. Unlike NHS performance data which is available and exists to a high degree of specificity and quality, the social care sector has no subset of data available in the same way. As the DMBC stated, the workforce demands would depend on uncertain factors including the "readiness of the services and the timescales for changes in the CSR

implementation plan" all of which were uncertain. That made it difficult to produce calculations. In any event, I share the judge's doubts that information obtained from the local authorities would have enabled the CCG to work out how, when and in what order the implementation of the new regime would occur, which were critical matters for any calculations.

49. In the circumstances, and bearing in mind the absence of any statutory or other obligation on the CCG to produce documents or calculations in respect of this issue, together with the wide discretion as to the method for commissioning services, I do not consider there is any basis for interfering with the judge's conclusion that the CCG was entitled not to have prepared calculations or produced documents showing such calculations. The Governing Body was put on notice of the approach adopted, which entailed considering the sufficiency of the social care workforce in the light of what the DMBC described as "a risk that they may not be available staff and resources in the system to deliver the future service models". They adopted this approach of the CCG nonetheless.

50. Finally, as the judge observed, with the benefit of hindsight, it will always be possible to suggest ways in which the consultation process might have been improved: see the observations of Sullivan J in *R* (*Greenpeace) v Secretary of State for Trade and Industry* [2007] Environmental Law Reports 29 at paragraph 62. But that of itself does not justify granting judicial review.

Issue 2: Alternative Investigations Issue

51. The appellant's case was and remains that the CCG failed adequately to investigate and to reach a conclusion on whether alternative community provision could be put in place before deciding to close hospital beds, contrary to the *Tameside* duty of careful inquiry, together with its duty to make further inquiries as to (i) what alternative community guidance would need to be put in place to achieve the reduction in demand for acute hospital care; (ii) how the workforce for this community provision would be recruited; and (iii) how it would be paid for. The appellant complained that the CCG proceeded on the basis of untested assumptions; that no reasonable public body could have proceeded on the basis of the information before it; and that it should have made further inquiries.

52. The appellant argued before the judge that there were two problems with the CCG's approach, which pointed to the volume of documentation it had produced and the bodies with whom it had liaised during the decision-making process. The first was the DMBC was clear that the workforce crisis was to be considered as a detail of implementation after the decisions were made, whereas, the careful inquiry required of the CCG had to be taken before and not after the critical Decisions were made. In the present case the inquiry that should have been made was by reference to the bed closure test. The second problem was that the CCG's enquiry was operated at too high a level of generality. It described a "vision" but did not provide any concrete evidence.

53. Sir Stephen Silber rejected the contention that the CCG failed to adequately investigate and reach a conclusion on whether alternative community provision could be put in place before deciding to close hospital beds. He relied on eight factors: the broad discretion of the CCG; the fact that the CCG had considered numerous models

and 65 potential options before choosing the proposed options; that it had not been shown there was a particular alternative option which should have clearly been explored; the important confirmation of Stage 2 assurance received from NHS England; the confidence of the NHS entities in the proposal; the decision of Dorset County Council not to refer the Decisions to the Secretary of State; and the fact that neither the JHSC nor the five constituent local authorities had made such a referral or sought to suggest that the CCG should have carried out further investigations. As the judge observed, if the appellant's case was correct it would mean that in almost every case it will be possible to think of some further inquiry that the decision-maker could have taken.

54. The appellant challenges this conclusion and contends the judge erred in rejecting this ground of challenge. In summary, Mr Coppel contends that the broad discretion of the CCG did not mean it could decide not to investigate and reach conclusions on whether alternative community provision would be in place before beds were closed. This is particularly true given that the health of vulnerable people was at stake: *R (Refugee Action) v Secretary of State for the Home Department* [2014] EWHC 1033 (Admin) [121]. The fact that the CCG had considered 65 potential options said nothing as to whether it had conducted a sufficient investigation. The judge's approach was "never mind the quality, feel the width." Moreover, it was not for the appellant to show there was a particular alternative that was not explored. So far as the views of other bodies were concerned, the Stage 2 assurance received from NHS England almost a year before the Decisions were taken says nothing as to whether the CCG had conducted a sufficient investigation into the practical availability of its alternative community provision. The same is true of the expressions of support by other NHS entities. Finally, the judge should not have given weight to the absence of a referral to the Secretary of State as Dorset County Council was still considering its position on referral.

55. The question is whether the CCG took reasonable steps to acquaint itself with the relevant information. There was no obligation to leave no stone unturned; such an approach would stifle all administrative decision-making. The CCG took its Decisions after a painstakingly detailed assessment of all the relevant factors, as evidenced in the documentation before the judge. After considering the evidence, the judge was unequivocal in his conclusion that the CCG was entitled to act as it did. In the light of the totality of the evidence, the context in which the decisions were being made, and the broad discretion afforded to CCGs in decision making, it is simply not arguable that the CCG failed to take reasonable steps to investigate alternative community provision.

56. Moreover, the Respondent submits that this ground is a blended reiteration of the first ground and the bed closure ground which is no longer pursued. I agree. The first ground addresses the steps taken by the CCG in considering the sufficiency of the social care workforce to support alternative community provision and whether this could be put in place. The appellant submitted that the careful inquiry required in this case was by reference to NHS England's bed closure test. The judge plainly took the view that the CCG considered the requirements of the bed closure test to the satisfaction of NHS England and this was determinative of the issue as NHS England were the arbiters of whether the test had been complied with. His approach was

endorsed in *Keep the Horton General v Oxfordshire Clinical Commissioning Group* [2019] EWCA 645 (CA).

Issue 3: The Travel Times Issue

57. The appellant's case before the judge on this issue was that the CCG failed to consider adequately the impact of increased travel times to RBH in emergency cases, if it were to become the major emergency hospital rather than Poole Hospital, which was said to be the more centrally located hospital. In summary, it was argued that the CCG failed to equip itself with essential information which it required in order to apply the accessibility criterion. Further, the CCG misdirected itself as to the conclusions to be drawn from the information which it did acquire and failed to consider the mandatory consideration of accessibility to services for those in the more isolated, rural areas. In this regard, the CCG failed to exercise its functions in accordance with its duty to secure continuous improvement in the quality of services provided in breach of s.14R of the National Health Service Act 2006.

58. The judge considered the evidence and arguments and held, contrary to the appellant's case, that the CCG equipped itself with the appropriate information required to apply the accessibility criterion and that it was open to the CCG to conclude that the advantages of improved health services under the proposed regime outweighed any problems caused by increased journey times to differently situated hospitals. In reaching this conclusion the judge rejected nine specific contentions advanced by the appellant.

59. One of those, (the first) was a submission that the CCG misrepresented the SWAST report's conclusion that *"the change of Poole General Hospital's emergency department to an urgent care clinic will have a minimal impact on emergency journey times for direct emergency adult admissions, adding an average of one minute to each journey. 16,113 patients had no difference in journey time, 650 had a shorter journey and 3,067 had to travel further. The longest additional time on top of the current journey length being 23 minutes*." The misrepresentation relied on was said to be the statement in the DMBC at paragraph 3.5.1, where the CCG said,

> " "the modelling resulted in a report which concluded that the CSR proposals have only a limited impact on emergency transport times, will reduce the number of inter-hospital transfers and that **there is minimum clinical risk**…" (Emphasis added).

60. The judge rejected that argument. He found the SWAST report showed that in a four-month period there were only 696 adult emergency/acute cases with longer journey times out of a sample of 21,944 cases in that period. Random sampling of 125 of these led to a finding of 27 cases which carried potential additional clinical risk as a result of increased travel time. The judge scaled back up to produce a figure out of 696 (ie. 696 x 27/150): 125 adult cases. There were also 4 paediatric cases and 3 maternity cases. The total was therefore 132 cases out of a total of 21,944 (that is to say 0.6%) where there was potential increased clinical risk as a result of implementing the proposed reconfiguration of medical services.

61. The judge held that the "*CCG with its broad discretion was quite entitled to conclude that the potential additional clinical risk quantification of 0.6% would indicate only a minimal clinical risk which may be caused by increased travel times…*".

62. Mr Coppel challenges that reasoning as plainly erroneous and based on a misreading of the critical passage of the DMBC by the judge. The assertion of "minimal critical risk" in that passage was not a description of the number of cases in which there could be increased clinical risk, but rather of the extent of clinical risk in any particular case. However, the extent of the clinical risk in any particular case was not ascertained. The only assessment of clinical risk made by the SWAST report was that more work needed to be done to ascertain the extent of the increased risk. The CCG accepted that further work was necessary and commissioned an expert review. However the only further work done was on 31 August 2017, the day before the publication of the DMBC, leaving little or no time to factor in any conclusions reached. In the event, the review was inconclusive so that the risk remained unquantified and should not have been described as minimal (which it certainly was not). The result is that this was such a serious misrepresentation by the CCG that it vitiates the Decisions.

63. Moreover, Mr Coppel contends that the CCG never considered how many patients could come to harm as a consequence of the additional travelling time caused by the reconfiguration. Had it done so, even on these figures, there were approximately 400 cases per year (132 x 3) where patients would be at potential increased clinical risk of harm. Even if that could be regarded as minimal in the abstract, it was not minimal given the weight placed by the CCG on the number of lives estimated to be saved by the reconfiguration proposals. Mr Coppel relies on the fact that a central plank of the CCG's argument in favour of its proposal to create separate specialist roles for Dorset's acute hospitals was that if implemented, it was estimated that "an extra 60 lives could be saved each year" (paragraph 2.1 of the DMBC). Plainly, if a significant number of patients could come to harm as a result of having to travel further to hospital, that would provide an important counterbalance to the 60 lives per year saved claim. Not only was that never assessed; but in any event, he submits that the 60 lives saved per year claim was unsupported by any evidence and, in the appellant's view, false. Moreover, the judge wrongly refused to entertain the appellant's criticism of the 60 lives per year saved claim notwithstanding that it had been raised in correspondence well before the hearing and the CCG had ample opportunity to respond to it.

64. Mr Coppel accordingly submits that the CCG failed to carry out a sufficient investigation of the issue of emergency travel times and misled its governing body as to the outcome of the investigations which had been carried out, preventing the governing body from taking into account the highly relevant consideration that a significant number of patients were potentially at increased clinical risk due to having longer emergency travel times should pool hospitals accident and emergency unit be closed. These matters were critical to the CCG fulfilling its statutory duty under s. 14R of the 2006 Act, to act only so as to improve patient outcomes.

65. This ground is also not arguable and is a merits, and not a process, challenge.

66. The vast majority of Mr Coppel's criticisms of the judge's reasoning is misplaced. There are two criticisms that have some force. I agree that the judge should not have prevented the appellant from relying on the "60 lives saved" point in the

circumstances of this case. Secondly, although he was entitled to rely on the absence of any reference to the Secretary of State at the date of his decision, in light of developments since, and the reference that has been made, this is no longer a factor that can be relied on by the CCG. Nonetheless, I am quite satisfied that neither of these points is significant in the context of the evidence and the findings made by the judge.

67. The judge dealt carefully and comprehensively with the evidence of the CCG's consideration of the impact of increased travel times. In summary, he found as follows. In January 2015 the CCG published its case for change in which it set out a number of proposals including that RBH and Poole Hospital would have different and distinctive roles: one would be a hospital for major planned care allowing for continuous delivery of treatment away from the disruption that urgent and emergency care can create; the other would be a major emergency hospital with more consultants available more of the time to deal with urgent and emergency care. By specialising in this way, the judge found, the evidence showed that outcomes for patients could be improved and more lives could be saved. In both options, Dorset Hospital would remain a district general hospital serving the west of the county and providing planned and emergency care. Safe access to emergency care was accepted as a relevant consideration by which to judge the proposals for change. Access was not by itself determinative of the outcome. It was however, one of six criteria for determining which option to select.

68. The CCG commissioned an organisation called Steer Davies Gleave ("SDG") (who are experts in the provision of transport consultancy) to conduct an analysis of travel times in order to analyse the impact of the options for reconfiguration and in particular the decision whether to locate a major emergency hospital service at RBH or at Poole Hospital. Although SDG concluded in one particular scenario that locating emergency services at Poole Hospital would result in a higher proportion of the whole of Dorset's population being able to reach these services within 30 minutes, further analysis resulted in RBH scoring better than Poole Hospital on the access criterion.

69. Following the consultation and in the face of concerns expressed during it about travel times for emergency cases and specialist maternity needs, a review was commissioned by the CCG from the SWAST. The SWAST was asked by the CCG "to establish the potential impact of the proposed CSR reconfiguration on the emergency ambulance services." The SWAST report was published in August 2017. It made clear that "no model can predict the future; it can only consider the potential impact of the Dorset CSR on historical data". It analysed 21,944 patient records covering all incidents when an ambulance attended and conveyed a patient to hospital in the period 1 January to 30 April 2017. The report considered maternity related calls, adult and child emergencies.

70. The inter-hospital or inter-facility transfers were discounted, leaving 19,830 cases involving direct admissions to hospital. At paragraph 5.2.4 the report said,

> "the model suggests that the change of Poole General Hospital's ED to an UCC will have a minimal impact on emergency journey times for direct emergency adult admissions, adding an average of one minute to each journey. 16,113 patients had no difference in journey time, 650 had a

> shorter journey and 3067 had to travel further. The longest additional time on top of the current journey length being 23 minutes."

A table set out the extra journey time in minutes for these patients. There are also tables predicting emergency journey travel times for inter-hospital transfers and giving the predicted distribution by hospital of the adult emergency department patients together with a map of the predicted geographical distribution of adult emergency department incidents by hospital. The report set out the same data for paediatric emergency cases and maternity cases.

71. At paragraph 5.4, the report dealt with clinical risk. It concluded that the change of Poole Hospital from an ED to an UCC would result in an overall one-minute increase in the average weighted journey time to hospital. However the report said, conversely, the same change would result in a 16 minute decrease in the 95th percentile travel time and a 56 minute reduction to the maximum travel time.

72. Overall, 16,000 odd patients had no difference in journey time and 3000 odd had to travel further. The report then identified the 696 incidents referred to above and explained that a randomised sample of 150 were selected for review. Of the 150 cases, a total of 27 cases were highlighted. These are detailed in table 12 at paragraph 5.4.5 where the age of the patient and the provisional diagnosis is identified, together with the extra journey time and whether or not there was potential harm. In some cases this is answered positively as "yes"; while in others it is answered as "possible". The report recommended a review of these cases.

73. In his judgment at paragraph 130, the judge described the exercise conducted by SWAST as leading to 132 cases (3 maternity cases, 125 adult emergency cases and 4 paediatric emergency cases) out of 21,944 cases where "extended journey times *may* increase the clinical risk". In relation to the 132 cases, SWAST recommended that the CCG should "support the expert review of cases identified where extended journey times may increase the clinical risk". The judge found in terms that those 132 cases, amounting to 0 .6% of the total, were cases where "the possible additional clinical risk remained unquantified".

74. The judge dealt with the expert review meeting which took place on 31 August 2017, involving various medical experts to consider the potential additional risk cases identified by SWAST as requiring further clinical review. He found that the meeting participants concluded that they were unable to comment further on the risk posed to patients from the proposed CSR changes for a number of reasons. These included the fact that to determine reliably whether a patient would come to harm with the extended journey time would require hospital notes of the medical condition, injury sustained and necessary treatment of the patient concerned. Accordingly, he found the meeting did not produce a conclusion on the risk posed to patients and no further meetings took place to review these cases.

75. The DMBC, published on 1 September 2017, referred to the additional work in the SWAST report and acknowledged that further work needed to be done during the implementation phase (and a Transport Reference Group to develop an integrated transport plan was set up). At paragraph 3.5.1 the DMBC referred to the analysis and impact modelling conducted by SWAST and continued : "the modelling resulted in a

report which concluded that the CSR proposals have only a limited impact on emergency transport times, will reduce the number of inter- hospital transfers and that there is minimal clinical risk."

76. The judge concluded that the figures in the SWAST report could be relied on as giving an accurate picture of the historical data to make reliable predictions about the future position. The judge rejected (as having no merit) the appellant's contention that there were unexplained and questionable steps used to reduce the total adult cases from 1,636 cases to 696 cases. The judge held that SWAST was entitled to reduce the number of patients to exclude those with a low risk diagnosis code. He rejected the argument based on the absence of a proper expert review of the 132. That review could only confirm the number or further reduce it. The expert review could not have increased the number of cases in which increased journey time could have resulted in potential harm to the patient and the CCG worked on the assumption that all of the 132 cases remained the only cases in which increased journey time could have resulted in harm to the patient. In any event, in light of the urgency of tackling the crisis in health and social care provision, the CCG was entitled not to await a further review. As for the argument that the CCG did not consider "outliers" (patients who would be most seriously affected by increased journey times) the judge rejected that criticism since the report referred to the maximum travel times for adult patients and children and that included outliers. The judge also dealt with the issues of total as opposed to just increased journey time, the effect of the SDG report, and the asserted failure of the CCG to consider the effect of increased travel times for self-presenting patients. He rejected the criticisms made and identified the reasons for doing so and the material he relied on. He concluded that the CCG equipped itself with appropriate information in order to apply the accessibility criterion.

77. In terms of the conclusion of minimal clinical risk, it seems to me that the figures in the SWAST report do show that for the vast majority of patients, the impact on travel times was minimal. For approximately 400 patients per annum (0.6% of patients) however, the increased travel time would have a potential impact and for that group the extent of the increased clinical risk was never quantified but as a matter of common sense must have included potential serious harm or death. The judge was well aware of the fact that the extent of that increased clinical risk remained unquantified and said so expressly at paragraph 130. Having done so, I do not consider that he intended to convey that the clinical risk itself was quantified at 0.6%. Though perhaps not as well expressed as it might have been, the judge was simply finding that the number of cases in which a potential clinical risk was identified was minimal.

78. Similarly I do not accept that the reference to 'minimal clinical risk' in the DMBC (cross-referenced to and supported by the SWAST report which was also available to the Governing Body) is misleading; nor is there evidence that anyone was misled. The maximum increased travel time identified was 23 minutes and it stands to reason that an emergency patient having to travel for an additional 23 minutes might come to some clinical harm. That was plain on the face of the report. In any event, the CCG was entitled to regard a potential clinical risk in a very small percentage of cases as approximating to an overall minimal clinical risk.

79. Furthermore, as the judge found, the evidence showed that on the footing that Yeovil and Shaftesbury would continue to provide general emergency services, if Poole

Hospital was the major emergency hospital, 71% of the population of Dorset would reach services in 20 minutes and 94% within 30 minutes with a maximum travel time of 40 minutes – well within the period of 45 minutes referred to as the maximum travel time for acute and emergency conditions on the appellant's side. On the other hand, if RBH was the major emergency hospital, 78% of the population of Dorset would reach services in 20 minutes and 95% in 30 minutes, with a maximum travel time of 40 minutes. So RBH was more accessible to a larger proportion of the population than Poole Hospital. RBH was also easier to reach by a larger proportion of the population by blue light, while Poole Hospital was regarded as better placed for public transport which suited a planned site there.

80. I do not read a central plank of the CCG's argument in favour of its proposal to create specialist hospitals, as being to save an estimated 60 lives. Although that figure was given, the real point was that national evidence showed that creating specialist hospitals as proposed was likely to improve outcomes for patients and more lives could be saved.

81. The judge also referred to a variety of additional reasons set out in the DMBC as to why RBH and not Poole Hospital was the proposed major emergency site. First there is better access to RBH as more of the population live in the east of the county and it is better for patients living in West Hampshire, a considerable number of whom use RBH. Secondly, RBH would be cheaper and easier to develop and expand than Poole Hospital. Thirdly, it had lower running costs than Poole Hospital. Fourth, unlike Poole Hospital it had emergency access for helicopters on site. None of those factors had been effectively challenged by the appellant.

82. The judge concluded that the CCG reached conclusions open to it on the information it acquired and considered appropriately the issue of access to services, including for those in the more remote areas. Here too there was a painstakingly detailed assessment of all the relevant factors, as evidenced in the documentation before the judge. In my judgment, in light of the evidence, the judge was amply entitled to conclude that "it was open to the CCG to conclude that the advantages of improved health services under the proposed regime outweighed any problems caused by increased journey times". I can see no arguable error of law or fact in his conclusion.

Conclusion

83. For all these reasons, the application for permission to appeal is not arguable and there is no other compelling reason for permission to be given. Sir Stephen Silber conducted a full and careful analysis of the evidence and reached conclusions that were open to him on the evidence and not arguably wrong. As Gross LJ acknowledged when directing a hearing in this case to include the issue of permission, "there is a real danger of over-judicialising administration, so impeding decision taking. Moreover, the court will not likely intervene on questions going to the allocation of scarce public sector resources. Still further and unpalatable though it may be for some, the delivery of public services does need to change from time to time". Those observations apply with considerable force in this case, where difficult judgments had to be made as to how scarce resources are best allocated to the maximum advantage of the maximum number of patients.

Lord Justice Bean:

84. I agree.

The Senior President of Tribunals:

85. I also agree.

Appendix 2

C1/2018/2334

IN THE COURT OF APPEAL
ON APPEAL FROM THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
(ADMINISTRATIVE COURT)

BETWEEN:

THE QUEEN
(on the application of
ANNA HINSULL)

Appellant

-and-

NHS DORSET CLINICAL COMMISSIONING GROUP

Respondent

ORDER

BEFORE the Senior President of Tribunals, Lord Justice Bean and Lady Justice Simler

UPON hearing Counsel for the Appellant, Jason Coppel QC and Hannah Slarks, and Counsel for the Respondent, Fenella Morris QC and Annabel Lee, on 24 July 2019 at a rolled-up hearing having been listed by Lord Justice Gross by order dated 22 February 2019

IT IS ORDERED THAT:

1. The Appellant is refused permission to appeal on all grounds;
2. The Appellant shall pay the Respondent's costs, subject to a detailed assessment if not agreed;
3. Paragraph 2 above shall not be enforced without an application for determination by a costs judge of the amount which is reasonable for the Appellant to pay in accordance with s. 26(1) of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 and Regulations 15 and 16 of the Civil Legal Aid (Costs) Regulations 2013; such application to be adjourned generally with liberty to restore;
4. There shall be detailed assessment of the Appellant's costs in accordance with the Civil Legal Aid (Costs) Regulations 2013 and CPR 47.18.

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INDEPENDENT RECONFIGURATION PANEL

Template for the NHS to provide information about contested proposals for changes to NHS services

Please read these guidance notes before completing the template:

- This template should be completed by NHS England with assistance as required from relevant NHS decision-making body/ies
- The completed template will be in the public domain
- This template, together with the referring body's report to the Secretary of State, forms the information required for the IRP to carry out its assessment of the referral
- Please complete all sections - the information provided should be comprehensive but proportionate to the matter under consideration
- A description of the IRP assessment process can be found in "*How we advise the Secretary of State for Health and Social Care"* available at: https://www.gov.uk/government/organisations/independent-reconfiguration-panel/about
- Exceptionally, we may advise that further information is required before reporting back to the Secretary of State – additional guidance will be provided where necessary
- Guidance on completing specific sections:
- Section 1.2 An image of the area covered must be placed in this section – links to more detailed maps may be included *additionally* if appropriate
- Section 1.3 Only place links to essential documents in this section, do not enter text other than as a description of the document – use common formats (e.g., Word, PowerPoint, pdf, hyperlink to specific documents but not to a generic website)
- Section 1.3 Examples of the essential documents common to most referrals are listed but may be adapted according to circumstances
- Section 2.1 A brief description only of the proposals is required to provide Panel members with an overview of the services and issues involved
- Section 2.2 The chronology of events will be cross-referenced with that from the referring body and will be used to describe the background to the issue in the Panel's advice – examples of previous Panel advice can be found at: https://www.gov.uk/government/organisations/independent-reconfiguration-panel
- Links to additional documents, including to generic websites, may be included in later sections but only if they will genuinely aid the Panel's understanding
- This template should be returned to the Department of Health and Social Care, Provider Policy Branch, for onward transmission to the IRP

1

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Website: www.gov.uk/government/organisations/independent-reconfiguration-panel

1	Organisations and essential documents Please provide:
1.1	Names and addresses of the main NHS bodies and sites involved, the contesting local authority and key stakeholders (including patient groups and any organisations actively campaigning about the proposal)

Names and Addresses of Main NHS Bodies

Dorset Clinical Commissioning Group
Vespasian House
Barrack Road
Dorchester
DT1 1TG

Dorset County Hospital Foundation Trust
Williams Avenue
Dorchester
Dorset
DT1 2JY

Poole Hospital NHS Foundation Trust
Longfleet Road
Poole
Dorset
BH15 2JB

Royal Bournemouth & Christchurch Hospital Foundation Trust
Castle Lane East
Bournemouth
BH7 7DW

Dorset HealthCare University NHS Foundation Trust
Sentinel House
Nuffield Industrial Estate
Nuffield Road
Poole
BH17 0RB

South Western Ambulance Service NHS Foundation Trust
Abbey Court
Eagle Way
Exeter
EX2 7HY

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Names and Addresses of Local authorities

Please note organisation names as at 31st March 2019 are used within this document to maintain integrity of events and organisations involved. Since 1st April 2019 Dorset County Council has re-organised into Dorset Council and Bournemouth and Poole councils have re-organised into Bournemouth, Christchurch and Poole council.

Dorset County Council
County Hall
Colliton Park
Dorchester
Dorset
DT1 1XJ

Borough of Poole Council
Civic Centre
Poole
BH15 2RU

Bournemouth Borough Council
Town Hall [
St Stephens Road
Bournemouth
BH2 6DY

Names and Addresses organisations actively campaigning about the proposal
Defend Dorset NHS
https://en-gb.facebook.com/defenddorsetnhs/

Keep Our NHS Public
Poole Labour Party
Swanage Labour Party
Save Poole A&E

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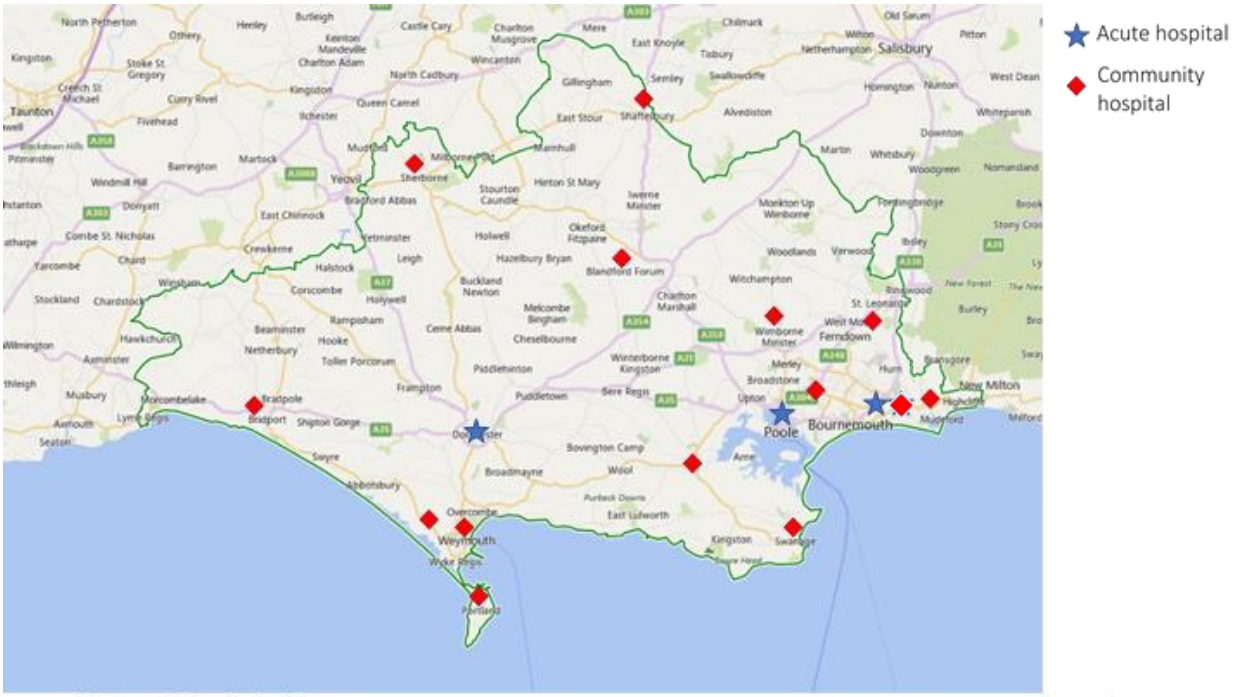
1.2 A map of the area showing key sites, population centres and transport links (links to a map may be provided in addition but are not an alternative to a useful image in this box)

The main acute hospitals and community hospitals are shown on the map below; with the thicker green line denoting the Dorset, Bournemouth and Poole boundaries:



Key sites in Dorset's Healthcare

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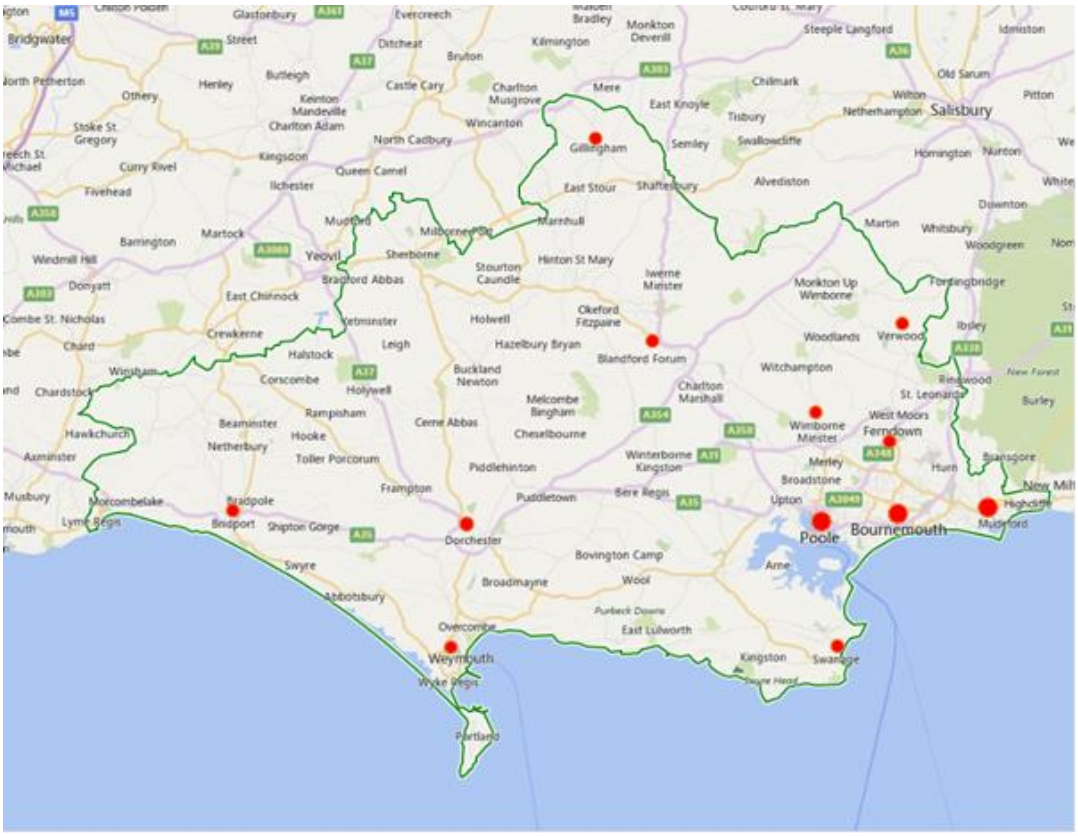
The second map shows towns with a population density of more than 10,000:



Towns in Dorset with populations of more than 10,000

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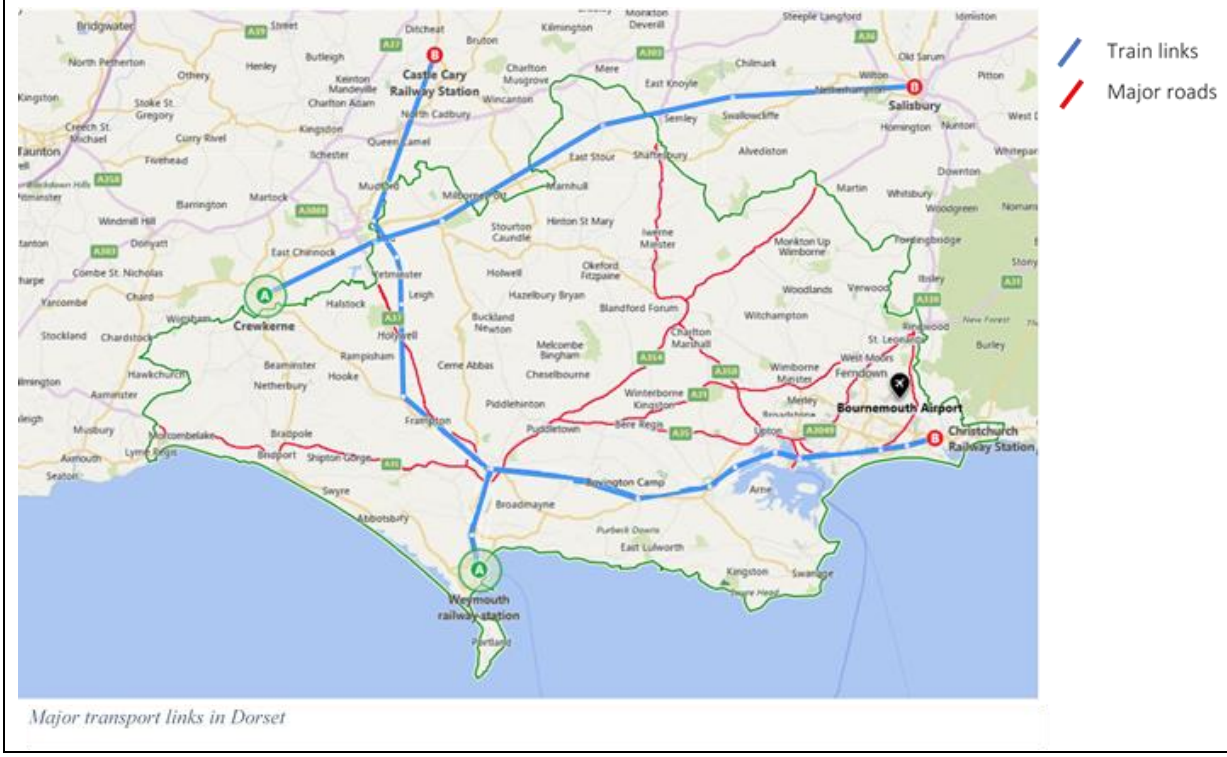
The third map shows the main transport routes within the Dorset, Poole and Bournemouth areas:



Major transport links in Dorset

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1.3 Electronic copies of the following essential documents (or state that they do not exist / are not relevant)

Section	Documents	File Name	Public Web Link (if available)
1: Clinical Senate Reports or Equivalent	1a: Clinical Senate Final Report on Clinical Services Review 1st December 2016	1_3_1a - Dorset_Clinical_Services_Senate_Council_Report_FINAL	https://wessexsenate.nhs.uk/wp-content/uploads/2019/02/20161118-Dorset-Clinical-Services-Senate-Report.pdf
2: Pre-consultation Business Case or Equivalent	2a: Dorset Clinical Commissioning Group Pre-Consultation Business Case (PCBC)	1_3_2a - DCCG-PCBC	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/DCCG-PCBC.pdf
	2b: PCBC Appendix A – Compendium of clinical evidence and case examples	1_3_2b - PCBC Appendix-A	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/10/pcbc-appendix-a.pdf
	2c: PCBC Appendices B, C, D, I, N, O	1_3_2c - PCBC Appendix-BCDINO	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/10/pcbc-appendix-bcdino.pdf
	2d PCBC Appendix E – Dorset locality reviews	1_3_2d - PCBC Appendix-E	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/10/pcbc-appendix-e.pdf
	2e PCBC Appendix F – Detailed evaluation of acute hospital options	1_3_2e - PCBC Appendix-F	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/10/pcbc-appendix-f.pdf
	2f PCBC Appendix G – 'Big Ask' research	1_3_2f - PCBC Appendix-G	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/10/pcbc-appendix-g.pdf
	2g PCBC Appendix H – NHS Dorset qualitative analysis	1_3_2g - PCBC Appendix-H	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/10/pcbc-appendix-h.pdf
	2h PCBC Appendix J – ICS (integrated community services) slides	1_3_2h - PCBC Appendix-J	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/10/pcbc-appendix-j.pdf
	2i PCBC Appendix K – ICS (integrated community services) modelling	1_3_2i - PCBC Appendix-K	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/10/pcbc-appendix-k.pdf
	2j Appendix L – RCPCH Dorset maternity and paediatrics	1_3_2j - PCBC Appendix-L	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/10/pcbc-appendix-l.pdf
	2k PCBC Appendix M – Acute vanguard 'One NHS in Dorset'	1_3_2k - PCBC Appendix-M	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/10/pcbc-appendix-m.pdf
	2l PCBC Appendix P – Acute scenario options evaluation	1_3_2l - PCBC Appendix-P	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/10/pcbc-appendix-p.pdf
	2m: PCBC Appendix Q – ICS (integrated community services) options for change	1_3_2m - PCBC Appendix-Q	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/10/pcbc-appendix-q.pdf

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3. The Consultation Document	3a: CSR Consultation Document	1_3_3a - CSR-Consultation-Document-CLOSED	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/CSR-Consultation-Document-CLOSED.pdf
	3b: Consultation Institute Gives CSR Consultation Good Practice Status	1_3_3b - Consultation Institute Giving CSR Consultation Best Practice Status	
	3c: Consultation Institute Final Report Confirming Best Practice for the Entire Process	1_3_3c - Consultation Institute Final Confirming Best practice for the entire consultation	
4. Evaluation of Responses to Consultation Report or Equivalent	4a: ORS on Interpreting the Consultation Findings	1_3_4a - ORS on Interpreting the Consultation Findings	
	4b: ORS Report of Findings	1_3_4b - ORS Report of Findings	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/10/ors-final-report.pdf
	4c: Summary Report of Findings	1_3_4c - Summary Report of Findings	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/10/ors-summary-report-of-findings.pdf
5. Decision Making Business Case or Equivalent	5a: CSR Decision Making Business Case	1_3_5a - CSR Decision Making Business Case	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/DMBC-CSR.pdf
	5b: CSR Decision Making Business Case - Appendices	1_3_5b - DMBC-CSR-Appendices	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/DMBC-CSR-App.pdf
6. NHS England Assurance Correspondence/Minutes	6a: Letter from NHSE Confirming Stage 1 Assurance	1_3_6a - Letter From NHSE Confirming Stage 1 Assurance Passed	
	6b: Health Gateway Review of Clinical Services Review	1_3_6b - Dorset Clinical Services Review Gateway_0_Final Report	
	6c: Letter from NHSE confirming stage 2 assurance and approval of the Dorset proposals proceed to consultation	1_3_6c - NHSE Letter approving progression to consultation of CSR	
7. Minutes of NHS Meetings Where Decisions Were Taken About the Proposal	7a: Governing Body Approval to proceed to Consultation	1_3_7a - GB Approve proceeding to Consultation	
	7b: Governing Body Decision to delay going to Public Consultation	1_3_7b - GB Decision to delay proceeding to Public Consultation	
	7c: Governing Body approval of Acute Hospital Site Specific Consultation Options	1_3_7c - GB Approval of Acute Hospital Site Specific Consultation Options 21.05.16	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/Governing-Body-Paper-Major-Hospitals.pdf

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	7d: Governing Body approval of Community Site Specific Consultation Options	1_3_7d - GB Approval of Community Site Specific Consultation Options 21.09.16	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/Governing-Body-ICS.pdf
	7e: 20th September 2017 Governing Body Approval of the recommended CSR Options	1_3_7e - 20th September 2017 - GB Approval of Recommended CSR Options	
	7f: 20th September 2017 - Minutes of Governing Body Special Meeting	1_3_7f - Special-GB - minutes-200917-200917-v4-TG-FW	
8. Judicial Review	8a: Full Judicial Review Judgement	1_3_8b - Judicial Review Judgement Full	https://www.judiciary.uk/wp-content/uploads/2018/09/hinsull-v-dorset-ccg-judgment.pdf
	8c: Summary Judicial Review Judgement	1_3_8c - Judicial Review Judgement Summary	https://www.judiciary.uk/wp-content/uploads/2018/09/hinsull-v-dorset-ccg-summary.pdf
	8d: Debbie Fleming Witness Letter	1_3_8d - DebbieFlemingWitnessStatement	
9. Merger Patient Benefits Case	9a: Merger Patient Benefits Case Summary	1_3_9a - PBC lite v4	
10. Dorset's Vision Website	10: www.dorsetsvision.nhs.uk		
11. Emergency Travel Reviews	11a: SWAST Report	1_3_11a – SWAST-Report-Sep-2017	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/swast-report.pdf
	11b: SWAST Clinical Risk Review Outcome Report	1_3_11b - SWAST-Clinical-Risk-Review-Outcome-Dec-18	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2018/12/SWAST-Clinical-Risk-Review-Outcome-Dec-18.pdf
	11c: SWAST Clinical Risk Review Data	1_3_11c - SWAST-Clinical-Risk-Review-Data-Dec-18	https://www.dorsetsvision.nhs.uk/wp-content/uploads/2018/12/SWAST-Data-Review-FINAL.pdf

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2 The Proposals
Please provide:

2.1 A ***brief*** description of the proposals

The referral to the Secretary of State by Dorset Health Overview and Scrutiny Committee (HOSC) relates to decisions taken by the Governing Body of Dorset CCG (the CCG) following a Clinical Services Review (CSR) and formal public consultation lasting three months.

The CSR was launched in October 2014 and, following lengthy consideration of the consultation responses, the CCG's Governing Body made its decisions in September 2017.

The CSR considered changes to out-of-hospital services based at 13 community hospitals and to the county's three acute hospitals. This included proposals to consolidate beds on some community sites and not on others, and to make changes to Accident and Emergency (A&E) and maternity and paediatric services by creating a specialised site for emergency care at the Royal Bournemouth Hospital and a specialised site for planned care at Poole Hospital. Dorset County Hospital will continue to provide emergency and planned care – with some enhancements – to serve its largely rural population.

A summary of the CSR is set out below:

The CSR was launched in October 2014, one day before the Five-Year Forward View, to look at how health and care services could be improved across Dorset. The need to change was clearly established to address difficulties in:

- Staffing services;
- the needs of a growing elderly population living with increasingly complex conditions;
- variations in the quality of care, especially difficulty in accessing primary care and some specialist hospital services;
- a growing financial challenge with a projected deficit of £158m by 2020/21, if the CCG continue to provide care in the way it currently does now.

Therefore, the CSR provided clear evidence that doing nothing would not provide safe, sustainable services in the future and was not an option.

The CSR was led by clinicians and health and social care professionals from across Dorset and featured strong staff, stakeholder and public engagement throughout.

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Acute Services

Currently, Dorset has three acute hospitals. The CSR proposed that the two hospitals in the east of Dorset – Poole Hospital and the Royal Bournemouth and Christchurch Hospitals - should each have distinct roles.

One would be a hospital for major planned care (sometimes termed a 'cold' site). This would allow for the continuous delivery of treatment away from the disruption that urgent and emergency care can create.

The other would be a major emergency hospital (sometimes termed a 'hot' site) with more consultants available more of the time to deal with urgent and emergency care. National evidence shows that outcomes for patients can be improved and more lives saved by specialising in this way.

The two hospitals are approximately 8 miles apart and serve the area of largest population in Dorset. Since CSR, the creation of 'hot' and 'cold' hospital sites is national NHS policy and is strongly supported in the NHS Long-Term Plan (Section 3.111), published in January 2019
https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf

The CSR also proposed that in the west of the county, urgent, emergency and planned care services would be maintained at Dorset County Hospital in Dorchester, in order to serve the largely rural population in its catchment area.

During the CSR, local stakeholders and NHS England each asked that the CCG should name a preferred option.

After a rigorous shortlisting process, two options were selected for consultation. These are described below.

Option A	Option B
• **Poole Hospital:** The Major Emergency Hospital • **Royal Bournemouth Hospital:** The Major Planned Hospital • **Dorset County Hospital:** The Planned and Emergency Hospital	• **Poole Hospital:** The Major Planned Hospital • **Royal Bournemouth Hospital:** The Major Emergency Hospital • **Dorset County Hospital:** The Planned and Emergency Hospital

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Details of how the CCG arrived at these options are available in the Decision-Making Business Case (DMBC)
https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/DMBC-CSR.pdf

Six evaluation criteria, developed with the CCG 's Patient and Public Engagement Group, were applied to each option. In most of these criteria, options were rated the same, with the exception of access and affordability. In both criteria, Option B was rated better. As a result, the CCG named the preferred option for consultation as Option B – the Royal Bournemouth Hospital as the Major Emergency Hospital and Poole Hospital as the Major Planned Hospital.

The Governing Body went on to approve Option B.

Maternity and Paediatrics

Proposals to change maternity and paediatric services were an integral part of the changes to acute hospitals. The plan was to create a single specialist centre at the Major Emergency Hospital in the east of Dorset. In line with the preferred option for the acute hospitals, this would mean moving consultant-led maternity and overnight children's services at Dorset County Hospital to the Royal Bournemouth Hospital.

This proved particularly contentious in the west of the county. The proposals were based on the future safety and sustainability of the service. Before the CCG finalised the CSR proposals, an independent review by the Royal College of Paediatrics and Child Health (RCPCH) published in April 2016, found that some aspects of care needed to be improved and updated as they could not be sustained in terms of staffing, facilities and finances.

The RCPCH recommended that Dorset County Hospital should open talks with Yeovil District Hospital about providing an integrated service to ensure safe and sustainable services for the future. If this option were not possible, then DCH must integrate with teams in the east of the county to provide one service for Dorset.

The proposal resulted in high-profile protests and the formation of a campaign to Save Kingfisher Ward.

For this reason and for absolute clarity, during the CSR consultation the CCG decided to make the options for maternity and paediatric services at Dorset County Hospital a separate question.
The options consulted on are tabled below.

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Maternity and Paediatrics (option A)	Maternity and Paediatrics (option B)
Two centres: one at the Major Emergency Hospital in the East of Dorset, and an integrated service across Dorset County Hospital and Yeovil District Hospital for residents in the West of Dorset.	Single specialist centre at Major Emergency Hospital in the East of Dorset.

In response to the consultation, the CCG named Option A as its preferred option and, subsequently, announced its intention to find a solution that would retain consultant-led maternity and paediatrics services at Dorset County Hospital. This followed confirmation that Somerset CCG was to launch its own review, which may affect the possibility of an integrated service across Dorset County and Yeovil Hospitals. As a result of this approach the campaign group; 'Save the Kingfisher Ward' were content with the changes to proposals
The CCG have pledged to work with communities and consult on the revised proposals when and if appropriate.

The Governing Body went on to approve Option A

Integrated Community Services

Following the same rationale for the acute hospital plans, the CSR also proposed a new model of community care which aimed to:

- Increase the number of people supported in the community as an alternative to major hospitals;
- Increase the range of services in the community such as outpatients and therapy services;
- Create joined-up teams of health and social care staff working together;
- Move towards 7-day services, available longer during the day;
- Improve the use of community hospitals as community hubs;
- Develop and support the mental health acute pathway review running alongside the CSR.

These plans would mean moving beds from some community hospitals to other sites where they could better match need and demand, and be safely staffed. This would result in an increase of up to 69 community beds, re-balanced across Dorset.
The table below shows the community options that the CCG consulted on:

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Community hubs with beds	Community hubs without beds
Poole or Bournemouth hospitals (subject to public consultation on the preferred major planned site)	Located at Shaftesbury (with care home beds)
Wimborne Hospital	Located at Christchurch (with care home beds in the Christchurch and Bournemouth area)
Bridport Hospital	Dorset County Hospital (also an acute hospital)
Blandford Hospital	Located at Portland
Sherborne Hospital	Located at Wareham (with care home beds)
Swanage Hospital	
Weymouth Hospital	

In response to what people said during the consultation, the CCG amended three of these proposals. These changes are described in section 2.3 below but mean that there will now be community beds at the major emergency hospital at Bournemouth, beds will remain at Shaftesbury Hospital until alternative provision can be agreed through continuing engagement with the local community, and beds would remain at Westhaven Community Hospital until Weymouth Hub was ready.

The proposals were approved by the CCG Governing Body on 20th September 2017, the detailed list of proposals can be found on Pages 86-93 of the DMBC

2.2 A chronological description of events in bullet form from initial development of the proposal through to referral to the Secretary of State

The overall chronology of the main events is as follows:

Date	Stakeholder	Event/Action
June 2013	Public	Launch of the Big Ask public engagement. 25,000 surveys were sent out to members of the general public and members of four citizen's panels. These generated 29,000 pieces of qualitative data that helped to inform the CSR proposals.
March 2014	Dorset CCG Governing Body	Governing Body decision to agree to start the CSR.

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September 2014	Dorset CCG	Dorset CCG recruits an external partner to assist with the CSR.
September 2014	Dorset Health Scrutiny Committee	Dorset Health Scrutiny Committee briefed on the launch of the CSR.
October 2014	Public	Government launches Five- year forward view.
October 2014	Public	Dorset CCG publicly and formally launched the start of the review process with a large-scale event at the Bournemouth International Conference Centre and the creation of Dorset's Vision, the CCG 's consultation website.
November 2014	GP Practices in Dorset	Dorset CCG clinical chair wrote to 100 general practices. The letter offered for the review team to meet with each practice to gain their involvement in shaping the design stage.
November 2014	Dorset Health Scrutiny	DHOSC receive a further briefing paper from the CCG.
November 2014	Finance Reference Group (FRG)	The Finance Reference Group (FRG) was formed to provide financial assurance on the models and solutions proposed in the Clinical Services Review. Its membership consisted of Directors of Finance from the CCG, RBHFT, PHT, DCHFT, and SWASFT and met monthly.
November 2014	Clinical Reference Group (CRG)	The Clinical Reference Group (CRG) was established to provide Dorset-wide clinical leadership for the CSR. Members include GP's, Medical Directors and Clinical Leads from the CCG, Hospitals, Ambulance Service and NHS England.
December 2014 to May 2017	Clinical Working Group (CWG)	The large Clinical Working Groups (CWG) were established to design the clinical models for the CSR. The group consisted of over 150 clinical members and the group met 15 times.
January 2015	Dorset CCG	The Need for Change published - setting out detailed supporting information in relation to the need for change.
January 2015	CSR Assurance Group	CSR assurance group approve evaluation criteria. The Evaluation Criteria were developed in consultation with clinicians (CWG), GPs, the Finance Reference Group, the Public and Patients Engagement Groups. The criteria were developed to facilitate objective differentiation between the available options based on what is most important to realising the vision for healthcare in Dorset.

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March 2015	Dorset CCG	Travel time analysis carried out.
March 2015	Wessex Clinical Senate	Wessex Clinical Senate review engaged to peer review the clinical design of the CSR.
March 2015	Patient and Public Engagement Group (PPEG)	PPEG Recommendations for CSR - Consultation principles were designed to inform plans and ensure meaningful engagement and consultation.
April 2015	NHSE	Confirmation of stage 1 assurance received from NHSE.
May 2015	Joint Health Scrutiny Committee (JHOSC)	A JHOSC was established.
May 2015–June 2015	Wessex Clinical Senate	Clinical Senate review of the Pre-Consultation Business Case (PCBC)
June 2015	Health Gateway	Health Gateway Review of CSR. Six recommendations were proposed from this review. These recommendations were implemented.
July 2015	CCG Governing Body	The Governing Body agreed that the integrated community services proposals and implementation plans should be further developed prior to formal public consultation.
July 2015	Wessex Clinical Senate	Wessex Clinical Senate external review report giving 16 recommendations that were implemented into the PCBC.
July 2015	Joint Health Scrutiny Committee (JHOSC)	First meeting of JHOSC.
September 2015-March 2017	Dorset Association of Parish and Town Councils	14 engagement meetings with the Dorset Association of Parish and Town Councils.
November 2015	Dorset HOSC	Briefing paper to the Dorset HOSC.
December 2015	JHOSC	JHOSC received revised timelines for CSR.
February 2016	Local Authority	Engagement with the Local Authority Directors in Bournemouth, Poole and Dorset.

