Merton Council

Healthier Communities and Older People Overview and Scrutiny Panel

Date: 7 November 2017

Time: 7.15 pm

Venue: Committee rooms C, D & E - Merton Civic Centre, London Road, Morden SM4 5DX

AGENDA

This is a public meeting – members of the public are very welcome to attend. The meeting room will be open to members of the public from 7.00 p.m.

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Healthier Communities and Older People Overview and Scrutiny Panel membership

Councillors:
Peter McCabe (Chair)
Brian Lewis-Lavender (Vice-Chair)
Laxmi Attawar
Mary Curtin
Brenda Fraser
Suzanne Grocott
Sally Kenny
Abdul Latif

Substitute Members:
Stephen Crowe
Joan Henry
Najeeb Latif
Ian Munn BSc, MRTPI(Rtd)

Co-opted Representatives
Diane Griffin (Co-opted member, non-voting)
Saleem Sheikh (Co-opted member, non-voting)

Note on declarations of interest

Members are advised to declare any Disclosable Pecuniary Interest in any matter to be considered at the meeting. If a pecuniary interest is declared they should withdraw from the meeting room during the whole of the consideration of that mater and must not participate in any vote on that matter. If members consider they should not participate because of a non-pecuniary interest which may give rise to a perception of bias, they should declare this, .withdraw and not participate in consideration of the item. For further advice please speak with the Assistant Director of Corporate Governance.

What is Overview and Scrutiny?
Overview and Scrutiny describes the way Merton's scrutiny councillors hold the Council's Executive (the Cabinet) to account to make sure that they take the right decisions for the Borough. Scrutiny panels also carry out reviews of Council services or issues to identify ways the Council can improve or develop new policy to meet the needs of local people. From May 2008, the Overview & Scrutiny Commission and Panels have been restructured and the Panels renamed to reflect the Local Area Agreement strategic themes.

Scrutiny's work falls into four broad areas:

⇒ **Call-in**: If three (non-executive) councillors feel that a decision made by the Cabinet is inappropriate they can 'call the decision in' after it has been made to prevent the decision taking immediate effect. They can then interview the Cabinet Member or Council Officers and make recommendations to the decision-maker suggesting improvements.
⇒ **Policy Reviews**: The panels carry out detailed, evidence-based assessments of Council services or issues that affect the lives of local people. At the end of the review the panels issue a report setting out their findings and recommendations for improvement and present it to Cabinet and other partner agencies. During the reviews, panels will gather information, evidence and opinions from Council officers, external bodies and organisations and members of the public to help them understand the key issues relating to the review topic.
⇒ **One-Off Reviews**: Panels often want to have a quick, one-off review of a topic and will ask Council officers to come and speak to them about a particular service or issue before making recommendations to the Cabinet.
⇒ **Scrutiny of Council Documents**: Panels also examine key Council documents, such as the budget, the Business Plan and the Best Value Performance Plan.

Scrutiny panels need the help of local people, partners and community groups to make sure that Merton delivers effective services. If you think there is something that scrutiny should look at, or have views on current reviews being carried out by scrutiny, let us know.

For more information, please contact the Scrutiny Team on 020 8545 3390 or by e-mail on scrutiny@merton.gov.uk. Alternatively, visit www.merton.gov.uk/scrutiny

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HEALTHIER COMMUNITIES AND OLDER PEOPLE OVERVIEW AND SCRUTINY PANEL
6 SEPTEMBER 2017

(7.15 pm - 9.35 pm)

PRESENT: Councillors Councillor Peter McCabe (in the Chair), Councillor Laxmi Attawar, Councillor Mary Curtin, Councillor Suzanne Grocott, Councillor Sally Kenny, Di Griffin and Saleem Sheikh

ALSO PRESENT: Daniel Elkeles, Chief Executive Epsom and St Helier, Dr James Marsh, Medical Director, St Helier, Charlotte Hall, Chief Nurse, Epsom and St Helier, Lyla Adwan-Kamara, Chief Executive Merton Centre for Independent Living, Matt Brown, Service Manager, Citizen's Advice Merton and Lambeth

Dr Dagmar Zeuner (Director, Public Health) and Hannah Doody (Director of Community and Housing) and Stella Akintan, Scrutiny Officer.

1 APOLOGIES FOR ABSENCE (Agenda Item 1)

Councillor Abdul Latif gave apologies and Councillor Stephen Crowe attended on his behalf.

Councillor Brian Lewis Lavender gave apologies and Councillor Najeeb Latif attended on his behalf.

Councillor Brenda Fraser gave apologies and Councillor Joan Henry attended on her behalf.

2 DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 2)

There were no declarations of pecuniary interests

3 MINUTES OF THE PREVIOUS MEETING (Agenda Item 3)

Mr Saleem Sheikh Co-opted member highlighted that he attended the last meeting of the Panel but this was not recorded in the minutes.

RESOLVED

That the minute is amended to show Mr Sheikh as present
That the minute is agreed as a true and accurate record of the meeting

4 EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST: 2020-2030 VISION (Agenda Item 4)

The Trust showed a video info graphic about the current challenges facing Epsom and St Helier hospitals. The Chief Executive reported that in the last year there were 900,000 patient contacts which is the highest number to date. Also, it was the only Trust in South East England to deliver the Accident and Emergency standard. The Panel congratulated the Trust on their achievements.

The Chief Executive reported that this engagement process is to consider the next steps after 2020. The current challenges are caused by the following issues:

- The current buildings are not designed for 21st healthcare
- Clinical staff currently work between Epsom and St Helier sites. This is not sustainable as there are not enough staff to provide high quality healthcare on both sites.
- The Trust needs to be financially sustainable.

A panel member said the consultation has been on-going since 2002 at an approximate cost of £40 million. Concern was expressed that this is yet another process and a decision should be made. St Helier was put forward as the most appropriate site given the high levels of deprivation in the surrounding area.

The Chief Executive said it is a concern that a decision has not been reached about this for the last 20 years. The good performance at the Trust is a good platform to highlight that the current situation is unsustainable and this issue needs to be resolved. It is a long process and there will not be a new hospital until at least 2024.

The Medical Director added that they need suitable buildings and sustainable levels of staffing to provide world class services. Staff need to be on a single site to provide this level of care. If the acute trust operated one site, there would be no need for agency staff.

A panel member asked what consultation response rate would be deemed as successful or in favour of one option. The Chief Executive reported that a consultation will take place when the NHS has made a decision on big service change, and we are nowhere near that stage yet. The Trust are being open and transparent from the beginning, outlining the problem, and potential solutions and want to engage. This will mean the consultation would have tackled the issues that are currently being raised. The Chief Executive reassured the Panel that all the options are deliverable.

Panel members were informed that this engagement process should lead to a consultation if there is enough support for the investment. A strategic outline case will be published in November and feed into the refresh of the Sustainability and Transformation Plan for Merton. The NHS need to agree a business case which will

take six months. The options, a public consultation and a full decision could be reached by 2019.

A panel member asked which of the three sites is best served by transport links. The Chief Executive said transport is poor when travelling between two sites. Ten percent of capital is for infrastructure which can address transport needs.

The Chair reiterated the councils support to maintain St Helier Hospital on the existing site and expressed concern that health inequalities has not been identified as a major issue of concern. The Chief Executive reported that the public health team at the council are the experts who lead on this and they will address this in responding to the three options for the future of the hospitals.

5 PERSONAL INDEPENDENT PAYMENT ASSESSMENT PROCESS (Agenda Item 5)

The Chief Executive of Merton Centre for Independent Living (Merton CIL) reported that there had been a number of re-occurring issues when supporting people through the Personal Independent Payments (PIP) process;

- Many assessment centres are inaccessible to wheelchair users and there no centres located within the borough.

- One of the assessment centre sites requires a journey of three changes on public transport.

- People are receiving appointment cancellations on route or experience long waits at the assessment centre.

- Assessments are inaccurate.

- The appeal process is lengthy and time consuming and the impact of losing benefit is wide-ranging; including housing re-possession. As a result they can only help a few people because they are so time consuming.

A local resident who had requested to speak about their experiences with this process addressed the Panel;

He has lived in Merton since 1968, and experienced a serious injury at work and a further injury when hit by a car some years later. As a result he has multiple health issues. Merton CIL helped him to fill in the forms for PIP. His appointment was cancelled without notice and he was not informed about the rescheduled date. A home appointment took place and he was refused increased rate of mobility because the assessor decided he could walk fifty metres although this was contradicted by the

claimant and doctors. It took nine months to complete the appeal which was very stressful. Full benefits were eventually reinstated but this process needs to be improved.

The Chief Executive of Merton Centre for Independent Living reported the reality is different from the DWP report which seems to outline best practice but this does not reflect what is happening on the ground.
.
The Service Manager at Citizens Advice Merton and Lambeth reported that claimants had often expressed concern about the examining medical practitioners process; assumptions are often made about level of mobility. This makes it difficult for DWP to make an accurate assessment. This is reflected in the tribunal figures. Overall DWP needs to apply more scrutiny to their contracts.

The Panel expressed concern that the Department for Work and Pensions did not attend the meeting. It was agreed that the Chair would write a letter to the DWP asking them to attend a meeting and ask both local MP's would be asked for their support.

RESOLVED

Merton Centre for Independent Living and Citizen's Advice Merton and Lambeth were thanked for attending the meeting and for their work in the local community.

Political groups will be asked to write to Stephen Hammond MP and Siobhain McDonagh MP to urge DWP to attend the Panel and answer questions.

Councillor Peter McCabe to write to a senior representative at DWP inviting them to attend a future meeting of the Panel to discuss the PIP process.

6 PREVENTING LONELINESS IN MERTON - DRAFT TASK GROUP REPORT (Agenda Item 6)

Councillor Sally Kenny thanked the scrutiny officer and task group members for their work.

The chair thanked the task group for their work.

The Panel raised a number of issues including:

The importance of working with faith groups

The challenges in tackling loneliness given the reduction of funding in the voluntary and community sector

The importance of working with a wide range of partners including supermarkets.

RESOLVED

The task group findings were welcomed by the Panel and it was agreed to send the report to Cabinet for approval.

7 WORK PROGRAMME 2017-18 (Agenda Item 7)

Noted by the Panel.

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Committee: Sustainable Communities Overview and Scrutiny Panel

2 November 2017

Healthier Communities & Older People Overview and Scrutiny Panel

7 November 2017

Children and Young People Overview and Scrutiny Panel

8 November 2017

Overview and Scrutiny Commission

15 November 2017

Agenda item:

Wards:

Subject: Business Plan Update 2018-2022

Lead officer: Caroline Holland

Lead member: Councillor Mark Allison

Contact officer: Roger Kershaw

Forward Plan reference number:

Recommendations:

1. That the Panel considers the proposed amendments to savings, a new saving and associated equalities analysis where applicable, set out in Appendix 1 and Appendix 4 of the attached report on the Business Plan 2018-2022 which it is proposed are incorporated into the draft MTFS 2018-22.
2. That the Panel considers the draft capital programme 2012-22 and indicative programme for 2022-27 set out in Appendix 3 of the attached report on the Business Plan
3. That the Overview and Scrutiny Commission considers the comments of the Panels on the Business Plan 2018-2022 and provides a response to Cabinet when it meets on the 11 December 2017.

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1. Purpose of report and executive summary

1.1 This report requests Scrutiny Panels to consider the latest information in respect of the Business Plan and Budget 2018-22, including proposed amendments to

savings previously agreed by Council, a new saving, and associated equalities assessments where applicable, and the draft capital programme 2018-22, and feedback comments to the Overview and Scrutiny Commission.

1.2 The Overview and Scrutiny Commission will consider the comments of the Panels and provide a response on the Business Plan 2018-22 to Cabinet when it meets on the 11 December 2017.

2. Details - Revenue

2.1 The Cabinet of 16 October 2017 received a report on the business plan for 2018-22.

2.2 At the meeting Cabinet

RESOLVED: That

1. That Cabinet agree the proposed amendments to savings set out in Appendix 1 and incorporate the financial implications into the draft MTFS 2018-22.

2. That Cabinet agrees the latest draft Capital Programme 2018-22 detailed in Appendix 3 for consideration by scrutiny in November and notes the indicative programme for 2022-27.

3. Alternative Options

3.1 It is a requirement that the Council sets a balanced budget. The Cabinet report on 16 October 2017 sets out the progress made towards setting a balanced budget. This identified the current budget position that needs to be addressed between now and the report to Cabinet on 11 December 2017, with further reports to Cabinet on 15 January 2018 and 19 February 2018, prior to Council on 28 February 2018, agreeing the Budget and Council Tax for 2018/19 and the Business Plan 2018-22, including the MTFS and Capital Programme 2018-22.

4. Capital Programme 2018-22

4.1 Details of the draft Capital Programme 2018-22 were agreed by Cabinet on 16 October 2017 in the attached report for consideration by Overview and Scrutiny panels and Commission.

5. Consultation undertaken or proposed

5.1 Further work will be undertaken as the process develops.

6. Timetable

6.1 The timetable for the Business Plan 2018-22 including the revenue budget 2018/19, the MTFS 2018-22 and the Capital Programme for 2018-22 was agreed by Cabinet on 18 September 2017.

7. Financial, resource and property implications

7.1 These are set out in the Cabinet report for 16 October 2017. (Appendix 1)

8. Legal and statutory implications

8.1 All relevant implications have been addressed in the Cabinet reports. Further work will be carried out as the budget and planning proceeds and will be included in the budget report to Cabinet on the 11 December 2017.

8.2 Detailed legal advice will be provided throughout the budget setting process further to any proposals identified and prior to any final decisions.

9. Human Rights, Equalities and Community Cohesion Implications

9.1 All relevant implications will be addressed in Cabinet reports on the business planning process.

9.2 A draft equalities assessment has been carried out with respect to the proposed replacement savings and new saving where applicable and is included as Appendix 4 to the Business Plan report (Appendix1).

10. Crime and Disorder implications

10.1 All relevant implications will be addressed in Cabinet reports on the business planning process.

11. Risk Management and Health and Safety Implications

11.1 All relevant implications will be addressed in Cabinet reports on the business planning process.

Appendices – the following documents are to be published with this report and form part of the report

Appendix 1: Cabinet report 16 October 2017: Draft Business Plan 2018-22

BACKGROUND PAPERS

12.1 The following documents have been relied on in drawing up this report but do not form part of the report:

Budget files held in the Corporate Services department.

2017/18 Budgetary Control and 2016/17 Final Accounts Working Papers in the Corporate Services Department.
Budget Monitoring working papers
MTFS working papers

13. **REPORT AUTHOR**

- Name: Roger Kershaw
- Tel: 020 8545 3458

email: roger.kershaw@merton.gov.uk

Cabinet

Date: 16 October 2017

Subject: Draft Business Plan 2018-22

Lead officer: Caroline Holland – Director of Corporate Services

Lead member: Councillor Mark Allison – Deputy Leader and Cabinet Member for Finance

Contact Officer: Roger Kershaw

Recommendations:

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1. That Cabinet agree the proposed amendments to savings set out in Appendix 1 and incorporate the financial implications into the draft MTFS 2018-22.
2. That Cabinet agrees the latest draft Capital Programme 2018-22 detailed in Appendix 3 for consideration by scrutiny in November and notes the indicative programme for 2022-27.

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1. **Purpose of report and executive summary**

1.1 This report provides an update on progress towards preparing the Business Plan 2018-22 and requests Cabinet to consider and agree some proposed amendments to savings, including replacement savings, which have been approved previously and are incorporated into the current MTFS.

1.3 The report also provides details of the latest capital programme, including new bids and an indicative programme for 2022- 2027

Details

2. Medium Term Financial Strategy 2018-22

2.1 At its meeting on 18 September 2017 Cabinet considered a report which updated the Business Plan 2018-22. At the meeting it was resolved by Cabinet:-

RESOLVED:

1. That the rolled forward MTFS for 2018-22 be noted.
2. That the latest position with regards to savings already in the MTFS be confirmed.
3. That the approach to setting a balanced budget using weighted controllable expenditure for each department as the basis for the setting of targets be agreed.

4. That the proposed corporate and departmental targets be agreed.
5. That the timetable for the Business Plan 2018-22 including the revenue budget 2018/19, the MTFS 2018-22 and the Capital Programme for 2018-22 be agreed.
6. That the process for the Service Plan 2018-22 and the progress made so far be noted.

2.2 In the September Cabinet report, the following budget gap in the MTFS was identified before identifying any new savings and income proposals:-

	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000
Budget Gap	0	5,619	15,284	828
Budget Gap (Cumulative)	0	5,619	20,903	21,731

2.3 The September Cabinet report set out initial targets, based on controllable spend and shortfalls in previously identified targets, to balance the MTFS at this stage for each department as follows:-

SAVINGS TARGETS BY DEPARTMENT	**2018/19 £000**	**2019/20 £000**	**2020/21 £000**	**2021/22 £000**	**Total £000**
Corporate Services	0	2,363	1,911	169	4,443
Children, Schools and Families	0	0	3,328	132	3,460
Environment and Regeneration	0	3,256	3,352	262	6,870
Community and Housing	0	0	6,693	265	6,958
Total	**0**	**5,619**	**15,284**	**828**	**21,731**
Cumulative	**0**	**5,619**	**20,903**	**21,731**	

3. Proposed Amendments to Previously Agreed Savings

3.1 In recent years, the introduction of multi-year financial planning has resulted in savings agreed in a particular financial year having an impact on future years. These have been incorporated into the Council's Medium Term Financial Strategy. The full year effect of savings in the current MTFS from 2018/19 onwards is shown in the following table:-

	2018/19 £000	**2019/20 £000**	**2020/21 £000**	**2022/22 £000**	**Total £000**
Corporate Services	2,043	301	0	0	2,344
Children, Schools & Families	489	429	0	0	918
Environment & Regeneration	1,358	650	0	0	2,008
Community & Housing	3,128	339	0	0	3,467
Total	**7,018**	**1,719**	**0**	**0**	**8,737**
Cumulative total	**7,018**	**8,737**	**8,737**	**8,737**	

3.2 Monitoring of the delivery of savings is important and it is essential to recognise as quickly as possible where circumstances change and savings previously agreed are either not achievable in full or in part or are delayed. The following changes to agreed savings are proposed in this report:-

3.2.1 Environment and Regeneration

There is a need to amend some savings previously agreed which are now seen to be undeliverable. The majority of these are in Development Control/Building Control where the slowdown in the economy and reduction in fee income has affected our income levels . In addition we have struggled to absorb the service changes without a significant impact on performance . Without the promised increase in planning fee charges proposed by Government earlier this year but yet to materialise we need to amend these savings . In addition some income assumptions in greenspaces have been over optimistic and whilst possible in the longer term will take more time to ramp up to.

A new saving, which will contribute towards meeting E&R's future savings target is also attached.

3.2.2 Further details of the proposed amendments to previously agreed savings and the new saving are provided in Appendix 1.

3.2.3 Equalities Assessments are included as Appendix 4.

3.3 Summary

The overall effect of the proposed amendments is set out in the following table:-

SUMMARY (cumulative)	**2018/19 £000**	**2019/20 £000**	**2020/21 £000**	**2021/22 £000**	**Total £000**
Corporate Services	0	0	0	0	0
Children, Schools & Families	0	0	0	0	0
Environment & Regeneration	0	300	0	0	300
Community & Housing	0	0	0	0	0
Total	**0**	**300**	**0**	**0**	**300**
Net Cumulative total	**0**	**300**	**300**	**300**	

4. Treasury Management: Capital Financing Costs and Investment income

4.1 The report to Cabinet in September 2017 provided information on the capital financing costs of the Capital Programme based on the July monitoring position.

4.2 Investment Income

There are two key factors that impact on the level of investment income that the Council can generate:-

- The amount invested
- The interest rate that is achieved

Based on latest information, the projected levels of investment income over the period of the MTFS have been revised. The following table show the latest projections compared with the amounts included in the MTFS approved by Cabinet in September 2017:-

Investment Income	**2018/19 Estimate £'000**	**2019/20 Estimate £'000**	**2020/21 Estimate £'000**	**2021/22 Estimate £'000**
MTFS (Cabinet September 2017)	**(393)**	**(283)**	**(258)**	***(1,184)**
Latest projections	**(566)**	**(452)**	**(428)**	***(1,355)**
Change	**(173)**	**(169)**	**(170)**	**(171)**

* Includes interest on Property Company loan

4.3 **Capital Programme for 2018-22**

This report includes the latest information on the draft Capital Programme 2018-22 based on August monitoring information including the addition of new schemes commencing in 2021/22. An indicative programme for 2022-27 is also provided. The draft programme is set out in Appendix 3.

4.4 The bidding process for 2021/22 was launched on 26 June 2017.

4.5 The current capital provision and associated revenue implications in the currently approved capital programme, based on August 2017 monitoring information, are as follows:-

	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000
Capital Programme	64,274	31,360	9,280	8,569
Revenue Implications (net of investment income	11,333	13,636	14,870	13,857

4.6 The change in the capital programme since that reported to Cabinet on 18 September 2017, based on July 2017 monitoring information, is summarised in the following table:-

	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000
Capital Programme:				
- Cabinet 18 September 2017	60,004	30,200	9,222	8,661
- Revised Position with Slippage revisions and new schemes	64,274	31,360	9,280	8,569
Change	4,270	1,160	58	(92)
Revenue impact (net of investment income)				
Cabinet 18 September 2017	11,506	13,567	14,731	13,717
Revised	11,333	13,636	14,870	13,857
Change	(173)	69	139	140

4.6 The programme has been rigorously reviewed and reduced where appropriate. The changes made to the programme are detailed within Appendix 3, along with movements when compared to the current programme. This review is continuing and it is envisaged that further information will be presented to December 2017 Cabinet.

5. Update to MTFS 2018-22

5.1 If the changes outlined in this report are agreed the forecast budget gap over the MTFS period is:-

	2018/19 £000	**2019/20 £000**	**2020/21 £000**	**2021/22 £000**
Budget Gap in MTFS	**0**	**5,215**	**20,742**	**21,571**

5.2 A more detailed MTFS is included as Appendix 2.

5.3 It is anticipated that new revenue savings/income proposals and revisions to the capital programme will continue to be identified during the business planning process and these will be included in future reports to Cabinet in accordance with the agreed timetable and these will go onto Overview and Scrutiny Panels and the Commission in January 2018.

6. Alternative Options

6.1 The range of options available to the Council relating to the Business Plan 2018-22 and for setting a balanced revenue budget and fully financed capital programme will be presented in reports to Cabinet and Council in accordance with the agreed timetable.

7. Consultation Undertaken or Proposed

7.1 All relevant bodies have been consulted.

7.2 The details in this report will be considered by the Overview and Scrutiny Panels and Commission on the following dates:-

Sustainable Communities	2 November 2017
Healthier Communities and Older People	7 November 2017
Children and Younger People	8 November 2017
Overview and Scrutiny Commission	15 November 2017

7.3 As for 2017/18, it is proposed that a savings proposals consultation pack will be prepared and distributed to all councillors at the end of December 2017 that can be brought to all Scrutiny and Cabinet meetings from 10 January 2018 onwards and to Budget Council. This makes the information more manageable for councillors and ensures that only one version of those documents is available so referring to page numbers at meetings is easier. It considerably reduces printing costs and reduces the amount of printing that needs to take place immediately prior to Budget Council.

7.4 The pack will include:

- Savings proposals
- Equality impact assessment for each saving proposal
- Service plans (these will also be printed in A3 to lay round at scrutiny meetings)

8. Timetable

8.1 In accordance with current financial reporting timetables.

8.2 The proposed timetable for developing the business plan and service plans was approved by Cabinet on 18 September 2017.

