London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Agenda

Monday 10 November 2014
5pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Councillor Vivienne Lukey, Cabinet Member for Health and Adult Social Care (Chair)
Dr Tim Spicer, Chair of H&F CCG (Vice-chair)
Councillor Sue Macmillan, Cabinet Member for Children and Education
Liz Bruce, Tri-borough Executive Director of Adult Social Care
Andrew Christie, Tri-borough Director of Children's Services
Philippa Jones, Managing Director, H&F CCG
Dr Susan McGoldrick, Vice-Chair, H&F CCG
Trish Pashley, Local Healthwatch representative
Meradin Peachey, Tri-borough Director of Public Health

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Date Issued: 31 October 2014

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Agenda

10 November 2014

Item		Pages
1.	**MINUTES AND ACTIONS**	1 - 9

(a) To approve as an accurate record and the Chairman to sign the minutes of the meeting of the Health & Wellbeing Board held on 8 September 2014.

(b) To note the outstanding actions.

2. APOLOGIES FOR ABSENCE

3. DECLARATIONS OF INTEREST

If a Member of the Board, or any other member present in the meeting has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.

At meetings where members of the public are allowed to be in attendance and speak, any Member with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Member must then withdraw immediately from the meeting before the matter is discussed and any vote taken.

Where members of the public are not allowed to be in attendance and speak, then the Member with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Members who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest.

Members are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Audit, Pensions and Standards Committee.

4.	**CHILDREN, YOUNG PEOPLE AND MENTAL HEALTH TASK AND FINISH GROUP**	10 - 61

The Children, Young People and Mental Health (CYPMH) Task and Finish Group's report presents a series of recommendations which aim to improve services for children and young people in the short to medium term.

5.	**SCHOOL NURSING REVIEW & SERVICE RE-DESIGN**	62 - 69

The report sets out the options for a new service model for school nursing.

6. SEXUAL HEALTH AND RELATIONSHIP EDUCATION IN SCHOOLS 70 - 117

The report by Healthwatch on sex and relationship education in west London provides useful information for Tri-borough sexual health commissioning.

7. LOCAL SAFEGUARDING CHILDREN BOARD: ANNUAL REPORT 118 - 174

The report sets out the achievements of the Local Safeguarding Children Board (LSCB) (2013/2014) against its four key priorities, evaluates the effectiveness of the LSCB overall, describes its activities, and future priorities and comments on the linkage to the Health and Wellbeing Board.

8. HAMMERSMITH & FULHAM CLINICAL COMMISSIONING GROUP CONTRACTING INTENTIONS: PROGRESS UPDATE 175 - 200

This report updates the Board and facilitates discussion on where members can still help shape the commissioning plans.

FOR INFORMATION

9. THE LONDON HEALTHCARE COMMISSION REPORT 201 - 206

This report gives a brief overview of the main recommendations of interest to the London Borough of Hammersmith and Fulham Health and Wellbeing Board, from the London Health Commission report, 'Better Health for London'.

10. HEALTH & WELLBEING BOARD LEARNING & DEVELOPMENT SESSIONS 207 - 208

This briefing sets out the benefits for Health and Wellbeing Board members in participating in these sessions and the suggested approach for delivery.

11. WORK PROGRAMME 209 - 212

The Board's proposed work programme for the municipal year is set out as Appendix 1 to this report.

The Board is requested to consider the items within the proposed work programme and suggest any amendments or additional topics to be included in the future.

12. DATES OF NEXT MEETINGS

The Board is asked to note that the dates of the meetings scheduled for the municipal year 2014/2015 are as follows:

19 January 2015
23 March 2015

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Minutes

Monday 8 September 2014

PRESENT

Committee members: Councillors Vivienne Lukey, Cabinet Member for Health and Adult Social Care (Chair)
Dr Tim Spicer, Chair of H&F CCG (Vice-chair)
Liz Bruce, Tri-Borough Executive Director of Adult Social Care
Andrew Christie, Tri—Borough Executive Director of Children's Services
Philippa Jones, Managing Director, H&F CCG
Councillor Sue Macmillan, Cabinet Member for Children and Education
Trish Pashley, H&F Healthwatch Representative
Meradin Peachey, Tri-borough Director of Public Health

Other Councillors: Rory Vaughan

Officers: Colin Brodie (Public Health Knowledge Manager), Holly Manktelow (Senior Policy Officer) and Sue Perrin (Committee Co-ordinator)

NHS England (London Region): Gemma Harris and Julie Sands

13. MINUTES AND ACTIONS

RESOLVED THAT:

The minutes of the meeting held on 30 June 2014 were approved and signed as an accurate record of the proceedings.

14. APOLOGIES FOR ABSENCE

Apologies were received from Dr Susan McGoldrick, Stuart Lines, Trish Pashley and, Councillor Sharon Holder.

15. DECLARATIONS OF INTEREST

There were no declarations of interest.

16. BETTER CARE FUND

Ms Attlee introduced the report, which set out the requirement on the Health & Wellbeing Board (HWB) to resubmit the Better Care Fund (BCF) Plan, which had been agreed on 24th March 2014 and submitted to the Department of Health (DH) in April 2014.

The Tri-borough BCF had been considered of good quality but other parts of the country had not been able to submit satisfactory plans. A key ambition of the BCF was to reduce pressures arising from unplanned admissions to hospital.

In July 2014, revised guidance and planning, and templates had been issued for submission by 19 September 2014. Each area was asked to demonstrate how the BCF Plan would reduce emergency admissions, as a clear indicator of the effectiveness of local health and care services in working better together to support people's health and independence in the community.

A proportion of the performance allocations would be payable for delivery of a locally set target for reducing emergency admissions. The balance of the allocation would be available upfront to spend on out of hospital NHS commissioned services, as agreed by the HWB. This would provide greater assurance to the NHS and mitigate the risk of unplanned acute activity.

The key delivery requirement of the BCF programme was captured diagrammatically. Work was still being completed on the financial assumptions and the revised report was not ready for presentation to the HWB at this meeting. The key revisions to the plan had been summarised in the report.

Ms Attlee then responded to members' queries.

The main issue of the Consultation had been to demonstrate provider engagement in the development of the BCF programme and understanding of the impact which BCF changes would make to activity. Discussions had been held with major providers, acute and community during June to September to increase their awareness of the detailed BCF programme.

Consultation had related to specifics of the BCF, not the totality. Whilst there were patient experience elements within the BCF, a wider service user engagement plan had not been fully implemented.

The Chair asked Dr Spicer to comment on the process from the CCG's aspect. Dr Spicer responded that the submission of additional data could be resolved within the timescale. The pilot would provide continuity of care for patients and, in addition, achieve savings.

RESOLVED THAT:

Final approval of the BCF updated plan templates be delegated to the Chair and Vice-chair, for submission on 19 September 2014.

17. PRIMARY CARE COMMISSIONING IN HAMMERSMITH & FULHAM

The HWB received a presentation, which set out the role and responsibilities of NHS England (NHSE) in primary care commissioning. In addition, the report provided information on the quality of primary care within the London Borough of Hammersmith & Fulham..

Julie Sands, representing Karen Clinton, Head of Primary Care, North West London, NHSE (London Region) responded to members' queries.

In respect of the GP practices which had recently closed their contracts with the NHS, one would be going out to procurement shortly, one was under consideration and the others had been closed.

It was difficult to forward plan as GPs were required to give only three months' notice and partnerships six months. This was a tight timescale, but it might be possible to plan the transition though caretaking arrangements or disbursing the list.

In respect of practices identified for review, performance tools indicated those practices which needed to be reviewed, on the basis of the data. This might be because the data was incomplete. Alternatively, it might indicate that a full practice review was necessary and advice should be sought from the Local Medical Committee.

The achievement categories could be equated to a traffic light system, with the 14 practices approaching review categorised as amber and the 12 practices where a review had been identified as red.

Mr Mallinson stated that Healthwatch had identified patient transfer issues, particularly in unscheduled care and that a seamless transfer was essential. Ms Sands responded that NHSE was interested to know of any issues and noted the importance of patient tracking, especially vulnerable patients, and clear communication. NHSE intended to again meet with Healthwatch.

Members queried progress in respect of the transformation of GP practices to support Out of Hospital Care and the Prime Minister's Challenge Fund.

Ms Sands responded that progress had been made with: GP Outcome Standards setting out expectations in respect of, for example, access, waiting times and referral; practice networks; and changes in the delivery of patient services. In addition, feedback from the independent GP Patient Survey was monitored.

GPs in North West London, including in Hammersmith and Fulham, had been awarded £5m from the Prime Minister's Challenge Fund to support schemes to make it easier for patients to see their GP. The money was being used to provide extended opening hours, weekend opening and better use of technology. Ms Jones noted the importance of the front desk experience and stated that the CCG had recently recruited someone to work with practices to obtain direct patient feedback.

Members noted the poor performance in respect of diabetes indicators and queried whether this was related to the number of nurses and practices undertaking health checks, and the support provided. Ms Sands responded that there were likely to be a combination of factors and these would be included when preparing for reviews of practices with issues.

Ms Jones responded that diabetes care was a priority for the CCG and that support was being provided by a GP working within the CCG three days a week. Ms Jones noted that the data was now slightly out of date.

Ms Sands stated that the reason for the lower level of patients with confidence and trust in their nurse In Hammersmith & Fulham was not known. However, the 2013/14 data analysis would be by practice, making it possible to identify themes. Dr Spicer noted the recruitment and retention issues in Hammersmith & Fulham. The satisfaction levels were partly a reflection of the isolation of practice nurses, although some networks were now beginning to share practice nurses.

Members queried how the prevention of avoidable emergency admissions and A&E attendances would be monitored. Ms Sands responded that the data would reflect only A&E attendances. There were a number of targets for practices in respect of frequent attendances.

Members queried the adequacy of GPs locally and how GPs would work with NHSE to ensure that the level of primary care services was adequate to meet the additional demands of out of hospital care. Ms Sands responded that the indications were not a measure of changing demand. There was a need to change how primary care was accessed and to work in different ways, with different forms of contract and funding being used more flexibly to benefit patients.

Members queried how the performance of individual practices would be presented, in order for patients to make an informed choice, and how good practice would be shared. Ms Sands responded that NHS Choices published healthcare data including satisfaction surveys and some quality indicators and My Health London published data to compare practices. In addition, practices worked in networks to discuss data and opportunities, facilitated by the CCG. Ms Jones confirmed that each practice should have a lay-person forum.

Dr Spicer referred to the national plans to increase GP places at medical schools, towards ensuring that 50% of medical students became GPs, over the next few years. GPs tended to move out of the central zone and therefore Hammersmith & Fulham needed to retain as many as possible.

Councillor Lukey concluded the discussion by commending the report for the good points of improving services locally and as a direction on which to focus.

RESOLVED THAT:

The report be noted.

18. MENTAL HEALTH TRANSFORMATION PROGRAMME

This item had been deferred.

19. CCG COMMISSIONING INTENTIONS 2015/2016

The Board received a presentation on the West London CCG Contracting Intentions for 2015/2016. The Commissioning Intentions would be circulated to providers in early October. In addition, a public and stakeholder facing document would be made available by December 2014.

The Commissioning Intentions would address:

- the delivery of the key NWL strategic priorities, including patient empowerment, primary care transformation, Whole Systems Integration and service reconfiguration; and
- responding to local issues, gaps and priorities.

The Commissioning Intentions for 2015/2016 built on the 2014/2015 Commissioning Intentions and the CCG's Out of Hospital Strategy and aimed to address JSNA priorities.

Members queried the future of the Milson Road site. Ms Jones responded that the site had initially been considered for closure, with services being redeployed, but this was currently being reconsidered. However, significant investment was required to update the site, and a business case was being submitted to NHSE.

Mrs Bruce highlighted the difference in planning timelines between the Council and the CCG, with the Medium Term Financial Strategy being at least two years compared to the Commissioning Intentions of only one year. In order to plan jointly, there was a need to align budgets and strategic time scales. Dr Spicer confirmed that the CCG would prefer to work on a timescale of more than one year. In respect of Whole System Integrated Care, these were the type of issues which needed to be resolved.

RESOLVED THAT:

The report be noted.

20. CHILDHOOD IMMUNISATION

Gemma Harris, Acting Patch Lead NWL, NHSE England (London Region) presented the report, which provided a background to the childhood immunisations programmes, with a focus on MMR; outlined roles and

responsibilities of organisations in relation to the section 7a immunisations programmes; provided the local context and data for Hammersmith & Fulham; set out NHSE's work streams; and partner organisations' roles in supporting an improvement in uptake of immunisation programmes.

Members noted the big reduction in uptake of the second dose MMR. Previously, data had been provided by the PCT, but was now provided through the Child Health Immunisation System, which included GP registered and unregistered children. Therefore the uptake for first and second doses were not comparable figures.

The unregistered cohort in Hammersmith & Fulham was steadily increasing. NHSE was looking at what services could be put in place to increase uptake.

Members queried the target for MMR uptake. Ms Harris responded that 95% was required to ensure resilience and that this was extremely challenging. Mrs Peachey confirmed that 95% was the level for herd protection, i.e. to prevent an outbreak. There was shared responsibility between NHSE, the CCG and Public Health; the three organisations needed to work in partnership.

Members suggested outreach possibilities via the third sector and children's services. Immunisation status could be checked at nursery/school enrolment and campaigns targeted depending on the response. Ms Harris noted that the data did not include children who had been vaccinated late.

Mrs Bruce stated that for outreach possibilities there would need to be a corresponding shift of funds from GPs.

RESOLVED THAT:

The report be noted.

21. PHARMACEUTICAL NEEDS ASSESSMENT

Mr Brodie presented the report, which set out the progress being made by the Pharmaceutical Needs Assessment (PNA) Task and Finish Group to prepare a new PNA for the London Borough of Hammersmith & Fulham (LBHF). There was a statutory requirement for a 60 day consultation on a draft PNA.

The LBHF HWB was required to publish a new PNA by 1 April 2015.It was proposed to begin the consultation on the draft PNA in October 2014. The draft PNA would be circulated to the HWB two weeks before publication for comment and steer. The final version would be brought back to the HWB before publication.

Members queried user involvement in respect of those more socially isolated and excluded. Mr Brodie responded that it was intended to work with agencies and Healthwatch, to co-ordinate the views of patients and service users.

Members proposed that views could be captured from people whilst in Chemists. Mr Brodie responded that resources had not been allocated for a full public consultation. Mrs Peachy added that the baseline consultation met the legal obligations, whilst the consultation proposed by members was a slightly different piece of work.

Members noted that the PNAs would be used primarily by NHSE to inform market entry decisions in response to applications from businesses.

Mrs Bruce noted that there was a bigger piece of work in mapping pharmacies and how people could be supported to stay out of hospital.

In respect of pharmacies and immunisation, Mr Brodie would refer this query to the Task and Finish Group

Action: Colin Brodie

RESOLVED THAT:

The progress in preparing the draft PNA for publication be noted.

22. TRI-BOROUGH LEARNING DISABILITY ACTION PLAN

The Learning Disability Action Plan identified the key priorities across the three boroughs within the current financial climate for improving the quality, quantity and choice of support for people with learning disabilities, and improvements in the following years. This included provisions funded by both health and social care.

Dr Spicer stated that the CCG was working closely with the Learning Disabilities team. Training was being offered to a range of staff to raise awareness.
Members were informed of the joint work around transitions.

The Children and Families Act had introduced new provision for 16 to 25 year olds. Implementation of the Act would be reviewed at the February 2015 Policy & Accountability Committee.

Ms Jones noted that the CCG had prioritised increased health checks for people with learning disabilities.

RESOLVED THAT:

(i) The report be noted.

(ii) The Action Plan be brought back to a future meeting for discussion.

23. JOINT STRATEGIC NEEDS ASSESSMENT 12 MONTH REVIEW

Mr Brodie introduced the report, which set out progress against evidence set out in deep dive JSNAs published in early 2013.

RESOLVED THAT:

The report be noted.

24. HEALTH AND WELLBEING BOARD PLAN

The Board received the report which set out:

- a proposed approach for the HWB in relation to undertaking engagement in relation to its statutory functions; and
- options for how the HWB could develop more effective engagement and communications across its areas of responsibility.

RESOLVED THAT:

The plan be brought to a future meeting for discussion.

25. PROTOCOL FOR GOVERNING THE RELATIONSHIP BETWEEN THE LOCAL SAFEGUARDING CHILDREN BOARD AND THE HEALTH AND WELLBEING BOARD

The Board received the report, which provided an overview of the role and responsibilities of the Tri-borough Local Safeguarding Children Board (LSCB) and its priorities for 2014/2015,

RESOLVED THAT:

(ii) The Governance arrangements be noted.

(iii) The formal working agreement between the HWB be considered at the next meeting.

26. WORK PROGRAMME

The Board received the draft work programme for 2014/2015.

The Chair requested that an agenda planning meeting be arranged.

Action: Sue Perrin

27. DATES OF NEXT MEETINGS

10 November 2014.

19 January 2015

23 March 2015

28. ANY OTHER BUSINESS

Letter of Support

West London Mental Health Trust had requested that the HWB supported its partnership bid for NHS England's Technology Fund, which was linked to the Better Care Fund. The application sought to secure funding for the technology to share data and tasks between the Trust's Electronic Patient Record Application and those of the GP Practices in the Ealing, Hammersmith & Fulham and Hounslow boroughs.

RESOLVED THAT:

A general letter of support be provided in respect of NWL individual and collective bids.

Action: Holly Maktelow

Meeting started: 4pm

Meeting ended: 6:15pm

Chairman .....

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	London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **10 November 2014**
Report of the Children, Young People and Mental Health Task and Finish Group	
Open Report	
Classification: For Review & Comment **Key Decision:** No	
Wards Affected: All	
Accountable Executive Director: Andrew Christie - Executive Director of Children's Services	
Report Author: Steve Buckerfield - Acting Head of Children's Joint Commissioning	**Contact Details:** Tel: 020 3350 4331 E-mail: steve.buckerfield@nw.london.nhs.uk

1. EXECUTIVE SUMMARY

1.1 The Children, Young People and Mental Health (CYPMH) Task and Finish Group's report presents a series of recommendations which aim to improve services for children and young people in the short to medium term. A summary of these recommendations is set out at the front of the full report attached at Appendix A.

1.2 The full report also frames the discussion for the Health and Wellbeing Board around the development of a new long-term vision for how children and young people access support for mental health illness across the borough.

1.3 Some key questions for the Health and Wellbeing Board to consider and discuss at the meeting are included in the Powerpoint presentation attached at Appendix B.

1.4 Additionally, following criticism of children's mental health services at a national level Norman Lamb, Minister of State for Care and Support has established a CAMHS Taskforce which is scheduled to report in the spring of 2015. The taskforce has been asked to consider how children's mental health service can be 'overhauled' and improved. Any local initiatives therefore need to contain flexibility to accommodate national recommendations which will emerge in early 2015.

2. RECOMMENDATIONS

2.1 To steer the development of a new vision, it is recommended that the Health and Wellbeing Board discuss the questions set out in the Powerpoint presentation at Appendix B.

2.2 It is also recommended that the Health and Wellbeing Board consider and endorse the immediate recommendations outlined in the full report attached in Appendix A.

3. REASONS FOR DECISION

3.1 The Children, Young People and Mental Health Task and Finish Group has been jointly commissioned by Hammersmith and Fulham, Westminster and Kensington and Chelsea Health and Wellbeing Boards to consider the issues set out in the full report at Appendix A.

3.2 The Task and Finish Group has prepared a report for the Health and Wellbeing Board to consider which recommends a wider discussion around a new vision for Children and Adolescent Mental Health Services.

4. INTRODUCTION AND BACKGROUND

4.1 The CYPMH Task and Finish Group were commissioned by Westminster Health and Wellbeing Board in December 2013 to consider how the Health and Wellbeing Boards could use their levers to improve outcomes for Children and Young People in relation to mental health and wellbeing.

4.2 This work was then extended across to Hammersmith and Fulham and Kensington and Chelsea on the advice of the Health and Wellbeing Boards in those boroughs.

4.3 The CYPMH Task and Finish Group were asked to focus its effort on three particular areas where it was agreed that more could be done to improve the outcomes for children and young people:

i) Ensuring early intervention and prevention in relation to children and young peoples' mental health and wellbeing.
ii) Reducing the impact of parental mental health disorders on children and young people.
iii) The transition from children's to adult mental health services

4.4 The CYPMH Task and Finish Group has drawn on the expertise of professionals and clinicians from across the local health and care system including Children's Services, the Voluntary and Community Sector (VCS), schools and the experience of users of local Children

and Adolescent Mental Health Services (CAMHS) through the mental health charity, Rethink.