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March 2016	Clinical Task and Finish Group	Clinical task and finish group tested activity assumptions for Integrated Community Services (ICS).
March to April 2016	Public	Nine locality based Integrated Community Services engagement events
March 2016	Wessex Clinical Senate	Wessex Clinical Senate review of work carried out to date and recommendations for further areas of development
April 2016	Royal College of Paediatrics and Child Health	RCPCH Review of CSR made multiple recommendations regarding maternity and paediatric care which became the evidence base for the final maternity and paediatric recommendations.
April 2016	Wessex Clinical Senate	Wessex Clinical Senate further review of clinical models.
May 2016	Dorset CCG	Governing Body approve Major Hospital public consultation subject to NHS England and Clinical Senate approval.
May 2016	Wessex Clinical Senate	Wessex Clinical Senate Council Report received by CCG.
June 2016	JHOSC Meeting	Update to the JHOSC.
June 2016	NHSE	Stage 2 assurance meeting with NHSE concluded the CSR was partially assured subject to national investment committee approval due to the scale of the reconfiguration.
June 2016	Public	Integrated Community Services Roadshows held in 27 locations.
June 2016	Wessex Clinical Senate	Submission to Wessex Clinical Senate Council.
July 2016	JHOSC	Informal meeting with committee members.
July 2016- – August 2016	The Oversight Group for Service Change and Reconfiguration (OGSCR)	OGSCR recommended approval of the CSR to proceed to consultation to the national investment committee.

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July 2016	Dorset CCG	Governing Body approve Integrated Community Services and Mental Health Public consultation, subject to NHS England and Clinical Senate approval.
August 2016	Dorset HOSC	Informal meeting with Dorset HOSC.
August 2016-October 2016	National Investment Committee	The Investment Committee met twice to familiarise themselves with the Dorset CSR and complete the NHS England assurance process for service change and reconfiguration.
October 2016	Dorset CCG	Publication of the Clinical Services Review consultation plan 2016/17.
October 2016	Public	Dorset STP Sustainability & Transformation Plan Launched– Built on the work undertaken in the CSR, the Dorset STP outlined how the five-year forward view would be delivered
October 2016	JHOSC	JHOSC received outcomes and proposals which would go forward to NHS England assurance and public consultation.
November 2016	NHSE	Confirmation of Stage 2 Assurance received from NHSE following completion of the National Investment Committee work.
November 2016	Public	CSR PCBC published.
December 2016	Public	Final Clinical Senate report published.
December 2016 – 28 February 2017	Public	CSR public consultation. Three months of public consultation with circa 20,000 responses, over 1000 telephone surveys and 14 focus groups
February 2017	JHOSC	JHOSC meeting resolved to draw up a formal response to consultation.
March 2017	JHOSC	Joint Health Scrutiny Committee's formal response to the CSR sent.
March 2017	Public	Dorset announced as 1 of 9 wave 1 sites to become Accountable Care Systems (later rebranded to Integrated Care Systems)
April 2017	Consultation Institute	CSR consultation awarded the 'good practice' accreditation by the consultation institute.
May 2017	Public	Findings of the public consultation were reported.
May 2017-August 2017	Dorset CCG	Additional work to address concerns raised during engagement and consultation - Dorset County Council undertook work on non-emergency travel times, the South West Ambulance Service undertook work on

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		emergency travel times, the CCG undertook work on equality impact assessments and clinical risk assurance and Public Health Dorset undertook work on the prevention aspect of the plans.
May 2017 to August 2017	Dorset CCG	Detailed deliberation of the consultation responses and additional work by the CCG Governing Body.
July 2017-September 2017	Public	Dorset system demonstrates positive benefits of the new model of Integrated Care Services.
July 2017	SWASFT/ Public	SWASFT Report 'Modelling the potential impact on the emergency ambulance service' published. The report noted the new model would deliver a significant reduction in inter-hospital transfers, have a limited impact on the ambulance service (approximately half a day of additional ambulance time required) and in many cases average travel times and maximum travel times would reduce under the new model.
July 2017	Public	CSR Equality Impact Analysis (EIA) report published.
July 2017	Public/Dorset County Council	Dorset County Council Review of transport report published concluding that CSR travel times are within similar and acceptable parameters. A transport reference group was set up led by Dorset County Council on behalf of the wider Dorset system, comprising health and local authority members.
July 2017	NHSE	Confirmation of capital support - later confirmed at £147m, equating to over a third of the national wave one STP capital allocation.
August 2017	DHOSC	Informal meeting of the DHOSC to provide an update
August 2017	JHOSC	JHOSC meeting to discuss consultation findings.
August 2017	Dorset CCG	Dorset CCG Clinical Risk Framework published.
September 2017	Dorset CCG	Publication of the Decision Making Business Case.
September 2017	Dorset CCG	Dorset CCG Governing Body decision-making meeting on CSR proposals in which all the CSR recommendations were approved.
September 2017	West Hampshire CCG	West Hampshire CCG Governing Body decision in Support of CSR.

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September 2017	Consultation Institute	The Consultation Institute confirmed that the CCG's consultation had been upgraded from Good Practice to Best Practice Accreditation
November 2017	DHOSC	DHOSC met to consider the CSR decisions.
November 2017	Purbeck councillors	Meeting with Purbeck Town and Parish councillors.
November 2017 – September 2018	Anna Hinsull Defend Dorset NHS	Judicial Review process initiated following the CCG decisions (Nov 2017) concluding with the Judicial Review judgement in September 2018 finding in favour of the CCG. An appeal has been lodged with the court of appeal to be heard July 2019
December 2017	JHOSC	JHOSC decision not to refer to Secretary of State.
December 2017	Dorset CCG	CCG announced to the DHOSC its intention to work to maintain a consultant-led maternity and overnight children's service in Dorchester.
December 2017	DHOSC	DHOSC resolved not to proceed to Secretary of State.
February 2018	Dorset County Council	Transport enquiry day organised by the Dorset County Council led health and local authority transport reference group at the request of the HOSC.
March 2018	DHOSC	DHOSC sets up a task & finish group. The group was established to reconsider existing and new evidence, which might be submitted in light of the concerns raised by Councillors and members of the public regarding the CSR plans.
May 2018-date	RBH / PHT	RBH and PHT Merger programme passes NHS Improvement's Stage 1 strategic review and enters full business case stage.
July 2018	Dorset CCG	CCG agree £13m investment in community services to support out of hospital care
August 2018	DHOSC	DHOSC task & finish group meeting.
September 2018	Anna Hinsull / Defend Dorset NHS	Judicial Review rules in favour of the CCG on all grounds.
September 2018	RBH / PHT	Architects and planners appointed for the One Acute Network Estates Design Work. Funded internally by Acute Trusts

September 2018	DHOSC	DHOSC task & finish group meeting recommended to the Dorset HOSC that the CSR proposals were **not referred** to the Secretary of State.
October 2018	DHOSC	DHOSC referral to Secretary of State.
October 2018	RBH / PHT	Estate masterplans completed for the Major Emergency Hospital and Major Planned Hospital
November 2018	BBC	Bournemouth Borough Council write letter in support of DCCG and against the referral
November 2018	West Hants CCG	West Hants CCG write letter in support of DCCG and against the referral
November 2018	RBH / PHT	Bournemouth and Poole hospitals appoint Principal Supply Chain Partner (PSCP) to complete detailed Estates Design work.
November 2018	SWAST	South West CCGs agreement to invest £12m into Ambulance Transformation to improve SWASFT performance and ambulance response times
December 2018	Dorset NHS partners	SWASFT report recommendation of a clinical risk review of extended travel times was completed
December 2018	RBH / PHT	PHT & RBH appoint an interim joint Chief Executive Officer and an interim joint Chair, following approval from the Competition and Markets Authority.
December 2018	Poole HOSC	Motion for Poole HOSC to refer to the Secretary of State was defeated. A letter in support of DCC referral was submitted instead
January 2019	JHOSC	Ambulance response times inquiry day with JHOSC
January 2019	NHSE	NHSE published the NHS Long-Term Plan
January 2019	NHSE / DHC	£4.2m capital funding allocation approved towards the development of a community hub at Blandford Hospital
January 2019	NHSE / RBH	£5.1m capital funding approved towards the implementation of the Pathology - Laboratory Information Management System (LIMS)
March 2019	RBH / PHT	Completion of the £147m capital Outline Business Case (OBC) for the re-provision of services across Bournemouth & Poole hospitals.
March 2019	RBH / PHT	Commencement of the Full Business Case (FBC) work for the re-provision of services across Bournemouth & Poole hospitals with appointed design partners.
April 2019	Local government	Establishment of new unitary councils under the Local Government Review (2 unitary Councils created from 9 councils)

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March 2019	System Leadership Team / Integrated Care System partners	Draft Integrated Care System operational plan 2019/20 developed.
May 2019	Local government	Local Elections for new Councils
June 2019	Dorset CCG	Secretary of State commissions Independent Reconfiguration Panel
24 July 2019	Anna Hinsull / Defend Dorset NHS	Judicial Review – "rolled up" hearing to consider permission to appeal, and if granted to hear and judge the appeal.

2.3 A description of how the proposal has developed in response to feedback from the public, staff, scrutiny committees, other interested parties – either through public involvement and engagement or through formal consultation

From its formative stage, the CSR was informed by extensive staff, public and stakeholder engagement. This started with the launch of the Big Ask, which generated 29,000 pieces of qualitative data from 25,000 surveys that were sent out to members of the general public and members of four Citizen's Panels.

Other examples included:

- 18 Patient (Carer) and Public Engagement Group (PPEG) meetings – providing feedback and challenge at all stages of the CSR, 525 local people attended public meetings during the formative stage of the CSR.
- 84 diverse forums, meetings and events providing information and opportunity for involvement to thousands of people.
- 3,900 Health Involvement Network (HIN) and 150 Supporting Stronger Voices members from local Dorset communities.
- 2 CSR young people's conferences co-designed and co-hosted with young people in October and November 2015.
- 4,100 people watched the CCG 's animated film 'Need to Change'.
- 339 local people attended nine locality-based Integrated Community Services public engagement events that were hosted in March and April 2016 providing 2,162 pieces of feedback.
- 26 locations across Dorset were visited by the Integrated Community Services Roadshow during two weeks in June 2016 travelling 650 miles and enabling 36 staff to speak with 100s of people who gave 1000s of pieces of feedback
- 157 people representing groups and organisations with an interest in community health and care in Dorset attended two public engagement events in June 2016 providing 100s of pieces of feedback.

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A comprehensive public consultation was carried out from 1 December 2016 to 28 Feb 2017 using a range of methodologies.

There were circa 20,000 responses in total from a wide reach of individuals and organisations across Dorset's demography, geography and diversity. The CCG followed legal requirements and national guidance, including the Gunning principles. The consultation planning, processes and documentation received 'good practice' accreditation from the Consultation Institute in June 2017 and this was upgraded to 'best practice' in light of the detailed consideration given to the consultation responses by Dorset CCG 's Governing Body.

For details of the consultation response please visit:
https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/10/ors-final-report.pdf

The CCG also met with campaigners and protest groups relating to Poole Hospital, Save Kingfisher Ward (the children's ward at Dorset County) and Shaftesbury Save Our Beds campaigns on numerous occasions. Representatives from these groups came in to meet with the CCG Chief Officer and other senior managers and clinicians. The CCG continue to engage with these forums through various methods, either individually or as part of a community reference group. Two of the leading campaigners have become governors at Poole and Dorset County Hospitals.

Other protestors from the Keep Our NHS Public campaign attended most of the meetings held during the consultation period, although the group declined all direct invitations to come to meet with the CCG.

Defend Dorset NHS did not come to the CCG 's attention until after the Governing Body had made its decisions and it announced its intention to support the claimant in the judicial review.

Amendments to the proposals post-consultation

Public and stakeholder feedback during consultation resulted in the CCG commissioning additional pieces of work in the following areas:

- *Urgent and emergency transport*
  The CCG commissioned South West Ambulance Service Trust (SWASFT) to look at any potential impact of the proposed CSR reconfiguration on the emergency ambulance services. The report analysed a total of 21,944 patient records covering all incidents where an ambulance attended and conveyed a patient to hospital during the period from 1 January 2017 to 30 April 2017.

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The SWASFT analysis showed that there were132 cases out of a total of 21,944 cases (0.6%) for which there may be additional clinical risk and in most case travel times remained similar or shorter than at present.

This was picked up by High Court Judge, Sir Stephen Silber, who, in his ruling on the judicial review, stated 'SWASFT's statistics and analysis indicated that the additional clinical risk caused by the increased travel times as a result of implementing the proposed reconfiguration of medical services was "minimal".

- *Non-urgent transport*
  Dorset County Council was commissioned to independently review the non-emergency travel analysis and transport issues raised in the CSR consultation and to set up a system-wide Transport Reference Group (TRG).

  The resulting analysis indicates that that CSR travel times are within similar and acceptable parameters to the routing software and analytical tools used in local authority transport planning activities.

- *Clinical risk*
  The aim of this review was to identify any potential clinical risks associated with the CSR; to provide assurance that the CSR had considered, and will continue to consider, clinical risk; and how any identified risks would be mitigated.

  The report concluded that services as they are currently configured, pose some clinical risks and acknowledged that there is further work required to identify risks specific to each service, as the implementation plans are developed.
  The full report can be found at:

  https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/Clinical-Risk-Approach-to-CSR.pdf

- *Equality impact assessment*
  Throughout the design and consultation phase the CCG continually tested the models of care against Equality Impact Assessments. In line with best practice, these were reviewed and updated to reflect some of the feedback provided by the CSR public consultation. In doing this, the CCG followed a robust process which involved review by the CCG and provider trusts' leads for service delivery and independent scrutiny by the Equality and Diversity Lead for Dorset Healthcare NHS Trust to ensure that the CSR plans would not adversely affect groups of people across Dorset's geography, demography and diversity.

  The CCG then arranged a second facilitated workshop for PPEG and additional invited members of the public/staff who collectively represented the nine protected characteristics. This was to ensure that the process was inclusive and realistic.

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The revised and updated EIA was then sent for legal review before being scrutinised by the Quality Assurance Group and publication in July 2017. The EIA can be can be found at; https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/11/CSR-EIA.pdf

- *Prevention-at-scale*
  Prevention-at-scale is an important part of the CCG 's plans to provide more care closer to home and avoid the need for people to travel to services. In response to the consultation, the CCG acknowledged that they could have said more about their plans to prevent people from becoming ill and to live better across Dorset. To redress this, the CCG commissioned a report from Public Health Dorset which explained 'Prevention at Scale' in more depth.
  https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/Prevention-at-Scale-Update.pdf

After giving full and detailed consideration to the consultation responses, the CCG Governing Body made changes to four of the original consultation proposals.

The revisions are detailed below:

North Dorset

Originally, the CCG proposed two community hubs with beds, one each at Sherborne and Blandford Hospitals and a hub without beds at Shaftesbury. After considering the consultation responses, the Governing Body revised this proposal so that beds would also be maintained in the community hub in Shaftesbury, whilst working with the local community on a sustainable model for future services based on the health and care needs of this locality. A new location for the community hub in Shaftesbury may need to be found, because Westminster Memorial Hospital at Shaftesbury Hospital has significant infrastructure limitations, which will reduce the potential to develop further the range of services on this site.

The reason for this change was the isolation of the area and access to community beds.

Bournemouth and Christchurch Localities

The CCG now propose to commission an additional hub with beds on the Major Emergency Hospital site at the Royal Bournemouth Hospital. This is in addition to the community hub with beds at the major planned care hospital and a hub without beds at Christchurch Hospital.

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Respondents to the consultation raised concerns about access to community hospital beds in parts of the Bournemouth, Christchurch, Ferndown and West Moors areas, where some of Dorset's more deprived communities live; patient needs for hospital care and diagnostics; whether the care market would best meet these needs, and the travel times to a community hub with beds for people in these areas.

Weymouth and Portland

During the CSR consultation, a review of the hospital sites in Weymouth and Portland were carried out.

The reviews of Weymouth and Westhaven Community Hospitals confirmed that the Westhaven site would not be large enough to become the community hub with beds and the site is less accessible than the Weymouth site for both private and public transport. In addition, the cost to move the beds on the Weymouth Community Hospital was found to be substantially larger than anticipated due, in part, to the quality of the current infrastructure.

The CCG still intends that the Weymouth Community Hospital should be a community hub with beds. However, it was decided that services and beds will be maintained at Westhaven Hospital, until the community hub with beds at Weymouth Hospital is established and both staff and services have been appropriately transferred.

The CCG continues to support engagement with communities affected by the CSR decisions, especially in North Dorset, Wareham and in Portland.

Maternity and Paediatrics Services

Prior to the public consultation, the CCG did not state a preferred option for maternity and paediatric services in the west of Dorset.

Following consultation, the Governing Body decided it would name Option A as its preferred option: namely, to commission the delivery of consultant-led maternity and paediatric services from the Major Emergency Hospital, while continuing to seek to commission the delivery of consultant-led maternity and paediatric services, integrated across Dorset County Hospital and Yeovil District Hospital Any proposed changes to services in either hospital would be subject to further local public consultation, by both Dorset and Somerset CCGs, as appropriate.

A further development took place in December 2017, when CCG Chief Officer Tim Goodson announced the CCG's intention to seek a solution that would allow consultant-led maternity and paediatric services to remain at Dorset County Hospital. This proposal will require future consideration by the CCG Governing Body and engagement and/or consultation with the local community as appropriate.

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The CCG is continuing to engage with the major campaigners to keep Kingfisher Ward open and with staff at the hospital.

2.4 A description of any action taken in light of referral of proposals to the Secretary of State by the contesting body/bodies

Note: This section also aims to address the points raised in the letter from the Secretary of State to the Independent Reconfiguration Panel

The grounds for Dorset Health Overview and Scrutiny Committee's (HOSC) referral reflect the concerns of some local protesters, primarily the Defend Dorset NHS group, who oppose the changes to Bournemouth and Poole Hospitals and the closure of beds at some community hospitals. The group did not become active until after the CSR consultation was completed and the decisions had been taken. Defend Dorset NHS is linked to the national campaign group Keep Our NHS Public and has leading members with direct affiliations to local branches of the Labour Party. It supported a local resident to take the CSR to judicial review (JR). The JR found in the CCG's favour and all seven grounds of legal challenge – including those concerns which relate to the HOSC referral – were resoundingly rejected.

In making the referral over a year after the CSR decisions were made, the HOSC has gone against the recommendations of its own Task and Finish Group, set up to collect evidence from Defend Dorset NHS, Healthwatch Dorset and the CCG. It also contradicted Dorset HOSC's earlier decision not to refer made in December 2017 and that of the Joint Overview Scrutiny Committee (JHOSC) not to refer, made in the same month. The JHOSC was set up specifically to scrutinise the CSR and included members of Dorset, Bournemouth, Poole, West Hampshire and Somerset local authorities.

The CCG has invited members of Defend Dorset NHS to discuss its concerns with its Chief Officer and Chair. Unlike other campaign groups that the CCG is continuing to engage with, Defend Dorset NHS has not responded to offers to meet directly with the CCG. A similar offer to meet with the Chief Executive of Bournemouth and Poole Hospitals was also rejected.

The proposals are in the interest of local health services with reference to South West Ambulance Services Trust (SWASFT), travel times, sustainability, community services and equity of access

Please see section 2.3 for additional work undertaken on ambulance response times and section 3.3 on travel analysis. Note that the SWAST report concluded that average travel times for maternity and paediatric patients will decrease as a result of the planned changes.

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SWASFT & Emergency Travel

Expert clinical review of ambulance travel times on patients at potentially higher risk.

More recently, the CCG has responded directly and positively to Dorset HOSC's concern that the SWASFT travel times required further investigation, so that the HOSC could be assured that they would not cause loss of life.

The CCG did this by bringing together an expert panel to comprehensively review the same 34 cases in the original SWASFT report.

The expert panel of Dorset's most senior clinicians from each hospital, concluded that increased travel times by ambulance, resulting from the CSR decisions, would not have changed the outcomes for these patients at potentially higher risk.

Members of the panel included senior A&E consultants and medical directors from each of Dorset's acute hospitals, leading paramedics from SWASFT and a Director of Nursing.

The aim was to re-investigate whether or not extended journey times resulting from changes to hospital services may increase clinical risk and could affect the potential outcome for patients. The panel had access to the patient notes held by the relevant A&E departments and SWASFT. Follow the link for further information https://ourdorset.nhs.uk/expert-review-concludes-that-csr-increased-ambulance-travel-times-would-not-have-changed-the-outcomes-for-patients-at-potentially-higher-risk/

Additional investment in ambulance services

Dorset CCG is the lead commissioner for ambulance services in the South West region. In November 2018 the CCGs in the South West agreed to invest £12m in SWASFT to improve performance and ambulance response times (with the Dorset share being circa £1.5 million). This will provide an additional 241 whole time equivalent staff and 63 vehicles over two years across the South West region.

The South West CCGs are continuing to work with SWASFT on a transformation programme to improve efficiency and reduce demand. This is aimed at bridging a funding gap resulting from changes to response time standards since this investment was made and a modification of some of the assumptions used.

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Working with local authorities on transport plans to ensure equity of access

Whilst the distance between RBH and PHT is only just over 8 miles, the CCG has nonetheless worked closely with local authorities in Bournemouth, Poole and Dorset as part of an integrated transport programme, the first of its type. The programme aims to address public concerns about equity of access to services by promoting the use of community transport schemes for healthcare journeys and to supporting congestion-reduction schemes such as a new relief road which will assist access to Bournemouth Hospital site. The CCG has set up two stakeholder reference groups to pilot community transport plans in rural north Dorset and the more urban area of Weymouth and Portland.

It is working with Dorset Council and community organisations on a campaign to increase the number of volunteer drivers to support community transport, especially in rural areas of the county.

It has also worked with members of the public and stakeholders to reassure them that the volume traffic is very small compared to the influx of people commuting to work or travelling from outside into the conurbation each day, and therefore the impact on congestion is similarly very small.

Work is also ongoing with the new Bournemouth, Christchurch and Poole (BCP) Council to develop a spur road for improved access to the new major emergency site. This scheme is being led by the local authority and has passed planning approval and funding has been identified for it. In addition to this scheme, journey times in the conurbation are being targeted with a 12% reduction in four years under a central government capital bid to tackle urban infrastructure issues.

The proposals are in the interests of the local health service – alignment to the NHS Long Term Plan

Since the CSR, the NHS Long Term Plan (LTP) has been published and specifically supports the move towards the ‘hot’ and ‘cold’ site model as the national direction of travel.

On page 74 para 3.111, the LTP states “separating urgent from planned services can make it easier for NHS hospitals to run efficient surgical services. Planned services are provided from a ’cold‘ site where capacity can be protected to reduce the risk of operations being postponed at the last minute if more urgent cases come in. Managing complex, urgent care on a separate ’hot‘ site allows trusts to provide improved trauma assessment and better access to specialist care, so that patients have better access to the right expertise at the right time. So we will continue to back hospitals that wish to pursue this model”.

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The Long Term Plan has a very strong focus on investing in community services and GP networks. This matches Dorset CCG's ambition to provide more care in the community, closer to home and reducing the need to travel. This has been backed by a national £4.5bn investment into these services to employ more staff and support the development of services in the community in line with the CSR decisions. Many of these posts have been filled and jobs would potentially be at risk should there be requirement to reverse the CSR decisions.

Patient benefits arising from the acute reconfiguration

Following requests from the Dorset HOSC and Healthwatch Dorset to increase public awareness of the CSR changes, the CCG published a supplement in the local media explaining how the creation of 'hot' and 'cold' sites – a major emergency hospital at Bournemouth and a major planned care hospital at Poole – will benefit the local population.

The benefits include, for example:

- 24/7 consultant delivered emergency care providing better care for over 35,000 patients per year who currently visit A&E when there is no on-site consultant;
- considerable reduction in transfers between hospital sites providing better care for over 3,500 patients per year;
- better use of scare specialist clinical resources;
- better quality services and improved outcomes, particularly for stroke and cardiac services;
- reduction in clinical variation between sites and adopting the 'best of both hospitals' in future service design, thereby increasing patient safety;
- fewer cancellations of elective surgery due to emergency admissions thereby reducing waiting times for over 6,000 patients per year;
- shorter waits for cardiac treatment for around 750 patients per year;
- a reduced length of stay for 400 people needing interventional cardiac treatment, saving between 11 to 21 lives per year.

Many more examples of how the changes will benefit local people are set out in the Patient Benefits Case for the merger of PHT and RBH. This case details how the merger will reduce clinical risk, reduce mortality and morbidity and improve outcomes *(summary version submitted as evidence "1_3_9a - PBC lite v4", full version available on request).*

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Community Services Provision

The development of primary care and community services

The CCG is supporting the development of primary and community services to bring care closer to home and reduce the need for people to travel to acute hospitals for treatment

To this end, the partner organisations in the Our Dorset Integrated Care System have agreed to a multi-million-pound investment, funded by the CCG, to enable people across Dorset get more care closer to home. The agreement resulted in £3m being invested the last financial year (2018/19) with £6.5m full year effect in 19/20 and an additional £6.5m in 20/21.
The money will be invested in a number of areas from September 2018, including:

- More healthcare professionals working in primary and community teams (to support people with complex needs);
- supporting people with diabetes or respiratory conditions;
- employing more community-based pharmacists;
- end of life care and support to people in local residential and nursing homes.

As part of this, there will be an increase of approximately 140 community and primary care staff because of this investment. Dorset Healthcare, the community and mental health services provider, will be employing over half of these staff. As of May 2019, Dorset Healthcare has recruited to 95.7 FTE of this new resource.

This investment is as a direct result of the CSR decision and is part of the implementation roll out. Case studies describing where local improvements to community services, such as the development of community hubs, integrated teams and virtual wards, are publicly available the Our Dorset (Integrated Care System) website. https://ourdorset.nhs.uk/#studies

An estimated £11.5m will also be invested through the 2019 GP Contract for developing primary care networks in Dorset, providing more services closer to people's homes

The CCG continues to support ongoing engagement with communities affected by the CSR changes especially in North Dorset, Weymouth and Portland and the Purbecks.

Assurance against the five reconfiguration tests

There was extensive involvement of NHS England and the Clinical Senate in developing and assuring the CSR proposals. The CSR assurance process was completed before the 5th bed test was introduced. Nevertheless, the CCG sought assurance from NHSE that the bed test had been met.

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As such the CSR proposals have been assured as meeting the required five key tests for service reconfiguration by NHS England and this same issue was examined by the JR with the same conclusions reached. Moreover, the Court of Appeal dismissed an appeal bought by Keep the Horton General against Oxfordshire CCG in April 2019 relation to the 5th bed test. This case had many similarities to one of the grounds of appeal for the Dorset JR and as such this part of the JR appeal was subsequently dropped by the Claimant in the Dorset JR appeal case.

Please see section 2.7 for NHS England assurance against the five key tests for reconfiguration and related Judicial Review judgement.

Implementation has progressed to the degree that halting changes at this stage would not be in the best interests of local health services:

Following the JHOSC and HOSC support for the CCG CSR decisions, the CCG and local trusts have made multi-million pound investments and progression towards implementing the CSR decisions, in both the acute hospital and community sectors, since the JR ruling was handed down. To halt or abandon the changes now would be damaging to the future of local health services, result in loss of significant financial investment and, potentially, jeopardise additional jobs that have been created.

For example, the CCG and NHS Foundation Trusts have so far spent or committed £1.2m on implementation costs for the changes to acute hospitals; £1m on planning with clinical teams; £1.6m for the appointment of Principal Supply Chain Partners for the next phase of detailed design; £13m on NHS investment plans; £6.7m to deliver the Full Business Case; £0.4m for health planning support, cost advisors, equipment reviews and site surveys; £1.2m for implementation costs of the support team; and £0.5m on expert support to ensure the experience-based, co-design patient involvement required to deliver the Full Business Case. All of the aforementioned investment would be lost were the implementation of the changes not to go ahead.

The Royal Bournemouth and Poole hospital trusts have appointed a single joint chair and joint chief executive and joint clinical leaders for four major services as part of the progression towards a single merged trust that would deploy its services over the planned and emergency sites. Closer working in these services is already showing benefits and financial savings.

The hospitals have already re-located beds based on the proposed changes.

There has also been significant investment into community and primary care services as a result of the CSR decisions including £6.5m each year to provide 140 new posts to improve access to more services in community settings. This is set out in in the section on the development of community and primary services above.

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Additionally, the CCG has invested in the region of £1.2m over the past two years to support increased access to psychological therapies for people with long term health conditions such as diabetes and chronic pulmonary disease. As a result of this investment there are now an additional 28 psychological therapists working out of GP practices and community settings.

There is uncertainty for staff in affected organisations due to ongoing legal and scrutiny processes and this has led to difficulty retaining and recruiting staff to some community hospital sites and at Poole Hospital. This is compounding existing workforce challenges and would be exacerbated were there to be any change or reversal of the plans. Conversely, improved recruitment at RBH and investment into the community workforce (mentioned above) as a result of the plans has been beneficial and this would be lost were the CSR changes to be reversed.

Continuing local authority scrutiny

The CCG and a strong contingent of senior executives and clinicians from partner NHS organisations attended a meeting of Poole Council's overview and scrutiny committee to present evidence and respond to questions at the CSR arising from Dorset HOSC's decision to refer to the Secretary of State. A large number of protesters, including those from Defend Dorset NHS and Poole Labour Party, attended the meeting to try to persuade the committee to make a second referral to the Secretary of State. After five hours, the committee decided not to make a referral but to write a letter to the Secretary of State in support of Dorset HOSC's referral.

Letters of support in favour of the CSR and support for **not making a referral** to the Secretary of State have been written by Bournemouth Borough Council and West Hampshire CCG to the Secretary of State

The Dorset HOSC's decision to refer was taken in the context of a local government reorganisation and consequential elections to the two new unitary authorities. This resulted in a reduction of councillors from 174 to 82 in Dorset Council. It is the CCG belief that a combination of the local elections, a reduction in overall seats available to councillors and a targeted social media campaign aimed personally at councillors resulted in a reversal of the original HOSC decision not to refer to the Secretary of State. This was despite the Dorset HOSC establishing a task and finish group prior to this meeting which made a recommendation not to refer the CSR to the Secretary of State.

The meeting at which the HOSC voted to refer – by a six to four majority- was attended by a persistent and vocal group of protesters led by members of Defend Dorset NHS. The meeting had to be halted at one point due to the protestors. Some of the protestors stood for election as Labour Party candidates in the elections to the new unitary

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authorities. Although unsuccessful in these elections, the Defend Dorset NHS's founder has been elected to Swanage Town Council. The JR claimant, backed by Defend Dorset NHS, has applied for permission to appeal against the JR ruling and this will be heard by the Court of Appeal on 24 July 2019.

Given the amount of engagement with the JHOSC and HOSCs, the level of information and evidence submitted to them by the CCG and the political context, it is difficult to determine what could have been done differently.

However, as a result of the local government reorganisation, Dorset HOSC has a new chair and, all bar two, new members. This offers an opportunity to refresh and strengthen engagement with the HOSC both within and outside of formal meetings. https://moderngov.dorsetcouncil.gov.uk/mgCommitteeDetails.aspx?ID=157

Unlike some other HOSCs, those in Dorset have retained their individual powers to make referrals to the Secretary of State rather than deferring these to a JHOSC when service change proposals span more than one council.

This is an area which the CCG and other Integrated Care System partners could explore to bring greater clarity to the overview and scrutiny process.

Alternative A&E models

The NHS Long Term Plan refers to an "A&E Local" model (Section: 3.111) '*in those locations where complete site shift to "cold" elective services is not feasible; we will also introduce a new option of "A&E Locals'*

Dorset's plans reflect current policy and that which was in place at the time the plans were devised.

The A&E model was clinically led by A&E consultants and will deliver the benefits of 24/7 consultant delivered A&E services on the major emergency site. This will be supported by a 24/7 A&E with 14/7consultant delivered services on site in the west of the county, a 24/7 Urgent Treatment Centre (UTC) at Poole Hospital and a network of UTC's spread geographically across the rest of the county, including the RBH site.

As national policy develops, any further transformation of A&E services will be in line with this.

2.5 Equality Impact Assessment (EIA)
Have the proposals been subject to an Equality Impact Assessment?
If not, please explain why not

Yes – please see above in section 2.3 for details of the additional work done on the EIA.

As part of the Judicial review process, the EIA was not in any way challenged by the claimants.

2.6 Co-operation and Competition
Do the proposals comply with the procurement, patient choice and competition regulations ("Section 75 regulations")? **Yes/No If** no, what action is being taken?

Yes, the proposals comply with the patient choice and competition regulations, however there will be a reduction of choice of acute providers as a result of the specialisation of Poole and Bournemouth into the planned and emergency hospitals.

Poole and Bournemouth Trusts both signalled their intention to merge following the CCG GB decisions in September 2017 and applied to NHS Improvement in October 2017. The trusts decided this was the best way to implement the CSR decisions, a view supported by the CCG. There has been much reduced competition and improved collaboration in the Dorset system as a result of Dorset being a wave 1 Integrated Care System and a national exemplar for the CSR and integration plans, with the Dorset system working to a shared financial control total and shared strategy and operating plan.

Both trusts are receiving specialist competition and legal advice on merging and at the time of this referral, have passed the NHS improvement strategic sense check stage and have a completed patient benefit case for merger. The trusts are expected to formally merge in Summer 2020 however timings are under discussion with NHSI and the CMA as the merger timing is linked to the approval of the outline business case for capital, which was submitted in March 2019.

There are three key mitigations NHS England have considered as vital as mitigation for the reduction in choice and competition:

- The clinical evidence base is clear that this change will have a positive impact on patient outcomes. The CCG and Poole/Bournemouth Trust benefits case is strong and clearly links changes in service delivery to multiple benefits for patients.
- The two Trusts already operate as parts of multiple networks, and not all services are provided equally at both sites e.g. cancer, neonatal, maternity.

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- By developing the community services as is proposed, the CCG are adding in new options for the public to receive care closer to home.

Are any of the organisations or services, involved in the proposals, currently the subject of a complaint or inquiry under Section 75 regulations? **Yes/No** If yes, give brief details.

No

2.7 A summary of NHS England's view of the proposals including whether the proposals are supported or not

The Dorset CSR represents five years of significant work to assess and plan for the future health needs of the Dorset population. An extensive assurance process by NHS England local teams has concluded that the Dorset CSR satisfies the four key tests and the fifth bed test in respect of service reconfiguration.

NHS England Assurance Process

The local assurance process for the Dorset CSR has followed NHS England guidance for assuring service change and reconfiguration which has been supplemented through the CCG assurance process and conversations at functional Directorate level.

Dorset CCG publicly and formally launched the CSR	Oct-14
Government launches 5-year forward view.	Oct-14
Stage 1 Strategic Sense Check — undertaken by NHS England Regional and Wessex sub-regional Team	09-Apr-15
SROG Briefing	Apr-15 to May-15
Participation in Dorset CEO Reference Group	Monthly
Ongoing Assurance discussions	Quarterly
Attendance at Governing Body approval meeting	20-May-15
Informal checkpoint support meeting with CCG	12-Jun-15
OGSCR Briefings	Jul-15 to Aug-15
CCG completion of Gateway Review action Ian.	Jun-15
NHS England review of evidence against best practice checks	Jun-15 to Jul-15
Informal checkpoint support meeting with CCG	03-Jul-15
Clinical Senate Review	May-15 to Jul-15
Clinical Senate re-review and final senate Paper sent to CCG	May-16 to Jun-16
Formal Stage II checkpoint meeting with CCG	08-Jun-16
Submission of additional evidence following checkpoint	Jun-16
Present Case at OGSCR for questions/comment	Jul-16

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Present case at OGSCR for approval	Aug-16
Present case at National Investment Committee	Aug-16
Present case at National Investment Committee	Sep-16
Dorset Sustainability & Transformation Plan Published	Oct-16
Confirmation of NHS England stage 2 approval	Nov-16
Dorset named as Wave 1 Integrated Care System	Mar-17
£147m Capital Investment announcement	Jul-17
Confirmation of Dorset becoming a Level 2 Integrated Care System	Jun-18

It is the responsibility of organisations involved in developing service change proposals to work together to assure themselves and their communities of the strength of evidence for each of the four key tests. NHS England, Wessex has worked with the CCG to ensure the provision of detailed information to support the key tests and best practice requirements as summarised below.

Assessment against the 5 Tests

Test 1 – Strong Public and Patient Engagement –

The CCG have carried out strong and extensive public engagement including:

- 29,000 pieces of feedback themed and used to inform the “Need to Change”.
- 12 Patient (Carer) and Public Engagement Group (PPEG) meetings – providing feedback at all stages of the CSR.
- Pan Dorset Engagement Leads Forum set up – representatives from 18 partner organisations.
- Public Meetings hosted across the initial CSR design phase – attended by 525 local people and filmed to reach out to a wider audience, including the working well, seldom heard etc.
- Information and opportunity for involvement provided at 84 forums, meetings and events.
- 3,900 Health Involvement Network (HIN) and 150 Supporting Stronger Voices members - regularly informed and involved.
- CSR and Young People posters and events
- Views collected across the whole CSR and themes, and responses presented back to public.
- Animation of the “Need to Change” produced and shared with over 4100 people. 95% understand the need to change
- 9 locality-based Integrated Community Services public engagement events were hosted in March and April 2016. 339 local people attended providing 2,162 pieces of feedback.
- Engagement “roadshows” have been undertaken.

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- A specific public facing website http://www.dorsetsvision.nhs.uk/

Across Dorset there were three local authority overview and scrutiny committees: Poole, Bournemouth, and Dorset that have been kept informed about the CSR Programme throughout the review stage. A joint scrutiny committee was established across Dorset, Somerset, and West Hampshire, made up of 5 Local authority HOCS's, for the purpose of scrutiny of the CSR Programme and this met with the CCG in May 2015.

MP engagement has been positive with the CCG meeting MPs intermittently to discuss key issues and sending out regular updates. The CCG reports the MPs are supportive of the approach and understand the case for change; however, the MPs final position is that they are there to represent the public. While there has been wide engagement, understanding of the case for change, and support for the model; public objections about aspects of the proposals will continue to be voiced.

NHS England (Wessex) reviewed the final consultation document and is assured against this key test.

Test 2 – Consistent with current and prospective need for patient choice.

While there will appear to be a reduction in choice of acute provider should two of the main Dorset providers specialise in emergency and elective care; there are three key mitigations the CCG have considered as vital in the review:

- The clinical evidence base is clear that this change will have a positive impact on patient outcomes. The CCG benefits case is strong and clearly links changes in service delivery to multiple benefits for patients.
- The two Trusts already operate as parts of multiple networks, and not all services are provided equally at both sites e.g. cancer, neonatal, maternity.
- By developing the community services as is proposed, the CCG are adding in new options for the public to receive care closer to home.

Given additionally the strong local case for change and the challenge to narrow the health, quality and finance gap nationally; it is clear ambitious changes are required. For the CCG, doing nothing is not an option. Our view in Wessex is that these proposals will have multiple impacts on choice, however that the patient benefits outweigh the negative impacts. The wide engagement and support for the model from the public, HOSC and user groups supports this view.

The CCG have worked closely with the Wessex Clinical Senate over the course of the CSR, and an External Review Team (ERT) was appointed to review their plans in May-

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July 2015 and was reconvened in May 2016. This team reported to the Wessex Clinical Senate Council who accepted their recommendations.

The Clinical Senate recognised that the issues of isolation, access and social deprivation required that a range of services were provided at Dorset County Hospital but noted that there were risks associated with sustaining an appropriate workforce. Dorset CCG's proposals reflect the recommendations in the Royal College of Paediatrics and Child Health report on paediatric and maternity service provision in West Dorset which was commissioned by the CCG and whose recommendations the Clinical Senate endorsed. The Clinical Senate Council was satisfied that implementation of these recommendations would result in the population of West Dorset having more choice for birth plans, better access to midwife-led services, safer and more sustainable services for neonates and more children being cared for out of hospital.

The Clinical Senate Council welcomed the aims of the model which was for the cancer service to be delivered close to home where possible and to improve access to radiotherapy and chemotherapy. The ERT had noted that there was a national shortage of radiotherapists, physics staff, and clinical oncologists so workforce plans which would need to be in place to address the sustainability of the new model.

Recognising that the competitions and market authority will take a view and the sequencing of this is beyond the CCG's control, the Wessex team have concluded that test 2 is satisfied at this stage.

Test 3 – A Clear Clinical Evidence Base.

At a high level, the model is clearly based on recommendations made by Sir Bruce Keogh's report on Transforming Urgent and Emergency Care Services and supported by an evidence base that shows benefit in centralisation of specialist services. The Wessex Clinical Senate was tasked with reviewing the evidence and the proposal in detail and giving their recommendation for level of assurance against this test.

The Clinical Senate welcomed the CCG's ambition to move aspects of services to community settings and found that the CCG's proposals for the acute hospital reconfiguration were reasonable and that the preferred option for Royal Bournemouth Hospital to be the 24/7 trauma unit was also reasonable.

The Clinical Senate recognised that many aspects of this major reconfiguration of services would be elaborated and refined in the coming years. Nevertheless, opportunities were identified, both for the promoting of public and patient insight into the benefits of the Dorset CSR and for enhancing clinical outcomes. Salient examples included the opportunity to co-localise in-patient cancer services with acute and critical

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care, to use local healthcare hubs to address health inequities, to define the pathways for the acute medical take proposed at Poole, to promote mental health and the parity of esteem and to ensure that there was cross-system planning and development of the workforce.

The Clinical Senate found that there was significant potential patient benefit from the proposed separation of emergency services in the 'Major Emergency Hospital' (or 24/7 trauma unit) and planned care (elective services) in the 'Major Planned Hospital'. These patient benefits would include: improved outcomes, patient safety, reduced length of stay and fewer cancelled operations, lower healthcare-acquired infection rates. The Clinical Senate Council agreed with the ERT that it was possible to quantify these benefits locally as they had been demonstrated elsewhere in the UK. It was also noted that if the CCG's preferred option was implemented then Poole Hospital would become the planned care site and Royal Bournemouth Hospital would become the emergency care site. The Clinical Senate Council agreed with the ERT view that, based on the information supplied, this site allocation would be reasonable.
The conclusion reached by the Wessex team, with the support of the external review team and the Wessex Clinical Senate is that "we conclude the CCG is ready to proceed to consultation under this test".

Test 4 - Support for Proposals from clinical commissioners.

The CCG, as the clinical commissioners, has engaged and consulted extensively with its clinical commissioners:

- 13 Locality based out of hospital discussion meetings
- 50 Cluster and Locality meetings
- 38 Practice Visits
- 4 Development Workshops and
- 2 Membership events

The development workshops and membership events have been used as major events through the process to update members on the progress of the CSR and to garner the input and further engage members in the process.

Additionally, as there is a significant patient flow from West Hampshire CCG to Royal Bournemouth Hospital, the CCG have worked with senior West Hampshire CCG members, clinicians, and communication and patient engagement teams to ensure they have been suitably involved and engaged throughout the process. West Hampshire CCG, as co-commissioners, support Dorset CCG's preferred option and made their own decision agreeing the proposals.

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NHS England have attended the Governing body meetings that approved the PCBC and CCG readiness for consultation, no concerns were voiced. “Therefore, in summary we consider the CCG ready for consultation under this test”.

Test 5 – Patient care test

On 3 March 2017, the NHS England announced that as from 1 April 2017, the patient care test, (bed closure test) would be applicable to local NHS Organisations (https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf). The CCG had at this point, completed stage II assurance process, Clinical Senate and had been through public consultation.

The CCG did consider the “fifth test”; The Governing Body of the CCG were informed in the DMBC, that in response to the patient care test, a report was prepared to provide assurance that the plans met the requirements outlined within the new patient care test.

In addition, a report was also provided to NHS England for further assurance that the requirements of the new patient care test were met. NHS England confirmed that the bed closure test did not apply to the Dorset CCG proposals. In addition, a letter was sent by NHS England on the 5th. April 2017 to local MP, Dr Andrew Murrison, stating that:

“the test being formally applied from 1 April 2017 will not apply, as the CCG’s proposals had completed the NHS England formal assurance process prior to consultation” and that “the tests do not formally apply to the Dorset scheme”

“While the tests do not formally apply to the Dorset scheme, we are confident that the CCG have considered the new tests and will continue to monitor the impact of proposed changes through implementation.”

“Steps were taken to ensure that sufficient alternative provision covering the Dorset CCG commissioning area as a whole, had been carefully considered”

The Judicial Review ruled that the CCG did not fail to comply with the fifth ‘Bed Closure Test’ that required the CCG to show that significant bed closures could satisfy one of three new conditions before NHS England would approve them to go ahead. The Judge ruled that ‘In this case, NHS England, who were the arbiters of whether the conditions were complied with, were satisfied that it had been complied with and that is determinative of the issue. The Governing Body was not entitled or required to look behind it and so this challenge fails’. This view was supported by the Court of Appeal as outlined in section 2.3.

The CCG has been through an extensive assurance process conducted by NHS England (Wessex) which has followed the best practice guide for assuring service changes and reconfigurations. This process has concluded that the Dorset CSR satisfies the four key tests and the fifth test in respect of service reconfiguration.

- See document *"1_3_8b - Judicial Review Judgement Full"* - https://www.judiciary.uk/wp-content/uploads/2018/09/hinsull-v-dorset-ccg-judgment.pdf
- See document *"1_3_8c - Judicial Review Judgement Summary"* - https://www.judiciary.uk/wp-content/uploads/2018/09/hinsull-v-dorset-ccg-summary.pdf

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3	Additional information Please provide **brief** details under each of the headings below.
3.1	Sites involved and activity (include a general description of the activity undertaken on each site involved and any useful indication of patient numbers, treatment complexity etc)

The CSR decisions primarily involved the three acute hospitals in Dorset and 13 community hospitals.

Royal Bournemouth and Christchurch Hospitals
RBH provides services from Royal Bournemouth Hospital and Christchurch Hospital. It gained foundation trust status in 2005, and currently has around 700 inpatient and day-case beds and 4,000 staff.

Royal Bournemouth Hospital provides urgent and emergency care, surgery, critical care, outpatient and diagnostic services. It has a midwife-led birthing unit and provides several services to the wider east Dorset region, including vascular surgery, urology, interventional cardiology, ophthalmology and elective orthopaedics. It is located on a 16.1-hectare site on the western side of the Bournemouth-Poole conurbation.

Christchurch Hospital offers specialist palliative care, outpatient clinics and diagnostic imaging services. It is around 2 miles (or less than 10 minutes' drive time) from Royal Bournemouth Hospital, and is also on the western side of the Bournemouth-Poole conurbation. The Trust has recently carried out refurbishment work at Christchurch hospital, and facilities that have been developed include a GP surgery, a retail pharmacy, a nursing home and assisted living accommodation.

Poole Hospital
PHT provides services from Poole Hospital, St Mary's Maternity Hospital and Forest Holme, a palliative care unit. Both St Mary's Maternity Hospital and Forest Holme are located a short walk across a road from the main hospital site in Poole. It gained foundation trust status in 2007, employs more than 4,000 staff and has approximately 670 inpatient and day-case beds.

PHT is the lead provider for Bournemouth-Poole in trauma, maternity care, paediatrics and ENT, and is also the NHS cancer centre, including radiotherapy services, for Dorset. The Trust has a high proportion of non-elective work, with 91% of its inpatient activity being non-elective.

Dorset County Hospital
Dorset County Hospital was awarded Foundation Trust status in June 2007.
DCH provides a full range of district general services, including an accident and emergency department, and links with satellite units in five community hospitals.

They are the main provider of acute hospital services to a population of around 250,000, living within Weymouth and Portland, West Dorset, North Dorset and Purbeck. DCH also provides renal services for patients throughout Dorset and South Somerset; a total population of 850,000.
Dorset County Hospital has approximately 400 beds, seven main theatres and two day theatres.

Acute activity by site

	Medical Beds (general and acute)		Maternity Beds	A&E attendances	Inpatient admissions		Maternity admissions	Outpatient appointments (1st & Fup)	Babies born
	Inpatient	Day Case			DC & EL	Non-elective			
PHT	498	90	59	66,287	22,990	36,821	5,530	161,020	4,923
DCH	293	42	31	44,780	23,639	19,814	3,650	127,195	1,872
RBH	551	144	3	95,230	48,237	31,885	307	205,408	396
DHC	234 (Inpatient and day case)		0	63,666 (MIU)	2,794	2,888		190,754	0

Dorset Healthcare
Dorset HealthCare is responsible for all mental health services and many physical health services in Dorset, delivering both hospital and community-based care.
Dorset Healthcare serves a population of over 770,690 people and employ around 5,000 staff, covering a wide range of expertise and specialisms. Services are provided from 12 community Hospitals as well as over 300 individual sites, ranging from village halls and GP surgeries to mental health inpatient hospitals and community hospitals - as well as in people's homes.

Dorset HealthCare's services include:

- Dorset's 12 community hospitals and minor injuries units
- Adult and children's community health services (physical and mental)
- Specialist learning disability services
- Community brain injury services

Community health services encompass district nurses, health visitors, school nursing, end of life care, sexual health promotion, safeguarding children, diabetes education, audiology, speech and language therapy, dermatology, podiatry, orthopedic services, wheelchair services, anti-coagulation services, pulmonary rehab, early discharge stroke services, Parkinson's care, community oncology and breastfeeding support services.

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Community activity by site

	MIU attendances	Inpatient planned admissions	Inpatient unplanned admissions	Outpatient (1st & Fup) appointments
N/K	[redacted]	729	745	2,323
Alderney Hospital	[redacted]	212	262	[redacted]
Blandford Community Hospital	4,809	178	173	6,231
Bridport Community Hospital	7,687	285	346	5,553
Portland Community Hospital	2,369	80	64	2,826
St Leonards Community Hospital	[redacted]	151	143	8,722
Swanage Community Hospital	6,687	110	103	9,924
Victoria Community Hospital – Wimborne	7,093	515	465	26,170
Wareham Community Hospital	[redacted]	104	88	4,682
Westhaven Community Hospital	[redacted]	189	204	[redacted]
Westminster Memorial Hospital – Shaftesbury	3,701	84	111	5,760
Weymouth Community Hospital	28,482	[redacted]	[redacted]	[redacted]
Yeatman Hospital – Sherborne	2,838	157	184	4,044
Other sites	[redacted]	[redacted]	[redacted]	114,519
Total	**63,666**	**2,794**	**2,888**	**190,754**

3.2 Population data (include total population involved, main centres, any growth areas, ethnic composition, any areas of deprivation)

Overall, Dorset's resident population of 770,690 Enjoys relatively good health, however, there is variation in life expectancy between those in the most affluent and

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deprived areas. “Life expectancy is 6.4 years lower for men and 5.5 years lower for women in the most deprived areas of Dorset than in the least deprived areas”.

Demographic and socio-economic profile

The population of Dorset is expected to grow to over 801,000 by 2023. (This annual growth of 0.6% is slightly lower than the overall England average of 0.7%).

The age profile of Dorset is older than the England average; around 17% of the population are over 70 (vs. England average of 12%). The population over 70 is expected to grow four times faster than the growth rate of the total Dorset population, and by 2023 one in every five Dorset residents will be over 70 (an increase of 30% between 2013 and 2023). The percentage of the population aged over 65 in Christchurch is 30.4%, almost double the national average.

At the same time, the core working age population (20–59) is expected to decline by about 1% whilst children and young people below the age of 20 are expected to grow by 7%.

Overall, Dorset’s population enjoys better than average social and economic conditions. However, there are some areas where the health needs are far greater, often as a result of greater socio-economic deprivation.

Disease and condition profile

Within Dorset there are relatively low rates of smoking prevalence and obesity in children. The aging population brings an increased likelihood of having a long-term condition or becoming frail. Dorset’s current disease prevalence profile reflects its older population with a higher prevalence of hypertension and coronary heart disease (CHD). Rates of diabetes, stroke and heart disease are expected to grow faster than the South West or the England average. In 2011 around 19% of people in living in Dorset had a long-term condition or disability that impacted on their health. By 2020, around 1 in 10 of the population could have diabetes and around 1 in 8 could have CHD

Population Figures (2018 mid-year estimates)

Dorset has a current resident population of 770,690 people.

Bournemouth:

Total Population – 194,750.

Diversity – 83.8% White British / 16.2% Black and Minority Ethnic / 5.9% Main Language not English / 85.1% Born in UK / 14.9% Born outside of UK.

Poole:

Total Population – 151,270.

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Diversity – 91.9% White British / 8.1% Black and Minority Ethnic / 1.9% Main Language not English / 91.8% Born in UK / 8.2% Born outside of UK.