9. Financial, resource and property implications

9.1 As contained in the body of the report.

9.2 The Chancellor of the Exchequer has announced that there will be an Autumn Budget published on 22 November 2017. The Autumn Budget sets out the government's plans for the economy based on the latest forecasts from the Office for Budget Responsibility (OBR). Overall funding allocations for local government will be notified in the review but details of provisional funding allocations for each local authority will not be known until the provisional Local Government Finance Settlement is published in mid/late December 2017.

10. Legal and statutory implications

10.1 As outlined in the report.

11. Human rights, equalities and community cohesion implications

11.1 None for the purposes of this report, these will be dealt with as the budget is developed for 2018 – 2022.

11.2 Equalities Assessments for replacement savings are provided in Appendix 4.

12. Crime and Disorder Implications

12.1 Not applicable.

13. Risk Management and health and safety implications

13.1 There is a specific key strategic risk for the Business Plan, which is monitored in line with the corporate risk monitoring timetable.

14. Appendices – The following documents are to be published with this Report and form part of the Report.

Appendix 1 – Proposed Amendments to previously agreed savings
Appendix 2 – Latest draft MTFS 2018-22
Appendix 3 – Draft Capital Programme 2018-22
Appendix 4 - Equalities analyses for new saving

15. Background Papers

15.1 The following documents have been relied on in drawing up this report but do not form part of the report:

Budgetary Control and Final Accounts Working Papers in the Corporate Services Department.
Budget Monitoring working papers
MTFS working papers

16. **REPORT AUTHOR**

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- Tel: 020 8545 3458
email: **roger.kershaw@merton.gov.uk**

E&R Swap/Alternative Savings

Introduction

As at Period 5 (August), we are reporting to DMT and Cabinet the following shortfall against our agreed savings:-

YEAR IMPLEMENTED	AMOUNT (£'000)
2016/17	612
2017/18	1,447
2018/19	709
TOTAL	**2,768**

Some of this shortfall may be achieved next year but it appears that, for whatever reason, a significant proportion simply cannot be achieved.

Therefore, we need to take this opportunity to mitigate these saving shortfalls as far as possible. Due to the scale of savings in question the mitigating action may arise from other areas/services that can assist with meeting the department's targets.

Pressures

The majority of 'at risk' savings relate to Sustainable Communities, notably Development and Building Control (D&BC) but other pockets of unachievable savings exist across the department. The below tables show the key savings that are currently at risk.

Savings implemented in 2016/17

Ref	Section	Description of Saving	Savings Required £000	2017/18 Expected Shortfall £000	17/18 RAG
E&R33a	**D&BC**	Various D&BC Budgets - Increase in income from commercialisation of services	75	75	**R**
E&R39	**Future Merton**	Pre-application income. This is in addition to any previous pre-app savings proposal.	50	50	**R**
E&R10	**Parking Services**	Back office reorganisation	80	80	**R**
E&R21	**Waste Services**	HRRC Site operations procured to external provider. Contractual savings.	30	30	**R**
		Total Environment and Regeneration Savings 2016	**235**	**235**	

Savings implemented in 2017/18

Ref	Section	Description of Saving	2017/18 Savings Required	2017/18 Expected Shortfall £00	17/18 RAG
D&BC1	D&BC	Fast track of householder planning applications	55	55	R
D&BC2	D&BC	Growth in PPA and Pre-app income	50	50	R
D&BC3	D&BC	Commercialisation of building control	50	50	R
D&BC5	D&BC	Eliminate the Planning Duty service (both face to face and dedicated phone line) within D&BC	35	35	R
D&BC6	D&BC	Stop sending consultation letters on applications and erect site notices only	10	10	R
ENV20	D&BC	Increased income from building control services.	35	35	R
ENV06	Parking Services	Reduction in transport related budgets	46	46	R
ENV18	Greenspaces	Increased income from events in parks	100	100	R
		Total Environment and Regeneration Savings 2017/18	**381**	**381**	

Savings to be implemented in 2018/19

Ref	Section	Description of Saving	2018/19 £000	2018/19 Deliver-ability Risk RAG
D&BC7	D&BC	Shared service collaboration with Kingston/Sutton	50	R
D&BC8	D&BC	Review of service through shared service discussions	274	R
		TOTAL	**324**	

Proposal

The main opportunities to assist with mitigating these pressures relate to Parking Services, as follows:-

- ENV33 = £250k saving implemented this year relating to the diesel surcharge is being exceeded by c£290k. With the permit fee increasing to £115 next year, the surplus should increase to around £440k.
- E&R8 = £500k growth currently built in to Medium term Financial Strategy (MTFS) for 2018/19

This provides the department with a total budget of £940k that can be used to help offset the department's above pressures. Therefore, it is proposed that:-

- E&R8 will be used as a swap saving
- The diesel surcharge surplus will be used as an alternative saving – an Equalities Assessment is provided in Appendix 4.

This income forms part of the On-Street Parking Account maintained by the Council. Any surpluses on the account can only be applied towards the specific purposes set out in section 55 of the Road Traffic Regulation Act 1984. For example, in 2016/17 the surplus was notionally applied to concessionary fares.

The details of the Parking Account are included within the annual Statement of Accounts, and reported to the Mayor for London.

The above savings relate to income that will be included as part of the 2017/18 Parking Account in the usual manner. The associated surpluses have materialised through existing pricing structures, either agreed by Cabinet (diesel surcharge) or the Secretary of State (Penalty Charge Notices), primarily aimed at improving both driver behaviour and air quality, and reducing congestion within the borough. The Council currently utilises significant General Fund resources for transport related costs.

The following table demonstrates that the additional £440k will fund specific purposes as per the Road Traffic Regulation Act 1984:-

	£000
Parking Surplus	(7,554)
Spend on Concessionary Fares	9,319
Amount over and above Surplus applied	1,765
Additional Parking income	(440)
Revised Amount above surplus	1,325

DEPARTMENT: ENVIRONMENT AND REGENERATION SAVINGS - BUDGET PROCESS 2018/19

Panel	Ref	Description of Saving		Baseline Budget 17/18 £000	2017/18 £000	2018/19 £000	2019/20 £000	Risk Analysis Deliverability	Risk Analysis Reputational Impact	Type of Saving (see key)
SC	ENR10	**Service/Section**	**Leisure & Culture**							
		Description	Two year extension of the GLL contract	**573**			**300**	**Med**	**Low**	**SP1**
		Service Implication	Extend continuity of service provision with same contractor for 2 further years.							
		Staffing Implications	None							
		Business Plan implications	Continuity of service maintained with existing contractual arrangements. Puts back the need to reprocure contract by two years							
		Impact on other departments	Procurement and legal - as re-procurement delayed by 2 years; Children, Schools and Families - continuity of service provision by current contractor for 2 further years - school curriculum swimming, etc.							
		Equalities Implications	Continuity of service maintained with existing contractual arrangements.							
		TOM Implications	Contract change creating efficiencies. Key officer across council will be involved in the detail of the changes to ensure delivery.							

Savings Type

SI1	Income - increase in current level of charges
SI2	Income - increase arising from expansion of existing service/new service
SS1	Staffing: reduction in costs due to efficiency
SS2	Staffing: reduction in costs due to deletion/reduction in service
SNS1	Non - Staffing: reduction in costs due to efficiency
SNS2	Non - Staffing: reduction in costs due to deletion/reduction in service
SP1	Procurement / Third Party arrangements - efficiency
SP2	Procurement / Third Party arrangements - deletion/reduction in service
SG1	Grants: Existing service funded by new grant
SG2	Grants: Improved Efficiency of existing service currently funded by unringfenced grant

Panel

C&YP	Children & Young People
CC	Corporate Capacity
HC&OP	Healthier Communities & Older People
SC	Sustainable Communities

Previously Agreed Savings

DEPARTMENT: ENVIRONMENT AND REGENERATION SAVINGS

Ref	Description of Saving		2016/17 £000	2017/18 £000	2018/19 £000	Risk Analysis Deliverability	Risk Analysis Reputational Impact	Type of Saving (see key)
E&R10	**Service/Section**	**Parking Services**	**80**			**Low**	**Low**	**SS1**
	Description	Back office reorganisation						
	Service Implication	Review the current back office structure						
	Staffing Implications	Reduction in staff						
	Business Plan	Improve efficiencies by reducing revenue expenditure						
	Impact on other	None						
	Equalities Implications	None						
E&R21	**Service/Section**	**Waste Services**	**30**			**Low**	**Low**	**SP1**
	Description	HRRC Site operations procured to external provider. Contractual savings.						
	Service Implication	None - Continuation of externalised service - current procurement in progress						
	Staffing Implications	TUPE and impact on transfer station.						
	Business Plan	None						
	Impact on other	None						
	Equalities Implications	None						
E&R33a	**Service/Section**	**D&BC Various Budgets - Increase in income from commercialisation of services**	**75**			**High**	**Low**	**SI1/SI2**
	Description	Increase in commercial income across a range of budgets following recruitment of commercial sales manager from 15/16. This includes events in parks / commercial waste / leisure/ building control and other income streams to be developed						
	Service Implication	Will work closely with Business managers in EandR and across Council						
	Staffing Implications	2 year Fixed term contract due to commence early 2015 funded from Transformation budgets alongside Marketing Manager.						
	Business Plan	Consistent with transformation Plan						
	Impact on other	Will work with other income generating staff across the council						
	Equalities Implications	None anticipated						
E&R39	**Service/Section**	**Traffic & Highways**	**50**			**Med**	**Med**	**SI2**
	Description	Pre-application income. This is in addition to any previous pre-app savings proposal.						
	Service Implication	Charging for pre-application services inputted from the T&H service as part of the pre application service.						
	Staffing Implications	Delivered within existing resources						
	Business Plan	Increased income						
	Impact on other	Will require close liaison with DC/BC team						
	Equalities Implications	None						

DEPARTMENT: ENVIRONMENT AND REGENERATION SAVINGS

Ref	Description of Saving		2016/17 £000	2017/18 £000	2018/19 £000	Risk Analysis Deliverability	Risk Analysis Reputational Impact	Type of Saving (see key)
D&BC1	**Service/Section**	**Building and Development Control**						
	Description	Fast track of householder planning applications		**55**		**Low**	**Low**	**SI2**
	Service Implication	New processes to be implemented and securely embedded						
	Staffing Implications	None. Sufficient staff will have to be retained to service the concept. Failure to deliver properly and the service will not be used thereby eliminating the income generation.						
	Business Plan implications	Increased income						
	Impact on other departments	None						
	Equalities Implications	None						
	TOM Implications	In line with TOM proposals						
D&BC2	**Service/Section**	**Building and Development Control**						
	Description	Growth in PPA and Pre-app income		**50**		**Med**	**Low**	**SI2**
	Service Implication	Responsiveness to service requests should not change.						
	Staffing Implications	As the service/income improves extra staffing will be needed and funded from a proportion of that extra income.						
	Business Plan implications	Increased income						
	Impact on other departments	Future Merton could also need to adjust staffing accordingly						
	Equalities Implications	none						
	TOM Implications	In line with TOM proposals						
D&BC3	**Service/Section**	**Building and Development Control**						
	Description	Commercialisation of building control		**50**		**High**	**Low**	**SI2**
	Service Implication	This has so far proven difficult mainly due to recruitment issues						
	Staffing Implications	Will need an invest to save with any additional staff funded by some of the increased income generation						
	Business Plan implications	Increased income						
	Impact on other departments	None . Expanded team could better support other internal users						
	Equalities Implications	None						
	TOM Implications	Integral part of the TOM for BC						

DEPARTMENT: ENVIRONMENT AND REGENERATION SAVINGS

Ref	Description of Saving		2016/17 £000	2017/18 £000	2018/19 £000	Risk Analysis Deliverability	Risk Analysis Reputational Impact	Type of Saving (see key)
D&BC5	**Service/Section**	**Building and Development Control**						
	Description	Eliminate the Planning Duty service (both face to face and dedicated phone line)		**35**		**Low**	**High**	**SS2**
	Service Implication	Callers will still try to contact officers by other means in any event, so there will have to be a clear understanding and agreed supported message that such calls will not be dealt with. Web site self service improvements will be required						
	Staffing Implications	Reduce by 1FTE						
	Business Plan implications	none						
	Impact on other departments	Less assistance for pre app enquiries (unless charged)						
	Equalities Implications	reduced assistance for all residents in understanding the planning process						
	TOM Implications	Reduced customer care, contrary to the general aims of TOM						
D&BC6	**Service/Section**	**Building and Development Control**						
	Description	Stop sending consultation letters on applications and erect site notices only		**10**		**Low**	**Med**	**SNS2**
	Service Implication	Site notices will be mandatory so failsafe system to be devised						
	Staffing Implications	none						
	Business Plan implications	None						
	Impact on other departments	none						
	Equalities Implications	Those without web site connections will find it difficult to search for application details						
	TOM Implications	None						
ENV06	**Service/Section**	**Parking Services**						
	Description	Reduction in transport related budgets		**46**		**Low**	**Low**	**SNS1**
	Service Implication	May result in slight reduction in quality of some areas of service, particularly in respect of civil enforcement						
	Staffing Implications	some changes in staff travel arrangements to ensure on site as effectively and efficiently as possible.						
	Business Plan implications	None						
	Impact on other departments	None						
	Equalities Implications	None						
	TOM Implications	consistent with TOM direction of travel						

DEPARTMENT: ENVIRONMENT AND REGENERATION SAVINGS

Ref	Description of Saving		2016/17 £000	2017/18 £000	2018/19 £000	Risk Analysis Deliverability	Risk Analysis Reputational Impact	Type of Saving (see key)
ENV18	**Service/Section**	**Greenspaces**						
	Description	Increased income from events in parks		**100**		**Med**	**Med**	**SI2**
	Service Implication	Increased income through a broader range of commercial opportunities - over and above those previously agreed.						
	Staffing Implications	Some unquantified extra resource likely to be required, linked to the business case for each initiative.						
	Business Plan implications	In line with the TOM outcomes						
	Impact on other departments	None						
	Equalities Implications	None						
	TOM Implications	In line with the TOM direction of travel						
ENV20	**Service/Section**	**Development & Building Control**						
	Description	Increased income from building control services.		**35**		**Med**	**Low**	**SI2**
	Service Implication	Increased income through a broader range of commercial opportunities - over and above those previously agreed.						
	Staffing Implications	None						
	Business Plan implications	In line with the TOM outcomes						
	Impact on other departments	None						
	Equalities Implications	None						
	TOM Implications	In line with the TOM outcomes however care will be needed to ensure there is no duplication of commercial income counting .						
D&BC7	**Service/Section**	**Building and Development Control**						
	Description	Shared service collaboration with Kingston/Sutton			**50**	**Low**	**Low**	**SI2**
	Service Implication	Combined analysis of service delivery should result in further additional income streams from PPA's and Pre-apps and more efficient working practices across the service						
	Staffing Implications	Additional service demand may need more staff. Efficiencies should result in less staff.						
	Business Plan implications	Increased income, PPA's and pre apps						
	Impact on other departments	None						
	Equalities Implications	None						
	TOM Implications	Significant progress on one of the main TOM strategies						

DEPARTMENT: ENVIRONMENT AND REGENERATION SAVINGS

Ref	Description of Saving		2016/17 £000	2017/18 £000	2018/19 £000	Risk Analysis Deliverability	Risk Analysis Reputational Impact	Type of Saving (see key)
D&BC8	**Service/Section**	**Building and Development Control**						
	Description	Review of service through shared service discussions			**274**	**High**	**Med**	**SI1; SI2; SS1; SS2;SNS 1: SNS2**
	Service Implication	To be determined through shared service discussions						
	Staffing Implications	To be determined through shared service discussions						
	Business Plan implications	To be determined through shared service discussions						
	Impact on other departments	None.						
	Equalities Implications	None.						
	TOM Implications	In line with the TOM.						
		TOTAL	**235**	**381**	**324**			
		Cumulative Total	**235**	**616**	**940**			

DEPARTMENT: ENVIRONMENT AND REGENERATION SAVINGS

Ref	Description of Saving	2016/17 £000	2017/18 £000	2018/19 £000	Risk Analysis Deliverability	Risk Analysis Reputational Impact	Type of Saving (see key)

Swap Saving

Ref			2016/17 £000	2017/18 £000	2018/19 £000	Risk Analysis Deliverability	Risk Analysis Reputational Impact	Type of Saving (see key)
E&R8	**Service/Section**	**Parking Services - ORIGINALLY A GROWTH ITEM**						
	Description	In response to residents concerns about traffic congestion, enforcement of moving traffic contraventions, following the Implementation of ANPR.			**500**	**Med**	**High**	**SI2**
	Service Implication	Improvement of traffic enforcement efficiency and compliance by motorists						
	Staffing Implications	Expansion of FTEs in PCN processing and Debt Registration teams by up to 100%						
	Business Plan implications	Increase in fines from PCNs and expenditure and a need for more accommodation						
	Impact on other departments	Corporate Services: increasing accommodation will require Facilities input along with support from Business Improvement and IT infrastructure						
	Equalities Implications	None						

Alternative Saving

Ref			2016/17 £000	2017/18 £000	2018/19 £000	Risk Analysis Deliverability	Risk Analysis Reputational Impact	Type of Saving (see key)
ALT1	**Service/Section**	**Parking Services/Regulatory Services Partnership**						
	Description	The further development of the emissions based charging policy by way of increased charges applicable to resident/business permits as a means of continuing to tackle the significant and ongoing issue of poor air quality in the borough.			**440**	**Med**	**Med**	**SI2**
	Service Implication	Will have no impact on service although the permit issuing system will need to be capable of accommodating changes to the price/variety of permits.						
	Staffing Implications	None						
	Business Plan implications	Will underpin the key aims and objectives of the emerging Air Quality Action Plan deisgned to encourage cleaner air quality and and change in motorist behaviour.						
	Impact on other departments	Will require continues close liaison between Parking and EH (P) team to monitor the effectiveness of this proposal as a means of tackling poor air quality.						
	Equalities Implications	None anticipated as vehicle emissions has no known correlation with equalities groups						
	TOM Implications	Both service area TOMS (Parking & RSP) are committed to takling traffic congestion and improving air quality. The propsal is entirely consistent with these aims.						
			0	**0**	**940**			

DEPARTMENT: ENVIRONMENT AND REGENERATION SAVINGS

Ref	Description of Saving	2016/17 £000	2017/18 £000	2018/19 £000	Risk Analysis Deliverability	Risk Analysis Reputational Impact	Type of Saving (see key)
Savings Type		**Panel**					
SI1	Income - increase in current level of charges	**C&YP**				**Children & Young People**	
SI2	Income - increase arising from expansion of existing service/new service	**CC**				**Corporate Capacity**	
SS2	Staffing: reduction in costs due to deletion/reduction in service	**HC&OP**				**Healthier Communities & Older People**	
SNS1	Non - Staffing: reduction in costs due to efficiency	**SC**				**Sustainable Communities**	
SNS2	Non - Staffing: reduction in costs due to deletion/reduction in service						
SP1	Procurement / Third Party arrangements - efficiency						
SP2	Procurement / Third Party arrangements - deletion/reduction in service						
SG1	Grants: Existing service funded by new grant						
SG2	Grants: Improved Efficiency of existing service currently funded by unringfenced grant						
SPROP	Reduction in Property related costs						

DRAFT MTFS 2018-22:	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000
Departmental Base Budget 2017/18	**151,131**	**151,131**	**151,131**	**151,131**
Inflation (Pay, Prices)	3,816	7,632	10,669	13,706
Autoenrolment/Nat. ins changes	315	315	315	315
FYE – Previous Years Savings	(7,018)	(8,737)	(8,737)	(8,737)
FYE – Previous Years Growth	974	(1,532)	(1,032)	(1,032)
Amendments to previously agreed savings	0	0	0	0
Change in Net Appropriations to/(from) Reserves	(1,257)	(993)	(851)	(984)
Taxi card/Concessionary Fares	450	900	1,350	1,800
Change in depreciation/Impairment (Contra Other Corporate items)	0	0	0	0
Growth	0	0	0	0
Other	1,360	1,436	3,323	3,604
Re-Priced Departmental Budget	**149,770**	**150,151**	**156,167**	**159,802**
Treasury/Capital financing	7,885	12,135	13,510	12,631
Pensions	3,469	3,552	3,635	3,718
Other Corporate items	(18,528)	(18,866)	(18,652)	(18,661)
Levies	614	614	614	614
Sub-total: Corporate provisions	**(6,560)**	**(2,565)**	**(893)**	**(1,698)**
Sub-total: Repriced Departmental Budget + Corporate Provisions	**143,211**	**147,587**	**155,274**	**158,104**
Savings/Income Proposals 2018/19	0	(300)	(300)	(300)
Sub-total	**143,211**	**147,287**	**154,974**	**157,804**
Appropriation to/from departmental reserves	173	(92)	(234)	(100)
Appropriation to/from Balancing the Budget Reserve	(1,977)	(3,473)	0	0
BUDGET REQUIREMENT	**141,406**	**143,722**	**154,740**	**157,704**
Funded by:				
Revenue Support Grant	(10,071)	(5,076)	0	0
Business Rates (inc. Section 31 grant)	(36,304)	(37,176)	(37,725)	(38,285)
Adult Social Care Improved BCF - Budget 2017	(2,115)	(1,054)	0	0
PFI Grant	(4,797)	(4,797)	(4,797)	(4,797)
New Homes Bonus	(3,110)	(2,984)	(2,000)	(1,500)
Council Tax inc. WPCC	(85,382)	(87,420)	(89,477)	(91,552)
Collection Fund – (Surplus)/Deficit	372	0	0	0
TOTAL FUNDING	**(141,406)**	**(138,507)**	**(133,999)**	**(136,134)**
GAP including Use of Reserves (Cumulative)	**0**	**5,215**	**20,742**	**21,571**