5. PROPOSAL AND ISSUES

5.1 The proposal and current issues are set out and covered within the Powerpoint presentation attached at Appendix B.

6. OPTIONS AND ANALYSIS OF OPTIONS

6.1. To steer the development of a new vision, we would welcome the Health and Wellbeing Board having an open conversation about how we may wish to "rethink" our approach to support children and young people's emotional wellbeing and mental health.

7. CONSULTATION

7.1 The CYPMH Task and Finish Group has drawn on the expertise of professionals and clinicians from across the local health and care system including Children's Services, the Voluntary and Community Sector (VCS), schools and the experience of users of local Children and Adolescent Mental Health Services (CAMHS) through the mental health charity, Rethink.

7.2 A full list of acknowledgements can be found at the back of the full report attached as Appendix A.

8. EQUALITY IMPLICATIONS

8.1 Young people with mental health needs can experience discrimination and reduced equality of opportunity. The recommendations of the task and finish group aim to improve services for young people and their families. These improvements will contribute to reducing inequalities experiences by this vulnerable group of young people.

9. LEGAL IMPLICATIONS

9.1 N/A

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1 The Task and Finish Group's report does not make specific recommendations for increases in funding. Children's mental health provision has however been described as the 'Cinderella of Cinderella services'. Children's mental health receives 6% of the national mental health budget.

10.2 In 'rethinking' the Hammersmith and Fulham approach to children's mental health and emotional wellbeing, a business case may be required to either strengthen or re-align services and sources of support

for families. Should this prove to be the case a separate report would be drafted and submitted to the appropriate local authority and/or clinical commissioning group committees.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	n/a		

LIST OF APPENDICES:

Appendix A: Full report of the Children, Young People and Mental Health Task and Finish Group.

Appendix B: Powerpoint Presentation on report of Children, Young People and Mental Health Task and Finish Group.

Report of the Tri-borough Children, Young People and Mental Health Task and Finish Group

November 2014

Contents

Summary of recommendations

Ensuring early intervention and prevention in relation to children and young peoples' mental health and wellbeing

1. An Out of Hours CAMHS Consultation, Advice and Referral (CAR) telephone line should be established across Tri-borough to ensure that young people are referred to the right service at the right time.

2. A programme of training accessible for front line professionals and 'co-produced' with young people should be developed for 2015-16 to improve mental health and emotional well-being awareness.

3. The Health and Wellbeing Board should support the Local Safeguarding Children Board's (LSCB) call for a 2015-16 programme of 'guidance, support and prevention' activities in schools to address: the stigma of mental health; managing self harm; suicide prevention; and cyber bullying.

4. Local commissioners and senior clinicians should continue to be engaged and contribute to NHS England's work on improving the care and treatment pathways for young people with eating disorders.

Reducing the impact of parental mental health disorders on children and young people.

5. All services providing mental health care to adults should be contractually required to demonstrate that the patient has been asked about their parental responsibilities and assessed the potential impact of their mental health problems may have had on the children they are responsible for.

6. Health and Wellbeing Boards should make improving local data and information sharing a priority for improvement. An inter-agency Data and Information Sharing Protocol or Policy should be developed to cover all services for families in the Tri-borough area.

7. A *Think Family* or 'Whole Family' approach should be adopted and championed in adult mental health services, with a view to: improving

'holistic' assessment processes, improving multi-agency planning and interventions and encouraging 'joint work' with families with multiple problems.

8. *Think Family* champions should be established, with the support of Health and Wellbeing Boards, Clinical Commissioning Groups (CCGs) and Public Health to develop a programme of engagement with ante and post-natal services.

9. Health and Wellbeing Boards should encourage local Health, Social Care and Voluntary providers to collaborate in publishing a 'local offer' explaining what services are available to support mental health and emotional well-being.

10. Health and Wellbeing Boards should support the development of a Young Carers Strategy across Health, Adult and Children's Social Care and the Voluntary Sector to improve inter agency working maximise outcomes for young people.

<u>The transition from Children's to Adult mental health services</u>

11. Further discussion is required with both Central and North West London NHS Foundation Trust (CNWL) and West London Mental Health NHS Trust (WLMHT) to clarify the position on numbers of young people in transition to clarify whether:

- A business case exists to develop a 16 to 25 service
- Whether young people are leaving CAMHS support prematurely at 16 plus
- Whether current transition data over or understates actual or potential movement between CAMHS and Adult Mental Health Services (AMHS).

12. With a successful outcome in mind, both WLMHT and CNWL should identify Transition Champions – one in CAMHS and one in AMHS, who together are challenged to deliver the improved transition planning envisaged by the CQC and the forthcoming NICE guidance.

1. Introduction

Background

1.1 On 12th December 2013, the North West London Commissioning Support Unit presented a paper to the Westminster Health and Wellbeing Board that summarised the current mental health and emotional wellbeing needs of young people and described the local NHS Child and Adolescent Mental Health Services (CAMHS) and council mental health services for young people and families.

1.2 The Westminster Health and Wellbeing Board commissioned a Task and Finish Group to consider:

a. **A new vision** – to think boldly about whether the current services delivered what young people needed

b. **Immediate key changes** - how the Health and Wellbeing Boards could use their levers to ensure that services were arranged and commissioned now and in the future to achieve improved outcomes for Children and Young People in relation to mental health and wellbeing.

1.3 Subsequently, the London Borough of Hammersmith and Fulham Health and Wellbeing Board and the Royal Borough of Kensington and Chelsea Health and Wellbeing Board asked for this work to be undertaken on a Tri-borough basis.

1.4 On 4th March 2014, Dr Ruth O'Hare, Chair of NHS Central London Clinical Commissioning Group convened a summit of practitioners and experts to launch this work and to agree the areas of focus for the Task and Finish Group.

1.5 Based on the themes raised during this summit, the Task and Finish Group agreed to focus on three particular areas where it was agreed that more could be done to improve the outcomes for children and young people. These areas were:

i) Ensuring early intervention and prevention in relation to children and young peoples' mental health and wellbeing.
ii) Reducing the impact of parental mental health disorders on children and young people.
iii) The transition from Children's to Adult mental health service

National Context

1.6 The debate around children's mental health care in England has accelerated over the past year and has culminated in charities and local councils warning of a "national crisis" in young people's mental health.[1] This discussion comes at a time where local authority and health partner budgets are under increasing pressure. However, it provides a unique opportunity for partners across the health, social care and voluntary sector to come together and discover new ways of working to ultimately improve the mental health outcomes for children and young people across Tri-borough.

1.7 The Government has challenged the health and social care community to go further and faster to transform the support and care available to children with mental health problems, and has committed to starting early to promote mental wellbeing and prevent mental health problems.[2] Norman Lamb, Minister of State for Care and Support, has also described CAMHS as 'not fit for purpose' and operating in the 'dark ages.'[3]

1.8 The Royal College of Psychiatrists has recently issued a manifesto with six asks the next government to improve the nations mental health. This publication includes calls for national investment in evidence-based parenting programmes to improve the life chances of children and the well-being of families.[4]

1.9 The Health Select Committee has been holding an inquiry into CAMHS. The committee heard evidence from experts[5] who described a service with inadequate data, multiple commissioners, reductions in funding, growing demand and a historic 4 tier system that is out of step with current initiatives to modernize, develop and deliver a more flexible, personalized NHS.

1.10 A national CAMHS Taskforce, to be led by Jon Rouse, Director General, Social Care, Local Government and Care Partnerships, has also been launched to make recommendations to improve commissioning and mental health services

[1] http://www.youngminds.org.uk/news/news/2094_devastating_cuts_leading_to_childrens_mental_health_crisis
[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf
[3] http://www.theguardian.com/society/2014/aug/20/child-mental-health-dark-ages-norman-lamb
[4] Royal College of Psychiatrists, Making Parity a Reality; Six asks for the next government to improve the nation's mental health, September 2014.
[5] Including written and oral evidence from local commissioners, Jacqueline Wilson and Steve Buckerfield – NWL CSU. Local NHS providers and Child Outcomes Research Consortium also submitted evidence.

for young people and their families. The CAMHS Taskforce will report in the Spring 2015.[6]

Local Context

1.11 West London Mental Health Trust (WLMHT) provides CAMHS for young people in Hammersmith and Fulham.[7] Central and North West London Mental Health Trust (CNWL) provide CAMHS for Kensington and Chelsea and Westminster young people.[8]

1.12 The majority of the funding is provided by the three Clinical Commissioning Groups: Hammersmith & Fulham, West London and Central London CCGs. All three local authorities also provide funding usually for specialist services such as CAMHS for looked after children, or to support targeted interventions by CAMHS in schools.

1.13 CAMHS is organised across 4 tiers of service:

Tier 1 - includes all front line health, social care and education services: social workers, teachers, Health Visitors and GPs. Tier 1 services do not have CAMHS training but may identify emotional and mental health issues, provide support or activate more specialist expertise;

Tier 2 – is composed of staff that have received CAMHS training and would typically include Primary Mental Health Workers who in reach into schools; staff employed by voluntary agencies e.g. West London Action for Children;

Tier 3 – is where clinicians with specialist and expert mental health knowledge and training are found: child psychiatrists, family therapists, psychologists; and

Tier 4 – this describes all psychiatric care for young people with severe and complex mental health needs that cannot be managed by Tier 3. Tier 4 provision includes inpatient units but also day programmes and specialist outpatient services, for example specialist services for Autism or

[6] http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-committee/childrens-and-adolescent-mental-health-and-camhs/oral/11442.html

[7] WL MHT also support young people in Ealing and Hounslow and provide an extensive Forensic Service which includes Broadmoor.

[8] CNWL also provide mental health and community health services across 10 of more London authorities, as well as services in Hampshire and Milton Keynes.

Eating Disorders. The Tier 4 provision locally would include the CNWL Collingham Gardens Unit and private provision operated by the Priory Hospital Group (e.g. Roehampton).

1.14 Tier 2 and Tier 3 services are often delivered (but not always) by the same community providers: WLMHT and CNWL. Tier 2 and 3 is effectively the local community children's mental health service.

1.15 Tier 4 in-patient provision was originally commissioned by local Primary Care Trusts (PCTs). A North West London PCT Consortium operated a contract with the Priory Group and spot purchased specialist in patient support as required (e.g. for eating disorders). The NHS Reforms removed Tier 4 from local control and tasked NHS England with commissioning in-patient child psychiatric provision. This development has complicated the pathway in and out of hospital for young people.

1.16 Prior to the Health and Wellbeing Boards establishing this Task & Finish Group, Councillors in Kensington and Chelsea led a working group which looked at CAMHS in the borough and took evidence from schools, local voluntary agencies and CNWL. Additionally, the Commissioning Support Unit (CSU) CAMHS Commissioner, Jacqueline Wilson, reviewed the Tier 2 and targeted mental health services (looked after children, young offenders and young people with learning difficulties).

1.17 Furthermore, as part of the annual contract round, consistent service specifications and performance indicators have been agreed with WLMHT and CNWL and with the support of the North West (NW) London Mental Programme Board, a review of NW London CAMHS Out of Hours support is underway.

1.18 Finally, members in Hammersmith and Fulham have confirmed that they intend to launch a CAMHS Taskforce in November to look in detail at provision for young people in the borough.

Local figures

1.19 To provide some local context, a table detailing the Tri-borough Children's Services customer profile is shown below:

Table 1: Children's Services customer profile

	LBHF	RBKC	WCC	Total
All ages resident population	182,493	158,649	219,396	560,538
Black, Asian & Minority Ethnic (BAME)Population [all ages]	58,271	46,632	84,066	188,969
0-19 resident population	35,996	29,720	41,005	106,721
0-4	11,900	9,189	12,617	33,706
5-10	10,172	9,027	11,537	30,736
11-19	13,924	11,504	16,851	42,279

1.20 In Hours CAMHS Tier 2 and Tier 3 funding for Hammersmith and Fulham CCG, West London CCG and Central London CCG (2014-15) are outlined in the table below.

Table 2: In Hours CAMHS funding across Tri-borough

CCG	CAMHS Tier 2	CAMHS Tier 3	Total for CCG
Hammersmith and Fulham CCG	£414,000	£1,956,863	£ 2,370,863
West London CCG	£140,562	£2,063, 000	£2,203,562
Central London CCG	£547,347.00	£1,084,000	£1,631,347

1.21 There are a range of professionals including mental health nurses, psychologists, psychotherapists, medical staff and systemic therapies employed in CAMHS. CAMHS Tier 2 and targeted services funded by the Local Authorities are outlined in the table below.

Table 3: CAMHS Tier 2 Staff breakdown across Tri-borough

Local Authority	Contract WTE	2013/14 charge
London Borough of Hammersmith and Fulham	8.40 posts	402,701
Royal Borough of Kensington and Chelsea	7.10 posts	490,968
Westminster City Council	10.20 posts	675,436

1.22 Current CAMHS caseloads at the end of August 2014 are as follows:

- West London CCG (CNWL) - 690
- Central London CCG (CNWL) - 437
- Hammersmith and Fulham CCG (WLMHT) - 491

Methodology

1.23 The Task and Finish Group has drawn on the expertise of professionals and clinicians from across the local health and care system, the Voluntary and Community Sector (VCS) and the experience of users of local CAMHS. Full acknowledgements are listed at the end of this report.

1.24 The Task and Finish Group has shaped its thinking around the role of the Health and Wellbeing Board in providing system leadership, with particular emphasis on opportunities for integration and joint commissioning. The Task and Finish Group has recognised the value of using the Board's influence over the wider determinants of health and discussions have incorporated this where appropriate.

1.25 The Task and Finish Group's recommendations have been informed by national research, data provided by Tri-borough Public Health and local providers, and experiences of experts working on the ground. Colleagues from mental health charity Rethink have also provided an invaluable contribution to this work through

sharing their own research and offering a service user insight into the issues discussed.

1.26 Over 9 months the Task and Finish Group has identified some thoughts and ideas to share in relation to a **new vision** for mental health services for young people.

1.27 In addition, a series of recommendations on **immediate key changes** for the Health and Wellbeing Board and individual organisations to take forward to improve mental health outcomes for young people across the Tri-borough have been proposed.

A New Vision?

1.28 To decide whether a 'new vision' for mental health and emotional wellbeing support for young people in Hammersmith & Fulham, Kensington & Chelsea and Westminster is needed, we firstly need to clarify what local child and adolescent mental health services are for. This means asking challenging questions about what exactly the services have been put in place to do and whether there is agreement on this between key stakeholders.

1.29 Clearly there are other important questions such as whether services are adequate, whether children wait too long and ways to improve transition that need to be explored. However, addressing the fundamental question of 'purpose' is the first step in developing a new vision for young people's mental health support.

1.30 The language used in relation to young people's emotional and mental health is ambiguous: emotional wellbeing, mental illness, mental health, emotional or mental disorders all suggest a slightly different take on the support and services provided for young people with problems in these areas.

1.31 An important consideration to grasp therefore is that young people's support and services for emotional well-being and mental health seek to address a spectrum of need, set out in the diagram below.

Table 3 - Young people and mental health services – a spectrum of need

Birth to school	**Primary**	**Secondary**	**16 plus**	**Young adulthood**
Attachment	***ASD***	***anxiety***		***longer term issues***
Emotional vulnerability		***ADHD***	***depression***	

1.32 During primary and secondary school a number of issues can arise for young people, particularly behavioural difficulties, anxiety and/or depression which vary considerably in their impact.

1.33 In most cases, CAMHS expertise is required, but in milder manifestations, parents, teachers, school counsellors, GPs and voluntary or faith groups may be able to provide the required support, encouragement and reassurance.

1.34 Locally, schools have explained that they are seeing a rise in these typically teenage issues. Anecdotal evidence suggests schools feel ill-equipped to respond to mental health issues and have insufficient time to do so, whilst much of the CAMHS expertise that could help is in short supply. Specialist services in the main are clinic based with some outreach work in schools where commissioned.

1.35 This leads us to return to the key question:

Do we expect the current children's mental health service to respond to the entire spectrum of need?

If realistically, current CAMHS is not able to respond to such a comprehensive demand then two additional challenges follow:

1. Should we re-commission CAMHS to take a more holistic approach to emotional well being, as well as treating young people with clear mental illness?

There are a number of ideas that could take this idea forward:

- Norman Lamb[9] has spoken about establishing a 'one stop shop' free of stigma, which could flexibly respond to young people's emotional and mental health needs
- Alternatively, CAMHS provision could move towards integration with children's social care with the new 'focus on practice' and/or educational psychology

2 Alternatively we could accept that CAMHS expertise has its strength in responding to diagnosed mental illness in a targeted, evidence based and hence effective way.

To complement this however early intervention could be strengthened:

- A voluntary organisation(s) could be commissioned to provide the stigma free support required, strengthening the tier 1-2 offer locally, with close links to CAMHS, schools and GPs.
- Schools could consider pooling resources to develop a school based support service for young people.
- Building on current work with adult patients in primary care, GP based care co-coordinators could extend their role to work with young people.
- A drop-in hub could be established as a pilot locally, drawing on national and international best practice examples, providing a range of services including mental health under one roof.
- Public Health prevention and promotion of positive mental health and well-being could be refreshed and re-launched.

1.36 These are just two options. This work will also inevitably be informed by the conclusions of the national CAMHS Taskforce and efforts have been made locally to maintain engagement with these national developments.

1.37 Another idea gaining credibility is that 'crisis intervention' support should be significantly improved for young people to avoid inappropriate admission to hospital and also support safe and speedy discharge.

[9] Minister for Care and Support

1.38 Whilst these thoughts are a combination of reconfiguring existing services, or commissioning alternatives with different thresholds for intervention and service re-design or re-commissioning, these should be underpinned by a **new vision** on how to respond to young people's spectrum of needs: emotional vulnerability to diagnosed mental illness.

1.39 The Task & Finish Group therefore recommends that the Tri-borough Health and Wellbeing Boards support a programme of activities to address these questions and develop a new vision for young peoples' emotional and mental health services which can then inform service development and strategy.

1.40 This vision will of course need to be informed by the overarching work happening on a national level through the CAMHS Taskforce and requires a recognition from all partners that the issues outlined will not be solved in one report. This does however represent a unique opportunity for partners to establish new ways of work together and ultimately improve the mental health outcomes for children and young people across Tri-borough.

2 Early Intervention and Prevention

2.1 Prevention requires taking measures early to stop a problem occurring in the first place. In the context of mental health, this could be activity to avert the initial onset of a mental disorder, identifying and targeting those at risk.

2.2 Early intervention requires taking action as soon as possible to tackle problems that have already emerged for children and young people and is generally provided in a community setting.[10]

2.3 Childhood and adolescent mental health problems are a significant risk period for the emergence of pervasive mental health problems in later life. Up to 40-50% of chronic and severe psychiatric disorders in adulthood started in late adolescence. This psychopathology often persists to a considerable degree into adulthood and as a result is likely to require ongoing and long term engagement with Adult Mental Health Services (AMHS).[11]

2.4 The case for early intervention and prevention has been strongly argued In the Michael Marmot's Review (Fair Society Healthy Lives[12]) and Graham Allen's work (Early Intervention: Next Steps[13]). Care Minister, Norman Lamb has also complained that children's mental health only receives 6% of national mental health spending and has urged commissioners to address this issue.[14]

2.5 The benefits of intervening to prevent mental illness early in life and the importance of early identification and treatment of mental disorder in children and young people has been highlighted by the World Health Organisation's Mental Health Action Plan 2013-2020.[15]

2.6 The Annual Report of the Chief Medical Officer (CMO) 2013 also states that early treatment for young people could prevent later life problems such as substance misuse, crime, unemployment and antisocial behaviour.[16] The CMO report also focused specifically on the impact of digital culture, cyber bullying, self-harm, access to services and transition - areas which this Task and Finish Group has considered.

[10] National CAMHS Support Service, Better Mental Health Outcomes for Young People, CHIMAT.
[11] Royal College of Psychiatrists, Introduction to conduct disorder, http://www.rcpsych.ac.uk/files/samplechapter/80_3.pdf
[12] Sir Michael Marmot, Fair Society Healthy Lives, February 2010
[13] Graham Allen, Early Intervention: The Next Steps, January 2011
[14] http://www.youngminds.org.uk/news/news/2094_devastating_cuts_leading_to_childrens_mental_health_crisis
[15] WHO, Mental Health Action Plan 2013-2020
[16] Annual Report of the Chief Medical Officer, 2013

2.7 The London Health Commission, an independent inquiry chaired by Lord Darzi, has also made a number of recommendations in relation to children, young people and mental health. The report entitled 'Better Health for London' calls for better, more innovative support for young people suffering from mental illness, recommending that the NHS must find better ways to adapt to meet the needs of potential mental health sufferers, such as by using smartphone applications to monitor mood.[17]

Access, Outcomes and a Single Point of Access

2.8 Experts and professionals have said that they wanted to be able to support the children and young people they worked with by being able to talk in a safe way about emotional wellbeing and mental health issues. Furthermore, children and young people themselves who have contributed to discussions, wanted to be more empowered to manage their emotional health and wellbeing and their mental health issues.