Weymouth and Portland:

Total Population – 65,750.

Diversity – 94.9% White British / 5.1% Black and Minority Ethnic / 1% Main Language not English / 94.6% Born in UK / 5.4% Born outside of UK.

Christchurch:

Total Population – 49,620.

Diversity – 95.1% White British / 4.9 Black and Minority Ethnic / 0.6% Main Language not English / 94.3% Born in UK / 5.7% Born outside of UK.

West Dorset:

Total Population – 102,060.

Diversity – 95.7% White British / 4.3% Black and Minority Ethnic / 0.6% Main Language not English / 94.4% Born in UK / 5.6% Born outside of UK.

East Dorset:

Total Population – 89,380.

Diversity – 96.2% White British / 3.8% Black and Minority Ethnic / 0.4% Main Language not English / 95.1% Born in UK / 4.9% Born outside of UK.

North Dorset:

Total Population – 71,100.

Diversity – 94.7% White British / 5.3% Black and Minority Ethnic / 1.3% Main Language not English / 93.2% Born in UK / 6.8% Born outside of UK.

Purbeck:

Total Population – 46,760.

Diversity – 96.2% White British / 3.8% Black and Minority Ethnic / 0.6% Main Language not English / 94.6% Born in UK / 5.4% Born outside of UK.

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3.3 Access and transport (include distances between main centres and/or key sites, road links, public transport links, hospital transport links)

Dorset is currently well served for acute hospitals, with residents able to access three within the Dorset boundary (Royal Bournemouth and Christchurch, Poole and Dorset County), with residents of North Dorset accessing Salisbury and Yeovil Hospitals, those in West Dorset accessing Taunton or Royal Devon and Exeter Hospitals and those in East Dorset accessing Southampton Hospital (the major tertiary referral centre for Dorset). Dorset also benefits from 13 Community Hospitals and 86 GP practices spread across the county.

Dorset has a mix of rural communities with poor access to public transport and higher than average car use and urban centres of Poole and Bournemouth with a more extensive public transport infrastructure.

Extensive travel analysis regarding the proposed CSR plans was conducted in 2015 by Steer Davis Gleave and is available on the Dorset Vision website. Steer Davies Gleave are world leaders in transport consultancy services and provided independent modelling and analysis to inform the options appraisal, the data used was based on tens of thousands of actual satellite navigation datasets.
Following public concerns regarding additional travel times, further work was commissioned from SWASFT and DCC covering emergency and non-emergency transport, the reports are available on the CCG website: https://www.dorsetsvision.nhs.uk/downloads

The Judicial Review was asked to rule on the travel times issue and Sir Stephen Silber concluded 'the CCG was entitled to conclude that SWASFTs statistics and analysis indicated that the additional clinical risks caused by the increased travel times as a result of implementing the proposed reconfiguration of medical services as "minimal"' The Judge also found that "I have concluded that contrary to the Claimant's case the CCG equipped itself with the appropriate information that it required to apply the accessibility criterion. It also reached conclusions open to it on the information which it had acquired and considered appropriately the issue of access to services for those in the more remote and isolated areas."

The travel time analysis undertaken for the CSR used validated and commonly used software and data, and assumptions based on tried and tested experience from elsewhere. It has shown that, for the majority of patients using hospitals in Dorset today, they will continue to do so, regardless of whichever options for change that may be considered. For the minority of patients that do need to travel further, the additional travel time is outweighed by the other aspects of the evaluation of the options, in particular, the ability to receive higher quality, more specialised care.

The table below highlights that under the new reconfiguration of acute hospitals, the time it will take for Dorset residents to reach a major emergency Hospital under blue light

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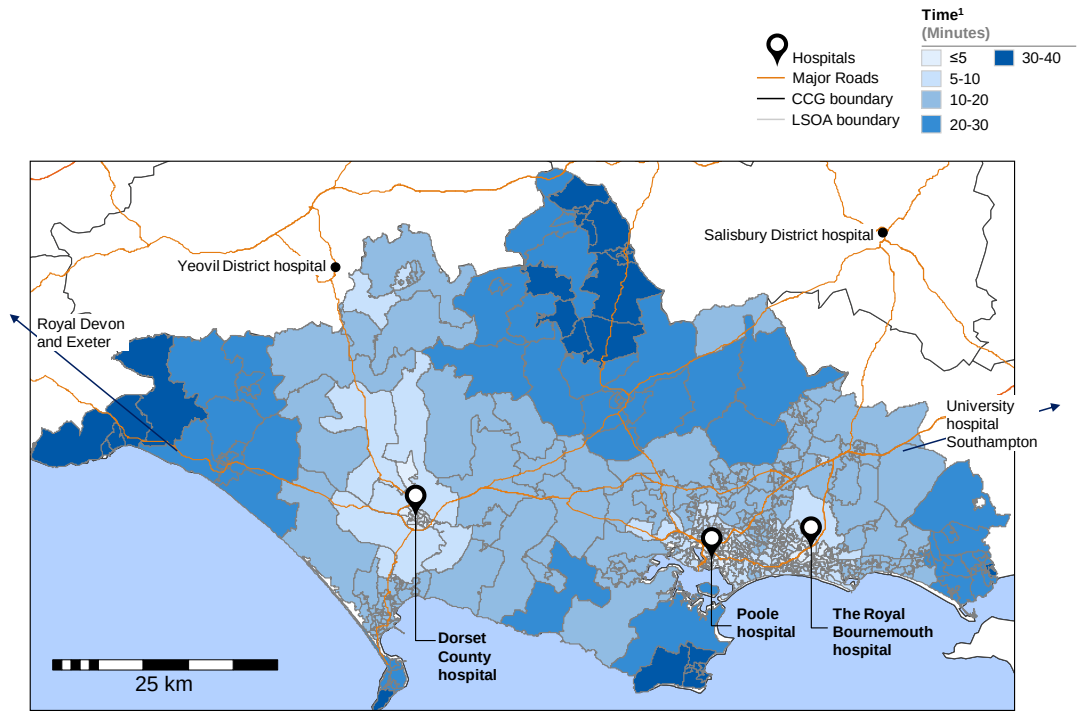
conditions. It should be noted that the travel distance between the two hospitals is approximately 8.3 miles.:

Blue Light Travel Time	% of Population to reach MEH
Under 20mins	78%
Under 30mins	95%
Under 40mins	100%

The current situation

Residents living in West Dorset, North Dorset Purbeck are furthest from local Hospitals (including those in Salisbury, Yeovil and others) yet all can reach services in 40 minutes under blue light emergency transport



Future Configuration

If services are moved from Poole Hospital the change in travel times impact is illustrated below – there is no change for the majority of patients in Dorset with those in Purbeck

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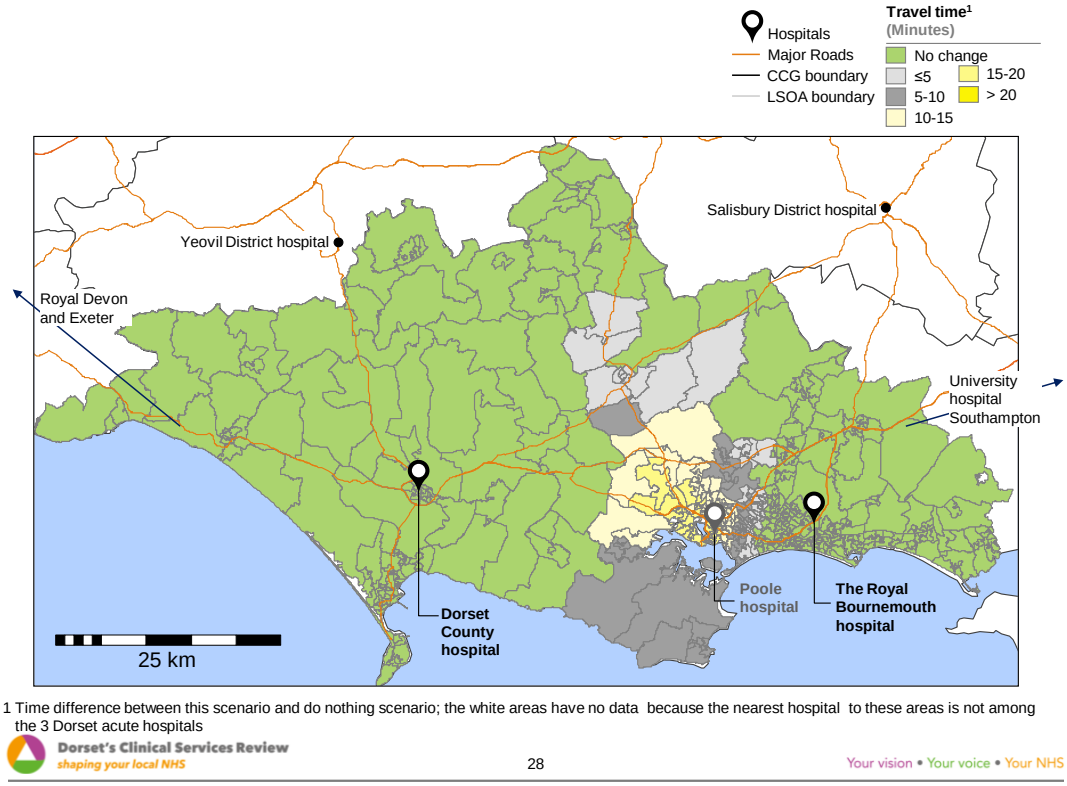
experiencing a potential 5-10-minute additional travel time, remaining within the 40-minute overall travel time.



1 Time difference between this scenario and do nothing scenario; the white areas have no data because the nearest hospital to these areas is not among the 3 Dorset acute hospitals

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Analysis of ambulance travel times in the case that Poole does not provide a service (i.e. in the case a service moves fully to Bournemouth such as in the case of Maternity) indicates 95% of the population of Dorset can reach services in 30 minutes, compared to 96% at present and 100% of the population can reach services in 40 minutes

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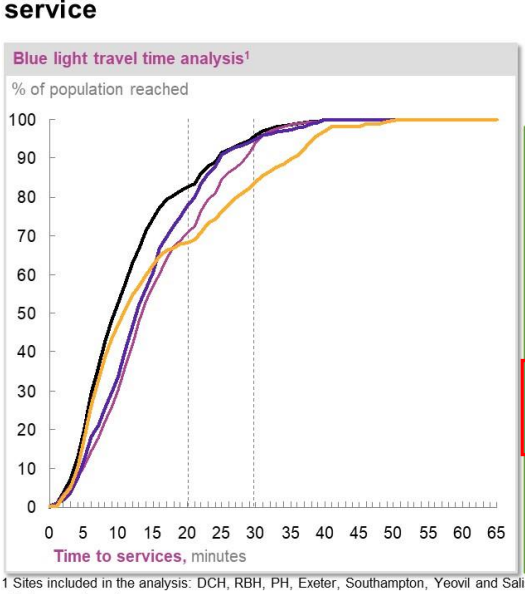
Travel time to services analysis – 1 hospital site no longer provides a given service



All sites provide service a given service
RBCH no longer provides a given service
Poole no longer provides a given service
DCH no longer provides a given service

	% of population reach services		Maximum time for population (100%) to reach services (minutes)
	In 20 min	In 30 min	
All sites provide a given service	83%	96%	40
RBCH site no longer provides a given service	71%	94%	40
Poole site no longer provides a given service	78%	95%	40
DCH site no longer provides a given service	68%	84%	51

1 Sites included in the analysis: DCH, RBH, PH, Exeter, Southampton, Yeovil and Salisbury. Population included: all people where a Dorset acute hospital is their nearest acute

Source: Steer Davies Gleeve data (night time travel times used to simulate blue light. This is on average 30% faster than a 50/50 blend of peak (33%faster) and off peak (26%faster) South Western Ambulance Service NHS Foundation Trust estimates travelling under blue light is 30% faster)

As shown in the graph above, under both options, 100% of residents can reach a major emergency hospital under blue light conditions in under 40 minutes. With RBH as the major emergency hospital, more of the population can reach a major emergency hospital in less time than if PHT were a major emergency hospital

The CCG has looked at the travel times for patients travelling by bus/car/ambulance going to Dorset County, Poole and Bournemouth Hospitals. The CCG are aware of the concern from people living in Purbeck but there is little difference in travel times from Purbeck to Poole and Purbeck to DCH, for example:

- The time by car from Swanage to Poole Hospital is about 37 minutes (20 miles) and
- From Swanage to DCH is 45 minutes (29 miles)
- Therefore, the difference in travel time by car is around 8 minutes and by blue light ambulance only in the region of 5 ½ minutes.

Clinical Risk Review into Emergency Travel

The CCG commissioned South West Ambulance Service Trust (SWASFT) to look at any potential impact of the proposed CSR reconfiguration on the emergency ambulance services.

The report analysed a total of 21,944 patient records covering all incidents where an ambulance attended and conveyed a patient to hospital during the period from 1 January 2017 to 30 April 2017.

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The SWASFT analysis reviewed all cases with a potential extended travel time under the new model of care and identified those with potentially higher risk (approximately 25% of the 3067 cases with an extended travel time). Clinical review of a sample of these records identified that there would be 132 cases out of the total of 21,944 cases (0.6%) for which there may be additional clinical risk. In most case travel times remained similar or shorter than at present.

This was picked up by High Court Judge, Sir Stephen Silber, who, in his ruling on the judicial review, stated 'SWASFT's statistics and analysis indicated that the additional clinical risk caused by the increased travel times as a result of implementing the proposed reconfiguration of medical services was "minimal".

Following on from this review, a number of false claims were being made by Defend Dorset about the clinical risk associated with increased emergency travel times based on the sample of 34 cases listed in the SWAST report. In November 2018 the CCG convened an expert panel to undertake a full case review on the same cases identified in the SWAST report to identify whether increased travel times would have directly impacted patient outcomes.

The meeting was chaired by the Director of Nursing and Quality, Dorset Clinical Commissioning Group and the review panel was made up from Medical Directors and Emergency Department Consultants from each of the three Dorset Acute Hospitals alongside Clinical Director and clinical Lead from SWASFT.

The expert panel had online access to the full medical records held by SWASFT and Poole Hospital for all the patients reviewed. This allowed detailed review of diagnoses, interventions, medications and diagnostic results as well as the clinical outcome for each patient.

Each patient case was reviewed individually. At the start of each discussion, the group was made aware of the actual journey time and what the additional journey time was predicted to be, according to the original SWASFT report.

Each review incorporated a discussion by clinical members on the chronology of events from initial condition of the patient at the scene and diagnosis, any clinical interventions provided by ambulance clinicians, arrival at hospital and any treatments provided in the emergency departments. In all cases paramedic and hospital notes were examined.

In all cases, the panel found interventions on scene, particularly by ambulance clinicians had helped to stabilise the patient prior to further treatment in hospital.

The expert clinical panel concluded that for all 34 patients, the additional travel time identified in the original SWASFT report would not have changed the outcome for these patients.

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Initial SWASFT Report:
https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/swast-report.pdf

Clinical Review Report and Data:
https://www.dorsetsvision.nhs.uk/wp-content/uploads/2018/12/SWAST-Clinical-Risk-Review-Outcome-Dec-18.pdf
https://www.dorsetsvision.nhs.uk/wp-content/uploads/2018/12/SWAST-Data-Review-FINAL.pdf

Congestion
The Bournemouth and Poole conurbation is recognised as a congested urban area and local travel planning by both Bournemouth, Poole and Dorset county councils has a strong emphasis on developing alternatives to car travel in the urban regions.

Both Bournemouth and Poole local authority travel officers recognise that the NHS proposals will have a very minor effect on congestion and that due to the current configuration of Poole Hospital being largely emergency work and Bournemouth Hospital being largely elective, the proposed changes will largely offset the current travel volumes.

The NHS plans indicate 42,000 patients **annually** currently treated at Bournemouth will in future be treated in Poole and a similar number treated at Poole will in future be treated at Bournemouth.

To put this into context there are between 30,000-50,000 car journeys on a busy roundabout **each day** in the conurbation and over 200,000 journeys **daily** into the conurbation over the River Stour bridges.

In addition, journey times in the conurbation will be reduced by 12 per cent in just four years, claim the councils which recently won part of a £1.2 billion government grant to tackle congestion in the conurbation.

3.4 Workforce (include number of staff employed and type, vacancy rates and any difficulties with recruitment)

A review of the workforce capacity and capability requirements was undertaken as part of the Clinical Services Review, details of which are found in the DMBC. The focus was on staff in priority service changes; due to the size and scale of the proposed changes or in relation to their impact on wider service changes.

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The staffing levels and vacancy rates across each of the 4 main NHS providers Dorset suggest a fairly stable workforce though in 2019 we are seeing a general increase in vacancy levels.

	May 2017 Board Report		May 2018 Board Report		April 2019 Workforce Dashboard	
	All staff Whole Time Equivalent	**Vacancy Rate**	**All staff Whole Time Equivalent**	**Vacancy Rate**	**All staff Whole Time Equivalent**	**Vacancy Rate (Apr 19)**
Royal Bournemouth and Christchurch	4395	7%	4514	5.6%	4239	6.2%
Poole	3433	5.39%	3481	3.62%	3543	5.3%
Dorset County	2248	6.1%	2321.3	5.8%	2417	8.2%
Dorset Healthcare	4589	8.6%	4631	3.58%	4743	5.3%

However, there are significant workforce challenges in a number of services areas, in both acute and non-acute settings.

To support the evidence required for this submission, in regard to emergency and urgent care services in the east, broadly speaking, there are enough staff to support the proposed changes. However, this can only be achieved by consolidating the existing teams across both sites. As described in the table below for medical staff, this would address the high trust vacancy rate across both sites, whilst centralising specialist teams in one location.

In the West, emergency services will be broadly comparable to the current services. However, in recognition of the vacancy rate, and the proposed changes, additional medical staff may be required. As part of the review, consideration has been given to a Dorset-wide network to ensure medical cover across the county, however, concerns have been raised in regard to distance and travel for consultants.

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	Total Workforce FTE	Total Medical Consultant FTE	Medical Consultant Vacancy Rate
East (Bournemouth and Poole)	238.3	20.42	0% Poole – no vacancies in Apr 19 12.68% Bournemouth
West (Dorset County)	71.31	7.6	3.8%

NOTE:
FTE Figures at April 2019 taken from the Workforce Dashboard, permanent FTE excluding Administration staff
Medical Consultant Vacancy Rate reported by Trusts. West (Dorset County) 3.8% taken from B.I. figure.

With regards to the community workforce, Dorset benefits from a larger than average GP workforce (64FTE/100,000 ranking in the 82nd Percentile for GP's per 100,000 population in England), providing confidence that there is enough primary care capacity to support the proposed changes.

In terms of the non-medical community workforce, this would need to increase significantly across a range of professions including nurses and allied health professionals in order to deliver the new care model. The existing challenge of recruitment to meet current staffing levels in the community are reflected in Dorset Healthcare's vacancy rates. At April 2019, there was a 5.3% vacancy rate within Dorset Healthcare and a 6.2% vacancy rate in the community services team following a concerted recruitment campaign. Within community services 95.7 full time equivalents, out of 140 additional workforce, have been recruited to support the new care model.

It should be noted that the national strategy for the NHS in the NHS Long Term Plan is broadly the same as the CSR, that being to increase number of paramedics, pharmacists, physiotherapists and other community based workers as part of a Primary Care Network (PCN) and the national investment that is associated with the PCN. As such the same changes recommended by the CSR are being implemented nationally in addition to Dorset.

In August 2018, Dorset HealthCare made the decision to close beds at Portland Community Hospital and Wareham Community Hospital, therefore consolidating staff and beds at Weymouth Community Hospital to ensure the sustainability of the service. As part of the CSR proposals, neither Portland or Wareham sites were planned to have inpatient beds and would become Community Hubs without beds.

A number of workforce initiatives are underway to address the workforce challenges in Dorset, including how the system retains and recruits staff to join its organisations. These are summarised in the Leading and Working Differently Strategy which was developed in partnership with stakeholders from across the health and social care system. This Includes, shared marketing of career opportunities across all NHS Dorset partners, a coordinated

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education programme for degree level apprenticeships to secure new workforce supply better utilisation of the well-established voluntary and 3rd sector workforces within Dorset.

Dorset CCG has set up the 'Primary Care Workforce Centre' (https://primarycaredorset.co.uk/) and the 'Join Our Dorset' (https://joinourdorset.nhs.uk/) programmes with dedicated websites to improve recruitment and retention within the Dorset primary and community care system. These are delivering promising results.

3.5 Finance (include budget size, financial summary including any budget deficit, any planned or actual capital expenditure including PFI)

The total financial gap for the Dorset STP Footprint (including all NHS commissioners), over the five-year period of the STP is estimated at £229m. This equates to £158m gap for the Dorset CCG footprint over the 5year period (excluding specialised commissioning and other commissioners). There is an additional £70m gap for local government. The CSR proposals seek to address the £158m gap.

Our STP identifies how the five-year gap will be closed and the solutions we have planned, one of which relates to the acute hospital reconfiguration see below:

STP Plan – What we said we would do

SOLUTIONS CATEGORIES	INTEGRATED COMMUNITY AND PRIMARY CARE SERVICES (ICPCS)	RIGHT REFERRAL RIGHT CARE	ACUTE RECONFIGURATION	PROVIDER COST IMPROVEMENT PLANS (2%)	SUSTAINABILITY AND TRANSFORMATION FUND	SPECIALIST COMMISSIONING	TOTAL
	£m	£m	£m	£m	£m	£m	£m
Managing demand together	35	28				20	83
Provider system efficiencies (2%)			19	81			100
Investment in community services	- 16						- 16
Draw-down from STF					55		55
Investment in nationally managed programmes					- 25		- 25
Health system stretch target	32						32
TOTAL SOLUTIONS							229

As part of the plans for 2019/20 the Dorset health system has been given an aggregate in-year financial control total deficit of £33.9m before Provider Sustainability Fund (PSF), Financial Recovery Fund (FRF) and Marginal Rates Emergency Threshold (MRET) funding. This would equate to a planned reported surplus target of £5.9m after the receipt of PSF, FRF and MRET. The Dorset Integrated Care System financial control total is analysed by organisation below:

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Organisation Name	Surplus / (deficit) (exc. PSF, FRF, MRET)	Surplus / (deficit) (Inc. PSF/FRF/MRET)
	£000's	£000's
NHS Dorset CCG	2,000	2,000
Dorset County Hospital NHS Foundation Trust	(9,023)	-
Dorset Healthcare University NHS Foundation Trust	(166)	2,036
Poole Hospital NHS Foundation Trust	(17,742)	-
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	(6,884)	-
Dorset NHS Control Total (for System PSF)	**(31,815)**	**4,036**
South Western Ambulance Service NHS Foundation Trust	(56)	1,868
	(31,871)	**5,904**

In order to achieve the ambition for the required business rules and efficiency savings required as mentioned above, it has been agreed that all Dorset providers will receive a 2.7% contract price uplift reflecting two years' Agenda for Change pay reform (2018/19 consolidated and 2019/20). This will allow the CCG to deliver its operating plan requirements and support the control of activity demand for hospital and community services.

This assumption underpins Dorset providers achieving the requirements to access all available PSF, FRF and MRET funding as already described, and both the CCG and the wider system meeting the required constitutional standard and delivery of the Integrated Care System Memorandum of Understanding.

In addition to agreeing to a 2.7% contract increase, Dorset providers have committed to delivering cost improvement plans in the order of 3%. The system is reliant on significant non-recurrent income in 2019/20, particularly at Dorset County Hospital and Poole Hospital. This includes access to £9.2m of non-recurrent funding which will be used for non-recurrent expenditure that will realise recurrent efficiencies and benefits from 2020/21. As part of the long term planning for the Integrated Care System, during the summer of 2019, this will be revisited alongside a system-wide financial recovery and sustainability plan.
Commissioner Efficiency Plan (QIPP)

Efficiency savings for the main CCG programmes encompass continuing healthcare, prescribing, CCG running costs and review of discretionary budgets, social care support and primary care. We are planning on ensuring the whole of the Dorset system can deliver these services within the settlement and will regularly monitor and review the efficiency savings plans.

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The combined CIPs and QIPP providing the system level of efficiency challenge required for 2019/20 can be seen in the table below.

Organisation Name	Recurrent Efficiencies	Non-Recurrent Efficiencies	Total Efficiencies	Efficiencies %
	£000's	£000's	£000's	£000's
NHS Dorset CCG	51,273	1,753	53,026	4.28%
Dorset County Hospital NHS Foundation Trust	4,038	3,092	7,130	3.76%
Dorset Healthcare University NHS Foundation Trust	4,262	6,169	10,431	3.61%
Poole Hospital NHS Foundation Trust	4,583	4,448	9,031	3.37%
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	6,476	3,976	10,452	3.60%
South Western Ambulance Service NHS Foundation Trust	6,806	2,700	9,506	3.78%
	77,438	**22,138**	**99,576**	

In terms of capital bids the table below summarises the Integrated Care System health overview of the capital bid position.
This incorporates wave 1 Acute and wave 4 bids – with the wave 1 bid confirmed and the wave 4 one Dorset Pathology and Blandford hub bid confirmed

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Scheme	CAPITAL						
	TOTAL	19/20	20/21	21/22	22/23	23/24	24+
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Wave 1 - Approved Capital							
East Acute Reconfiguration	£145,748	£7,415	£38,929	£61,374	£38,030		
TOTAL WAVE 1 (PDC)	**£145,748**	**£7,415**	**£38,929**	**£61,374**	**£38,030**	**£0**	**£0**
Wave 4 - PDC Capital bids							
DCH ED, ICU and Integrated Hub	£24,386		£24,386				
One Dorset Pathology	£5,099	£5,099					
Blandford Hub	£4,186	£1,340	£2,846				
Alderney	£10,025	£25	£6,000	£4,000			
TOTAL WAVE 4 (PDC)	**£43,696**	**£6,464**	**£33,232**	**£4,000**	**£0**	**£0**	**£0**
TOTAL CAPITAL (PDC)	**£189,444**	**£13,879**	**£72,161**	**£65,374**	**£38,030**	**£0**	**£0**
Wave 4 - RHIC bids							
St Ann's 35 bed unit	£15,956		£7,978	£7,978			
St Anns Perinatal new build	£5,906	£1,906	£3,500	£500			
Alumhurst ward refurb for AMH	£4,000		£75	£3,925			
Twynham ward refurb for AMH	£2,107				£2,107		
Alumhurst Rd new CAMHS PICU	£12,075	£75	£7,000	£5,000			
Alumhurst Rd refurb for MH admin	£360	£0	£200	£160			
Alumhurst Rd CaMHS Pebble extension	£700	£500	£200				
Wareham	£200		£200	£0			

3.6 Estate (include current condition as categorised by NHS Estates Performance Indicators, any issues requiring urgent attention, longer terms plans)

Planning permission to develop all three of Dorset hospital sites is underway, with planning permission details for the acute developments at PHT and RBH available from the Local Authority websites and the outcome of these applications expected in September 2019.

Royal Bournemouth Hospital
Royal Bournemouth Hospital
is a low-rise, low density site, situated approximately four miles from the centre of Bournemouth, near the A338 / A3060 junction and occupies 16.2 hectares, dominated by the main hospital building in a classic nucleus hospital design, which opened in 1989.

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Road and public transport access is good and, in response to reported congestion, a number of potential future improvements to aid traffic flow have been identified, including changes to the adjacent bus lane and altering priorities with traffic signalling. Whilst access to the site by train is not easy, the hospital has several bus stops on campus served by around 10 bus routes and a bus hub. £6m of government funding has been approved for a new road junction for a "spur" road off the A338, which would also release land for development.

Royal Bournemouth & Christchurch Hospitals combined have a GIA of 90,000m2. The entire stock of buildings are in, at least, condition B with a few areas at condition B+. These areas include the Jigsaw building in Bournemouth and the imaging and outpatients areas at Christchurch. With regard to Backlog maintenance, the Trust has no High Risk backlog, circa £1.3m significant risk backlog and total estimated backlog level of £11m. The significant risk backlog reflects the fact the trust buildings are in the main over 30 years old, plant and equipment will be approaching the end of its useful life and, although well maintained, plans are in place to replace this over the next 3-5 years. In comparison to many Trusts this level of backlog is low.

Poole Hospital

Poole Hospital occupies a town centre location on the B3068 road and comprises a high density, vertical development on a restricted site. The main Poole hospital building was developed in 1969 on the site of the old Cornelia hospital re-named Poole Hospital in 1947. Past expansion solutions have developed the site through a series of new builds and extensions up and out which have reinforced the layout that a high rise hospital offers. The site which now has a GIA of 83,000 m2 has space for further development and expansion however this will be limited in construction to additional high-rise developments on the 4Ha site.

At Poole Hospital NHS Foundation Trust the current stated backlog maintenance figure is £17.5m of which 'significant risk' backlog is £2.59m. The current high risk backlog is £196k and relates to a range of fire safety works which are being carried out over a multi-year period, this current project is the ongoing replacement of the hospital fire doors which are coming to the end of their life and form an essential compartment system across the building floors and levels

In a similar way the other remaining significant backlog of £2.39m includes for a wide range of works from replacement boilers, new lighting, access improvements and the ongoing upgrade of the fire alarm system to the modern L1 standard with a detector in every space and demonstrates the commitment the Trust has to maintaining the safety of the patients while at hospital.

The medium and low backlog elements form the residual cost including for major ward refurbishments and the works that would be required if the Maternity unit were not to relocate to RBH as planned.

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Dorset County Hospital

Dorset County Hospital, is purpose built, 3 storey hospital in a town centre location. The hospital was built in the late 1980's and expanded throughout the 90's, it is situated in the county town of Dorchester with road and rail links for residents living in Weymouth and Portland and the more rural West and North Dorset areas.

Dorset County Hospital has a GIA of 50,500m2. The largest part of the accommodation is at condition B, although some of the older support buildings are condition C. It is intended to replace these poorer buildings through the delivery of the trusts masterplan. With regard to backlog maintenance, the Trust has circa £1,25m high risk backlog, circa £3m significant risk backlog and a total estimated backlog level of £8.7m. The high and significant risk backlog reflects the fact that a large proportion of trust accommodation is over 30 years old and plant, equipment and some building fabric is approaching the end of its useful life. In comparison to the Trusts peer group the Trust's backlog is considered high. Plans are in place to prioritise and reduce the high risk backlog to zero over the next 3 – 5 years

Dorset Healthcare

Dorset Healthcare University NHS Foundation Trust operate out of over 300 building with a combined GIA of approximately 124,000m2. The property portfolio includes 17 Community Hospital and Mental Health Inpatient units covering 75,126m2. All the Community Hospitals and Mental Inpatient Units are in condition B. The Trust has no High Risk Backlog, circa £6.1m significant risk, and a total estimated backlog level of £10m. The significant risk backlog reflects the fact that a number of the sites have building elements that are over 50 years old and are subject to planning restrictions. Some plant and equipment are approaching the end of their useful life and, although well maintained using in house staff and external contractors, plans are in place to continue to replace many of these systems over the next 5 years.

Acute and Community estate development plans are included within the DMBC, the largest capital investment being the £147m investment into establishing the major planned and emergency hospitals.

Future Estate of Bournemouth and Poole Hospitals

The future estate as a result of the £147m capital investment is outlined in the plans and impressions below as taken from the planning applications.

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The Royal Bournemouth Hospital – Main Entrance

Masterplan RBH

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Poole Hospital - Planning discussion sketches

Looking northeast up Longfleet Road towards St Mary's

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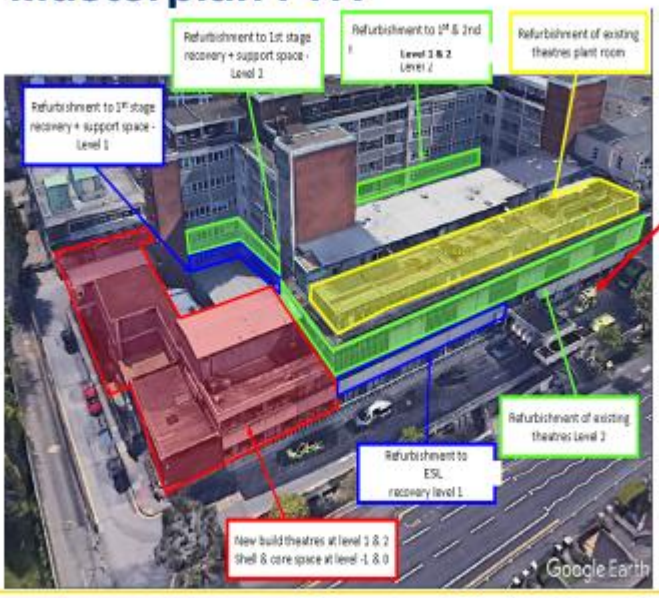
Developing One NHS in Dorset

Masterplan PHT

NHS



Theatre tower gives options for "infills" of c500m² new builds at ground and lower ground

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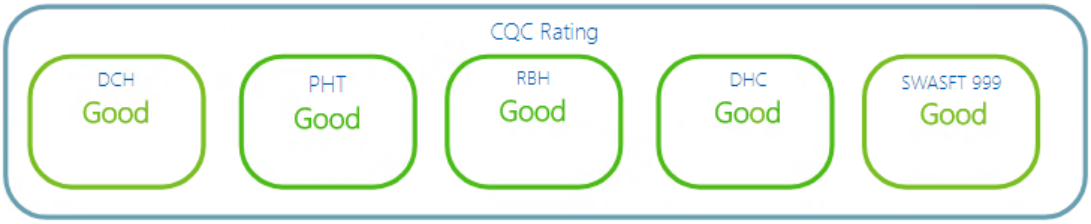
3.7 Care Quality Commission status and reports in the last two years



Dorset County Hospital, Poole Hospital Trust, Royal Bournemouth Hospital, Dorset Healthcare and SWASFT 99 have all been rated good by the CQC this is an improvement on the previous inspection where all provider trusts were rated as required improvement.

Links to the latest CQC reports can be seen below:

- **Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust (RBH) 13 – 27 March 2018:**
  https://www.cqc.org.uk/sites/default/files/new_reports/AAAH1897.pdf

- **Poole Hospital NHS Foundation Trust (PHT)**
  20 – 21 June 2018:
  https://www.cqc.org.uk/sites/default/files/new_reports/AAAH4241.pdf

- **Dorset County Hospital NHS Foundation Trust (DCH)**
  16 July to 04 September 2018:
  https://www.cqc.org.uk/sites/default/files/new_reports/AAAH4954.pdf

- **Dorset Healthcare University NHS Foundation Trust (DHC)**
  10 October 2018:
  https://www.cqc.org.uk/sites/default/files/new_reports/AAAH2736.pdf

- **SWASFT – 26 June to 18 July 2018:**
  https://www.cqc.org.uk/sites/default/files/new_reports/AAAH3969.pdf

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4.4 Any other information

Personal Statement from Tim Goodson, Chief Officer, NHS Dorset CCG

The CSR proposals were not just CCG driven: they were formed by doctors and health professionals who serve the population of Dorset and surrounding areas. They are supported by all the partner NHS organisations across Dorset. They are in line with NHS Five Year Forward plan and with the NHS Long Term Plan, published in January 2019.

The following extract from the Long Term Plan supports the CSR models of care already planned for Dorset:
'*separating urgent from planned services can make it easier for NHS hospitals to run efficient surgical services. Planned services are provided from a 'cold' site where capacity can be protected to reduce the risk of operations being postponed at the last minute if more urgent cases come in. Managing complex, urgent care on a separate 'hot' site allows trusts to provide improved trauma assessment and better access to specialist care, so that patients have better access to the right expertise at the right time. So we will continue to back hospitals that wish to pursue this model. In those locations where a complete site shift to 'cold' elective services is not feasible, we will also introduce a new option of 'A&E locals'*

The CCG appreciates that the process has involved some difficult conversations and some local residents are concerned about some of the CSR decisions. These concerns were raised during the CSR consultation and the CCG met with a number of local residents and the groups representing them. This included 'Save Kingfisher Ward', 'Please Don't Axe Poole's A&E department', and Shaftesbury 'Save Our Beds' campaigns and this has led to several of the original preferred options that were consulted on being revised prior to the final Governing Body decisions.

The CCG met and engaged regularly with the Joint Overview Scrutiny Committee, the three local authority HOSCs and Healthwatch Dorset throughout the CSR process including the consultation and beyond.

The CCG has not had this level of engagement with NHS Defend Dorset. Despite offers to meet with them by the CCG and the local NHS Trusts, Defend Dorset have chosen not to meet but rather to take their concerns directly through a judicial review after the CSR decisions were made.

The High Court emphatically ruled in favour of the CCG on all seven grounds put forward in the judicial review.

The CSR decisions will not change services overnight. It is an evolutionary process that will ensure that current levels of services are maintained until the new services are safely in place.

The CCG will continue to work with local communities and their elected representatives to influence the implementation of local services, many of which do not involve building or large capital investments. A good example of this is the reference group in North Dorset that brings together a wide range of representatives to inform and test out how we develop community services in Shaftesbury, Gillingham and the surrounding areas.

In summary, the local health and care system are all agreed that NHS services need to change in order to continue to deliver high quality, safe and sustainable services for future generations. Dorset CCG has followed the prescribed NHS England processes and assurance, been accredited best practice in consultation, has demonstrated the strong patient benefits that will arise by implementing the CSR. The CCG is re-assured that all plans align with the national strategy for the NHS as outlined in the NHS Long Term Plan and in particular for the 'hot' and 'cold' sites. This has taken considerable time and investment from a workforce dedicated to improving the lives of the people who use the NHS services in Dorset.

There was a decision to be made about which of Poole Hospital or Bournemouth Hospital, was to be the emergency or the planned site. This was a very difficult decision and after carefully weighing the evidence, Bournemouth was chosen for the emergency site and Poole for the planned site. Following the post decision scrutiny and assurance processes, including JHOSC and HOSC, the NHS in Dorset fully backs the CSR decisions and is already implementing the agreed recommendations in order that the patient benefits can be delivered to all of those who use the NHS services in Dorset.

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Report subject	• **Joint Business Plan of the Dorset and Bournemouth, Christchurch & Poole Safeguarding Adults Board** • **Draft Annual Report of the Bournemouth, Christchurch & Poole Safeguarding Adults Board**
Meeting date	Monday 2nd September 2019
Status	Public Report
Executive summary	**Business Plan** To advise of the progress on objectives in 2018-19 and to outline the overarching aims of the Board for 2019-20 and how we plan to achieve these. **Annual Report** The achievements of the Board and its member organisations are showcased under the headings of Effective Prevention, Effective Safeguarding, Effective Learning and Effective Governance. The report looks at some of the trends identified by analysis of safeguarding data as well as future challenges in store for the coming year for what is now the Bournemouth, Christchurch & Poole Safeguarding Adults Board.
Recommendations	Members are asked to note and comment upon the content of the attached report of the Bournemouth and Poole Safeguarding Adults Board. Reports will be published on Board website following approval at autumn 2019 Board meeting. https://www.bcpsafeguardingadultsboard.com/about-the-bcpsab.html

Reason for recommendations	The Local Authority is statutory lead for the Safeguarding Adults Board and the committee is asked to review the Business Plan and Annual Report as part of their scrutiny arrangements.
Portfolio Holder(s):	Cllr Lesley Dedman Portfolio Holder for Adults and Health
Corporate Director	Jan Thurgood Corporate Director for Adult Social Care
Contributors	Barrie Crook, Independent Chair Claire Hughes, Business Manager
Wards	All BCP Council area
Classification	For Information

Background

The remit of the Bournemouth and Poole Adult Safeguarding Board is all encompassing and works across agencies to achieve its aim:

This Board exists to protect adults at risk from abuse, significant harm or neglect.

We will achieve this through strategic leadership and collective accountability.

The Business Plan looks at 2018-19, the first year of an agreed three-year joint strategy for the Dorset and Bournemouth, Christchurch & Poole Safeguarding Adults Boards.

The annual report is produced to communicate and reflect on the work and outcomes for 2018/19 and to look at some of the future challenges.

BUSINESS PLAN

Progress on Objectives in 2018-19:

- Refresh of multi agency procedures, including protocol for Large Scale Enquiries and information sharing guidance in light of GDPR.
- There has been greater outreach to the community via information stalls at the Emergency Services day and other local events.
- Organisations have responded to an independent audit of decision-making in respect of section 42 enquiries and increased their own auditing of cases to oversee improvements in practice.

- Internal audits also focus upon Making Safeguarding Personal and how far individuals are asked about the safeguarding outcomes they would like and to what degree these have been met.
- Concern about the low use of advocacy in safeguarding enquiries has been monitored by the Quality Assurance sub group via meetings with both the provider and commissioners.
- A new 3 year training strategy has been agreed. A training framework has been developed for adoption by statutory agencies which addresses the lessons learned from reviews in terms of risk assessment, risk management and information sharing. Business Managers and training leads of the SABs, Safeguarding Children Boards (LSCB) and the Community Safety Partnerships (CSP) meet regularly to develop a combined approach to embedding shared lessons from reviews.
- A number of training sessions have been run across the county on contracture management, following the findings of a SAR in Dorset.
- The SABs and LSCBs organised a listening event involving practitioners and managers from a wide variety of organisations to focus on implementing a whole family approach.
- Members of the Boards have been briefed on the progress of preparations for Local Government Reorganisation and continued to make line of sight visits to one another's offices and hospitals.
- There has been increased engagement with carers and service users through the Learning Disability Partnership Boards (LDPB), especially in relation to the SAR in respect of 'Harry'.
- The Boards have assumed responsibility for overseeing the final stages of implementing recommendations from the Advocare independent report.

Work for 2019-20

At a development session in December emerging issues ands plans for the new business year were identified. These were shared at a Provider Event in February.

Alongside the business as usual, the Board will work on three overarching aims:

- domestic abuse
- exploitation
- neglect and self-neglect

ANNUAL REPORT

Safeguarding Adults Boards are bound to produce an annual report. This report examines the activity and achievements of the board and how member organisations have contributed to the safeguarding adults agenda. When considering the effectiveness of adult safeguarding four headings are used :

- Effective prevention;
- Effective safeguarding;
- Effective learning;
- Effective governance.

The 2018/19 Annual report gives an overview of the work of the Board and its subgroups during the year.

The report includes details of safeguarding work undertaken by the Board and its partner agencies across local authorities, health, police and emergency services, probation and representatives from the voluntary and provider sectors.

The report touches on some of the challenges of safeguarding in the coming year.

Achievements

Key achievements for the Bournemouth and Poole Safeguarding Adults Board this year include:

- Listening event for practitioners to follow up the successful joint conferences on the theme of working with the Whole Family Provider.
- Event to engage with care providers and share an overview of the Board's activity.
- Increased engagement with the Learning Disability Partnership Board including presenting to this group on the findings of the 'Harry' SAR/DHR.
- Increased engagement with the public through attendance at events.
- Worked with the local authorities before Local Government Reorganisation to help ensure a smooth transition.

Effective prevention

- The Provider event delivered information on recognising and preventing Domestic Abuse both in clients and staff, as well as important safety measures regarding the fire risks associated with emollient creams.

- Engagement with local organisations about the role of the Safeguarding Adults Board.

Effective safeguarding

- Revision of the pan-Dorset multi-agency policy and procedures documents.

- A development morning was held to gather views of Board members on challenges to effective safeguarding and key emerging themes. The aim was to shape future strategic priorities.

- The Communications Strategy has sought to strengthen the branding of the Board in order to promote the Board and its work. For the first time branded merchandise was purchased for use at events with the general public to promote the work of the Board.

Effective learning

- Work continued on a project to update Safeguarding Adult Practitioner training to devise a modular approach which will allow for flexible delivery and for other groups to access this training. The first module was delivered in autumn 2018.

- The Shared Learning group was formed with representatives from the Safeguarding Adults and Children's Boards and the Community Safety Partnerships to ensure learning from SARs and DHRs is shared effectively.

Effective governance

- The Executive Group continues to use the risk register to monitor and manage risk as the safeguarding landscape changes.

- The subgroups carry forward the business of the board as outlined in workplans.

- The Quality Assurance subgroup examines the data collected by partner organisations and seeks assurance that measures are in place to record and respond to what the data tells us.

- A review of the Safeguarding Adults Board was considered and steps taken to arrange once Local Government Reorganisation had taken place.

Background papers

This report was complied using contributions from Board member organisations and data from the Safeguarding Adults Collection (SAC Return) for Borough of Poole and Bournemouth Borough Council.

Appendices

1. Joint Business Plan of the Dorset and Bournemouth, Christchurch & Poole Safeguarding Adults Board
2. Draft Annual Report of the Bournemouth, Christchurch & Poole Safeguarding Adults Board

Appendix 1

Dorset Safeguarding Adults Board

Bournemouth, Christchurch & Poole Safeguarding Adults Board

Joint Business Plan 2019-20

Version: 10.06.19

Dorset and Bournemouth, Christchurch and Poole Safeguarding Adults Boards

Joint business plan 2019-20

Introduction

In 2018 the Safeguarding Adults Boards (SABs) of Dorset and Bournemouth and Poole agreed a new three year joint strategy. The core values and approach to adult safeguarding are outlined in the strategic plan.

The Boards will also continue to be guided by the 6 person-centred principles set out in the Care Act

- empowerment
- prevention
- proportionality
- protection
- partnership and
- accountability

Progress on objectives in 2018-19

During 2018-19 there has been a refresh of the multi-agency procedures, now including a protocol for large scale enquiries and information sharing guidance in the light of GDPR. A specific section in the procedures now sets out the approach to be taken between Safeguarding Adult Services and MARAC when an individual in need of care and support is subject to domestic abuse.

There has been greater outreach to the community via information stalls at the Emergency Services day and other local events.

Organisations have responded to an independent audit of decision-making in respect of section 42 enquiries and increased their own auditing of cases to oversee improvements in practice. For example in Dorset Council 26% of concerns now progress to a Section 42 enquiry compared to less than 10% prior to the audit.

Internal audits also focus upon Making Safeguarding Personal and how far individuals are asked about the safeguarding outcomes they would like and to what degree these have been met. The recorded figures are still at a relatively low level.

Concern about the low use of advocacy in safeguarding enquiries has been monitored by the quality assurance sub group via meetings with both the provider and commissioners.

A new 3 year training strategy has been agreed. A training framework has been developed for adoption by statutory agencies which addresses the lessons learned from reviews in terms of risk assessment, risk management and information sharing. Business Managers and training leads of the SABs, Safeguarding Children Boards (LSCB) and the Community Safety

Partnerships (CSP) meet regularly to develop a combined approach to embedding shared lessons from reviews.

A number of training sessions have been run across the county on contracture management, following the findings of a SAR in Dorset.

The SABs and LSCBs organised a listening event involving practitioners and managers from a wide variety of organisations to focus on implementing a whole family approach.

Members of the Boards have been briefed on the progress of preparations for Local Government Reorganisation and continued to make line of sight visits to one another's offices and hospitals.

There has been increased engagement with carers and service users through the Learning Disability Partnership Boards (LDPB), especially in relation to the SAR in respect of 'Harry'.

The Boards have assumed responsibility for overseeing the final stages of implementing recommendations from the Advocare independent report.

Draft work programme for 2019-20

In December each Board held a development morning to identify emerging issues and plans for the new business year. These were shared with independent providers at events in February and their views also taken into account.

The Boards have agreed to focus attention on 3 overarching concerns whilst also maintaining progress on 'business as usual' through their 5 joint sub-groups.

The key concerns will be

- domestic abuse
- exploitation
- neglect and self-neglect

Overarching aims

Domestic Abuse

Aims

Adults in need of care and support are identified and protected from the risk of domestic abuse

Adults in need of care and support are able to protect themselves from the risk of domestic abuse

Adults in need of care and support who are subject to domestic abuse receive a service that meets their needs and provides them with specialist support and advice

Professionals know when to intervene to protect an adult with care and support needs who is subject to coercion and control

Current position

The 'Harry' SAR/DHR indicated that at the time of the review MARAC and Safeguarding were not aligned and that Domestic Abuse Advisors (DAA) were not equipped to respond appropriately to adults with a learning disability.

An appendix (6) has been added to the multi-agency procedures providing guidance to staff to improve integration between MARAC and safeguarding.

All DAAs have since received Safe Lives training regarding 'safeguarding vulnerable adults' and have completed a workbook pp 34-40, Block 4, Key Choices, Options, Support Available to High Risk Clients, Safe Lives.

6.6 FTE advocate posts are to be appointed in the east and west of the county to improve liaison between heath and domestic abuse services.

An independent multi-agency audit of adults with a learning disability who were subject to domestic abuse was undertaken in February. It highlighted findings that

- Health and social care professionals had not fully embraced key learning about how to handle risks arising from domestic abuse.
- Referrals were not being made to involve specialist DAAs in casework.
- The DASH was not being completed.
- When an individual was referred to MARAC, it was not clear from files what was the outcome of that referral.
- It was therefore not possible to conclude if staff were following the guidance set out in the procedures.

Next steps

- Health and social care organisations to ensure that staff are fully aware of key learning in respect of domestic abuse and that this is embedded in their day to day practice.
- All organisations need to ensure that their staff understand the role played by partner agencies in preventing and managing domestic abuse.
- The author of the independent audit has been asked to provide case summaries of those cases reviewed in the audit.
- Further detailed review/evaluation of case highlighted by author within audit report to be undertaken by manager independent from casework to inform action plan in response to learning.
- The author be invited to run a workshop(s) with practitioners and managers focussing on the learning from the audit.
- A robust pathway from adult social care into MARAC processes is developed, initially using learning disability as a model.
- The learning synopsis from 'Harry' to be disseminated to both staff in statutory services and independent providers and presented at multi-agency workshops. Evaluation of the impact of learning from the review will be collated.
- The SAB is working with the LDPB in Bournemouth, Christchurch and Poole to develop a Keeping Safe workshop(s).
- The SAB to seek an understanding from the Police and Domestic Abuse Strategy Group that domestic abuse community services are actively receiving medium and standard risk domestic abuse referrals from the police and that these services are equipped to respond appropriately to adults with a learning disability.
- Liaise with the Domestic Abuse Strategy Group concerning programmes for perpetrators, especially where the perpetrator has care and support needs.
- Take stock of progress following the multi agency workshops to determine further developments required in respect of pathways; training; commissioning; the skills mix in services.

Exploitation

Aims

Adults with care and support needs subject to exploitation are identified and supported at an early stage and, where appropriate, enabled to move away from crime.

Support services for victims of exploitation should be accessible and sensitive to their needs.

Current position

Whilst exploitation is an emerging issue for adults with care and support needs, the Boards do not yet have sufficient data about the nature and level of threat to focus their planning.

Independent providers have referred to adults in their care being targeted as part of county lines. The Police have information about 'vulnerable' adults being cuckoo-ed and subject to both financial and sexual exploitation.

There are a number of organisations involved in formulating a partnership response to exploitation, each with individual action plans. County Lines has so far concentrated more on the response to children but it is recognised that there should also be a focus on adults at risk of criminal exploitation.

Next steps

Hold discussions with the leads for exploitation issues concerning the best way for the SAB to contribute to action plans currently being configured for 2019-20, particularly in respect of county lines, sexual violence, modern slavery and sexual exploitation of the homeless.

Encourage coordination and clarity of governance of the partnership response to exploitation.

Continue discussions with Bournemouth University concerning the development of a tool to assess vulnerability to exploitation, similar to the CAROL model for young people.

Identify a SAB that has already made progress on this issue and learn from its model.

Neglect and self-neglect

Aims

Targeted initiatives to prevent instances of neglect and self-neglect result in a reduction of safeguarding concerns.

Current position

As with exploitation the Boards do not at present have a sufficient analysis of neglect and self-neglect to focus its planning. There is a difference however in that the Boards themselves collect a substantial amount of data and that 'neglect and acts of omission' are the most prevalent reason behind safeguarding concerns.

Neglect and acts of omission in 2017-18 accounted for 55% of safeguarding concerns in Dorset Council compared with a national average of 32%. The figure is lower for Bournemouth and Poole (44% respectively in Q4 2018-9) but still above the previous year's national average.

South West Ambulance Service report a high number of ambulance call-outs are for reasons of neglect and self-neglect especially in rural areas of Dorset.

In respect of self-neglect it is known that staff are largely unaware of the guidance and toolkit produced on this issue and held on the Boards' websites.