Capital Programme as at August 2017

APPENDIX 3

	Approved 2018/19	Approved 2019/20	Approved 2020/21	Indicative 2021/22	Indicative 2022/23	Indicative 2023/24	Indicative 2024/25	Indicative 2025/26	Indicative 2026/27
Capital	**58,162**	**26,380**	**8,432**	**8,944**	**7,457**	**9,852**	**7,869**	**13,855**	**6,902**
Corporate Services	**16,798**	**10,626**	**2,135**	**3,962**	**2,510**	**4,800**	**2,862**	**4,560**	**1,920**
Business Improvement	**1,362**	**0**	**0**	**2,042**	**100**	**3,075**	**682**	**2,550**	**0**
Customer Contact Programme	**0**	**0**	**0**	**2,000**	**0**	**900**	**0**	**2,000**	**0**
IT Systems Projects	1,012	0	0	42	100	75	682	550	0
Social Care IT System	350	0	0	0	0	2,100	0	0	0
Facilities Management Total	**1,250**	**1,250**	**950**	**950**	**950**	**950**	**950**	**950**	**950**
Works to other buildings	300	650	650	650	650	650	650	650	650
Civic Centre	300	300	0	0	0	0	0	0	0
Invest to Save schemes	300	300	300	300	300	300	300	300	300
Water Safety Works	100	0	0	0	0	0	0	0	0
Asbestos Safety Works	250	0	0	0	0	0	0	0	0
Infrastructure & Transactions	**1,085**	**630**	**1,060**	**970**	**760**	**775**	**630**	**1,060**	**970**
Planned Replacement Programme	1,085	630	1,060	970	760	775	630	1,060	970
Resources	**0**	**0**	**125**	**0**	**700**	**0**	**0**	**0**	**0**
Financial System	0	0	0	0	700	0	0	0	0
ePayments System	0	0	125	0	0	0	0	0	0
Corporate Items	**13,101**	**8,746**	**0**	**0**	**0**	**0**	**600**	**0**	**0**
Acquisitions Budget	5,000	0	0	0	0	0	0	0	0
Capital Bidding Fund	0	0	0	0	0	0	0	0	0
Multi Functioning Device (MFD)	0	600	0	0	0	0	600	0	0
Housing Company	8,101	8,146	0	0	0	0	0	0	0
CPOs Morden									
Community and Housing	**629**	**480**	**630**	**280**	**280**	**280**	**280**	**630**	**280**
Housing	**629**	**280**	**280**	**280**	**280**	**280**	**280**	**280**	**280**
Disabled Facilities Grant	629	280	280	280	280	280	280	280	280
Libraries	**0**	**200**	**350**	**0**	**0**	**0**	**0**	**350**	**0**
Library Enhancement Works	0	200	0	0	0	0	0	350	0
Major Library Projects	0	0	350	0	0	0	0	0	0
Children Schools & Families	**16,905**	**7,536**	**650**	**650**	**650**	**755**	**650**	**650**	**650**
Primary Schools	**650**	**650**	**650**	**650**	**650**	**650**	**650**	**650**	**650**
Schs Cap Maint & Accessibility	650	650	650	650	650	650	650	650	650
Secondary School	**8,847**	**5,781**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Harris Academy Morden	2,194	800	0	0	0	0	0	0	0
Harris Academy Merton	100	0	0	0	0	0	0	0	0
St Mark's Academy	1,624	3,681	0	0	0	0	0	0	0
Harris Academy Wimbledon	4,930	1,300	0	0	0	0	0	0	0
SEN	**7,304**	**1,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Perseid	650	0	0	0	0	0	0	0	0
Secondary School Autism Unit	1,330	0	0	0	0	0	0	0	0
Unlocated SEN	5,324	1,000	0	0	0	0	0	0	0
CSF Schemes	**104**	**105**	**0**	**0**	**0**	**105**	**0**	**0**	**0**
Admissions IT System	0	105	0	0	0	105	0	0	0
Capital Loans to schools	104	0	0	0	0	0	0	0	0
Environment and Regeneration	**23,830**	**7,738**	**5,017**	**4,052**	**4,017**	**4,017**	**4,077**	**8,015**	**4,052**
Public Protection and Developm	**0**	**60**	**0**	**35**	**0**	**0**	**60**	**0**	**35**
Parking Improvements	0	60	0	0	0	0	60	0	0
Public Protection and Developm	0	0	0	35	0	0	0	0	35
Street Scene & Waste	**5,790**	**340**	**340**	**340**	**340**	**340**	**340**	**4,338**	**340**
Fleet Vehicles	400	300	300	300	300	300	300	300	300
Alley Gating Scheme	40	40	40	40	40	40	40	40	40
Smart Bin Leases - Street Scen	6	0	0	0	0	0	0	0	0
Waste SLWP	5,344	0	0	0	0	0	0	3,998	0
Sustainable Communities	**18,041**	**7,338**	**4,677**	**3,677**	**3,677**	**3,677**	**3,677**	**3,677**	**3,677**
Street Trees	60	60	60	60	60	60	60	60	60
Highways & Footways	3,581	3,067	3,067	3,067	3,067	3,067	3,067	3,067	3,067
Unallocated Tfl	1,865	0	0	0	0	0	0	0	0
Mitcham Area Regeneration	2,032	301	0	0	0	0	0	0	0
Morden Area Regeneration	3,000	3,000	1,000	0	0	0	0	0	0
Morden Leisure Centre	4,501	169	0	0	0	0	0	0	0
Sports Facilities	1,550	250	250	250	250	250	250	250	250
Parks	1,452	491	300	300	300	300	300	300	300

Proposed Capital Programme as at August 2017 with Bids

APPENDIX 3

	Proposed 2018/19	Proposed 2019/20	Proposed 2020/21	Proposed 2021/22	Proposed Indicative 2022/23	Proposed Indicative 2023/24	Proposed Indicative 2024/25	Proposed Indicative 2025/26	Proposed Indicative 2026/27
Capital	**59,212**	**26,630**	**8,432**	**8,844**	**7,697**	**8,952**	**7,869**	**12,855**	**7,902**
Corporate Services	**17,848**	**10,876**	**2,135**	**3,862**	**2,650**	**3,900**	**2,862**	**3,560**	**2,920**
Business Improvement	**2,412**	**250**	**0**	**1,942**	**100**	**2,175**	**682**	**1,550**	**1,000**
Customer Contact Programme	1,050	250	0	1,900	0	0	0	1,000	1,000
IT Systems Projects	1,012	0	0	42	100	75	682	550	0
Social Care IT System	350	0	0	0	0	2,100	0	0	0
Facilities Management Total	**1,250**	**1,250**	**950**	**950**	**950**	**950**	**950**	**950**	**950**
Works to other buildings	300	650	650	650	650	650	650	650	650
Civic Centre	300	300	0	0	0	0	0	0	0
Invest to Save schemes	300	300	300	300	300	300	300	300	300
Water Safety Works	100	0	0	0	0	0	0	0	0
Asbestos Safety Works	250	0	0	0	0	0	0	0	0
Infrastructure & Transactions	**1,085**	**630**	**1,060**	**970**	**900**	**775**	**630**	**1,060**	**970**
Planned Replacement Programme	1,085	630	1,060	970	900	775	630	1,060	970
Resources	**0**	**0**	**125**	**0**	**700**	**0**	**0**	**0**	**0**
Financial System	0	0	0	0	700	0	0	0	0
ePayments System	0	0	125	0	0	0	0	0	0
Corporate Items	**13,101**	**8,746**	**0**	**0**	**0**	**0**	**600**	**0**	**0**
Acquisitions Budget	5,000	0	0	0	0	0	0	0	0
Capital Bidding Fund	0	0	0	0	0	0	0	0	0
Multi Functioning Device (MFD)	0	600	0	0	0	0	600	0	0
Housing Company	8,101	8,146	0	0	0	0	0	0	0
CPOs Morden									
Community and Housing	**629**	**480**	**630**	**280**	**380**	**280**	**280**	**630**	**280**
Housing	**629**	**280**	**280**	**280**	**280**	**280**	**280**	**280**	**280**
Disabled Facilities Grant	629	280	280	280	280	280	280	280	280
Libraries	**0**	**200**	**350**	**0**	**100**	**0**	**0**	**350**	**0**
Library Enhancement Works	0	200	0	0	0	0	0	350	0
Major Library Projects	0	0	350	0	0	0	0	0	0
Children Schools & Families	**16,905**	**7,536**	**650**	**650**	**650**	**755**	**650**	**650**	**650**
Primary Schools	**650**	**650**	**650**	**650**	**650**	**650**	**650**	**650**	**650**
Schs Cap Maint & Accessibility	650	650	650	650	650	650	650	650	650
Secondary School	**8,847**	**5,781**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Harris Academy Morden	2,194	800	0	0	0	0	0	0	0
Harris Academy Merton	100	0	0	0	0	0	0	0	0
St Mark's Academy	1,624	3,681	0	0	0	0	0	0	0
Harris Academy Wimbledon	4,930	1,300	0	0	0	0	0	0	0
SEN	**7,304**	**1,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Perseid	650	0	0	0	0	0	0	0	0
Secondary School Autism Unit	1,330	0	0	0	0	0	0	0	0
Unlocated SEN	5,324	1,000	0	0	0	0	0	0	0
CSF Schemes	**104**	**105**	**0**	**0**	**0**	**105**	**0**	**0**	**0**
Admissions IT System	0	105	0	0	0	105	0	0	0
Capital Loans to schools	104	0	0	0	0	0	0	0	0
Environment and Regeneration	**23,830**	**7,738**	**5,017**	**4,052**	**4,017**	**4,017**	**4,077**	**8,015**	**4,052**
Public Protection and Developm	**0**	**60**	**0**	**35**	**0**	**0**	**60**	**0**	**35**
Parking Improvements	0	60	0	0	0	0	60	0	0
Public Protection and Developm	0	0	0	35	0	0	0	0	35
Street Scene & Waste	**5,790**	**340**	**340**	**340**	**340**	**340**	**340**	**4,338**	**340**
Fleet Vehicles	400	300	300	300	300	300	300	300	300
Alley Gating Scheme	40	40	40	40	40	40	40	40	40
Smart Bin Leases - Street Scen	6	0	0	0	0	0	0	0	0
Waste SLWP	5,344	0	0	0	0	0	0	3,998	0
Sustainable Communities	**18,041**	**7,338**	**4,677**	**3,677**	**3,677**	**3,677**	**3,677**	**3,677**	**3,677**
Street Trees	60	60	60	60	60	60	60	60	60
Highways & Footways	3,581	3,067	3,067	3,067	3,067	3,067	3,067	3,067	3,067
Unallocated Tfl	1,865	0	0	0	0	0	0	0	0
Mitcham Area Regeneration	2,032	301	0	0	0	0	0	0	0
Morden Area Regeneration	3,000	3,000	1,000	0	0	0	0	0	0
Morden Leisure Centre	4,501	169	0	0	0	0	0	0	0
Sports Facilities	1,550	250	250	250	250	250	250	250	250
Parks	1,452	491	300	300	300	300	300	300	300

Variance between Proposed and Approved Programme

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
Capital	**1,050**	**250**	**0**	**(100)**	**240**	**(900)**	**0**	**(1,000)**	**1,000**
Corporate Services	**1,050**	**250**	**0**	**(100)**	**140**	**(900)**	**0**	**(1,000)**	**1,000**
Business Improvement	**1,050**	**250**	**0**	**(100)**	**0**	**(900)**	**0**	**(1,000)**	**1,000**
Customer Contact Programme	**1,050**	**250**	**0**	**(100)**	**0**	**(900)**	**0**	**(1,000)**	**1,000**
IT Systems Projects	0	0	0	0	0	0	0	0	0
Social Care IT System	0	0	0	0	0	0	0	0	0
Facilities Management Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Works to other buildings	0	0	0	0	0	0	0	0	0
Civic Centre	0	0	0	0	0	0	0	0	0
Invest to Save schemes	0	0	0	0	0	0	0	0	0
Water Safety Works	0	0	0	0	0	0	0	0	0
Asbestos Safety Works	0	0	0	0	0	0	0	0	0
Infrastructure & Transactions	**0**	**0**	**0**	**0**	**140**	**0**	**0**	**0**	**0**
Planned Replacement Programme	0	0	0	0	140	0	0	0	0
Resources	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Financial System	0	0	0	0	0	0	0	0	0
ePayments System	0	0	0	0	0	0	0	0	0
Corporate Items	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Acquisitions Budget	0	0	0	0	0	0	0	0	0
Capital Bidding Fund	0	0	0	0	0	0	0	0	0
Multi Functioning Device (MFD)	0	0	0	0	0	0	0	0	0
Housing Company	0	0	0	0	0	0	0	0	0
CPOs Morden									
Community and Housing	**0**	**0**	**0**	**0**	**100**	**0**	**0**	**0**	**0**
Housing	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disabled Facilities Grant	0	0	0	0	0	0	0	0	0
Libraries	**0**	**0**	**0**	**0**	**100**	**0**	**0**	**0**	**0**
Library Enhancement Works	0	0	0	0	0	0	0	0	0
Major Library Projects	0	0	0	0	0	0	0	0	0
Children Schools & Families	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Primary Schools	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Schs Cap Maint & Accessibility	0	0	0	0	0	0	0	0	0
Secondary School	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Harris Academy Morden	0	0	0	0	0	0	0	0	0
Harris Academy Merton	0	0	0	0	0	0	0	0	0
St Mark's Academy	0	0	0	0	0	0	0	0	0
Harris Academy Wimbledon	0	0	0	0	0	0	0	0	0
SEN	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Perseid	0	0	0	0	0	0	0	0	0
Secondary School Autism Unit	0	0	0	0	0	0	0	0	0
Unlocated SEN	0	0	0	0	0	0	0	0	0
CSF Schemes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Admissions IT System	0	0	0	0	0	0	0	0	0
Capital Loans to schools	0	0	0	0	0	0	0	0	0
Environment and Regeneration	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Public Protection and Developm	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Parking Improvements	0	0	0	0	0	0	0	0	0
Public Protection and Developm	0	0	0	0	0	0	0	0	0
Street Scene & Waste	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Fleet Vehicles	0	0	0	0	0	0	0	0	0
Alley Gating Scheme	0	0	0	0	0	0	0	0	0
Smart Bin Leases - Street Scen	0	0	0	0	0	0	0	0	0
Waste SLWP	0	0	0	0	0	0	0	0	0
Sustainable Communities	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Street Trees	0	0	0	0	0	0	0	0	0
Highways & Footways	0	0	0	0	0	0	0	0	0
Unallocated Tfl	0	0	0	0	0	0	0	0	0
Mitcham Area Regeneration	0	0	0	0	0	0	0	0	0
Morden Area Regeneration	0	0	0	0	0	0	0	0	0
Morden Leisure Centre	0	0	0	0	0	0	0	0	0
Sports Facilities	0	0	0	0	0	0	0	0	0
Parks	0	0	0	0	0	0	0	0	0

Equality Analysis – ENR10 – Leisure & Culture Development Team

Guidance for carrying out Equality Impact Assessments is available on the intranet.

What are the proposals being assessed?	To make Leisure Centre Contract Savings at the time of the opening of the new Morden Leisure Centre (MLC) and the demise of the existing Morden Park Pools (MPP) by way of a Change to the existing Leisure Management Contract with Greenwich Leisure Limited (GLL)
Which Department/Division has the responsibility for this?	Environment & Regeneration – Public Space Division
Stage 1: Overview	
Name and job title of lead officer	Christine Parsloe, Leisure & Culture Development Manager
1. What are the aims, objectives and desired outcomes of your proposal? (Also explain proposals e.g. reduction/removal of service, deletion of posts, changing criteria etc)	Outcome: To achieve leisure management contract savings Aims: To open a new MLC, close & demolition the existing MPP Proposals: 1) The new Morden Leisure Centre (MLC) is due to be completed in the Autumn of 2018 and this will result in a Deed of Variation with the contractors Greenwich Leisure Limited (GLL) to discontinue operation of the existing Morden Park Pools (MPP) and move to operate the new MLC. In doing this we expect to be making savings on the contract sum.
2. How does this contribute to the council's corporate priorities?	Delivers savings and transformation of services
3. Who will be affected by this proposal? For example who are the external/internal customers, communities, partners, stakeholders, the workforce etc.	Customers, community organisations, schools, other departments, stakeholders etc. as we open a new leisure centre and close the existing MPP. The main terms of the contract pricing structures, membership, etc. will not change, rather a new suite of leisure opportunities will be provided generating a saving on the leisure management contract.
4. Is the responsibility shared with another department, authority or organisation? If so: Who are the partners and who has overall responsibility?	No

Stage2: Collecting evidence/data

6. What evidence have you considered as part of this assessment? List the data, results of consultation, research and other sources of evidence reviewed to determine impact on the protected characteristics (equality groups). Where there are gaps in data you may have to address this by including it in the action plan.

Type of evidence
The range and type of facilities to be included in the new MLC has already been fully considered and consulted upon with the community through formal and informal consultations, planning applications and will continue to occur as the plans and designs implemented. This will include local interest groups, disability organisations, schools, those from ethnic minority communities and faith groups.

Stage 3: Assessing impact and analysis

7. From the evidence you have considered, what areas of concern have you identified regarding the potential negative impact on one or more protected characteristics (equality groups)?

Equality group	**Positive impact**		**Potential negative impact**		**Reason**
	Yes	**No**	**Yes**	**No**	
Age	√			√	The facility mix for sports & leisure opportunities will be increased for all. The service contract will remain as is in making this saving.
Disability	√			√	
Gender Reassignment	√			√	
Marriage and Civil Partnership	√			√	
Pregnancy and Maternity	√			√	
Race	√			√	
Religion/ belief	√			√	
Sex	√			√	
Sexual orientation	√			√	
Socio-economic status	√			√	

8. How do you plan to mitigate the negative impact that has been identified above? Also describe how you will promote equality through the policy, strategy, procedure, function or service?

No negative impact identified above.

Stage4: Decision

9. Decision – Please indicate which of the following statements best describe the outcome of the EIA (✓ tick one box only)

Outcome 1 - √	**Outcome 2 -**	**Outcome 3**	**Outcome 4**
Outcome 1 – No change required: when the EIA has not identified any potential for discrimination or negative impact and all opportunities to promote equality are being addressed.		Your analysis demonstrates that the proposals are robust and the evidence shows no potential for discrimination and that you have taken all appropriate opportunities to advance equality and foster good relations between groups. If this conclusion is reached, remember to document the reasons for this and the information that you used to make this decision.	
Outcome 2 – Adjustments to remove negative impact identified by the EIA or to better promote equality. List the actions you propose to take to address this in the Action Plan.		This involves taking steps to remove barriers or to better advance equality. It can mean introducing measures to mitigate the potential negative effect. Remember that it is lawful under the Equality Act to treat people differently in some circumstances, for example taking positive action or putting in place single-sex provision where there is a need for it. It is both lawful and a requirement of the general equality duty to consider if there is a need to treat disabled people differently, including more favorable treatment where necessary.	
Outcome 3 – Continue with proposals despite having identified some potential for negative impact or missed opportunities to promote equality. In this case, the justification needs to be included in the EA and should be in line with the PSED to have 'due regard'. List the actions you propose to take to address this in the Action Plan. (You are advised to seek Legal Advice)		This means a recommendation to adopt your proposals, despite any negative effect or missed opportunities to advance equality, provided you have satisfied yourself that it does not unlawfully discriminate. In cases where you believe discrimination is not unlawful because it is objectively justified, it is particularly important that you record what the objective justification is for continuing with your proposals, and how you reached this decision. This is very important to show that you have paid 'due regard' to the Public Sector Equality Duty	

Outcome 4 – Stop and rethink: when your EA shows actual or potential unlawful discrimination.	If a policy shows unlawful discrimination it **must** be removed or changed.
Note: If your EA is assessed as **outcome 3**, explain your justification with full reasoning to continue with your proposals?	Include information as to why you suggest going ahead with your proposals despite negative impact being identified.

Stage 5: Making adjustments – Improvement Action Pan

10. Equality Analysis Improvement Action Plan template – Making adjustments for negative impact

This action plan should be completed after the assessment and analysis and outlines the action to be taken to mitigate the potential negative impact identified.

Risks or improvements identified in the EIA	Action required	Performance measure & target(s)	By when	Uses existing or additional resources?	Lead Officer	Progress
No negative impacts identified,						

Have you incorporated these actions into your divisional service plan or team plan? Please give details of where they have been included.

Included as part in the existing Leisure & Culture Development Team's transformation and service plans.

11. How will you share lessons learnt from this assessment with stakeholders and other council departments?

We will share any learning from this with others through one to one support, advice and guidance as appropriate and time allows.

Stage 6: Monitoring **The full impact of the decision may only be known after the proposals have been implemented; therefore it is important the effective monitoring is in place to assess the impact.**
How will you monitor the impact of the proposal once it has been implemented? Monitoring will be done through the leisure management contract monitoring processes within existing business practices **How often will you do this?** Quarterly through formal meetings, otherwise through day to day working and business operations.

Stage: 7 Reporting outcomes (Completed assessments must be attached to committee reports and a summary of the key findings included in the relevant section with in them)	
Summary of the assessment ➢ What are the key impacts – both negative and positive? ➢ What course of action are you advising as a result of this assessment? ➢ Are there any particular groups affected more than others? Do you suggest to proceeding with your proposals although a negative impact has been identified?	**Summary of the key findings:** None.

Stage 8: Sign off by Head of Service			
Assessment completed by: **Name/Job Title**	Christine Parsloe Leisure & Culture Development Manager	**Signature:** C A Parsloe	**Date:** **29 Sept 2017**
Improvement action plan signed off by Head of Service	Graeme Kane, Head of Public Space Division	**Signature:** G Kane	**Date:** **29 Sept 2017**
Department	**Environment & Regeneration**		

Equality Analysis

06 E&R Parking Services (Ref No. TBC)

What are the proposals being assessed?	**Further development of an emissions based charging Policy for resident/business permits**
Which Department/ Division has the responsibility for this?	**Enfv & Regeneration /Public Protection/Parking and CCTV Services**

Stage 1: Overview	
Name and job title of lead officer	Paul Walshe Head of Parking and CCTV Services
1. What are the aims, objectives and desired outcomes of your proposal? (Also explain proposals e.g. reduction/removal of service, deletion of posts, changing criteria etc)	To encourage cleaner air quality and contribute to the public health agenda
2. How does this contribute to the council's corporate priorities?	To improve the health of the Community.
3. Who will be affected by this proposal? For example who are the external/internal customers, communities, partners, stakeholders, the workforce etc.	Residents, Businesses and Trade who purchase a parking permit
4. Is the responsibility shared with another department, authority or organisation? If so, who are the partners and who has overall responsibility?	The responsibility is not shared with any other department. The section will work closely with the Shared Regulatory Service Pollution Team when implementing the proposal.

Stage 2: Collecting evidence/ data

5. What evidence have you considered as part of this assessment?
Provide details of the information you have reviewed to determine the impact your proposal would have on the protected characteristics (equality groups).

It is not believed that levels of vehicle emissions have a correlation with motorists with protected characteristics. If, during the implementing of the policy, it becomes evident that this is not the case, this assessment will be reviewed.

Stage 3: Assessing impact and analysis

6. From the evidence you have considered, what areas of concern have you identified regarding the potential negative and positive impact on one or more protected characteristics (equality groups)?

Protected characteristic (equality group)	Tick which applies Positive impact		Tick which applies Potential negative impact		Reason Briefly explain what positive or negative impact has been identified
	Yes	No	Yes	No	
Age	x			x	Healthy environment
Disability	X			x	No surcharge will be applied to a vehicle used by a Blue Badge holder
Gender Reassignment	X			x	Healthy environment
Marriage and Civil Partnership	X			x	Healthy environment
Pregnancy and Maternity	X			x	Healthy environment
Race	X			x	Healthy environment
Religion/ belief	X			x	Healthy environment
Sex (Gender)	X			x	Healthy environment
Sexual orientation	X			x	Healthy environment
Socio-economic status		X	x		The increase in costs may affect this group

7. Equality Analysis Improvement Action Plan template – Making adjustments for negative impact

This action plan should be completed after the analysis and should outline action(s) to be taken to mitigate the potential negative impact identified (expanding on information provided in Section 7 above).

Negative impact/ gap in information identified in the Equality Analysis	**Action required to mitigate**	**How will you know this is achieved?** e.g. performance measure/ target)	**By when**	**Existing or additional resources?**	**Lead Officer**	**Action added to divisional/ team plan?**
N/A						
N/A						
N/A						

Note that the full impact of the decision may only be known after the proposals have been implemented; therefore it is important the effective monitoring is in place to assess the impact.

Stage 4: Conclusion of the Equality Analysis

8. Which of the following statements best describe the outcome of the EA (Tick one box only)
Please refer to the guidance for carrying out Equality Impact Assessments is available on the intranet for further information about these outcomes and what they mean for your proposal

OUTCOME 1	**OUTCOME 2**	**OUTCOME 3**	**OUTCOME 4**
	X		

Stage 5: Sign off by Director/ Head of Service			
Assessment completed by	**Paul Walshe Head of Parking and CCTV Services**	**Signature:**	**Date: 10th Nov 2015**
Improvement action plan signed off by Director/ Head of Service	**John Hill Head of Public Protection**	**Signature:**	**Date:**

Committee: Healthier Communities and Older People Overview and Scrutiny Panel

Date: 07 November 2017

Agenda item:

Wards: ALL

Subject: Services for people who have experienced brain Injury – Somerset Safeguarding Adults Board Serious Case Review.