2.9 Local teachers have reported that they frequently refer young people to CAMHS and fear they will not meet the threshold for support but are uninformed and unsure of the appropriate local alternatives.

2.10 Research undertaken by mental health charity Rethink has shown that young people want to raise their mental health concerns with professionals that they know or are close to. This is a particularly the case for 'looked after' young people. The research also found that young people wanted to be able to talk direct to mental health services and would welcome the opportunity to self-refer and access services which could also help with 'normal' teenage problems.[18]

> '*Every phone line I called was either only open in the mornings or did not take direct calls any longer; several explicitly stating that this was due to 'government cuts' on their answerphone messages'.*
>
> *'Mental illness tends to be an out-of-hours crisis issue, so "out-of-hours" should not exist; the service needs to be a full service 24/7.'*
>
> **Service Users - Rethink Report on Young People's Out of Hours Service**

[17] The report of the London Health Commission, Better Health for London, October 2014.
[18] Rethink Mental Health, Mental Health in Co-production, http://www.rethink.org/about-us/mental-health-in-co-production

2.11 The group has also researched and discussed the merits of drop-in hubs for young people such as the Brandon Centre in Camden and 'Headspace' in Australia. Such hubs which provide a multitude of services under one roof can help to reduce the stigma attached to accessing mental health services for young people. Linking mental health with physical or sexual health also appears to be an effective tool for destigmatising the access to services for young people.

> "I liked the feeling of not being judged and feeling like my therapist was devoted to establishing and working through my issues. I felt I was in a very safe environment. I think overall the sessions were really good for me as they helped me ground my issues and develop an understanding of them. The people here are very friendly, the service quick and the facilities are plenty and comfortable."
>
> ***Service user quote taken from the Brandon Centre Annual Report.***

2.12 Data and evaluation gathered from these innovative drop-in hubs illustrates their success. Since its inception in 2012, Headspace Australia has assisted 100,000 young people through 60 physical centres, online, telephone and school support services. Community awareness of headspace grew from 34% to 47.5% in this period.[19] Of the young people that visited Headspace, almost a third were between the ages of 15-17, almost half were influenced to visit headspace through a family member or friend, and over 85 per cent were satisfied or extremely satisfied with their experience.[20]

[19] http://www.headspace.org.au/core/Handlers/MediaHandler.ashx?mediaId=27768
[20] Ibid

Case Studies – Health and Wellbeing Drop-In Hubs for Young People

The Brandon Centre in Camden provides help and advice for young people aged 12-21 and drop-in services up to the age of 24. The services offered include free counselling, psychotherapy and multi-systemic therapy but also provides sexual health advice and parenting classes. It is integrated into Camden and Islington CAMHS but significantly also accepts self-referrals and drop-ins. Its status as a 'hub', where young people can access a range of services not associated with their school or GP, contributes to its resistance of helps to reduce the stigma of accessing mental health services, and the provision of a drop-in service means young people can access services before the point of crisis.

Effective examples of best practice also exist internationally.

Headspace is a mental health and wellbeing hub with 60 centres across Australia. It is officially the National Youth Mental Health Foundation but operates under a more 'youth friendly' name and provides a range of services in addition to mental health and counselling, including general and sexual health; employment services; and drug and alcohol support. It also provides training for schools in relation to suicide prevention. It is this provision of a number of different services which deflects stigma from the physical centres by reducing their perceived association with mental health. The service is aimed at 12-25 year olds with mild to moderate mental health problems and is staffed by a range of professionals including GPs, psychiatrists, social workers and youth workers.

Awareness and Confidence for Front-line Staff

2.13 In addition to feedback from service users, GPs and other agency professionals reported that they would value improved access to expert CAMHS advice on how respond to young people with mental health needs. A recent survey of 500 GPs carried out by *Pulse Magazine* noted that a significant number of GPs felt that they did not have sufficient training in adolescent mental health and therefore often referred young people to secondary care because they lacked confidence

or support in supporting patients locally.[21] Anecdotal GP evidence to this Task and Finish group also reflects these findings.

2.14 Work undertaken by Rethink with Looked After Children (LAC) and young people in Hammersmith and Fulham echoes the findings of the *Pulse* article reported above.[22] Anecdotal evidence also suggests that front line social work, youth and teaching staff do not feel confident raising mental health issues with young people or their families.

2.15 Rethink's work also concluded that young people themselves often felt it was hard to raise the subject of mental health and that if they did, it was very hard to talk openly and honestly about their concerns.

> *"I think if they had more support workers or that, people who maybe young people know have been through mental health problems, they're more likely to maybe… because obviously sometimes psychiatrists are going to be involved and social workers because they're professionals, but if there were people there maybe that while you were waiting to be seen by the psychiatry nurse, people who had been there, been through it, maybe that would be a good way of sort of helping people stay calm."*
>
> ***Service User - Rethink Report on Young People's Out of Hours Service***

2.16 To address this identified need, Hammersmith & Fulham's Looked After Children CAMHS service has collaborated with Rethink's Co-production Project and devised a training package for front line staff.

2.17 The training is designed for non-clinical teams who work with young people in school or community settings: key workers, school staff and social workers. The training aims to:

a) Improve the quality and consistency of support provided to young people;

b) Improve practitioners' confidence in talking about mental health and helping young people to access services where required; and

[21] http://www.pulsetoday.co.uk/clinical/therapy-areas/mental-health/one-in-five-gps-report-patient-harm-as-mental-health-services-struggle-to-cope/20007397.article#.U-EDVT-Uyt8
[22] Rethink Mental Health, Mental Health in Co-production, http://www.rethink.org/about-us/mental-health-in-co-production

c) Encourage the resourcing of early intervention and prevention initiatives, co-produced as appropriate with young people.

2.18 Young people supported by Rethink have successfully delivered a pilot training package for social work staff and received excellent feedback from participants.

2.19 Any generic training for practitioners on having 'difficult conversations' with young people and/ or their parents/carers would have additional benefits beyond the scope of this Task and Finish Group. Frontline workers report finding it as difficult to start conversations about child obesity and female genital mutilation as they do about adolescent mental health.

Cyber Bullying

2.20 The Anti-Bullying Alliance defines cyber bullying as follows:

> '**Cyber Bullying** - bullying via electronic means. This could be via the internet, phone, laptop, computer, tablet or online gaming.'

It can take place on a range of online or mobile services, such as text, email, social networking sites, video-hosting sites, messenger, photo sharing services, chat, webcams, visual learning environments and online games.[23]

2.21 38 per cent of young people have been affected by cyber bullying, with abusive emails (26 per cent) and text messages (24 per cent) being the most common methods.[24] An estimated 5.43 million young people in the UK have experienced cyber bullying with 1.26 million subjected to extreme cyber bullying on a daily basis.[25]

Case Study – Cyber Mentors

Cyber Mentors is an online initiative from Beat Bullying charity, which takes young people aged 11-17 through intensive face-to-face training so that they are able to mentor young people both offline within their community and online, through the Cyber Mentors website. This helps to tackle issues such as cyberbullying and wellbeing through peer support.

[23] Anti-bullying Alliance, Cyberbullying and Children and Young People with SEN and Disabilities: Guidance for Teachers and other Professionals, May 2014
[24] Tarapdar, Saima and Kellett, Mary (2011) **Young people's voices on cyber-bullying: what can age comparisons tell us?** London: The Diana Award & cited on NSPCC website at June 2013).
[25] Ditch the Label, The Annual Cyberbullying Report, September 2013

2.22 Local Head Teachers confirm that cyber bullying is an increasing problem in schools. Although schools have a duty to develop anti-bullying policies[26], feedback from colleagues in education suggests that it can be difficult to protect young people from cyber bullying beyond the school gates.

2.23 There is, however, emerging evidence of local best practice. Westminster Academy's experience of using an E-safe[27] software with its ability to detect inappropriate and illegal images; identify grooming, cyber bullying, radicalisation, suicide and self-harm etc through text and website detection, was encouraging.

> *"We were the trial school chosen and we withdrew because we could no longer afford this on the basis that no other school is using it. It is absolutely brilliant for detecting self-harm issues, depression and suicide, gang activity etc. I gave an example of how the programme helped me to prevent what could have been a very serious case of undetected anorexia but there are many others such case studies."*
>
> **Smita Bora – Head Teacher Westminster Academy and member of the Task and Finish Group**

2.24 Links are now being made between the Local Safeguarding Children Board, schools, early intervention services and Public Health to consider the wider application of E-safe or other similar alternative cyber bullying solutions.

Self Harm

2.25 Self harm is commonly defined as a deliberate act of inflicting damage on oneself, no matter what the outcome. Self harm causes significant distress to the individual, family, school, and professionals and it is associated with mental health problems. Self-harm also increases the likelihood that the person will eventually die by suicide by between 50- and 100-fold above the rest of the population in a 12-month period.[28]

[26] https://www.gov.uk/bullying-at-school/the-law
[27] http://www.esafeeducation.co.uk/
[28] Self-Harm: The NICE Guideline on Longer-term Management, May 2012.

2.26 There have been a number of programmes put in place by the Government to support those, in particular teenagers, who are self-harming or at risk of self-harming including:

- MindEd, an interactive e-learning programme on mental health designed to help any adult working with children and young people. [29]
- Department for Education advice for school staff on mental health and behaviour.[30]
- Self-harm being identified as a priority for action in the Department of Health Mental Health Action Plan.[31]

2.27 Local CAMHS providers, CNWL and WL MHT, were contacted to ascertain what data was available on self-harm. However, self-harm is not a separate diagnostic category but a manifestation or consequence of mental illness or distress so specific data on self-harm is not available.

2.28 This data deficit is recognised nationally and may well be addressed by the national CAMHS Taskforce. Locally, CCG commissioners are exploring how hospital Accident and Emergency departments, CAMHS providers and Adult Mental Health Liaison Psychiatry can be commissioned through the annual contract round to report the incidence of self harm.

2.29 Following the Local Safeguarding Children Board (LSCB) short life group on 'Self harm and Suicide Prevention', recommendations have been made to strengthen the guidance and support offered to schools in responding to self-harm. Although at an early stage the CAMHS Task and Finish Group clearly wants to support this initiative and is keen to see how schools, GPs, CAMHS and local voluntary groups can be brought together to ensure this initiative has maximum impact.

Mental Health and Gangs

2.30 In August 2013, the Westminster Health and Wellbeing Board received a Tri-borough Public Health report, Understanding the Mental Health Needs of Young People involved in Gangs'.[32]

[29] www.minded.org.uk
[30] Department for Education, Mental Health and Behaviour in Schools, June 2014
[31] Department of Health, Closing the Gap: Priorities for essential change in mental health, February 2014.

2.31 The report identified increased prevalence of mental health problems amongst young adult gang members. The largest study quoted[33] looked at gang population aged 18-34 in the UK, and noted increased rates of anti-social personality disorder, suicide attempts, psychosis and anxiety disorder.

2.32 The report recommended sustaining the mental health input into the Integrated Gangs Unit (IGU) and this is now being considered, although questions have arisen about quantifying and evidencing the impact and outcome of the work.

Eating Disorders

2.33 Eating disorders have high rates amongst young people. Anorexia nervosa is a serious mental health condition which can be life threatening. It is an eating disorder in which people display distorted body image, problematic eating behaviours such as restricting the amount of food they eat, making themselves vomit and exercising excessively and maintaining an unhealthy low weight. Anorexia and eating disorders cause significant physical and emotional implications.

2.34 Locally, there are some specialist CAMHS community eating disorder services available from providers. For example, South London and Maudsley (SLAM) NHS Foundation Trust and local CAMHS commissioners have a budget to allow for purchasing of these services when clinically indicated. In SLAM, all community CAMHS refer to the specialist service regardless of the severity as they have a contract with local commissoners. This is not the case for CNWL where clients are only sent to specialist services when they are severe.

2.35 The number of CAMHS cases with eating disorder as a diagnosis appears relatively low when taken as a percentage of total caseload. For Westminster and Kensington and Chelsea, CNWL figures show 28 cases of eating disorder as a diagnosis, 2.5% of the total CAMHS caseload. These cases are broken down as follows; anorexia nervosa (12), atypical anorexia nervosa (3), Bulimia nervosa (2), overeating associated with other psychological disturbances (1), other eating disorders (2), eating disorder, unspecified (8).[34]

[32] Understanding the Mental Health Needs of Young People involved in Gangs, Tri-borough Public Health report, August 2013.
[33] Gang membership, violence and psychiatric morbidity, American Journal of Psychiatry: Coid, J.W.et al, 2013
[34] Note caveat on numbers as recorded diagnosis is not 100%.

2.36 For Hammersmith and Fulham, WLMHT figures report 5 cases, 1 % of the total CAMHS caseload. Three of these are diagnosed as anorexia nervosa, and two as atypical anorexia nervosa.

2.37 Eating disorders are often present with comorbidities such as depression or anxiety. If the symptoms of the comorbid condition are more severe and dominant to the eating problems, then a patient sometimes remains under a generic CAMHS team (for example a young girl with depression who displays some eating difficulties but the frequency and severity do not warrant a specialist service).

2.38 These low numbers suggests the majority of community cases are not presenting to services. Evidence suggests that the numbers go up when there is an identified specialist service taking direct GP referrals. There is good evidence for Early Intervention Services in tackling eating disorders which makes it vitally important that services are easily accessible to young people who require treatment.

2.39 The recently released CAMHS NHS England Tier 4 report[35] has recommended that further work needs to be done to look at developing community provision for specialist eating disorder services. This will be rolled out against the context the NHSE service specifications, guidance recommendations from the Health Select Committee CAMHS Enquiry and the national CAMHS Taskforce.

Recommendations

The Task and Finish Group has focused on a small number of specific issues in relation to early intervention and prevention and proposed a series of recommendations which the Health and Wellbeing Board are asked to consider.

Recommendation 1

A CAMHS Consultation, Advice and Referral (CAR) telephone line should be established for Hammersmith and Fulham, Kensington and Chelsea and Westminster. This 'single point of contact' will ensure that young people are referred to the right service at the right time, to CAMHS or on to a wider network of support. Establishing a CAR service will provide immediate support to GPs, teachers, social workers and parents who are concerned about young people with emotional and mental health needs. The CAMHS CAR service should have

[35] NHS England, Child and Adolescent Mental Health Services, Tier 4 Report, July 2014.

the capacity to operate out of hours, in a similar way to the Emergency line provided for adults with urgent mental health needs.

Recommendation 2

A programme of training, 'co-produced' with young people should be developed for 2015-16 to improve mental health and emotional well-being awareness. The programme should bring together learning from:

- the LSCB work on self harm
- the Kensington and Chelsea councillor led CAMHS working group
- the Tri-Borough Suicide Prevention Strategy Group
- Public Health's leadership on promotion of emotional well-being

The training should be accessible for front line professionals in Hammersmith and Fulham, Kensington and Chelsea and Westminster and should build on the successful Rethink model and Mindfulness programmes.

Recommendation 3

Building on recommendation 2 above, the Health and Wellbeing Board should support the LSCB's call for a 2015-16 programme of 'guidance, support and prevention' activities in schools to address:

- The stigma of mental health;,
- managing self-harm;
- suicide prevention; and
- Cyber Bullying.

The programme should build on the success of the Public Health commissioned Healthy Schools initiative, include relevant safeguarding professionals (Health, Education and Social Care) and encourage links between schools, GPs, CAMHS and voluntary providers such as West London Action for Children or Young Minds.

Recommendation 4

Local commissioners and senior clinicians should continue to be engaged and contribute to NHS England's work on improving the care and treatment pathways for young people with eating disorders.

3. Parental Mental Health

3.1 The Task and Finish Group combined with the Local Safeguarding Children Board (LSCB) working group to consider the issues outlined in this report around parental mental health.

3.2 Working together, the two groups identified two key areas for improvement:

- Introducing the *Think Family* approach into mental health access opportunities, assessments and care pathways to improve outcomes for whole families.

> *Think Family* means reforming systems and services provided for vulnerable children, young people and adults to secure better outcomes for children, by coordinating the support they receive from children's, adults' and family services.

- Improving services for the *young carers* of parents with mental illness.

3.3 The work has also been underpinned by research undertaken by Healthwatch which has looked at how parents engage with services.

Background

3.4 Estimates suggest that between 50% and 66% of parents with a severe and enduring mental illness live with one or more children under 18 - approximately 17,000 children and young people across the UK.[36]

3.5 Furthermore, research suggests that the mental health and wellbeing of the children and adults in a family where a parent has a mental health problem are closely linked. Despite this evidence, services are generally structured either around the adult's mental health or children's identified needs. Very few services are structured, lead and designed to systematically take a holistic view of a family's needs.[37]

3.6 The Social Care Institute for Excellence notes that adult mental health services and children's services are usually separated by organisational design;

[36] Gopfert. M, Webster. J, & Seeman. M, (1996) *Parental Psychiatric Disorder.* Cambridge: Cambridge University Press.
[37] Stanley, N., and Cox, P. (2009) Parental mental health and child welfare: reviews of policy and professional education, London: SCIE.

professional background and training; policy and legislation; data and recording systems and organisational culture. Practitioners can also be reluctant to work outside established professional boundaries.[38] Whilst these divisions may have emerged to provide the necessary focus and expertise (safeguarding, prioritizing the needs of children etc.) there can be unintended consequences for 'joined up' work with families.

3.7 The 2001 census identified approximately 150,000 young carers aged 5 – 18 in the UK. By 2011 this had increased by 19% to approximately 178,000.[39] Research conducted in 2010 estimates that nationally there are around 250,000 young carers of parents with mental illness.[40] The existing young carers' contract with Spurgeons is based on the 2001 data and equates to:

- 540 young carers in Westminster (19% uplift adds 103)
- 425 young carers in Hammersmith and Fulham (19% uplift adds 81)
- 303 young carers in Kensington and Chelsea (19% uplift adds 58)

3.8 Nationally, these incidence figures are regarded as underestimates with a significant number of young carers remaining "hidden".

3.9 Prior to 2013, services for young carers were provided on a borough basis by separate providers. In September 2013 a Tri-borough young carers contract was awarded to Spurgeons. The Spurgeons' service is based on an outreach model and provides support to young people in the communities where they live.

Local progress – performance indicators

3.10 Locally, a Commissioning for Quality and Innovation (CQUIN) performance indicator has been introduced into CNWL's 2014 - 15 contract. The CQUIN seeks to improve the quality of assessment and care planning for parents with mental health needs. The CQUIN was developed because it had become clear that within Adult Mental Health services, children's emotional welfare assessments were not routinely in place and often only generated by a crisis. Similarly, joint assessments between Adult Mental Health, CAMHS and Adult and Children's Social Care remain rare.

[38] SCIE. (2009) Think child, think parent, think family: a guide to parental mental health and child welfare, London: SCIE.
[39] Census 2011, Office for National Statistics - http://www.ons.gov.uk/ons/rel/census/2011-census/detailed-characteristics-for-local-authorities-in-england-and-wales/index.html
[40] BBC (2010) Young carers are 'four times' the official UK number. www.bbc.co.uk/newsbeat/11758368

3.11 The CQUIN recognises that good quality holistic mental health needs assessments are an essential first step in devising a care plan capable of supporting the parent's mental health whist at the same time ensuring the children's well-being.

3.12 CNWL will now work in partnership with Children's Social Care services to develop joint procedures for parents receiving mental health services where the threshold for children's early help and/or safeguarding is met.

3.13 In addition to the contract based CQUIN, the parental mental health group has looked at the application of the 'think family' approach for assessment pathways and improving services for young carers. This led to developing a series of recommendations based on three themes.

- Data collection and information sharing
- Multi-agency working
- Staff awareness and training

Data collection and information sharing

3.14 Across Hammersmith and Fulham, Kensington and Chelsea, and Westminster there is a lack of clarity about what data and information can or should be collected and circumstances in which this knowledge can be shared. This is presenting a significant barrier to improving partnership working between health, social care and adult and children's services.

3.15 The introduction of SystmOne for Tri-borough GP practices will resolve some information sharing issues within health but there are many other systems in use by the local agency networks. If improving data collection and information pathways and sharing was recognised as a Health and Wellbeing Board priority, cost effective early intervention or 'early help' solutions for families in crisis will become significantly easier to develop and implement.