Next steps

1. Analysis of data held about neglect to identify the most common themes – Dorset council has decided to sub divide the 'neglect and acts of omission' code so as to identify more specific data in respect of

   missed visit(s)

   medication error

   provider not following care plan

   pressure sores

   carer not following professional advice/care plan

   carer stress

2. The training and workforce sub-group to publicise again the self-neglect guidance
3. CQC to report at the next cycle of Board meetings on levels of neglect found among providers and to steer the Boards as to how prevention efforts may be improved
4. The forthcoming audit of Multi Agency Risk Management meetings (MARM) to identify how far neglect is the reason for calling a MARM and document what outcomes and benefits have followed from meetings.
5. Present examples of good practice in responding to self-neglect at Board meetings so that these can be disseminated and built upon.

Key Business as usual objectives being progressed by the Boards' sub- groups

Effective Prevention

- Update the Boards' communications plan to ensure wide awareness of adult abuse and neglect and its impact
- Develop the Boards' websites, publicity materials and use of social media
- Continue to work with commissioners and the CQC to ensure early intervention when providers do not meet adequate standards of care and safety
- Improve use of safeguarding data to identify where prevention approaches should be focussed
- Enhance prevention by maximising the influence of Board members who sit on other partnership boards

Effective Safeguarding

- Continue to ensure that MARAC and adult safeguarding interventions are aligned
- Jointly with the CSPs undertake a 'deep dive' audit into the effectiveness of Multi Agency Risk Management meetings (MARM)
- Seek assurance that, where 'risk remains' following a safeguarding enquiry, appropriate measures are in place to try to protect the individual
- Improve the frequency with which feedback is provided when a safeguarding concern has been raised
- Continue to develop the Making Safeguarding Personal approach
- Engage with prisons locally to support approaches to safeguarding in custody using the recommendations from the national ADASS/Safeguarding Chairs survey

Effective Learning

- Deliver events to disseminate learning from the inquest and SAR into the death of 'Harry'
- Meet any training needs emerging from the independent domestic abuse audit and the MARM 'deep dive'
- Develop approaches to involving carers and service users in the design and provision of training
- Deliver training in relation to pressure ulcers and keep safeguarding training up to date, e.g in respect of changes to the Liberty Protection Safeguards
- Further develop the joint approach with the Childrens Boards and CSPs to implementing the learning from all reviews

Effective Governance

- Conduct a review of the organisation of the Safeguarding Adults Boards that takes account of wider developments such as LGR and changes to the structure of the Safeguarding Childrens Boards
- Continue to engage in a coordinated way with other partnership boards on working with the whole family/Think Family approach.
- Link with Carers Reference groups, service user organisations and the new Healthwatch provider to further develop stakeholder engagement with the Board
- Increase the level of auditing to examine the effectiveness of multi-agency practice

Resources

One objective not followed through in 2018-19 was a review of the Boards' budgets and the contributions of members to them. This has been carried forward into the new year as part of the overall review of the organisation and joint working practice of the two Boards.

For 2019-20 therefore it is proposed that member contributions and the budgets of the Boards remain unchanged.

Risk register

The Boards' risk register has been reviewed and risks which have been reduced or are no longer relevant have been removed. When available the register will be cross referenced with the inter-agency risk register being developed.

Conclusion

Board members are invited to discuss and approve the business plan for 2019-20.

Barrie Crook

Independent Chair

10th June 2019

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ANNUAL REPORT 2018-19

Bournemouth & Poole Safeguarding Adults Board – working in partnership to develop, share and implement a joint safeguarding strategy to protect adults at risk from abuse, significant harm or neglect. We will achieve this through strategic leadership and accountability.

Safeguarding is Everybody's Business

Version 20 08 2019

NOTE: The Board has been known as the Bournemouth, Christchurch & Poole Safeguarding Adults Board since 1st April 2019.
This report is for the period immediately preceding this change and therefore the Board is referred to as the Bournemouth & Poole Safeguarding Adults Board.

DORSET & WILTSHIRE
FIRE AND RESCUE

INDEPENDENT CARE PROVIDERS

VOLUNTARY SECTOR

Introduction from the Independent Chair

In 2018-19 the Safeguarding Adults Board, working together with the Dorset Board, has

- Strengthened the joint work between safeguarding and community safety partnerships
- Focussed upon areas for improvement identified in reviews and audits
- Engaged more widely with providers, service users, carers and the public
- As well as maintaining important 'business as usual' activities

There has been a refresh of the multi-agency procedures, now including a protocol for large scale enquiries and information sharing guidance in the light of GDPR. A specific section in the procedures now sets out the approach to be taken between Safeguarding Adult services and MARAC when an individual in need of care and support is subject to domestic abuse.

There has been greater outreach to the community via information stalls at the Emergency Services day and other local events.

Organisations have responded to an independent examination of decision-making in respect of section 42 enquiries and increased their own auditing of cases to oversee improvements in practice. There is nonetheless still scope for greater consistency across the local authorities in respect of the proportion of concerns that become subject to an investigation. This position may be assisted in the coming year by national development work on this issue.

Internal audits also focus upon Making Safeguarding Personal i.e. how far individuals are asked about the safeguarding outcomes they would wish to see and to what degree these have been realised. The recorded figures are still at a relatively low level and would therefore benefit from further analysis. However more detailed case studies show that staff are attentive to the need to involve individuals in choices about their care and to assess capacity clearly.

I am pleased to note the continuing impact on levels of risk where enquiries are undertaken. In 81 % of cases in Bournemouth and 97% of cases in Poole risk was removed or reduced.

Concern about the low use of advocacy in safeguarding enquiries has been monitored by the quality assurance sub-group via meetings with both the provider and commissioners.

A new 3 year training strategy has been agreed. A training framework has been developed for adoption by statutory agencies which addresses the lessons learned from reviews in terms of risk assessment, risk management and information sharing. Business Managers and training leads of the SABs, Safeguarding Children Boards (LSCB) and the Community Safety Partnerships (CSP) meet regularly to develop a combined approach to embedding shared lessons from reviews.

A number of training sessions have been run across the county on contracture management, following the findings of a Safeguarding Adult Review (SAR) in Dorset in 2017.

There has been increased engagement with carers and service users through the Bournemouth and Poole Learning Disability Partnership Board (LDPB), especially in relation to the SAR in respect of 'Harry'. More detail in respect of this SAR/DHR (Domestic Homicide Review) is set out later in this report. Prior to a resumed inquest into his death an independent audit was commissioned to establish current practice in respect of adults with a learning disability who are subject to domestic abuse. More detailed work on involving specialist domestic abuse services in such cases is incorporated into the 2019-20 business plan.

A specific meeting was convened to brief providers about the learning from the 'Harry' SAR. In addition the Boards engaged as usual to consult providers about their new business plan and emerging safeguarding concerns. This was also an opportunity to advise them about the safe use of emollients following the death by fire of a resident locally.

The Boards have also widened the scope of deaths and serious incidents where they consider if a SAR should be commissioned. In the past year two deaths of rough sleepers have been evaluated and referrals have been received from the Learning Disabilities Mortality Review programme.

Members of the Boards have been briefed on the progress of preparations for Local Government Reorganisation and continued to make line of sight visits to one another's offices and hospitals. The initial transition to the new authorities has been planned thoroughly with good liaison between Dorset, Bournemouth and Poole concerning the transfer of adult social care cases from Christchurch.

It is perhaps inevitable that such major change and continuing resource pressures on member organisations have adversely affected attendance at some sub-group meetings. I am nonetheless grateful for the continuing commitment of members to the activities of the Board.

For 2019-2020 the Boards have determined to focus development work on three overarching priorities

- Further alignment of safeguarding and domestic abuse interventions
- Contributing to effectively tackling exploitation, including county lines and
- More targeted approaches to preventing neglect and self neglect

Once again I express my gratitude to the staff of the Board in Bournemouth and Poole and chairs of sub groups whose diligence and enthusiasm underpin all that the Board has achieved this year.

Barrie Crook

August 2019

Contents

EXECUTIVE SUMMARY

The Bournemouth & Poole Safeguarding Adults Board has been working towards delivering the strategic objectives set out in the three-year Strategic Plan encompassing the period from April 2018 to March 2021.

This Annual Report seeks to examine the activities of the Safeguarding Adults Board and its members from April 2018 to March 2019, the first year of the three-year Strategic Plan.

The achievements of the Board and its member organisations are showcased under the headings of Effective Prevention, Effective Safeguarding, Effective Learning and Effective Governance.

The report looks at some of the trends identified by analysis of safeguarding data as well as future challenges in store for the coming year for what is now the Bournemouth, Christchurch & Poole Safeguarding Adults Board.

In the appendices to the report are some examples of feedback and safeguarding cases demonstrating the work carried out by partners.

1. ABOUT US

Who are we?

The Bournemouth and Poole Safeguarding Adults Board has been the partnership body for Safeguarding in Bournemouth and Poole since its inception nine years ago. It is a partnership Board with senior representatives from those organisations listed at the front of this document.

The overarching purpose of a Safeguarding Adults Board is to help and safeguard adults with care and support needs. We aim to stop abuse or neglect wherever possible and prevent harm occurring. We strive to address the causes of abuse or neglect. Our work includes raising awareness of safeguarding issues so these can be identified, and supporting affected people in making choices to resolve issues.

Our Mission

This Board exists to protect adults at risk from abuse, significant harm or neglect.

We will achieve this through strategic leadership and collective accountability.

Our Structure

The Bournemouth and Poole Safeguarding Adults Board is comprised of representatives from the Local Authorities, Health, Police, Emergency Services and Probation as well as from the voluntary and independent sector.

The Board has an Independent Chair, who also fulfils this role for the Dorset Safeguarding Adults Board which helps facilitate the close alignment of the two Boards in their quest to safeguard adults Pan Dorset. The Board has 5 subgroups which are comprised of members from the Bournemouth and Poole Safeguarding Adults Board and the Dorset Safeguarding Adults Board:

What we do

The overarching purpose of a Safeguarding Adults Board is to help and safeguard adults with care and support needs. The Bournemouth and Poole Safeguarding Adults Board seeks to assure itself

that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance. The Board seeks assurance that Safeguarding practice is person-centred and outcome-focused and that partners work collaboratively to prevent abuse and neglect where possible.

In the event that abuse or neglect have occurred, the Board calls on agencies and individuals to give timely and proportionate responses so that lessons can be learned to inform the preventative agenda.

Safeguarding practice ought to improve and enhance the quality of life of adults in the area.

Core duties

SABs have three core duties. They must:

- Develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute.
- Publish an annual report detailing how effective their work has been.
- Commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these.

The six safeguarding principles

All safeguarding activity should have at its core these six principles:

Empowerment, Prevention, Proportionality, Protection, Partnership, Accountability.

2. SAFEGUARDING ADULT REVIEWS

Safeguarding Adults Boards have three core duties; as well as the development and publication of a strategic plan and annual report Safeguarding Adults Boards are responsible for the commissioning of safeguarding adults reviews (SARs) for any cases which meet the criteria for these.

It is important to note that a death does not need to have occurred for a SAR to take place, although sadly a death will have occurred before a Domestic Homicide Review (DHR) is undertaken. The responsibility for commissioning new DHRs now sits with the local Community Safety Partnerships, although completed reports are still quality assured by the Safeguarding Adults Board.

The Safeguarding Adult Review Subgroup of the Board is comprised of members from Bournemouth, Poole and Dorset and meets twice per quarter to review those cases where serious harm has occurred or may have occurred. This subgroup examines cases presented for consideration and works collaboratively with partner agencies, requesting full and frank contributions from partners in order to systematically assess whether a SAR ought to be commissioned.

The objective of any SAR is not to apportion blame but to extract the key learning points from a potentially tragic or shocking occurrence with a view to fulfilling the aims of effective learning and safeguarding, and above all in this context prevention of a recurrence.

The SAR Subgroup report their findings to the Board, and collaborate with the other subgroups of the Board.

The SAR Subgroup has overseen progress on several ongoing SARs and Domestic Homicide Reviews (DHRs). The learning from these cases is distilled via the Shared Learning group which is attended by the Business Manager and Training Coordinator from the Board as well as their counterparts in the Dorset Safeguarding Adults Board, the Children's Boards for Bournemouth, Poole and Dorset and the Community Safety Partnerships for the area. The Shared Learning group link with the subgroups to ensure the learning is included in training and reflected in the policies and procedures of the Board; there are clear pathways to enable this.

In the year 2018/19 there was one new SAR commissioned in Bournemouth and Poole. The circumstances of the case are complex and it has been decided to proceed with a joint SAR/DHR/MAPPA review in order to gather information and commission a thorough review so that learning can be shared.

'Harry' SAR/DHR

March 2019 saw the publication of the joint SAR/DHR Report into the death of 'Harry', a young man with learning disabilities who was murdered in 2015 by two people known to him who are referred to as 'John' and 'Karen' in the report. Both are currently serving life sentences for Harry's murder.

Although the report had been completed and had been granted Home Office approval for publication, this was postponed until the conclusion of the criminal justice process and Coroner's Article 2 inquest into the murder. The Coroner recorded that Harry had been unlawfully killed.

The report and related documents can be found on the Board website:

Introduction to the Safeguarding Adult Review and Domestic Homicide Review into the death of 'Harry'
Joint SAR and DHR Final Report into the death of 'Harry'
Executive Summary of Joint SAR and DHR into the death of 'Harry'
Multi Agency Action Plan following the death of 'Harry'

A number of important themes for learning and improvement have been highlighted through the review:

Information sharing

Risk assessment and management

Mental capacity

Engagement with the perpetrators

The impact of social media

Mate crime

Information sharing is a recurring theme in SARs and DHRs. It is important that all agencies accurately record information when a person is at risk and share this with partners also involved with the individual. Where incidents are treated in isolation it limits the ability of agencies to see the bigger picture of the various risks that an individual may be exposed to. It is important to recognise that risks change and to reassess when changes in circumstances occur.

There is a dilemma balancing the rights of the individual with capacity and their prerogative to make unwise decisions and being able to protect them. Working together with individuals professionals can take steps to ensure that a person has capacity to make decisions for the specific situation they are in, recognising that capacity can fluctuate.

The perpetrators who murdered Harry were themselves known to various agencies. Growing up Children's Services had been involved in Karen's life and her transition to adulthood was complicated. John, too had a degree of emotional ill health and presented a risk to himself and others which was not fully assessed. After Harry's death the Multi Agency Risk Management process

was introduced and is used widely by agencies. This process would now be another vehicle by which John's risk and need could have been assessed

Social media is how Harry first became acquainted with Karen. Harry was keen to develop friendships, especially with women and after meeting Karen online arranged to meet her in person just a few days later. Social media is a useful way to communicate and engage with others but poses many risks.

Dorset Police have been involved to advise people with learning disability on how to keep safe online. This theme remains part of the Bournemouth and Poole Learning Disability Partnership's Keeping Safe work plan and an event is planned for 2019 focussing on social media exploitation and domestic abuse. The Safeguarding Adults Board highlighted the risks of social media to a person with learning disability and how they should be reported through its poster campaign.

For a time Harry and Karen were in a relationship. Harry had previously been assessed as having capacity to engage in a sexual relationship. Karen became pregnant and Harry was unsure if he was the father of her child. Once Karen formed a relationship with John, Harry was subject to frequent bullying and abuse by text on his phone, including messages threatening to kill him.

Harry's murder has been linked to 'mate crime' as Harry believed that Karen and John were his friends. Mate crime is a form of crime in which the perpetrator befriends a vulnerable person with the intention of then exploiting him/her financially, physically or sexually. Perpetrators may take advantage of the isolation and/or vulnerability of their victim to win their confidence. Harry was a young man with a learning disability who was being supported to live independently in the community. He was abused by Karen and John not only emotionally and physically, but also financially.

The abuse escalated to the point where Harry was held against his will in Karen's flat.

Harry had been advised not to continue seeing Karen and John but decided to return to the flat again believing they were his friends. He was murdered there in May 2015.

The impact of Harry's death on his family, friends and those who knew him cannot be overestimated.

The Independent Chair has met with Harry's family and expressed condolences to them.

The Board is committed to working together to help prevent such tragedies. The recommendations from the report have been implemented and further training is planned for staff. An easy read version of the Synopsis of Learning has been commissioned so that other adults with learning disabilities can access this report.

3. DATA ANALYSIS

Safeguarding data is examined by the Quality Assurance subgroup on a quarterly basis. The local authority data is based on the Safeguarding Adults Collection (SAC) return.

The QA subgroup looks at data from each of the local authorities as well as health and police. By examining data together common themes or indeed anomalies can be identified.

For some time there have been ongoing efforts to align the safeguarding data in Bournemouth and Poole and to examine any differences therein, and whether these are due to differing practice or recording, or other factors.

Each local authority has its own case management system which presents a challenge when making comparisons however the volumes of concerns and Section 42 Enquiries are illustrated below.

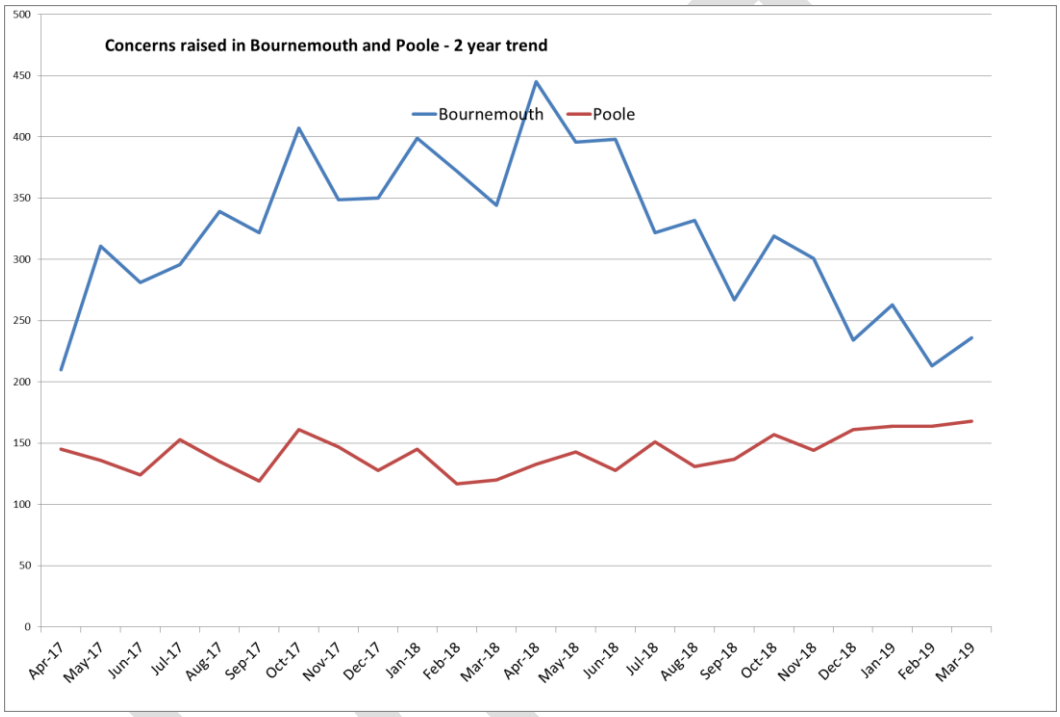


Figure 1

During the last two years the volume of concerns received in Poole has remained fairly consistent. The trend in Bournemouth has been more varied. The high volumes in April and May 2018 can be attributed to two large scale enquiries which saw greater numbers of concerns raised, the decrease in the months that followed suggested that the volume of concerns received was then more reflective of what was to be expected.

Figure 2 below illustrates the 2-year trend of Section 42 enquiries conducted in Bournemouth and Poole.

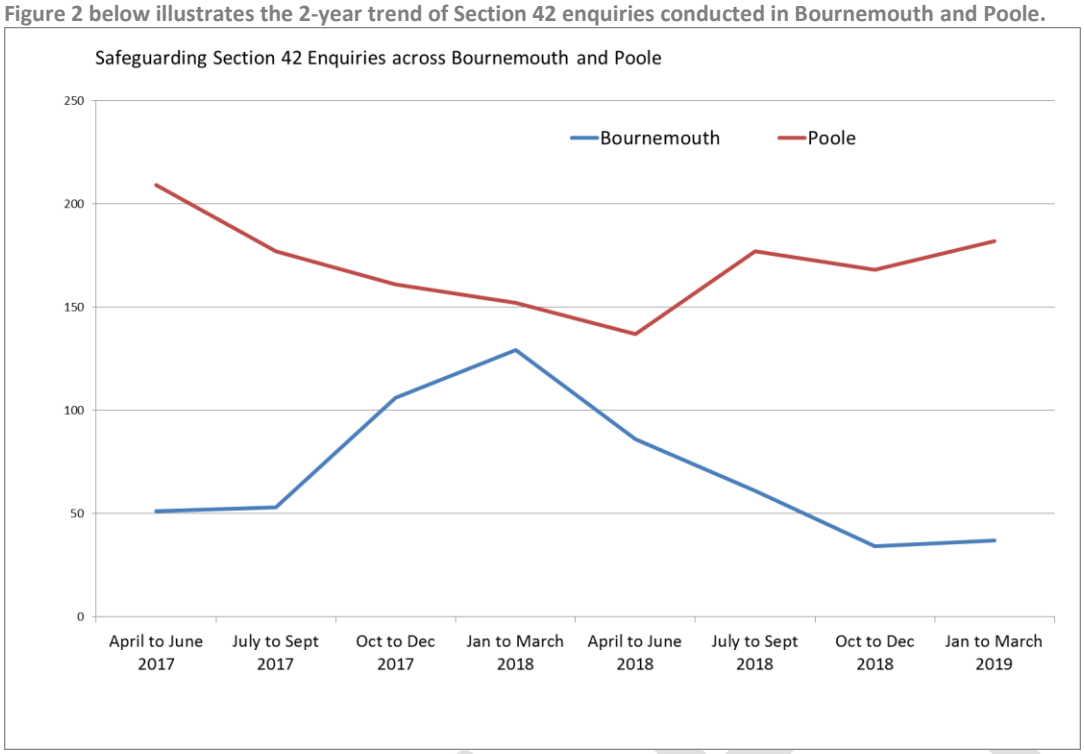


Figure 2

While Bournemouth receive many more concerns this graph illustrates that Poole in fact have more Section 42 Enquiries.

The proportion of enquiries converted to Section 42 continues to be higher in Poole, usually around a third whereas in Bournemouth the proportion converted to Section 42 is typically lower, perhaps around 10 to 15%. In Bournemouth there also tends to be a small proportion of concerns (around 5%) converted to Other Safeguarding Enquiries.

It is anticipated that over time there will be an increased conversion rate of concerns to Section 42 enquiries in Bournemouth, and a lower conversion rate to Other Enquiries.

On the following pages there is an overview of some of the data for Bournemouth & Poole and the **5580** concerns received in 2018-19 resulting in **812** Section 42 Enquiries.

In both authorities, for concerns and enquiries, females consistently outnumber males.

In Bournemouth there tend to be more people in the 18 to 64 age group, usually almost half of concerns, whereas in Poole it is usually closer to a third in this age group.

The most common location of abuse is in a person's own home, audits have been carried out in the last year to ensure that recording is accurate. One hypothesis is that as significant numbers of

people are supported to stay at home this will imply a rise in incidents occurring there whereas staff are on hand and policies are in place to help prevent incidents in residential settings.

The most common type of abuse is Neglect and Acts of Omission. This reflects the national picture although percentages in Bournemouth and Poole tend to hover a few points above the national average of 32%[1]. Further work is planned to better understand this type of abuse in order to reduce incidents where possible.

Physical and financial abuse are usually the next most prevalent types of abuse. Other less common types of abuse such as organisational abuse and modern slavery have their own categories on the SAC return to ensure that they are recorded appropriately where they are identified.

There is much emphasis on Making Safeguarding Personal and it is encouraging that when desired outcomes are expressed in the majority of cases these are fully or partially met (usually over 90% in both authorities). Further work is ongoing to ensure greater a proportion of people are asked for their views, although it is recognised that it may not always be possible or appropriate to ask due to issues of capacity or where a person has become too unwell.

Risk assessment is looked at in the QA subgroup and in a large majority of cases risk is reduced or removed, usually upwards of 90%.

It has been noted at Board meetings that a better understanding of the reasons behind the figures will be a useful step to improving safeguarding. Efforts to improve the data presented to the Board are ongoing. In the next reporting year as the local authorities become one BCP Council further research into other areas with a similar profile will be undertaken.

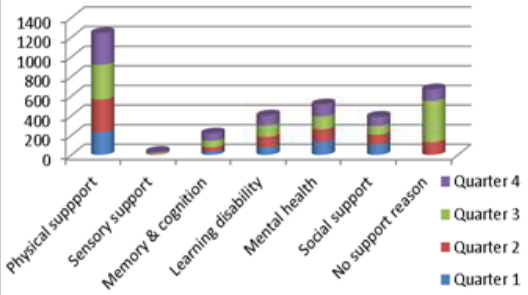
[1] https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/annual-report-2017-18-england

The 2018-19 Safeguarding Adults Collection report has not yet been published

Safeguarding Activity & Performance Information 2018/2019 Q1-4

No. of concerns received by B&P
5580 (Activity counts, not individuals)
Q1=1646 Q2=1339
Q3=1387 Q4=1208

Primary support reasons for individuals involved in safeguarding concerns



Progressing to section 42 Enquiries
(No. of individuals)

812

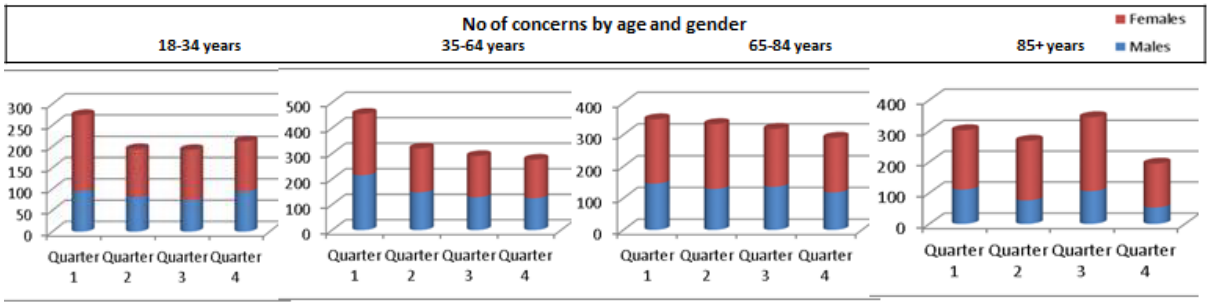
Males	Females
Q1 =72	Q1=136
Q2=81	Q2=136
Q3=72	Q3=115
Q4=64	Q4=136

Location of abuse

In the persons own home
Q1 = 61%
Q2 = 53%
Q3 = 57%
Q4 = 55%

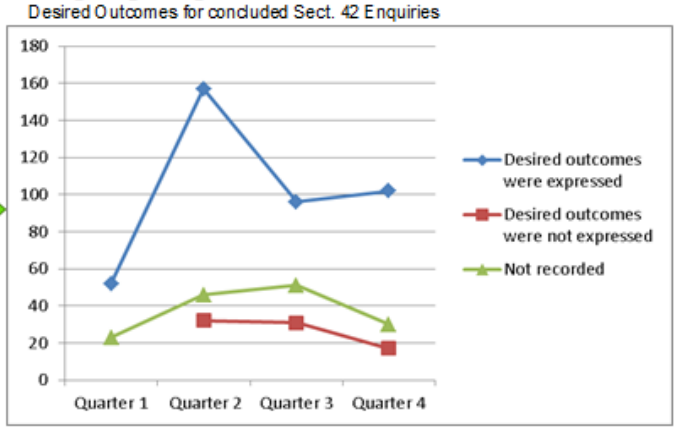
Other identified high risk areas
Q1 Mental Health hospital 29%
Q2 Care Home- residential 21%
Q2 Care Home- nursing 9%
Q3 Care Home- residential 20%
Q3 Care Home- nursing 5%
Q4Care Home- residential 16%
Across all locations of abuse
57% were known to the individual
34% were known to a service provider

No of concerns by age and gender

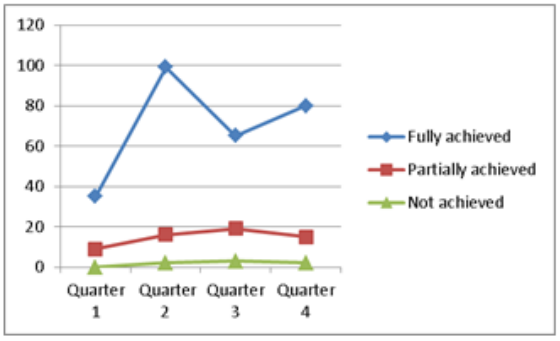


Most common types of abuse recorded in Section 42	Q1	Q2	Q3	Q4
Neglect/ Acts of Omission	68	115	95	88
Physical	11	57	41	30
Financial/ material	2	61	38	23
Domestic Abuse	5	27	19	16
Psychological	7	23	19	16
Sexual	2	14	15	18
Modern slavery	0	1	0	0

Making Safeguarding Personal:
Desired Outcomes for concluded Sect. 42 Enquiries



Making Safeguarding Personal:
Achieved Outcomes for concluded Sect. 42 Enquiries where expressed



Safeguarding Adult Reviews	Numbers (Individuals who died)
Quarter 1	0
Quarter 2	0
Quarter 3	0
Quarter 4	1 x aged 75-84 years

4. KEY ACHIEVEMENTS AND FUTURE CHALLENGES

During 2018-19 the Board worked towards achieving the priorities set out in the Strategic Plan for 2018-2021.

Support the development of a more robust independent provider market that leads to fewer safeguarding concerns

Each year the Board holds a provider event to engage with care providers and hear from them regarding current challenges which can inform the Board's future business, and to share with them an overview of the Board's activity.

In February at the Lighthouse in Poole over 70 attendees heard from the Independent Chair, who encouraged engagement with the Board and asked them to consider how the Board can support them in their work. The Fire Service gave a presentation on the dangers of emollient creams especially for smokers; this very practical topic followed the sad death of a gentleman in the area and it is hoped that this awareness-raising will help prevent similar incidents. Attendees also heard from an expert on Domestic Abuse and were guided through some of the types of abuse to look out for, whether they were providing residential or domiciliary care, as this close working relationship means carers are well placed to spot warning signs. Attendees were reminded too of the prevalence of domestic abuse and to be alert to the possibility that some of their staff may also be victims, and given advice on how to support them.

As well as the annual provider event the Board were involved in a Learning Disability provider event in November to consider concerns providers might have as a result of the 'Harry' SAR/DHR.

Reduce the instances of people with care and support needs being involved in Domestic Abuse and improve the interface between Domestic Abuse and Safeguarding

In Appendix 2 there is further information about an independent audit of cases where adults with learning disabilities were experiencing domestic abuse.

Nationally there has been some concern regarding the classification of Domestic Abuse when the victims are elderly, in the past agencies may have recorded as 'safeguarding' incidents which ought to have been classed as Domestic Abuse. Locally much has been done to address this issue. The Business Manager attended a conference looking at this issue in greater detail and shared the learning with colleagues.

Help to establish working with the whole family as standard practice

Following the very successful 'Think Family' conference in the previous year there was a Listening Event in October for practitioners. Speakers from Waltham Forest Safeguarding Partnership who had started to embrace this ethos before Dorset, Bournemouth and Poole helped facilitate the event, attended by a very wide range of people working to safeguard children and adults including social workers, addiction services, health professionals, police, teachers and others.

Evidence lessons from SARs and DHRS really have changed the way we work

The Business Teams from the Safeguarding Adults Boards, Safeguarding Children Boards and Community Safety Partnerships have formed a Shared Learning Group to look at themes from SARs and DHRs. This group links with subgroups, in particular Training & Workforce Development around learning and also with the Policy & Procedures group in case any learning necessitates an amendment to the pan Dorset safeguarding procedures.

Other achievements to note:

The 7 minute learning tools have been successfully used to share learning on contractures, pressure ulcers, neglect, and fire safety and are available on the board website.

The Business Team attended several pop up events including the Emergency Services and Family Fun days in Bournemouth and Poole in summer and in a retail setting in winter. For the first time branded merchandise was purchased and the investment proved to be a way of engaging with the public and raising the profile of the Board.

Advocare
The Board held an extraordinary meeting to examine the Advocare report and recommendations. Some work was undertaken to provide assurance that the issues raised by the group at the time (pre Care Act) would not occur in the present day, due to changes in practice.

Learning Disability Partnership Board (LDPB)
The June Board meeting was attended by several members of the LDPB and the Board agreed to sign up to People First Forum's Bill of Rights. The Business Manager then attended the LDPB and gave a presentation on the Safeguarding Adults Board. Due to ongoing work with the Harry SAR/DHR the Independent Chair attended several LDPB meetings to speak to the group about some of the details around what had happened to 'Harry' and the Coroner's inquest.

The Business Manager became a full member of the LDPB and a member of their Keeping Safe subgroup. This has strengthened the links between the Safeguarding Adults Board and the LDPB.

Local Government Reorganisation (LGR)
During the year Bournemouth and Poole local authorities were involved in intense preparations for LGR. The Safeguarding Adults Board was involved in some of the workstream planning meetings. The Board also needed to prepare by ensuring that the name and logo of the Board were amended and that the Board website was updated to reflect the new arrangements. Further work will be undertaken to amend Board documents to reflect the new local authority.

Development session
In December a Board development session was held which checked progress and contributed to the Board's priorities for the coming year.

Review
There will be an independent review of the Safeguarding Adults Boards in BCP and Dorset. The Children's Safeguarding arrangements in Dorset have already been reviewed following the Wood

report but with LGR on the horizon it was impossible to also review the adult safeguarding arrangements at the same time.

Future Challenges

The Board will continue to work towards the objectives in the 3 year Strategic Plan and the priorities set out in the Business Plan.

Many of the Board partners are striving to continue to deliver high levels of service in the face of intense pressure on resources. As partner organisations working to achieve the same end goal, the reduction of a service in one area can lead to increased pressure in another so channels of communication need to remain open for collaborative working which benefits all.

Regardless of the outcome of the Board review it makes sense to make better use of technology available, where possible easing the burden for arguably the greatest resource, the people working together to safeguard adults.

APPENDIX 1 – PARTNER CONTRIBUTIONS

The Board works with partner agencies to ensure that safeguarding activity is making a difference.

The Board uses four headings (below) to look at how the work undertaken by partners contributes to safeguarding, although there is frequently overlap.

EFFECTIVE PREVENTION

Adults are safe from avoidable harm and avoidable death

Effective and early intervention using a pro-active approach which reduces risks and promotes safe services whilst ensuring independence, choice and control

EFFECTIVE SAFEGUARDING

Adults know that their concerns about safety will be listened to and dealt with at an early stage and that they are safe and in control with people who work with them

EFFECTIVE LEARNING

People working with adults are aware of their safeguarding responsibilities and have access to appropriate guidance, procedures and training. Learning from Safeguarding Adults Reviews and Investigations is disseminated to multi-agency professionals to ensure effective learning, learning transfer and continuous improvement.

EFFECTIVE GOVERNANCE

Hold partnerships to account for their contribution to safeguarding Adults at Risk: Accountabilities to the public, its constituent bodies and individuals at risk for example – hate crime, domestic abuse, mental health, sexual offences, and overall quality of health services.

Partners were invited to share some details of what their organisation has done over the last year to safeguard adults; these are listed on the pages which follow:

1. LOCAL AUTHORITIES – ADULT SOCIAL CARE

In recent years much effort has been focussed on aligning the Adult Social Care services in Bournemouth and Poole. In 2018-19 these efforts were redoubled with the imminent Local Government Reorganisation (LGR) to create a new local authority.

Even before LGR one post holder fulfilled the roles of Head of Adult Social Care Services, Borough of Poole and Service Director, Adult Social Care, Bournemouth Borough Council. The Joint Service Manager – Statutory Services was Safeguarding Lead in Adult Social Care across both local authorities.

The point of access to Adult Social Care in Poole was Helpdesk whilst in Bournemouth the point of access was Care Direct. Whilst this means two separate 'front doors' the Statutory Services Manager and the Operational Managers for each authority have worked closely to ensure that once contact has been made that the response, practice and outcomes for residents are the same regardless of where they live.

In October Bournemouth implemented a new case management system, MOSAIC. One of the issues with the previous system was that it did not allow for easy recording and tracking of information about providers to analyse patterns of Concerns raised about providers and manage potential large scale enquiries.

Ahead of LGR Adult Social Care workstreams were identified and meticulous planning was undertaken by project teams and task and finish groups to ensure a smooth transition on Day One.

Research into various safeguarding models nationally was undertaken and a decision was reached that both Bournemouth and Poole would retain their existing modus operandum to allow teams to cope with the demands placed upon them by LGR and to allow further consideration to be given to the pros and cons of favoured models across the country, thus learning from the experience of other areas before deciding on a new model and case management system for Adult Social Care in the new BCP Council.

Effective Prevention

Staff from Bournemouth Safeguarding Hub have developed strong links with colleagues in Contracts and other agencies such as Dorset Healthcare to formulate a Multi Agency Provider Support approach known as MAPS. The approach seeks to prevent harm occurring when standards of care in a Provider setting have fallen below acceptable levels. This approach has been written into the Board's procedures as a way of preventing Large Scale Enquiries or further harm.

Effective Safeguarding

Making Safeguarding Personal is embedded in practice in Bournemouth and Poole, the Joint Service Manager – Statutory Services has undertaken small scale audits during the year to examine how outcomes are being recorded, further focussed work on recording outcomes is planned.

Intensive planning was undertaken with colleagues from Bournemouth, Poole and Dorset to ensure the authorities were ready for day one of the Local Government Reorganisation. Decisions were taken based on assuring the smoothest transition possible for Christchurch residents, in order to keep them safe. The Service Manager for Statutory Services influenced the decision that Safeguarding Concerns should be made via Care Direct and follow the Bournemouth model of Safeguarding. Strong links between the Safeguarding Hub and Christchurch Locality were established and Dorset staff received refresher training ahead of April.

Bournemouth and Poole participated in the review of the Audit into Section 42 Enquiries completed on behalf of the Board in May 2018 by Kate Spreadbury, by providing a range of cases. After the audit was completed, the findings were reviewed and considered by the Safeguarding Lead.

Bournemouth acknowledged that their Case Recording system at the time required practitioners to complete data collection forms retrospectively and this issue was contributing to a degree of confusion of whether a case constituted a Section 42 or not. This issue has now been resolved by the introduction of a new system in October 2018, which requires practitioners to decide at the appropriate time whether they are undertaking a Section 42/other Enquiry, 'NFA' or alternative intervention.

The Safeguarding Lead concluded that some cases were mistakenly called Section 42, when in fact they were not. However, a good standard of practice was noted and effective, preventative and personalised risk management was undertaken. This practice continues, but would now be defined under 'NFA' (no further action for safeguarding) or 'other enquiry' data record.

The new BCP Council will continue to actively contribute to the Task & Finish Group which is considering issuing further guidance to staff on Decision Making, i.e. what constitutes a Section 42 or other enquiry. This work may result in internal guidance for ASC staff in BCP Council or may be presented to the Board for inclusion in Procedures. BCP Council look forward to implementing the recently-issued National guidance on this subject.

Effective Learning

The Service Manager for Statutory Services meets regularly with the Staff Development Manager and the Trainer responsible for delivering Safeguarding Training. This helps to ensure staff are receiving relevant and up to date training that ensures they are fit for practice.

Lessons learnt from SARs/DHRs and Audits are shared and then included in future training. Staff meet on a regular basis with the Training Coordinator of the Safeguarding Adults Board to share learning and plan. Learning outcomes are discussed and agreed.

Effective Governance

The Service Manager for Statutory Services has proactively taken part in the production of Independent Management Reviews (IMRs), and developed and implemented Action Plans where required.

Regular small scale audits are undertaken to provide assurance and identify examples of good practice which are fed back via the Quality Assurance sub group. The Service Manager for Statutory Services meets with the Business Manager of the Safeguarding Adults Board to examine the quarterly activity reports for Adult Social Care teams in Bournemouth and Poole and analyse the findings.

LOCAL AUTHORITIES – LEARNING & DEVELOPMENT

The Board's business team, in particular the Training Coordinator, continues to work closely with the workforce development teams.

Work is ongoing to ensure consistency of training across Bournemouth and Poole and ensure course content is updated to include current themes in safeguarding.

Steps have been taken to improve the quality of course outcomes including through reduced commissioning of courses, increasing internal courses allowing course material to be tailored to the identified training needs.

Effective Prevention

Bespoke Safeguarding Essential Skills training has been provided to many external organisations including provider services, charities, community organisations and church groups.

Effective Safeguarding

A review of Safeguarding Adult Practitioners and Managers annual training updates determined that more frequent update training was needed due to developments in Safeguarding Adult practice. Update sessions were held twice yearly instead of annually.

Training was delivered on Making Safeguarding Personal and the Care Act in practice.

Effective Learning

The Safeguarding Adult Practitioner Training course aims and outcomes were reviewed leading to the launch of a new modular course in September. The new course utilises a blended learning approach with flexible modules; knowledge is closely linked to practice to enable deeper practice learning for effective outcomes in Safeguarding practice.

In line with the Board's aims a Whole Family Approach Safeguarding course was developed and delivered to other Local Authority departments including Housing and Tourism.

Learning from cases including SARs is available to Safeguarding Adult Practitioners and managers in sessions which encourage reflection on good practice and areas of development locally.

In conjunction with the Community Safety Partnership and the Safeguarding Adults Board training sessions to share the learning from the joint SAR/DHR 'Harry' will be developed and delivered.

LOCAL AUTHORITIES – HOUSING & COMMUNITIES

The Homelessness Reduction Act 2017 came into force in April 2018. This was the most significant legislative change in Housing since 1996 and sets out new duties and extends existing duties around prevention and housing advice for customers. In order to deliver this new service which aims to avoid or relieve homelessness as early as possible the local authority invested in additional staffing and reviewed customer delivery. Additional staff were recruited and working practices were revised to meet the new prevention and relief duties. Every customer receives a detailed assessment and a personal housing plan to follow which will assist in preventing or relieving their homelessness.

Further reorganisation is planned in the coming year to incorporate policy and resources to meet the housing needs of BCP residents.

There is an increase in the number of people with complex needs temporarily accommodated under a housing duty, which is possibly as a result of the new legislation and the reduction in supported housing. Options for delivering additional support for this cohort of vulnerable people whilst in temporary accommodation are being developed and funded through successful Ministry of Housing, Communities & Local Government bids.

In 2018/19 5 additional properties were purchased and 3 were built in Bournemouth to meet the needs of homeless people and Housing Register applicants.

The local authorities welcomed 3 new families under the Syrian Resettlement Programme.

Rough Sleeper Initiative

Bournemouth area were successful in bidding for additional homelessness grant funding which has enabled the following:

• Further 'Housing First' provision for the most entrenched and disenfranchised rough sleepers

• Additional outreach staff for the rough sleeper team

• Psychological intervention worker who works alongside the rough sleeper team

• A duty to refer coordinator who works with all the agencies that now have a duty to refer under Clause 10 of the Homelessness Reduction Act 2017

• A coordinator post to recruit and manage all the additional work and staffing.

This funding has been awarded under the Rough Sleeping Strategy 2018 and in line with the aim of reducing rough sleeping and ending it for good by 2027.

Housing provided safe temporary housing for Rough Sleepers in cold and extreme weather under the Severe Weather Emergency Protocol.

Effective Prevention

Work continues to identify provision to meet the needs of BCP residents where a statutory duty to assist is in place. The offer to residents cannot be wholly reliant on the private rented sector.

Pre-eviction protocol review with Poole Housing Partnership has reduced evictions from council accommodation; further work on this is planned for the coming year.

Effective Safeguarding

Housing made referrals to the Safeguarding Adults Board's Safeguarding Adults Review (SAR) subgroup. A decision was taken not to undertake a SAR but with the subgroup Housing are looking at learning from these referrals.

B&B and Guest House accreditations were completed for all units in the BCP conurbation, ensuring Health & Safety compliance and assured service standards with proprietors. Additional checks for new premises are in place with periodic cycle of re-accreditation.

Pilot Complex Housing Resources Panel - A revised Terms of Reference for the panel to support the coordination of complex resources for those with a range of needs and behaviours which may be putting tenancies at risk and / or those who require support resource plans in place in order to access housing.

Effective Learning

Trauma-informed training was provided for housing practitioners in Bournemouth & Poole. Frontline officers have used this training to improve the quality of housing needs assessments, increase awareness of trauma and Adverse Childhood Experiences (ACEs) and to inform housing options and appropriate support. This training has been extended to the Rough Sleeper outreach team.

Effective Governance

The previously commissioned Floating Support Team delivered by BCHA in the Bournemouth area was brought in-house. This decision was made to achieve efficiencies and align with other services for a more coordinated approach.

A review of Housing-related support and services for Adults with Mental Illness and complex needs took place, further work on aligning access pathways is ongoing.

LOCAL AUTHORITIES – COMMISSIONING

Services for Adults who require Care and Support at home or in a residential setting, or community services, are commissioned under the Tender for Care and Support at Home Framework 2017-2022. Providers are contractually bound to comply with safeguarding procedures and encouraged to link with third sector providers to engage in preventative work.

The small framework of providers allows for close quality monitoring, open communication and effective market management and specialist training is offered to all contracted providers.

The contracts team have introduced client feedback into the monitoring process and any issues raised are dealt with appropriately.

Information on providers of concern is shared with the Quality Assurance subgroup.

Intelligence relating to concerns is reviewed and graded before being added to staff caseload in order to monitor and assess risk, and intervene to support providers to improve and evidence the resulting positive changes.

Effective Prevention

Practical measures in place include working in partnership with public health to offer flu vaccinations to staff thereby maintaining workforce capacity and reducing the spread of such illnesses among service users.

Increased capacity in the Independent Living Service has meant that self-funders have been able to access support in making decisions around their care, empowered to make the right choices and reassured by the advice from experienced staff.

The Provider Safeguarding and Compliance Forum meets every 6 weeks to decide how best to share information, identify gaps and changes relating to safeguarding and provider performance. Low level concerns can be shared with the aim of preventing escalation.

Effective Safeguarding

The community reablement offer at Coastal Lodge for clients who no longer required their acute hospital beds due to being medically fit, but required further support prior to returning home, enabled these people to be safeguarded effectively.

Effective Learning

Bespoke training was designed for care home residents and the staff that work with them. This included Action Learning Sets; Experiential Dementia Awareness Training using virtual reality; Dementia Communication delivered within care home settings; Resilience and Wellbeing training.

Effective Governance

The service has engaged in contingency planning including preparations for Brexit and the potential impact on staffing.

Established communication channels with providers supports the market.

2. DORSET POLICE

Dorset Police continue to work closely with partners to safeguard adults across Dorset.

Police incidents are increasingly involving vulnerable adults with missing persons reports and concern for safety calls to police placing significant demand on policing. Dorset Police have presented at the Board to share the increasing demand that protecting vulnerable adults is having and seeking support from other agencies to work effectively to protect those most at risk of harm. Dorset Police have redeployed staff to Public Protection teams to manage these risks.

Dorset Police are developing their approach to adult safeguarding with the focus on risk identification, assessment and management including signposting to community services and better quality referrals to other agencies, by way of a Public Protection Notices (PPNs), when necessary. This is work in progress.

Identifying and responding to vulnerability is a key priority for the Force and this starts from the initial call to the police, through Force tasking and coordinating processes and to the allocation and deployment of resources.

Dorset Police have uncovered 'hidden' forms of harm such as vulnerable people being trafficked or subjected to forced labour. The Force has created a county line neighbourhood policing approach to target organised crime groups and safeguard vulnerable people who may be at risk of exploitation.

Effective Prevention

Dorset Police have worked hard to understand the effectiveness of the Force response to vulnerable people with reviews of domestic abuse investigations, missing person incidents and modern slavery and human trafficking offences.

The Force has worked with national partners to develop and implement effective safeguarding practices, for example, the National County Lines Coordination Centre and the College of Policing.

Effective Safeguarding

Dorset Police have developed a more effective way of sharing reports following police contact with vulnerable people with partner agencies. A team of Safeguarding Referral Officers (SRO) now manage the referrals for vulnerable adults, domestic abuse and vulnerable children within the Safeguarding Referral Unit (SRU).

Dorset Police make referrals to the Safeguarding Adults Review Subgroup and contribute to the assessment of referrals submitted by partner organisations.

Dorset Police have implemented the learning from Safeguarding Adult Reviews, for example the Domestic Abuse Investigation and Vulnerable and Intimidated Victims and Witnesses Policies and Procedures have been updated.

Dorset Police have developed their capability to effectively investigate Modern Slavery and Human Trafficking (MSHT) offences with new procedures being implemented and training for Detective Inspectors.

Further training for frontline staff and the introduction of MSHT Investigative Champions is planned for 2019-20.

Effective Learning

The College of Policing 'Look beyond the obvious' vulnerability training was delivered to all front line officers between September 2018 and April 2019. This one-day training sought to further improve the skills of the frontline to effectively support the complex needs of vulnerable individuals, to encourage professional curiosity and to ensure the Force is better equipped to deal with the shift in demand towards safeguarding and public protection. This training has had a positive impact on officers and the way they identify, assess and deal with vulnerability.

Further training for frontline officers on Mental Health and Missing People is taking place during the autumn 2019.

Effective Governance

The Dorset Police and Crime Plan 2017 – 2021 sets out 4 priorities:

- Protecting People At Risk of Harm
- Supporting Victims, Witnesses and Reducing Reoffending
- Working With Our Communities
- Transforming For The Future

The Chief Constable with the Police and Crime Commissioner hold a monthly Force Performance Meeting which provides governance and drives the Force vulnerability agenda. The Police focus on Crime Data Integrity has continued over the last year ensuring effective crime recording in line with the national standards set by the Home Office and is now much improved. This ensures that victims are identified and afforded their rights within the Victim Code of Practice. Internal audit and review continues to be developed and conducted by the Force Make The Difference Team.

Quarterly Adult PPN data is now shared with the Quality Assurance sub group which enables partners to better understand the types and volumes of PPNs.

Multi Agency Risk Management (MARM) meetings are utilised by Dorset Police. They will participate in a future audit of the use of MARM in Adult Safeguarding.

The Dorset Police Adult Safeguarding Team now has offices at Bournemouth and Weymouth police stations and they provide specialist safeguarding advice and support for the most vulnerable. Their work includes MARAC, Clare's Law disclosure requests, attendance at the specialist domestic abuse courts and initial triage of adult at risk referrals.