Lead member: Councillor Peter McCabe, Chair of the Healthier Communities and Older People overview and scrutiny panel.

Contact officer: Stella Akintan, stella.akintan@merton.gov.uk; 020 8545 3390

Recommendations:

A. That Panel members comment on the Somerset Safeguarding Board Serious Case Review and the lessons to be learned in Merton.

B. That the Panel members take into consideration the factors outlined in paragraph 2.4 in this covering report.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. At the topic suggestion workshop in May 2017 this Panel decided to scrutinise services for people who have experienced brain injury. This topic summary is attached at **Appendix A.**

1.2. Somerset Safeguarding Adults Board published a "Death of Tom-Serious Case Review" Report in June 2016, this is attached at **Appendix B**. The report outlines the experience of someone with serious brain injury who did not receive they support they needed to manage the condition. This case study provides important lessons for the NHS, local authorities and the voluntary and community sectors. Colleagues from NHS and Merton Adult Safeguarding team will also attend the meeting to present reports and answer questions.

2 DETAILS

2.1. Somerset Safeguarding Adults Board report "Death of Tom-Serious Case Review" has been summarised below by Alisha Mahmood, Graduate Management Trainee whilst doing a placement in the democracy Services team.

2.2. **What happened to Tom?**

Tom was known to the NHS at an early age as he sustained a head injury when he was knocked down by a car. Throughout his early life he also had a number of minor head injuries (at 8 years old,14 years and 17 years old).

He struggled with alcohol and substance misuse throughout his life, and due to being intoxicated, he was involved in a road traffic accident at the age of 22. Tom sustained a significant brain injury and developed epilepsy, chronic

insomnia, depression and muscle/skeletal pain. He was involved in multiple accidents after this, due to his alcohol misuse.

Tom's case can be described as a "series of crisis" that would indicate that he was a vulnerable individual with complex needs , these include: Tom's brain injury, his substance and alcohol misuse; his bicycle accident (having been advised not to ride a bike), his association with particular drug users (who were known to target vulnerable people); his former status as an "intentionally homeless" man; the concern of Taunton Deane Borough Council that he felt that he could not suitably process information or understand consequences and was unable to identify his own risks."

On June 2014 at the age of 43, Tom took his own life.

2.3. **What failings in services were identified?**

Despite voicing their concerns about Tom's mental health and depression(he frequently asserted that his life was "not worth living" his families concern's were not prioritised or used to inform a risk or capability assessment.

- Somerset Partnership Trust states that, even now, he would remain ineligible for any mental health service if he were to be referred during 2016.Services do not easily respond to individuals whose lives appear chaotic and who are barely compliant.

- A professional-led, multi-agency approach was required, however this was absent as gatekeeping criteria and service "thresholds" meant that Tom remained in harm's way. Tom's family grieved for him throughout his post brain-injury circumstances – which came increasingly unsafe - and yet their requests for help did not result in integrated working.

- Although no single agency could address Tom's support needs, it appears that nothing impelled health and social care services to work collaboratively within and across their own provision to provide direction and resolution. Multiple assessments spanning many years, including risk assessments and plans did not enable professionals across disciplines to pool their knowledge, agree priorities and review progress.

2.4.**Recommendations of the Report:**

i. Somerset's Safeguarding Adults Board seeks reassurance that the "case study" of Tom's circumstances features in sector-led and multi-agency training and that multi-agency work with individuals with complex support needs is shaped by shared goals and clear leadership.

ii. The fact of a person's traumatic brain injury and mental capacity is foregrounded in professional assessments and referrals and that family involvement is prioritised.

iii Public Health, Somerset County Council and NHS commissioners should set out how local practice and priorities match good practice concerning the support of people

with brain injury, dual diagnoses (Department of Health 2002), and the expectations of the National Suicide Prevention Strategy for England (Department of Health 2012).

v. Homefinder Somerset and housing partners identify how tenants with extensive Support needs, including those with acquired brain injuries, may access supported Housing.

2.4. **Key things for Merton councillors to take into consideration :**

- The purpose of the Report was to inform but also encourage debate on this issue; Councillors could debate the recommendations of the report in relation to practice at Merton. This could involve looking at what measures Merton has in place to prevent this happening, as well as what else could be done at Merton Council to improve our ability to serve individuals with brain injuries.

- To have an awareness of the numerous organisations and individuals that a service user with brain injuries (especially with complex needs) will come into contact with, and to consider how, at Merton, we can promote and utilise an integrated and multi faceted approach to their problems.

- To consider the importance of family members and close relatives to local authorities when assessing the mental health and risk of an individual and to look at Merton's process for engaging with family members of service users.

3 ALTERNATIVE OPTIONS

The Healthier Communities and Older People Overview and Scrutiny Panel can select topics for scrutiny review and for other scrutiny work as it sees fit, taking into account views and suggestions from officers, partner organisations and the public.

Cabinet is constitutionally required to receive, consider and respond to scrutiny recommendations within two months of receiving them at a meeting.

3.1. Cabinet is not, however, required to agree and implement recommendations from Overview and Scrutiny. Cabinet could agree to implement some, or none, of the recommendations made in the scrutiny review final report.

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. The Panel will be consulted at the meeting

5 TIMETABLE

5.1. The Panel will consider important items as they arise as part of their work programme for 2017/18

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. None relating to this covering report

7 LEGAL AND STATUTORY IMPLICATIONS

7.1. None relating to this covering report. Scrutiny work involves consideration of the legal and statutory implications of the topic being scrutinised.

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. It is a fundamental aim of the scrutiny process to ensure that there is full and equal access to the democratic process through public involvement and engaging with local partners in scrutiny reviews. Furthermore, the outcomes of reviews are intended to benefit all sections of the local community.

9 CRIME AND DISORDER IMPLICATIONS

9.1. None relating to this covering report. Scrutiny work involves consideration of the crime and disorder implications of the topic being scrutinised.

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. None relating to this covering report

11 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

- Appendix A: Brain Injury topic suggestion summary
- Appendix B: Somerset Safeguarding Adults Board report "Death of Tom-Serious Case Review, June 2016.

12 BACKGROUND PAPERS

12.1.

Topic: Services for people who have experienced Brain Injury

"Brain injury is the leading cause of death and disability in young people" [1]. Approximately one million people in the UK are living with the effects of an acquired brain injury (ABI)[2]. ABI is an injury that has occurred since birth. It includes traumatic brain injury (TBI) which is an injury caused by an external force such as in a road traffic collision, violent assault or a fall. Non-traumatic brain injury includes tumours, strokes and encephalitis.

Someone is admitted to hospital with a brain injury every 90 seconds in the UK. Within Merton for 2013/14, there was a total incidence rate of 545 per 100,000 for acquired brain injury (ABI) whilst the prevalence of traumatic brain injury (TBI) in the borough was 2396. The total of ABI admissions from the Merton Clinical Commissioning Group for 2013/14 listed 938 individuals whilst Sutton and Merton Community Service listed a total of 2128 admissions in 2012/13.

Even after a minor head injury, brain function can be impaired while the more severe the brain injury, the more pronounced the long-term effects are likely to be. Brain injury can lead to physical, cognitive, emotional and behavioural problems. Survivors of more severe brain injury are likely to have psychiatric co-morbidity and complex long-term problems affecting their personality, their relationships and their ability to lead an independent life.

Rehabilitation is concerned with helping an injured person to recover, as far as possible, the functions that they used to have before the injury. Where this is not possible, it aims to help the individual to achieve the highest possible level of independence. Rehabilitation is critical to recovery after a brain injury because, unlike most other cells in the body, brain cells do not regenerate when they are damaged.

Research shows that effective rehabilitation of brain injury is cost-effective, reduces health inequalities and enables people to manage their own health and wellbeing as independently as possible. This, in turn, is likely to lead to a reduced reliance on state support in the long term as people are able to maximise their recoveries and care for themselves.

Better services for brain injury survivors within the borough would reduce isolation and health inequalities, enable people to remain or regain independence and prevent individuals from seeking long term care and avoid survivors of a brain injury from coming into contact with the criminal justice system.

Residents who sustain an ABI in Merton benefit from having an internationally renowned acute service at St George's University Hospitals NHS Foundation Trust

[1] Health Select Committee : Head Injury Rehabilitation, March 2001
[2]Alan Tennant, The epidemiology of head injury, Department of Rehabilitation Medicine, The University of Leeds, March 2005

on their doorstep. Subsequently, there is an excellent neurorehabilitation service provided at St George's. This service is provided for patients who require intensive therapy. In-patients are admitted for a 12-week programme and follow individually tailored programmes based on goals set by the patient and their family or carers, in collaboration with the treating team.

How could scrutiny look at it?

- This could be considered as an in-depth task group review
- A visit could be made to the acute neurosciences centre and neurorehabilitation services at St George's to see how services manage patients and their rehabilitation.
- Evidence could be sought from rehabilitation specialists to consider if there is adequate provision in Merton and what services are provided to brain injury survivors on discharge to smooth their transition from hospital to home.
- An in-depth review of commissioned services for brain injury survivors could be completed for the Healthier Communities and Older People Panel, where scrutiny could invite participation from Public Health, St George's University Hospitals NHS Foundation Trust, Adult Social Care, Merton CCG and the voluntary sector.
- Scrutiny could propose improved services for individuals who have sustained a brain injury. This might include developing a prevention strategy, reducing admissions to hospital or residential care by offering short-term, focused support when survivors or their families face a potential crisis. Public Health may identify strategies to reduce head injuries caused by road traffic collisions, improved cycle safety and a reduction in falls.

SOMERSET SAFEGUARDING ADULTS BOARD

The death of 'Tom'

A Serious Case Review

Margaret Flynn,

CPEA Ltd

June 2016

Introduction

The Circumstances that led to the review

1. Tom was born in 1971. He was the eldest of his mother's three children. Tom's parents separated when he was eight years old. As a young child he was "sweet natured and very protective of his siblings. He was very fond of animals…there was nothing nasty or aggressive about him…he was always anti-authority."
2. Tom became known to the NHS at an early age. In addition to the usual childhood illnesses and injuries, primary care services noted that, as a three-year-old, Tom sustained a head injury when he was knocked down by a car. He had a minor head injury as an eight-year-old; had concussion and a head injury when he was 14 (which his family attribute to school sport activities); and had a minor head injury and laceration when he was 17. Tom's family also recalled that he had "a number of motorbike accidents." It was during his teenage years that Tom began drinking. At 20, he was receiving help initially for alcohol abuse and subsequently for drug misuse. He had several convictions.[1]
3. At the age of 22, Tom sustained a significant brain injury resulting from a road traffic accident. Even after this accident he sustained more head injuries during December 2011, June 2012, July 2012 and June 2013 - all of which were associated with his being intoxicated.
4. As a young teenager Tom had attended a Child Guidance Clinic. According to his family, he was abler than his examination results attested. He had won a scholarship to a prestigious school. It was membership of a particular group of his peers that was associated with his shoplifting and being expelled from this school, after which, "it went downhill from there…he did crazy things on motorbikes and was on and off drugs." His family were unable to divert him from his involvement in criminal activities which led to an appearance at a juvenile court plus a referral to social services.
5. Following his brain injury, Tom became known as a local character and was a familiar sight sporting a Mohican haircut, camouflage gear and listening to Classic FM at a high volume. He attached a horn to his electric wheelchair to warn pedestrians of his approach. Professionals who knew him considered Tom to be "intelligent, politically aware and anti-establishment."[2] After his brain injury Tom believed that his life was "not worth living." He developed epilepsy, chronic insomnia, depression and muscle/skeletal pain.
6. Tom lived with his partner, Liz, until 2013 when he was evicted. He had had a rolling tenancy agreement. Initially, Tom acted as her carer because Liz had herself sustained a brain injury. However, their relationship deteriorated when his substance misuse became so hazardous that he could no longer provide essential care-giving tasks. Liz became fearful of the people he allowed into her home. Tom became homeless. His final placement on an impoverished estate was calamitous.
7. Tom was 43 when he took his own life during June 2014.

[1] Avon and Somerset Police IMR

[2] Tom's family confirmed that he would "probably have appreciated being known as anti-establishment"

About this Serious Case Review

Terms of Reference

8. The following questions were asked of the services which had contact with Tom:
    i. Did your agency follow its own policies and procedures and wider professional standards? Did it act in accordance with the terms of the multi-agency Safeguarding Adults Policy in respect of Tom at the relevant times?
    ii. Was Tom's capacity assessed with regard to making decisions about his welfare and do your records demonstrate that his wishes and feelings were ascertained and considered in the decision-making process?
    iii. Were assessments and decisions adequately recorded and did decisions and actions accord with assessments? Were appropriate services and support offered/ provided?
    iv. Was information shared appropriately between agencies and at an appropriate level of seniority? Were there any issues in respect of communication, information sharing (including transfer of records where appropriate) or service delivery? Were relevant enquiries made in the light of information provided including, where appropriate, requests for records from other areas?
    v. What impact, if any, did Tom's brain injury, cognitive ability, mental health and substance misuse have on proposed interventions and decision-making?
    vi. Did your agency respond in a timely and appropriate manner to any concerns being raised by family members and carers?

Chronology

9. Pivotal events 1993 - 2003

During **1990**, Tom left the family home. He had "a very repetitive [desk] job…which he hated and later left, about 1991/2… [his family] didn't really know all he got up to, details emerged later, especially when he did a spell inside for begging in the street. Apparently, he had been involved in stealing cars, several police chases, ram-raiding shops, a few burglaries, then taking drugs and drinking."[3]

At the beginning of **1993**, Tom was drinking heavily. He was arrested; he was admitted to hospital with alcohol toxicity. He discharged himself from hospital, but continued to drink and was readmitted because he had had a "possible fit."

By mid-1993, Tom had been dry for several months during which time he became unmotivated and suicidal. His appearance deteriorated. He was described by primary care as "not amenable to medical help."

During **October 1993**, Tom stole a car, was arrested and during December appeared in court and was fined.

On **22 December 1993**, Tom's family recall that he had been working on a car which was neither taxed nor insured. However, he took it for a test-run and sustained traumatic brain

[3] Information from Tom's family

injuries in a collision. The accident resulted in three weeks of intensive care treatment followed by acute treatment. Tom became hemiplegic, he had aphasia,[4] he developed epilepsy and he developed insomnia.

During **February 1994**, Tom was transferred to a rehabilitation unit for a period of "extensive neuro-rehabilitation with comprehensive multi-professional and multi-agency support" including speech therapy and physiotherapy. Musgrove Park Hospital noted that he attended "many outpatient appointments where his various ongoing health needs were assessed." However, it noted that "…some actions Tom agreed to were not followed through and also, it is not clear if…actions required by other agencies…were undertaken."

During **May 1994**, Tom was discharged from the rehabilitation unit. He married his girlfriend[5] who had shared the intensive care, bedside vigil with his family. She left him after two months.

Tom's family recall that during 1994, Tom was subject to "rapid mood swings" and he became "irritable and aggressive" after his brain injury. It was difficult distinguishing the agitation caused by his brain injury from the irritability provoked by his profound awareness of his compromised abilities. In spite of the rehabilitation programme, his family accepted that "He couldn't take things in - although socially, his manner suggested that he could…He could be volatile so you had to be careful what you said. It was like treading on eggshells." He was referred for further physiotherapy due to his painful right hip and right knee.

Tom was now eligible for *inter alia,* the Disability Living Allowance.

Tom's family can recall no occasion when they were invited, by either health or social care professionals to share with them his pre-brain-injury biography. Although the gap between the vibrant capability of his pre-brain-injury and his post-brain injury disability was most evident to his family, "we were never privy to any of the assessments…after the injury he didn't see the point of living."

During **1995 - 98**, Tom was prescribed various medications and his drug and alcohol abuse persisted. He trialled the use of an electric wheelchair;[6] was issued with an Orange badge;[7] and sustained a fall. Although he wanted to recover his driving licence, his GP and the DVLA decided that he should not drive.

Tom began to receive incapacity to work benefits. He sprained a knee and was referred to physiotherapy.

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[4] Loss of the ability to speak or understand spoken or written language

[5] It has been speculated that, during this period, perhaps more information was disclosed to his girlfriend than to his family

[6] Although *Tom used an electric wheelchair to cover longer distances* he *managed with an unsteady gait, to walk shorter distances…over time this caused wear on his hip and increased associated pain*

[7] This became a Blue Badge, that is, a parking permit which permits disabled drivers and passengers to park nearer to where they are going

During **June 2000**, Tom referred himself to Headway.[8] He disclosed a drug habit which he stated was "under control." He attended Headway's centre for one day a week. According to his family he spent the rest of his week, "pottering about. He was good at making things. He was good at woodwork. He made bird tables and planters and when he moved in with his girlfriend, he made a stand for her and adapted an exercise bike for her. He set up bird feeders and he enjoyed watching them and the badgers. He was good at calligraphy and he carved house names in 3D. Over time the physical aspect of woodworking became painful and he couldn't stand easily. He listened to music – punk and classical – and he enjoyed the TV programme Countdown." Tom's mental arithmetic skills were unaffected by his brain injury.

Tom's family cited Headway as the only specialist service which he received. It provided "a bridge between pottering and doing something rehabilitative."

Tom sprained a knee once more and was referred to orthopaedics. He also sprained a shoulder, for which he was referred for physiotherapy.

Tom received a social care assessment during 13 June 2000 - 11 August 2000, although there are no apparently documents as evidence of this or its outcome.[9]

During **2001**, Tom continued to receive physiotherapy for his shoulder sprain. His drug and alcohol abuse persisted. Tom disclosed that he was not feeling himself due to his drug use and "stress" in his relationship with his partner Liz.[10]

During **2002**, Headway wrote to Tom informing him that he could not bring alcohol or drugs to the centre since this was contrary to policy. Within months it issued Tom with a "final warning" concerning his behaviour and outbursts at the centre.

During **2003**, Tom was a daily cannabis user; he was taking prescription medication for pain management to excess; he was drinking to excess; and he was having fits. He was referred to the neurology department, not least because of his depression and mood swings. He required reminding about his anti-social behaviour at the centre. He told centre staff that his life was "not worth living." He agreed to be referred to a psychiatrist. He also disclosed concern about his home life.

10. From 2004 – 2012

During **2004**, Tom was known to be refusing help for his addictions.[11] Although subject to low moods he declined counselling. He was diagnosed[12] with post traumatic epilepsy. He

[8] A UK - wide organisation, the mission of which is: *to promote understanding of all aspects of brain injury and provide information, support and services to survivors, their families and carers.*
See www.headway.org.uk/about-brain-injury/ (accessed on 3 January 2016)

[9] Similarly, there are no documents evidencing assessments of 7 May 2008 and two during July 2008

[10] Liz had sustained brain injury from an accident which left her wheelchair dependent. She was awarded compensation which enabled her family to purchase an adapted bungalow. Her relatives were Court Appointed Deputies

[11] Primary Care IMR

was warned of the risk of cycling, counselled on drug and alcohol use and his GP was advised to refer him to agencies for support. The Headway service was concerned about Tom's poor mental state and he was referred to neuropsychology. An MRI scan revealed that Tom had "bilateral temporal lobe atrophy, left more than right, and some left-sided atrophy in the upper brain stem."[13]

During **2005**, Tom sustained a wrist fracture and was prescribed medication for pain. His continuing shoulder pain resulted in a referral to physiotherapy.

Tom shared his misgivings about attending the Headway service since it made him "more upset." He acknowledged that he was taking recreational drugs and declined access to counselling and support.[14] He reported to a clinical psychologist that he was "no good in life, would like help re-engaging…feels doesn't fit in. He was drinking alcohol, smoking cannabis and using diamorphine. Wants to change substance misuse…Liaise with mental health services. Send Tom record sheets for recording substance misuse."[15] He attended an anger management session. His sister became his advocate.

During **October 2005**, Tom and his sister attended an outpatient appointment for his substance misuse. He explained to a clinical psychologist that he used drugs and alcohol "to numb" his mind. Contact was made with local drug and alcohol services and Tom was requested to record his substance use and mood. Tom's family were concerned that he was in contact with many professionals and yet "he could not take anything in." It is his family's perception that professionals believed they were engaging with a man who was mentally capable following his rehabilitation and processes of compensatory adaptation. However, Tom was experiencing chronic insomnia after his brain injury. He was plagued by depression[16] and, unsupervised, his addictions compromised his cognitive abilities.

During **November 2005**, Tom met the clinical psychologist once more. It was noted that he had not completed the substance record sheets and was still using drugs and alcohol. "Not sure if he wants to change. Will consider reducing habit…low self-esteem and drug/alcohol problem coping strategy in stressful situations. To attend Turning Point. To work on self-esteem through setting long-term, medium-term and short-term goals."

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[12] Taunton and Somerset NHS Foundation Trust

[13] Temporal lobe injuries damage the brain's organisation and categorisation of verbal information, language comprehension, long term memory and affective behaviour for example. http://www.neuroskills.com/brain-injury/temporal-lobes.php (accessed 27 January 2016)

[14] Headway IMR chronology

[15] Musgrove Park Hospital IMR chronology

[16] The Primary care IMR notes that during 1993 and 1994 Tom was treated with antidepressants, referred Tom to psychology (in 1995) neurology (in 2003 and 2004) arising from "depression and mood swings," neuropsychology (in 2005 and 2013)

During **2006**,[17] Tom moved in with Liz. He became Liz's carer; she paid him £100 per week in recognition of the support he provided to her. His family believe that caring for Liz "gave him a purpose."

Tom's sister, who is a psychologist, shared the family's concern about the combination of Tom's brain injury, his addictions and depression. Tom's biographical memory was compromised by his brain injury. His concentration and speed of processing had become limited, his attention to detail was ephemeral and "he had no complex problem solving ability." Information about appointments was sent directly to Tom even though his family asked if they could be involved. He was forgetful, and could be so incapacitated that he missed appointments.

During **2007**, Tom was admitted to hospital for five days for hip problem treatment. He had been overdosing as pain management. An MRI scan of his left hip was planned. His family recalled that Liz was left without assistance at this time.

A social worker and Tom's GP addressed a problem with his Disability Living Allowance.

During **2008**, Tom sustained a further knee sprain. Headway made contact with his sister because of his continuing drug use at the centre.

During **2009**, Tom was prescribed medication for the "stress" associated with caring for his partner. He disclosed to Headway that he was spending £50 a week on drugs.[18]

During **May 2009**, Tom attended A&E. He had fallen off his bike and fractured a shoulder.

During **2010**, Headway identified and assessed the risks associated with Tom bringing alcohol into the centre and his history of drug and alcohol dependency.

During **2011**, Tom was prescribed medication for his chronic insomnia.

A friend, who was himself a drug user and had been involved in some of the offences for which Tom had been convicted, was noted by the police to be a "regular visitor" to Liz's home.

At the end of the year, Tom arrived at the Headway service so inebriated that he had a fall. He explained that he was "trying to block out the memory of his accident" (18 years previously) and that "all the Christmas hoo-ha" reminded him of this.