3.16 Ofsted and the Care Quality Commission (CQC) have both called on the Government to make it mandatory for mental health services to collect data on

children whose parents or carers have mental health difficulties and report this nationally.[41]

3.17 At a local level there is concern adult mental health assessments do not clearly identify whether the service user has parental responsibility for a child under 18 or has regular contact with or is living with children.

3.18 In recognition of these deficits, Central London CCG's Primary Care Plus initiative is changing mental health assessment and referral forms completed by GPs to include parental information. Some costs arise in adapting forms or computerized referral systems, but these are small scale when compared with the benefits to be achieved by strengthening the current system and ensuring that children and parent's needs are no longer overlooked.

3.19 Information sharing is also a barrier to effective identification of young carers at school which can prevent pro-active engagement and intervention. Too often schools only become aware of a young carer's situation when concerns have been raised by behavioural issues, poor attendance, under performance etc.

Multi-agency working

3.20 Feedback from some professionals suggests that ante-natal and peri-natal support services (midwifery, health visitors and children's centres etc.) may not be assessing the whole family, specifically the needs of fathers, despite evidence linking adverse outcomes with paternal mental ill health and factors such as unemployment. Importantly a review of perinatal services is underway across Tri-borough, which recognises the need to ensure that parental mental health is encompassed as a perinatal mental health service is developed.

3.21 For young carers, the existing Tri-borough Spurgeons young carers service is well placed to address the engagement needs of young carers through their activities programme. However, they are less able to and arguably don't have the capacity within the existing contract, to work more therapeutically with the whole family.

3.22 Although there is a relatively new young carers' service across the three Inner London local authorities, there is no overarching Young Carers' Strategy which might integrate work with Health and Children with Adult Social Care.

[41] Ofsted, What about the Children? Joint working between Children's and Adult Services when parents or carers have mentally ill health and/or drug and alcohol problems, March 2013

Strengthening leadership for young carers' services through a developing a strategy or inter-agency protocol, possibly supported by a strong strategic group would encourage a forward focused and more 'integrated' and *think family* direction for young carers service. Such a development is overdue.

3.23 As the new Spurgeons Young Carers' service is at an early stage of delivery, schools currently have little knowledge of the service. Spurgeon's will be addressing this through targeted marketing and awareness raising activities over the next six months.

3.24 In addition to raising awareness for young carers, further work should also be done to raise awareness of parental mental health and parental substance misuse issues with schools to: strengthen recognition of signs and symptoms and improve awareness of services and support services.

Early Progress

Colleagues in Children's Services are already leading on organising and delivering an initial workshop targeting up to 60 designated teachers, schools nurses and other school staff with delegated responsibility for young carers from Westminster schools. Attendees at the workshop will help develop a young carers resource pack, which will be useful and accessible to all schools across Tri-borough.

The Local Safeguarding Children Board will be taking this work forward with the aim to ensure that all schools across Tri-borough have a named lead for young carers. Rethink and Spurgeons are both involved in the work to ensure that service user views are both heard and reflected in its outputs.

Case Study – Kidstime

Kidstime is a project that bridges the gap between activity based provision and whole family therapeutic support using monthly workshops for children, young people and their parents who are affected by mental health issues in their family. It's a place where children can have fun, learn and get support from people who understand what's going on in their lives. Using drama workshops, they can explore their concerns and begin to develop the resources to cope with difficult situations at home, in school, or in their daily lives. Parents and children are engaged separately and as a family unit. The project has operated out of the Marlborough Centre in the past.

Staff awareness and training

3.25 Adult mental health and healthcare staff regularly undertake children's safeguarding training and do refer safeguarding issues to children's social care. However, some practitioners view safeguarding referrals as a punitive measure and some are frustrated that the outcome of the referral is not always reported back. Similarly, some of the children's social care workforce have stated that they lack confidence in addressing adult mental health issues.

3.26 In Westminster, a Mental Health Exchange programme between Children's Services and the Community Mental Health Team is beginning to yield positive results in narrowing the knowledge and experience gap for both services through the use of joint training, named contacts to seek feedback from on referrals and to clarify referral pathways and thresholds.

Early Progress

An awareness raising training package around safeguarding and the range of support available to staff, with Adult Mental Health colleagues in attendance is already being developed. This will save money by increasing early intervention hence reducing the need for more urgent and specialist child protection interventions and improve professional links with mental health teams.

3.27 Some frontline workers expressed confusion over the purpose, access routes and range of Early Help services available to families. The development of the Early Help offer and the 'single front door' systems for Children's Services is not always understood outside of Children's Services and is exacerbated by slightly different terminology being used in each of the three local authorities.

3.28 The new Focus on Practice initiative, which will be implemented from late 2014 for a three year period, will begin to address some of these issues. It is an ambitious whole system change programme to improve the impact and effectiveness that practitioners have in their work with families. The Focus on Practice Framework will provide a common language and understanding of our practice with families across all three boroughs.

3.29 Some schools have reported that there is no current mechanism for up-dating them on new children's mental health support services or voluntary sector initiatives. There is no published 'local offer' for mental health and emotional support services as there now is for other services.

3.30 Opportunities to align local authority led 'early help' systems with CCG developed Connected Care for Children (paediatric health hubs), GP networks or villages and Primary Care Plus are at an early stage, although thinking has commenced.

Early Progress

A training package is already being developed by Improving Access to Psychological Therapies (IAPT) services explaining the signs and symptoms which non-clinical staff working with children and families should be aware of and lead them to encourage parents to seek mental health support. The provision of this training will also save money by increasing the number of adults who are referred, or who self refer with the encouragement of a professional, with lower level symptoms rather than allowing their situation to worsen, with more impacts on children which would then require greater intervention.

Recommendations

The Task and Finish Group has come up with a series of recommendations which the Health and Wellbeing Board are asked to consider and endorse.

Recommendation 5

All services providing mental health care to adults should be contractually required to demonstrate that the patient has been:

a) Asked about their parental responsibilities and

b) The service/professional has considered/assessed the potential impact of their mental health problems may have had on the children they are responsible for.

This could also include extending the current CQUIN to include evidence of crisis planning and joint work to assist families.

Recommendation 6

Health and Wellbeing Boards should make improving local data and information sharing a priority for improvement.

An inter-agency Data and Information Sharing Protocol or Policy should be developed to cover all services for families in the Tri-borough area.

This should include the voluntary and community sector and health and social care, so there is clarity about what can be collected and shared to improve outcomes and 'joined up' services for families, whilst adhering to the law and maintaining appropriate confidentially.

Recommendation 7

A *Think Family* or 'Whole Family' approach should be adopted and championed in adult mental health services, with a view to: improving 'holistic' assessment processes, improving multi-agency planning and interventions and encouraging 'joint work' with families with multiple problems.

This should also include looking at what can be learnt from the Family Recovery and Multi-Systemic Therapy (MST) models.

A training package currently being developed by colleagues in Children's Services seeks to share knowledge and build closer professional working relationships with staff in Adult mental health services. These training sessions should continue to be developed, supported by senior management and rolled out across the Tri-borough.

Recommendation 8

Think Family champions should be established, with the support of Health and Wellbeing Boards, CCGs and Public Health to develop a programme of engagement with ante and post-natal services (health visitors, midwifery and children's centres etc.) to:

a) identify opportunities to improve 'holistic assessments and interventions e.g. work with fathers and extended family and community networks

b) explore and agree appropriate implementation strategies with ‘quick wins’ e.g. revised assessment tools or awareness training

Recommendation 9

Health and Wellbeing Boards should encourage local Health, Social Care and Voluntary providers to collaborate in publishing a ‘local offer’ explaining what services are available to support mental health and emotional well-being. This should be hosted on CCG and local authority websites (for example People First) with appropriate links to local providers and where appropriate, national organisations offering support and advice.

Recommendation 10

Health and Wellbeing Boards should support the development of a Young Carers Strategy across Health, Adult and Children’s Social Care and the Voluntary Sector to improve inter agency working maximise outcomes for young people.

4. Transition from Children's to Adult Mental Health Services

National Context

4.1 More than 40,000 people in England aged under-18 have complex health needs caused by physical disabilities, special education needs, or life-limiting or life-threatening conditions.

4.2 Such young people often rely on a range of therapies and treatments, which can get complicated as they move from children's and adult services.

4.3 This move, known as transition, is a vulnerable time for young people and their families. This is because they may stop receiving services they have received since birth or at a young age, or they may lose continuity in care.

4.4 In June 2014 the Care Quality Commission (CQC) published, 'From the Pond to the Sea – Children's transition to adult health services', looking across the NHS at how effectively young people with complex health needs moved from children's to adult health services.[42]

4.5 The CQC report has four key messages which have informed this report to date and will continue to do so as partners work together on improving transition.

- Young people and their families know what works. Clinical commissioning groups and local authorities must listen and learn from their experiences.
- There is no excuse for not following existing guidelines which describe the steps to be taken to plan for transition from age 14.
- GPs should be more involved, at an earlier stage, in planning for transition. A new enhanced service is being introduced in 2014/15 to ensure proactive and personalised care for patients, including young people, with complex health needs.
- Adolescence and young adulthood should be recognised across the health service as an important developmental phase – with NHS England and Health Education England taking a leadership role. A named lead should co-ordinate care.

[42] Care Quality Commission, From the Pond into the Sea, Children's Transition to Adult Health Services, June 2014

4.6 The National Institute for Clinical Excellence (NICE) has been tasked to build on the findings of the CQC report produce a guideline on the transition from children's to adult services.

4.7 The guideline, although not specific to young people's mental health care, will make recommendations that focus specifically on 'what works' for young people in transition.

4.8 The NICE Guidance on Transition will be published in February 2016 and Westminster City Council and CNWL have registered with NICE as contributing stakeholders.

Local context

4.9 When considering the issue of transition from Children's to Adults Mental Health Services, the Task and Finish Group has noted several positive findings in addition to the national developments explained above:

- West London Mental Health NHS Trust (WLMHT) and Central North West London NHS Foundation Trust (CNWL) both have transition protocols in place to guide staff practice.
- Both mental health trusts are actively developing plans to modernize or 'transform' local services, and this includes endorsing 'co-production' principles to listen to and work with service users to improve the young person's journey.
- The recently negotiated 2014-15 mental health contracts with WLMHT and CNWL both include a CQUIN[43] indicator for Safer Discharge/Transfer, focusing on discharge to GPs.

4.10 However, whilst both the national and local perspectives suggest an appetite for change and improvement to transition arrangements, there are a number of obstacles to tackle:

- Local data
- Service Model and thresholds to care
- Leadership

[43] CQUIN – Commissioning for Quality and Innovation

Local data

4.11 Obtaining reliable data for CAMHS is problematic. At the national level for example, NHS England recently concluded in their review of in-patient provision that they simply did not know how many beds were required as the demand and performance data was so fragmented and unreliable. This is a direct consequence of mental health trusts collecting data on numerous different systems against a variety of changing commissioning and performance targets. Although steps have been taken locally with WLMHT and CNWL to report on common Key Performance Indicators (KPI's), performance data is still patchy.

4.12 Based on some helpful material provided by CNWL it is estimated that approximately 20 – 30 young people transition into Adult Mental Health Services each year in each of the three local authorities: Westminster; Kensington & Chelsea and Hammersmith & Fulham. Interestingly, WLMHT data seems to suggest lower numbers and CNWL's analysis also points to significant numbers of 16 – 18 year olds curtailing treatment, either at their own request (39) or by failing to attend (90). Conclusions can only be tentative: formal transition numbers seem small; fall out rates for 16 – 18 year olds appear to be significant.

4.13 Different thresholds between CAMHS and AMHS mean that sometimes CAMHS clinicians may discharge someone to GP and voluntary sector without referring to AMHS. For example, for young people with Attention Deficit Hyperactivity Disorder (ADHD), once they reach their 18th birthday there is no specialist Adult ADHD service

Service Model and thresholds to care

4.14 An obvious question to address in considering 'transition' between children and adult mental health services is whether the answer is simply to remove the fence and move either to a 'life time' mental health service, or introduce a 16 to 25 service. The latter has received some recent attention as the Children & Family Act 2014 extends SEN and Disabilities responsibilities to age 25 and support for care leavers also now extends into young adulthood.[44]

4.15 The view of the Task and Finish Group is that, on the current numbers of 20 – 30 in each local authority or CCG, whole scale system change does not seem justified. It should be possible to get transition 'right' for these young people.

[44] Children and Families Act 2014, http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted

There is also the danger that changing the age range simply moves the transition 'cliff edge' elsewhere – to the age of 26 for example.

4.16 However, there are some larger considerations. Norman Lamb recently criticised CAMHS as 'not fit for purpose' and operating in the 'dark ages'. Kids Company have also recently attacked services for vulnerable teenagers and called for a systematic restructuring in favour of more flexible, young people drop in facilities with activities and diversions, as well as clinical staff.[45] These issues are now being looked at by the national CAMHS Taskforce which will report in the Spring of 2015. This taskforce is also looking at the support available to young people in crisis and at risk of admission to psychiatric hospital.

4.17 The recommendations of the national CAMHS Taskforce may well have a significant impact on the service model for mental health support for young people and implications for any changes to be made locally for transition planning and structures.

Leadership

4.18 Strong leadership is key to achieving change and driving through improvements, often in the face of organisational difficulties and constraints. Leadership on transition between CAMHS and Adult Mental Health Services (AMHS) appears weak. AMHS has a vast number of complex issues to resolve, of which the young people seeking support post 18 is only one. Whilst this has been the position for some considerable time, the combination of local and national drivers for change should improve the opportunities for success.

4.19 The Task and Finish Group has not finished its work on transition and plans to continue to meet with a view to:

- Producing a clear analysis of 16 – 18 discharge and the implications for transition to AMHS and GP services and learning disabilities services;
- Strengthening engagement with WLMHT on transition planning and action;
- Exploring with WLMHT, CNWL and Clinical Commissioning Groups whether a 16 to 25 service has advantages for young people's mental health; and
- Strengthening user input and co-production for transition.

[45] Adele Eastman, Enough is Enough, A report of child protection and mental health services for children and young people, June 2014.

4.20 The group has also identified some immediate recommendations to ensure that progression in clarifying the picture and improving transition locally so we are well placed to contribute and react to the emerging national debate.

Recommendations

Recommendation 11

Further discussion is required with both CNWL and WLMHT to clarify the position on numbers of young people in transition to clarify whether:

- A business case exists to develop a 16 to 25 service
- Whether young people are leaving CAMHS support prematurely at 16 plus
- Whether current transition data over or understates actual or potential movement between CAMHS and AMHS

This work is required to ensure that we have a comprehensive understanding of local discharge and transition activity, in preparation for the CAMHS Taskforce's conclusions and suggestions next year.

Recommendation 12

With a successful outcome in mind, both WLMHT and CNWL should identify Transition Champions – one in CAMHS and one in AMHS, who together are challenged to deliver the improved transition planning envisaged by the CQC and the forthcoming NICE guidance.

5. Acknowledgements

This work undertaken by Children, Young People and Mental Health Task and Finish Group was only possible due to the time, freely given, by a number of individuals and organisations. Their expertise, professionalism and commitment were fundamental to the production of this report and the recommendations within.

Thanks go to:

Central London Clinical Commissioning Group

West London Clinical Commissioning Group

Hammersmith and Fulham Clinical Commissioning Group

Westminster City Council

Royal Borough of Kensington and Chelsea

London Borough of Hammersmith and Fulham

Central and North West London NHS Foundation Trust

West London Mental Health NHS Trust

Healthwatch

Cardinal Hume Centre

Spurgeons

Rethink

Westminster Academy

Local Safeguarding Children Board

Westminster IAPT

Imperial College Healthcare NHS Trust

Central London Community Healthcare NHS Trust

Children, Young People and Mental Health

Report of the Task and Finish Group

November 2014

Reviewing CAMHS.....

Local reviews	• **CAMHS Tier 2 and Targeted Services Review** • RBKC Councillors **CAMHS Working Group** • HWBB **CAMHS Task & Finish Group -** early intervention, transition and parental mental health • Public Health - Tri-B and 3 CCG **Suicide Prevention Strategy** • LCSB **Self Harm & Suicide Prevention** report • North West London CAMHS **Out of Hours review**
National reviews	• NHS England who are now responsible for commissioning adolescent psychiatric beds across the UK have just published a '**CAMHS Tier4 Report**' which looks at demand, systems and resources and makes 20 recommendations for action. This includes exploring 'collaborative commissioning models' including 'care delivered at Tiers 3 and 4' and will look at 'how best local authority services can be involved in the model. • **Health Select Committee** led by Dr Sarah Wollaston MP has concluded an 'Enquiry' into CAMHS and a report is expected for the Autumn and looked at: historic under funding; fragmented commissioning; poor and out of date JSNA data; perceived growth in self harm and cyber bullying etc. Joint commissioners provided written and oral evidence to the committee. • A **CAMHS Taskforce** was launched in July 2014 to improve child and adolescent mental health services (CAMHS) following concerns raised by NHS England about inappropriate care and bed shortages. It will look at overhauling the way CAMHS are commissioned. The taskforce will be chaired by the government's social care director general Jon Rouse and will involve representatives from NHS England, the Department for Education, local councils, the charity sector as well as young people with mental health issues. • The **Local Government Association** has called for an overhaul to mental health services for children (August 2014)

Task and Finish Group: Recommendations

Early Intervention and Prevention

- A CAMHS Consultation, Advice and Referral (CAR) line should be established
- A programme of training for front-line professionals should be developed, co-produced with C&YP
- The H&WB should support the call for a 2015-16 programme of 'guidance, support and prevention' activities in schools
- Local commissioners should continue to engage with NHS England on improving care and treatment pathways for young people with eating disorders

Parental mental health

- All services providing mental health care to adults should be contractually required to ask about parental responsibilities and the impact this has on their parenting.
- Make improvements to local data and information sharing.
- A whole family approach should be adopted in adult mental services
- Think Family champions should develop a programme of engagement with ante and post-natal services
- A 'local offer' of mental health and emotional wellbeing support should be published
- A young carers strategy should be developed

Transition to adult mental health

- Progress further work to clarify the numbers and needs of young people in transition
- Implement transition champions charged with improving transition planning

Rethinking children's mental health?

As the work of the CYPMH Task and Finish Group developed, questions arose about whether the traditional CAMHS service model which is currently delivered in LBHF is the best model to meet the needs of children and young people today.

It also became clear that further consideration needs to be given to how we support those who are emotionally vulnerable although do not require clinical treatment.

These questions have led the Task and Finish Group to recommend that **a new long-term vision** is developed for how we meet the emotional wellbeing and mental health needs of children and young people effectively across the whole system.

To steer the development of a new vision, we would welcome the Health and Wellbeing Board having an open conversation about how we may wish to "rethink" our approach to support children and young people's emotional wellbeing and mental health

Rethinking children's mental health services

Emotional Vulnerability ⟷ Diagnosed Mental Illness

A new vision

A new vision?

Key questions for the Health and Wellbeing Board to consider

The Health and Wellbeing Board are invited to discuss:

1. What an ideal “fit for purpose” mental health and emotional wellbeing service for LBHF could look like?
2. What we need to do together to deliver this ideal?
3. Whether there are alternative service models for the treatment of diagnosed mental illness which might be more responsive to emerging needs and more attractive to potential users than the traditional CAMHS?
4. How important the role of community and individual resilience is and what role should the Voluntary and Community Sector, Schools and other organisations play in improving emotional wellbeing and resilience?

Next steps…

In order to focus specifically on the needs of young people in Hammersmith and Fulham:

- A councillor led **Children and Young Peoples' Mental Health Taskforce** is to be established, in partnership with Hammersmith and Fulham CCG, to build on existing work and establish a clear future direction.

- The **Taskforce** would hear evidence from key Hammersmith and Fulham stakeholders and in particular local young people.

- The **Taskforce's** finding will seek to take account of anticipated national developments expected in 2015.