~~Dorset Police continue to work closely with partners to safeguard adults across Dorset.~~

~~The Police have been increasingly involved in working with adults with degrees of vulnerability and have presented at the Board to share details of their project to map this work and the complexities of trying to achieve a common approach with other partners given the differing focus of each organisation. Whilst policing was traditionally associated primarily with criminal justice over time the numbers of 'Adults At Risk' as defined by the Police have increased to the point where Dorset Police, in line with other force areas, are increasingly concerned with the safeguarding adults agenda.~~

~~Organisation Business Design has led to the redeployment of staff to Public Protection areas. This has seen a growth in areas of safeguarding of one Detective Sergeant and two Police Constables.~~

~~Dorset Police are developing their approach to the use of Public Protection Notices (PPNs) and signposting to community services in order to manage the demand associated with protecting the vulnerable and statutory safeguarding. This is work in progress.~~

~~The Force Intelligence Bureau ('FIB') now focusses on an intelligence-led approach to threat, risk and harm. The FIB has a dedicated vulnerable adults desk, an analyst and a researcher, developing and supporting vulnerable adult investigations~~

~~The threats and risks to the public are changing over time, this is reflected in the work of Dorset Police and their development of internal and partnership processes to prevent and respond to concerns regarding victims of modern day slavery.~~

~~Effective Prevention~~

~~The Dorset Police Make the Difference Team completed a force-wide domestic abuse audit to identify areas for improvement. The Force has appointed a Superintendent to lead the development work identified.~~

~~National County Lines Coordination Centre supported and promoted the safe and well checks conducted by neighbourhood officers of criminally-exploited vulnerable people in West Dorset by drug dealers. This successful initiative has now been rolled out across the force area.~~

~~Effective Safeguarding~~

~~Creation of Safeguarding Referral Officers (SRO) in the Safeguarding Referral Unit (SRU). The SROs will consider all referrals of adults, Domestic Abuse and children into the SRU. The new process avoids duplication of effort and increases staff resilience.~~

~~Dorset Police make referrals to the Safeguarding Adults Review Subgroup and contribute to the assessment of referrals submitted by partner organisations.~~

~~Dorset Police have updated their Vulnerable and Intimidated Victims and Witnesses Policy and Procedure. In light of the learning from the 'Harry' SAR/DHR the policy now makes it clear that where an officer or member of staff identifies a witness who may be eligible for a video recorded interview they need to identify an officer who is trained in interviewing vulnerable and intimidated witnesses.~~

~~Several Detective Inspectors have undertaken training in Modern Slavery and Human Trafficking (MSHT).~~

~~Significant development of procedures and support has been received from National Modern Slavery Transformation Unit who undertook a case audit and provided learning. Further training for frontline staff, and for some officers to become MSHT Investigative Champions is planned for 2019-20.~~

~~Effective Learning~~

~~The College of Policing 'Look beyond the obvious' vulnerability training and communication awareness material has been implemented within Dorset Police between September and April. The objectives of this full day of training are to further improve the skills of the frontline to effectively support the complex needs of vulnerable individuals, to encourage professional curiosity and to ensure forces are better equipped to deal with the shift in demand towards safeguarding and public protection.~~

~~Effective Governance~~

~~Dorset Police focus on Crime Data Integrity in relation to Domestic Abuse, one of the Board's strategic priorities. Performance is regularly audited.~~

~~Quarterly Adult PPN data is now shared with Quality Assurance sub group which enables partners to better understand the types and volumes of PPNs. Further work is planned with police staff on identifying when PPNs need to be shared with Adult Social Care.~~

~~Dorset Police Domestic Abuse policy and procedure has been updated to reflect early learning from DHR D6.~~

~~Multi Agency Risk Management (MARM) meetings are utilised by Dorset Police. They will participate in a future audit of the use of MARM in Adult Safeguarding.~~

~~Adult At Risk triage team at Bournemouth will be further developed to manage referrals and to better direct criminal investigations. Current methods of data collection for this group are time consuming and work is ongoing to improve this.~~

3. DORSET CLINICAL COMMISSIONING GROUP (CCG)

Dorset Clinical Commissioning Group (CCG) is the main commissioning organisation for health services across the whole county of Dorset. The CCG commissions planned and emergency health care across Dorset, as well as rehabilitation, and community mental health services. The CCG has responsibility for Continuing Health Care across the county. The CCG works closely with partner members of the Safeguarding Adults Board, and in particular with Dorset HealthCare, Poole Hospital Trust and the Royal Bournemouth and Christchurch Hospitals Trust.

Throughout the year the CCG has retained focus on the Adult Safeguarding agenda.

Last year the Safeguarding Lead GP's developed a Quality Assurance tool for visits to all GP surgeries. This tool provides a framework for checking that robust safeguarding processes are in place; this has been further developed to include other NHS providers.

Workshops on issues such as domestic abuse, coercion and control, stalking, adolescent to parental violence, and the Mental Capacity Act have been offered to primary care workers.

A series of short films aimed at practitioners and service users regarding the Mental Capacity Act were commissioned in collaboration with Dorset County Hospital.

Collaborative efforts to develop safeguarding guidance where pressure ulcers are involved continue with the Safeguarding Adults Board.

The CCG has been developing safeguarding templates to support IT systems within GP practices and facilitate recording of information.

A visit from the NHS England National Head of Safeguarding in the autumn gave a useful overview of the national safeguarding agenda from a health perspective, a further visit is planned for May 2019.

Effective Prevention:

Complementing the Board's strategic priority of Domestic Abuse, the delivery of Domestic Abuse training to primary care, practice nurses and pharmacists has increased the awareness of the overall agenda of Domestic Abuse as well as making clear the responsibilities of staff.

The Designated Adult Safeguarding Manager (DASM) attended the Safeguarding Adults National Network and the national Mental Capacity Act huddle. They are also an active member of the following pan Dorset groups: Domestic Abuse Strategic Group, PREVENT group and the Antislavery Partnership. The CCG is represented by the DASM at the Community Safety Partnerships and has undertaken work with the Business Manager for multiagency risk assessment conference (MARAC) to review the requirements of health representation. The annual adult safeguarding training to the CCG Governing Body was delivered by the safeguarding team.

Effective Safeguarding:

Domestic Homicide Reviews have been shared across all commissioners to consider how current services are delivered and to influence commissioning arrangements. The Police and Primary Care have joined forces to consider the effective management of public protection notifications (PPNs).

The Designated Adult Safeguarding Manager has developed links with probation services to review the communication with the current multiagency public protection arrangements. They also work with the CCG Patient Safety and Risk team to review Learning Disability Mortality Review Programme (LeDeR) reviews from a safeguarding perspective.

Effective Learning:

Regular Adult Safeguarding health leads supervision sessions have been held throughout the year, which embrace supervision and learning on a monthly basis.

In line with Think Family, Legal Literacy training was provided to safeguarding health leads for children and adults and attended by the Safeguarding Adults Board.

The DASM chairs the Training and Workforce Development subgroup and supported the delivery of a presentation around safeguarding, domestic abuse and mental capacity to the Mental Capacity Act conference.

The Intercollegiate adult safeguarding competencies have been adopted throughout the health system and plans are being developed to ensure these are embedded within the next three years.

Effective Governance:

Considerable work was undertaken throughout the year to quality assure the safeguarding arrangements within GP practices and NHS providers utilising an assurance safeguarding framework for all NHS providers. This links with key lines of enquiry for CQC that embrace both children's and adult safeguarding.

The CCG seeks assurance from all commissioned services that they have adequate safeguarding processes in place. The CCG collects regular data from these providers, which is then analysed and submitted to the Quality Assurance subgroup on a quarterly basis. This allows any themes or trends to be identified.

4. DORSET HEALTHCARE

Dorset HealthCare University NHS Foundation Trust remains committed to fulfilling its statutory requirements to work in collaboration with partner agencies to ensure that the population of Dorset maintain their right to live their lives free from abuse or harm.

Dorset HealthCare is responsible for all mental health services and many physical health services in Dorset, delivering both hospital and community-based care.

The Trust works collaboratively with Bournemouth University which benefits both staff and patients.

In 2018/19 Dorset HealthCare has invested in the development of a pocket guide for staff to improve implementation of the Mental Capacity Act. This practical tool for health practitioners offers support, suggestions and considerations designed to encourage implementation and promote best practice.

Effective Prevention

Dorset HealthCare's Safeguarding Adults Service has continued to provide advice and support to staff caring for people who were demonstrating self-neglect. Staff have made use of the Multi-Agency Risk Management (MARM) process in order to manage risk, this process has become embedded in practice in Dorset Healthcare.

In line with the Safeguarding Adults Board priority of Domestic Abuse Dorset Healthcare supported national drives such as Stalking Week and the 16 Days of Action project for Domestic Abuse. Information was made available to staff on the intranet that included national helpline details.

The Think Family Group ensures that safeguarding and promoting the welfare of children, young people and adults at risk, is integral to clinical practice within the Trust. It is also a Trust-wide forum for disseminating safeguarding learning via service safeguarding leads, addressing frontline safeguarding issues and embedding safeguarding policies and procedures into practice.

Effective Safeguarding

The Safeguarding Team has continued to provide advice and support to staff on safeguarding concerns.

Dorset HealthCare continued to support Large Scale Enquires during 2018/19. This has ranged from sharing details of care provided by Dorset HealthCare to completing joint assessments of residents' care needs with the Local Authority or attending professionals meetings. Staff also supported a task force approach led by Local Authorities to help minimise risks, collate information and support care and nursing homes that are subject to a Large Scale Enquiry. Dorset HealthCare have their own Large Scale Enquiry protocol.

Dorset HealthCare is represented at the Safeguarding Adults Board subgroups. Over the last year this has included the review of guidance around Pressure Ulcers, Falls and Nutrition with the Policy and Procedure Group contributing to the development and updating of procedures.

A document has been drafted that is designed to set out the patient journey from the point of admission to discharge for patients who lack capacity to make decisions about their welfare and residency at the point of discharge. The tool is being promoted particularly for patients where there

is likelihood of the matter being referred to the Court of Protection for a decision. The aim of the document is to support staff in following due process in these complex cases and avoid delayed discharges. A care plan document has also been developed to help manage the transition process when the Court of Protection does mandate a change of residence.

Effective Learning

Members of the Safeguarding Adults Team attended Dorset HealthCare's Prescribers' Conference and supported a safeguarding stand at Dorset HealthCare's Quality Matters Conference and the annual Mental Capacity Act conference. They regularly present at monthly Pressure Ulcer Workshops to increase awareness of Safeguarding Adults Process and the Mental Capacity Act.

Mental Capacity Act training has been delivered to Community Mental Health Teams and is in the process of being delivered to District Nursing groups.

The Safeguarding Adults and Children's Teams together with the Serious Incident Team and Quality Assurance have begun to explore how learning from DHRs, SARs and SCRs can be effectively disseminated and action plans monitored. Learning and best practice from other health trusts will be researched and used to plan a strategy around this for Dorset HealthCare.

Prevent awareness training has been provided to staff to highlight this emerging risk.

Effective Governance

The Safeguarding Adults Team continue to quality assure all Nominated Enquiry Reports (NERs) to ensure that all appropriate learning has been identified and interventions are in place to reduce the risk of reoccurrence. It is the responsibility of service managers to implement action plans that are derived from the safeguarding enquires.

The Safeguarding Adults Team continue to review all safeguarding adults incidents to ensure that concerns are raised with the Local Authority and/or the police as required and experience regarding risk management strategies is shared. A scorecard detailing the volume of safeguarding concerns identified and raised by Dorset HealthCare staff is submitted to the CCG for compilation into a Health Providers report. A summary of trends identified within the concerns is also submitted for inclusion in the report.

The Safeguarding Adults Team reviewed a sample of root cause analysis (RCA) forms on pressure ulcers that had developed whilst a person is under Dorset HealthCare care and were able to provide assurance that adult safeguarding concerns are identified and raised appropriately. No further actions were identified in any of the sample cases.

Following an audit of Multi-Agency Risk Assessment Conference, (MARAC), Dorset HealthCare's Safeguarding Adults Team identified the need to update the DASH assessment form that is used, to incorporate the additional stalking questions which are included in the full version of the assessment. Additional good practice points will be incorporated into Domestic Abuse eLearning package that is being developed. This is in line with the priorities of the Board over the coming year.

More robust processes are being developed for the coming year with the Patient Safety Team to identify Serious Untoward Incidents that may also be a safeguarding concern. The new system will enable cases to be cross referenced and identify lessons to be learnt and shared.

5. POOLE HOSPITAL NHS FOUNDATION TRUST

Poole Hospital provides acute services for the local population of Poole, Purbeck and East Dorset, and is the lead provider for the Bournemouth, Poole and Christchurch conurbation for trauma, maternity, paediatrics and ENT services. The staff at Poole Hospital strive to provide friendly, professional, patient-centred care with dignity and respect for all.

With a history of innovation, the Trust provides pioneering services across a range of clinical specialties and keeps safeguarding adults at the heart of its work.

Last year the Trust introduced a system of alert flags on the records of patients with learning disabilities and a resource folder with key tools to assist communication. The Trust has now built on this by developing a Learning Disability Strategy. The strategy was informed by a workshop in which 40 people representing people with Learning Disabilities, their families, informal and professional carers, the Safeguarding Adults Board, along with hospital staff came together to consider how the trust could better meet their needs in respect of 4 areas: keeping safe, staying healthy and independent, the right care and support in hospital, communication and engagement with support for families.

Poole Hospital will continue to implement the strategy over the next three years and during 2019 will provide a care-planning masterclass for staff and consider further how the health screening services that the Trust offers can be more accessible to people with Learning Disabilities.

The Trust recognises the increasing activity with respect to patients with mental health needs who attend the hospital. To support this activity a Mental Health Steering Group has been formed to provide oversight and coordination of the work to support people with mental ill health whilst receiving care in a physical health setting. Ongoing work will focus on 7 priority areas: Developing the governance framework; developing staff skills, provision of a safe environment, suicide prevention, access to specialist services, support to staff and supporting patients and families.

The Trust makes use of technology to improve working practices where possible. To simplify the process for staff when raising concerns an electronic referral form has been developed. Linked to the electronic patient record, this reduces the time taken in form completion and improves accuracy of information transfer. The form has been evaluated well by staff and the Local Authority. Further work to facilitate safe and easy transfer of information, share ideas and experience and develop consistent approaches across organisations is welcomed through the working of the Board and its subgroups.

Effective Prevention

Recruitment of a skilled workforce, with ongoing development and education of our staff is central to prevention of safeguarding concerns both within the trust and in the community. The hospital is actively developing new recruitment strategies to prevent shortfalls in workforce. Safeguarding training is organised to ensure that it embraces the complexity and range of safeguarding concerns which arise in the community and beyond.

The hospital's elderly care unit has received national acclaim for its pioneering model of multidisciplinary care.

Effective Safeguarding

Safeguarding continues to be central to the work to provide safe, caring, effective, responsive and well-led care within the hospital and acts as an enduring thread in the delivery of our strategic objectives.

The expanding understanding of the potential threats to the vulnerable alongside an increasingly frail and elderly population with chronic health concerns means that this work is growing year on year and becoming increasingly complex.

We continue to value working collaboratively with partner agencies to achieve the best outcome for patients. Further work to facilitate safe and easy transfer of information, share ideas and experience and develop consistent approaches across organisations is welcomed through the working of the Board and its subgroups.

Effective Learning

Poole Hospital continues to value working collaboratively with partner agencies to achieve the best outcome for patients. The hospital has strong relationships with other health leads and ensures that learning is shared with these.

The learning from safeguarding concerns and enquiries is shared through a variety of forums. Such learning from local and national events is also used throughout the trust 'update and induction training' as individual case studies to provide context to discussions and connection with staff own roles.

Further staff have undertaken the role of safeguarding champions to act as local links in clinical practice and help increase knowledge and confidence in wards and departments. These staff receive additional education through planned seminars with local experts.

Training is reviewed on an ongoing basis and this year additional time has been allocated to support the understanding of the Mental Capacity Act and reform of the Deprivation of Liberty Safeguards (DoLS).

Effective Governance

The Trust received it's CQC inspection report in January 2018 and was pleased to receive an overall rating of 'good', this included a rating of good for the well-led domain. The Trust agreed and implemented an action plan with CQC and Dorset CCG to address those areas where further improvement was required. The Learning Disability Strategy and Mental Health Plan referenced above are examples of improvements initiated by the Trust.

6. THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST

The Royal Bournemouth and Christchurch Hospitals provide healthcare for the residents of Bournemouth, Christchurch, East Dorset and part of the New Forest with a total population of around 550,000, which rises during the summer months. Some specialist services cover a wider catchment area, including Poole, the Purbecks and South Wiltshire.

The Trust strives to provide safe, caring, effective, responsive and well-led care within the Royal Bournemouth and Christchurch Hospitals and safeguarding is an important component of this.

The hospitals in the Trust have strong relationships with other health leads and ensure that learning is shared with these. The Trust also works in partnership with Pan Dorset partner agencies to promote and strive towards the priorities of the Safeguarding Adults Board and the alignment of practice in the CCG and in all Dorset Acute Trusts.

The electronic Cause for Concern form developed last year has improved confidentiality of sensitive information, and reduced misunderstandings that previously occurred due to illegible handwriting. This form is intentionally not password-protected so that the information can be seen by all staff in line with the principle that 'Safeguarding is Everybody's Business'.

The Royal Bournemouth and Christchurch Hospitals are committed to Making Safeguarding Personal and have made improvements in the referral processes.

There is a culture of appreciating the role of staff members in safeguarding patients.

The Trust has endeavoured to incorporate the 'Think Family' ethos.

The Trust is working to develop paid carers agreement and standards in recognition of the important role of carers in the lives of their patients and how this relationship can enhance safeguarding.

Effective Prevention

The Trust is confident that the visibility of the Adult Safeguarding (ASG) Team in the hospitals on a daily basis enables staff to access the team to seek advice, or assistance in raising concerns in order to prevent instances of harm from occurring.

Analysis of quarterly data is undertaken to ensure that concerns reported by staff are appropriate. Staff receive feedback on outcomes of concerns raised in order to understand cause and effect, and either prevent repeated similar issues or have the tools to deal with these as they arise.

Effective Safeguarding

The Adult Safeguarding Team have an "open door" policy. They work closely with Social Care partners to share concerns or advice, on a weekly basis they meet to screen referrals. There is a Trust culture of safeguarding being everybody's business.

The hospitals work in partnership with Police, Ambulance and Fire and Rescue to effectively safeguard the public.

Staff actively participate as and when required in Safeguarding Adults Reviews or other reviews.

The Trust has increased the number of Learning Disabilities Mortality Review (LeDeR) reviewers available and subsequently the number of reviews undertaken by the Trust for agencies.

Staff are aware of their Duty of Candour to the public and accountability for their actions. The Trust has a whistle blowing policy in place.

Effective Learning

The Trust target for training is 90%; however the Trust is pleased to report that Adult Safeguarding Training is continually over 95%.

The Adult Safeguarding Team attend Essential Core Skills training meetings so that the safeguarding ethos is perceived as core business.

The Adult Safeguarding Team work closely with the Training department to ensure training delivered is robust and reflects national legislation.

Effective Governance

The Trust participates in local and national safeguarding audits and initiatives, ensuring awareness of changes in legislation and adjusting practice accordingly.

The Trust Board receives quarterly and annual reports. Internally the Safeguarding Committee, which reports directly to Board, undergoes regular review and external audit.

Adult Safeguarding leads monitor, record and evaluate issues with the Deputy Director of Nursing.

The Trust is represented by the Deputy Director of Nursing or Adult Safeguarding lead nurse at Safeguarding Adults Board meetings and subgroups.

7. NHS ENGLAND AND NHS IMPROVEMENT (SOUTH WEST)

NHS England are focused on developing and maintaining strong safeguarding partnerships across health and social care to enhance how they protect, support and improve the lives of those at risk in local communities.

NHS England and NHS Improvement have demonstrated commitment to working with multi-agency partners to ensure that the interests of those at risk inform decision making. Health organisations strive not only to meet their legislative obligations, but also to listen to the voices of communities as well as those caring for them both professionally and in a caring, voluntary capacity.

The South West safeguarding team have worked in partnership with the NHS England and NHS Improvement National Safeguarding Team and local safeguarding partners to support the delivery of the national safeguarding priorities across the South West, and to support the networking of professionals across England to ensure sharing of best practice and learning from risks and issues.

As the safeguarding agenda is continuously developing, in both its complexity and scope, so too must the NHS priorities also evolve.

Effective Prevention

The South West safeguarding networks have worked with Primary Care to support the awareness of Domestic Abuse/Violence.

Effective Safeguarding

A safeguarding General Practice audit tool has been developed. Dorset have taken a lead on this work and this has received good feedback from General Practice participants.

The South Region Named GP Safeguarding Forum was first convened in March and brought contribution from partners across the South. The event was well-attended with over 30 Named GPs present and plans to expand on this forum are under way.

Effective Learning

Health Network developments across the South West have brought Clinical Commissioning Group safeguarding leadership teams together to create a community of practice and peer support. A key focus of the network meetings was to review the challenges across local areas, identify priorities and support collaboration and successes in their safeguarding work, as well as opportunities for learning from each other's good practice.

A strong focus on learning from cases both nationally and locally has been an ongoing theme in the work of the safeguarding networks. Learning from both child and adult reviews, has supported development of health and care systems across the South West.

The annual conference held in September 2018 was attended by 100 delegates from across the region. The focus of the day was exploitation and there were a range of speakers with specialist knowledge of County Lines, Prevent, Domestic Abuse and Modern Slavery.

This was followed by a Prevent Workshop in March 2019 with guest speakers from the Home Office and Police, attendees had the opportunity to work through Prevent issues local to them and to hear the journey of restorative care and support provided by the Home Office. Further workshops are planned for 2019/20.

Effective Governance

NHS England South (South West) team worked closely with local representative committees in Primary Care to raise the profile of safeguarding and identify any local or regional learning needs for Primary Care providers.

8. DORSET & WILTSHIRE FIRE AND RESCUE SERVICE

Dorset and Wiltshire Fire and Rescue Service (DWFRS) continue to develop and embed safeguarding standards across the organisation supported by a rolling programme of training.

DWFRS work in collaboration with local safeguarding boards, councils and other partners to ensure the Service is compliant with national safeguarding legislation, and is subject to independent audit.

The Safeguarding Lead meets monthly with Health Leads to share best practice.

The service is involved in a broad range of safeguarding activity and has implemented training on many topical issues including County Lines, Internet safety, Hate and Mate Crime, Domestic Abuse, Safeguarding Black and Minority Ethnic (BME) groups, Mental Capacity, Hoarding, Legal Literacy, Honour-based Violence and Homelessness.

DWFRS have made use of technology to remove barriers to reporting concerns by adding a safeguarding prompt question and a shortcut to their intranet as well as the planned development of an electronic safeguarding referral form.

The Fire Service have sought engagement with the public through social media campaigns on public intelligence gathering around Modern Slavery and Human Trafficking.

DWFRS are striving to raise the profile of the service in the safeguarding arena and ensure that partner agencies are aware of the advice and practical assistance that they can offer as part of their wider remit. Many providers and other attendees benefitted from advice from DWFRS at the Safeguarding Adults Board Provider Event.

The service continues to be challenged by the dilemma of supporting those involved in self-neglect and hoarding and works with partner agencies towards achieving positive outcomes.

Effective Prevention:

The Fire Authorities' policy and the Service's procedures adopt a 'whole system approach' to adult and children's safeguarding and they are reflected in the key principles. Safeguarding arrangements are delivered via a broad spectrum of activities including:

- Through support and promotion of both national and local safety campaigns (Prevention).
- Through specific intervention such as operational incidents, Safe and Well visits, Fire setter programmes and other children and young people (CYP) programmes.
- Multi agency training and awareness.
- Through formal safeguarding arrangements, in partnership with Local Authority Safeguarding Teams and other key agencies.

By working closely with other agencies, using information sharing to help safeguard vulnerable people and to keep others safe, including DWFRS staff.

Dorset and Wiltshire Fire and Rescue Service are increasingly sharing stations with The Police and working more closely with the Ambulance Service and have Memorandums of Understanding in place with these services.

By raising low level concerns early DWFRS aims to prevent the situations from becoming more serious.

The service has updated recruitment policies around safer recruiting and reviewed roles which require additional checks such as Disclosure and Barring Service (DBS) checks.

Effective Safeguarding:

Dorset and Wiltshire Fire and Rescue Service is committed to their duty to protect vulnerable people and work with partners to ensure processes are in place to provide the right support to those people when they need it. Staff are trained to understand their responsibilities in relation to safeguarding, and supported to deal with often challenging situations to safeguard the staff themselves.

Formal safeguarding arrangements are developed and delivered predominantly by the Safeguarding Lead who is responsible for supporting the organisation in its policy commitment to safeguarding and promoting the welfare of children, and adults at risk. To ensure organisational resilience, there is continuous cover in place for matters related to safeguarding.

The Safeguarding Lead represents the service on local sub groups and meetings where the service is actively involved in safeguarding, including Multi Agency Risk Management Meetings (MARM).

A clear training delivery plan which includes corporate induction and continuation training provides guidance to all staff and service volunteers on how to recognise when an adult with for care and support needs is either experiencing harm, abuse or neglect.

DWFRS have worked with 'You Trust' and now have Domestic Abuse Champions whom staff can approach for advice.

DWFRS make a valuable contribution to the self-neglect and hoarding panel which sets out the shared understanding across key agencies of a joined up response to very serious situations of adult self-neglect.

Effective Learning:

The Safeguarding Lead meets twice a year with Safeguarding Adults and Community Services Learning & Organisational Development Advisor. All training is discussed.

A pre and post training survey is circulated to monitor whether training has been embedded.

A survey was circulated to all front facing staff to measure to what extent safeguarding has been embedded in the service. Results were reviewed and a 99% positive outcome was achieved.

The origin of referrals is reviewed quarterly by the Safeguarding lead and Station Managers. Findings are shared with Group Managers and Area Managers with the aim of identifying any training needs.

The safeguarding lead attends Local Authority 'train the trainer' sessions.

Learning is shared with the Safeguarding Adults Board and local authorities. Staff attended the Safeguarding Adults Board provider event in February 2019 to share learning regarding the risks associated with emollient creams and the 7 Minute Learning tool on the subject has been widely shared.

Effective Governance:

The Safeguarding Lead meets with Devon and Somerset FRS, Hampshire FRS and Avon FRS safeguarding leads 3 to 4 times a year to share best practice.

The Safeguarding Lead attends monthly meetings with health leads.

When selected we are involved in the Line of Sight programme.

Area Managers give strategic management representation on all Local Safeguarding Boards.

The Safeguarding lead represents the service on the National Fire Chiefs Council Safeguarding Workstream.

The service provides locality based evidence of ongoing projects and report progress and opportunities to Members of the Fire Authority through Local Performance and Scrutiny Committees (LPSC's) on a quarterly basis. This is also reported to Full Fire Authority on a 6 monthly and annual basis.

Audited as required by HRMIC FRS*. (Commenced 2018).

*Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) independently assesses the effectiveness and efficiency of police forces and fire & rescue services – in the public interest.

9. SOUTH WEST AMBULANCE SERVICE NHS FOUNDATION TRUST (SWASFT)

The Trust's Safeguarding Service states "We support the Trust to work with partner agencies to ensure that children, vulnerable adults, victims of domestic abuse, victims of radicalisation, victims of modern slavery and victims of human trafficking are protected from those who would seek to harm them. To achieve this, the Trust needs to ensure that its staff and agents understand how to identify signs of possible or potential abuse in patients and members of the public they come into contact with and what action to take to ensure they are adequately protected. We also support the Trust to ensure that it provides a safe service to vulnerable people."

The Safeguarding Service analyses the impact of ten core activities. These activities cover external relationships, expert advice, education, referrals, information sharing, investigations, analysis of child death, service development, managing allegations and corporate advice.

The Trust is aligned to 28 Local Safeguarding Adults and Children Boards within its geographical area of operations. The Safeguarding Service endeavours to maintain relationships with all of these organisations by attending a representative selection of meetings. The Head of Safeguarding attended the Bournemouth & Poole Safeguarding Adults Board development session in December.

During 2018/19 the Trust generated 19750 safeguarding referrals from approximately 1.5 million contacts with patients across emergency and urgent care services. This represents a significant increase of 33% compared to the previous year.

Effective Prevention

It is noted that staff interaction with service users may be such that compared to other services time spent with the person can be very limited or the person may be unwell and unable to fully communicate. Staff are encouraged and trained to use their judgement and professional curiosity to ask pertinent questions and relay safeguarding concerns to partner agencies.

During 2018/19 the Safeguarding Service received notifications for 20 Safeguarding Adult Reviews and 12 Domestic Homicide Reviews across their geographical region.

Effective Safeguarding

During 2018/19 the Safeguarding Service managed 325 calls for advice from staff. This was increase of 18% compare to the previous year. This may be related to the introduction of the Safeguarding Helpline.

SWASFT have analysed referrals and highlight that the most common reasons for safeguarding concerns were self-neglect and domestic abuse.

A specialist seminar addressing corporate safeguarding principles was delivered to the Trust's Board during 2018.

Safer recruitment and selection procedures in place in line with best practice.

Effective Learning

In preparation for delivery of a new 3-year safeguarding training strategy, the teams worked closely during 2018/19 to develop and test a new method of safeguarding training using a threading-and-embedding method. This style moves away from teaching safeguarding as a standalone subject and instead focusses on practical application through delivering core safeguarding learning outcomes whilst delivering scenario-based clinical training.

By the end of 2018-19 the Trust had achieved 92% compliance for level 1 Safeguarding training and 95% for level 2.

Effective Governance

The Trust's Safeguarding Service has produced an annual report which is required to be reviewed and approved by the Trust's Quality Committee. The report highlights the Trust's strategy for governance, education, and management of safeguarding.

During 2018/19 the Trust's safeguarding team was restructured to improve efficiency and accessibility. The primary change was the introduction of the Safeguarding Business Manager. The purpose of this new role is to provide a single point of contact for external partner agencies.

SWASFT's Safeguarding Policy is published on their public website.

The Trust is subject to external scrutiny by the Care Quality Commission. In addition, the Safeguarding Service voluntarily utilises occasional local scrutiny panels provided by Local Safeguarding Boards to benchmark performance.

The Head of Safeguarding is a member of the National Ambulance Safeguarding Group (NASG) which facilitates discussion and peer review between the national NHS ambulance providers.

10. NATIONAL PROBATION SERVICE

The National Probation Service in Dorset is committed to the Safeguarding Adults agenda and implements new policy and procedures, sends staff on appropriate training and undertakes a number of Quality Assurance activities as well as making appropriate referrals.

The service was subject to a full inspection in August and achieved a 'Good' rating.

Effective Prevention

The National Probation Service engages in joint working with other agencies through Multi Agency Public Protection Arrangements (MAPPA), Multi Agency Risk Assessment Conferences (MARAC), Stalking Clinics and Professionals Meetings. Staff seek to support victims and perpetrators in order to reduce safeguarding concerns.

Appropriate use of recall, licence variation conditions and breach of community orders support prevention and safeguarding.

Effective Safeguarding

National Probation Service staff work to support vulnerable victims of crime and to seek to reduce the risks of serious harm by perpetrators by use of one to one work and appropriate group interventions while recognising that some of these adults may have dual roles of perpetrator and victim.

Staff make referrals into the local authority Adult Safeguarding team in relation to adults they are working with and engage in joint working and use of Care Act referrals.

Effective Learning

The National Probation Service cooperates fully with the Safeguarding Adult Review (SAR) procedures in relation to known offenders, sits on panels and implements learning from all SAR's.

Staff undertake training in Domestic Abuse and Safeguarding – the majority of staff have completed this training.

Following a Domestic Homicide Review a Domestic Abuse audit was led by Dorset Community Safety Partnership. The outcomes are applicable Pan Dorset and demonstrated an excellent engagement and risk assessment / service delivery to Domestic Abuse perpetrators and victims within the National Probation Service.

Effective Governance

Senior management from the National Probation Service contribute to various Pan Dorset boards which seek to support adult safeguarding including MAPPA, Domestic Abuse and Sexual Violence Strategy Group, Children's Safeguarding and Community Safety and Criminal Justice Strategy Group. The Head of Service in Dorset seeks to ensure full engagement and integration across the various boards to support linked up thinking and deliver statutory responsibilities.

APPENDIX 2 – CASE STUDY AND FEEDBACK

One of the Board's strategic priorities for 2018-19 was to reduce the instances of people with care and support needs being involved in Domestic Abuse and improve the interface between Domestic Abuse and Safeguarding.

As previously mentioned in this report an audit of cases where adults with learning disabilities were experiencing domestic abuse was carried out in February and further work is ongoing to arrange workshops for practitioners.

The case study below is an example of an adult with a learning disability who found herself in an abusive marriage. Some of the multiagency approach to her case is outlined below. Some details have been changed to maintain confidentiality.

Karen is a woman with a learning disability who has been married for 2 years to Tom.

Karen confided in Adult Social Care staff that she was a victim of domestic abuse, following this she was supported to contact the police.

A DASH* risk assessment was completed and referral made to a refuge as her husband refused to leave their home.

The case was considered at MARAC and a Domestic Abuse Adviser was appointed.

Karen spent several weeks staying in the refuge, during this time Adult Social Care liaised with the refuge staff.

Karen was supported in contacting a solicitor about her case and a non-molestation order was put in place. Her husband Tom was convicted of sending abusive messages.

Adult Social Care worked with housing management to move Tom out of their home. With support from a housing officer Karen was able to return home. She felt safer with the non-molestation order in place.

Liaison was undertaken with Community Learning Disability Team and the local authority Finance department who were appointee for Karen's benefits.

*Domestic Abuse, Stalking and Honour-based violence

On a personal note, can I express my gratitude on behalf of my wife and myself for the support you have provided to my father-in-law recently. Your support has given him the confidence to speak openly about his current care arrangements.

The family have thanked the social worker for her role in resolving a serious family issue, and have complimented her on this positive outcome due to her interventions. Thank you for your good work!"

Bournemouth

Praising all the hard work and skilled interventions you have been involved with on a joint case.

I want to contact you and thank you again for a really interesting session... The students seemed really engaged and interested in both the presentation and case study, and I noticed you both had students wanting to continue to discuss things at the end of the session with you...I need to acknowledge it is not easy engaging a group of students on a Monday afternoon and I really appreciate the enthusiasm and humility you both brought to a challenging session. This fits well with their other unit on risk and complexity too.

My sincere thanks to you all for the help you have given me ...a few weeks ago I joined the exercise class at the care home which has been most enjoyable. I have now registered with a home care company. Things are looking much brighter now thanks to your sympathy and understanding of my situation and the advice and help you have given.

'I have been extremely impressed by Poole Adult Services' attentiveness and professionalism throughout my wife's time in care. 'We find it [the DoLS process] to have been satisfactory and helpful.'

Poole

I think every visitor, visit, phone call from this department has been really excellent. No-one has been hasty or disinterested and I praise everyone who has visited or written to me.

I just wanted to say a big, big, thank you for your help as following your assistance and the advice from the social worker we have been referred by the GP, seen the Adult CMHT and received a diagnosis with an action plan. We are really happy with the support we are now receiving. Until your help we were stuck in the system and going nowhere and your perseverance in getting us an answer is really appreciated. Please, if appropriate, feel free to pass this onto your manager/team. You made a real difference.

Photos from the Emergency Services Day in Bournemouth and a Partners in Care Conference.

APPENDIX 3 – SAFEGUARDING POSTERS

Below are the posters used by the Safeguarding Boards. These will be updated for the 2018-19 year with the contact details of the new local authorities. A print run in some of the most commonly used foreign languages is also planned.

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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Report subject	**Mental Health Rehabilitation Report**
Meeting date	2 September 2019
Status	Public Report
Executive summary	Executive Summary: Dorset Clinical Commissioning Group and Dorset HealthCare carried out a review of Mental Health (MH) Rehabilitation services. MH Rehabilitation (Rehab) provision is for people who have severe enduring mental illness and usually a range of other complex issues. The review was fully co-produced from the outset with Dorset Mental Health Forum, Local Authorities including people from housing and social care such as integrated managers and other stakeholders that have an interest in mental health rehabilitation and complex care pathways such as homelessness and mental health assertive outreach. The case for change is that people who require rehab or complex care should be able to: • Access the support and treatment required in in the community where possible and in hospital when necessary • Have a much better experience of treatment and support in community settings with much better outcomes • Avoid being placed out of area in hospital for longer than necessary and in turn losing contact with people and communities • Access treatment and ongoing support in a variety of different settings in the community The proposals are anticipated to provide benefits through: • Reduced number out of area placements • Better use of in county inpatient facilities with shorter admissions and

	• Appropriate exit routes into a range of accommodation • Blended model of bed provision more cost effective than just NHS bed provision The review is being done in stages and thus far stages one and two are complete. The plan is to move in to the assurance stage and public consultation if required. 1. Needs analysis and View seeking 2. Modelling 3. NHS Assurance 4. Consultation (if required) 5. Implementation The coproduction groups agreed the project objectives, critical success factors and constraints. The proposed model for MH Rehab, which does align with the national direction of travel is described below: • High Dependency Unit (70% male 30% female) • Community Rehab Units (one east and one west) • Community Team: including a Community Rehab Team, Assertive Outreach • Supported Living/Housing/residential care There are several possibilities in terms of how these components can be configured. The proposal is for a blended model that is delivered by a mix of NHS and Third sector providers which means the proposal includes using non NHS providers to deliver some of the bed spaces or accommodation units.
Recommendations	HOSC is asked to approve the paper and the review findings and to provide a recommendation concerning the need for public consultation.
Reason for recommendations	The reason for the recommendation are: • The project is in a position to move to the next stage

	• NHSE Assurance requires advice and support from HOSC

Portfolio Holder(s):	Councillor Lesley Dedman
Corporate Director	Jan Thurgood - Corporate Director for Adult Social Care
Contributors	Dorset HeatlhCare – Colin Hicks
Wards	All BCP Council areas
Classification	For Information and advice

Background

1. Introduction

1.1 Dorset Clinical Commissioning Group (CCG) and Dorset HealthCare (DHC) have carried out a review of Mental Health (MH) Rehabilitation and Assertive Outreach (AOT). Rehabilitation (Rehab) and AOT provision is for people who have severe enduring mental illness. The review has been co-produced from the outset with Dorset Mental Health Forum (DMHF), Local Authorities and other stakeholders that have an interest in mental health rehabilitation and complex care pathways such as homelessness and mental health assertive outreach.

1.2 The strategic context is the NHS Long Term Plan which highlights MH rehabilitation services and the need for community options plus ensuring that people who experience severe enduring mental illness are able to have the kind of life they want including work and leisure. This is framed by the national NHS mandate which outlines the objectives for the NHS as a whole:

- Preventing people from dying early
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

1.3 The proposals will ensure improvement in the care and support of people who have long term mental health needs. The changes will mean access to treatment and support in the community rather than hospital as well as ensuring that when hospital is needed it is available to them. In addition the case for change is that people who require rehab or complex care should be able to:

- Access the support and treatment required in settings other than inpatient units
- Have a much better experience of treatment and support in community settings with much better outcomes
- Avoid being placed out of area
- Avoid losing contact with people, families and communities and avoid spending more time in hospital than is absolutely necessary
- Access treatment and ongoing support in a variety of settings in the community

Proposals are anticipated to provide benefits through:

- Reduced number out of area placements
- Better use of in county inpatient facilities with shorter admissions and appropriate exit routes into a range of accommodation
- Blended model of bed provision that is more cost effective

2 Background

2.1 Dorset CCG is committed to reviewing and transforming all mental health services across the Integrated Care System (ICS) to improve mental health care for people who need to use mental health services. The Mental Health Rehabilitation Service is a key element of delivering against that commitment.

2.2 The Rehab review has been led by Dorset HealthCare, Dorset CCG and Dorset MH Forum as part of the programme of transformational work. The governance of the project sits with the MH Integrated Programme Board (MH-IPB) which has oversight of all the programmes of transformational work and the MH-IPB feeds up to the Integrated Community and Primary Care Services Portfolio Board.

2.3 The CCG's mental health commissioning team and Dorset HealthCare teams are working together with Dorset Mental Health Forum and the partners in the review share the responsibility for the design and delivery of the review and form the core part of the project team.

2.4 The review's objectives are to improve services for people who currently access the Inpatient rehabilitation services and the Assertive Outreach Teams and to plan the future delivery of this complex care pathway.

2.5 The Homeless Health Service was originally in scope of the review but it was decided that the homeless health offer needs much more focussed attention and in the context of other homelessness and housing work, such as the development of new housing and homelessness strategies in Dorset Council and BCP Council. It is however noted that a number of clients who are homeless would meet the criteria for MH Rehab and AOT.

2.6 Currently all MH rehab is carried out in Inpatient settings. Rehab in inpatient settings on their own are not reflective of the national direction of travel for MH

Rehab. Community rehabilitation and assertive outreach models are much more central to the way the services are to be delivered in the future.

2.7 Inpatient facilities are to part of a whole pathway and will help support people who require containment and treatment in a safe, calming inpatient setting but only as required and not the default place.

2.8 The aim is to provide MH Rehab in the most appropriate place possible for the individual and for some that will be in hospital for a time and for others Rehab and or other long-term support will be provided in the community by community teams.

2.9 The review is being carried out using a tried and tested format and has the following stages:

- Stage 1 Needs analysis,
- Stage 2 View seeking,
- Stage 3 Model development,
- Stage 4 Assurance and consultation
- Stage 5 Implementation.

2.10 Helen Killaspy described rehab as:

"A whole system approach to recovery from mental ill health which maximises an individual`s quality of life and social inclusion; done by encouraging skills, promoting independence and autonomy in order to give them hope for the future and which leads to successful community living through appropriate support" *(Killaspy et al., 2005)*

2.11 Through coproduction the outputs of the review are in line with the above statement and described below:

i. The development of a clinically informed pan Dorset rehabilitation and complex care pathway that easily connects with the Mental Health Acute Care Pathway and other parts of the system:

ii. The dynamic and responsive commissioning of an effective mental health rehabilitation and complex care pathway to improve physical, mental health and social outcomes for people who have or who are at risk of becoming seriously mentally unwell.

3 Project stages

3.1 The services in scope of the rehabilitation review project are listed below:

- Inpatient units; Nightingale Court, Nightingale House and the Glendinning Unit

- The Assertive outreach teams (AOT)
- The Out of Area Locked Rehabilitation

3.2 **Stage 1. Needs analysis** designed and delivered by CCG and Dorset HealthCare and including Public Health and other national and local data. The high level themes are described below:

- There is rising demand and current services are not set up in the right way to manage the demand in the least restrictive, recovery focussed way.

- There is little community provision and few supported housing options at the moment, which leave inpatient services being the primary rehabilitation and complex care option.

- It is likely with targeted reshaping of the current services that the offer for people who require ongoing rehabilitation or assertive support could be improved and enhanced.

- The percentage prevalence of SMI is not expected to change for the foreseeable future however there is anticipated population growth and so the SMI register numbers will proportionately increase.

3.3 **Stage 2. View-seeking** led by Dorset HealthCare in partnership with Dorset CCG, Dorset Mental Health Forum and the local authorities. There were in total 144 people that participated and contributed 156 different views. All views were compiled into a thematic analysis report. The high level themes are described below:

- Mental health issues don't stop at the weekend;

- No one talks about me leaving here;

- Being in hospital for a long time doesn't help;

- Continued support for people who have been inpatients when they leave hospital should include support for getting involved with community activities, paying bills and budgeting, planning GP, outpatient appointments, house hold tasks and volunteer/employment assistance;

- Staff are a good team and are genuinely caring and supportive;

- AOT is quick to help me with housing, always on time for my visits and always turn up. Wouldn't ever have had CBT if not under the team;

- Being in the service makes access to other help i.e. drug and alcohol services easier;

- Encouraged to be more independent to adjust to life outside.

3.4 **Stage 3. Coproduced modelling** of the new pathway and the options for its achievement from the design of the project to the delivery of the modelling work. The coproduction was between people who have lived experience of mental illness and of using services and staff including team managers and clinicians.

3.5 The modelling and shortlisting work was carried out over approximately 8 sessions over approximately 9 months. In all there were 13 events. The project team consisted of approximately 20 people and the stakeholder sessions involved up to 65 people approximately. They represented housing and social care from the LA, other third sector and voluntary organisations, also people using services were represented. The measured approach enabled background activity such as detailed modelling and costing to be done in the background and between each session. The sessions are described below:

Project Meetings	
Project team meetings consisting of staff, managers, service user representation	4
Wider stakeholder events including the local authorities, housing and mental health providers and services user. This group sense checked the project team's work and enhanced it	4
Staff engagement events for any one working in any of the services in scope	2
Shortlisting event involving the project team and then sense checked in a wider stakeholder meeting	1
DHC Facilitated session to agree the pathways vision including project team	1
Cross checking with people who use services. This was tailored to the individuals so each person may have been seen more than once.	

3.6 In January 2019 the final stakeholder sessions took place and shortlisting finished with a preferred way forward being clearly identified. Following the stakeholder session further modelling and costing work was carried out. The output of that work will form a significant part of the Strategic Outline Case (SOC) which is near to being finalised. It was presented to the project group in the week commencing the 26th August 2019.

3.7 Crosschecking with patients and their carers enabled them to comment on the proposals. It was important that people who use services were able to comment on the proposed model and for them to see how their initial views and comments

helped to shape the new model: The following provides a snapshot of cross check comments: A full report summarising all the cross check views will be completed by Bournemouth University Market Research department and presented along with the SOC but the following are a flavour of some of the comments:

- The community rehab team development is welcome because people said that their rehab should be continued outside of hospital
- A team that follows them into different types of accommodation settings is viewed positively
- The reduction in Out of Area placements is seen as good especially by people who had been required to travel miles to visit the people they care for.

4 Model Options

4.1 The coproduction process addressed several questions about what a good rehab/complex care pathway would look like. The coproduction groups agreed objectives, the critical success factors and constraints and came up with a proposal for what services should be included in rehab/complex care pathway and these broadly align with national guidance and general direction of travel for complex care pathways. The following components were agreed from a long list:

- High Dependency Unit (70% male 30% female)
- Community Rehab Units (one east and west of the county)
- Community Team: including a Community Rehab Team, Assertive Outreach teams
- Supported Living/Housing/residential care

4.2 There are several possibilities in terms of how these components can be configured. The proposal is for a blended model that is delivered by a mix of NHS and Third sector providers.

4.3 There are examples across the country where services are delivered in this way by NHS and third sector providers working in partnership. The aim is to support people in the least restrictive setting. The benefits of the approach are:

- More options for rehabilitation and other support in the community
- Additional resources funded by CCG available in the community such as the Community Rehab Team and enhanced AOT.
- The introduction of additional community resources will enable support to be provided to people in already existing support services such as supported housing provision or registered care.

- Recovery and strengths focussed treatment and support at home rather than in hospital where ever possible.

- Repatriation of people currently placed out of area. The general principle to be applied as soon as the pathway is implemented is that out of area placements will not be used unless there are exceptional clinical reasons.

4.4 The proposed pathway will ensure where possible, that people who present with a complex range of needs are:

- Supported to have the life they want to live in a place they want to live

- Able to live as independently as possible

- Able to live outside of hospital settings

- Supported in the least restrictive way possible

4.5 The preferred option is for a blended model of service provision. The blend being between NHS and third sector organisations. The modelling in relation to bed numbers and potential level of blend between NHS and other providers has been carried out using predictive tools and by looking at actual demand and use of the current service. As part of the review the project team also carried out a patient review.

4.6 All patients in all inpatient settings were reviewed to understand who a) might have benefited from rehab and b) might have not required a hospital admission were a community Rehab team in place. This patient review is being validated and the findings will be compared with the estimated numbers. This validation work will help to determine the final level of investment required and optimal level of the blended mix of beds.

4.7 The current investment in mental health rehabilitation and complex care is shown in the table below and is one of the constraints of the project.

Service	Total Budget (£)
AOT	289,378
AOT Weymouth	220,815
Glendinning	535,156
Nightingale Court	668,615
Nightingale House	1,038,353

Out of area	1,800,000
	4,552,317

4.8 The modelling and pricing has been done as far as possible within the existing budget.

4.9 The costs will be based on the modelling work and will be finalised for the Strategic Outline Case. The anticipated outcome though is additional investment into services for this client group. It is likely that these service improvements will be funded largely through the NHS Mental Health investment standard.

4.10 The implications of developing this model are:

- One less NHS bed (the bed numbers are described in table below)
- More beds/accommodation overall
- Changes to the existing units to enable reconfiguration
- Additional community resources in the Community Rehab Team and enhanced Assertive Outreach Teams.

Current 38 NHS Beds	Future Model
Glendinning Unit (9)	14 Bed HDU
Nightingale Court (13)	9 Beds west and
Nightingale House (16)	14 beds east
	20 Supported Housing Units
38 in total	**57 in total**

5. Interdependencies

5.1 There is an interdependency with Dorset HealthCare estates review: Dorset HealthCare is looking strategically at all their estate in relation to the amount and quality and particularly in relation to all the transformational work that has arisen from the MH Acute Care Pathway Review (ACP) and other transformation programmes and CQC requirements. The changes include:

- 12 new MH Acute beds at St Ann's
- 15 beds moving to St Ann's from the Linden Unit.
- Relocation and development of the perinatal service (proposed expansion to 8 beds)
- The development of a female low secure ward (currently Twynham low secure is male only)
- Children and young people's Psychiatric Intensive Care Unit being planned.

- CQC require patients to have single rooms and in one rehab unit there are shared rooms and this will have to be addressed.

5.2 The programme of work linked to the estates review has implications for the rehab provision but not for the review itself. The estates work does not pre-empt the outcomes of the review.

6 Conclusion and recommendation

6.1 The preferred model of mental health rehabilitation is to be much more community focus with inpatient provision being part of the whole pathway rather than the pathway. The beds provided will be the right number to meet the needs of the Dorset population but will be delivered by a mix of NHS and other providers.

6.2 A Strategic Outline Business Case is being developed to support the NHSE Assurance processes. The SOC will be presented to HOSC as required.

6.2 The NHS Assurance will follow on from the HOSC meetings in Dorset and Bournemouth, Christchurch and Poole. It will be done in this order because NHSE values and relies on the view of the HOSC in relation to the review's robustness and future consultation requirements.

6.3 In preparation for NHSE assurance and possible consultation it is also the intention to develop the housing options with LA colleagues and local developers, landlords and providers to ensure a mix of accommodation that meets the proposed model requirements and adds to the already existing provision and enhances those services.

6.4 The recommendations are that:

I. HOSC endorses the review findings and proposals to develop a more community based Rehab model of care
II. HOSC supports the intention to go through NHS Assurance with the proposed model including the proposed bed changes
III. HOSC makes a recommendation about the need for public consultation on the proposals in the paper

Summary of financial implications

The financial implications are mostly to the Clinical Commissioning Group however there may be some implications related to community placements and Section 117 funding. This will not be additional numbers of people but will be due to shorter admissions and placement in the community.

That said it is important to note that the rehab clients are not new people in to the BCP area and health and social care system. They are existing patients who are in hospital for a time but returning to their own or supported accommodation settings and this will need funding through section 117.

Summary of legal implications

There are no legal implications

Summary of human resources implications

There are no HR implications for BCP

Summary of environmental impact

NA

Summary of public health implications

NA

Summary of equality implications

The outcomes of the review will improve the range and quality of treatment and support for anyone who has a serious mental illness who requires NHS mental health rehabilitation or assertive outreach.

Summary of risk assessment

NA

Background papers

Mental Health Rehabilitation Needs Analysis and View Seeking Report

Appendices

- Needs analysis
- View seeking thematic analysis report
- PP presentation slides

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Appendix 1

NHS
Dorset
Clinical Commissioning Group

Mental Health Rehabilitation Review

For People with a Serious Mental Illness

Data Needs Analysis

28th August 2018



DOCUMENT TRAIL AND VERSION CONTROL SHEET	
Heading	Review of the Mental Health Rehabilitation Pathway **Mental Health Rehabilitation- Data Needs Analysis**
Project Sponsor	Colin Hicks
Purpose of document	Present an outline and analysis of available data to inform the Mental Health rehabilitation review case for change
Date of document	28th August 2018
Authors	Melissa Scott Julie Brown Elaine Hurll Suzanne Green Lisa Spriggs Melissa Paxton
To be Approved by	Rehabilitation Services project board MH - IPG
Date approved	
Effective from	
Status	For comment
Version	V6.0

1. INTRODUCTION

1.1 NHS Dorset Clinical Comissioning Group (CCG) and Dorset HealthCare NHS University Foundation Trust (Dorset HealthCare, DHC) are undertaking a review of adult mental health rehabilitation services for people with a serious/severe mental illness (SMI) in Dorset, the review focusses upon functional mental illness and excludes organic conditions such as dementia. Serious mental illness includes psychosis, severe depression, bipolar disorder, personality disorder, schizophrenia and schizoaffective disorder.

1.2 This report aims to identify the needs and demand profile of the local population of people who have a SMI and use rehabilitation or complex care pathways. This will enable an evidence based business case to be developed.

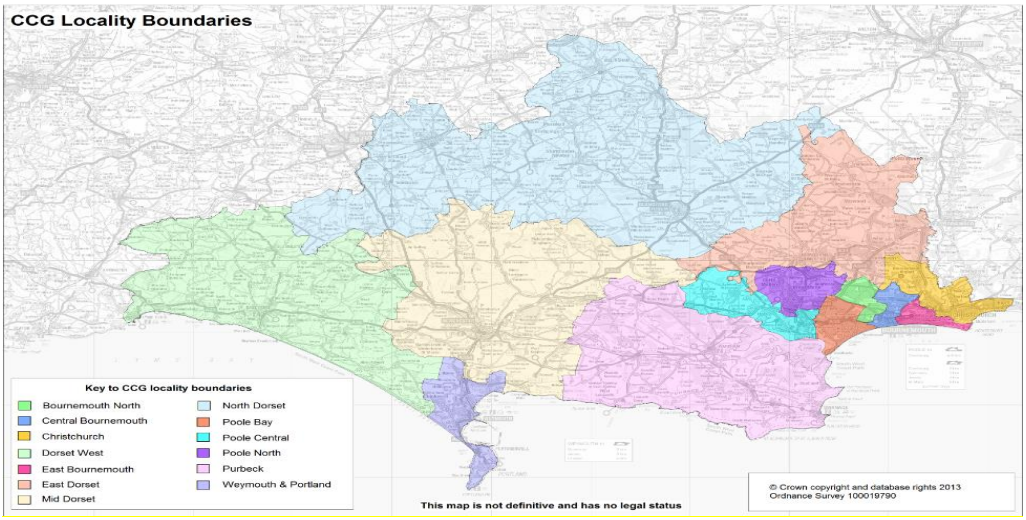
2. DEMOGRAPHIC PROFILE OF DORSET

2.1 Dorset covers an area of 1,024 square miles and is bordered by Devon to the west, Somerset to the south west, Wiltshire to the north-east and Hampshire to the east.