Tom's alcohol and drug use presented additional challenges for the Headway centre during **2012**, not least since its driver was no longer willing to provide Tom and Liz with transport. During March 2012, Liz disclosed to Headway staff that Tom had not been sober for the last few days and had been unable to provide her with the support she required. Tom "had very

[17] Email correspondence from Tom's family during October 2013, stated that Tom *saw a neuropsychologist in 2006/2007 who felt he had depression but refused to work with him until he addressed his alcohol and drug issues…a cop out as the drug use and depression are too closely linked…can't fix one at a time – both need addressing in tandem*

[18] Tom's family believe that Tom could fund his drug addiction because he didn't eat adequately. One of the consequences of his brain injury was that he did not feel hungry and his sense of smell was compromised

little insight into the problem…he opted to go home straight after lunch after becoming verbally aggressive with staff and clients."

During **May 2012**, adult social care decided that Tom was eligible "at substantial level for ongoing day centre support" but ineligible for transport or personal care. (Initially, Tom and Liz accessed the centre using public transport and, subsequently, Liz paid a private taxi.)

The social care assessment was "written from Tom's own perspective." It is acknowledged to be inadequate since there was "no holistic assessment of how Tom managed risk and the capacity assessment is very limited." This and all preceding assessments did not take account of Tom's role as Liz's partner and carer. His family believes that professionals "missed the subtleties of his condition by dealing with bits – it's just drugs, it's drinking, it's homelessness – no one put the whole picture together and saw him as a depressed, vulnerable man who was brain damaged with mental health problems exacerbated by drugs and alcohol."

During **June 2012**, Tom sustained a head injury/laceration above his right eyebrow. The hospital noted that he had "fallen from his wheelchair after drinking alcohol." According to Tom he had not been drinking "to excess."

There were two occasions during **July 2012** when Tom arrived at the Headway service confused and disoriented. On the first occasion Tom was taken to hospital for observation. On the second, he fell and cut his head. He was allocated a social worker "to look at day services issues."

During **August 2012**, police records state that: "found on stairs at the address was a mirror and a foil wrap containing burnt powder and an empty cling film wrap. There are concerns for Liz's welfare." This information was shared with adult social care.

During **October 2012**, Tom had a fit while in a café after which he informed the police that his phone had been stolen. This was not borne out by the CCTV coverage.

Tom was visiting primary care throughout 2012, requesting treatment for backache, and his hip and knee problems. At the end of the year he was prescribed antibiotics for food poisoning.

11. 2013

During **January 2013**, adult social care undertook a review of Tom's day service support. Also, he was referred to orthopaedics, and then to rheumatology, because of his knee. He had a rheumatology review during February.

During **February 2013**, a police intelligence report stated that two drug users had moved into Liz's home and a third was a frequent visitor. Liz was reported to be "afraid of them but because Tom is her primary carer and seems to have said it is OK for them to be there, she feels very vulnerable and unable to get rid of them…[she] has no other care package or involvement from Adult Social Care/Social Services."

At the end of the month, social workers visited Tom and Liz. They declined help with personal care and domestic chores.

During **March 2013**, Headway contacted the Department of Work and Pensions on Tom's behalf. He was distressed because he could not access his benefits.

A member of the public advised the police that Tom was walking down the street wearing a top hat and black jacket with no footwear. A welfare-check established that Tom was "a little eccentric."[19]

During **April 2013**, Headway noted that Tom appeared to be taking a lot of painkillers. He spoke about "buying drugs to help with the [hip] pain." At Tom's rheumatology outpatient appointment, it was noted that his substance misuse was chronic and that he was drinking "a bottle or two of wine a few times a week." He was discharged from the clinic during May 2013.

A police intelligence report stated that Tom and Liz had been "targeted" by two people who had moved into Liz's home and taken money from them, one of whom had "bail conditions" not to enter the locality and specifically, not to enter Liz's home. Another drug user continued to associate with Tom.

Tom's family recall that there was a "case review" during **May 2013** at which it was concluded that "an emergency care plan" was required for Tom and Liz. It was noted that, "…over the past year there have been several instances when Tom has been incapable of caring for Liz, either due to alcohol or drug abuse or due to his own physical disabilities…nothing has ever been done about this."[20]

On **5 June 2013**, an engineer carrying out checks at Liz's home heard a man "calling through his door saying he was unwell.**"** The police and ambulance service gained entrance and found Tom in bed asleep.

Tom's social worker contacted Headway. Headway had alerted adult social care to Tom's deteriorating condition between **8 May** and **4 June**. It had become difficult for Headway staff to witness the trauma that the pain was causing Tom, since he "continues to be almost reduced to tears with the pain in his hip and has described his increasing use of 'street drugs' because the medicines he is prescribed don't touch the pain."

On **29 June 2013**, Tom fell out of his wheelchair, lacerated his chin and sustained a right, lower leg injury. He was taken to the Emergency Department by ambulance. He explained that he was "due for a left total hip replacement[21] on 1 July 2013 for osteoarthritis; he smokes heroin for pain relief, and denies intravenous drug use for last six months –

[19] It is not known whether or not Tom made a deliberate and capacitated decision to live his life in an unconventional way or even if he considered himself to be eccentric. He had enjoyed wearing his top hat and his jacket from a morning suit which had brightly coloured buttons. He was buried wearing this jacket.

[20] Letter of complaint dated 18 November 2013

[21] In correspondence, Tom's family assert that the hip replacement was *desperately required in part because he has been supporting and caring for Liz*

previously injected into left arm…says he drinks 8-12 units of alcohol a week…nothing abnormal detected." He was admitted to the Medical Admissions Unit to start intravenous antibiotics. Whilst there, he declined to wash and twice declined to have his pressure areas checked. He self-discharged.

In their complaint, Tom's family states that because Tom was admitted to hospital, Liz was "…left with no care arrangements in place. Liz had to call on her sister in the middle of the night for support as her emergency alarm people would not respond to the call."

On **1 July 2013**, Tom presented at Trauma and Orthopaedic Outpatients. He was wearing only a dressing gown. He "passed out in the waiting room with pinpoint pupils…was unarousable for some time. When he woke up he urinated on the floor and was unable to communicate." Although Tom was not due to have surgery on this date, the consultant decided that there were "major concerns about Tom's current state of mind. Surgery would require a degree of cooperation and compliance with treatment and post-operative rehabilitation. The evidence of today's consultation would seem to indicate other major health, psychiatric and psychological problems which would greatly increase the risks of surgery and the chances of a poor outcome…Would not be prepared to operate on him in his present state."[22]

The following day adult social care was informed by primary care that Tom arrived at the hospital "stoned" and that his hip operation was cancelled. (Although the GP notes state that Tom had a "fit," the hospital notes state that he was intoxicated.) A relative rang Tom's GP to express concern that he was in bed having taken drugs and alcohol. The GP wrote back explaining that there would be "no operation" until Tom addressed his addictions.

On **3 July 2013**, the GP met Tom and his mother. Tom agreed to be referred to Turning Point.[23] He was told that he "must be stable prior to any hip surgery." The GP sent a referral letter on **8 July 2013**.

At the end of the month, Tom wrote to the Orthopaedic Consultant stating that he drank "to help him sleep…was sleep deprived when he spoke to the consultant and is not addicted to alcohol." He had made the decision to be free of drugs and requested hip surgery. A supporting letter from his girlfriend was included.

On **17 August 2013**, Tom locked the door of Liz's home when her carers were providing her with support. This and other concerning behaviour resulted in the care agency contacting his social worker.

In early **September 2013**, Tom called 111 because of the pain in his left hip and an arm. He explained that he had had a drink and he couldn't cope with the pain. He disclosed that he

[22] In correspondence with an MP on 5 November 2013, Tom's family noted that surgery could not take place since *the amount of anaesthetic that would be needed to knock him out would kill him.* It is possible that this was Tom's understanding because it does not feature in any clinical records

[23] A social enterprise providing specialist services supporting people with learning disabilities, mental health problems and people who misuse substances. See http://www.turning-point.co.uk/ (accessed 4 January 2016)

was using heroin six times a week but denied that he had a drug habit. He was given pain relief.

On **23 September 2013**, one of Liz's carers contacted the ambulance service to report that Tom had fallen again, hit his head and had a seizure. He was treated at the scene.

In their letter of complaint,[24] Tom's family state that on **4 October** "Tom was found out in the street naked, shouting and screaming at Liz and was reported to Liz's family by neighbours.[25] This was then followed up by him passing out and leaving Liz without care again."[26]

On **5 October 2013**, Tom called 999. He had fallen and was intoxicated. He was treated at the scene. Two days later, the ambulance service made a safeguarding alert since Tom had been heavily intoxicated and concern was expressed about his "ability to care with his increasing alcoholism…would like them to receive alternative care and alcohol advice." It was proposed by adult social care that Tom should visit the GP weekly to address his need for pain relief and his drug use, that is, "it was not felt to be safeguarding." Primary care was informed that Tom had been intoxicated and naked in the street.

On **8 October 2013**, Tom's mother contacted primary care requesting enhanced pain control for Tom. The patch strength was increased on **10 October 2013**.

In their letter of complaint, Tom's family state that on **9 October** "a meeting was called by Liz's family and Tom's mother. At this meeting, social services offered no support or assistance to Tom. When rehabilitation services were suggested, a social worker stated that there were none available. Liz's family believed that Tom had been extorting money from Liz by threatening not to care for her if she didn't give him the money…why did social services not launch an investigation into this accusation? Liz is a vulnerable adult who requires protecting too…nothing at all was done."

In the same letter, the family state that on **18 October 2013**, "Tom passed out in his wheelchair outside the house, Liz had no care and nobody could get in to help her as Tom was in the doorway…his family ensured that he was moved back into the house and that Liz was safe until her brother-in-law could come and arrange for her to go to…residential care. Following this, Tom was issued with a one-week eviction notice[27] on **19 October**…Tom is a vulnerable adult…social services did not visit...to help him sort out accommodation."

On **19 October 2013**, Tom arrived at Headway in an inebriated state. He had been drinking heavily for a few days. When he arrived at the centre he was very tearful and expressing

[24] Dated 18 November 2013

[25] There were no safeguarding alerts concerning Liz

[26] Since Tom *was no longer able to lift Liz properly because of his own physical problems, Liz's family called in a care firm…*Tom *continued to assist Liz into bed at night as this was 'outside' of core care provision hours. Tom's drug and alcohol use escalated as did the frequency and degree of incidents that placed Liz at risk. Their reliance on emergency services and care agency support increased and Liz's family raised concerns about Tom's ongoing role in her life.* In addition, *regular amounts of money were missing from Liz's bank account*

[27] Tom had a six-month rolling tenancy agreement

suicidal ideas. He felt very unwell and couldn't see the point in carrying on. He was also threatening violence towards Liz's family in that he blamed them for him having to move out of Liz's home. He was very unsteady on his feet and quite volatile. Tom was allowed to remain at the centre and sleep. The social worker suggested contacting the GP and the latter suggested contacting the social worker. The GP also suggested phoning his sister.

On **25 October 2013**, Tom's family emailed social services asking about "a mental health assessment for him…he is no longer capable of caring for himself let alone Liz and…if he doesn't get help soon he will end up in the gutter or dead."

On **28 October 2013**, Tom's family received an emailed reply stating that any mental health assessment will need to be accessed through his GP.[28]

On **30 October 2013**, Tom's mother informed primary care that Tom had been given notice to quit his accommodation.

On **31 October 2013**, a police intelligence report stated that Liz was seeking to remove Tom from her home due to his alleged use of illegal substances, heavy drinking and damage to the property.

A further eviction notice was issued.[29] Tom's family were unsuccessful in their attempts to engage social services by telephone on **31 October** and **1 November**.

In early **November 2013**, a carer from the support team working with Liz contacted the police "concerned for suicide attempt of Tom."[30] Tom had been distraught and had told the police that he planned to hang himself. It was noted too that Liz's home was unsafe due to used needles lying around.

"Police…feel Tom's physical disabilities may hinder him in any attempts to carry out his thoughts." The complaint[31] from Tom's family states that on 2 November, Tom "became dangerously unstable and threatened to kill Liz's sister and brother-in-law and then himself."

The police referred Tom to the crisis mental health team which assessed him as being a "low risk" of deliberate self-harm, accidental self-harm and suicide. The community psychiatric nurse's assessment had concluded that he was not suffering from mental health issues but was "reacting to life events." He was advised to contact his social worker. The assessment also concluded that there was "no evidence of acute mental illness…needs may be better met through Drug and Alcohol services." It was noted that Tom had previously engaged with Turning Point but was reluctant to do so again.

[28] The letter of complaint of 18 November 2013, states that they followed this up with the community mental health team which advised, *that social services can indeed make a referral to them for assessment*

[29] There had been a query concerning the legality of the original one

[30] Tom's family were aware that Tom considered taking his own life after his accident. Also, they knew that he did not want to take an overdose because he did not want *to be more like a vegetable*

[31] Dated 18 November 2013

The Trust's assessment excluded the knowledge and insight of Tom's relatives and professionals who had known him for many years. "Physical health and falls were identified as significant risks…no crisis plan detailed as level of risk was not assessed as sufficiently high to require this." Tom was advised "to contact his GP to sort out appropriate pain relief as he had missed scheduled appointments. A clear follow-up plan and review plan was established and actioned."

On **3 November 2013**, mental health professionals visited Tom to explain the rationale for not providing a service. His mother and a representative of the care agency supporting Liz were also present. Neither could understand the decision. The Trust's clinical risk assessment did not refer to (i) the *Somerset Partnership Dual Diagnosis Policy*, (ii) the protocol, *Joint Working with Specialist Drug and Alcohol Services (Turning Point)* or (iii) its *Safeguarding as a Vulnerable Adult Policy,* since Tom "was not assessed as having either, an acute or, severe and enduring mental illness and he was not identified as a vulnerable adult at the times of contact." Somerset Partnership Trust noted that there was "evidence from notes and staff interviews that additional discussions around processes for assessment of cognitive function had occurred." However, because these discussions were not recorded it seems unlikely that they were going to be acted upon.

Tom's mother referred to this experience in correspondence with her Member of Parliament. The family could not understand why neither adult social care nor mental health professionals perceived Tom as "a vulnerable adult." Tom had "expressed a wish to be sectioned so that he could dry out; have the replacement hip; and get back to something like a normal life." He had no morphine patches; he had not had heroin for two weeks because the money he was "unofficially being paid by Liz's Trust" had ceased; and he was due to be evicted from Liz's home on **9 November 2013**. Although Tom's social worker and social work manager were unavailable, the "council…advised Tom to present himself at the council offices on 9 November regarding his homelessness." Concern was expressed that his unsettled social situation "has resulted in deterioration of his mental health." The GP wrote a letter to support Tom's re-housing.

On **4 November 2013**, a police intelligence report noted Tom's intention to hang himself. "He was also making…comments about harming family members. Upon attendance Tom was sitting in his wheelchair and calm. He was drinking alcohol…said he did not intend to harm any [of Liz's] relatives…He is upset that he is due to be evicted…The care company supporting Liz was checking on him regularly…until the eviction."

Primary care expressed concern that Tom was "presenting as vulnerable and falling between services." It undertook to contact social services to request they offer a service that will meet his accommodation and physical needs "in the hope that this will improve his mental health."

The crisis team confirmed with adult social care that it had discharged Tom.

On **5 November 2013**, Tom attended the Headway centre where he appeared tired and lethargic.

On **6 November 2013**, Tom's family contacted primary care concerning Tom's referral to the pain clinic and neuropsychological help. A GP[32] sought information from the mental health team concerning information and direction about a referral to psychology.

On **7 November 2013**, primary care made a safeguarding referral concerning Tom's impending homelessness. This was "not felt to be safeguarding as adult social care already referred Tom to Housing Department and was supporting him with re-housing."

The crisis team was seeking neuropsychological help for Tom.

On **8 November 2013**, Tom was placed in a hotel as temporary accommodation while homelessness duties were checked.[33] Tom disclosed to a housing officer that he had recently had suicidal ideation due to the eviction. On arrival at the hotel he had a grand mal seizure and was taken to hospital. The hotel later declined to accommodate Tom because of the perceived high medical risk.

Tom's mother contacted the Emergency Duty Team to report that her son was homeless. She explained that Tom had taken an overdose which had been followed by an epileptic seizure while at the hotel. The hospital assessed Tom as "medically fit" and in the absence of alternative accommodation she took him home.

On **11 November 2013**, the Housing Department had negotiated a placement at a unit for homeless people. However, no room was immediately available.

Tom's sister rang primary care concerning events of 8 November and the ongoing challenge of finding accommodation for Tom. He attended the GP practice with his mother. Although his alcohol intake was high, he said that he had had no heroin for two weeks.

On **18 November 2013**, Tom's sister wrote a letter of complaint to adult social care about the poor service her brother and his partner had received. Adult social care did not become aware of this letter until **October 2015**. It is not clear how it became "lost" in Tom's file.

Tom attended an appointment at Turning Point and disclosed that he was drinking a bottle of wine each day.

Primary care increased the patch strength of Tom's pain treatment.

On **20 November 2013**, Tom attended a pain management outpatients' appointment. He had left hip pain from osteoarthritis. "Not for consideration of surgery unless alcohol and drug (heroin) use is under control." It was noted that although Tom had been referred to Turning Point, it was unable to help since "he does not have an addiction due to ability to

[32] Although Tom's family were concerned about the discontinuity of GPs and Tom's contact with locums, primary care did attend to such non-medical concerns as the crises surrounding his welfare benefits and his prospective homelessness

[33] Under the Housing Act 1996, local authorities must give priority to certain groups when they provide accommodation for unintentionally homeless people

abstain." [34] It was noted that he was staying with his mother and that he was on a waiting list for accommodation. "Able to walk short distances but also uses an electronic wheelchair…says he stopped taking heroin a month ago. Trying to drink less…consider a TENS machine."[35]

On **21 November 2013**, Tom was placed at a guest house in Taunton.

Tom's family recall that he was drinking throughout November.

December 2013

On **5 December 2013**, Somerset County Council concluded that Tom was not homeless. He moved to a service for homeless people because the hotel in which he had had a fit (see 8 November 2013) declined to admit him "due to risks from drink/drugs/others in his room." Tom's family believe that this transition was a significant watershed because "he was in contact with people who made him worse. In total he had five mobile phones stolen and because he gave people his bank card's pin number, his account was cleaned out."

On **10 December 2013**, social services contacted Turning Point. It was unable to assist since it did not have Tom's signed consent.[36]

On **11 December 2013**, Tom did not attend the pain management clinic. He was sent a letter stating that if he wished to re-engage his GP would have to re-refer him.

On **16 December 2013**, the GP informed adult social care that Tom was not keeping appointments.[37]

On **17 December 2013**, Headway noted that "Tom took part in Christmas celebrations but was very preoccupied with issues relating to his homelessness…is requiring a lot of support when he attends Headway…his behaviour towards Liz causes concern, as do his drinking/drug habits."

On **19 December 2013**, a social worker visited Tom at the unit for homeless people and reminded him of the importance of keeping to the "no drink or drugs" rule.

On **23 December 2013**, the unit for homeless people informed adult social care that Turning Point was visiting Tom.

12. 2014

January 2014

[34] It has been speculated that this conclusion is based solely on Tom's description of his use of substances, that is, it is ahistorical and difficult to square with the experiential knowledge of his family, Headway, primary care and the police and contradicts Tom's claim of 18 November

[35] A method of pain relief involving the use of a mild electrical current

[36] In the context of Tom's deteriorating circumstances, this is unhelpful. His sister had sought to act as his advocate since 2005, with Tom's agreement

[37] Primary care records indicate the following references to Tom's *did not attend* clinical appointments: 1987x1; 1991x1; 1993x1; 1994x1; 1996x1; 1997x1; 1998x1; 1999x1; 2006x2; 2008x1; 2010x2; 2013x4; 2014x2

On **12 January 2014**, Tom attended Accident and Emergency which noted his "hip pain, alcohol and heroin use." He requested pain relief and was low in mood. This was attributed to his recent court order, chronic pain and use of alcohol and heroin to top-up prescription medication for pain relief. He was very unhappy, requested psychological support and admitted to feeling "more psychological pain than physical." Christmas was the anniversary of the Road Traffic Accident that permanently disabled him. "Not making threats to harm self. Now homeless…presenting problems sound much the same as when last assessed e.g. struggling with pain management…taking over prescribed dose (of pain relief medication), still misusing heroin and alcohol…A&E and unit for homeless people requesting mental health re-assessment…substance misuse issues would need to be addressed…will offer triage to ascertain whether a routine assessment appointment necessary or signposting to Turning Point the most appropriate course of action…no suicide ideation expressed."

Tom was discharged from mental health because "it would be difficult to establish any underlying psychological issues relating to his mental health whilst experiencing physical symptoms and dependency." Tom was "advised to engage with Turning Point…possible referral via GP to pain clinic…any future mental health concerns contact GP to discuss mental health referral."[38]

The Somerset Partnership Trust acknowledged that Tom had "longstanding…multiple complex difficulties…substance use was almost consistently problematic throughout Tom's life and represented a barrier to accessing and remaining engaged with services and sometimes presented significant risks to Tom's physical and mental health…he had difficulties with erratic mood and this may be part attributable to his head injury (and most likely further exacerbated by substance misuse). He experienced a number of historical losses, including family relationships and his identity as a physically intact being with a range of life choices, which continued to trouble him. During the time Tom had contact with the Somerset Partnership he was facing further significant loss, his relationship with Liz and his home and income. His presentation was that of a vulnerable adult with limited physical and psychological capacity to keep himself safe and avoid exploitation by others…his housing arrangement was not stable…his associations with drug users frequently alienated him from services who were unable to visit him at home due to the presence of drug users and drug paraphernalia…his exploitation by other drug users…further compromised the stability of his accommodation. Tom was known to multiple services and care providers…but there was no lead agency clearly identified to coordinate and oversee an appropriate and comprehensive programme of care…there was no defined multi-agency approach to try and meet his complex needs."

On **17 January 2014**, Tom kept an appointment at Turning Point at which he stated that he had cut down his alcohol consumption to three times a week.

[38] Reference to 19 October 2013 underlines the disconnectedness of professionals' responses

On **21 January 2014**, Headway was exercised by the dynamics between Tom and Liz. She did not understand that Tom was accessing Headway in his own right. The animosity between them, coupled with Tom's drinking, was troubling others using Headway's service.

On **28 January 2014**, Tom discussed his future support with Headway staff. He agreed to a referral being made to Turning Point and acknowledged that he required help to address his drinking in order to have the hip operation. A support plan was agreed with Tom involving a volunteer from Headway. This was shared with Tom's sister.

On **30 January 2014**, Tom met with a Turning Point recovery worker and discussed his drinking patterns.

February 2014

On **3 February 2014**, adult social care sought information from primary care about Tom's referral for a neurological assessment.

On **5 February 2014**, adult social care visited Tom. He was "in a good mood and settled in…no re-housing news yet. He had an appointment card for Turning Point. He was still using alcohol for pain." The service advised that Tom should be referred back to the pain management clinic.

On **11 February 2014**, Tom's sister visited Headway to discuss his circumstances.

On **14 February 2014**, Tom's sister took him to Headway. He was reported as being "happy to be supported in trying to get himself sorted out in readiness for a hip replacement sometime soon."

On **19 February 2014**, Tom was accompanied to Turning Point by the Headway volunteer. He received Hepatitis A and Hepatitis B injections while there. Tom advised the volunteer that he "had not drunk more than a bottle of wine…it was apparent that he was high…later he disclosed that he had smoked heroin on two occasions the night before."

On **21 February 2014**, messages were left with adult social care concerning transport to Headway. This was "still being provided by family."

On **25 February 2014**, Tom attended Headway. "Despite denial, he was clearly under the influence of some substance…he had enjoyed the support and attention but was fairly incoherent and did not join in with any activities."