Acknowledgements

This work undertaken by the Task and Finish Group was only possible due to the time, freely given, by a number of individuals and organisations. Thanks go to:

- Central London Clinical Commissioning Group
- West London Clinical Commissioning Group
- Hammersmith and Fulham Clinical Commissioning Group
- Westminster City Council
- Royal Borough of Kensington and Chelsea
- London Borough of Hammersmith and Fulham
- Central and North West London NHS Foundation Trust
- West London Mental Health NHS Trust
- Healthwatch
- Cardinal Hume Centre
- Spurgeons
- Rethink
- Westminster Academy
- Local Safeguarding Children Board
- Westminster IAPT
- Imperial College Healthcare NHS Trust
- Central London Community Healthcare NHS Trust

	London Borough of Hammersmith & Fulham **Health and Wellbeing Board** **10th November 2014**
SCHOOL NURSING REVIEW & SERVICE RE-DESIGN	
Report of the Divisional Director: Meradin Peachy, Director of Public Health	
Open Report	
Classification: Review & Comment **Key Decision:** NO	
Wards Affected: ALL	
Accountable Executive Director: Liz Bruce, Executive Director of Adults & Health	
Report Author: Julia Mason Families and Children's Public Health Commissioner	**Contact Details:** Tel: 020 7641 4653 E-mail: jmason@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1 From April 2013, local authorities became statutorily responsible for delivering and commissioning public health services for children and young people aged 5-19, including School Nursing. A review of Tri-Borough School Nursing services has been undertaken to inform the proposed re-commissioning of School Nursing services to improve outcomes for school aged children and to provide a more equitable, efficient, evidence based and consistent service across the boroughs.

1.2 The Review found that the School Nursing service in Hammersmith & Fulham is effectively delivering the core requirements of the Healthy Child Programme 5- 19 years (vision and hearing screening and health assessments), the NCMP (national child measurement programme), immunisations and safeguarding but have insufficient capacity to provide a comprehensive preventive and early help service to schools. To meet the needs of the local school population, the SN service needs to be part of an integrated school health model to address changing priorities and new technologies.

1.3 Options for a new service model are proposed, within the current financial envelope, which makes best use of School Nursing (SN) resources and skills. Also, as NHS England are the responsible commissioners for school aged immunisation, additional capacity will be released through provision of a NHSE commissioned school based immunisation service proposed to be in place by the start of the next school year (September 2015) .

2. RECOMMENDATIONS

That the Health and Well Being Board reviews the options in paragraph 6 and provide a steer for the direction of travel for the re-commissioning of a school health/school nursing service.

3. REASONS FOR DECISION

School Nursing services are commissioned by Public Health, but have an impact on both health and children's services and align to the LBHF HWB strategy.

4. INTRODUCTION AND BACKGROUND

4.1. Schools provide an important learning and nurturing environment for the vast majority of children and adolescents throughout the years of critical physical, social and psychological development. Besides parents and the wider family, school is a primary institution for improving children's health

and well being. This is why effective provision of support, and relevant health services, for pupils, their families and the wider school community, is essential for the current and future health of the local population.

4.2. The move of commissioning to local authority Public Health provides an opportunity to review school nursing services to develop a new locally tailored modernised service that is responsive to the changing needs of children, families and the schools communities. It also addresses dissatisfaction with the current model and the historic inequity of provision across the boroughs.

4.3. The review process included:

- Health needs analysis of school aged children
- Evidence of effectiveness of SN and school based health interventions
- Analysis of current provider's performance and capacity
- Benchmarking and review of different models and innovative approaches to SN commissioning and service provision in other local authorities
- Consultation with school nursing teams, children and young people, schools, parents and carers, and other key stakeholders

4.4. The review has also taken into account recent guidance and legislation:

- A new national vision and guidance for School Nursing which aims to raise the profile of school nurses and refresh the service model, focusing on the needs of more vulnerable cyp including excluded children, young carers, cyp with mental health needs. (DH, 2012).
- Guidance to support the commissioning of public health provision for school aged children 5-19: *Maximising the school nursing team contribution to the public health of school aged children (*DH/Public Health England, 2014).
- Requirements of the Children and Families Act (2014), including the development of a joint EHC (Education Health and Care) plan for all children with special educational needs.
- School nurses' responsibilities to identify girls at risk of FGM and take action, and to help teachers have the confidence to intervene.

4.5. A School Nursing Advisory Group of key stakeholders, which includes Schools, Paediatric Health Services, Children's and Early Help Services Parent Representatives, and Youth Representation via Healthwatch, is providing critical overview to the review process.

5. PROPOSAL AND ISSUES

5.1. An evidence review of the effectiveness of school based health models found that nurses working in schools are well placed to make a positive difference to children's physical and emotional health. Nurses are trusted

and popular with parents and schools and provide good value for money by supporting children's attendance, reducing school staff time in managing health problems and reducing children's use of emergency care services.

5.2. The evidence also supports an integrated social model of school health with school nurses taking an active role in liaising with related community based services, and planning and implementing health promotion strategies within the school community.

5.3. Nationally there is only a small pool of registered post-graduate SPHN (Specialist Public Health Nurse) School Nurses, currently about 1,300 in England. Any service model needs to make best use of their public health and leadership skills to manage a grade and skill mixed workforce of Staff Nurses, Nursery Nurses and SN Assistants.

5.4. Other drivers and priorities have informed the proposed new SN model:

- Children are starting school and nursery earlier and more vulnerable children need significant support to achieve a good level of school readiness (a key early years' public health outcome).

- School Nurses need to contribute to specific integrated customer journeys/care pathways for priority public health interventions such as child oral health promotion programmes or the Healthy Family Weight and Young People's Sexual Health services.

- Schools and parents need more consistent and accessible SN services and increased provision at secondary school, particularly for excluded and vulnerable young people.

- Increasing numbers of children with long term health conditions and disabilities attend mainstream education and schools need qualified health support to ensure their health needs can be safely met.

6. OPTIONS AND ANALYSIS OF OPTIONS

6.1. Increased capacity will be released by de-commissioning of the provision of school based immunisation and a SN workforce formula will be used to allocate staff on the basis of schools and pupils needs.

6.2. It is proposed that a new effective service model is commissioned, within current levels of funding, to include all the components described below.

- Provision of school aged immunisation is de-commissioned, but health promotion of immunisation is retained to ensure local immunisation rates are maintained and improved;
- Provision of the Healthy Child Programme of screening and health assessments and delivery of the NCMP;
- A school health information website & 'virtual school nurse' and confidential text service is commissioned;

- Evidence-based interventions with clear outcomes linked to child public health programmes and priorities (e.g. obesity prevention and oral health promotion) are commissioned and current ineffective interventions e.g. *Fit and Fruity* healthy eating sessions, are decommissioned;
- Skill and grade mix team of SPHN SNs (post graduate qualified school nurses) registered nurses, nursery nurses and health workers or assistants is established to work to most efficacy;
- A lead SN for excluded children is in place;
- Safeguarding: a pilot is commissioned of the Shropshire school nursing health needs assessment model for all children subject to initial or review Child Protection conferences.

6.3. In addition to the components of the new model described above, two different workforce options have been developed.

6.4. **Option 1** includes a number of lead or specialist roles to provide additional expertise, training capacity and co-ordination to support specific public health outcomes e.g. sexual health, mental health. This could also provide career opportunities for SNs, which may help staff recruitment and retention. Further consultation would be undertaken to ensure that these roles reflect priority health needs locally.

6.5. **Option 2** deploys qualified SPHN SN workforce where they are most needed - in secondary schools, high need primary schools and MLD special schools. It utilises skills of other staff to support lower level primary school pupils' needs e.g. nursery nurses are skilled at working with young children and families. This model requires less specialist roles as SNs will have more capacity to develop and lead health promotion initiatives according to priority needs of each school population.

7. CONSULTATION

7.1. Service users', staff and stakeholders' views and suggestions were obtained through a wide range of different consultation and engagement methods including on-line and Healthwatch surveys, focus groups, a young people's workshop, individual and group meetings and school visits. Consultation findings have been used to inform the proposed new service model.

7.2. Local cyp (children and young people's) views reflected those of the National Youth Council's cyp consultation on school nursing services (2011). CYP want improved access to health information, advice and support in a school setting from a trusted and approachable health professional which is confidential and easily accessible. They stated a preference for individual face to face consultations, also text and web based information and advice on all aspects of physical and emotional health but particularly on sexual health, weight and body changes, drugs

and access to counselling. There is also interest in SNs supporting peer led initiatives.

7.3. Parents of primary school children asked for increased access to SN and health information and advice on childhood development and health issues e.g. sleep, minor illness, growth and healthy eating, delivered through coffee mornings and group sessions, assemblies and open evenings. They also want more SN engagement on supporting schools to meet the health needs of children with long term health conditions and disabilities.

7.4. Parents of older children found it hard to talk to their teenage children about sexual health and other issues. They thought there needed to be a full time nurse at each secondary school, and sessions for teenagers to talk about health worries and stress in a confidential and non-stigmatising setting, as they were very reluctant to go to a GP for help and advice. They would also value web based information and parent drop-ins.

7.5. Most schools in Hammersmith and Fulham expressed a good level of satisfaction with the quality of current SN services but felt it was insufficient to identify and meet the meet the wider health needs of pupils, their families and the school community, especially at secondary level. Their priorities for a new SN service:

- Co-ordinating and supporting management of care plans for increasing number of children with long term health conditions and special educational needs in mainstream school
- Targeted early years SN provision for vulnerable children and families on transition to nursery and reception
- More SN involvement in integrated team around the school, early help services and whole school initiatives e.g. Healthy Schools Partnership, obesity prevention
- Health screening and co-ordinating access to other health services, especially GPs, CAMHS and adult mental health services.
- Delivery of specific health education and promotion sessions for children and parents e.g. on puberty, hygiene, FGM.
- Safeguarding and targeted provision for excluded children and those in alternative provision

7.6. SN staff consulted felt they were managing to deliver the core and more routine requirements of the service well but were frustrated by lack of time and training to deliver other public health work and to support whole school interventions.

7.7. SNs also reported a significant proportion of their time was spent on safeguarding, especially attending in case conferences when it was not always clear what value they could bring to the meeting. They reported

that it was difficult to cover vacancies or sickness and this resulted in gaps in service, low visibility and lack of continuity.

7.8. Other stakeholders consulted welcomed a review of the existing service and a clearer more targeted role for school nurses within an integrated school health model. Closer working with Paediatricians and Specialist Paediatric Nurses was seen as a useful way forward to providing more joined up support for children with long term conditions. A lack of SN support for 3-5 year olds was identified as a gap. Improved visibility, communication and increased access were seen as priorities.

8. EQUALITY IMPLICATIONS

Not Applicable

9. LEGAL IMPLICATIONS

NCMP is one of 6 local authority mandated public health functions set out in the Public Health Grant Conditions (Jan 2013).

10. FINANCIAL AND RESOURCES IMPLICATIONS

Adequate budget and resources have already been allocated

11. RISK MANAGEMENT

Not Applicable

12. PROCUREMENT AND IT STRATEGY IMPLICATIONS

See Appendix 1 for the SN Review and Procurement Timetable

LIST OF APPENDICES:

Appendix 1: School Nursing Review and Procurement Timetable

Appendix 1

Tri-borough School Nursing Review and Procurement Timetable	
Month	**Activity**
May 2014	• Briefing Councillors on review process • First meeting of School Nurse Review Advisory Group • Desktop analysis of public health/schools' data and evidence base • Stakeholder mapping & consultation planning • Initial engagement with CLCH service managers • Initial analysis of school nursing service performance and capacity
June – September 2014	• Consultation with school nursing services • Consultation with key stakeholders • Analysis of findings
Sept 2014	• Analysis of findings and drafting report
Oct- Nov 2014	• Presentation of draft report to School Nurse Review Advisory Group • Presentation of report to 3B Cabinet members, PHITB • CoCo sign off • Gate 1 approval including finance and legal sign off
November 2014	• Development of service specification
December 2014	• Market event • PQQ
Jan 2015	• ITT and final service specification
February 2015	• Tender evaluation & recommendations
March 2015	• Gate 2 approval • Bi-borough, WCC and ASC finance sign off • Cabinet member informal discussion about contract award
April 2015	• Cabinet member and Cabinet Executive decision • Award contract
May – July 2015	• Contract implementation
August 2015	• New school nursing service starts

	London Borough of Hammersmith & Fulham
	1. **HEALTH & WELLBEING BOARD** **10 November 2014**
TITLE OF REPORT: Sexual Health and Relationship Education in Schools	
Report of Meradin Peachy, Director of Public Health	
Open Report	
Classification - For Review & Comment **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director of Adults and Health	
Report Author: **Dr Andrew Burnett** *Interim Consultant in Public Health Medicine* Strategic lead for Tri-borough sexual health services **Gaynor Driscoll** *Head of Commissioning for Substances Misuse Services/ Offender Health/ Sexual Health Services*	**Contact Details:** Tel: 020 7641 4668 E-mail: aburnett@westminster.gov.uk

The report by Healthwatch on sex and relationship education in west London provides useful information for Tri-borough sexual health commissioning.[i] The report is based on the outcomes of an internet-based survey and focus group discussions with 181 people aged 13-25 years, of whom some 70% attended west London schools.

i Healthwatch Central West London. *Sex and relationship education report.* Healthwatch Central West London. London. 2014

The report confirmed that most young people prefer to discuss sex and relationship issues with people other than their school teachers, and that they find information about contraception and sexually-transmitted infections (STIs) of greatest value. Young people also want information about a wider range of issues including domestic violence and female genital mutilation.

Within H&F council we invest £375,000 on young people's initiatives, with £236,000 invested in family and children's locality services and the remainder in schools and smaller community groups to promote sexual health and reduce the transmission of sexually-transmitted disease. This is under review to ensure that the approach to young people's sexual health and healthy relationships links into the wider reviews including the Whole Family Project; substance misuse provision for young people; and the work of the Children and Young People Mental Health Task and Finish Group.

In adult sexual health services there is a greater emphasis on HIV prevention than other STIs. We are looking have a greater focus on the prevention of all types of STIs.

We are also in discussion with providers and other stakeholders in relation to developing procurement plans which will promote sexual health services that:

- are tailored to the needs of different groups in terms of age, cultural values and beliefs, and ethnicity;
- will better enable skill development in topics such as consent and condom negotiation, and not just providing information;
- cover a range of topics such as those identified in the Healthwatch report including sexual orientation, abuse and pornography;
- will ensure that the pathways to the various services available are clear.

LOCAL GOVERNMENT ACT 2000

LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	None		

LIST OF APPENDICES:

Sex and Relationship Education Report

healthwatch Central West London

Sex and Relationship Education Report

April 2014

Executive Summary

The Healthwatch Central West London Sex and Relationship Education report assesses young people's experiences of sex and relationship education, their ideas of how they want sex and relationship education to be delivered and their knowledge of sexual health services.

Healthwatch Central West London worked with young people and young people's organisations to design and disseminate a questionnaire that could be completed by young people, the questionnaire was also disseminated through Facebook, Twitter and e-mail distribution lists.

This report is coming at an important time as sexual health remains a priority for the Tri-Borough Public Health team and comes only one year after a report by Ofsted revealed that over a third of schools across England are failing to provide appropriate sex and relationship education.[1]

Sample of findings:

- Just under a fifth of respondents (18%) said they had not received or did not know if they had received sex and relationship education.
- A strong majority of respondents (72%) want some involvement from external organisations in delivering their sex and relationship education.
- Respondents indicated they wanted a wide range of topics included in sex and relationship education, including domestic violence, emotional support, sexuality and female genital mutilation (FGM).
- The report identified some significant gaps in respondents knowledge of sexual health services, including a lack of knowledge of where to access free condoms (44%), emergency contraception (63%) and support around healthy relationships and domestic violence (78%).
- We found no significant difference when results were filtered for ethnicity.

Sample of recommendations:

- Consider what role external providers can have in delivering sex and relationship education, in light of young peoples expressed wishes to have external provision.
- Consider giving more prominence to information around healthy relationships and domestic violence in sex and relationship education.

[1] Not yet good enough: personal, social, health and economic education in schools, 2013

- Utilise all available information forms/pathways that young people also use to spread key messages around sexual health and healthy relationships, e.g. websites, youth clubs etc.

Table of contents

1. Introduction

Healthwatch Central West London is a new, independent charity and membership organisation working to ensure your voice counts when it comes to shaping and improving local health and care services. We currently support over 4,500 people who live, work and/or use services in Hammersmith and Fulham, Kensington and Chelsea and Westminster.

We aim to empower and represent the diverse communities of our boroughs to engage, provide evidence and influence the planning and delivery of publicly-funded health and social care services. Our services should meet our needs. We also provide information to help people access and make choices about their health and wellbeing services.

As part of our work Healthwatch organises and supports project groups in key priority areas each year, this year one of those priority areas was young people and sexual health. Our young people and sexual health project group has been meeting bi-monthly since September and is made up of young people, representatives of sexual health services and representatives of young people's services. The group identified the key areas of concern/interest that drove this piece of research.

2. Aims and objectives

Members of the young people and sexual health project group expressed concerns around sex and relationship education provision, particularly in Hammersmith and Fulham, there were concerns that it was not working as well as it had in the past especially around signposting to services, and that the future of sex and relationship education provision in Hammersmith and Fulham was uncertain. As a result of these discussions the project group agreed to undertake a research project with local young people with the following objectives:

- To identify what sex and relationship education young people are receiving.
- How young people rate the quality and content of the sex and relationship education they are receiving.
- To identify what topics young people think sex and relationship education should cover.
- To identify how young people think sex and relationship education should engage with them.
- To identify key gaps in knowledge young people have around sexual health and sexual health services.
- To identify where young people currently get their information about sexual health and sexual health services

3. Local picture/context

Poor sexual health has been identified as a key local concern across Hammersmith and Fulham, Kensington and Chelsea and Westminster. Kensington and Chelsea has the 14th (out of 326 local authorities) highest rate of sexually transmitted infections, Westminster has the 10th highest rate and Hammersmith and Fulham the 4th highest rate[2]. The percentage of sexually transmitted infections affecting young people (15-24 years old), 34% in Hammersmith and Fulham. is also relatively high, compared to the rest of London and England[3]. In addition the under 18 conception rates are higher in Hammersmith and Fulham than the rest of London, 42.6 per 1000 15-17 year old girls[4].

Added to the local picture of poor sexual health was a concern that a previously commissioned sex and relationship education (SRE) provision, delivered by Tender, was coming to an end in March 2014 with uncertainty over what would replace this provision. On a national level concerns about sex and relationship provision were raised by an OFSTED report in May 2013 that looked at the whole range of personal, health, social and economic education, the report indicated that too much emphasis was placed on the mechanics of reproduction rather than the importance of healthy sexual relationships, it also highlighted the lack of pornography and sexuality as topics as an area of concern as well as the lack of expertise of teachers in teaching sex and relationship topics.[5]

Of additional local context is the End FGM European campaign that has gained prominence recently, this campaign is lead my Amnesty International Ireland and works with other organisations to put the issue of female genital mutilation (FGM) high on schools agendas. This should be of particular interest as Hammersmith and Fulham has a relatively high prevalence of communities at risk of FGM[6] and local concerns have been raised about the lack of FGM as a topic in sex and relationship education.

It is clear that local statutory bodies recognise the importance of addressing sexual health and young people's sexual health in particular, the local Health and Well Being Board in Hammersmith and Fulham and the Tri-Borough

[2] Sexual Health JSNA, 2013
[3] Sexual Health JSNA, 2013
[4] Sexual Health JSNA, 2013
[5] Not yet good enough: personal, social, health and economic education in schools, 2013
[6] Sexual Health JSNA, 2013

public health team both have sexual health as a key priority[7]. In recognition of the local picture and local priorities Healthwatch Central West London committed itself to raising the experiences, views and voices of local young people on the issue of SRE provision.

4. Methodology

We collected information from young people in two ways

1. Survey

The young people and sexual health project group designed a questionnaire this was distributed to young people in a variety of ways, through outreach by Healthwatch staff to youth clubs / youth centres, through Facebook and twitter, through the Healthwatch CWL website, through the Healthwatch "Opportunity Of The Week" E-mail, through the healthy schools partnership newsletter. The questionnaire consisted of 33 questions, and we received 146 responses to the questionnaire, see appendix 1 for all the survey questions.

2. Focus groups

Healthwatch staff also conducted several small focus groups at various outreach events, participants were asked to talk about the sex and relationship education they had received and what they thought would have made it better. We had a total of 35 participants in our focus groups, see appendix 2 for all focus group questions.

All research took place between November 2013 and February 2014 with a total of 181 young people participating in the study.

5. Findings and analysis - Survey

5.1 Respondent demographics

Of the 146 respondents who completed the questionnaire 140 agreed to give equalities data, participants were given the option to provide any or all of the following:

- Age
- Gender
- Sexuality

[7] London Borough of Hammersmith and Fulham Health and Well Being Strategy, 2013-2015

- Ethnicity

From the 25 people we collected focus group information from the only equalities information we collected was age. Please see appendix 3 for all charts.

Age

Of the 146 people who completed the questionnaire 140 gave their age and 6 declined, all respondents fell between 13 and 25 years old with 15 years old being the most common age (30.7%) and with over three quarters of respondents falling between 14 and 17 years old (76.7%).