2.2 The county town is Dorchester which is in the south-west of Dorset. The largest urban areas are Poole, Bournemouth, Christchurch and Weymouth & Portland. Around half the population lives in the south east area, while the rest of the county is largely rural with a low population density.

2.3 NHS Dorset Clinical Commissioning Group operates on the basis of a locality model with the geography of Dorset divided into 13 GP localities (Diagram 1 below). All 86 GP practices are sub-grouped into these locality groups (or geographical areas). Each locality has a Locality Chairperson (a local GP), who is also a member of the CCG's Governing Body which ensures CCG decisions are clinically-led.

Diagram 1. Dorset CCG GP localities



2.4 The county of Dorset has a resident population of 776,304 (all ages) and is served by three local authorities comprising the Borough of Poole (151,300, 19.7% of pan Dorset population), Bournemouth Borough Council (194,800, 25.7% of the pan Dorset population) and Dorset County Council (424,700, 54.6% of the pan Dorset population). To note the councils are due to merge into 2 unitary authorities during 2019. (ONS mid -year population 2017)

2.5 Table 1 below indicates the Dorset Registered GP Practice Populations (December 2017), accessed from NHS digital (2018).

Table 1. Dorset Registered GP Population

		Male					Female						
Urban/Rural	CCG Locality	0-17 yrs	18-64 yrs	65+ yrs	Total (18+ yrs)	Total (All ages)	0-17 yrs	18-64 yrs	65+ yrs	Total (18+ yrs)	Total (All ages)	Grand Total (18+ yrs)	Grand Total (All ages)
Urban	Bournemouth North	5,409	22,445	5,108	27,553	32,962	5,123	22,560	6,085	28,645	33,768	56,198	66,730
	Central Bournemouth	6,025	19,583	4,368	23,951	29,976	5,642	18,714	5,244	23,958	29,600	47,909	59,576
	Christchurch	4,726	14,438	7,562	22,000	26,726	4,372	14,327	9,350	23,677	28,049	45,677	54,775
	East Bournemouth	6,692	25,555	6,053	31,608	38,300	6,593	22,841	7,146	29,987	36,580	61,595	74,880
	Poole Bay	6,625	23,467	7,713	31,180	37,805	6,120	22,096	9,242	31,338	37,458	62,518	75,263
	Poole Central	6,090	18,889	6,109	24,998	31,088	5,829	18,949	7,335	26,284	32,113	51,282	63,201
	Poole North	5,172	15,272	5,613	20,885	26,057	4,953	15,441	6,639	22,080	27,033	42,965	53,090
	Weymouth & Portland	6,883	21,819	8,665	30,484	37,367	6,687	21,609	9,933	31,542	38,229	62,026	75,596
Urban Total		**47,622**	**161,468**	**51,191**	**212,659**	**260,281**	**45,319**	**156,537**	**60,974**	**217,511**	**262,830**	**430,170**	**523,111**
Rural	East Dorset	6,342	18,061	9,777	27,838	34,180	6,120	18,405	11,684	30,089	36,209	57,927	70,389
	Mid Dorset	4,145	12,341	5,371	17,712	21,857	3,875	12,456	6,424	18,880	22,755	36,592	44,612
	North Dorset	8,700	22,959	10,560	33,519	42,219	8,527	23,752	12,519	36,271	44,798	69,790	87,017
	Dorset West	3,299	10,481	6,231	16,712	20,011	3,120	11,061	7,048	18,109	21,229	34,821	41,240
	Purbeck	2,847	9,315	4,744	14,059	16,906	2,668	9,336	5,425	14,761	17,429	28,820	34,335
Rural Total		**25,333**	**73,157**	**36,683**	**109,840**	**135,173**	**24,310**	**75,010**	**43,100**	**118,110**	**142,420**	**227,950**	**277,593**
Grand Total		**72,955**	**234,625**	**87,874**	**322,499**	**395,454**	**69,629**	**231,547**	**104,074**	**335,621**	**405,250**	**658,120**	**800,704**

2.6 The population table above illustrates that approximately 35% of the population are located in the rural areas of Dorset and 65% are in the urban areas, primarily in Poole and Bournemouth. This broadly reflects the rest of the country.

2.7 It must be highlighted that there is no singular definition of rurality but rather a number of different approaches to it. This encompasses spatial classification (based on population density, distance to cities and urban centres); a socio economic classification (based upon principle forms of employment in an area) and more complex definitions combining both of the above. (Nicholson, 2008 in Advances in psychiatric treatment).

2.8 Table 2 below is the predicted Bournemouth, Poole and Dorset local authority (LA) adult resident population figures taken from Office National Statistics (2018).

Table 2. Predicted Adult Local Authority Population

Local Authority	Age Group	2016	2018	2023	2026
Bournemouth	18-64	123,220	124,844	126,193	127,708
	65+	35,121	35,705	38,372	40,739
Bournemouth Total		**158,341**	**160,549**	**164,565**	**168,447**
Poole	18-64	87,093	87,101	86,812	86,815
	65+	33,438	34,182	36,422	38,272
Poole Total		**120,531**	**121,283**	**123,234**	**125,087**
Dorset	18-64	226,076	224,983	221,802	220,038
	65+	119,700	123,546	134,210	141,904
Dorset Total		**345,776**	**348,529**	**356,012**	**361,942**
Pan Dorset	18-64	436,389	436,927	434,807	434,561
	65+	188,259	193,433	209,004	220,915
Pan Dorset Total		**624,648**	**630,360**	**643,811**	**655,476**

Data source - ONS, Population projections - local authorities SNPP Z1 (May 2018)

There is a predicted 4.9% increase in the overall Pan Dorset adult population year on year from 2016 to 2026. This increase is almost exclusively in the over 65 age group. The 18 to 64-year-old age group population is expected to reduce slightly within Poole and Dorset local authorities from 2019.

2.9 Projected changes to the population profile of the county are not expected to alter the existing prevalence of serious mental illness locally but there will be a slight increase in numbers of people potentially requiring services in line with the overall growth.

3. LOCAL CONTEXT

3.1 Table 3 below shows the current prevalence and projected prevalence increase in Dorset for people with a serious/severe mental illness.

Table 3. Projected Increase for SMI

	2016/17			2021/22			2026/27		
CCG Locality	Practice List Size	Practice Register SMI	SMI Prevalence	Practice List Size	Practice Register SMI	SMI Prevalence	Practice List Size	Practice Register SMI	SMI Prevalence
Bournemouth North	66,832	627	0.94%	68,437	642	0.94%	70,079	657	0.94%
Central Bournemouth	57,904	612	1.06%	59,294	627	1.06%	60,717	642	1.06%
Christchurch	54,627	399	0.73%	55,939	409	0.73%	57,281	418	0.73%
East Bournemouth	74,312	1,172	1.58%	76,097	1200	1.58%	77,922	1229	1.58%
Poole Bay	74,572	897	1.20%	76,363	919	1.20%	78,195	941	1.20%
Poole Central	62,773	548	0.87%	64,280	561	0.87%	65,822	575	0.87%
Poole North	52,708	418	0.79%	53,974	428	0.79%	55,268	438	0.79%
Weymouth & Portland	75,170	856	1.14%	76,975	877	1.14%	78,822	898	1.14%
Urban Sub-total	**518,898**	**5,529**	**1.07%**	**531,359**	**5,662**	**1.07%**	**544,105**	**5,798**	**1.07%**
East Dorset	69,911	410	0.59%	71,590	420	0.59%	73,307	430	0.59%
Mid Dorset	44,308	373	0.84%	45,372	382	0.84%	46,460	391	0.84%
North Dorset	86,928	648	0.75%	89,015	664	0.75%	91,151	679	0.75%
Dorset West	41,070	444	1.08%	42,056	455	1.08%	43,065	466	1.08%
Purbeck	34,044	293	0.86%	34,862	300	0.86%	35,698	307	0.86%
Rural Sub-total	**276,261**	**2,168**	**0.78%**	**282,895**	**2,220**	**0.78%**	**289,681**	**2,273**	**0.78%**
Grand Total	**795,159**	**7,697**	**0.97%**	**814,254**	**7,882**	**0.97%**	**833,786**	**8,071**	**0.97%**

Population figures for 2021/22 and 2026/27 are based on Dorset CCG population increases taken from ONS, Population projections - CCG SNPP Z2 (May 2018)

Projected SMI practice register figures assume SMI prevalence percentage for each locality remains stable over time

3.2 The table above shows how the current SMI prevalence varies across the county with the highest prevalence in the East Bournemouth CCG locality (1.58%) and the lowest in the East Dorset CCG locality (0.59%). Further analysis by practice shows how SMI prevalence varies significantly within CCG localities. Prevalence is higher in the urban areas of Dorset (1.07%) compared to the rural areas (0.78%) with the exception of West Dorset.

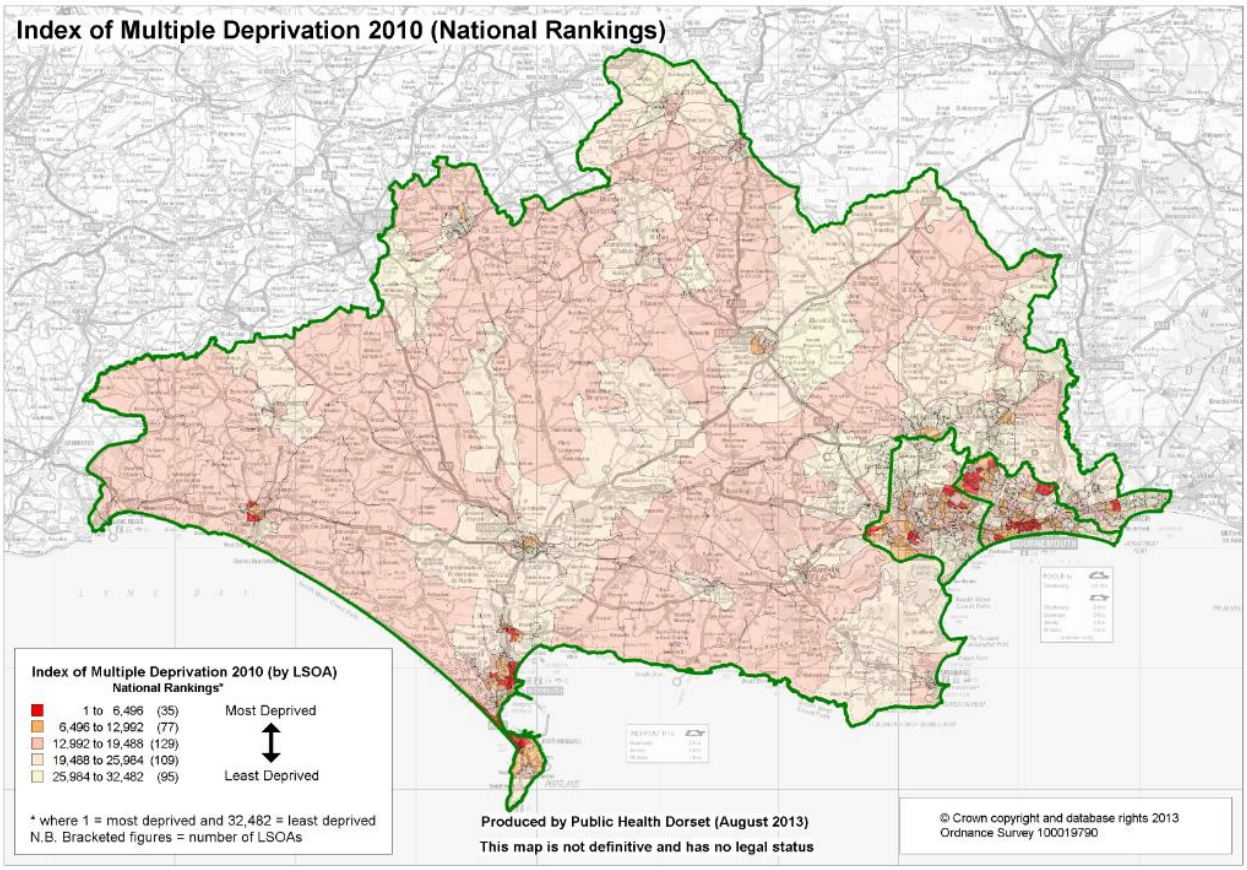
3.3 The table above also shows a projected additional 185 patients (2.4%) on the Dorset CCG SMI practice register between 2016/17 and 2021/22. By 2026/27 an additional 374 patients (4.9%) are expected on the Dorset CCG SMI practice register. The projections are crude and don't take into consideration the age and sex difference in population projections and whether certain groups (age and sex) of people are more likely to experience SMI.

3.4 Public Health England (PHE) has outlined numerous factors to inform local profiles of severe mental illness which link to socioeconomic deprivation: this was recommended to be used as the key determinant of Serious Mental Illness. The Index of Multiple Deprivation (IMD) 2015 is a composite of the following factors and weightings:

- Income (22.5%)
- Employment (22.5%)
- Health and Disability (13.5%)
- Education, Skills and Training (13.5%)
- Barriers to Housing and Services (9.3%)
- Crime (9.3%)
- Living Environment (9.3%)

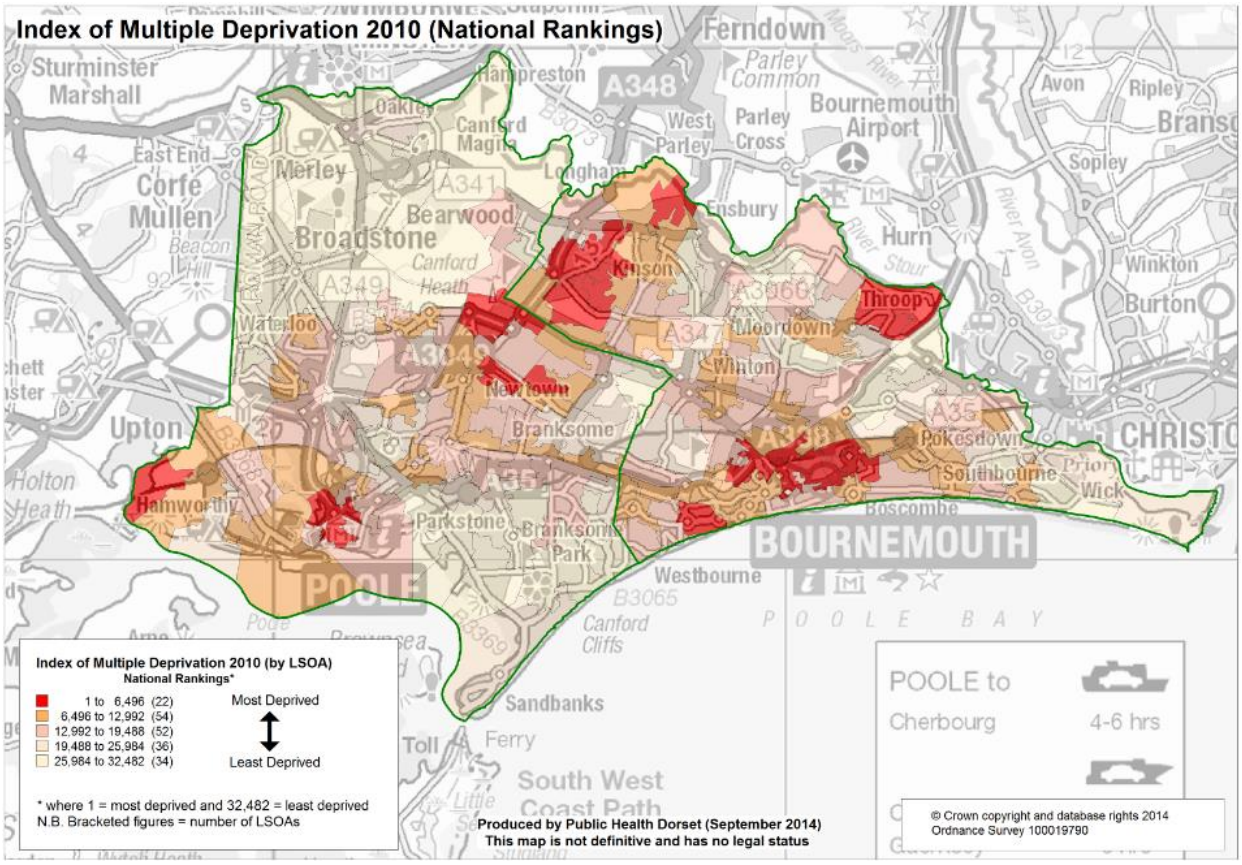
3.5 The maps included below outline Index of Multiple Deprivation (IMD) 2010 national rankings. These demonstrate a wide variance in the levels of deprivation across the geographical boundaries of Dorset CCG ranging from some of the poorest areas in the country to those that are more affluent.

Diagram 2. Multiple Deprivation National Rankings - Dorset



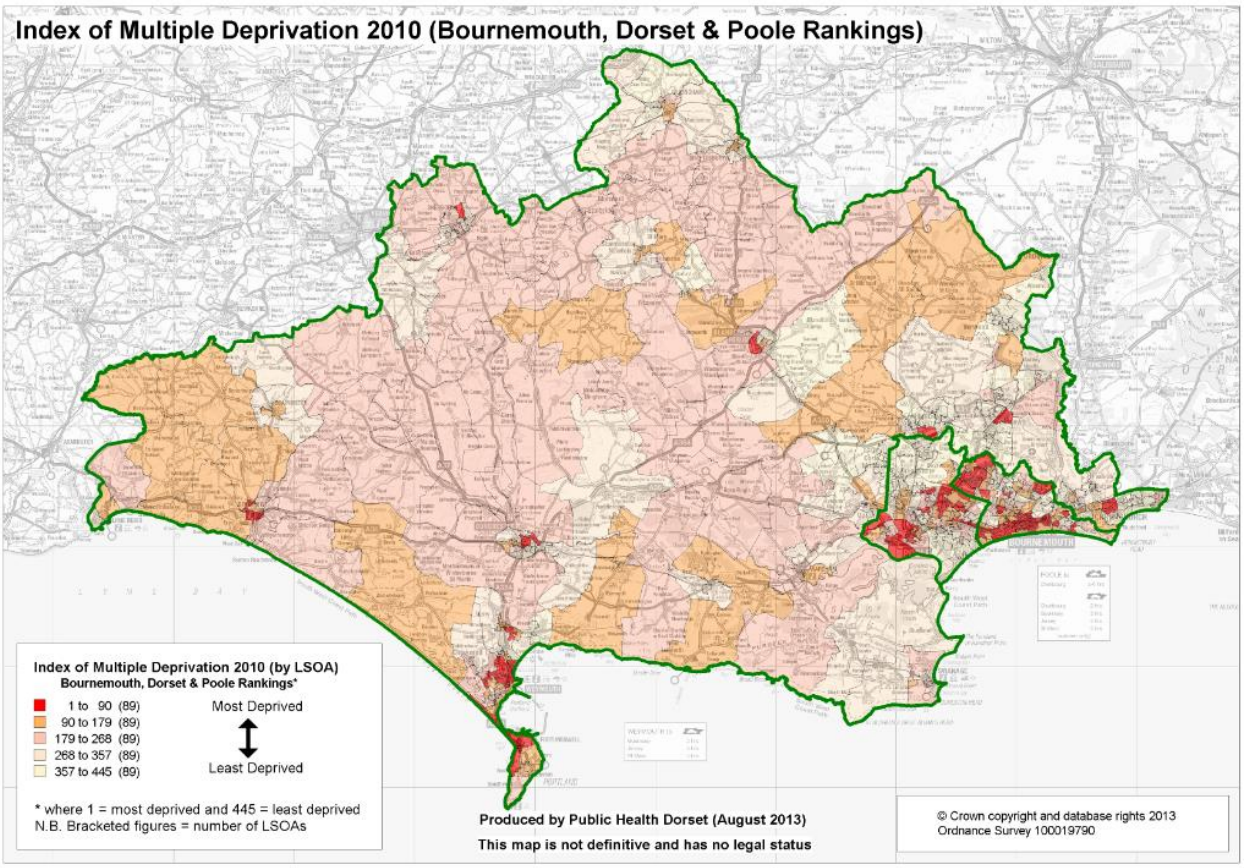
3.6 The maps of deprivation below for Dorset and the Bournemouth and Poole area show differences in deprivation levels in Dorset based on national quintiles (fifths) of the Index of Multiple Deprivation 2010 by area (Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in Dorset. The areas with most significant deprivation are mainly located in the urban areas of Bournemouth, Poole and the Weymouth & Portland locality. There are also some pockets of deprivation in Christchurch and Bridport.

Diagram 3. Multiple Deprivation National Rankings – Bournemouth & Poole



3.7 The map below illustrates a more detailed overview of *relative* deprivation across Dorset. To determine relative deprivation, the level of deprivation in each area is ranked and divided into local quintiles. The relative deprivation shows that in addition to the urban areas, relatively speaking Sherborne, Bridport, Blandford and parts of East Dorset and Dorchester also have relatively high levels of deprivation when compared to other areas in Dorset.

Diagram 4. Multiple Deprivation National Rankings – Lower Support Output Area (LSOA)



Risk Factors

3.8 Mental illness has a huge impact on health and wellbeing. People with mental health problems are more likely to develop significant preventable conditions such as diabetes, heart disease, bowel cancer and breast cancer, and at a younger age (King's Fund, 2014).

3.9 People with severe mental illness on average tend to die earlier than the general population and this is referred to as premature mortality. There is a 10-25-year life expectancy reduction in people with severe mental illness (World Health Organisation, 2013).

3.10 Life expectancy is even lower for people who are homeless with the average life expectancy for males being 47 and female 43 (Crisis, 2011).

3.11 Around 20% of service-users presenting to mental health services for the first time with a psychotic illness will go on to require rehabilitation services and 1% of them may require hospitalisation (Joint Commissioning Panel for Mental Health, 2016). This equates to 1531 people from our current SMI register who may require rehabilitation/assertive approaches to their care and support at times.

3.12 On average people referred to mental health rehabilitation care have been in contact with mental health services for more than 13 years and have had repeated admissions (Care Quality Commission, 2018).

Benchmarking

3.13 The Academic Health Science Network (AHSN) have produced a profile pack for Dorset CCG in year which figures for Dorset were compared with 10 other similar CCGs. Key highlights are outlined below:

- Although there is a need for local interpretation, the data suggests the estimated number of people with a psychotic disorder in NHS Dorset CCG is nearly 20% higher than other areas.
- Over 40% more people subject to the Mental Health Act.
- Dorset CCG has a higher percentage of known service users who have psychosis (30% compared to Wessex average of 26%).
- A greater number of service users with psychosis reach old age.
- Higher than expected proportion of psychosis amongst service users of a minority ethnic background.
- Service users with psychosis in Dorset require three times as many health professional contacts when compared with other mental health conditions.
- 27% of service users with psychosis get admitted to mental health inpatient wards (less than Wessex average of 30%) but stay twice as long in hospital when compared to others

3.14 The NHS Benchmarking Network Inpatient and Community Mental Health Benchmarking Report published in November 2017 shows that in 2016/17 the average length of stay within longer term complex/continuing care beds (excluding leave) for Dorset (covering Dorset HealthCare rehabilitation beds) was 367 days, this is lower than the UK median average of 394 days.

3.15 The benchmarking report also shows that in 2016/17 the bed occupancy within longer term complex/continuing care beds (excluding leave) for Dorset (covering Dorset HealthCare rehabilitation beds) was 94.2%, this is higher than the UK median position of 85.1%. There are contributing factors for the higher percentage bed occupancy for Dorset i.e. accommodating overspill from the acute wards during times of bed pressures.

3.16 The data suggests that, in Dorset the bed occupancy rates are higher than the national average and that people out of area do less well because they are out of area and disconnected from their peers and families and friends. The national drive is not to use out of area placements and that suggests in Dorset we need additional resource in the community to support exit from inpatient services and to make sure that people do not go out of area.

3.17 NICE 2018 highlighted that in areas where there is a lack of local rehabilitation services, people will access 'Out of Area Treatments' (OATS), OATS displace people with severe and enduring mental illness from their communities and families and are 65% more expensive than local placements in England. Around £350 million each year is spent on OATS for people with severe and enduring mental illness. Locally our current spend is approximately £1.5 million.

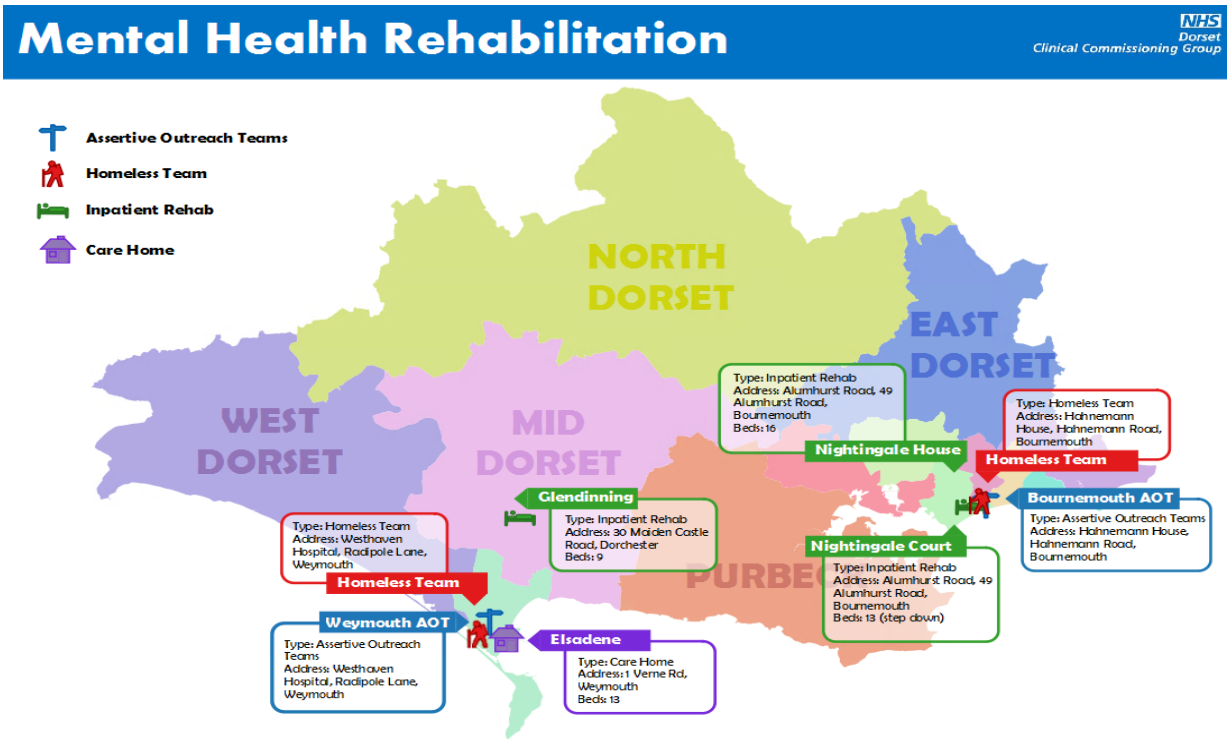
3.18 The Care Quality Commission's March 2018 report and the Joint Commissioning for Mental Health Panel 2016 report suggests mental health rehabilitation highlighted the concern for the recovery of patients receiving treatment away from their home increasing isolation and building links with services that will support them post discharge.

4. CURRENT SERVICE PROVISION

4.1. Dorset HealthCare is the main provider of specialist mental rehabilitation health services across Dorset. The locations of the various services are shown on the map below.

4.2. The mental health rehabilitation services within Dorset have been in existence for many years but have never been fully reviewed.

Diagram 5. Map of Services



4.3. There are four elements considered within the scope of the mental health rehabilitation review and are as follows:

- Residential Rehabilitation Units – Nightingale House located in Westbourne, Nightingale Court located in Westbourne and the Glendinning Unit located in Dorchester.
- Out of area locked rehabilitation placements which are funded through the named patient budget
- The Assertive Outreach Teams located in Weymouth (including Portland), Bournemouth and Poole
- The Homeless Health Service located in Bournemouth and Poole and West Dorset

4.4 For noting:

- Elsadene is a registered care home located in Weymouth that used to be a private hospital that worked with slow stream rehabilitation patients. The care home has been part of the Dorset rehabilitation service provision to date and this was to be considered as part of the review. However, as part of the background work on the review there are contractual issues that need to be resolved outside of the context of this review and is therefore not in scope of the review.

Residential Rehabilitation Services

4.5 **Nightingale House:** Is a 16 bedded mixed sex unit, providing controlled access (not a 'locked' or 'secure' rehabilitation unit) solely for patients with severe complex care needs that do not require acute psychiatric inpatient admission or their needs cannot be met in an open rehabilitation unit. Nightingale house provides high dependency rehabilitation services to clients with active symptoms of psychosis and other related mental health conditions, complex needs and challenging behaviours. The usual aim of treatment is to prepare patients to step down to other rehabilitation services prior to independent or supported living. Patients can be admitted into these beds from a variety of sources, including secure services, and directly from the community with prior assessment.

4.6 **Nightingale Court:** 13 bedded step-down inpatient unit for adults who experience complex, severe and enduring mental illness. A multidisciplinary team comprising of mental health nurses, occupational therapy staff, medics and clinical psychologist work collaboratively to provide a holistic and supportive approach to enable and promote patients on their personal journey of recovery and enhance their quality of life and wellbeing. The patients will often have had previous multiple admissions and unsuccessful discharges from other services and require a longer period of stability to consolidate their recovery and rebuild skills and confidence before moving back out into the community.

4.7 **Glendinning Unit:** 9 bedded rehabilitation unit in Dorchester. The patient group predominantly suffers from psychosis often with other related mental health conditions. The main sources for referrals are from other inpatient settings within Dorset HealthCare. The unit helps people develop strategies for living with their health condition, encourage people to take responsibility to self, enable the building of skills and develop confidence through direct experience. This support includes community integration which is delivered in collaboration with allied health, voluntary and third sector agencies.

4.8 **Table 4.** below illustrates the inpatient data for admission, discharges and length of stay (LOS) for the 3 inpatient mental health rehabilitation units in Dorset.

Table 4 Inpatient rehabilitation unit inpatient data

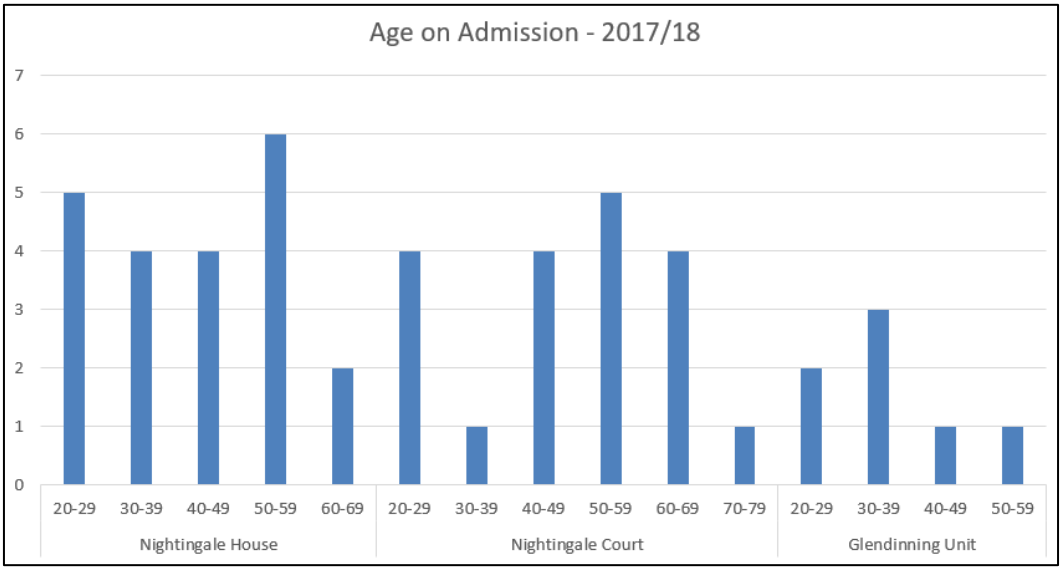
Unit		2015/16	2016/17	2017/18
Nightingale House	Admissions	20	21	21
	Discharges	8	6	11
	Min Length of Stay on Ward (days)	1	0	7
	Max Length of Stay on Ward (days)	1007	692	358
	Avg Length of Stay on Ward (days)	252	233	148
Nightingale Court	Admissions	9	10	19
	Discharges	6	8	11
	Min Length of Stay on Ward (days)	3	0	0
	Max Length of Stay on Ward (days)	945	694	417
	Avg Length of Stay on Ward (days)	514	209	164
Glendinning	Admissions	7	11	7
	Discharges	3	8	4
	Min Length of Stay on Ward (days)	0	2	116
	Max Length of Stay on Ward (days)	714	619	415
	Avg Length of Stay on Ward (days)	275	285	290

4.9 The table above shows admission numbers and length of stay at the three residential rehabilitation units for the past three years. The figures show that admissions are consistent over the 3-year period in Nightingale House and Glendinning Unit however admissions were high in Nightingale Court during 2017/18 compared to the previous two years.

4.10 There is a marked reduction in length of stay at both Nightingale Court and Nightingale House over the 3-year period, however Glendinning remains stable. The average length of stay over 2017/18 across the 3 sites is 200 days.

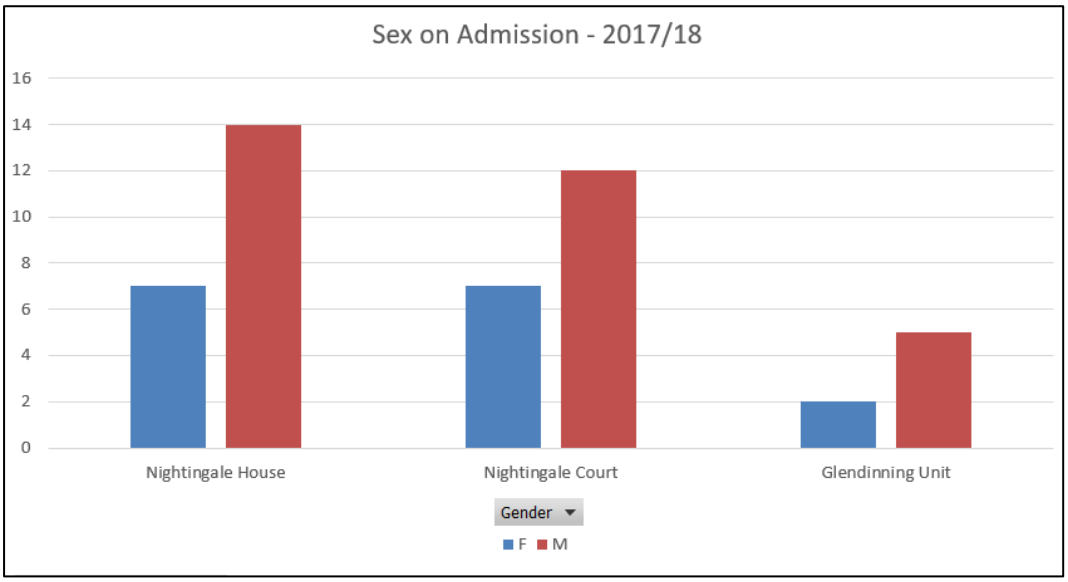
4.11 Graph 1 below shows the age range of patients admitted to a rehabilitation bed during 2017/18. The average age of patients admitted to Nightingale House during 2017/18 was 42.9 years, at Nightingale Court it was 47.8 years and at Glendinning the average age was 36.9 years.

Graph 1. Inpatient Age Range



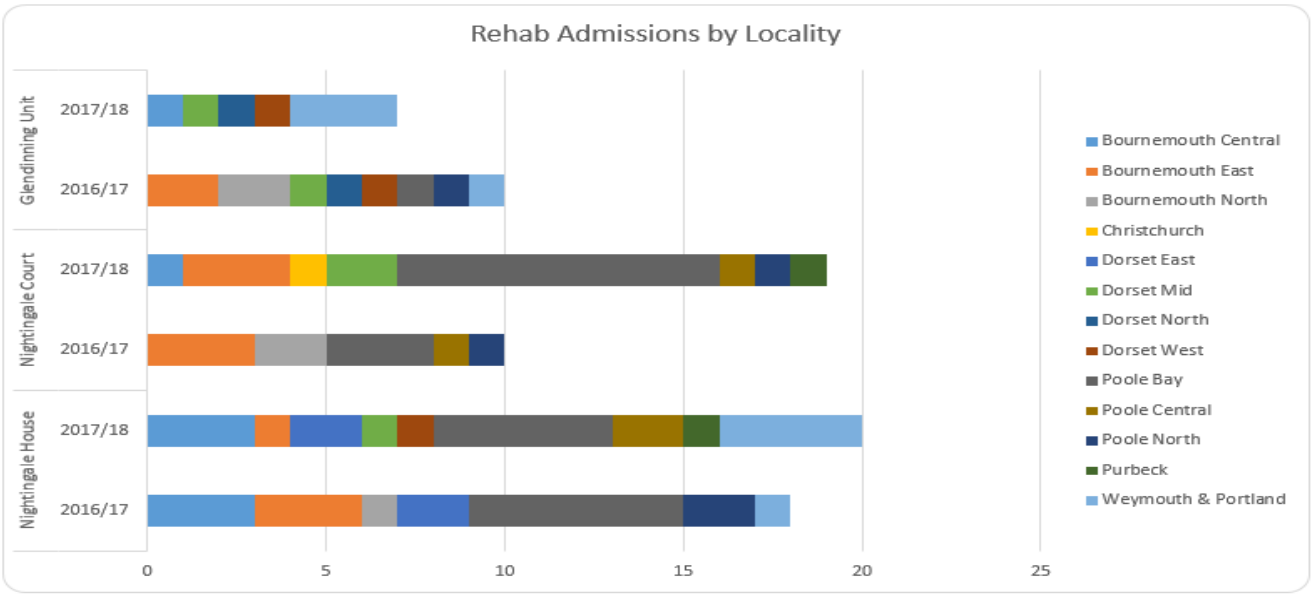
4.12 Graph 2 below shows the number of males and females admitted to the rehabilitation units during 2017/18. Across the rehabilitation service admissions for males were higher than females with 34% of admissions for females and 66% for males. Male admissions were higher within each of the rehabilitation units.

Graph 2. Inpatient Admissions by Sex



4.13 Table 10 is a breakdown of the inpatient admissions at the 3 inpatient rehabilitation units by GP Locality:

Table 10. Rehab Admissions by GP Locality



Source: Mental Health local dataset (RiO)

4.14 The breakdown by locality shows some particular themes; a large proportion of the admissions in the last two years have been from Poole Bay locality. There are also a proportion of the Weymouth & Portland locality utilising East services. Bournemouth Central are showing consistent usage of Nightingale house year on year, whilst Bournemouth East are following a similar pattern but at Nightingale Court. Most of the other localities are remaining fairly static year on year.

Bed Occupancy

4.15 Table 5 below shows a breakdown of the bed occupancy from October 2017 to June 2018.

Table 5. Bed Occupancy Rates

Without home leave

Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
97.0%	96.8%	94.6%	94.7%	89.1%	93.3%	93.8%	95.6%	95.8%

With home leave

Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
100.8%	100.2%	101.6%	99.7%	96.1%	97.8%	97.0%	98.8%	97.8%

4.16 The table above show that the units run to capacity most of the time. It also shows that section 17 leave allows units to use a bed for more than one person i.e. when another patient is on section 17 leave. This indicates units run over capacity as shown between October - December 2017. In addition to this Dorset uses a number of out of area placements because the units in county are running to capacity and has not got a community rehabilitation service. At any time, there is an average of 8 or 9 people in out of area placements.

4.17 Table 7 below shows the community teams that have Care Coordination responsibility for individuals on each unit. The table shows that there is a good spread of teams holding Care coordination responsibility and that the most referrals are from the teams that are in conurbations where psychosis prevalence is generally higher than in the other areas.

Table 7. Care Co-coordinating teams by Ward

Ward	Team	Total
Glendenning Unit	Bridport CMHT	1
	Poole West CMHT	1
	Shaftesbury CMHT	1
	Weymouth Assertive Outreach Team	3
	Weymouth CMHT	2
	Early Intervention Team	1
Glendenning Unit Total		**9**
Nightingale Court	Bournemouth East CMHT	2
	Bournemouth West CMHT	4
	Christchurch & Southbourne CMHT Team	1
	Poole Central CMHT	3
	Shaftesbury CMHT	1
	Bridport CMHT	1
	Early Intervention	1
Nightingale Court Total		**13**
Nightingale House	Bmth & Poole Assertive Outreach Team	4
	Bournemouth East CMHT	1
	Christchurch & Southbourne CMHT	2
	Dorchester CMHT	2
	Bmth West CMHT	1
	Poole Central CMHT	1
	Poole West CMHT	1
	Weymouth CMHT	2
	Wimborne CMHT	1
	Early Intervention Team	1
Nightingale House Total		**16**
Grand Total		**38**

4.18 Table 10 below is a breakdown of the Mental Health Act section status of the current inpatients at the 3 inpatient rehabilitation units.

Table 10. Mental Health Act Section Status – Rehab Inpatient Wards

Section	Glendenning Unit	Nightingale Court	Nightingale House	Grand Total
Informal	3	4	1	7
Section 3 - Admission for treatment	6	9	14	26
Section 37/41	0	0	1	1
Grand Total	**9**	**13**	**16**	**38**

4.19 Table 11 below shows 7 delayed transfers of care (DTOC) for people who are ready to be discharged. There are also 7 people who were delayed between 9 to 89 days from the units. The report indicates that delays are attributable to waiting for placements in the community or packages of care/housing placements.

Delayed discharges/transfers - from June 2017 – June 2018

Table 11. Delayed transfers of care

Applicable Local Authority	Ward	Delay Reason	Total Delayed Days Wait
Weymouth and Portland	Glendenning Unit	Awaiting nursing home placement	22
Bournemouth	Nightingale House	Awaiting care package in own home	89
Bournemouth	Nightingale House	Awaiting further non-acute	25
Bournemouth	Nightingale Court	Patient or Family choice - Community	58
Bournemouth	Nightingale Court	Awaiting public funding	70
Dorset	Nightingale Court	Awaiting further non-acute	9
Weymouth and Portland	Nightingale House	Awaiting care package in own home	33

Out of Area Treatment (OATS)

4.20 Currently Dorset HealthCare has 11 service users placed in out of area locked rehabilitation units. This client group has diverse and complex needs and may have had contact with the criminal justice system. There is no local provision that provides locked rehabilitation and if individuals require out of area locked rehabilitation they are offered services out of area that can accommodate their needs.

4.21 The absence of a dedicated Dorset Community Rehabilitation Services managing out of area placements and actively working towards transitioning individuals back to area is a huge financial and personal cost to individuals placed outside of Dorset.

Assertive Outreach Teams (AOT)

4.22 Assertive Outreach Teams (AOT) are specialist community services and part of secondary mental health. AOT work with adults of working age with serious mental illness and particularly complex needs who require intensive support.

4.23 Services users within the AOT services have multiple needs. This group of services users require a proactive case management approach. Typical AOT clients may have multiple contacts with police and a forensic history, multiple admissions to inpatient units under the mental health act, high levels of substance misuse and limited insight into their illness. Some service users experience homelessness and some may be unable to maintain housing.

4.24 The Assertive Outreach Team operates the following referral criteria:

- A severe and persistent mental illness (i.e. schizophrenia, major affective disorder) associated with a high level of disability.
- A history of frequent use of inpatient or intensive home based care (i.e. more than two admissions or more than 6 months in inpatient care in the past two years).
- Detained under Mental Health Act on at least one occasion in the past 2 yrs.
- Difficulty in maintaining lasting and consenting contact with services.
- Multiple, complex needs including a number of the following:
- History of violence or persistent offending
- Significant risk of persistent self-harm or neglect
- Poor response to previous treatment
- Dual diagnosis of substance misuse and serious mental illness
- Unstable accommodation or homelessness
- Subject to Care Programme Approach (CPA).

4.25 The skill set of the AOT staff centre around the individual to meet their needs and operate a flexible and adaptive approach to engaging with service users. This can include visits being undertaken at a range of locations, supporting with medication compliance, developing life skills, increasing access to opportunities for employment and occupation and monitoring physical health. The current community provision for rehabilitation is partially covered by the Assertive Outreach Teams.

4.26 Dorset HealthCare currently has two Assertive outreach teams that operate differently in each area however cover some rehabilitation work in absence of a defined local service. Table 14 below indicates the Assertive Outreach Team Caseloads and the difference in service provision which provides an unequitable service across the county. Table 14a shows the case load split by gender (this table also included homeless service gender split).

Table 14 Assertive Outreach Team Caseloads

AOT – Bournemouth/Poole	AOT - Weymouth
Caseload: 60	**Caseload: 32**
• Dedicated administrative assistant • Social Workers in team • No Occupational Therapist • No psychology input into the team • No dedicated medic based within the team – use locality medics • Primary referrals from rehabilitation services • Overcapacity	• No dedicated administrative assistant • No Social Workers in the team • Has Occupational Therapist in the team • Has Psychology input to the team • Has dedicated Psychiatrist • Primary referrals from Weymouth CMHT and Glendinning • Overcapacity

4.27 By crude comparison it can be seen that the allocation of workforce resources is not consistent. The professional breakdown with each team also differs by way of whole time equivalent (wte) allocation. It is not clear how individual team workforce profiles have been determined with apparent inconsistencies between ratios of administrative and clinical staff.

Table 14a. Gender split on AOT and Homeless Service caseloads

Team	Males on caseload	Females on caseload	Totals
AOT Bournemouth/Poole	47	12	59
AOT Weymouth	24	8	32
Homeless Health Service	35	9	44

4.28 There are a total of 106 males on the caseloads, 29 females equating to 135 people.

4.29 Medical staffing in the team varies with one team having dedicated medical input and another using a variety of medical input from the Community Mental Health Teams (CMHT).

4.30 There are no AOT teams covering Christchurch, Purbeck, North Dorset, Dorchester or Bridport. Individuals who met the remit for care under an AOT are managed within a generic CMHT.

4.31 Table 15. Below shows the number of contacts and DNAs carried out by the Assertive Outreach Teams. It shows that there are a lot of contacts and a lot of cancelled or DNA appointments especially in the follow up contacts.

Table 15. AOT DNAs

Appointment Type	Appointment Status Description	2015/16	2016/17	2017/18
First	Attended	26	10	35
	Did not attend	9	3	8
	Healthcare Provider Cancelled	8	4	7
	Patient Cancelled	0	0	0
First Total		43	17	50
Follow-up	Attended	5,177	4,920	5,217
	Did not attend	934	926	921
	Healthcare Provider Cancelled	197	187	130
	Patient Cancelled	16	18	20
Follow-up Total		6,324	6,051	6,288
Grand Total		**6,367**	**6,068**	**6,338**

4.32 The table indicates the complexity of the AOT client group where there are a significant numbers of DNA's for offered appointments.

4.33 Table 16 below shows the Assertive Outreach Teams caseloads per annum for each year:

Table 16 AOT caseloads

Team	Gender	2015/16	2016/17	2017/18
AMH Bmth & Poole Assertive Outreach Team	F	18	16	11
	M	50	53	49
AMH Christchurch Assertive Outreach Team	M	3		
AMH Weymouth Assertive Outreach Team	F	9	8	6
	M	24	26	26
Grand Total		**104**	**103**	**92**

4.34 In 2017/18 there were 73 males and 17 females on the AOT caseloads. The caseloads remain consistent with a slight decrease in 2017/18 but it is apparent there are more males than females within the service.

4.35 Table 17 below shows the Assertive Outreach Teams Caseload by cluster. Clusters are defined by an identifier and a description associated for reporting purposes.

Table 17 Assertive Outreach Teams Caseload by cluster

Cluster	Cluster Description	2015/16	2016/17	2017/18
P11	Ongoing recurrent psychosis (low symptoms)	6	8	4
P12	Ongoing/recurrent psychosis (high disability)	7	7	8
P13	Ongoing/recurrent psychosis (high symptom & disability)	14	14	15
P14	Psychotic crisis	2		
P16	Dual diagnosis (substance abuse and mental illness)	32	36	24
P17	Psychosis and affective disorder difficult to engage	40	36	26
P99	Un clustered	2	2	15
Total		**104**	**103**	**92**

4.36 Table 17 above indicates that the majority of the AOT caseload are categorised in clusters P16 and P17. This is what would be expected on an AOT caseload where there are high proportions of clients who present with complex needs including drug use and marginalisation meaning that the team work hard to provide care for clients who often do not wish to be under mental health services. There are also a number of people in other cluster groups and it might be argued that people not in clusters 16 or 17 could be managed by the CMHTs potentially.

4.37 Table 19 below data shows the caseload discharges for the Assertive Outreach Teams.

Table 19 AOT caseload discharges

Caseload Discharges		2016/17	2017/18
Bmth & Poole Assertive Outreach Team	F	2	7
	M	5	10
Bmth & Poole Assertive Outreach Team Total		7	17
Weymouth Assertive Outreach Team	F	1	2
	M	2	4
Weymouth Assertive Outreach Team Total		3	6
Total Discharges		**13**	**23**

4.38 Table 19 above illustrates the higher number of discharges in 17/18 for both teams.

Homeless Health Service

4.39 Dorset HealthCare currently provides a service via Mental Health Practitioners and Nurse Practitioners working across the Bournemouth, Poole and West Dorset Locality to offer access to mental health service assessments and physical health assessments for those who are rough sleeping.

4.40 The Service has an open referral system and anyone can refer to the Homeless Health Service. However, the main referrers are the homeless outreach services. The team accepts referrals from service users who may not have been seen bedded down by the homeless outreach services however are known to be a rough sleeping.

4.41 Staff working within the Homeless Health Service carry out street outreach in an attempt to locate service users and provide health support and advice. The team work closely with the street outreach services to joint work service users. Current provision is as below on table 20.

Table 20. The Homeless Health Team provision for Street Outreach

West Dorset	**Bournemouth and Poole**
Case load: 26	**Case load: 18**
• Full time mental health practitioner • 22.5 hours of Nurse Practitioner • Under capacity • Offers a service under the broad definition of homelessness – rough sleeping, temporary accommodation • Offers a service, consultation and advice to those living in hostel accommodation • No separate commissioned GP in area but single practice with interest in homelessness	• Part time mental health Practitioner covering larger and more populated area with higher prevalence of homelessness • 15 hours Nurse Practitioner in post • Overcapacity • Only offers a service to rough sleepers • No input into hostel units • GP in Boscombe has contract with CCG to provide service to the Homeless

4.42 From the above table inconsistencies can be seen in service provision across the 2 areas. The caseload numbers are higher in West Dorset however this is due to higher staffing levels and are not needs related. It must be noted that homelessness is not just a health issue and for the purposes of this review the focus is on homeless individuals who experience serious mental illness.

4.43 There is no service covering Christchurch, Purbeck or North Dorset. Currently individuals who meet the criteria for the Homeless Health Service are managed within a generic CMHT, within primary care or have access to no services.

4.44 Table 21 below indicates the amount of people rough sleeping broken down by local authority.

Table 21 Street counts and estimates of rough sleeping by local authority district

Local Authority/District	2015	2016	2017	Number of households 2017 ('000)	2017 rough sleeping rate (per 1,000 households)
Bournemouth	47	39	48	90	0.53
Weymouth and Portland	6	11	18	29	0.62
Poole	10	11	13	67	0.19
Christchurch	8	10	5	22	0.22
North Dorset	0	1	3	31	0.10
West Dorset	6	2	2	46	0.04
East Dorset	3	0	1	39	0.03
Purbeck	5	2	1	20	0.05

Data Source - Rough sleeping in England: autumn 2017 (ONS)

Notes - The Autumn rough sleeping counts and estimates were carried out between 1 October and 30 November. A count is a single night snapshot of the number of rough sleepers in a local authority area. An estimate (shown in grey) is the number of people thought to be sleeping rough in a local authority area on any one night in a chosen week.