On **28 February 2014**, Tom's mother transported him to Headway. He was "in a relatively good mood…did not seem under the influence of drugs although seemed that he had a drink."

March 2014

On **3 March 2014**, Tom sustained a head laceration.

On **4 March 2014**, adult social care agreed to fund Tom's transport to Headway.

On **7 March 2014**, Tom did not attend Headway and had not made any contact. Messages were left on his mobile.

On **11 March 2014**, Tom sent a text to the Headway volunteer.

On **14 March 2014**, "Tom attended Headway, brought by his mother. He had been depressed and suicidal in the previous week. Still wants support. New risk assessment carried out."

On **19 March 2014**, Tom was to have been supported to attend Turning Point but he did not attend.[39] He was "not compliant with their conditions of treatment and help." The Headway volunteer tracked Tom down to a park where he was waiting to purchase drugs. Tom was with another person with whom he had struck up friendship and upon whom he was reliant. His support package was described as "in jeopardy."

On **21 March 2014**, Tom was brought to Headway by his mother. Whilst there, he slept and appeared under the influence of drugs. He had been served notice by the unit for homeless people to remove himself in seven days due to his use of alcohol and drugs.

On **24 March 2014**, a police intelligence report noted that Tom was associating with a known drug user. They were stopped and searched.

On **25 March 2014**, Tom had an orthopaedic assessment. He had "osteoarthritis to left hip…was reviewed at hospital last year but was compromised by drug and alcohol use…so surgery was felt to be inappropriate…states free from drugs since orthopaedic review last year. Does have the odd alcoholic drink but does not abuse it. Keen for surgery to be reconsidered…refer to hospital for orthopaedic review."

On **27 March 2014**, the Taunton housing team was advised that due to concerns about Tom's "drinking and bringing people back to his room and his poor hygiene,"[40] he had been given a seven-day warning of possible eviction. A referral was made to adult social care for a "full independent living assessment with a view to living independently in social housing."

April 2014

On **3 April 2014**, the independent living assessment was declined because Tom "has no permanent accommodation. Tom was given another warning of eviction due to alcohol misuse."

On **4 April 2014**, it was noted that Tom's "community support package has been withdrawn…as risks involved and commitment issues…meant that support package proved unsafe for support staff. Tom's mother brought him to the new Headway premises. A risk assessment was prepared in anticipation of the move…spent most of his time asleep in his wheelchair not wanting to join in activities. His social worker has suggested registering with housing website." The new building was unsuitable for Tom since he could not be separated from his peers and staff when he was intoxicated.

[39] Tom *did not attend* appointments negotiated by Turning Point during August 2013; January 2014; March 2014; and May 2014. Tom cancelled an appointment with a recovery worker during March 2014

[40] Tom's family noted that *his self-neglect got worse towards the end*

On **8 April 2014**, Tom was suspended from Headway and volunteers had ceased accompanying him to Turning Point appointments. This was due to the risks from his drug and alcohol use and some aggressive behaviour with staff and other users [it is not clear whether or not these risks featured in risk assessments]. Tom had been increasingly under the influence of drugs when attending the centre recently. His sister was informed.

On **17 April 2014**, a referral was made to temporary accommodation for Tom, and a ground floor bedsit was identified. Adult social care assured housing of Tom's ability to live independently irrespective of concerns expressed by housing officers.

Tom ceased to attend the Headway service during **April 2014**.

May 2014

On **1 May 2014**, Tom was evicted from the unit for homeless people. A new homelessness application was created and he was placed in temporary accommodation while the council's homelessness duty was investigated.

On **7 May 2014**, a letter was hand-delivered to Tom's temporary accommodation "with regards to suspected breaches of tenancy, that is, he had a dog in the property and people were staying overnight. He was verbally advised of the letter's content."

On **19 May 2014**, Tom moved into a bedsit.[41] His family helped to equip his new home.

On **21 May 2014**, it was accepted that Tom had a priority need due to his health status, his disabilities and homelessness.

On **23 May 2014**, because of a report received by local police, Tom was visited by a housing support officer in relation to anti-social behaviour. He was "continuing to allow others to stay at his address overnight…a potential tenancy breach…Tom presented as if he was under the influence of either drink or drugs" and there were other people at the address. He was given advice about (i) sustaining his tenancy and (ii) contacting his GP because he disclosed that he was feeling unwell. One of the men present "presented particularly aggressively to housing staff and the police." Another person expressed concern that Tom was "being exploited" by street drinkers. The housing support officer submitted a safeguarding referral and copied this to adult social care. This described Tom as being "spaced out" and friends "taking money from him."

Tom's risk of eviction was increased because of the non-payment of service charges which included electricity and water rates. He was offered support to ensure these payments were made and to carry out domestic chores.

June 2014

On **5 June 2014**, a multi-agency safeguarding strategy meeting was held. In spite of a number of absentees a "comprehensive multi-agency action plan resulted" which included

[41] Taunton Deane Borough Council noted that it was assured by Adult Social Care of Tom's *ability to live independently although no formal assessment took place*

an ABC chart.[42] Neither Tom nor his relatives were invited.[43] At the meeting the Headway service noted that "even when Tom is not under the influence he still has difficulty processing things due to his brain damage." It was suggested that a neuropsychologist "may help to make some kind of decision as to whether Tom has the capacity to make decisions about his lifestyle and welfare…a suggestion was made around the possibility of [a relative] organising an appointeeship for Tom's welfare benefits."

The police advised that adult social care staff "should not visit without the police."

On **9 June 2014**, adult social care discussed Tom's mental capacity with a local authority solicitor.

On **13 June 2014**, adult social care noted that Tom was "tearful today…will now accept help…implementing ABC chart to help him control who comes into his home."

Adult social care acknowledged that Tom "was particularly vulnerable to the influence and coercion of others and had limited ability to protect himself. Visitors to his home were well known drug/heroin users and Tom was vulnerable to financial abuse although continued to manage his own money."[44]

On **16 June 2014**, Tom did not attend an orthopaedic outpatient appointment. A letter was sent to Tom and his GP discharging him from care.

On **19 June 2014**, a police intelligence report noted that Tom was associating with known drug addicts.[45]

Adult social care emailed Tom's mother to invite her and Tom "to meet to discuss outcomes of the safeguarding meeting of **5 June**."

On **20 June 2014**, Tom signed the Acceptable Behaviour Contract in the presence of his mother and a police officer.

A police intelligence report noted that one of the persons who was not allowed into Tom's property was living there.

Tom's family recall that his bank account had been "cleaned out 10 days before his death."

On **25 June 2014**, adult social care completed the "risk assessment document as agreed at the safeguarding meeting. This identified Tom to be at significant risk of: health damage from alcohol abuse…drug abuse combining prescribed and illegal drugs…and poor nutrition; involvement with organised drug crime; financial abuse; eviction from his temporary

[42] An Acceptable Behaviour Contract specifying three conditions: Tom should not allow, (i) *overnight visitors* (ii) *people to access the property in his absence* and (iii) *two named individuals into the property*

[43] It is noted that towards the end of his life the communication between Tom's family and other professionals became *more frequent and intense*. However, there was *little evidence to demonstrate clear information sharing to move forward actions or outcomes*

[44] At the strategy meeting of 5 June 2014, it was noted that Tom was *in control of his bank card and has willingly given out his pin number to people*

[45] These people were *known to prey on vulnerable people.*

accommodation and becoming homeless; mobility limitations compromising the control of his own from door."[46]

On **26 June 2014**, a police intelligence report noted that Tom was obtaining drugs and owed a drug debt to the person who was not allowed into the accommodation.

On **30 June 2014**, Tom's mother emailed a friend. She wrote "I am increasingly feeling that I am batting my head against a brick wall and that…he is going to be found dead one day having overdosed accidently or otherwise."

On the same day the police summoned the ambulance service to Tom's property. He had taken his own life.

Analysis

13. Trauma to the brain has a profound impact on a person's life course, family and interpersonal dynamics. The crisis of brain injury arising from road traffic accidents and the long term medical and rehabilitation interventions associated with such accidents transform lives (see Spinney 2016)
14. Personality change is well documented (Hubert, 1995; Knechel Johansen, 2002; and Daisley *et al* 2009). Tom's brain injury was associated with rapid mood swings and irritability which arguably impacted on his relationship with his girlfriend at the time of his accident. Their marriage lasted only weeks after his discharge from rehabilitation.
15. During the rehabilitative aftermath of Tom's accident, it became evident that he had lost the full range of movement on one side of his body. This compromised his mobility and inhibited his ability to consciously perform actions. Although his impaired language skills were short term, his writing skills (as reflected in correspondence with an orthopaedic consultant during July 2013) were suggestive of cognitive impairment in terms of ordering his ideas and the points he wanted to make.
16. Tom lacked insight into his post brain-injury support needs and his abilities as he sought to negotiate his former world. Driving is a symbol of independence and although it was the cause of criminal convictions and his brain injury Tom wanted to drive again and he believed that he could.
17. Prior to Tom moving into Liz's home, her family had taken the precaution of securing a lasting power of attorney. Liz had received compensation and her family's actions gave expression to the concern that her compensation might attract individuals who would not be engaged by her best interests. However, it was after Tom became her live-in partner and carer that his behaviour changed and he was known to be dependent on Liz for such matters as financing his alcohol, drugs and transport costs to get to Headway for example. Ultimately Liz's best interests became remote from Tom's concerns as he ceased to provide the care she required and, *inter alia,* allowed known drug users into her home. Because Liz's family assumed responsibility for managing her finances and her support, and she had a social worker, she was perhaps less visible than she should have been to adult social care. **There was neither a local authority Community Care Assessment nor an assessment of**

[46] There was no reference to the risk of suicide. See 2 and 4 November 2013

Tom as a carer in his own right [emphasis added], irrespective of his deteriorating circumstances and growing concern about the mutuality of his relationship with Liz. Once the couple became known to an array of services, not least because of Tom's addictions, the local authority acknowledge that Tom's role should have been assessed.

18. Over-drinking and intoxication were features of Tom's life before his brain injury. During the years following his accident these addictions escalated. On a single occasion during December 2011, Tom attributed his drinking to an attempt to obliterate the memory of his accident (which is the only glimpse professionals had of Tom's perception of his post-accident circumstances) and he ascribed his drug use to his means of relieving physical pain. Yet Tom's brain injury is likely to have reduced his tolerance to drugs and alcohol and to have interacted adversely with his prescribed medication.
19. Tom did not follow the professional advice he received – most particularly the advice of clinicians. He had chronic conditions and yet the attention he received from health and social care was dispersed and consisted simply of a series of discrete interventions in particular settings. If he did not cooperate or keep appointments he was discharged.
20. During 2003, Tom was referred to neurology. He was subject to depression and mood swings. During 2004, he declined counselling and he was referred to neuropsychology. During 2009, Tom was prescribed medication for the stress he associated with caring for his partner. During 2011, he was prescribed medication for chronic insomnia. During July 2013 an orthopaedic consultant declined to consider Tom for hip surgery due to, inter alia, "psychiatric and psychological problems which would greatly increase the risks of surgery and the chances of a poor outcome." Although Tom's family were acutely aware of Tom's deteriorating mental health and the incongruities between his pre and post brain-injured self, Somerset Partnership NHS Trust's clinical assessment was ahistorical and took no account of their experiential knowledge. His family remain bewildered that mental health professionals declined to pay necessary attention to Tom's post brain-injury despair and enduring depression. They question the merit of service responses which do not build on an interdisciplinary and competent assessment of a person with a brain injury – who frequently asserted that his life was "not worth living."
21. Avon and Somerset Police gathered information about Tom from the Halcon One Team[47] which includes representatives from partner agencies such as housing and the local authority and seeks to address the underlying causes of crime with bespoke support packages for individuals. Tom's address at the end of his life was well known to the Halcon One Team, not least because of its proximity to a police station. Police officers were instrumental in "offering ongoing support…by way of regular attendance at the address with a view to encouraging him to access the support available for his drug use." Tom advised these officers that he chose to use illegal drugs and would decline any support "to aid him with becoming abstinent." This was not known to the clinicians who were concerned that

[47] http://www.avonandsomerset-pcc.gov.uk/News-and-Events/News-Archive/2014/July/Ground-breaking-crime-reduction-project-to-be-rolled-out-further-after-major-funding-boost.aspx (accessed 7 February 2016)

Tom's drug use was compromising his prescribed medication and the likelihood of orthopaedic surgery being carried out.

22. Headway had a high tolerance of Tom's behaviour and remained a constant in his life until he was suspended during April 2014. However, Headway did not follow its policy insofar as it allowed Tom to continue attending when he was intoxicated and long after he had been given a final warning. For example, he was allowed to rest in a part of the service where he did not distract or cause distress to others. Since he was receiving no other service input, Headway provided health promotion advice and it undertook "relevant risk and general assessments, most particularly concerning his use of drugs and the bringing of alcohol into the centre."

23. **Tom's mental capacity was assumed** [emphasis added] notwithstanding the limited references to his capacity and discussions concerning neuropsychology and neurological assessments. Although a discussion with the County's solicitor is noted during June 2014, the outcome of the discussion was not documented. Over time, it would have been prudent for assessments to have been carried out in the light of Tom's brain injury; his substance and alcohol misuse; his bicycle accident (having been advised not to ride a bike); his association with particular drug users (who were known to target vulnerable people); his former status as an "intentionally homeless" man; his failure to comply with the terms and conditions of his tenancies; the concern of Taunton Deane Borough Council that Tom had begun to self-neglect; and acknowledgement that Tom "was making decisions and was felt that he could not suitably process information or understand the consequences because of his acquired brain injury…had difficulties in complying with expectations and was unable to identify his own risks."[48] Although adult social care might have assumed responsibility for initiating a mental capacity assessment, health services might also have initiated a capacity assessment, perhaps when he refused medical interventions such as checking for pressure ulcers (during June 2013), refusing to wash and discharging himself from hospital. The Safeguarding Strategy Meeting Minutes of 5 June 2014 confirmed that a mental capacity assessment was required and it was determined that adult social care should "contact GP re the possibility of a referral being made to the neuropsychologist" – who, it was envisaged, would undertake the assessment.

24. The Somerset Partnership Trust came to the conclusion that "Tom had capacity when assessed by Mental Health Services in November 2013." The extent to which this was an in-depth and contextualised assessment is not known. There is no information about what information Tom was offered and whether or how he retained it, weighed it and used it to make a judgement. This assessment was not shared with Tom's family or other agencies. Musgrove Park Hospital noted that "Tom was identified as having a number of factors that may have impacted on his capacity for some decision-making. This included brain damage from his previous head injury, epilepsy and drug/alcohol use."

25. The police attended Tom's address during November 2013 "following his comments…about taking his own life and/or harming others…Tom clarified to officers that he did not intend to

[48] Headway IMR

harm others given his limited capacity…due to his physical disability. Officers subsequently made the necessary arrangements to have Tom appropriately assessed by a qualified mental health nurse…Tom was referred by police to the Crisis Team at Musgrove Park Hospital."

26. The South Western Ambulance Service noted that Tom "was aware" that the safeguarding referral was being made.
27. More generally, **the assessment processes experienced by Tom were not integrated and had no impact on inter-professional working** [emphasis added]. Adult social care's assessments were scant, unfocused, barely documented and disconnected from professional judgement and decision-making. It follows that it is not possible to determine either the purpose of these assessments or the social work goals which informed them. The basis for Adult Social Care assuring Taunton Deane Borough Council of Tom's ability to manage a placement in independent living accommodation during 2014 is not known because no documented assessment took place.
28. Although three events (of 10 July 2012; 7 October 2013; and 7 November 2013) were not considered to be sufficient to meet the criteria for requiring a safeguarding assessment, adult social care attribute this to staff adopting an ahistorical approach which did not take account of the changing nature of Tom's circumstances.
29. Taunton Deane Borough Council investigated Tom's circumstances and his priority in terms of re-housing following his evictions from Liz's home and then from the unit for homeless people. A tenancy agreement sought to isolate him from two drug dealers who were known to target vulnerable people. Numerous visits characterised its contact with Tom when he was in independent living accommodation which were triggered by breaches of his tenancy agreement (as required by procedures for addressing anti-social behaviour). These led to a safeguarding referral to adult social care during May 2014. Although Taunton Deane Borough Council acknowledge that information raised via the Halcon One Team was inconsistently recorded on its own system, this did not impact on the support it provided to Tom in terms of trying to sustain his tenancy. However, Tom was not believed to be an "adult at risk" by adult social care. The latter was responsible for two thirds of the resulting actions required at the Strategy Meeting of 5 June 2014. It is not certain that these were undertaken. This was in breach of its policy and procedures.
30. Adult social care acknowledges that its recorded evidence concerning Tom's circumstances was scant. Headway, Tom's partner and his family were in regular contact with his social workers and raised concerns and yet these were not reflected in adult social care records.
31. In terms of information sharing, Musgrove Park Hospital noted that **information seems to have been shared appropriately**, "but the communication with mental health services is not clearly documented." Headway observed that all services managing Tom's needs "were not totally linked up enough to fully understand how his general health and wellbeing was [impacting]…on his day to day challenges such as his drug and alcohol abuse and his anxieties."

32. At a locality level, when Tom was re-housed within the Halcon One team area, information was shared about his circumstances during regular meetings. However, no skilled practitioner was identified to work with Tom to clarify his perspective and determine the options which made sense to him. Although information from the South Western Ambulance Service and Avon and Somerset Police was shared appropriately and at the appropriate level of seniority, as Tom's relative noted to an MP, "nobody will take responsibility for helping him."
33. The Somerset Partnership Trust acknowledges that generally, there was a lack of a coordinated proactive approach to follow-up and interagency communication. However, it did liaise with the care agency supporting Liz, Tom's GP and the unit for homeless people after its contact with Tom during November 2013 and January 2014. The Trust acknowledges that there were no discussions with drug and alcohol services or "proactive attempts to engage Tom with the specialist drug and alcohol service (Turning Point) despite his complex physical health problems and needs and accommodation and financial difficulties, which would most likely act as a barrier to his accessing treatment independently."
34. The police and the Halcon One Team were "aware of Tom's **vulnerabilities** [emphasis added] and raised concerns" about the targeting and exploitation of these vulnerabilities. The support of the Halcon One Team included engaging with drug support agencies and voluntary work, despite the fact that he ostensibly declined such support. Also, Avon and Somerset Police took action to safeguard Tom by imposing bail conditions on his peers when he was sharing Liz's home. Taunton Deane Borough Council's Housing Options service reasonably questioned adult social care's assertion that Tom could "manage independently." Given its misgivings concerning Tom's mental health, cognitive ability and substance misuse, Housing Options involved Tom's family, with his consent, to ensure that he had an advocate on his behalf. It appreciated that the voluntary Acceptable Behaviour Contract, which served to try and protect Tom from those who were minded to exploit him, would potentially isolate him from two of the four people he perceived to be his friends.
35. The responses of Adult social care were wanting prior to and at the time of recording that Tom's brain injury "did appear to affect his mental health…his substance misuse…appeared to dominate his life in a more uncontrolled, unprotected and vulnerable way once he lost his home with his partner. He was subjected to abuse and coercion from people he believed were his friends." The Somerset Partnership Trust acknowledged that Tom's A&E attendance during January 2014 was a "missed opportunity."
36. Musgrove Park Hospital acknowledged that it was "difficult to determine how much Tom's behaviour and cognition were affected by his head injury as he was identified as having problems with substance use and having a non-conformist personality prior to the injury. It seems likely that there was some ongoing impact but this is difficult to quantify."
37. Even though different professionals and agencies acknowledged that Tom was "**at risk**," [emphasis added] there is no clarity about Tom's perspective on the risks in his life and what he believed should be done about them. It does not appear that the risks of not eating,

living in unhygienic conditions, the risks of self-neglecting, the risks of tolerating discarded needles in his home, the risks of combining prescribed and street drugs, the risks associated with being with exploitative peers, and of suicide, for example, were considered individually or collectively. It does not appear that these assessments took account of the possible outcomes, their likelihood and how mitigation efforts were to be managed. This would have required explicit collaborative enterprise, rather than embarking on, yet another, disconnected assessment. They should have involved Tom and his family, which had provided long-term support, transport services and default accommodation. Although his sister had been a willing advocate since 2005, she could not understand the activities of professionals and recalled being advised on one occasion that Tom was "not eligible for an assessment." Her overall sense was that "Everyone seemed to buck pass."

38. Tom's family sought the engagement of a Member of Parliament during November 2013 because they could not comprehend a single mental health assessment which determined that he had no mental illness, asserting that he was "merely reacting to life's problems;" they wanted adult social care to "help by getting Tom into rehab;" and to deal with his prospective homelessness.

39. Housing Options engaged positively with Tom's family since it recognised that his relatives were extremely concerned about the consequences of his deteriorating circumstances. Tom's family was encouraged that a housing officer "knew it was ridiculous to describe him as intentionally homeless."

40. Somerset Partnership Trust state that they liaised with Butterfield Care (which was commissioned by Liz's family to support her) and with Tom's mother as part of its assessment and follow up process. This was not experienced as liaison since both parties learned that Tom was ineligible for its assistance. They could not make a dent in professionals' misunderstanding concerning Tom's mental capacity.

41. The association of substance misuse with traumatic brain injury and suicide is well documented (Harris and Barraclough, 1997; Leon-Carrion 2001; Teasdale and Engberg 2001). It was Tom's family which correctly anticipated that he would take his own life. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness showed that there were 4,799 male suicides in the general population during 2013. The National Confidential Inquiry noted:

"Suicide in men is sometimes blamed on a reluctance to ask for help…our findings suggest the drivers of these increases [that is in terms of numbers of male suicides] may be risk factors such as (a) alcohol misuse is a common antecedent but most patients are not in contact with alcohol services (b) economic pressures…[49] [para 6].

Our findings make it clear that working more closely with families could improve suicide prevention [para 12].

[49] Patient suicides are those that occur within 12 months of mental health service contact

One example of how services can improve contact with families…how [do] services respond when a patient does not attend an appointment. In only 22% the service contacted the family when the patient missed the final appointment before the suicide occurred [para 13].
Our findings suggest that good physical health care may help reduce suicide risk in mental health patients:

- *Physical health needs, especially long term needs, should be reflected in mental health care plans*
- *Mental health staff should regularly review care with GPs or specialist clinics"* [para 26].

Lessons

42. Tom's circumstances highlight the fraught boundaries between personal responsibility, public obligation and the assumption of mental capacity. Mantell (2010) has argued that an assumption of mental capacity is risky because a person's severe brain injury usually results in a degree of cognitive impairment. Certainly Tom was situationally incapacitated by exploitative and drug using peers - a fact that was known to many professionals who did not question the absence of mental capacity assessments.

43. In Somerset, the Mental Capacity Act 2005 is not meeting the higher standards than were expected when the need for such legislation was identified. Reference only to Appointeeship for Tom's welfare benefits, as the legislation was approaching its 10th anniversary, confirms the concern of the House of Lords (2014) that "the Act has suffered from a lack of awareness and a lack of understanding."

44. Little was known about Tom's life before he sustained his brain injury. Although his family was an obvious source of information, and his mother provided him with emergency accommodation during November 2013, their role as reflected in contacts with services became one of pleading for engagement and help. Butterfields, which was supporting Tom's former partner, became knowledgeable about Tom's deteriorating circumstances by default. It experienced frustration that his detrimental and harmful decisions merited no credible response. Headway had bent its own rules for over 13 years to support Tom; Housing Options officers had sought to protect him from harmful relationships; and the police had sought, *inter alia,* to protect visiting professionals from his hazardous living circumstances. So although no single agency could address Tom's support needs, it appears that nothing impelled or even required health and social care services to work collaboratively within and across their own provision to provide direction and resolution. There was, and there remains, a strong sense that a man with a brain injury, depression and addictions requires the sustained assistance of mental health services - and yet Tom was deemed ineligible.