Gender

Of the 146 respondents 138 gave their gender and 8 declined, of those who gave their gender, slightly more respondents were male than female (52.9% compared to 47.1%).

Sexuality

Of the 146 respondents 122 gave their sexuality and 24 declined, a large majority of respondents gave their sexuality as heterosexual (90.2%) a minority as homosexual (9.8%) and none as bisexual.

Ethnicity

Of the 146 respondents, 127 gave their ethnicity and 19 declined, of those who gave their ethnicity, the largest group was White British (50.4%) followed by Black African (18.9%) and Black Caribbean (16.5%).

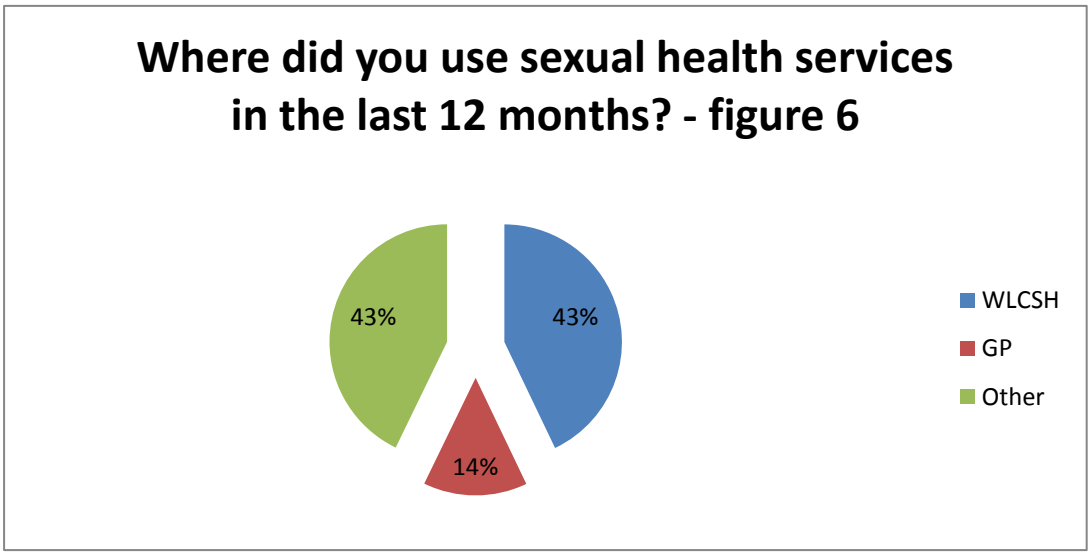
5.2 Looking back on use of sexual health services

The first section of the questionnaire set out to ascertain what recent use respondents had made of sexual health services and what their experiences of using them had been. Some charts have been included in this section but for ease of reading some have been moved to appendix 4.

The questionnaire asked respondents if they had used any sexual health services in the last 12 months. As shown in figure 5 a minority (15.1%) of respondents answered that they had recently used sexual health services, the remainder (84.9%) responded that they had not used sexual health services recently.

Those who had answered yes to the previous question were then asked where they had used sexual health services in the last 12 months. As shown in figure 6 of the people who responded yes to, the two most popular

responses was the West London Centre for Sexual Health (42.9%), a much smaller number (14.3%) specified their GP. The other respondents specified the following: “The Naz project” “The Stowe Health Centre” “Boots” “Mattock Lane” “Sexual health services in Leicester” “Hammersmith Hospital”



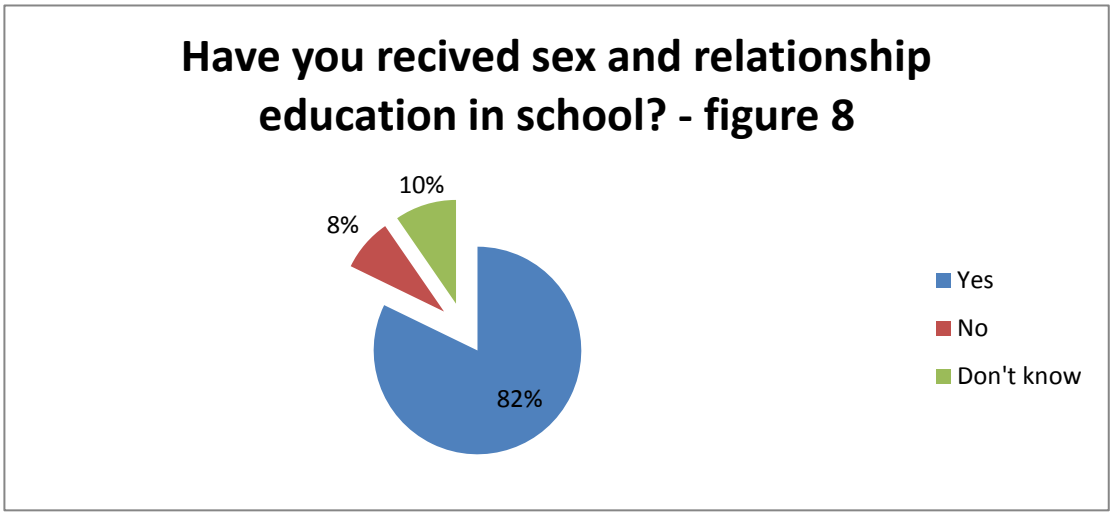
Feedback given about these services in the survey was generally very good, one respondent commented that the West London Centre for Sexual Health was particularly good on cultural sensitivity, though one respondent commented on the long waiting times at the West London Centre for Sexual Health.

5.2 Experiences of sex and relationship education.

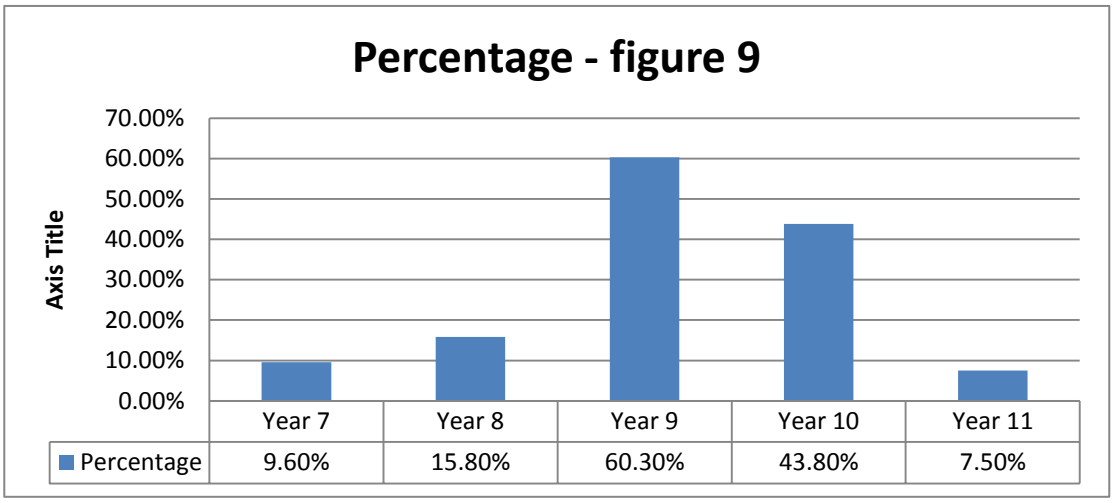
The second section of the questionnaire set out to ascertain what sex and relationship education respondents had received and how they viewed its worth.

The majority of respondents (70.5%) answered that they are in school, the remainder (29.5%) replied that they were not. Schools attended by respondents included: “Phoenix” “Burlington Danes” “Ashcroft” “Fulham College” “Hurlingham” “Bridge Academy” “Lady Margaret”.

As shown in figure 8 the majority of respondents (82.2%) answered that they had received sex and relationship education in school, the remainder answered that they had not (8.2%) or answered that they did not know whether they had or not (9.6%).

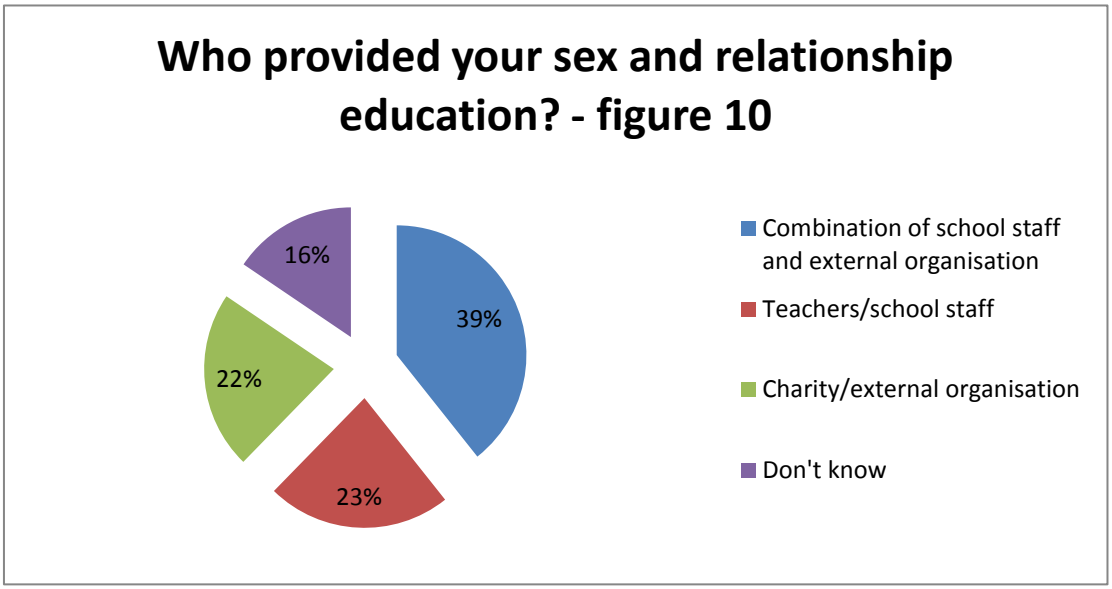


Respondents were asked to select which years they had recived sex and relationship education in and were able to choose multiple years, as shown in figure 9 the most popular choice was Year 9 (60.3%), followed by Year 10 (43.8%), Year 8 (15.8%), Year 7(9.6%), and Year 11 (7.5%). Together Years 9 & 10 represent the vast majority of responses with very few responses falling outside these two years.



When looking at who provided their sex and relationship education sessions, respondents were able to choose from teachers/school staff, charity/external organisation, combination of school staff and external organisation, don't know and I haven't received SRE. As shown in figure 10 the responses to this question were fairly evenly split, with a combination of school staff and an

external organisation (39%) ahead, followed by between teachers/school staff (22.8%) and charity/external organisation (22%), respondents reporting that they don't know who provided their SRE (15.4%), the remainder either skipped the question or reported that they had not received SRE (0.8%) over half of respondents reported some external involvement in providing their SRE (61%).



The questionnaire asked how many sessions on average respondents had received in a year. The most common response given was 4 sessions per year and the median response was also 4 sessions per year.

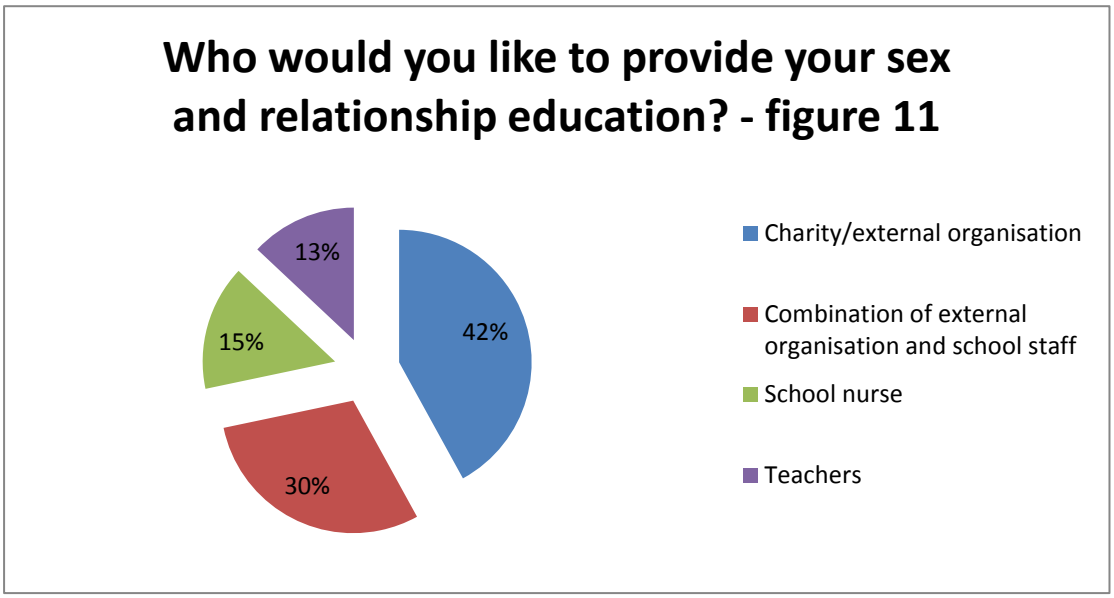
Respondents views on the quality of the sex and relationship education they received were mixed, respondents were asked to score their sex and relationship education sessions out of 10. Looking at all the results together, the most common response given was 7/10 and the median response was also 7/10. However when looking at just those respondents who had chosen charity/external organisation as their SRE provider the most common response was 9/10 and the median response 8/10, alternatively when looking at just those respondents who had chosen teachers/school staff as their SRE provider the most common response was 5/10 and the median response 6/10.

When asked to give their views on what the most valuable topics their sex and relationship education sessions had covered, respondents gave a wide range of answers to this question but the two most common responses were contraception (31.4%) and sexually transmitted infections (11.4%).

5.3 Young people's views on the sex and relationship education they want.

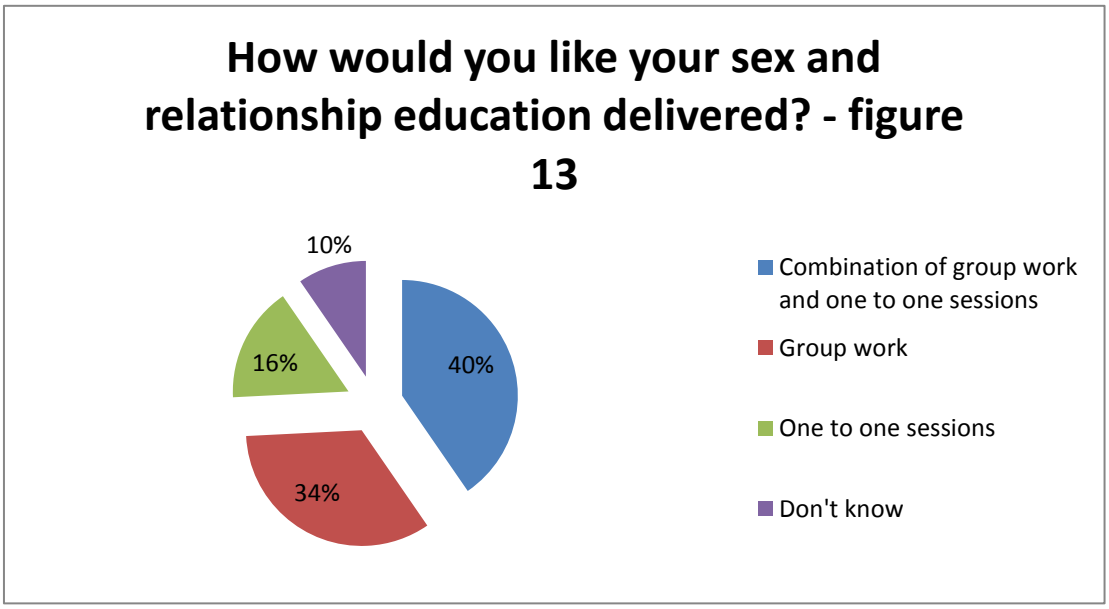
The third section of the questionnaire looked at collecting young people's views on what form they thought sex and relationship education should take.

The questionnaire began this section by asking who young people would like to provide sex and relationship education. As shown in figure 11 the most common answer to this question by respondents was charity or external organisation (42%) followed by a combination of external organisation and school staff (29.7%). School nurse followed (15.3%) and then teachers (13%), though two respondents did name a specific teacher they would like to continue to deliver SRE, highlighting good practice.



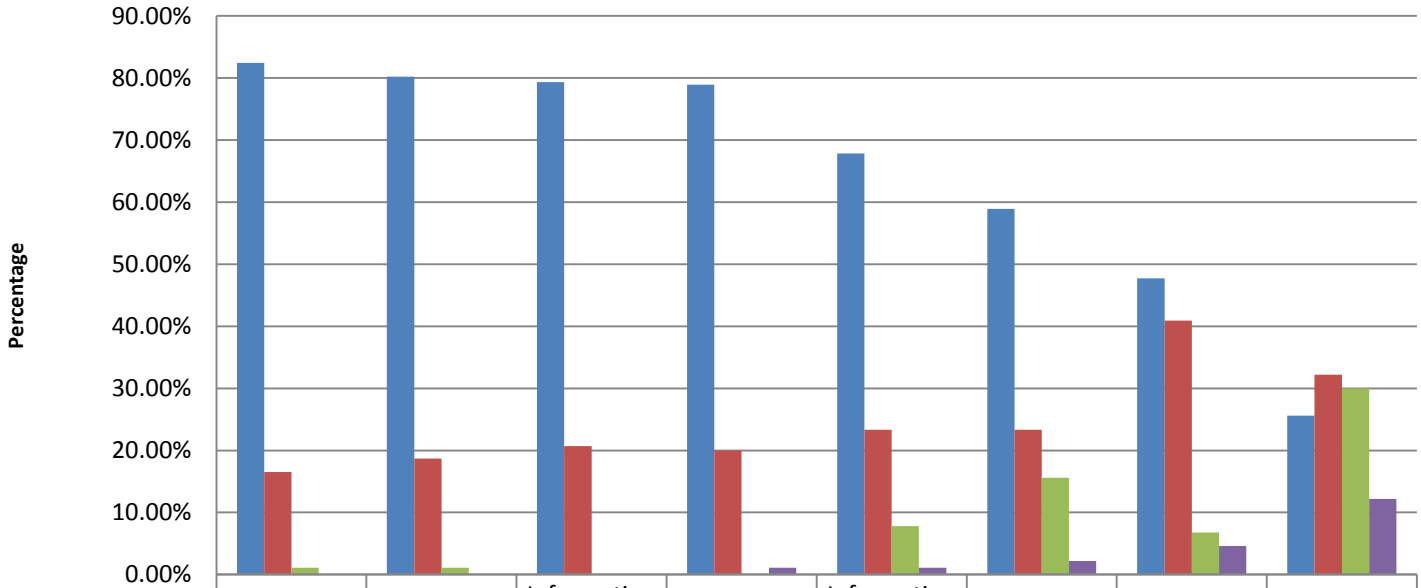
When asked if they thought the age of the person delivering the sex and relationship education was important, a majority of respondents answered yes (63.5%) with a variety of reasons given, including: "Other young people would be good" "An older person would be weird" "easy to relate to" "Young people are better" "Because talking to an older person is awkward" "relate to young people" "I think it is important to have someone who is still young as you can approach them and feel they have faced similar issues recently say in past 5 /10 years" "so they understand my point of view". Of those who said no (36.5%) they gave the following reasons: "Because with experience comes richness of information" "as long as they are engaging and knowledgeable on the subject" "because what every age if they are mature it doesn't matter" "it's not age specific"

When asked about the structure of their sex and relationship education, respondents were able to choose from group work, one to one sessions, combination of group and one to one sessions and don't know. As shown in figure 13 most respondents either chose a combination of group work and one to one sessions (40.4%) or group work (33.8%), a small number chose one to one sessions (16.2%) and a smaller number didn't know (9.6%). A small number of respondents made additional comments, all of which emphasised the need to have someone who young people feel comfortable with deliver SRE.