4.45 Table 21 above shows the number and rate of rough sleeping per 1,000 households for Dorset local authority districts. In 2017 the number of rough sleepers was highest in Bournemouth local authority (estimate of 48). Weymouth and Portland district had the highest rate of rough sleepers per 1,000 households (estimate of 0.62).

4.46 Table 22 and 22a below shows the number of DNAs across mental health services and highlights the homeless services have the highest DNA rate, closely followed by CMHTs and AOT. All three teams are higher than DHC average DNA rates. It is not possible to do a 3 year comparison as data has only been captured in these areas as the team was not created until November 2016. The information below is taken from Business Objects (DHC reporting tool).

Table 22 DNA by the homeless health team

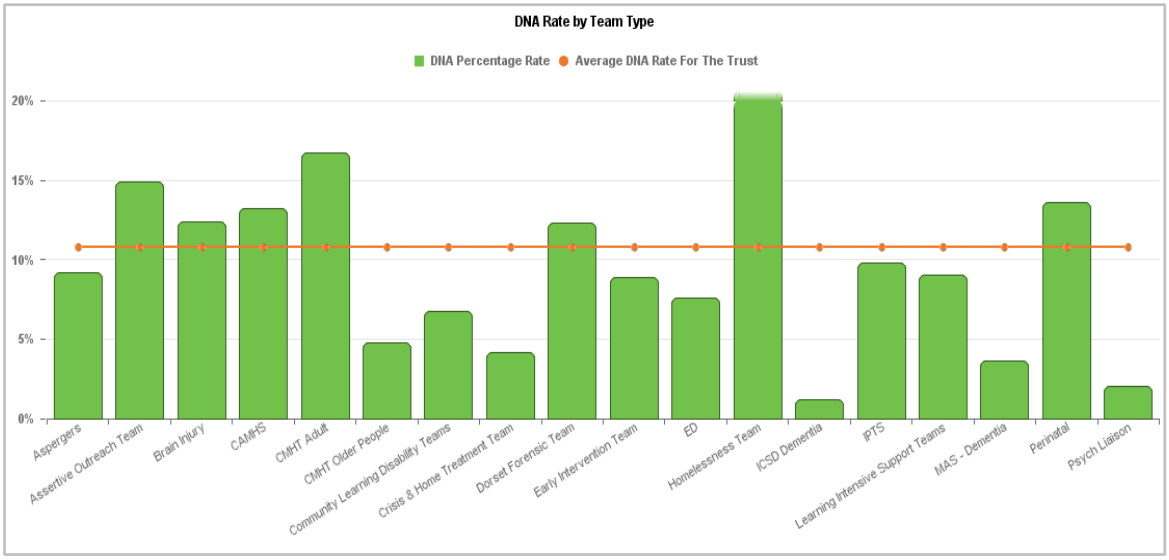
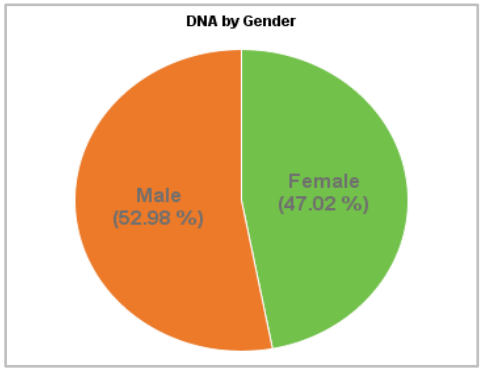


Table 22a – DNA by gender



4.47 Table 22a shows DNA rates by gender across the system and shows that men DNA more than women.

4.48 It should be noted on the homelessness service DNA rates that there is a distinction between did not attend and did not find. The staff assertively look for people sleeping out and if they are not found where they were previously seen sleeping out that cannot be considered to be a DNA.

4.49 Table 23 below shows referral activity for the Nurse Practitioner in Weymouth for 2017/18. Due to a post being only recently being in place for the east of the county there is no comparison to be made for this report.

Table 23 Weymouth Nurse Practitioner referral activity

Weymouth Homeless Service	2017/18
Number of new referrals	32
Number of open referrals	165
Number of contacts	58

4.50 The Nurse Practitioner provides a physical health outreach services to the homeless. The individuals seen do not have to have an SMI and can present with any health need. The role provides assessment and treatment of physical health conditions and supports individuals to access mainstream primary care or secondary care services.

Homeless attendance to A&E

4.51 Homeless people struggle to access health services because they are often asked to provide forms of ID such as proof of address, mobile numbers and addresses. Exclusion from these services puts people's health at further risk, and places additional pressure on emergency and urgent care services to treat illnesses -- some of which are preventable.

4.52 Homeless people are 5 times more likely to attend A+E (Dr Pippa Metcalf, The Royal College of Physicians presentation 2017)

4.53 Table 24 below illustrates the number of Emergency department (ED) attendances by individuals who are homeless over the last 3 years for the main 3 acute hospital providers.

Table 24 ED attendances by acute provider split

Provider		2015/16	2016/17	2017/18
Poole Hospital	Number of Visits	307	310	259
	Number of Individuals	164	127	122
Royal Bournemouth	Number of Visits	568	509	562
	Number of Individuals	267	250	270
Dorset County	Number of Visits	Not available	Not available	110
	Number of Individuals	Not available	Not available	56

Source: Provider data

4.54 This shows there are particularly higher number of homeless individuals attending ED at Royal Bournemouth compared with the other two providers. All three providers are showing that there are multiple re-attendances of the same patients given number of individuals is proportionately half of the number of attendances. For Royal Bournemouth and Poole numbers have stayed fairly static over the 3 years noted.

4.55 From Dorset HealthCare Homeless Health Audit (2017) 37% of those surveyed (155) had attended A+E within the last 12 months.

5. CONCLUSIONS AND SUMMARY ANALYSIS

Future Demand

5.1 Statistics suggest that by 2020/21 the number of people in Dorset forecasted to have a serious mental illness will increase to approximately 7,882. The number of people who may subsequently require rehabilitation (20%) is approximately 1576 and a further 1% (78.82) of people may require inpatient rehabilitation at some time.

5.2 The age of Dorset's population is rising and a greater number with SMI reach older age. This suggests that services need to be all age and not exclusively to adults as the complexity of client group will not usually change with age.

5.3 Dorset currently has 38 rehabilitation inpatient beds. During 2017/18 there were 47 admissions to those beds and the average length of stay was 200 days. Based on the forecasted increase there is an estimated 79 people (1% of SMI register) by 2020/21 who may require rehab inpatient beds and if nothing else is done additional beds may be require however with community team and housing provision is in place it is possible that fewer would be required.

5.4 Based on population data the higher proportion of services will need to be provided in the conurbation as these have the highest population density and highest SMI rates. The deprivation figures also indicate there are levels of deprivation in Christchurch and Bridport and in the west of the county e.g. Bridport SMI rates are slightly higher than the national average. However the highest rates are primarily in Bournemouth East and Poole. This is also evidenced in the proportion of homeless people in these areas. Furthermore, as the community services in

the review are not pan Dorset this indicates that a population of people who would benefit from these services are currently missing out on the specialist support.

Community Teams

5.6 It is apparent that community teams are working at overcapacity at times and resources are not matched to meet demand. Teams may need to work differently to manage the demand and could better meet the need for a pan Dorset service.

5.9 The current rehabilitation service in Dorset focusses on inpatient facilities and less on community and supporting people to live as independently and as well as possible in the community. The community offer is currently AOT and the Homeless Health Service and although skill sets of staff are arguably the same, the service remits have a slight difference in terms of responsiveness to treatment through rehab.

5.10 The skills of the staff across rehab, AOT and homelessness are broadly the same, staff work assertively, they form and hold the relationship with the person when they are not able or do not want to, they are able to engage with people who do not necessarily want to engage or do not see the value in engaging, they manage risk and work. There is argument in terms of the demand profile that there should be one team that supports people who have complex needs. Bringing the teams together will make them more robust and sustainable and give greater resilience.

5.11 Based on the inconsistencies and disparity of service provision and the skill mix within the teams there could be a case developing a for a community team that provides a pan Dorset service to meet the populations needs in a different and more fluid/flexible way.

Inpatients

5.12 People with a serious mental illness experience long length of stay during their inpatient admission and can often result in delayed discharges. Possible reasons for this include the limited supported accommodation options locally and a lack of an active and engaging community team supporting discharge with packages of care or waiting for placements.

5.13 National research data suggests that that people out of area do less well because they are disconnected from their peers, families and friends. The national drive is to cease out of area locked placements. Dorset will need to accommodate people being repatriated back into the county and provide resource to accommodate them.

5.14 There are a higher proportion of males accessing rehabilitation services. This could be for a number of reasons that have not been identified specifically within the analysis. This is consistent within the AOT service, the homeless health team service and the out of area locked rehab units with 7 males and 4 females and inpatient units that have 26 males and 12 females. The future bed provision will need to take this into consideration.

5.15 In total there are currently 180 people on the caseloads within our support services including inpatient rehabilitation. The forecast indicates this number will increase and this will need to be taken into consideration with shaping of future rehabilitation services for Dorset.

5.16 In summary there is rising demand and current services are not set up in the right areas to manage the demand in the least restrictive way.

5.17 There is little community provision and few supported housing options at the moment, which leave inpatient services being the primary rehabilitation and complex care option.

5.18 It is likely with targeted reshaping of the current services that the offer for people who require ongoing rehab or assertive support could be improved and enhanced.

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Care Quality Commission report March 2018

Dr Pippa Metcalf The Royal College of Physicians 2017 presentation

Appendix 2

NHS
Dorset
Clinical Commissioning Group

Mental Health Rehabilitation Service Review View Seeking Report



DOCUMENT TRAIL AND VERSION CONTROL SHEET	
Heading	Review and Design of the Mental Health Rehabilitation Pathway **Mental Health Rehabilitation Service View Seeking Report**
Project Sponsor	Colin Hicks
Purpose of document	Present an outline of the view seeking information gathered to inform the MH rehabilitation review case for change.
Date of document	21st August 2018
Review Date	
Authors	Melissa Scott Elaine Hurll Alissa Tromans Lisa Spriggs Julie Brown
To be Approved by	Rehabilitation services project board
Date approved	
Effective from	
Status	For comment
Version	V2.0

Mental Health Rehabilitation Report

View Seeking Report

1 Introduction

1.2 NHS Dorset Clinical Comissioning Group (CCG), Dorset HealthCare (DHC) and Dorset Mental Health Forum are undertaking a review of adult mental health rehabilitation services for people with a serious/severe mental illness (SMI) in Dorset. This is titled the rehabilitation review.

2. Co-production

2.1 This review is underpinned through co-production with key stakeholders, including people who use services and their families/carers. The aim has been to ensure that patients, carers, public, communities of interest and geography are engaged fully within the different stages alongside the process. As part of the review we felt it was imperative that service users within the mental health rehabilitation hospitals were offered 1:1 support from a peer specialist to ensure that their voices are heard.

3. Services in scope

3.1 There are six services within the rehabilitation review and consist of:

1. Three Inpatient Rehabilitation Units – Nightingale House and Nightingale Court located in Westbourne and the Glendenning Unit located in Weymouth
2. Out of area locked rehabilitation
3. The Assertive Outreach Teams located in Weymouth and Portland
4. The Assertive Outreach Teams located in Bournemouth and Poole
5. The Homeless Health Service

4. Methodology

4.1 There were individual 144 responses to the different view seeking methods. There were 71 attendees at the community events. Sixteen people attended the outreach events and meetings.

4.2 Views were gathered from 37 service users, 24 carers, 69 staff and 26 other agencies that worked with the services included in the review.

4.3 Please not that some individuals identified as belonging to 2 user groups which accounts for the difference in totals.

Type of Response		Number
Online survey		60
Postcards		79
Emails		5

4.4 **Online survey -** The online survey was designed and the web link promoted by NHS Dorset CCG, Dorset HealthCare and Dorset Mental Health Forum.

4.5 **Postcards -** The postcards were designed and distributed to all services involved in the review and a number of agencies who work alongside the services involved in the review. The postcards were freepost to NHS Dorset CCG.

4.6 **Community events -** NHS Dorset CCG, Dorset HealthCare and Dorset Mental Health Forum held 7 community drop in events across the whole of Dorset and during the daytime to give as many participants as possible the opportunity to attend. These meetings lasted for 2-4 hours and gave information about the purpose of the review and approach. Participants were given the opportunity to discuss issues and were then invited to write their views down with assistance offered if necessary.

4.7 **Outreach events -** Five outreach events were held across the county for service users and carers. The information about the purpose of the approach was given alongside the opportunity to discuss issues. Individuals were invited to write their views down by facilitators and note takers from Dorset CCG, Dorset Healthcare and Dorset Mental Health Forum. Alternatively, if individuals preferred they could write their own views.

4.8 All three approaches to engagement followed the same process and asking participants a set of 3 broad questions around rehabilitation services and for the purposes of the report the responses are colour coded. The questions are:

From your knowledge/experience of mental health rehabilitation services what currently works well?

From your knowledge/experience of mental health rehabilitation services what doesn't work well?

How can mental health rehabilitation services be improved?

Themes and from people who use services

5. Helpful and dedicated staff

5.1 The quotes in 5.3 are from people who use services who responded to the view seeking questions. The quotes are based on common themes emerging from the view seeking sessions. The themes were; helpful dedicated staff, food, workshops, activities, peer support.

5.2 Throughout the view seeking staff were generally praised for their commitment to helping the service users in their recovery and for being friendly and easy to talk to. They also said that staff encourage them to focus on their recovery and the future and being able to build positive relationships with staff members. People also said

how well staff worked as part of a team and liaised with other services/family members to ensure the best care was provided.

5.2 Across all groups (staff members, service users and family members) one of the most common themes was that staff members are dedicated, skilled and caring. Multiple service users emphasised that staff offer a lot of support and encouragement and that staff have been helpful in their recovery.

5.3 The following are quotes from people who use services.

- *"I would be a 'wreck' without AOT. Happy staff with a smile."*
- *"Staff are a good team. Genuinely caring and supportive."*
- *"Some of the staff have been really helpful. They listen to me and help me let off steam"*
- *"Staff help me all the time - they are very supportive." "Staff are very easy to chat to. Staff pop in and see me and encourage me when I'm not feeling great. It's very caring and supportive."*
- *"AOT – quick to help me with housing, always on time for my visits and always turn up. Wouldn't ever had CBT if not under the team. Being in the service makes access to other help i.e. drug and alcohol services easier"*
- *"The food is good"*
- *"Food quite nice - A choice of food menu. "*
- *"I like going to the groups, particularly the ones that get me outside."*
- *"Roots is really good group - gets people out and about. Doing activities helps build relationships."*
- *"Lots of different activities on offer."*
- *"OT is good"*
- *"The music group is very helpful"*

- *Not enough variation in weekend activities"*
- *"Sometimes I get bored because there is not enough going on."*
- *"Having to spend so much time on the ward is hard."*

6. Workshops and activities

6.1 Service users spoke about how workshops were helpful, giving them a sense of purpose and having something positive to focus on to aid their recovery.

6.2 Many service users said that they would like more activities and resources to attend activities because it gives them something to do to manage boredom levels.

6.3 Some services have links with RSPCA, Gyms etc. which helps with community integration. Some people said that cooking Groups and moving forward groups are helpful. But they also mentioned that that there is a lack of OT in AOT.

6.4 The following comments address how rehabilitation services can be improved.

- *"More Workshop like groups where I can talk about what's happening with others"*
- *"More cooking/eating meals together"*

7. Peer Support

7.1 People said that they valued peer support and that they find peer support beneficial in their recovery.

- *"The only people who really understand me is other patients/Peers."*

8. Time devoted is invaluable

8.1 People said that dedicated time really helps. They said that a real positive of the rehabilitation services is that, there is time devoted to caring for them and that this was really important in helping them to recover and for making them feel worthy.

8.2 People suggested spending time getting to know the service user is more beneficial in helping the individual to recover in the long-term. Devoted time shows that staff truly care about the service users' individual needs. The following are comments about what works well:

- *"AOT helped me get out. They spend longer with you than other services. See them more frequently. Feel much more supported that way."*
- *"It's a specialist service - they understand the service-users; they take time to get to know you. I can talk to the team about anything."*
- *"Staff talk respectfully to individuals and really take time to get to know people."*
- *"Staff know individuals very well and are committed to providing support and managing wellbeing"*
- *"Having time spent on an individual to boost their confidence/self-esteem is invaluable. Rushing people into so called mental wellbeing doesn't work."*

9. Safe Environments

9.1 People felt that it was important to have a safe environment. People said that they felt safe using the services, where they get support from peers and staff whenever they need it.

9.2 People said that the places of residence are free from judgement and there is a real sense of staff wanting to help promote positivity and recovery.

9.3 People suggested that kindness and compassion helps them to feel safe and supported.

9.4 The following are comments from people about what is working well and what is working less well along with suggestions of improvement:

- *"Place of safety and containment"*
- *"It has been a protective bubble"*

- *"Mental health issues don't stop at the weekend"*
- *"Having weekend AOT so I can see somebody."*

- *"Service users would like a 7-day AOT service"*

10. Listening and understanding

10.1 There were other thoughts and views about how important listening and understanding are and some people said that they had experienced negative attitudes.

10.2 Service users spoke about how important it is for their needs and feelings to be listened to by staff members and their peers. Being able to share their problems is fundamental to building relationships and aids their recovery. This is especially important for those who need longer-term treatment. People want to be listened to and generally need more time to recover.

10.3 Even though many service users felt the staff are friendly, a couple of service users felt that staff can be too negative and harsh. They also said that communication can sometimes be poor especially in relation to leave arrangements and medication. The following comments say how things are not working so well.

- *"Doctors don't listen to me. No one talks to me about leaving here."*
- *"doctors are over cautious, leave can be hard to get as staff don't trust me"*
- *"A staff member was rude to me. … Some staff are really harsh."*
- *"Always telling me what to do. Staff can sometimes be negative and restrictive*
- *Psychology made me pressured and judged."*

10.4 People suggested that things could be improved and the following are examples about how things could work differently.

- *"Staff to listen to me more about where I want to move to."*
- *"More talking therapies - counselling services. Stronger advertising campaigns to reach people about MH education."*

11. Individualised Care

11.1 People had views about individualised care. Service users emphasised how they would like more contact with services on a 1:1 basis. They said how positive AOT

had been in many cases and they felt that they would like more of this service and specifically to support them on an individual basis.

11.2 There were comments about links to the community when people leave the units. People had concerns about the lack of psychology and the over use of medication. Some people also noted that there was a lack of physical healthcare if a person is homeless.

11.3 People said that these things were not working well

- *"Given phone numbers when left unit but felt too afraid to call"*
- *"Don't normally mix with people, I get told off for not mixing with people here"*
- *"More support when I left"*
- *"Treat humans individually."*
- *"Rushed into leaving the service/recovery"*

11.4 And suggested these for improving services:

- *"Learning life skills, one to one and group support and social exposure work"*
- *"more personal centred care and 1-1 time."*
- *"1 to 1 support work when at home."*

12. Recovery and Future Focussed

12.1 Service users said that recovery should be at the forefront of their whole experience in the service, and that focus on moving forward. They said that rehab should concentrate on the future and leaving inpatient rehab, rather than focus on staying in rehab. People said that this would give individuals a sense of hope that they will get better.

12.2 Multiple service users felt the staff members give them support and encouragement to gain independence, learn skills and to go out in to the community. And that confidence has been built.

12.3 Feedback was given that some people who are ready and able to leave the unit are held back due to lack of suitable housing and they would like more support once leaving units. The following are quotes about what works and what does not and how things can be improved.

- *"Staff are helping me to move on - talking to me about staying motivated."*
- *"It has helped me look in depth at what will help me, and given me time to look at myself"*
- *"Lots of interest in recovery skills and managing stress and anxiety"*
- *"They (AOT) encourage me to go out – wouldn't go out if it wasn't for them."*

- *"Staff encouragement. Supported with future. Like art and craft groups. The groups that get me out in the community"*

- *"Being in hospital for a long time doesn't help"*
- *"Doesn't work in rehabilitating people back to living meaningful lives"*
- *"Feel like I'm just here waiting when I am ready to leave"*

- *"To come from a much more recovery focused stand point"*
- *"Focus on discharge from day 1"*
- *"More community team work when out"*

Themes from NHS Staff

13. Community reintegration

13.1 Staff members spoke about how essential it is to provide service users with the tools needed to be able to get back to living independently in the community once leaving ng inpatient rehab care. Building relationships with community services is an integral part of the recovery process and being able to get back to 'normal' living including more access to volunteering/working when reintegrating into the community. Comments include:

- *"Recovery hubs/houses, integration in community, less focus on containment and more focus on independent living"*
- *"Funding into supported living with more focus of living a life in the community"*
- *"Involve in community programmes that helps towards confidence progress."*
- *"Better community support for service users as many declined cares to history (aggression/drugs) so can't get housing."*

14. Independence

14.1 People said that they wanted to move away from an 'institutionalised' way of living to being independent and this is something that needs to be addressed seriously. Whilst it is good to help service users with daily activities e.g. shopping, going for coffee, more focus needs to be on ways to help individuals gain these skills individually, giving them the confidence and abilities to pursue this more. Some of the views about this are expressed below.

- *"encouraged to be more independent to adjust to life outside i.e. cook for themselves"*
- *"Staff encourage and assist patients to engage in activities they may continue after moving on"*

- *"To come from a much more recovery focused stand point - to teach people much more everyday living skills."*
- *"getting support with carrying out healthy lifestyle, improve physical wellbeing, learn to budget, improve social interaction, optimise medication with regular reviews."*

15. Care for the most vulnerable/ill patients

15.1 Staff said that the services for those who are most in need and most unwell are essential in helping and providing the best care possible.

15.2 The staff were praised for being helpful to individuals who are the most unwell and suggested that more focus should be directed at keeping these facilities running because individuals depend on these services to live.

- *"Having a service that deals with some of Dorset's most vulnerable and poorly patients with no judgement just with kindness and compassion - with the aim of giving them a decent life."*
- *"Improve access to services for people with long term/severe and enduring mental illness."*
- *"Ensure that rehab services and the assertive outreach teams continue to provide services for some of Dorset's very poorly patients."*
- *"Service manged challenging group balancing risk and recovery."*

16 Close links/relationships

16.1 Staff spoke about how different services have close and well-established links with family members/carers and other community resources. They said that the whole extended team of people involved in the individual's care works well together.

16.2 People said that more work needs to be done to continue this teamwork and strengthen these links especially for more vulnerable groups that need more support.

16.3 Staff said that in absence of an AOT in an area the CMHT will cover.

16.4 They also highlighted the need for closer relationships with inpatient and addiction services. Comments related to this are seen below.

- *"Good links homeless team – come to team meeting. CMHT cover AOT clients - mixed into caseload and manage AOT approach in absence of a team."*
- *"There has been good links with assertive outreach teams to help with the transition from inpatient rehab service to independent living in the community."*

- *"A multi-disciplinary team of dedicated staff to support increases insight, learn and develop life skills."*

17. Staffing issues such as resources and better use of services

17.1 Staff expressed concerns about not having enough staff or staff being under-resourced to be able to cope with the demand of the service users and help people in the most effective possible way. For example, some services e.g. AOT have too many long-term cases which limits their capacity to be able to take on new clients.

17.2 There needs to be better communication and integration with other services to work better as a whole term, to take the pressure off some areas, and to help other areas where the patient's needs may not be met as well as they could be.

17.3 More family therapy and more psychological therapy needs to be available.

- *"No structure. No feedback re input to SU. Too many cross over services."*

- *"Have clear timescales if AOT approach is not working should not keep on caseloads for years - what's the point"*
- *"AOT may wish to look at their caseload and see those long-standing clients that could be transferred back to CMHT"*
- *"The service is much needed but has to be available to new referrals - perhaps having a time period of 2 years to see if this method of working increases engagement in treatment plans and quality of living for those clients."*
- *"Referrals take too long to be accepted - they have very limited capacity despite having small caseloads. Keep people for too long - should have clear exit strategy to free up capacity"*
- *"Accessing services difficult as so under-staffed."*
- *"More admin for AOT"*
- *"More medics"*
- *"Skill mix is not correct - No medic, psychologist or AMHP. These key professions have a role with this client group who often then fail to be able to access medication, trauma focused therapy and co-coordinating MHA assessments in the current climate if difficult and often need to be called multiple times before someone who is homeless is hospitalised. Also, these key professionals help support the team in formulation, reflection and risk management. The team are often dealing with high risk unknown clients and there is no oversight by a medic"*
- *"Specialised worker with skills working with Brain Injury. Estimated 45-55% of homeless have a BI yet there is no service. "*
- *"Creation of an Assertive Contact Team that works with homeless, migrants, gypsy/travellers and underserved communities"*

18. Long term rehabilitation

18.1 Staff expressed concerns that some individuals require much longer care than others to facilitate proper recovery to prevent relapse.

18.2 There should be more facilities and better-care plans in place to support those that need longer periods of rehab especially for more complex and ongoing issues that cannot be resolved quickly – it takes time for people to recover fully.

18.3 It was also noted that staff are sometimes too quick to remove privileges from service users.

- *"Too quick to remove privileges e.g. leave when patients make mistakes."*
- *"The rehabilitation process can be lengthy and does not always focus on promoting the skills of patients for independent living."*
- *"Many AOT clients have remained under the team for years with little or no movement. This may have contributed to a loss of independence and autonomy rather than promoted it. The same could be said of inpatient rehab where some patients have been in rehab for many years with no real movement onwards."*
- *"It can be restrictive and there is always the potential for people to become institutionalised, however for a few people this service is a necessity and has proved invaluable."*
- *"the waiting times for rehab beds particularly for men is too long"*
- *"Institutionalised care, not recovery focused, poor environment to enable sufficient recovery and care"*

- *"Provide community rehab service to provide long term support. Increase availability of supported housing and care packages."*
- *"Environment of some inpatient units not conducive to rehab - restricted rehab opportunities. More supported accommodation. More long-term treatment ward."*

19. Peer Support

19.1 Staff felt that peer support in rehabilitation is important in recovery.

- *""Get peer specialists to work on the wards to help with drug and alcohol"*
- *"Having a place for people with complex needs to receive treatment without threat of pre-emptive discharge. Peer support."*

20. Homeless Service

20.1 It was noted that there is a lack of psychiatric help and intervention for homeless people and that mental health act assessments for people sleeping rough are difficult to coordinate.

- *"Mental health act assessments for rough sleepers are not an effective process."*

- *"homeless practitioner dedicated to support rough sleepers & another MH practitioner to support hostels and housing team. Staff to support their clients as homeless to the council"*
- *"Increase hours of mental health nursing time for Homelessness. Dedicated consultant psychiatric time for Homelessness."*

20.2 **Homeless Health Service data**

20.3 The attendance at the view seeking events by homeless clients was inconsistent but there was other recent view seeking done asking the same question with this population of clients and the comments have been included below:

What worked well?

My key workers give me good advice and support
The mental health team is good
Floating support helps, manage appointments with advocacy.
Overall, things are good
1:1 therapy works best
drop in centres and aftercare groups
Every health worker I saw
Having BH1 project to fall back on for every need, support to get back on my feet and get a job
Having daily activities to do during the day
having people who understand your needs who offer correct support
I don't get any support
I receive adequate support for all my health needs
Medication helps me
NHS 111 is helpful. Dorset Mind news leaflet
People that respect me get the most out of me
Practical/emotional help Talking therapy
Rough sleepers team
Unsure
Total

What could be improved:

A centre where all health professionals are based
Accommodation provided for people who are homeless
Better communication between GP and Hospital. Recording of records
Better intervention service
Health service staff to come onto the streets to see more people
I need a dentist
I need talking therapy
I was misdiagnosed with schizophrenia when I didn't agree with.
Inconvenience of where Drs are for people, people should be able to register wherever they are
More health services and staff available
More support in B&B, more health professionals visiting.
More workshops at my hostel to tackle depression and anxiety
People shouldn't be discharged to the street from hospital, it is not nice coming back out after being indoors, warm and had food
Timely access to health services
Waiting times for appointments
Nurses to check peoples physical health & check wounds & talk about medication
Alcohol and Mental Health services should merge into one
Total

Other comments

Happy with support from housing provider. They helped with anything I need help with and been very supportive and they guided me into the right direction I've needed help with
I have had incidents where medical records have been lost or even not recorded for attempted suicide (very serious).
I think there should be more health support for homeless people. It would be helpful to have a set place where you can go for health workers
I would like to have my own home
more normal places to see people, café type set up and more time so staff can take the time to listen to silly stuff
More outreach from housing services, food banks and rough sleepers team to outreach day and night
Should be more mental health services and a better transition into accommodation
System is crap, resources are wasted on people who I believe do not always need help. More help earlier on in life and if people don't want help then services move on.
The need to feel safe not vulnerable when homeless
Transportation provided to access food and for work
Transportation to get to and from appointments

21. Individualised Care

21.1 Staff were praised for individualised care. Staff said that service users get choices and that the care is person centred.

- *"Collaborative care provided by staff positive risk taking"*
- *"Glendinning has been a creative environment which has improved the quality of life of a patient whom I was allocated cco.It is an upbeat forward-thinking environment which benefits the service users. Their recent experience of two clients being moved to rehab due to bed pressures which has resulted in a much quicker effective route into rehab"*

- *"A separate expert system for those who have severe psychotic conditions and are show to recover is extremely valuable as they need prolonged specialist interest"*
- *"Having a smaller building and team like Nightingale Court, that offers more personal centred care and 1:1 time"*
- *"Regular support tailored to the needs of the individual"*
- *"Help with language needs"*

22. Encouragement and motivation to change

22.1 Staff felt that although it was important to provide the right care and support for the patient's overall recovery, it was also vital to provide patients with the tools needed to help themselves to get better.

22.2 Staff said patients need to have self-motivation and encouragement from their peers to perform daily activities for example, to make the changes necessary to leave the service and get back into independent living and in the community.

- *"Helping patients to help themselves. Exercise, discussion, monitoring, observation, info, action and encouragement."*
- *"Staff struggle to motivate residents at times and this can lead to frustration. More talk about recovery skills is missing."*
- *"More recovery-based conversations and skills groups to engage individuals in thinking about self-management and moving on"*
- *"Focus on people's lives, their futures and their capacity for change"*

23. Better discharge planning

23.1 Multiple staff members wrote that there is a need for clearer plans at discharge as well as more information about the number and type of services that are available to individuals once they leave a unit.

- *"Care plans that include discharge goals."*

- *"Continued support for people who have been inpatients when they leave hospital – this will include more support for getting involved with community activities, paying bills and budgeting, planning GP, OPA etc., house hold tasks and volunteer/employment assistance"*

24. Communication between services

24.1 Many staff members mentioned the lack of communication between different services. This relates to communication between different in-patient services as well as communication between in-patient services and community services.

- *"The communication links between the Assertive Outreach Team and CMHTs should be strengthened and there should be greater rate of transfer between the services."*

25. Activities

25.1 Some staff mentioned activities as an aspect of support that works well. They mentioned activities that centre on learning skills (cooking, shopping) alongside activities such as art, pottery and music. Multiple service users also mentioned activities such as arts and crafts as a positive thing.

25.2 Staff highlighted the importance of physical activity for this client group.

- *"Activities are provided for inpatients"*
- *"Rehab services at Nightingale House are working well. Patients engage in cookery, planning and shopping, art and pottery, gym work, music, relaxation and mindfulness, walks and community trips. It may take a short while to encourage patients to engage with the groups but once a programme is established with individuals it proves to be a success in most cases. Staff encourage and assist patients to engage in activities that they may continue after moving on."*

- *"Lack of activities - meaningful activities for people who are unable to 'move on' and require long term support."*

- *"Physical activities which are essential. To keep fit in the wards."*

26. Safe environments

26.1 Staff highlighted that Rehab hospitals can be a restrictive environment and that people can be there too long.

26.2 Physical space at both Nightingale house and court are not suitable. Staff feel there should be single rooms.

26.3 People with history of Personality Disorder and or self-harm aren't accepted in the unit.

26.4 Location of hospitals were noted as positive as they have nice surroundings and are generally close to amenities also people felt that they need to be in units close to where the live.

26.5 Staff noted that there is no safe environment for homeless clients. A central base for Bournemouth, Poole Weymouth for multiple agencies to provide adequate services for Homeless would be beneficial.

26.7 Finally in this section, the addition of low secure beds in Dorset would be viewed positively.

- *"Residents feel safe here." "The location of mental rehab hospital is in a building with pleasant peaceful grounds."*

- *"Sharing bedrooms does not promote dignity and can hamper that person's recovery"*
- *"People who cannot go to St Anne's and there are no beds come to us and it is not a suitable environment"*
- *"Keep people for too long"*
- *"Building not fit for purpose"*
- *"Not conducive to a recovery-based environment"*

- *"Single rooms would aid recovery"*
- *"Sex segregation would help"*
- *"Patients with a history of PD or self-harm are not accepted in the unit, but would benefit from a short stay in rehab"*
- *"A safe place for people that cannot get accommodation"*
- *"Safe environment with 24-hour care, able to promote and actively increase community exposure"*
- *"low stress environments for complex individuals who have had multiple placements."*
- *"they should be a low risk light and airy unlocked facility"*
- *"Provision of inpatient rehabilitation across East and West Dorset. It is important that people are admitted to hospital close to where they will be discharged facilitating social inclusion. Provision of inpatient rehabilitation across East and West Dorset. It is important that people are admitted to hospital close to where they will be discharged facilitating social inclusion"*

Themes from 3rd Sector staff or other agencies

27. Communication

27.1 Third sector staff highlighted that communication can be good but there is room for improvement e.g. link meetings between agencies.

- *"Committed Staff, and communication between rehab services and 3rd sector."*

- *"Not sharing information between agencies and NHS staff"*

- *"Communication could improve between agencies to stop people losing their accommodation"*
- *"A link person to help a person through recovery from unit to community is lacking"*

28 Activities

28.1 Third sector staff view they have different activities on offer at the hospitals but there could be more offered i.e. cooking

- *"Food could be improved - more cooking could be done on site. "*
- *"Engaging with patients in useful occupations e.g. cooking a meal, shopping for meals. Supporting them to placements in the community that are suitable for their wellbeing. "*

29. Staff

29.1 Third sector staff noted that staff can spend too much time in the office and could spend more time with individuals. There should be more "live in staff" in hostels

- *"Staff spend too much time in the office"*

- *"More staff and a mental health worker working in hostels"*

30. Rehabilitation, recovery and discharge

30.1 A more recovery-based approach would be beneficial.

30.2 It was noted by 3rd sector staff that length of stay and discharge times are inconsistent and it seems that some service users are either discharged too soon or stay to long in the unit.

- *"Staff should have more focus on personal recovery strengths and use less negative language"*
- *Putting too much pressure on people too soon."*
- *"It appears some patients are in there for a long time"*

- *"More recovery focused work"*
- *"Focus on people's lives, their futures and their capacity for change"*
- *"Recognition that it not always possible to 'fast track' rehabilitation and recognise that some individuals will reach maximum potential in a 24-hour service."*

31. Accessibility

31.1 Accessibility to rehab staff could be Improved

- *Accessibility - Its ok having talented/committed and resourced staff but you need to be able to access them."*

32. Care pathways

- *"There are unclear rehabilitation pathways associated with the majority of patients I have encountered"*

33. Training and Framework Knowledge

33.1 Rehab staff can be lacking in knowledge of frameworks such as S117. Training that is offered by 3rd sector to staff is not always prioritised or taken up,

- *"Staff have limited to no knowledge around important functions such as S117 framework."*
- *"Nursing staff must be made aware of the eligibility framework of S117 funding arrangements, and the practicalities associated with this. Far too often I have experienced staff promising packages of care to patients, prior to discharge, where there is no evidence of eligibility"*
- *"Training when offered is not taken up by NHS staff"*

Themes from family members and carers

34. Care and compassion

34.1 Family and carers described how beneficial it was for the staff that staff are compassionate and caring towards the patients. They said this really makes a difference to helping and supporting them, by showing that they truly care about what they do. It also shows that facilitating patient's recovery was the focus of everything they do. Carers said the support is invaluable, not only to service users

but also towards the families and carers and this helps to build trust and strong relationships.

- *"Form good relationship with AOT as a Carer. They are very caring for my son. They are supportive."*
- *"The relationship with son's support worker really close and supportive - understand my needs as a carer and my son."*
- *"Support Worker accepted son and took time to get to know him."*
- *"The compassionate care that is given to my son in Nightingale by members of staff and the doctors."*
- *"Staff make family feel welcome"*
- *"Staff can't be faulted, caring, encouraging, support to son seems to be making progress"*

35. Focus on independent living

35.1 Family and carers said that it is important for staff to be able to put care plans in place, motivate and assist patients to perform daily tasks independently. Helping patients with these skills with the end view of being discharged into the community is integral part of care that gives patients the hope, skills and confidence they will need to manage independently once they leave the services.

35.2 It was noted that there is a lack of privacy for people who are inpatients.

35.3 Many service users and family members felt the staff are very helpful in supporting service users in practical matters e.g. finding a place to live or buying a bus pass.

35.4 Some family members wrote that there is a need for more activity as patients do not have enough to do to fill their time and are allowed to sleep all day. Carers and families suggested that there should be more activities especially at the weekends with more encouragement to go out. Some people suggested that the activities need to be personalised activities.

- *"Rehabilitation was supported to help my son become more independent. To help with his diet, cooking and shopping and taking him out on regular trips. This doesn't happen very often due to few staff."*
- *"Proactive with helping my son get a bus pass"*
- *"AOT very good support for my son. Helped him get his own flat and transition worker really helped."*

- *"Activities offered for my son were not tailored to his interests. Staff lacked time to go out with people and my son wasn't encouraged to go out and was like a zombie."*
- *"The lack of structure in getting patients up in a morning and having no routine. Allowing patients to stay in bed all day not doing any programs. Rehab should be the next step to moving on in life and it should not be treated like a hotel."*

- *"Motivating and giving more encouragement to maintain activities. My son gives up too easily – can 'reward' be considered?"*
- *"Time to look for job and get creativity which lost in their acute mental health disorder. Involve in community programmes that helps to confidence progress."*

36. Safe environment

36.1 Some families and carers highlighted that the rehab units are not close enough to family

- *"It is an old cold building and very little happening at the weekends. It is based near Bournemouth with no connection to local/home community in Bridport to facilitate integration within the community. A promise of a more local move has not materialised, and he has been hospitalised / Rehab service for almost 18 months."*

37. Communication

37.1 It was emphasised that communication should be at the core of everything so that the right decisions are made about care practices and medication etc.

37.2 Some families/carers as well as patients said that more needs to be done to ensure that all parties fully understand and are aware of the patient's circumstances e.g. in regard to medication, therapy, daily activities, goals for life after discharge.

37.3 Some families/carers and patients may be uncertain about what is happening, e.g. in regard to accommodation or different referrals so this needs to be made clearer for everyone through better communication.

- *"They communicate with me really well"*

- *"Couple of staff 'not on the ball'. Had to fight a couple of battles regarding communication."*

- *"Families, groups, networks so important and in west need people from this area to have opportunity here."*
- *"Having conversations about getting better."*
- *"My son to get more care when he comes home."*

38. Listening

38.1 Whilst family/carers generally praise staff for listening to their concerns and input to determine the most optimal care for patients, some people said that they sometimes feel a bit neglected. They would like to be made to feel like they are an important part of the team that is made up to support the individual and not seen as a separate support network.

38.2 People said that it is important to listen to views from family/carers as they are likely to know the patients more than the staff so may have valuable input that could strongly help towards their recovery and discharge.

- *"The relationship with son's support worker really close and supportive - understand my needs as a carer and my son"*

- *"Listened to a bit more as a carer. Give family more support."*
- *"Carers/supporters need to be seen as core part of the team, to understand family support and relationships are a core part of recovery."*

39. Service takes the pressure off the family

39.1 Family members felt the service takes the pressure off the family.

- *"Having son in rehab inpatient has given me a rest."*

Themes that were consistent across all the groups

40. Long referral times

41. An area for improvement that was mentioned multiple times in all groups (staff members, service users and family members) was about long referral times. Staff felt the referral process is long and sometimes it is difficult to get a referral accepted. Service users and family members felt that it took too long to get appropriate care.

- *"It took a long time for my son to get into rehab. 6 years of failed attempts in the community." – A family member*
- *"CMHT not interested, suicidal and had to wait a year. No community support offered." – A service user*
- "Referral process appears long and protracted." *– A staff member*

41. More support in the community

41.1 All groups felt there is need for more support in the community. Staff members especially mentioned the need for more support after service users have been discharged.

- *"More services based in the community to enable people to be supported in their own homes." – A carer*

42. Caring and skilled staff

42.1 Across all groups (staff members, service users and family members) one of the most common comments was that staff members are dedicated, skilled and caring.

- *"Staff are a good team. Genuinely caring and supportive."-A Service user*

43. Specific services

43.1 During the course of the view seeking sessions some specific services were mentioned. In compiling all the data in to the report it was considered that it is helpful to include these comments about the specific services. Please note that these comments were made by staff members unless otherwise stated.

Elsadene

"Very good service - with both primary and secondary care input. Holds unwell/vulnerable residents in community environment - where other placements have failed"

"Often facilitates earlier discharge of patients from secondary care settings. Good patient/staff rapport. Homely environment"

"Elsadene vital unit. Please, please, please do not close it and throw out highly vulnerable patients to isolation and anonymity."

Nightingale House

"The Nightingale House team recognise that the building is not fit for purpose and that high dependency/locked rehabilitation cannot realistically be provided there. The unit is also relatively isolated and so the staff lack back up when dealing with violent situations"

"Staff encourage and assist patients to engage in activities that they may continue after moving on."

"Patients move on to either independent or supported accommodation with the support of the whole team"

"need to be more dynamic and offer more individualised care to promote recovery."

Nightingale Court

"It is helpful having a smaller building and team like at nightingale court. Nightingale Court seems to offer more person centred care and 1-1 time."

Homeless Health Service

"The work I have observed by the homeless health services both directly and in liaison with other agencies is vital for the wellbeing of this vulnerable group."

"I have no doubt that without their essential work the population they serve would suffer and other agencies trying to compensate would do an inferior job, and be costlier and time consuming"

"Homeless Health services are proactive and have excellent skills engaging the client group."

"community based, where the people are. Drop in based so not set appointments making it easier to access for clients, relaxed atmosphere, access to other services based at some of the drop ins."

Assertive Outreach Team

"The Assertive Outreach Team have been dedicated to the rehabilitation services for too long and have been working with clients who do not meet their criteria."

"The Assertive Outreach Team in Bournemouth do an excellent service but are under resourced which creates frustration for CMHT's who wish to refer to AOT."

"AOT team are absolutely superb, the way they connect with clients, non-judgemental approach."

"Some of the most challenging patients are looked after by a dedicated team who can provide out of the box care and treatment as required (AOT)."

"AOT helped me get out. They spent longer with you than other services. See them more frequently. Feel much more supported that way." – a service user

Glendenning

"Glendenning Unit has a great ethos for patient choice and responsibility for their healthcare and responsibility."

"Glendenning – service good. Get to go out. RSPCA Monday, dog walk, charity shops and food shops." – A service user

"The majority of patients who come to Glendenning have been shown to have significant cognitive deficits and have benefited from the highly structured and supported setting there to enable them to function at the optimum potential." – A staff member

44.1 During the view seeking session there were also a range of comments that did not fit in with the other general themes but are included because they provide insight to be considered during the review.

Other interesting comments

"Provision for rehabilitation after discharge from hospital for deaf people recovering from major psychosis is woeful. If you look at the Dorset County Council spend for social work for mental illness in adults or sensory impairment, you will find very low spending compared with other counties. So, if you are a deaf person with mental illness you will receive a very inadequate service in Dorset. In fact, no help. Remember the deaf have no voice. I imagine this is why it is possible to ignore them in the provision of rehabilitation and help from psychiatric social workers." – A staff member and a family member

"It has been a protective bubble. In response to my diagnosis they have behaved appropriately. Has helped me to look in depth at what will help me. It has given me time to look at myself." – A service user

"Staff help me see what direction I'm going. Help me to gain insight." – A service user

"I get easily bored. Feel like I'm locked up all day. Sometimes I feel down because I don't know when I am going to get out of here." – A service user

"Homeless health service. My clients not being able to access MH support due to substance misuse and when in hostels don't fall under homeless health and CMHT do not accept – too chaotic and big overall on services. Staff in hostels desperate for MH advice/support/training the team does not support hostels." – A staff member

45. Conclusions and Summary

45.1 The overarching themes broadly fit in to three categories and for the purposes of summarising the report just the key words or topics from comments in the report have been used.

Staff and people focus	Service and people Focus	Environment and system
Compassion and care	Community reintegration	Safe environment
Team-work	Independence	Expand on current facilities
Better communication	Individualised care	Make better use of services to relieve pressure in system
Devoted quality time	Focus on future	Long waiting times to get into rehab
Support for most vulnerable /ill	Activities	
Listening	Life skills that promote independence and look to the future.	
Psychologist support	Workshops with peers	
	Focus on life outside of the inpatient service	
	More community support	

45.2 Throughout the report and in reference to all the services there are constant references to staff who are perceived to be caring, kind, compassionate and these qualities are really important to people who use services and their families and carers.

45.3 There are references throughout to the need for a focus on moving on from inpatient services, recovery, independence and having life skills that enable people to live as well and as independently as possible. Staff suggested that their focus needs to change from containment to independence.

45.4 In quite a few areas peer support was mentioned as a valuable on wards and in the AOT and people using services said that peers are the people who understand them.

45.5 Throughout the report were comments about life beyond the inpatient settings and the need for staff and patients to work towards as independent a life as possible and in this context there was also a focus on having the right support in the community.

An assertive contact team was mentioned and that raises the question about whether such a team could support the whole range of service users who have a complex range of needs in the community to enable them to live as well and as independently as possible.

46.5 In staff comments there was an acknowledgement that the current estate is not right and that to deliver the service they want to deliver estate is important.

47. Conclusion

47.1 Overall there were positive views about staff and the care and support they provide. There was also an acknowledgement that resources are tight and that this impact on the type and prevalence of work delivered especially in relation to activities and workshops and limits their ability to focus on future for patients.

47.2 The focus on independence and life outside of the units is limited by resources on the units and outside of the units for example a lack of the right type of supported living and so work will need to be done to rebalance that.

47.3 The current estate is crucial to delivering the right type of inpatient provision and this was acknowledged by people and this enables conversations in the review to look at what is needed and how much can be redistributed to enable the community aspects of the service to be developed in the way people hope.

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Appendix 3

Mental Health Rehabilitation Review

NHS
Dorset
Clinical Commissioning Group

BCP
Health and Adult Social Care
Overview and Scrutiny Committee

YOUR NHS
Working together to shape
Dorset's Health

Let's work together to shape Mental Health rehabilitation services in Dorset.

Review stages

NHS Dorset Clinical Commissioning Group

Needs analysis and View Seeking

Options Development

NHS Assurance

Implementation

Coproduction Coproduction Coproduction Coproduction

Needs analysis

NHS Dorset Clinical Commissioning Group

- By 2020/21 the number of people in Dorset who experience serious mental illness will increase to approximately 7,882
- The number of people who may subsequently require rehabilitation (20%) is approximately 1576 and approximately 1% (78.82) of those individuals may required inpatient rehabilitation
- There is an anticipated increase in the demand for rehabilitation services
- There is a national imperative to reduce the use of out of area placements and to repatriate people back into county

View seeking

- Mental health issues don't stop at the weekend
- No one talks about me leaving here
- Being in hospital for a long time doesn't help
- Continued support for people who have been inpatients when they leave hospital – to include more support for getting involved with community activities, paying bills and budgeting, planning GP, Out patient appointments, house hold tasks and volunteer/employment assistance Staff are a good team. Genuinely caring and supportive
- AOT is quick to help me with housing, always on time for my visits and always turn up. Wouldn't ever had CBT if not under the team.
- Being in the service makes access to other help i.e. drug and alcohol services easier
- Encouraged to be more independent to adjust to life outside

Benchmarking

NHS Dorset Clinical Commissioning Group

- Benchmarking shows a range of different approaches across the country
- Oxford partnership has supported housing and other third sector providers working with the NHS to ensure that most people requiring rehabilitation are supported in the community and not in hospital
- The partnership in Oxford works with the person and identifies the best housing or other support to meet the needs of the individual
- Dorset Project Group decided that there is still a need for NHS beds plus supported living settings so not following the Oxford model.

Interdependencies

NHS Dorset Clinical Commissioning Group

- The programme has been developed within the context of national drivers for change, and local pressures.
- The Acute Care Pathway review identified and agreed the need for additional capacity and a re-shaping of acute beds
- Specialist commissioners have agreed the development of several new services locally to reduce out-of-area referrals
- CQC requirements for single room accommodation
- Parts of the Trust estate have been highlighted as in urgent need of upgrading and this includes Nightingale House and Nightingale Court

Success factors, Objectives and Constraints

NHS Dorset Clinical Commissioning Group

Objectives

- Community facing
- Deliver equity and consistency in Dorset
- Culture and Philosophy
- Range of rehab services

Success Factors

- The service will be safe and sustainable
- The option will be affordable, within the existing budget
- It will be a better experience for those that use the service
- The service will be accessible

Constraints

- Available budget
- Estates
- Time length of review
- Reduce Out of Area placements
- Travel distance 31 miles if possible

Crosscheck with people using services

People who gave views initially said that:

- They liked the potential for shorter hospital stays as long as the support outside is in place
- Community Rehab and Assertive Outreach will be good and help to keep them out of hospital
- Staff training is really important for work in the community
- Said shorter stays in hospital should not mean rushing people
- The additional options in the pathway will mean easier and better transition from hospital to the community

Possible models

NHS Dorset Clinical Commissioning Group

Option 1 Preferred

- High Dependency Unit
- 1 Community Rehab unit in east and west of the county
- Community Rehab Team and Assertive Outreach Teams
- Supported housing

Option 2

High Dependency Unit

1 Rehab unit to serve the whole county

Community Rehab Team and Assertive Outreach teams

Supported housing

Option 3

- High Dependency Unit
- 1 Community Rehab unit in east Dorset and 1 in west Dorset
- Community Rehab Team and Assertive Outreach Teams

Implications Preferred Option

NHS Dorset Clinical Commissioning Group

Current 38 NHS Beds	Future Model
Glendinning Unit (9)	14 Bed HDU
Nightingale Court (13)	9 Beds west and
Nightingale House (16)	14 beds east
	20 Supported Housing Units
38 in total	**57 in total**

Implications Preferred Option

NHS Dorset Clinical Commissioning Group

- Develop a 14 bed High Dependency Unit
- Have a Community Rehab Unit in the west and east of the county
- The development of Supported Housing option plans (part of a wider piece of work)
- Beds or accommodation would not just be provided by NHS provider but by 3rd sector in different setting such as registered care or supported housing
- One of the current rehab units will need to close in order to reconfigure the inpatient part of the service
- The number of beds or accommodation is likely to increase from 38 (current) to 43 beds plus 14 HDU beds
- The development of Community Rehab Team and enhancement of the existing Assertive Outreach Team will provide additional community support and treatment to clients already in the MH system

Questions and comments

NHS Dorset Clinical Commissioning Group

Thankyou

Any questions

Health and Adult Social Care Overview & Scrutiny Committee

Report subject	**BCP Council Corporate Safeguarding Strategy**
Meeting date	2nd September 2019
Status	Public Report
Executive summary	Ensuring that the Council's Safeguarding responsibilities are fulfilled and delivered is the responsibility of all officers and Councillors. The BCP Council Corporate Safeguarding Strategy sets out how the Council will deliver its safeguarding duties; the accountabilities of individual officers and Councillors; the training and development standards across the Council and how the Council will monitor the delivery of the framework.
Recommendations	**It is RECOMMENDED that:** **Overview & Scrutiny Committee have opportunity to consider and comment upon the Safeguarding Strategy ahead of Cabinet on 30 September 2019**
Reason for recommendations	This is a key strategy. As BCP Council has both a statutory and moral duty to make appropriate arrangements to safeguard the welfare of children, young people and adults at risk of harm.
Portfolio Holder(s):	Councillor Lesley Dedman, Portfolio Holder for Adults and Health Councillor Sandra Moore, Portfolio Holder for Children and Families
Corporate Director	Jan Thurgood, Corporate Director, Adult Social Care Judith Ramsden, Corporate Director, Children's Social Care
Contributors	Sarah Webb, Service Manager – Statutory Services, ASC David Vitty, Service Director – ASC Phil Hornsby, Service Director – Adults Commissioning Kelly Ansell – Service Director – Housing Tanya Coulter – Service Director – Legal & Democratic

	Sam Johnson – Policy & Performance Manager Anthi Minhinnick – Community Safety Partnership Manager Tracy Kybert – Housing Manager (Integrated Health & Social Care)
Wards	All
Classification	For Recommendation

Background

Safeguarding is about supporting and protecting people in their relationships with other people. It can range from taking responsibility for not causing harm through our interactions, to being mindful of people's emotional wellbeing & welfare, through to reporting concerns about a child, young person or vulnerable adult being at risk of harm or abuse.