45. It remains to be determined where brain injury, depression and addictions reside in terms of service provision in Somerset. Brain injuries transform people's lives and their relationships. As the intensity of life-saving medical interventions discontinue, the slow processes of rehabilitation begin, which are experienced by families as seemingly less-urgent. The

continuities and discontinuities spanning Tom's brain injury were not known to professionals who became known to Tom. He frequently stated that his life was "not worth living." Addictions are harmful. They are known to devastate relationships and the ability to function. They are a significant factor in domestic and public violence. Not even the final risk assessment took account of Tom's known wish to take his own life.

46. During October 2013, primary care and adult social care appear to have run out of options when Headway sought assistance, that is, the social worker suggested contacting the GP and the latter suggested contacting the social worker. The GP also suggested phoning Tom's sister. What is the point of multiple assessments spanning many years, including risk assessments, and plans if they do not enable professionals across disciplines to pool their knowledge, agree priorities and targets and review their progress? It is not known why Turning Point prioritised Tom's "consent" over the necessity of engaging with colleagues across sectors, at a time when these sectors failed to identify any credible intervention.

47. Carrot and stick approaches had zero impact in persuading Tom to curtail his appetite for alcohol and drugs. His long term substance misuse and depression meant that he was at greater risk of non-compliance. There is a gap between knowing that these are excessive and harmful and changing behaviour. After Tom's death, and following contact with his family, it would appear that degree of agency and freedom of choice that Tom had after his brain injury was more severely compromised than professionals (with the exception of Headway) had appreciated.

Conclusions

48. *Most patients who commit suicide suffer major psychiatric illness, most commonly depression or alcoholism* (Black and Winokur, 1990).

49. Somerset County Council's adult social care, Somerset Partnership Trust and Turning Point did not provide a service to a man who was brain injured, who was depressed, who could not sleep, who abused alcohol and drugs and who had expressed his intention to take his own life. Somerset Partnership Trust states that, even now, he would remain ineligible for any mental health service if he were to be referred during 2016.[50] Services do not easily respond to individuals whose lives appear chaotic and who are barely compliant.

50. Working with people with multiple and complex needs, across agencies, has to hinge on coordinated assessment, care management and working with the risk of harm together. Tom's family grieved for him throughout his post brain-injury circumstances – which became increasingly unsafe - and yet their requests for help did not result in integrated working. In part, he became a stranger to his family: he became indifferent to his diet and self-care and he developed severe, generalised depression. Tom did not benefit from

[50] During April 2016, Somerset Partnership Trust requested that this review should "incorporate" the findings of a report "…compiled following a review of our Independent Management Review submission, Significant Incident Requiring Investigation and the draft…review." Also, it hinged on the disquiet of all contributors to this SCR process that Tom was ineligible for assistance from mental health services. The Trust has subsequently reviewed this position and now asserts that Tom was indeed eligible and that he should have received a Trust service

credible social work input since meetings and actions arising from these were inadequately documented. Social work did not even address the many "for now" concerns, which was the principal reason that Tom's family wrote a letter of complaint. The purpose of the social work input is unknown. He did not receive mental health input since he declined to address his addictions (see October 2005). Turning Point did not proactively engage with Tom's family or primary care and the risk assessments which were undertaken were compromised by inattention to the principal risk of suicide. A professional-led, multi-agency approach was required and this was entirely absent as gatekeeping criteria and service "thresholds" meant that he was placed in remained "in harm's way."

51. Tom's circumstances may be viewed as a series of crises. For example, although threatened eviction from the home with his partner and subsequently from a unit for homeless people were significant events, neither resulted in any professional or agency willing to assume a lead role in determining a multi-agency resolution. Significantly, Tom threatened to take his life and yet it appears that the practices and cultures of organisations and professional groups got in the way of grounded decision-making and the provision of collaborative support. Some professional decision-making was frankly bizarre. For example, during April 2013 the independent living assessment was declined because Tom had "no permanent accommodation." Also, during November 2013, it was noted that although Tom had been referred to Turning Point, it was unable to help because "he did not have an addiction due to ability to abstain." It is unlikely that the basis for these positions is known to the commissioners of services in Somerset.

Recommendations

52. It is recommended that:

i. Somerset's Safeguarding Adults Board seeks reassurance that the "case study" of Tom's circumstances features in sector-led and multi-agency training for Somerset Adult Social Care, Somerset Partnership Trust, Turning Point, Avon and Somerset Police, NHS England/Somerset, Primary Care, South Western Ambulance Service and the acute hospitals; and that multi-agency work with individuals with complex support needs is shaped by shared goals and clear leadership;

ii. The fact of a person's traumatic brain injury and mental capacity is foregrounded in all professional assessments and referrals and that family involvement is prioritised with a view to understanding the continuities, the discontinuities and the unpredictable and complex process of reconstructing the self which arise from such a critical injury;

iii. Even accepting some basic similarities in brain injury and the fact that not two injuries will be alike, a learning event should be hosted concerning Tom and others currently known to Headway Somerset. The event should involve (i) service commissioners, including Public Health, and (ii) practitioners, with a view to identifying a purposeful, strongly led and multi-disciplinary response. It is possible

that Headway and Tom's family may be willing to assist in designing and contributing to such events;

iv. Public Health, Somerset County Council and NHS commissioners should set out how local practice and priorities match good practice concerning the support of people with brain injury, dual diagnoses (Department of Health 2002), and the expectations of the National Suicide Prevention Strategy for England (Department of Health 2012);

v. Homefinder Somerset and housing partners identify how tenants with extensive support needs, including those with acquired brain injuries, may access supported housing;

vi. This review is shared with Headway UK for dissemination beyond Somerset to stimulate debate.

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Acknowledgements

This review owes a special debt of gratitude to Tom's family. It could not have been undertaken without the professional participation of people from Adult Social Care – Somerset County Council, Avon and Somerset Police, Butterfields, Headway Somerset, Housing Options - Taunton Deane Borough Council, Musgrove Park Hospital, Somerset Partnership NHS Foundation Trust, and South Western Ambulance Service Trust. Their critical commentaries and ideas have been invaluable.

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Committee: Healthier Communities and Older People Overview and Scrutiny Panel

Date: 07 February 2017

Wards: ALL

Subject: Provision of Specialised Commissioning Neuro Rehabilitation Services for People with Traumatic Brain Injury.

Lead member: Councillor Peter McCabe, Chair of the Healthier Communities and Older People overview and scrutiny panel.

Contact officer: Stella Akintan, stella.akintan@merton.gov.uk; 020 8545 3390

Recommendations:

A. That the Panel comment on the attached NHS report.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. The purpose of the attached report is to provide an overview of services for people with traumatic brain injury commissioned by NHS England. It also responds to the Somerset Adult Safeguarding Board, serious case review.

2 DETAILS

2.1. Senior representatives from NHS England will attend the Panel to give an overview of the report and answer questions.

3 ALTERNATIVE OPTIONS

The Healthier Communities and Older People Overview and Scrutiny Panel can select topics for scrutiny review and for other scrutiny work as it sees fit, taking into account views and suggestions from officers, partner organisations and the public.

Cabinet is constitutionally required to receive, consider and respond to scrutiny recommendations within two months of receiving them at a meeting.

3.1. Cabinet is not, however, required to agree and implement recommendations from Overview and Scrutiny. Cabinet could agree to implement some, or none, of the recommendations made in the scrutiny review final report.

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. The Panel will be consulted at the meeting

5 TIMETABLE

5.1. The Panel will consider important items as they arise as part of their work programme for 2017/18.

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. None relating to this covering report

7 LEGAL AND STATUTORY IMPLICATIONS

7.1. None relating to this covering report. Scrutiny work involves consideration of the legal and statutory implications of the topic being scrutinised.

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. It is a fundamental aim of the scrutiny process to ensure that there is full and equal access to the democratic process through public involvement and engaging with local partners in scrutiny reviews. Furthermore, the outcomes of reviews are intended to benefit all sections of the local community.

9 CRIME AND DISORDER IMPLICATIONS

9.1. None relating to this covering report. Scrutiny work involves consideration of the crime and disorder implications of the topic being scrutinised.

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. None relating to this covering report

11 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

- NHS England Report

12 BACKGROUND PAPERS

Provision of Specialised Commissioning Neuro Rehabilitation Services for People with Traumatic Brain Injury

Introduction

The aim of this paper is to provide the Merton Overview and Scrutiny Panel assurance on the current provision of Specialised Commissioning Neuro Rehabilitation services for people with Traumatic Brain Injury. Although this paper makes references to the whole patient pathway, its focus is on the Level 1 and 2a services commissioned by NHS England's Specialised Commissioning team, rather than the transition and post discharge settings which are commissioned by Clinical Commissioning Groups (CCGs) and Local Authorities (LAs).

This paper outlines the commissioned structure of neuro rehabilitation services in London, the scope of specialised commissioning services and the current patient pathway. It also provides detail on the current provision in South West London (SWL) and current challenges. To conclude, the paper will consider lessons from the Somerset Serious Case Review and make recommendations for the future provision of neuro rehabilitation services in South West London.

Commissioning Structure:

Specialised Commissioning

Since the reorganisation of the NHS following the Health and Social Care Act 2012, NHS England Specialised Commissioning is the responsible commissioner of tertiary specialised **(Level 1 and 2a)** rehabilitation for patients with highly complex needs (all ages) as per NHS England Service Specification D02 S/a (Appendix 1). Traumatic Brain Injury (TBI) is one of the conditions that give rise to complex disability as classified by the Long Term Conditions National Service Framework.

These services are normally provided in co-ordinated service networks planned over a regional population of 1-5 million through specialised commissioning arrangements.

These services are sub-divided into:

- Level 1a - for patients with high physical dependency
- Level 1b - mixed dependency
- Level 1c - mainly more physically able patients with cognitive/behavioural disabilities.

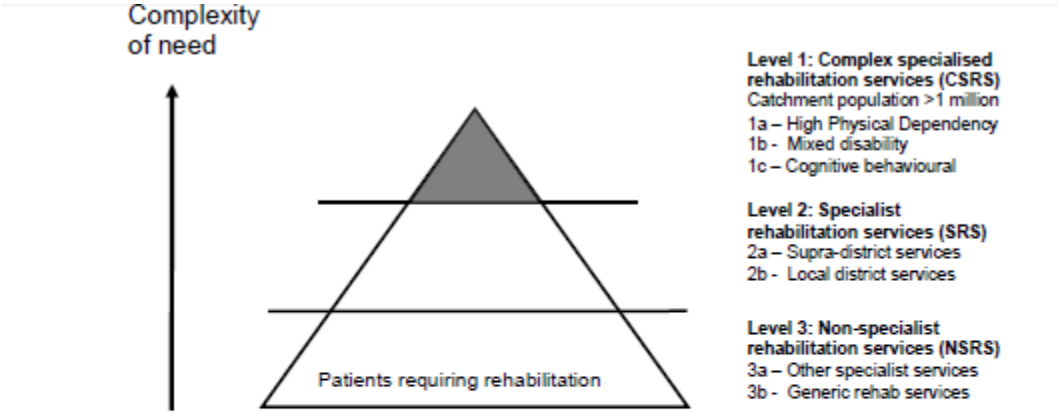
Key aims of the service are to provide rehabilitation for patients with complex needs in order to assist them to achieve their maximum potential for physical, cognitive, social and psychological function, participation in society and activities of daily living.

The services also play an important role in relieving pressure on acute services and facilitating discharge to the community or on-going placement.

Interface with CCG's

The level of complexity involved in the patient's rehabilitation will determine if the responsible commissioner is NHS England **(Level 1& 2a)** or a CCG **(Level 2b and 3)** as illustrated in Figure 1.

Figure 1: Levels of Neurorehabilitation Services



TERTIARY SPECIALISED REHABILITATION SERVICES- provided at regional / national level		
Level 1:	**Specialised rehabilitation services** Provided by specialised rehab teams led by consultants trained and accredited in the specialty of rehabilitation medicine (RM) (and/or neuropsychiatry):	
	Serving a regional or supra-regional population and taking patients with Category A needs – ie severe physical, cognitive communicative disabilities or challenging behaviours, with highly complex rehabilitation needs* that are beyond the scope of their local specialist rehabilitation services, and have higher level facilities and skilled staff to support these. Collect and report full National Specialist Rehabilitation Dataset	Catchment: 1-3 million Predominantly highly complex caseload: At least 85% pts have Category A needs on admission At least 70% pts with RCS-E score ≥11 cross-sectionally
LOCAL REHABILITATION SERVICES - provided at district level		
Level 2:	**Local (district) specialist rehabilitation services** Provided by inter-disciplinary teams led/supported by a consultant in RM, and meeting the BSRM standards for specialist rehabilitation services	
Level 2a	Led by consultant in RM. Serving an extended local population in areas which have poor access to level 1 services. Take patients with a range of complexity, including Category B and some Category A with highly complex rehabilitation needs* Collect and report full National Specialist Rehabilitation Dataset	Catchment: 600K-1 million Mixed caseload 50-80% Category A needs on admission 50-70% RCS-E score ≥11 cross-sectionally
Level 2b	Led/supported by a consultant in RM. Serving a local population, predominantly patients with Category B needs. Collect and report at least the minimum national dataset	Catchment: 250-500K Less complex caseload eg 30-50 % Category A needs on admission 30-50% RCS-E score ≥11 cross-sectionally
Level 3:	**Local non-specialist services.** Includes generic rehabilitation for a wide range of conditions, provided in the context acute, intermediate care and community facilities, or other specialist services (eg stroke units)	
Level 3a	Other specialist services led or supported by consultants in specialties other than RM - eg services catering for patient in specific diagnostic groups (eg stroke) with Category C needs. Therapy / nursing teams have specialist expertise in the target condition	
Level 3b	Generic rehabilitation for a wide range of conditions, often led by non-medical staff, provided in the context acute, intermediate care and community facilities, for patients with Category D needs	

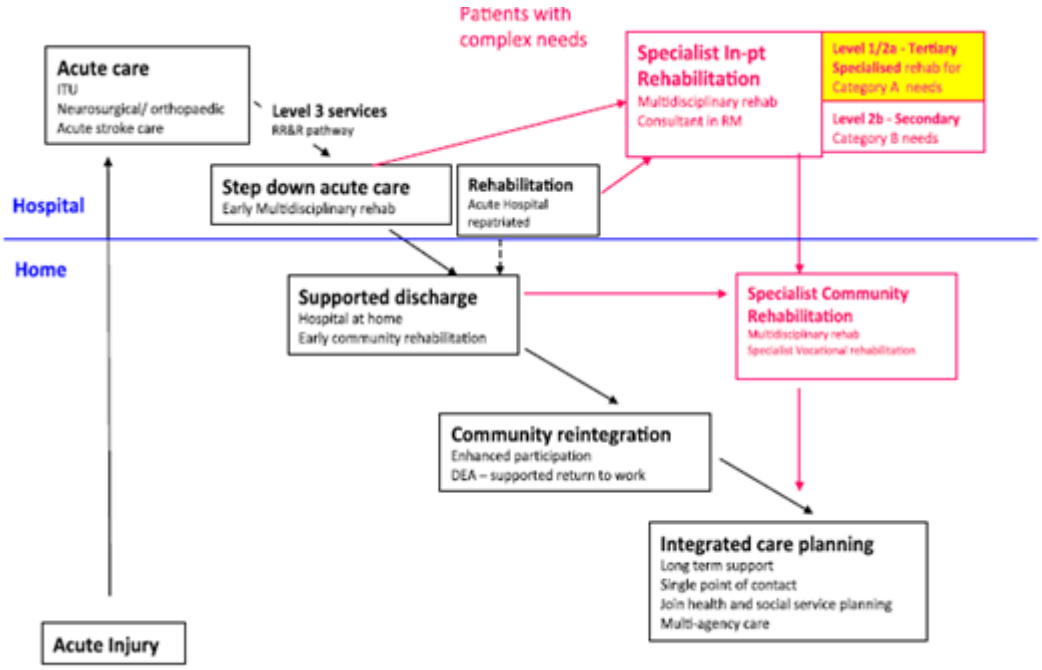
Patient Pathway

Patients' rehabilitation needs are assessed to identify the appropriate service for the patient at that time depending on the level of need that is identified via a clinical assessment. The level of need is defined using the Department of Health Specialist Services National Definition Set (SSNDS), that defines four categories of patient need (A,B,C,D)

After severe disabling illness or injury many patients have category C or D rehabilitation needs and will progress satisfactorily down the pathway to recovery with the support of the local recovery, rehabilitation and re-enablement (R R &R) Level 3 services (commissioned by CCGs and local authorities).

A significant number of patients will have more complex (Category B) needs requiring more prolonged treatment in a specialist (Level 2) rehabilitation service (commissioned by NHSE if 2a and CCG if 2b). (Please see Appendix 2 for map of Level 1 and 2b provision in London)

Figure 2: Pathways for rehabilitation following illness or injury



Red part of the pathway: CCG commissioned rehabilitation
Yellow cell: Tertiary specialised services- NHS England commissioned
Black part of the pathway: Usually provided by non-specialist (Level 3) rehabilitation services

Admission notification and discharge planning

In general, neuro rehab providers have good communication systems in place to notify CCGs of the intended patient admissions, progress on individual patient improvements and likely intended discharge.

It is important that complex neuro-rehabilitation providers ensure efficient use of bed resources and provide good communication to relevant stakeholders throughout the inpatient episode. The relevant CCG is responsible for leading the continuing healthcare

process in collaboration with the neuro-rehab provider. The Decision Support Tool (DST) will be completed with the CCG and Adult Social Care with input from the patient and/or their representative.

Generally, a multidisciplinary team (including medical, nursing, social work and Allied Health Professionals) should anticipate a projected discharge date as early into a patient's admission as possible. This allows for early communication with patients, their families and other key stakeholders. All members of the team are responsible for ensuring that relevant onward referrals are made as appropriate to the patient's needs.

Patients who require medications for discharge must have 'To Take Away' (TTA) medications dispensed by the pharmacy department. This request must be made as soon as the discharge date is confirmed.

The keyworker and Discharge Coordinator on the team take the lead role in the discharge planning process from the point of initial assessment. They liaise with the relevant Clinical Commissioning Groups, Social Services departments and other outside involvements as appropriate in consultation with the MDT and patient and/or family. The social worker in the team supports this process and also provides a supportive counselling role to the patient and/or family during the discharge planning process. The Discharge Coordinator and keyworker are the primary contact for the coordination of the discharge plan

Due to the complexity of the patient pathway, Neuro-navigators have been introduced to facilitate more integrated working between hospitals and specialist neurological rehabilitation services. They are Allied Health Professionals/Nurses with specialist knowledge and experience in neuro-rehabilitation and have a pivotal role in working with referrers, patients and their families/carers to identify which service is most appropriate for the individual at that time. Investment in neuro-navigators has been actively developed across North West and Central London CCGs with less cover in the south of London (although provision in increasing in SEL). See Appendix 2.

Current Specialised Complex Neuro Rehab Inpatient Provision in London

Specialised Commissioning currently commission a total of 186 beds in London, 71of which are in South West London

Table 1: Bed commissioned by Specialised Commissioning

PD: Physical Disability CB: Cognitive Behavioural

Name	Sector	Level	Bed base	Type
RRU Northwick Park	NW	1a	24	PD Hyperacute (4 beds)
RHND Putney	SW	1a	39 flex to 42	PD Slow stream
RNHU Homerton	NE	1b	24 flex to 27	Mixed PD and CB
UCLH	NC	1b	18	Mixed PD and CB
FCRU King's	SE	1b	15	Mixed PD and CB
Lishman Unit SLAM	SE	1c	7	CB
Blackheath TBIRU	SE	1c	16	CB
Blackheath HNDU	SE	2a	17	Mixed PD and CB
Wolfson	SW	2a	32	Mixed PD and CB
TOTAL			192	

Service provision in Merton

Table 2 below shows the individual referral rate per 100K population for the South West London (SWL) sector. The borough of Merton (highlighted in grey) is on the mid-range scale, with 29 annual referrals per year, of which 14 resulted in admissions.. It should be noted that not all referrals result in admission either because (a) they are duplicate referrals (b) they are not appropriate for 1 and 2a services. The introduction of Neuro-navigators should see a drop in this type of referral as they support referring hospitals to get the referral right first time

Table 2: Individual referral rate per 100K population in SWL

	Croydon	Wandsworth	Merton	Richmond	Sutton	Kingston
Referrals per annum	93	37	29	30	23	11
Population	400,679	384,971	221,096	210,369	190,700	202,786
Rate per 100,000	23	10	13	14	12	5

Source: BadgerNet and UKRoC data (average of 2015 and 2016 data)

Overall for SWL sector there have been some significant reported delayed discharge issues for the sector resulting in a business case being presented to Directors of SWL CCGs requesting additional access to level 2b step down beds for SWL patients. Approval for the RHND Putney to provide this additional level 2b bed capacity has now been agreed.

For Merton specific patients, the issue of delayed discharges has not been reported as a key issue, however some recent cases have been flagged as being challenging and complicated with particular issues around patient choice for ongoing care. A recommendation was also made by Specialised Commissioning in 2016 to Wandsworth CCG to consider strengthening the role of neuro navigators across all SWL CCGs as currently there is only 1 WTE discharge co-ordinator/neuro-navigator role in SWL (focusing predominantly on Wandsworth patients). However, this recommendation was not taken forward in the report that was recently submitted to the SWL Directors of Commissioning.

Provision at the Wolfson Rehabilitation Service, St George's Hospital

Inpatient Service

Innovative pathway redesign at The Wolfson Neurorehabilitation Services has been undertaken over the past 12 months for patients with TBI. The Major Trauma Centre (MTC) is one of the only units in London where patients with TBI are cohorted to the care of one consultant who has oversight of the patients' recovery and onward pathway through to rehabilitation. This Acute TBI MDT includes all therapies and a Consultant Neurologist and Neuropsychiatrist who work in an integrated, transdisciplinary approach across the physical and mental health of patients after TBI.

Those patients with Category A needs that are referred to rehabilitation are then moved directly from the Acute TBI team to a Level 1 rehabilitation bed collocated in the MTC and led by the Consultant Neuropsychiatrist in Neurorehabilitation.

An evaluation of this pathway has identified that in comparison to a control group of patients after TBI receiving care as usual, this patient cohort receives intensive rehabilitation much earlier (48% decrease in days waiting for rehabilitation) and have a significantly decreased admission in the MTC acute bed (Length of stay in MTC decreased by 36%). Also, significantly, the care costs on discharge for the early rehabilitation pathway patients were decreased by £830 per week, per patient in comparison to those receiving rehabilitation as usual.

Following discharge from Level 1 rehabilitation, the pathway also provides a Multidisciplinary TBI Outpatient Service which includes reviews by a Consultant Neurologist, Consultant Neuropsychiatrist, Neuropsychologist and Physiotherapist with the additional benefit of a complex case multidisciplinary meeting where an integrated approach to assessment and ongoing treatment is maximised.

For those patients with ongoing cognitive rehabilitation needs which cannot be provided by the community neurorehabilitation an intensive (i.e. 5 days a week) outpatient Cognitive Rehabilitation pathway is currently being piloted and evaluated. A vocational rehabilitation pathway is well established and also compliments outpatient services.