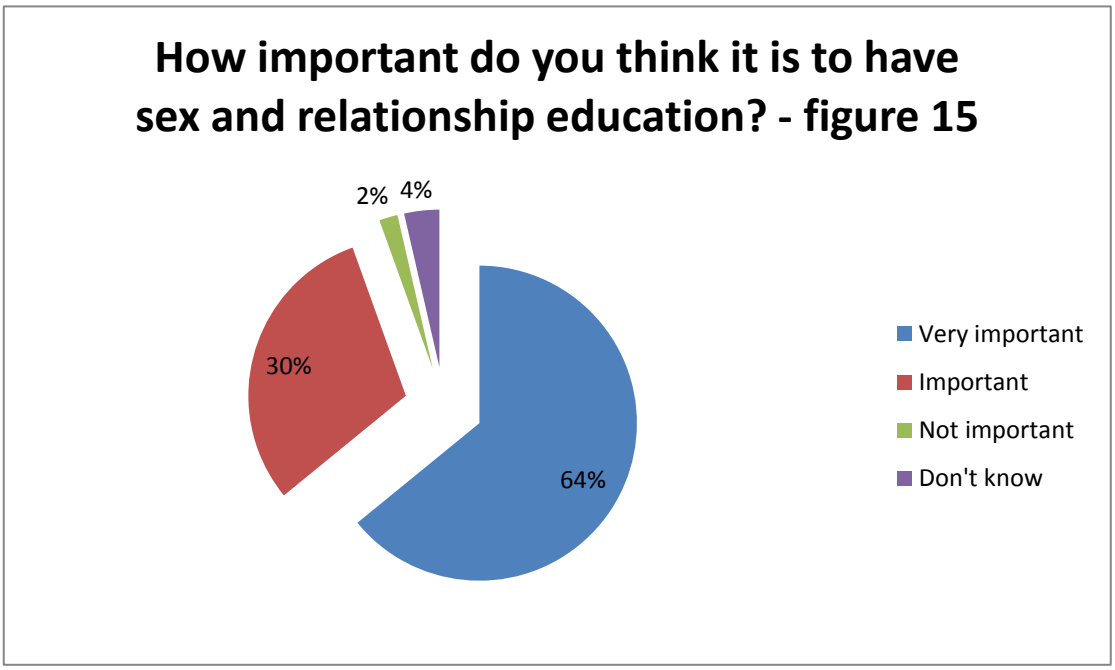
Respondents were asked to rate the following, signposting to sexual health services, information about contraception, information about sexually transmitted infections, information about safe sex, information about healthy relationships, information about domestic violence, emotional support, information about pornography, respondents were able to rate these as very important, important, not important and don't know. As shown in figure 14 the three topics that respondents valued most were signposting to sexual health services (82.4% awarded very important), information about contraception (80.2% awarded very important) and information about sexually transmitted infections (79.3% awarded very important). These were closely followed by safe sex (78.9% awarded very important) and healthy relationships (67.8% awarded very important). There were slightly mixed responses to other topics, domestic violence (58.9% awarded very important, 23.3% awarded important), emotional support (47.7% awarded very important, 40.9% awarded important) and information about pornography (25.6% awarded very important, 32.2% awarded important, 30% awarded not important). Other topics that young people felt were important to include in SRE included: "information about HIV", "abuse" and "Information about sexual orientation". There were slight differences in response when participants were divided by sex but no significant difference.

How important is it to have the following in SRE? - figure 14a



	Signposting to sexual health services	Information about contraception	Information about sexually transmitted infections	Information about safe sex	Information about healthy relationships	Information about domestic violence	Emotional support	Information about pornography
Very important	82.40%	80.20%	79.30%	78.90%	67.80%	58.90%	47.70%	25.60%
Important	16.50%	18.70%	20.70%	20%	23.30%	23.30%	40.90%	32.20%
Not important	1.10%	1.10%	0%	0%	7.80%	15.60%	6.80%	30%
Don't know	0%	0%	0%	1.10%	1.10%	2.20%	4.60%	12.20%

As shown in figure 15 a majority of respondents felt it was very important to have sex and relationship education sessions (64.1%), most other respondents felt it was important (30.4%) a very small number of respondents felt it was not important (1.9%) and some respondents did not know (3.6%).



The final part of this section asked respondents if there was anything else they would like to say about sex and relationship education. Comments from respondents included:

"Good but need more", "Should be more", "Its important", "Not sure when it will happen", "Should have had more", "needs to be more frequent", "teachers shouldn't be involved", "have specialists in the area go into schools", "not sure when it will happen", "Its important", "I didn't receive it", "it would have been good to have received it in year 7/8", "I believe most schools should do it in year 6 now" "I think it would be good to be taught about the body as well as sex".

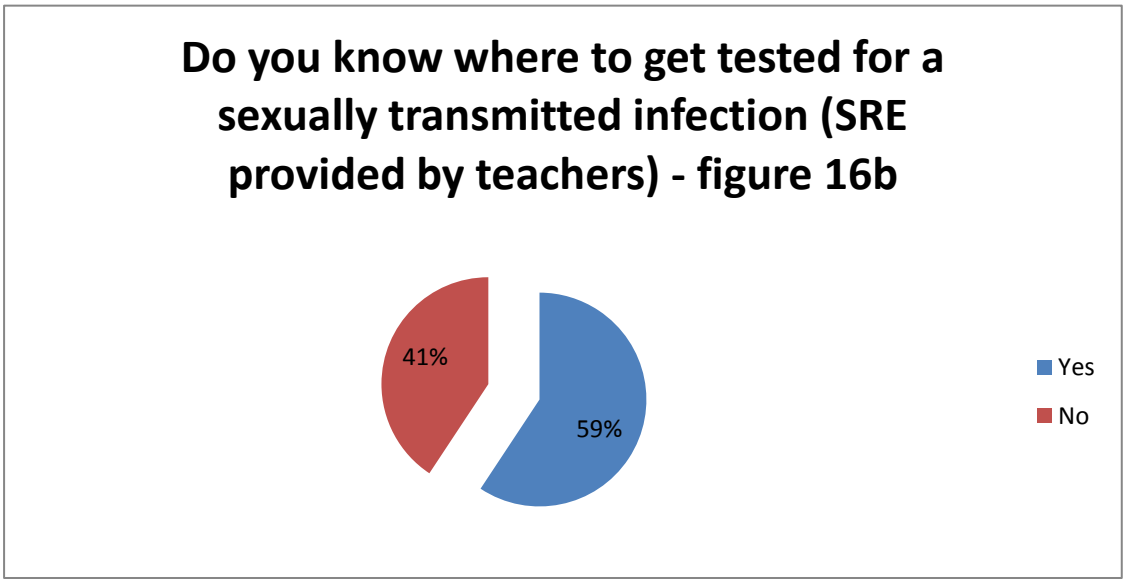
5.4 Young people's knowledge

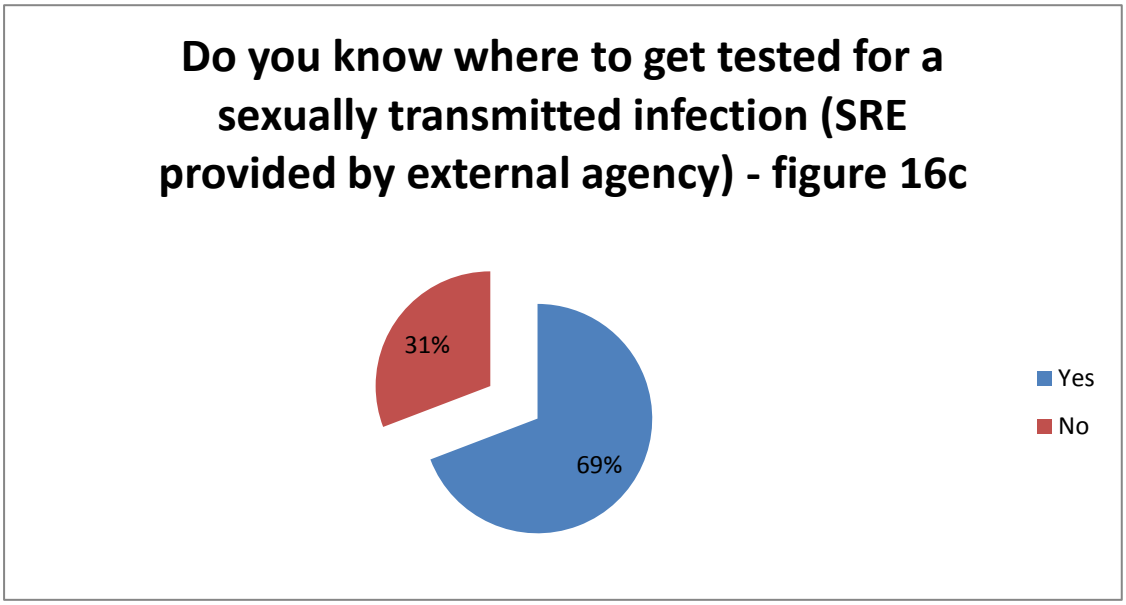
The final section of the questionnaire looked at the knowledge young people had about sexual health services locally. The first question of this section asked if respondents knew where to go to get tested for a sexually transmitted infection. A majority of respondents answered yes to this question (67.8%), when asked where they would go the vast majority specified a sexual health clinic (60%), the remainder specified GPs and hospitals.

When the above was broken down to look at those respondents who stated they had received sex and relationship education and those that hadn't there was little difference in the percentage of respondents answering yes to this

question. However when asked where they thought they could get tested very few respondents who had not received SRE were able to specify a service, 4.6 % compared to 38.5% for those who had received sex and relationship education.

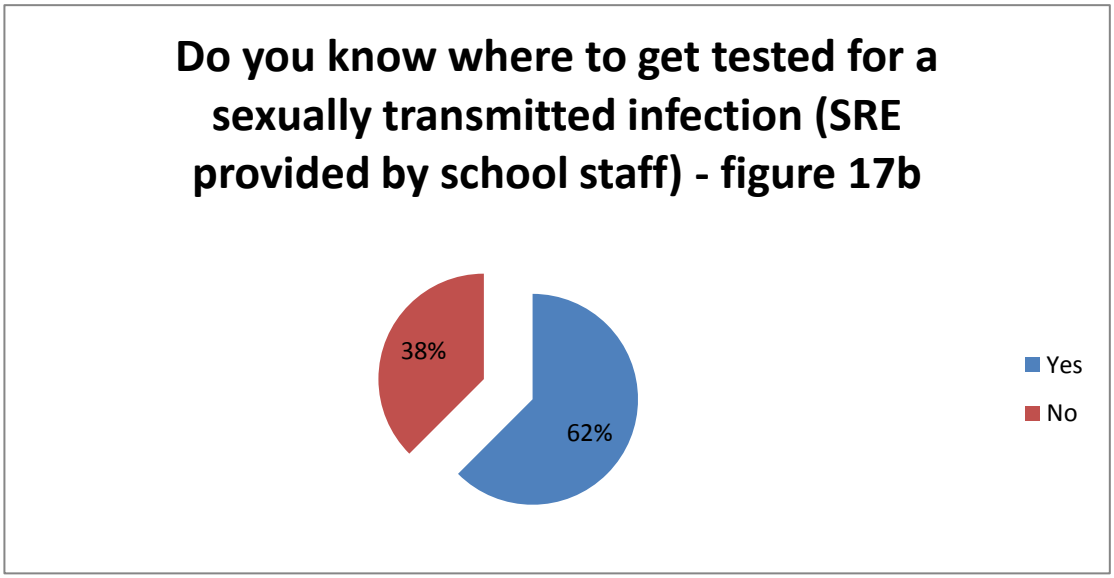
When broken down to look at who provided respondents sex and relationship education those where it was provided by teachers had a lower percentage answering yes (59.3%, figure 16b) than those who received their sex and relationship education from an external provider (69.2%, figure 16c)

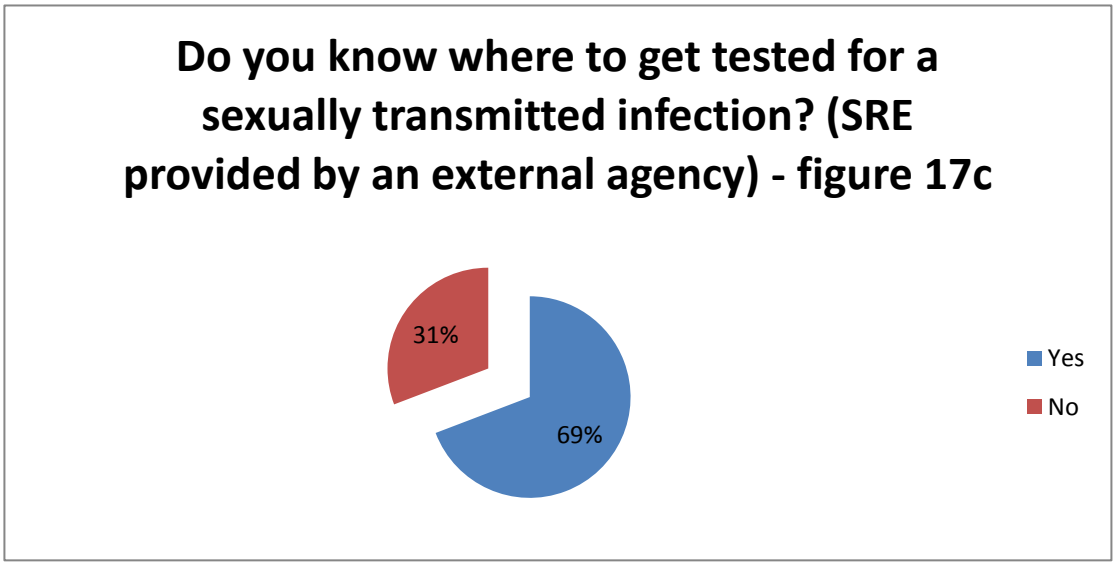




In terms of where to get tested for a sexually transmitted infection. Again a majority of respondents answered yes to this question (70.1%). As above, when respondents are broken down by who provided their sex and relationship education, those who had their sex and relationship education provided by teachers/school staff had a lower yes percentage (62.5% figure

17b) than those who had their sex and relationship education provided by an outside agency (69.2% figure 17c)



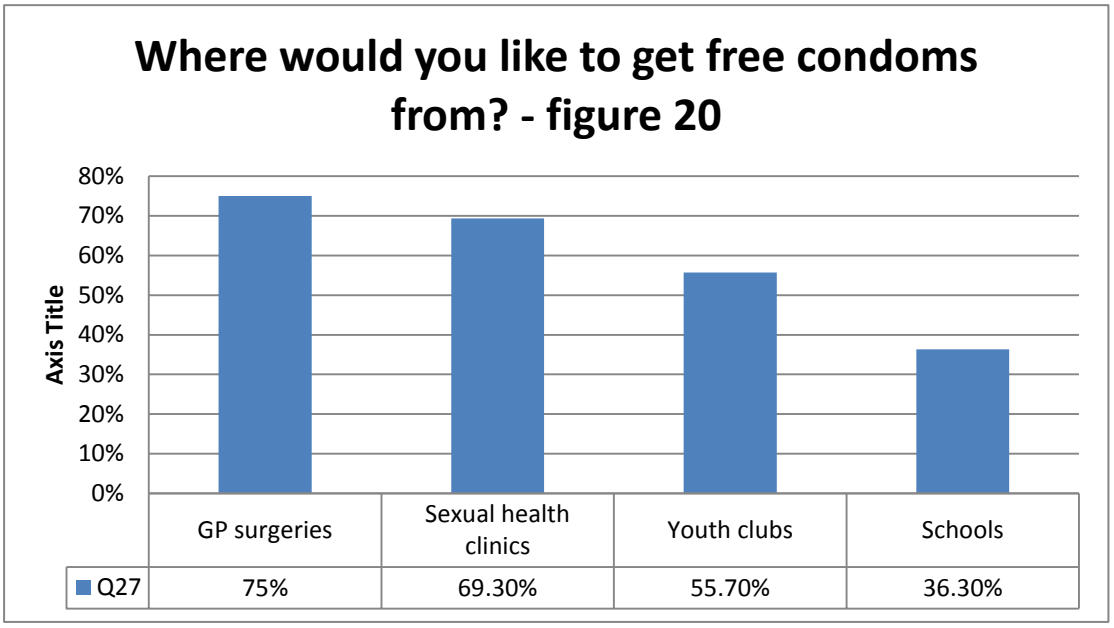


Moving on to if respondents had ever been shown how to use a condom properly. A small majority of respondents (56.8%) answered yes to this question. When looking at those respondents that had received SRE a similar percentage had been shown how to use a condom properly those who hadn't received sex and relationship education. Similarly there was little difference between those who had their sex and relationship education provided by teachers compared to provided by an outside agency.

When assessing if respondents knew where to get free condoms from. Again a small majority of respondents (55.7%) answered yes to this question, when asked where they think they can get them from, the most popular choice of respondents was sexual health clinics (50.9%), followed by GP surgeries

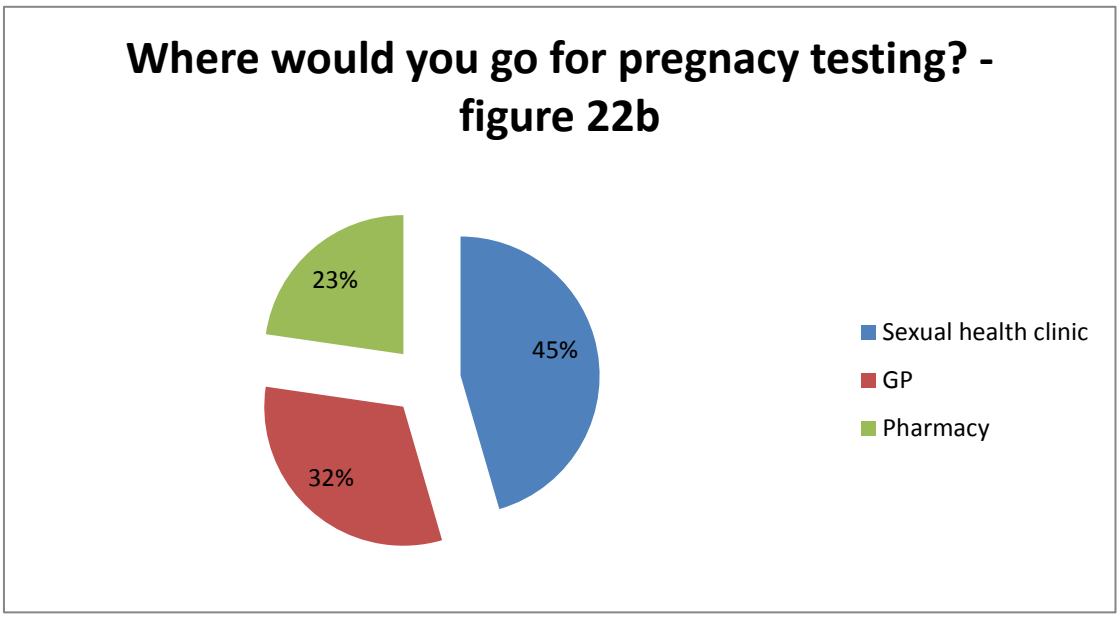
(33.7%) then equally school (7.7%) and Connections (7.7%). When broken down to look at those who had received sex and relationship education and those that hadn't there was little difference in the percentages answering yes to this question, however the percentage able to specify a service where they could receive free condoms was higher for those who had received sex and relationship education (36.3%) than for those that hadn't (8.7%).

The questionnaire followed this up by asking respondents where they would like to get free condoms from, respondents were able to choose from GP surgeries, sexual health clinics, youth clubs and schools, respondents were able to select multiple options. As shown in figure 20 the most popular choice of respondents was GP surgeries (75%), followed by sexual health clinics (69.3%), then youth clubs (55.7%) and finally schools (36.3%). A significant number of respondents also specified "community projects" as somewhere they would like to get free condoms from.



When asking respondents if they knew where to access emergency contraception, a significant majority responded no to this question (63.2%), of those that responded yes, they specified the flowing places they believed they could access emergency contraception, sexual health clinic (52.9%) and pharmacy (47.1%).