Safeguarding is not just about meeting our statutory duties, it is about keeping each other and ourselves safe, it is about speaking out and taking appropriate action to prevent any kind of harm or abuse from happening.

Through this Strategy, BCP Council seeks commitment from its staff and representatives to promote the welfare of children, young people and adults at risk of harm, to ensure that it's residents have local, timely and high-quality services that support them to stay safe. It seeks to reinforce that this is not just the responsibility of those who work directly with these groups of people.

This Strategy emphasises that BCP Council believes this responsibility should be the 'golden thread' which runs through all our work with our communities and staff.

Summary of financial implications

1. The Council provides training in safeguarding across a range of levels to suit the many roles across the Council and it is not expected that the training requirements in the Strategy will lead to additional costs.
2. DBS Checks for Councillors may lead to additional costs. The amounts are yet to be determined and will be based upon the numbers and types of DBS Checks undertaken.

Summary of legal implications

The Council has statutory responsibilities to Safeguard children, young people and adults at risk of harm. This Strategy seeks to support the Council in carrying out these statutory duties.

Summary of human resources implications

The Strategy sets out the Council's commitments to safe recruitment of officers, volunteers and sessional employees and expectations in relation to staff training, development and support in relation to safeguarding.

Summary of environmental impact

None anticipated

Summary of public health implications

The purpose of the Strategy is to protect the wellbeing of residents and protect those most vulnerable from harm.

Summary of equality implications

In exercising its safeguarding duties, the Council needs to take full account of its duties under Equalities Legislation to ensure that it understands the needs to people with protected characteristics in relation to safeguarding and to ensure that it can meet the needs of all residents in relation to safeguarding.

Summary of risk assessment

The Strategy seeks to raise awareness and therefore reduce risk of harm occurring. This in turn reduces risks to the Council or to residents if the Council does not fulfil its statutory safeguarding duties.

Background papers

None

Appendices

Appendix 1 – BCP Council Safeguarding Strategy

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Appendix 1

BCP COUNCIL SAFEGUARDING STRATEGY

Author: Sarah Webb
Version: V3.6
Date: 14 August 2019

1. Purpose

This Safeguarding Strategy supersedes the safeguarding policies and strategies of the preceding Councils of Bournemouth, Christchurch and Poole. In this Strategy BCP Council sets out what you can expect from us and others who are expected to comply with this strategy.

1.1 Definition of 'safeguarding'
Safeguarding is about supporting and protecting people in their relationships with other people.

It can range from taking responsibility for not causing harm through our interactions, to being mindful of people's emotional wellbeing & welfare, through to reporting concerns about a child, young person or vulnerable adult being at risk of harm or abuse.

Safeguarding is not just about meeting our statutory duties, it is about keeping each other and ourselves safe, it is about speaking out and taking appropriate action to prevent any kind of harm or abuse from happening. For further detail, see Appendix 1.

1.2 BCP Council has a statutory and moral duty to make appropriate arrangements to safeguard and promote the welfare of children and adults at risk of harm.
The key pieces of legislation are the Care Act and Childrens Act.

BCP Council is committed to ensuring that it's residents, who are at risk of being unable to protect themselves from harm or abuse, have local, timely and high-quality services that support them to stay safe.

Safeguarding and promoting the welfare of children, young people and adults at risk of harm is a responsibility for all BCP Council staff and its representatives and not just the responsibility of those who work directly with these groups of people.

BCP Council believes this responsibility should be the 'golden thread' which runs through all our work with our communities and staff. We seek to promote awareness of the personal contribution that any individual can make towards Safeguarding others.

This strategy:

- sets out how BCP Council meets its legal obligations
- ensures staff and representatives understand their responsibilities
- sets out how we will protect and safeguard children, young people and adults at risk of harm or abuse
- embeds Safeguarding at the heart of planning, commissioning, decision making and delivery of services
- seeks to maximise the opportunities to identify and respond to Safeguarding needs

2. Who does the Strategy apply to?

2.1 BCP Councillors; employees; people on work placements; contractors; volunteers; partners and anyone delivering a service on behalf of BCP Council or its representatives.

2.2 We will ensure that all employees, potential employees and contractors are made aware of this Strategy and any acceptance of an offer of employment or contract will automatically be taken as a commitment of acceptance of the Strategy and a pledge to demonstrate that commitment in their performance.

2.3 This Strategy is applicable to all who represent BCP Council and applies in day to day interactions with customers and staff.

3 The Strategy

3.1 Safeguarding is everyone's responsibility. BCP Council has a leadership role and seeks to promote this ethos within our communities and, through promotion of joint working with our partners.

3.2 BCP Council believes that anyone who may have direct or indirect contact with children, young people or adults at risk of harm - or who has access to information about them - have a responsibility to safeguard and promote their welfare.

3.3 The Safeguarding Strategy focuses on the workplace responsibilities of staff, although BCP Council recognises that responsibilities of safeguarding and promoting welfare extends to an individual's personal and domestic life.

3.4 It is BCP Council's Strategy to ensure that no act or omission on the part of BCP Council, or that of its staff puts a child, young person or vulnerable adult at risk

3.5 In doing so, this Strategy highlights how BCP administers systems and processes.

- **Prevent Harm -** robust systems and procedures to proactively prevent harm from occurring, to safeguard and promote the welfare of children, young people and adults at risk and support staff to fulfil their obligations;
- **Competent & Aware -** that BCP Councillors, employees and volunteers are confident, competent, capable and receive training, so they are aware of their roles and responsibilities; for example, officers in Trading Standards or staff responsible for Licensing Taxis, will need to be aware of issues such as domestic violence, modern slavery and exploitation and how to report it.
- **Information -** to provide staff with information about the procedures they must adopt if they suspect a child or vulnerable adult may be at risk of experiencing harm or abuse;
- **Welfare and wellbeing -** of children and adults at risk is considered throughout planning and commissioning processes.

- **Public awareness -** is raised through the provision of accessible information which helps people understand different types of abuse, how to stay safe and, how to raise a concern;
- **Oversight** - of work which involves safeguarding practice through line management arrangements (i.e. Supervision / line management / appraisal processes), so it is robust;
- **Quality assurance -** thorough scrutiny processes and systems, which measure the effectiveness of services, including that effective recording and monitoring are in place;
- **Partnerships –** collaborative working with statutory, voluntary and independent agency partners, sharing responsibility for Safeguarding and providing good examples of leadership. For example, the Local Authority Education Safeguarding Advisor and Local Authority Designated Officer (LADO) works with the designated safeguarding leads in schools to promote the safeguarding agenda.

4. How is this Strategy implemented and communicated?

4.1 The following procedures will support the implementation of this strategy:

- Recruitment and selection procedures
- Induction, training and supervision procedures
- Whistleblowing policy
- Complaints procedure
- Children's safeguarding procedures
- Bournemouth, Dorset and BCP Council Multi-Agency Safeguarding Adults policy and procedure
- in the planning, design, commissioning and delivery of all BCP Council Services

4.2 This Strategy will be made publicly available on BCP Council's website.

4.3 The Strategy will also be publicised amongst staff. Information and training material will be issued to all new staff and Councillors as part of their induction package.

4.4 The Strategy will be shared with all partners through relationships e.g. Safeguarding Boards

5. Roles and Responsibilities

5.1 The Role of BCP Councillors

BCP Councillors are accountable for ensuring that safeguarding priorities are identified, and sufficient resource is available for these needs to be addressed. They will undertake scrutiny to understand the issues and whether safeguarding is effective within BCP Council.

BCP Councillors have a responsibility to support BCP Council's commitment to the safeguarding of children, young people and adults at risk of harm within BCP Council and should:

- adhere to the BCP Councillors Code of Conduct;
- attend safeguarding training to ensure that they fully understand the key issues with regards to the BCP Council's statutory safeguarding duties and responsibilities;
- scrutinise the BCP Council's Policies and Procedures on Safeguarding;
- hold the Leader, Chief Executive, Corporate Directors and Portfolio Holders with responsibility for these areas to account;
- listen to complaints /allegations and report all concerns to the appropriate BCP Council Units.

Where elected members do not act in a way that promotes safeguarding or in line with their codes of conduct, there may be grounds for reporting their behaviour to the Standards Committee, which may require an investigation under the BCP Councillor Code of Conduct.

If a safeguarding issue occurs relating to a BCP Councillor, the Designated Officer informed of the breach should contact the Monitoring Officer immediately. Where there is evidence of illegal activity, the BCP Councillor will be reported to the relevant authorities and may face criminal investigation. Annual awareness training will be offered to BCP Councillors.

In view of the raised awareness of safeguarding issues and to set an example, it is appropriate for all elected BCP Councillors to be requested to undertake a basic DBS check.

In line with the Police Act 1997 (Criminal Records) Regulations 2002, BCP Councillors undertaking regulated activity will be required to agree to undertake an Enhanced DBS.

Regulated activity includes if they:

- discharge, as a result of their membership, any education or social services function;
- are a Cabinet Member (the Cabinet discharges education and social services functions);
- are a Member of a committee of the council which discharges education or social service functions;
- are a Member of a fostering/adoption panel
- are a Member of the Corporate Parenting Board

BCP Council will fund the checks. A log of DBS checks will be maintained by Legal and Democratic Services.

BCP Councillors will be expected to review their DBS every four years on re-election.

5.2 Leader of the BCP Council

The Leader of the BCP Council is responsible for the following with regards to safeguarding:

- to encourage all BCP Councillors to attend training and seek each Political Group Leader's support in ensuring all BCP Councillors do attend specific training provided;
- to hold the Chief Executive, Directors and Officers to account to ensure the Local Authority is fulfilling its statutory role with regards to safeguarding;
- to appoint a Portfolio Holder with the capability and willingness to undertake the Champion role and statutory role for Children's Services;
- to appoint a Portfolio Holder with responsibility for Adult Safeguarding who is also aware and politically accountable for ensuring the Local Authority fulfils its legal responsibilities with regards to safeguarding adults.

5.3 Lead BCP Councillors Roles

Lead BCP Councillor roles include certain Portfolio Holders, Chairs of Overview & Scrutiny Committees and Chairs of Licensing Boards.

They are politically accountable for ensuring that the local authority fulfils its legal responsibilities for safeguarding and promoting the welfare of children, young people and adults at risk of harm abuse or neglect. Chairs of relevant Committees and Boards need to work with relevant officers to ensure that Councillors on the Committees and Boards have sufficient and relevant training and development in related safeguarding issues.

They should focus on satisfying themselves that there are systems in place for effective co-ordination of work with other agencies with relevant responsibilities (such as the police and health).

Lead BCP Councillors should also take steps to assure themselves that effective quality assurance systems are in place and functioning effectively in the local authority, and for challenging partner agencies on how they fulfil their responsibilities.

The roles of the Portfolio Holders with responsibility for safeguarding children, young people and adults at risk of harm are to:

- challenge and ensure that partner agencies are fulfilling their roles in safeguarding;
- support, challenge and monitor the roles of the Chief Executive, Corporate Directors and officers in their safeguarding roles and responsibilities.

For more information about the Lead Member for Children's Services (LMCS), see Appendix 2.

5.4 Safeguarding Responsibilities - The Role of BCP Council Officers

Whilst safeguarding is everyone's responsibility, there are several specific safeguarding roles that individuals hold within BCP Council.

The following is a guide as to the safeguarding roles within the BCP Council:

5.4.1 Chief Executive

The Chief Executive has overall responsibility regarding all aspects of safeguarding. They are expected to understand how safeguarding operates on the front-line through reporting processes and other means of hearing and observing this (this is described as a 'line of sight').

The Chief Executive is responsible for ensuring that the Directors of Children's Services and Adult Services champion safeguarding within the organisation, are fulfilling their managerial responsibilities for safeguarding and promoting the welfare of children, young people and adults at risk of harm or abuse, including by ensuring that the Safeguarding Children's Arrangements and the Safeguarding Adults Board are working effectively.

The Chief Executive and other executive officers have a Governance role to ensure that both of the above are working effectively.

5.4.2 Corporate Director of Children's and Corporate Director of Adults Services

These roles have specific responsibilities:

- to provide effective strategic professional leadership for the Children's and Adult's Services and ensure the delivery of improved outcomes for children, young people and adults in the BCP Council;
- to champion Safeguarding throughout the organisation
- to support effective interagency and partnership working to protect children, young people and adults at risk from harm;
- to lead improvements of preventative services and those delivering early interventions;
- to lead and manage any necessary cultural change;
- to lead the implementation of standards and ensure performance and practice monitoring arrangements are in place;
- to be a member of the relevant Safeguarding Board (i.e. Safeguarding Children's Arrangements or the Safeguarding Adults Board);
- to provide an example to partner agencies and organisations of good leadership and accountability in safeguarding;
- to have a line of sight of practice across services, through reporting processes and some direct contact.

5.4.3 Corporate Director Human Resources

This post holder works to ensure that stringent recruitment procedures are in place and that appropriate checks are made on staff working with children and vulnerable adults. This includes being responsible for the administration of the Disclosure and Barring Service (DBS) checks and ensuring that DBS referrals are made if appropriate.

The post holder will act as the first point of call for staff reporting safeguarding allegations against employees and will link with relevant Local Authority Designated Officer (LADO).

5.4.4 Corporate Directors

Corporate Directors of other Services:

- will ensure that staff within their Directorates have good awareness of Safeguarding, are aware of their associated responsibilities.
- will ensure their staff are aware of the processes which support BCP Council's commitment to Safeguarding and to work effectively across the organisation.
- where there are ways to support the Safeguarding commitment, they will enable their staff to do so.
- will provide leadership to promote a commitment to Safeguarding
- ensure safeguarding is considered in business planning and service delivery

5.4.5 Service Directors

- maintain a clear organisational and operational focus on safeguarding;
- identify within their Unit a Safeguarding Champion
- ensure the Safeguarding Strategy is taken account of within Service and Team plans

The roles of the Service Directors within Children and Adults Social Care Services, relating to safeguarding responsibilities are to:

- play a key role as Senior Officers in promoting the safety and wellbeing of children and adults who may be at risk of harm, abuse of neglect;
- ensure that relevant statutory requirements and other national standards are met
- contribute fully to the effective working of the relevant Safeguarding governance arrangements which cover the BCP Council area:
- ensure that effective liaison and management of any concerns about the health and welfare of a child or an adult who may be at risk of harm are responded to in line with the relevant safeguarding adults or safeguarding children's policy and procedures

5.4.6 Safeguarding Lead Managers in Adult's and Children's Services

The post-holders will:

- work to ensure the effective implementation of the Safeguarding Policies & Procedures throughout BCP Council
- raise awareness of safeguarding issues amongst staff and equip them with the information and links, including facilitating the Safeguarding Champion's network meetings;
- establish and maintain effective multi-agency working with all relevant statutory and non-statutory agencies;
- identify needs and oversee provision of staff training, including disseminating lessons learnt;
- provide professional support and advice to other colleagues and Safeguarding Champions across BCP Council and from partner organisations.

5.4.7 Line Managers across the BCP Council

Managers across the BCP Council:

- will ensure that recruitment procedures are followed and that appropriate checks for all job roles, particularly for staff working with children and vulnerable adults, including agency, voluntary, temporary or work placements. This also includes requesting Disclosure and Barring Service (DBS) checks and ensuring that DBS referrals are made if appropriate.
- will carry out the correct safeguarding induction process for all new staff including ensuring the appropriate training is attended.
- will ensure that all staff within their remit are made aware of the relevant safeguarding procedures and have the appropriate ongoing training.
- provide management oversight to ensure that the Safeguarding principles communicated through training are implemented in day to day practice
- will support Service unit Safeguarding Champions to attend relevant training and meetings relevant to their role
- will support staff to raise safeguarding concerns when necessary
- to ensure that accurate records are kept in relation to any concerns raised

5.4.8 Service Unit Safeguarding Champions

Each Service Unit will identify at least one Safeguarding Champion and they will be supported to attend quarterly network meetings led by the Safeguarding Lead officers.

This role will ensure that effective liaison and management of any concerns about the health and welfare of a child or an adult who may be at risk of harm, are responded to in line with the BCP Council safeguarding adults and safeguarding children's policy and procedures.

The key responsibilities of the Service Unit Safeguarding Champion are:

Please note that this is not a job description but allows clarity of the role of the Service Unit Safeguarding Champion:

- to attend the safeguarding meetings
- to act as a source of support, advice, and expertise when staff within the Team / Unit have a concern about possible risk or harm
- to assist colleagues to refer any cases of concern of suspected harm or abuse in conjunction with their line manager
- to receive and consider safeguarding messages and update and disseminate them, as relevant within the Unit/Team
- to ensure staff know how to access relevant safeguarding Adults and Children awareness training and Domestic Violence awareness training
- to attend regular Safeguarding Champion liaison meetings and disseminate information within their Unit/Team
- to contribute to Audits, Internal Management Reviews and Serious Case Reviews as and when required and relevant
- to give feedback on existing safeguarding policies and procedures and their development

5.4.9 Outside Organisations, Contractors and Partnership Agencies

Organisations delivering services involving children or vulnerable adults on behalf of BCP Council are required to comply with the relevant Safeguarding Policies and, where relevant, to have their own policy and procedures in place.

This includes the requirement that all specifications for contracted and commissioned services are required to comply with this Strategy.

This will be part of commissioning and contracting arrangements, which is in line with the Public Services (Social Value) Act 2012, having regard to the economic, social and environmental well-being of the public.

Relevant and proportionate safeguarding criteria will be built into the procurement documents and processes as required.

Remember "Safeguarding is Everyone's Business"

6. Behaviours, Induction, Training and Supervision

6.1 So that the behaviours of those involved in service delivery, including BCP Councillors, are above reproach and they are equipped with the skills to Safeguard vulnerable people in our community, BCP Council will ensure that all staff have an appropriate level of awareness to recognise and respond to signs of harm or abuse.

6.2 This will be done by:

- A requirement that anyone who will have contact with or access to records about children, young people, or adults at risk of harm, is subject to the appropriate statutory DBS checks before being allowed to work unsupervised with these groups or have access to their records.
- A requirement to adhere to BCP Council's Code of Conduct. BCP Councils Behaviour Framework or the appropriate Code of Conduct
- A requirement that all staff, BCP Councillors and contracted services will undertake a basic level of awareness training as part of their induction. Some staff will be required to undertake additional training depending upon their role.
- A commitment from BCP Council to uphold the Behaviour Framework or the relevant Code of Conduct

7. Enforcements and Sanctions

7.1 Failure to comply with our Safeguarding Strategy could have significant legal and financial implications for BCP Council and individuals. That is why it is important to embed Safeguarding and demonstrate consideration of Safeguarding in our strategies, policies, plans and procedures.

7.2 BCP Councillors who fail to comply with this Strategy will be subject to procedures set out in their code of conduct. Officers who breach this Strategy will be subject to BCP Councils Disciplinary Procedure

8. Information Sharing and Reporting Concerns

8.1 BCP Council will ensure that there are clear and effective procedures in place to enable the reporting of any suspected or actual cases of abuse or harm.

8.2 When there is a reasonable cause to believe that a child, young person or vulnerable adult, may be experiencing, or at risk of experiencing neglect abuse or harm, consideration must always be given to referring these concerns to Children's or Adults Social Care. Matters must be referred to the Police if there is suspicion that a crime may or has been committed.

8.3 Feedback must be given to the referrer about the action taken. However, the persons' right to confidentiality may limit the detail that can be given to third parties.

8.4 The above principles of confidentiality apply to all BCP Councillors, employees and contracted staff. However, information about children, young people, families and adults at risk of harm, neglect or abuse will be shared appropriately, and always in accordance with BCP Council's Information Management and Data Sharing Strategy. If there is any doubt whether the information ought to be shared advice must be sought from the Information Governance Team.

Contact details for reporting harm or abuse relating to an child, young person or adult can be found here.

8.5 BCP Council will apply the principles set out in its Whistle Blowing Strategy to encourage the reporting of legitimate concerns and by reassuring staff, representatives or anybody acting on their behalf that they will be protected from victimisation or future disadvantage if they raise legitimate concerns in good faith.

8.6 If you feel that a BCP Councillor has not behaved in a correct way you can make a complaint to the BCP Council to request the matter is investigated.

8.7 More information about how you may raise your concerns about a BCP Councillor can be found here.

Appendix 1 – Definitions of Safeguarding

Safeguarding is about supporting and protecting people in their relationships with other people

It can range from taking responsibility for not causing harm through our interactions, to being mindful of people's emotional wellbeing & welfare, through to reporting concerns about a child, young person or vulnerable adult being at risk of harm or abuse

Safeguarding is not just about meeting our statutory duties, it is about keeping each other and ourselves safe, it is about speaking out and taking appropriate action to prevent any kind of harm or abuse from happening

Children and Young People

Are defined as anyone under the age of 18

Safeguarding children includes:
- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children grow up with care that keeps them safe and well; and acting to enable all children to have the best outcomes

Children can be harmed through:
- witnessing and being involved in domestic violence;
- neglect of their physical care, emotional needs or living in poor home conditions;
- the impact of drug or alcohol misuse by parents;
- sexual exploitation / trafficking often linked with going missing and running away;
- exploitation involving criminal activity
- sexual abuse by family people in authority /other young people /people linked to the family;
- physical abuse;
- the impact of parents' mental health problems or learning disability;
- being victims of anti-social behaviour / bullying;
- cybercrime, including on-line grooming;
- exposure to radicalisation

Adults at risk
An adult at risk is anyone aged 18 and over who:
- has needs for care and support (whether or not the local authority is meeting any of those needs, e.g. the person may be purchasing their own care, or having it provided by family) and;
- is experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

An adult at risk may therefore be a person who:
- is frail due to age, ill health, physical disability or cognitive impairment;
- has a learning disability;
- has a physical disability and/ or a sensory impairment;

- has mental health needs including dementia or a personality disorder;
- has a long-term illness /condition;
- is addicted to alcohol or illicit substances;
- is a victim of domestic violence or abuse;
- is an unpaid carer or unpaid member of family/ friend who provides support and personal care

Other adults who may face risk may not be considered as an adult at risk of harm within the definitions above, they may be:

- victims or witnesses of domestic abuse;
- victims or people at risk of honour-based violence;
- victims of sexual violence;
- victims or people at risk of forced marriage;
- adults susceptible to radicalisation;
- victims or people at risk of human trafficking or modern slavery

Appendix 2 Further Information about lead responsibilities

Statutory guidance on the roles and responsibilities of the Director of Children's Services (DCS) and the Lead Member for Children's Services For local authorities (April 2013) states:

The Lead Member for Children's Services (LMCS)

Section 19 of the Children Act 2004 requires every top tier local authority to designate one of its BCP Councillors as Lead Member for Children's Services. The LMCS will be a local BCP Councillor with delegated responsibility from the BCP Council, through the Leader or Mayor, for children's services. The LMCS, as a member of the BCP Council Executive, has political responsibility for the leadership, strategy and effectiveness of local authority children's services. The LMCS is also democratically accountable to local communities and has a key role in defining the local vision and setting political priorities for children's services within the broader political context of the BCP Council.

The LMCS is responsible for ensuring that the needs of all children and young people, including the most disadvantaged and vulnerable, and their families and carers, are addressed. In doing so, the LMCS will work closely with other local partners to improve the outcomes and well-being of children and young people. The LMCS should have regard to the UNCRC and ensure that children and young people are involved in the development and delivery of local services. As politicians, LMCSs should not get drawn into the detailed day-to-day operational management of education and children's services. They should, however, provide strong, strategic leadership and support and challenge to the DCS and relevant BCP Councillors of their senior team as appropriate.

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BCP COUNCIL SAFEGUARDING STRATEGY

Author: Sarah Webb
Version: V3.7
Date: 21 August 2019

1. Purpose

This Safeguarding Strategy supersedes the safeguarding policies and strategies of the preceding Councils of Bournemouth, Christchurch and Poole. In this Strategy BCP Council sets out what you can expect from us and others who are expected to comply with this strategy.

1.1 Definition of 'safeguarding'
Safeguarding is about supporting and protecting people in their relationships with other people.

It can range from taking responsibility for not causing harm through our interactions, to being mindful of people's emotional wellbeing & welfare, through to reporting concerns about a child, young person or vulnerable adult being at risk of harm or abuse.

Safeguarding is not just about meeting our statutory duties, it is about keeping each other and ourselves safe, it is about speaking out and taking appropriate action to prevent any kind of harm or abuse from happening. For further detail, see Appendix 1.

1.2 BCP Council has a statutory and moral duty to make appropriate arrangements to safeguard and promote the welfare of children and adults at risk of harm.
The key pieces of legislation are the Care Act and Childrens Act.

BCP Council is committed to ensuring that it's residents, who are at risk of being unable to protect themselves from harm or abuse, have local, timely and high-quality services that support them to stay safe.

Safeguarding and promoting the welfare of children, young people and adults at risk of harm is a responsibility for all BCP Council staff and its representatives and not just the responsibility of those who work directly with these groups of people.

BCP Council believes this responsibility is core to the work of BCP Council and therefore, runs through all our work with our communities and staff. We seek to promote awareness of the personal contribution that any individual can make towards Safeguarding others.

This strategy:

- sets out how BCP Council meets its legal obligations
- ensures staff and representatives understand their responsibilities
- sets out how we will protect and safeguard children, young people and adults at risk of harm or abuse
- embeds Safeguarding at the heart of planning, commissioning, decision making and delivery of services
- seeks to maximise the opportunities to identify and respond to Safeguarding needs

2. Who does the Strategy apply to?

2.1 BCP Councillors; employees; people on work placements; contractors; volunteers; partners and anyone delivering a service on behalf of BCP Council or its representatives.

2.2 We will ensure that all employees, potential employees and contractors are made aware of this Strategy and any acceptance of an offer of employment or contract will automatically be taken as a commitment of acceptance of the Strategy and a pledge to demonstrate that commitment in their performance.

2.3 This Strategy is applicable to all who represent BCP Council and applies in day to day interactions with customers and staff.

3 The Strategy

3.1 Safeguarding is everyone's responsibility. BCP Council has a leadership role and seeks to promote this ethos within our communities and, through promotion of joint working with our partners.

3.2 BCP Council believes that anyone who may have direct or indirect contact with children, young people or adults at risk of harm - or who has access to information about them - have a responsibility to safeguard and promote their welfare.

3.3 The Safeguarding Strategy focuses on the workplace responsibilities of staff, although BCP Council recognises that responsibilities of safeguarding and promoting welfare extends to an individual's personal and domestic life.

3.4 It is BCP Council's Strategy to ensure that no act or omission on the part of BCP Council, or that of its staff puts a child, young person or vulnerable adult at risk

3.5 In doing so, this Strategy highlights how BCP Council administers systems and processes.

- **Prevent Harm -** robust systems and procedures to proactively prevent harm from occurring, to safeguard and promote the welfare of children, young people and adults at risk and support staff to fulfil their obligations;
- **Competent & Aware -** that BCP Council's Councillors, employees and volunteers are confident, competent, capable and receive training, so they are aware of their roles and responsibilities; for example, officers in Trading Standards or staff responsible for Licensing Taxis, will need to be aware of issues such as domestic violence, modern slavery and exploitation and how to report it.
- **Information -** to provide staff with information about the procedures they must adopt if they suspect a child or vulnerable adult may be at risk of experiencing harm or abuse;
- **Welfare and wellbeing -** of children and adults at risk is considered throughout planning and commissioning processes.

- **Public awareness -** is raised through the provision of accessible information which helps people understand different types of abuse, how to stay safe and, how to raise a concern;
- **Oversight** - of work which involves safeguarding practice through line management arrangements (i.e. Supervision / line management / appraisal processes), so it is robust;
- **Quality assurance -** thorough scrutiny processes and systems, which measure the effectiveness of services, including that effective recording and monitoring are in place;
- **Partnerships –** collaborative working with statutory, voluntary and independent agency partners, sharing responsibility for Safeguarding and providing good examples of leadership. For example, the Local Authority Education Safeguarding Advisor and Local Authority Designated Officer (LADO) works with the designated safeguarding leads in schools to promote the safeguarding agenda.

4. How is this Strategy implemented and communicated?

4.1 The following procedures will support the implementation of this strategy:

- Recruitment and selection procedures
- Induction, training and supervision procedures
- Whistleblowing policy
- Complaints procedure
- Children's safeguarding procedures
- Pan Dorset Multi-Agency Safeguarding Adults policy and procedure
- in the planning, design, commissioning and delivery of all BCP Council Services

4.2 This Strategy will be made publicly available on BCP Council's website.

4.3 The Strategy will also be publicised amongst staff. Information and training material will be issued to all new staff and Councillors as part of their induction package.

4.4 The Strategy will be shared with all partners through relationships e.g. Safeguarding Boards

5. Roles and Responsibilities

5.1 The Role of Councillors

Councillors are accountable for ensuring that safeguarding priorities are identified, and sufficient resource is available for these needs to be addressed. They will undertake scrutiny to understand the issues and whether safeguarding is effective within BCP Council.

Councillors have a responsibility to support BCP Council's commitment to the safeguarding of children, young people and adults at risk of harm within BCP Council and should:

- adhere to the Councillors Code of Conduct;
- attend safeguarding training to ensure that they fully understand the key issues with regards to the BCP Council's statutory safeguarding duties and responsibilities;
- scrutinise the BCP Council's Policies and Procedures on Safeguarding;
- hold the Leader, Chief Executive, Corporate Directors and Portfolio Holders with responsibility for these areas to account;
- listen to complaints /allegations and report all concerns to the appropriate BCP Council Units.

Where elected members do not act in a way that promotes safeguarding or in line with their codes of conduct, there may be grounds for reporting their behaviour to the Standards Committee, which may require an investigation under the Councillor Code of Conduct.

If a safeguarding issue occurs relating to a Councillor, the Designated Officer informed of the breach should contact the Monitoring Officer immediately. Where there is evidence of illegal activity, the Councillor will be reported to the relevant authorities and may face criminal investigation. Annual awareness training will be offered to Councillors.

In view of the raised awareness of safeguarding issues and to set an example, it is appropriate for all elected BCP Councillors to be requested to undertake a basic DBS check.

There is no national guidance available, from sources such as the Local Government Association (LGA), in relation to DBS Checks for Elected Members.

However, in line with the Police Act 1997 (Criminal Records) Regulations 2002, Councillors undertaking regulated activity will be required to agree to undertake an Enhanced DBS.

Regulated activity includes if they:

- are the Leader of the Council
- discharge, as a result of their membership, any education or social services function;
- are a Cabinet Member (the Cabinet with responsibility for discharging education and social services functions);

- are a Member of a committee of the council which discharges education or social service functions;
- are a Member of a fostering/adoption panel
- are a Member of the Corporate Parenting Board

BCP Council will fund the checks. A log of DBS checks will be maintained by Law and Governance Services.

Councillors will be expected to review their DBS every four years on re-election.

5.2 Leader of BCP Council

The Leader of the BCP Council is responsible for the following with regards to safeguarding:

- to encourage all Councillors to attend training and seek each Political Group Leader's support in ensuring all Councillors do attend specific training provided;
- to hold the Chief Executive, Directors and Officers to account to ensure the Local Authority is fulfilling its statutory role with regards to safeguarding;
- to appoint a Portfolio Holder with the capability and willingness to undertake the Champion role and statutory role for Children's Services;
- to appoint a Portfolio Holder with responsibility for Adult Safeguarding who is also aware and politically accountable for ensuring the Local Authority fulfils its legal responsibilities with regards to safeguarding adults.

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Lead Councillor roles include certain Portfolio Holders, Chairs of Overview & Scrutiny Committees and Chairs of Licensing Boards.

They are politically accountable for ensuring that the local authority fulfils its legal responsibilities for safeguarding and promoting the welfare of children, young people and adults at risk of harm abuse or neglect. Chairs of relevant Committees and Boards need to work with relevant officers to ensure that Councillors on the Committees and Boards have sufficient and relevant training and development in related safeguarding issues.

They should focus on satisfying themselves that there are systems in place for effective co-ordination of work with other agencies with relevant responsibilities (such as the police and health).

Lead Councillors should also take steps to assure themselves that effective quality assurance systems are in place and functioning effectively in the local authority, and for challenging partner agencies on how they fulfil their responsibilities.

The roles of the Portfolio Holders with responsibility for safeguarding children, young people and adults at risk of harm are to:

- challenge and ensure that partner agencies are fulfilling their roles in safeguarding;
- support, challenge and monitor the roles of the Chief Executive, Corporate Directors and officers in their safeguarding roles and responsibilities.

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The Chief Executive and other executive officers have a Governance role to ensure that both of the above are working effectively.

5.4.2 Corporate Director of Children's and Corporate Director of Adult Social Care Services

These roles have specific responsibilities:

- to provide effective strategic professional leadership for the Children's and Adult's Services and ensure the delivery of improved outcomes for children, young people and adults in the BCP Council;
- to champion Safeguarding throughout the organisation
- to support effective interagency and partnership working to protect children, young people and adults at risk from harm;
- to lead improvements of preventative services and those delivering early interventions;
- to lead and manage any necessary cultural change;
- to lead the implementation of standards and ensure performance and practice monitoring arrangements are in place;
- to be a member of the relevant Safeguarding Board (i.e. Safeguarding Children's Arrangements or the Safeguarding Adults Board);
- to provide an example to partner agencies and organisations of good leadership and accountability in safeguarding;
- to have a line of sight of practice across services, through reporting processes and some direct contact.

5.4.3 Corporate Directors

Corporate Directors of other Services:

- will ensure that staff within their Directorates have good awareness of Safeguarding, are aware of their associated responsibilities.
- will ensure their staff are aware of the processes which support BCP Council's commitment to Safeguarding and to work effectively across the organisation.
- where there are ways to support the Safeguarding commitment, they will enable their staff to do so.
- will provide leadership to promote a commitment to Safeguarding
- ensure safeguarding is considered in business planning and service delivery

5.4.4 Director of Organisational Development

This post holder works to ensure that stringent recruitment procedures are in place and that appropriate checks are made on staff working with children and vulnerable adults. This includes being responsible for the administration of the Disclosure and Barring Service (DBS) checks and ensuring that DBS referrals are made if appropriate.

The post holder will act as the first point of call for staff reporting safeguarding allegations against employees and will link with relevant Local Authority Designated Officer (LADO).

5.4.5 Service Directors

- maintain a clear organisational and operational focus on safeguarding;
- identify within their Unit a Safeguarding Champion
- ensure the Safeguarding Strategy is taken account of within Service and Team plans

The roles of the Service Directors within Children and Adults Social Care Services, relating to safeguarding responsibilities are to:

- play a key role as Senior Officers in promoting the safety and wellbeing of children and adults who may be at risk of harm, abuse of neglect;
- ensure that relevant statutory requirements and other national standards are met
- contribute fully to the effective working of the relevant Safeguarding governance arrangements which cover the Bournemouth, Christchurch and Poole areas
- ensure that effective liaison and management of any concerns about the health and welfare of a child or an adult who may be at risk of harm are responded to in line with the relevant safeguarding adults or safeguarding children's policy and procedures

5.4.6 Safeguarding Lead Managers in Adult's and Children's Services

The post-holders will:

- work to ensure the effective implementation of the Safeguarding Policies & Procedures throughout BCP Council
- raise awareness of safeguarding issues amongst staff and equip them with the information and links, including facilitating the Safeguarding Champion's network meetings;
- establish and maintain effective multi-agency working with all relevant statutory and non-statutory agencies;
- identify needs and oversee provision of staff training, including disseminating lessons learnt;
- provide professional support and advice to other colleagues and Safeguarding Champions across BCP Council and from partner organisations.

5.4.7 Line Managers across BCP Council

Managers across BCP Council:

- will ensure that recruitment procedures are followed and that appropriate checks for all job roles, particularly for staff working with children and vulnerable adults, including agency, voluntary, temporary or work placements. This also includes requesting Disclosure and Barring Service (DBS) checks and ensuring that DBS referrals are made if appropriate.
- will carry out the correct safeguarding induction process for all new staff including ensuring the appropriate training is attended.
- will ensure that all staff within their remit are made aware of the relevant safeguarding procedures and have the appropriate ongoing training.
- provide management oversight to ensure that the Safeguarding principles communicated through training are implemented in day to day practice
- will support Service unit Safeguarding Champions to attend relevant training and meetings relevant to their role
- will support staff to raise safeguarding concerns when necessary
- to ensure that accurate records are kept in relation to any concerns raised

5.4.8 Service Unit Safeguarding Champions

Each Service Unit will identify at least one Safeguarding Champion and they will be supported to attend quarterly network meetings led by the Safeguarding Lead officers.

This role will ensure that effective liaison and management of any concerns about the health and welfare of a child or an adult who may be at risk of harm, are responded to in line with the BCP Council safeguarding adults and safeguarding children's policy and procedures.

The key responsibilities of the Service Unit Safeguarding Champion are:

Please note that this is not a job description but allows clarity of the role of the Service Unit Safeguarding Champion:

- to attend the safeguarding meetings
- to act as a source of support, advice, and expertise when staff within the Team / Unit have a concern about possible risk or harm
- to assist colleagues to refer any cases of concern of suspected harm or abuse in conjunction with their line manager
- to receive and consider safeguarding messages and update and disseminate them, as relevant within the Unit/Team
- to ensure staff know how to access relevant safeguarding Adults and Children awareness training and Domestic Violence awareness training
- to attend regular Safeguarding Champion liaison meetings and disseminate information within their Unit/Team
- to contribute to Audits, Internal Management Reviews and Serious Case Reviews as and when required and relevant
- to give feedback on existing safeguarding policies and procedures and their development

5.4.9 Outside Organisations, Contractors and Partnership Agencies

Organisations delivering services involving children or vulnerable adults on behalf of BCP Council are required to comply with the relevant Safeguarding Policies and, where relevant, to have their own policy and procedures in place.

This includes the requirement that all specifications for contracted and commissioned services are required to comply with this Strategy.

This will be part of commissioning and contracting arrangements, which is in line with the Public Services (Social Value) Act 2012, having regard to the economic, social and environmental well-being of the public.

Relevant and proportionate safeguarding criteria will be built into the procurement documents and processes as required.

Remember "Safeguarding is Everyone's Business"

6. Behaviours, Induction, Training and Supervision

6.1 So that the behaviours of those involved in service delivery, including BCP Councillors, are above reproach and they are equipped with the skills to Safeguard vulnerable people in our community, BCP Council will ensure that all staff have an appropriate level of awareness to recognise and respond to signs of harm or abuse.

6.2 This will be done by:

- A requirement that anyone who will have contact with or access to records about children, young people, or adults at risk of harm, is subject to the appropriate statutory DBS checks before being allowed to work unsupervised with these groups or have access to their records.
- A requirement to adhere to BCP Council's Code of Conduct, BCP Councils Behaviour Framework and any relevant professional Code of Conduct
- A requirement that all staff, BCP Councillors and contracted services will undertake a basic level of awareness training as part of their induction. Some staff will be required to undertake additional training depending upon their role.
- A commitment from BCP Council to uphold the Behaviour Framework or the relevant Code of Conduct

7. Enforcements and Sanctions

7.1 Failure to comply with our Safeguarding Strategy could have significant legal and financial implications for BCP Council and individuals. That is why it is important to embed Safeguarding and demonstrate consideration of Safeguarding in our strategies, policies, plans and procedures.

7.2 Councillors who fail to comply with this Strategy will be subject to procedures set out in their code of conduct. Officers who breach this Strategy will be subject to BCP Councils Disciplinary Procedure

8. Information Sharing and Reporting Concerns

8.1 BCP Council will ensure that there are clear and effective procedures in place to enable the reporting of any suspected or actual cases of abuse or harm.

8.2 When there is a reasonable cause to believe that a child, young person or vulnerable adult, may be experiencing, or at risk of experiencing neglect abuse or harm, consideration must always be given to referring these concerns to Children's or Adults Social Care. Matters must be referred to the Police if there is suspicion that a crime may or has been committed.

8.3 Feedback must be given to the referrer about the action taken. However, the persons' right to confidentiality may limit the detail that can be given to third parties.

8.4 The above principles of confidentiality apply to all Councillors, employees and contracted staff. However, information about children, young people, families and adults at risk of harm, neglect or abuse will be shared appropriately, and always in accordance with BCP Council's Information Management and Data Sharing Strategy. If there is any doubt whether the information ought to be shared advice must be sought from the Information Governance Team.

Contact details for reporting harm or abuse relating to an child, young person or adult can be found here.

8.5 BCP Council will apply the principles set out in its Whistle Blowing Strategy to encourage the reporting of legitimate concerns and by reassuring staff, representatives or anybody acting on their behalf that they will be protected from victimisation or future disadvantage if they raise legitimate concerns in good faith.

8.6 If you feel that a Councillor has not behaved in a correct way you can make a complaint to the BCP Council to request the matter is investigated.

8.7 More information about how you may raise your concerns about a Councillor can be found here.

Appendix 1 – Definitions of Safeguarding

Safeguarding is about supporting and protecting people in their relationships with other people

It can range from taking responsibility for not causing harm through our interactions, to being mindful of people's emotional wellbeing & welfare, through to reporting concerns about a child, young person or vulnerable adult being at risk of harm or abuse

Safeguarding is not just about meeting our statutory duties, it is about keeping each other and ourselves safe, it is about speaking out and taking appropriate action to prevent any kind of harm or abuse from happening

Children and Young People

Are defined as anyone under the age of 18

Safeguarding children includes:
- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children grow up with care that keeps them safe and well; and acting to enable all children to have the best outcomes

Children can be harmed through:
- witnessing and being involved in domestic violence;
- neglect of their physical care, emotional needs or living in poor home conditions;
- the impact of drug or alcohol misuse by parents;
- sexual exploitation / trafficking often linked with going missing and running away;
- exploitation involving criminal activity
- sexual abuse by family people in authority /other young people /people linked to the family;
- physical abuse;
- the impact of parents' mental health problems or learning disability;
- being victims of anti-social behaviour / bullying;
- cybercrime, including on-line grooming;
- exposure to radicalisation

Adults at risk
An adult at risk is anyone aged 18 and over who:
- has needs for care and support (whether or not the local authority is meeting any of those needs, e.g. the person may be purchasing their own care, or having it provided by family) and;
- is experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

An adult at risk may therefore be a person who:
- is frail due to age, ill health, physical disability or cognitive impairment;
- has a learning disability;
- has a physical disability and/ or a sensory impairment;

- has mental health needs including dementia or a personality disorder;
- has a long-term illness /condition;
- is addicted to alcohol or illicit substances;
- is a victim of domestic violence or abuse;
- is an unpaid carer or unpaid member of family/ friend who provides support and personal care

Other adults who may face risk may not be considered as an adult at risk of harm within the definitions above, they may be:

- victims or witnesses of domestic abuse;
- victims or people at risk of honour-based violence;
- victims of sexual violence;
- victims or people at risk of forced marriage;
- adults susceptible to radicalisation;
- victims or people at risk of human trafficking or modern slavery

Appendix 2 Further Information about lead responsibilities

Statutory guidance on the roles and responsibilities of the Director of Children's Services (DCS) and the Lead Member for Children's Services For local authorities (April 2013) states:

The Lead Member for Children's Services (LMCS)

Section 19 of the Children Act 2004 requires every top tier local authority to designate one of its BCP Councillors as Lead Member for Children's Services. The LMCS will be a local BCP Councillor with delegated responsibility from the BCP Council, through the Leader or Mayor, for children's services. The LMCS, as a member of the BCP Council Executive, has political responsibility for the leadership, strategy and effectiveness of local authority children's services. The LMCS is also democratically accountable to local communities and has a key role in defining the local vision and setting political priorities for children's services within the broader political context of the BCP Council.

The LMCS is responsible for ensuring that the needs of all children and young people, including the most disadvantaged and vulnerable, and their families and carers, are addressed. In doing so, the LMCS will work closely with other local partners to improve the outcomes and well-being of children and young people. The LMCS should have regard to the UNCRC and ensure that children and young people are involved in the development and delivery of local services. As politicians, LMCSs should not get drawn into the detailed day-to-day operational management of education and children's services. They should, however, provide strong, strategic leadership and support and challenge to the DCS and relevant Councillors of their senior team as appropriate.

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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Report subject	**Forward Plan**
Meeting date	2 September 2019
Status	Public Report
Executive summary	The Chair and Vice Chair of the Health and Adult Social Care Overview and Scrutiny (O&S) Committee have worked with Officers to identify early priority areas of work for the Committee. The possible scrutiny engagement in these topics has been scoped in accordance with the requirements of the Council's Constitution. This detail is outlined in the proposed Forward Plan attached at Appendix A. The Committee is asked to consider the proposals contained in the Forward Plan and approve or amend the contents.
Recommendations	**It is RECOMMENDED that the Overview and Scrutiny Committee amend as appropriate and then approve:** 1) The Forward Plan attached at Appendix A to this report.
Reason for recommendations	The Council's Constitution requires all Overview and Scruitny bodies to set out proposed work in a Forward Plan which will be published with each agenda.

Portfolio Holder(s):	Councillor Lesley Dedman, Portfolio Holder Adults and Health
Corporate Director	Jan Thurgood, Corporate Director Adult Social Care
Contributors	Lindsay Marshall, Overview and Scrutiny Specialist Samineh Richardson, Senior Democratic and Overview and Scrutiny Officer
Wards	N/A
Classification	For Decision

Background

1. All Overview and Scrutiny (O&S) bodies are required by the Constitution to consider work priorities and set these out in a Forward Plan. When approved, this should be published with each agenda.
2. The Constitution requires that the Forward Plan of O&S bodies shall consist of work aligned to the principles of the function. The Bournemouth, Christchurch and Poole O&S function is based upon six principles:
    1. Contributes to sound decision making in a timely way by holding decision makers to account as a 'critical friend'.
    2. A member led and owned function – seeks to continuously improve through self-reflection and development.
    3. Enables the voice and concerns of the public to be heard and reflected in the Council's decision-making process.
    4. Engages in decision making and policy development at an appropriate time to be able to have influence.
    5. Contributes to and reflects the vision and priorities of the council.
    6. Agile – able to respond to changing and emerging priorities at the right time with flexible working methods.
3. The O&S Committees may take suggestions from a variety of sources to form their forward plans. This may include suggestions from members of the public, Officers of the Council, Portfolio Holders, the Cabinet and Council, members of the Committee, and other Councillors who are not on the Committee. Pending further Committee-wide discussions on scrutiny work priorities, the attached draft Forward Plan provides an outline of suggested initial priorities for the Committee. These priorities have been proposed by the Chair and Vice Chair, following consultation with Officers.

4. The Constitution requires that all suggestions for O&S work will be accompanied by detail outlining the background to the issue suggested, the proposed method

of undertaking the work and likely timescale associated, and the anticipated outcome and value to be added by the work proposed. No item of work shall join the forward plan of any O&S Committee without an assessment of this information.

Summary of financial implications

5. When establishing a Forward Plan, the Constitution requires the Overview and Scrutiny Committee to take into account the resources, including Councillor availability, Officer and financial resources, available to support their proposals.
6. To ensure sufficient resource availability across all O&S bodies, Officer advice is that, in addition to Committee items, one additional item of scrutiny inquiry work may be commissioned by an Overview and Scrutiny Committee at any one time. This may take the form of a working group or task and finish group, for example. Bodies commissioned by the Overview and Scrutiny Committees may have conferred upon them the power to act on behalf of the parent Committee in considering issues within the remit of the parent Committee and making recommendations directly to Portfolio Holders, Cabinet, Council or other bodies or people within the Council or externally as appropriate.

Summary of legal implications

7. The Council's Constitution requires all Overview and Scrutiny bodies to set out proposed work in a Forward Plan which will be published with each agenda.

Summary of human resources implications

8. N/A to this decision

Summary of environmental impact

9. N/A to this decision

Summary of public health implications

10. N/A to this decision

Summary of equality implications

11. Any member of the public may make suggestions for Overview and Scrutiny work. Further detail on this process is included with Part 4 of the Council's Constitution.

Summary of risk assessment

12. N/A to this decision.

Background papers

None

Appendices

Appendix A – Health and Adult Social Care O&S Committee Forward Plan

Forward Plan – BCP Health & Adult Social Care Overview and Scrutiny Committee

Updated 19.08.19

The following forward plan items are suggested as early priorities to the Health O&S Committee by the Chairman and Vice Chairman, following consultation with officers.

	Subject and background	Anticipated benefits and value to be added by O&S engagement	How will the scrutiny be done?	Lead Officer
	Meeting date – 2 September 2019			
1	**Up-date on the Outcome of a Judicial Review process related to changes to local health services proposed by Dorset Clinical Commissioning Group and Up-date on the Independent Review Panel process following referral to the Secretary of State of local health service changes proposed by Dorset CCG**	To receive a BCP Council update on this matter from the monitoring officer. This will ensure that Councillors are aware of progress and are fully informed and able to consider whether further council engagement in this matter is required.	Committee report	To be presented by Tanya Coulter – Monitoring Officer and Service Director for Legal and Democratic Services
2	**Safeguarding Adults Board - annual report and business plan for the year** **(suggested annual recurring item)**	The introduction to this area of work will provide the Committee with an understanding of this matter along with the opportunity to scrutinise the	Committee report	To be presented by Barrie Crook the Independent Chair of the Adult Safeguarding

	Subject and background	Anticipated benefits and value to be added by O&S engagement	How will the scrutiny be done?	Lead Officer
	The Committee will receive an introduction to the Adult Safeguarding Board and will be able to scrutinise the annual report and business plan.	annual report and business plan. The item will also provide opportunity for the Committee to consider how it would like to engage in future scrutiny opportunities relating to the Adult Safeguarding Board and consider any Committee training needs in this respect.		Board.
3	**Dorset Clinical Commissioning Group (CCG)-Mental Health Rehabilitation Services** To receive information from the CCG on a proposed new model of service for mental health rehabilitation services.	The information provided will ensure that Councillors are aware of proposals in this respect, and the views of the Committee will help inform the next stage of the process to be undertaken by the CCG.	Committee report	CCG lead – Elaine Hurll Principle Programme Lead, Mental Health
4	**Bournemouth, Christchurch and Poole Council's Safeguarding Strategy**	To comment on the BCP Safeguarding Strategy prior to its consideration at Cabinet on 30th September	Committee Report	Sarah Webb – Joint Service Manager Adult Social Care
	Meeting date – 18 November 2019			
	Adult Social Care Charging Strategy	The findings of a scrutiny working	Working group investigation, with	Pete Courage, Service

	Subject and background	Anticipated benefits and value to be added by O&S engagement	How will the scrutiny be done?	Lead Officer
5	To receive feedback from a working group of the Health O&S Committee, established to consider options relating to the BCP Adult Social Care Charging Policy. To also consider the draft Policy and proposals for public consultation and provide scrutiny, prior to consideration by Cabinet.	group will strengthen the final strategy by testing options available to the council in respect of adult social care charging.	findings to be reported to the full Committee in November.	Manager, Adult Social Care
	Meeting Date TBC			
6	**Outcome of Independent Reconfiguration Panel relating to Dorset Clinical Commissioning Group Clinical Services Review** To receive feedback on the findings of the Independent Reviewing Panel (IRP) commissioned by the Secretary of State.	The update on this matter will ensure that Councillors are aware of progress and are fully informed and able to consider whether further council engagement in this matter is required.	Committee report Note - this date is subject to change and based on the timescales of the IRP.	Tanya Coulter, Monitoring Officer and Director of Law and Governance
Commissioned Work				

	Subject and background	Anticipated benefits and value to be added by O&S engagement	How will the scrutiny be done?	Lead Officer
Work commissioned by the Committee (for example task and finish groups and working groups) is listed below. Note – to provide sufficient resource for effective scrutiny, one item of commissioned work will run at a time. Further commissioned work can commence upon completion of previous work.				
7	**Adult Social Care Charging Strategy Working Group –** as detailed at item 5 above.	As detailed at item 5 above.	In a working group August 2019 – April 2020, to include a report to Committee in November 2019 on proposals for public consultation.	Pete Courage, Service Manager, Adult Social Care