Outpatient Service

An intensive (5 day a week) outpatient cognitive rehabilitation service is currently being piloted to reduce demand for inpatient Level 2 beds. This service reconfiguration aligns with the local CCGs and NHS England's (NHSE) strategic vision[1] for increased provision of services for category B patients[2].

[1] CF. Minutes from *NHSE Transforming Specialised Services in London Neurorehabilitation Review meetings (2016);* ***The National Clinical Audit of Specialist Rehabilitation following Major Injury (2016)***

[2] Definition of category B patients and Level 2 services can be found in NHSE's service specification for specialised rehabilitation for patients with highly complex needs

Outpatient based neurorehabilitation services are well established at SGFT, comprising of group therapy and day patient packages of specialist cognitive and functional rehabilitation. The service consists of neuropsychology, neuropsychiatry, neurology, rehabilitation medicine, physiotherapy, occupational therapy, dietetics, speech and language therapy, and social work. There is also a vocational rehabilitation programme, which provides specialist assessment, treatment, and on-the-job support to help patients learn to compensate for their cognitive disability in the workplace.

This is a unique regional service serving Greater London, and provides the intensity of comprehensive holistic interdisciplinary neuropsychological rehabilitation that cannot be provided by community teams; and has been demonstrated via randomised control trials to be more effective than multidisciplinary rehabilitation[3i] & [5ii] (which is the delivery model employed by community teams). The service enables patients over 16 and under 65 (or older adults who are still working) with complex cognitive disability to successfully reintegrate into the community, thus reducing overall long-term costs to the health and social care economy.

The waiting time for the Wolfson Outpatient Cognitive Rehabilitation Services (WOCRS) in November 2016 was 12 months, as it only ran 1-2 days a week prior to the 5-day pilot service. This demonstrates that outpatient demand outstripped supply. Often patients suitable for day patient treatment were referred to the Level 2 inpatient service, as it was the only way to access the intensity of cognitive rehabilitation required (i.e. therapy five days a week). Consequently, patients with low nursing needs but cognitive disabilities caused delayed discharges from the major trauma centre and acute care beds. Alternatively, patients were discharged home to supportive families while awaiting admission to a Level 2 bed. Without any guidance regarding how to care for their relative, it often led to family breakdown, loss of social roles (e.g. work), and development of secondary mental health problems (e.g. depression and anxiety).

The primary objective of this pilot study is to evaluate the effectiveness of providing neurorehabilitation activity, previously delivered via four inpatient beds, via an intensive day patient cognitive rehabilitation programme, which employs a holistic neuropsychological rehabilitation model of delivery.

The pilot service aimed to:

1. Expedite discharge from acute care, thus facilitate more timely community reintegration for patients with no specialist nursing needs. In turn, this should improve

[3i] Cicerone, KD., Mott, T., Azulay, J., Sharlow-Galella, MA., Ellmo, WJ, Paradise, S., & Friel, JC. (2008). A randomised controlled trial of holistic neuropsychologic rehabilitation after traumatic brain injury. Archives of Physical Medicine Rehabilitation, Dec 89 (12), 2239-49

[5ii] Cicerone KD, Langenbahn DM, Braden C, Malec JF, Kalmar K, Fraas M, Felicetti T, Laatsch L, Harley JP, Bergquist T, Azulay J, Cantor J, Ashman T (2011) Evidence-based cognitive rehabilitation: updated review of the literature from 2003 through 2008. Arch Phys Med Rehabil. 2011 Apr;92(4):519-30.

long-term outcomes for patients with an acute presentation of cognitive, behavioural, and/or communication deficits secondary to a neurological diagnosis.

2. Improve the flow of patients into specialist neurorehabilitation earlier in the patients' rehabilitation journey. This will be achieved by redressing some of the inequity regarding patients' waiting times to access Level 2 neurorehabilitation services, especially for people who primarily have cognitive and behavioural needs, in the South West London region.

   The flow of patients through community neurorehabilitation teams should also be expedited[4] by working in partnership with community teams to allow them to focus on the core community based goals (e.g. improved independence in travel, personal, and domestic care tasks), while delivering the patients' intensive cognitive rehabilitation needs in a controlled environment (e.g. memory aid training). It is well known in clinical practice that cognitive compensatory aid training occurs quicker when training is conducted in a controlled environment versus a community setting[5]. Furthermore, research indicates that earlier community reintegration reduces long-term costs to the health economy[6]. The importance of timely access to cognitive rehabilitation is widely acknowledged within the empirical literature[7]. Patients are known to use health services more frequently at 17-years post-injury if they have unresolved cognitive and psychological difficulties, rather than physical impairments[8]. Therefore, it is reasonable to surmise that improved access to appropriate intensive day patient cognitive rehabilitation should also help reduce long-term mental health problems and dependency on health services.

3. Enable a significant cohort of current Level 1 and 2 inpatients to access outpatient services as soon as they no longer require specialist nursing care, thus facilitating graded discharges and reducing the overall length of stay for inpatient beds. In turn, this will improve the flow of patients across the regional neurorehabilitation pathway.

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[4] CF. Royal College of Physicians: British Society of Rehabilitation Medicine (2003) Rehabilitation following acquired brain injury: National clinical guidelines. RCP London.

[5] CF. Sohlberg, M., Johansen, A., Geyer, S., & Hoornbeek, S. (1994). A manual for teaching patients to use compensatory memory systems. Association for Neuropsychological Research and Development, WA

[6] Whyte, E., Skidmore E., Aizenstein, H, Ricker, J, & Butters, M. (2011). Cognitive impairment in acquired brain injury: a predictor of rehabilitation outcomes and an opportunity for novel interventions. PM & R, Jun Vol 3 (6 suppl 1), S45-51

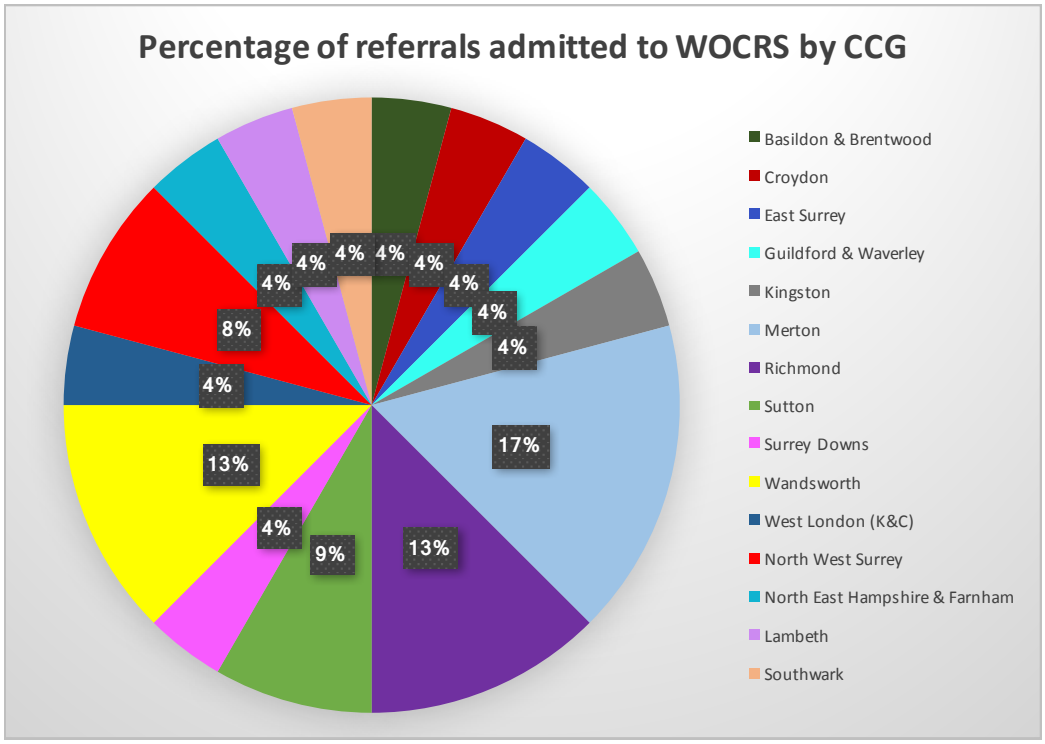
[7] Cicerone, KD., Dahlberg, C., & Kalmar, K. (2000). Evidence-based cognitive rehabilitation: recommendations for clinical practice. Archives of Physical Medical Rehabilitation, 81, 1596-1615

[8] Hodgkinson, A., Veerabangsa, A., Drane, D., & McCluskey, A. (2000). Service utilization following Traumatic Brain Injury. Journal of Head Trauma Rehabilitation, Vol 15 (6), 1208-1226

Referring CCGs

To date the patients treated within WOCRS have come from across the South West region. The pie chart below (Figure 3) illustrates the percentage of patients treated from each Clinical Commissioning Group (CCG). However, it is noteworthy that the largest percentage of referrals came from Merton. The higher rate of referrals from Merton reflects the lack of provision of neuropsychology services in the local community neurorehabilitation team. This is a significant gap in service for Merton patients; it results in Merton patient requiring treatment via WOCRS who would be treated in the local community neurorehabilitation team if they lived in Wandsworth. This is not a good use of a highly specialist service and means that Merton is not compliant with best practice guidelines. It also means that patients who have neuropsychological and neurobehavioural needs often go undetected until their problems escalate to a level that is unmanageable by the community neurorehabilitation team, thus warranting a referral to a specialist service such as WOCRS.

Figure 3: Percentage of referrals admitted to WOCRS day patient service by CCG (N = 24)

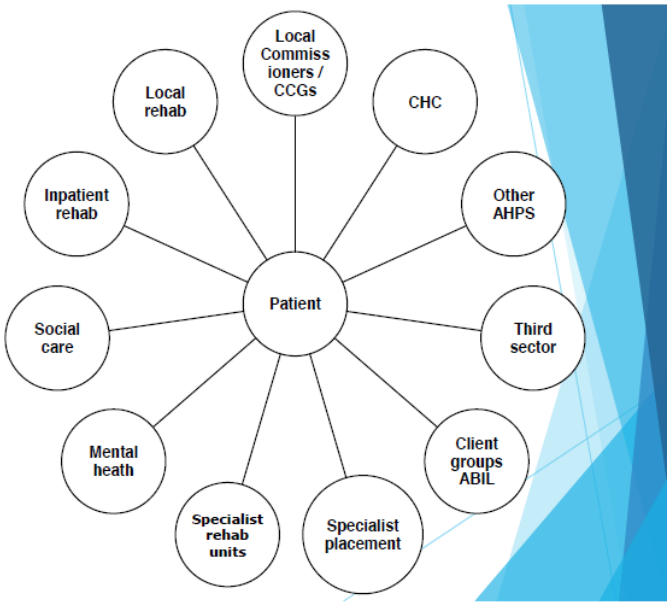


<u>Learning from the Somerset Serious Case Review (SAR):</u>

One of the key lessons from the Somerset SAR was a greater need for collaboration between health and social care services to avoid patients falling through gaps between different commissioning boundaries.

Although this is the case for most pathways requiring inter agency collaboration, the neuro rehab pathway is particularly complex, with over 10 different agencies being involved in one patients care (Figure 4).

Figure 4: Agencies involved in neuro rehab pathway



Source: ABIL Conference- Improving the pathway after brain injury

Another important lesson to draw out it the need to have a specific TBI pathway where all agencies can ensure they are following best practice in the management of these patients. This will also ensure that correct processes in place to be responsive to patients and their families so they access the services they need when they need them.

Recommendation

There is recent evidence of joint working between neuro rehabilitation commissioners in SWL, as part of the recent neuro rehabilitation review where key recommendations were to develop a central data system for referrals and to increase the use of neuro navigators to support patients through the pathway. The central data system is now in place (London wide) supported by specialised commissioning in its commissioned tertiary centres and their referring Trusts. A proposal to expand neuro-navigator capacity is also being taken forward. However, it is clear that further formal collaboration is required across the STP to ensure a robust system is in place to support TBI patients and their families across the whole pathway. The evolving Sustainability and Transformation Partnerships (STPs) provide an opportunity to formalise these links. The SWL draft Five Year Forward Plan identifies the neuro rehabilitation service as one of their areas of local priority "*London's neuro-rehabilitation service has experienced continued pressure across the range of its services. The patient pathway is fragmented with bottlenecks and blockages both for accessing and discharging of patient" (page 82).*

To enable change, the STP have committed to a more collaborative approach to commissioning services on an STP or multi STP footprint. This will include planning and designing services together and providing financial incentives for pathway improvement, supported by the pooling or delegation of budgets as appropriate. This collaborative

commissioning approach has already been started in the area of Adult Secure Mental Health, with a plan to replicate this approach in other pathways such as neuro surgery and neuro rehabilitation. Specialised Commissioning is fully engaged with this work and continues to work closely with the STP to ensure that neuro rehabilitation patients and their families have access to integrated and responsive services that meet their needs.

This paper has set out how specialised commissioning and commissioned specialist providers are rising to this challenge. It does not cover the full range of community services commissioned by CCGs and Local Authority colleagues which contribute to a complete pathway.

To be fully assured with respect to the Somerset SCR, the Overview and Scrutiny Committee may want to explore the full pathway in a future discussion, where the challenges highlighted in the is paper regarding community provision can be further explored.

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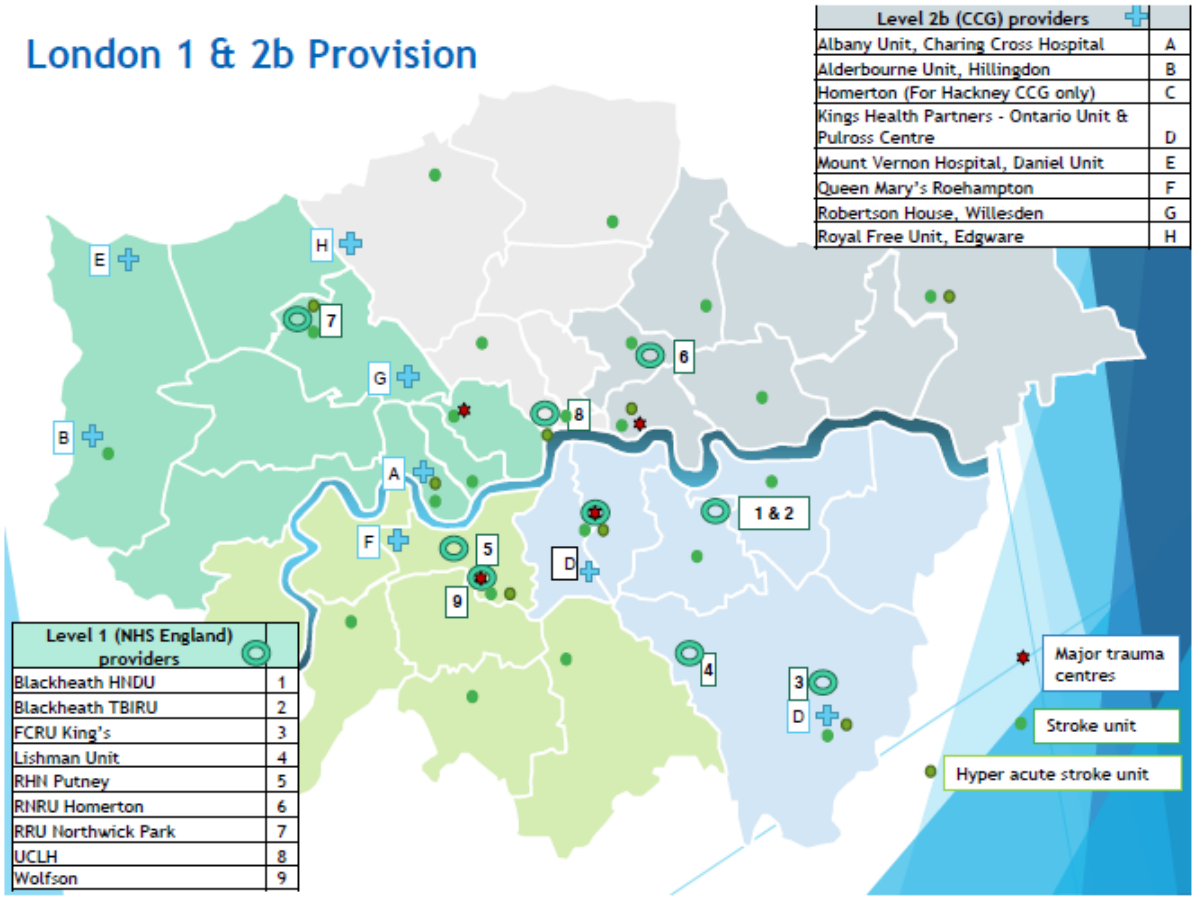
Appendix 1

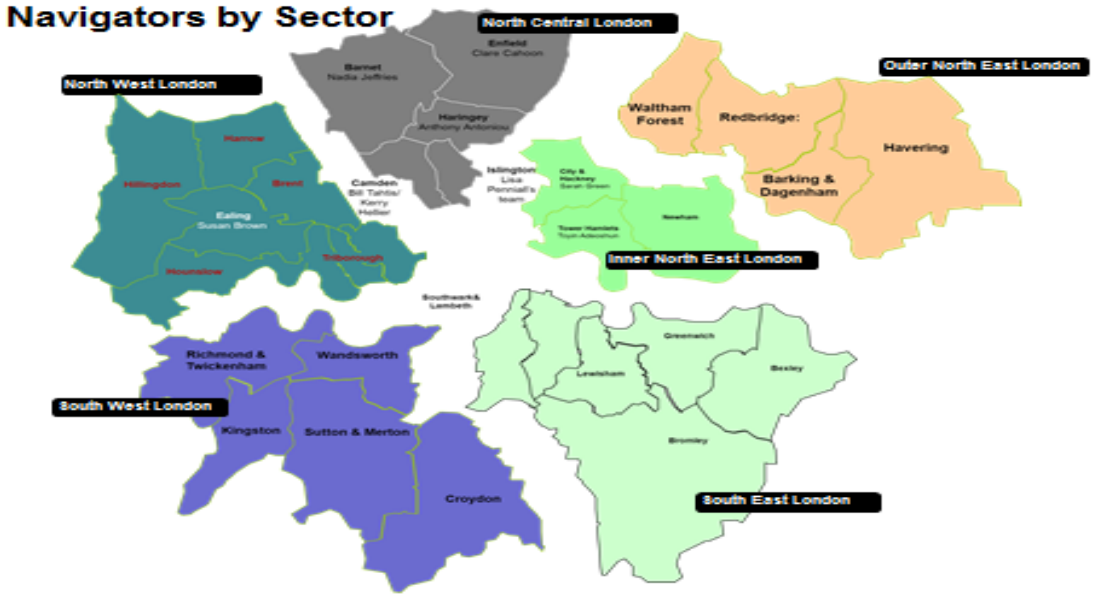
NHS England Service Specification D02/Sa - Specialised Neuro Rehabilitation for patients with highly complex needs (All ages).

d02-rehab-pat-high-needs-0414.pdf

Also available at https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-d/d01/

Appendix 2





1 WTE in post for SEL and SWL and 1 WTE recently appointed for Waltham Forest CCG.

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Healthier Communities and Older People Work Programme 2017/18

This table sets out the draft Healthier Communities and Older People Panel Work Programme for 2017/18. This Work Programme will be considered at every meeting of the Panel to enable it to respond to issues of concern and incorporate reviews or to comment upon pre-decision items ahead of their consideration by Cabinet/Council.

The work programme table shows items on a meeting by meeting basis, identifying the issue under review, the nature of the scrutiny (pre decision, policy development, issue specific, performance monitoring, partnership related) and the intended outcomes. The last page provides information on items on the Council's Forward Plan that relate to the portfolio of the Healthier Communities and Older People Panel so that these can be added to the work programme should the Commission wish to.

The Panel is asked to identify any work programme items that would be suitable for the use of an informal preparatory session (or other format) to develop lines of questioning (as recommended by the 2009 review of the scrutiny function).

Scrutiny Support

For further information on the work programme of the Healthier Communities and Older People please contact: -
Stella Akintan (Scrutiny Officer)
Tel: 020 8545 3390; Email: stella.akintan@merton.gov.uk

For more information about overview and scrutiny at LB Merton, please visit www.merton.gov.uk/scrutiny

Meeting Date 27 June 2017

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Performance Monitoring	St George's University Hospitals NHS Foundation Trust.	Verbal update at the Panel	Dr Andrew Rhodes, Acting Medical Director, St George's Hospital	Panel to receive an update on the improvements since the recent CQC inspection.
Performance Monitoring	South West London and St George's Mental Health NHS Trust	Verbal update at the Panel	David Bradley, Chief Executive, SWLST Mental Health Trust.	Panel to receive update on proposed changes to Autistic services.
	Work programme report	Report to the Panel	Cllr Peter McCabe, Chair Stella Akintan, Scrutiny Officer	To agree the work programme for 2017-18

Meeting date – 06 September 2017

Scrutiny category	Item/Issue	How	Lead Member/ Lead Officer	Intended Outcomes
Consultation	Epsom and St Helier University NHS Trust – Update on current priorities	Report to the Panel	Daniel Elkeles, Chief Executive, Epsom and St Helier	Panel to receive an update on the Trust Estate Strategy
Performance Review	Access to local assessment Centres and the assessment process	Report to the panel		
Scrutiny Review	Loneliness Task Group – Final Draft Report.	Report to the Panel	Councillor Sally Kenny	To consider the report and recommendations arising from the review

Meeting Date – 07 November 2017

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Policy Development	Services for people who have experienced brain injury	Report to the Panel	Specialised Commissioning Group Merton Safeguarding Adults Board	To review the services available for this group
Performance Monitoring	Budget	Report to the Panel	Caroline Holland, Director of Corporate Services	To comment on the council's draft budget

Meeting date – 11 January 2018

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Performance Monitoring	Budget	Report to the Panel	Caroline Holland, Director of Corporate Services	To comment on the council's draft budget
Policy Development	MCCG Primary Care Strategy	Report to the Panel	Dr Andrew Murray, Chair, Merton Clinical Commissioning Group.	Look at succession planning for GPs and the efficiency of the local health economy.

Meeting date – 13 February 2018

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Policy Development	Preventing the rise in Tuberculosis	Report to the Panel	MCCG, Public Health, local charities	To review the services available for this group
Policy Development	Sexual transmitted	Report to the Panel	MCCG, Public Health,	To review the services

	infections		local charities	available for this group
Scrutiny Review	Preventing Loneliness in Merton Task Group – Action Plan	Report to the Panel	Public Health Team.	The Panel to review the department action plan to implement the recommendations arising from the report.
Scrutiny Review	Update from the work of the diabetes task group	Report to the Panel	Dr Dagmar Zeuner, Director of Public Health	Progress with implementing the recommendations

Meeting Date – 13 March 2018

Scrutiny category	**Item/Issue**	**How**	**Lead Member/Lead Officer**	**Intended Outcomes**
Performance Monitoring	Update from the Health and Wellbeing Board	Report to the Panel	Dr Dagmar Zeuner, Director of Public Health	Review outcomes from the work of the Board
Performance Monitoring	Review of Health and Wellbeing Strategy	Report to the Panel	Dr Dagmar Zeuner, Director of Public Health	Review progress with the projects in the Strategy
Performance Monitoring	Update on Healthwatch	Report to the Panel	Brian Dillon, Healthwatch Chair.	Review outcomes from the work Healthwatch
Policy Development	Services for people with Sickle Cell disease in Merton	Report to the Panel and representation from the Sickle Cell Society	Merton Clinical Commissioning Group	To review the services available for this group