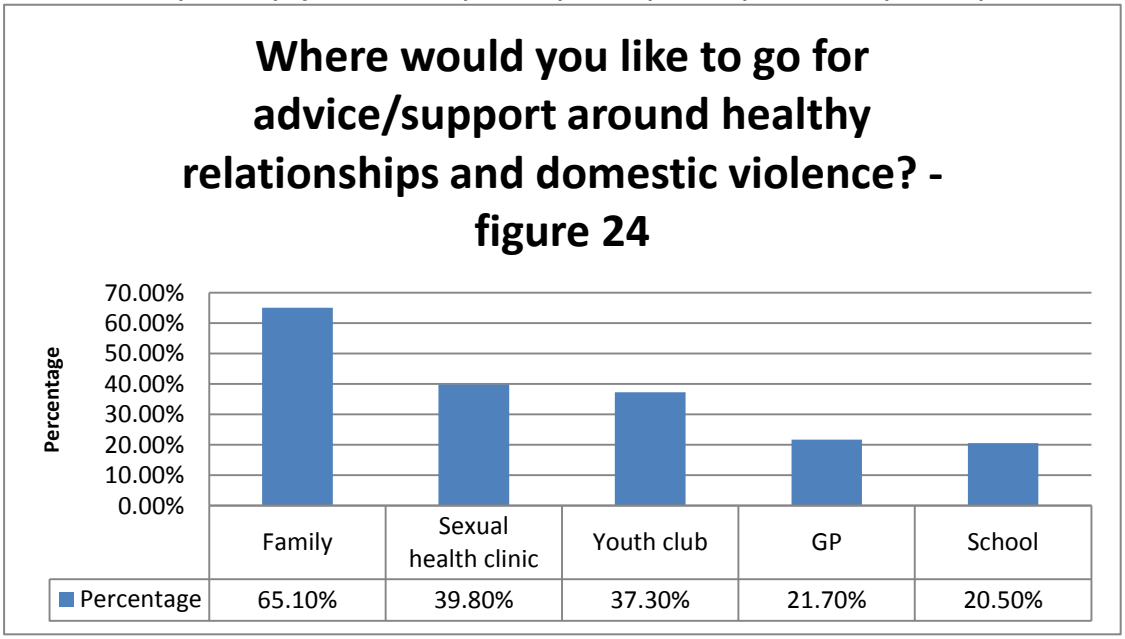
The questionnaire then asked respondents if they knew where to go for pregnancy testing. As shown in figure 22a a majority responded yes to this question (54.7%), when asked where they would go (see figure 22b) the most popular response was a sexual health clinic (45.5%), followed by your GP (31.8%) and then pharmacy (22.7%).



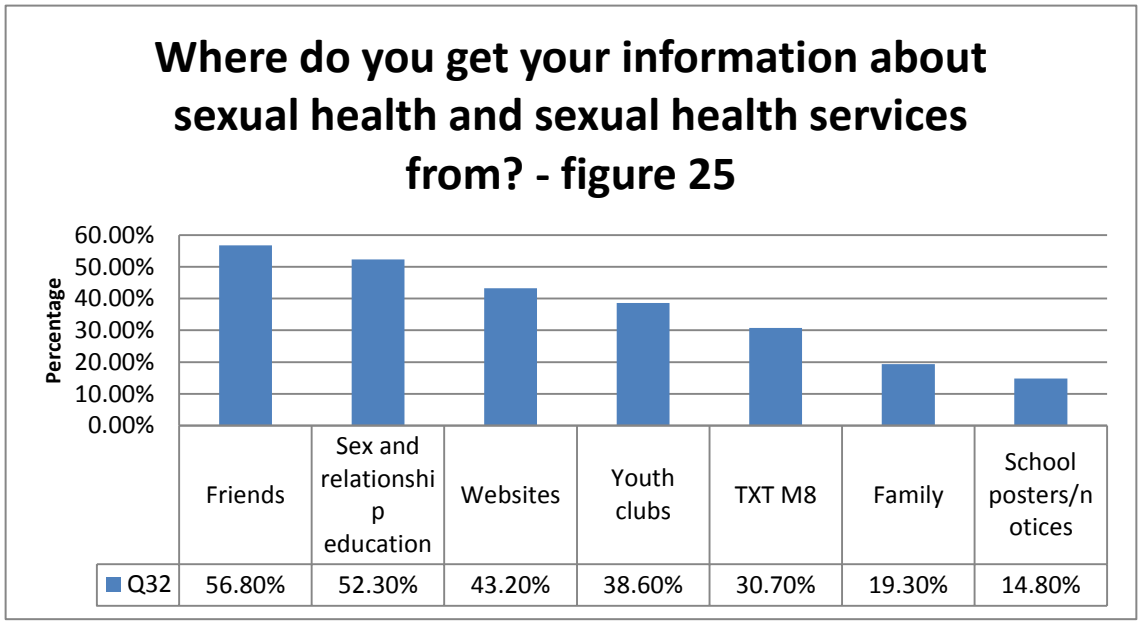
Respondents were asked if they knew where they could go for advice/support around healthy relationships and domestic violence. As shown in figure 23 a large majority of respondents (77.6%) answered no to this question, of those who answered yes they specified GPs and families as places they would go for advice/support.

The questionnaire then followed this up by asking respondents where they would like to go for advice/support around healthy relationships and domestic violence.

Respondents were able to give multiple responses to this question, as shown in figure 24 the most popular response was family (65.1%) followed by sexual health clinic (39.8%), youth club (37.3%), GP (21.7%), School (20.5%).



Finally the questionnaire asked respondents where they got the majority of their information about sexual health and sexual health services from. Respondents were able to give multiple responses to this question, as shown in figure 25 the most popular choice was friends (56.8%), closely followed by sex and relationship education (52.3%), then websites (43.2%), youth clubs (38.6%), TXT M8 (30.7%), family (19.3%) and finally school posters/notices (14.8%).



5.6 Focus Group Comments

Healthwatch took part in a young people's service user engagement event at the West London Centre for Sexual Health at Charing Cross Hospital, hosting two workshops and taking part in a larger debate session, we used a series of focus group questions to explore young people's experiences of sex and relationship education and how they thought sex and relationship education could be improved, in addition we took these questions on outreach sessions to youth clubs / youth centres. In total at both the West London Centre for Sexual health event and on our outreach visits we collected the responses of 35 young people (all aged 14 to 18 years) to our focus group questions.

What was good about the sex and relationship education (SRE) you received?

The young people we spoke to reported that they felt that their SRE had worked well when the sessions had focused on experiences and situations that young people could relate to.

"Used real life scenarios"

"talked about things we did"

Young people also felt that they gained a lot from drop in sessions being made available to them.

"Drop in sessions were great"

"Good to be able to see someone when you need to"

What was bad about the sex and relationship education (SRE) you received?

The age of those delivering SRE was highlighted as a concern for the young people we spoke to

"The people taking the lessons were too old"

"Older people delivering our SRE wasn't good"

Young people also showed concern about their experiences of mixed sex sessions.

"Mixed boys and girls didn't work"

"It was uncomfortable having the lessons with boys"

How could sex and relationship education be improved?

Young people we spoke to indicated that they though SRE could be improved if it was delivered by external people rather than teachers or other school staff.

"No teachers/outside organisations"

Young people also felt that SRE should engage with them using real life situations/experiences, people they could relate to, and well known issues.

"Focus on role models in media and life"

"Should link in to stories in the wider media, particularly around bullying and exploitation"

"Have speakers with real life experience"

"Include more information on gangs and exploitation"

It was also seen as important to have appropriate communication in SRE sessions focusing on making them informal, relaxed settings.

"The way you communicate is really important "

"Sessions should be informal"

"Should relieve the pressures on young people"

Single sex sessions were also identified by young people as something they would like to see, to make the sessions more comfortable and address issues specific for boys and girls.

"Working with boys around acceptable behaviour"

"Should work specifically with girls around what they should expect from sex and relationships"

"Sessions should be single sex"

Young people also identified a series of topics they felt should be the focus in SRE sessions.

"More info and awareness about FGM"

"Should focus on bad relationships"

"Should try and build resilience in children"

"Should offer relationship support especially around violent relationships"

"Should go into more depth around STI's"

"Should look at how to build a good relationship"

"Condoms and other contraception should be promoted"

"Emotional support is important"

"Don't just focus on pregnancy"

Young people we spoke to also identified mental health and emotional wellbeing as key areas SRE should link in with.

"Should link in with mental health"

"Should link in with self-harm and CAMHS"

"Should try and improve self-esteem"

"should look at how sexting effects us"

Involving and communicating with parents and young people's families was also identified as important.

"Working with parents"

"Support for families and parents"

6. Conclusions and recommendations

Conclusion

The study has highlighted a key number of areas of potential concern and recommendation. Firstly the wide spectrum of views and the willingness of young people to contribute their views and experiences to this study highlights the opportunities and worth of future engagement with young people.

In conclusion we can see that whilst the vast majority of respondents received sex and relationship education it is not universal, the delivery of sex and relationship education also seems to be inconsistent, in terms of who delivers it, in what years it is delivered, how many sessions a year young people receive and the reported quality of sex and relationship education.

Looking forward, a majority of respondents seemed quite clear about having at least some provision from external organisations, though it's important to note that a significant minority were in favour of school staff (either teacher or

school nurse) continuing to deliver sex and relationship education. A wide variety of forms of delivery is also popular (including group sessions, one to ones and drop ins) as well as a wide variety of content, respondents indicated that sex and relationship education should go beyond the core content of safe sex, STI's, contraception and healthy relationships and also include support around domestic violence, sexuality, emotional well being, mental health, pornography and new technology. Respondents almost unanimously recognise the importance of sex and relationship education, and many call for more and wider provision.

The study revealed some striking gaps in young people's knowledge, the most worrying being around knowledge of where to access free condoms and where to access support around healthy relationships and domestic violence, though all the gaps are worrying considering the vast majority of respondents had received sex and relationship education. It is also particularly interesting that only just over half of the respondents indicated that they received information about sexual health and sexual health services from sex and relationship education, this could indicate a significant gap.

Recommendations

The following recommendations are points we believe local commissioners should take into account when evaluating, planning and designing sexual health priorities that include sex and relationship education.

For Tri-Borough public health commissioners:

The Tri-Borough Public Health team should consider the following when commissioning new sexual health services for young people:

1. Ensure external providers have a place in delivering sex and relationship education, in light of young peoples expressed wishes to have external provision.
2. Ensure adequate signposting to condom distribution, STI testing services and emergency contraception provision both in sex and relationship education and wider.
3. Utilise all available information forms/pathways that young people also use to spread key messages around sexual health and healthy relationships, e.g. websites, youth clubs etc.
4. Ensure that free condoms are available at the places young people have requested.
5. Ensure that when school nursing services are commissioned that they reflect young people's wishes around sex and relationship support.

For the Hammersmith and Fulham Health and Wellbeing Board:

The Health and Wellbeing Board should take these findings into account when considering how to implement the 'supporting young people into healthy adulthood' and 'better sexual health across the Tri-Borough with a focus on those communities most at risk of poor sexual health' priorities of the Hammersmith and Fulham health and Wellbeing strategy 2013-2015:

6. Quality assure the content of sex and relationship education and standardise content where ever possible.
7. Include the use of peer networks, peer teaching and peer learning to spread key messages and information around sexual health and healthy relationships, in forthcoming health and well being strategies.

For Hammersmith and Fulham Clinical Commissioning Group (H&F CCG):

8. H&F CCG should support the availability of free condoms at GP surgeries in Hammersmith and Fulham.

For schools:

9. Sex and relationship education and support should be offered throughout the school year as and when young people need it.
10. Give more prominence to information around healthy relationships and domestic violence in sex and relationship education.
11. Schools should look to partner with external providers to reflect young people's wishes and ensure better quality sex and relationship education.
12. When sex and relationship education is provided by teachers / school staff ensure that teachers receive appropriate training to be able to effectively deliver sex and relationship education.
13. Include families in sex and relationship education where appropriate.
14. Link in sex and relationship education to wider emotional and mental well being, ensure that support is available for young people in these areas.

Appendix 1

Sex and Relationship Education (SRE) survey.

Thank you for taking the time to complete this short questionnaire, your answers will help us understand what services are needed locally for young people like you. This survey is being carried out by Healthwatch Central West London, we are the new consumer champion for everyone who uses health and social care services, we exist to listen to local people about their experiences of health and social care services and to ensure their voices are heard.

We are trying to find out what young peoples experiences of sex and relationships education (SRE)are and what kind of SRE young people think would work best in the future. We are also trying to find out what young peoples experiences of using sexual health services are, this questionnaire is voluntary and all the information collected is anonymous.

We will use this information to write a report to be delivered to local commissioners who are responsible for sexual health services, the information in the report will help them to:

- improve sexual health and relationship education (SRE) within schools locally
- improve access and signposting to services for young people
- improve existing services to meet your needs

Everyone completing the questionnaire will be entered into a prize draw for the chance to win one £100 Westfield gift voucher.

If you have any questions or comments about this survey you can contact Healthwatch on 0208 969 4852 or e-mail: sam.wallace@hestia.org

1. Age

2. Gender

Male ☐

Female ☐

Other (please specify)

3. Sexual orientation

Heterosexual ☐

Homosexual ☐

Bisexual ☐

Other

Would rather not say ☐

4. Ethnicity

5. First two or three digits of post code e.g. W1 or SW6

6. Have you used any sexual health services in the last 12 months?

Yes ☐

No ☐

7. If yes where?

8. What did you think of these services?

9. Are you currently in School

Yes ☐

No ☐

If yes, which school?

10. Have you received Sex and Relationship Education (SRE) in school?

Yes ☐

No ☐

Don't Know ☐

11. If yes, in which years did you receive SRE?

Year 7 ☐

Year 8 ☐

Year 9 ☐

Year 10 ☐

Year 11 ☐

I haven't received SRE ☐

12. Who provided your SRE?

Teachers/School Staff ☐

Charity ☐

A combination of teachers and Charity ☐

Don't know ☐

I haven't received SRE ☐

13. On a scale of 1 to 10 how would you rate your SRE?

☐

14. Can you remember how many sessions of SRE you received in one year?

15. What part or parts of your SRE did you find most useful?

16. Who would you prefer to provide your SRE?

Teachers ☐

School nurse ☐

Charity / external organisation ☐

Combination of teachers and charity / external organisation ☐

Don't know ☐

Other (please specify)

17. Do you think the age of the person delivering the SRE is important?

Yes ☐

No ☐

Why?

18. How would you like your SRE provided?

In groups ☐

One to one ☐

A combination of group work and one to one ☐

Don't know ☐

Other (please specify)

☐

19. How important is it to have the following in SRE?

	Very Important	Important	Not important	Don't know
Information about pornography				
Information about sexually transmitted infections				
Signposting to sexual health services				
Information on safe sex				
Information about contraception				
Information about healthy relationships				
Information about				

domestic violence				
Emotional support				
Other (please specify)				

20. How important do you think it is to have SRE sessions?

Very important ☐

Important ☐

Don't know ☐

Not important ☐

21. Is there anything else you would like to say about SRE provision in your school?

22. Are you aware of where to get tested for a sexually transmitted infection?

Yes ☐

No ☐

If yes, where?

☐

23. Are you aware of where to get treated for a sexually transmitted infection?

Yes ☐

No ☐

24. Have you ever been shown how to use a condom properly?

Yes ☐

No ☐

25. Do you know where to get free condoms from?

Yes ☐

No ☐

If yes, where?

☐

26. Where would you like to get free condoms from?

School ☐

GP ☐

Sexual health centre ☐

Youth club ☐

Other (please specify)

☐

27. Do you know where to access emergency contraception?

Yes ☐

No ☐

If yes, where?

☐

28. Do you know where to go for pregnancy testing?

Yes ☐

No ☐

If yes, where?

☐

29. Do you know where to go for advice/support about violent/abusive relationships?

Yes ☐

No ☐

30. Where would you like to go for advice/support about violent/abusive relationships?

School ☐

Family ☐

GP ☐

Sexual health centre ☐

Youth club ☐

Other (please specify)

☐

31. Where do you get the information about sexual health and sexual health services?

SRE lessons ☐

Posters/notices in school ☐

txtm8 (a text advice service) ☐

Youth club/Youth centre ☐

Friends ☐

Family ☐

Websites ☐

Other (please specify)

If you would like to be entered into the prize draw for a £100 Westfield voucher then please enter your name and contact details below.

Appendix 2

Focus group questions for young people and sexual health survey.

1. What are your experiences of sex and relationship education (SRE) in school?
    - What was good?
    - What was bad?
    - What for you were the most important things you covered?

2. Has SRE helped you understand what sexual health services are available locally?
    - Services for STI screening?
    - Pregnancy testing and advice?
    - Relationship support?
    - Domestic violence services?

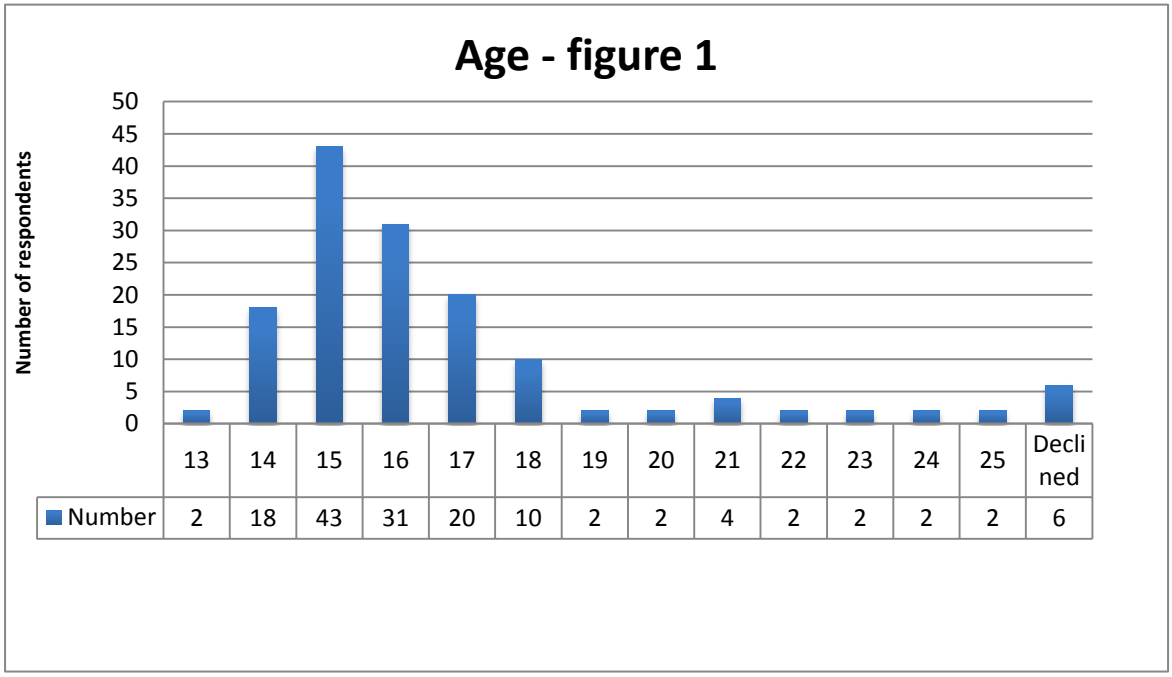
3. How do you think good SRE is delivered?
    - In groups or one to one?
    - By teachers or outside professionals?
    - On-going and regular, one off or as and when?

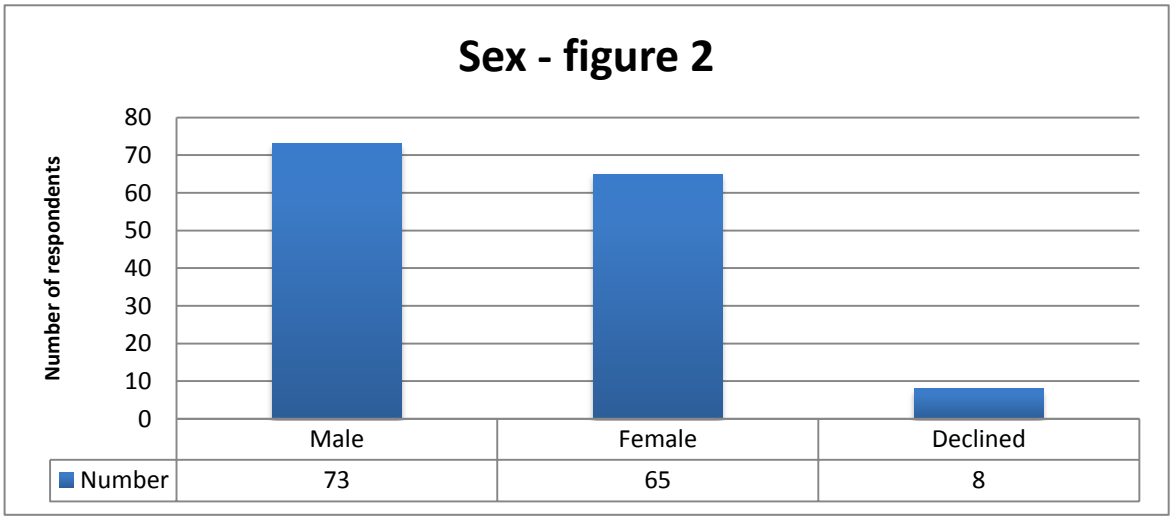
4. Do you think your SRE has helped you understand:
    - What STI's like chlamydia are and how you get it?
    - What HIV is and how you get it?
    - What safe sex is?
    - What a healthy relationship is?

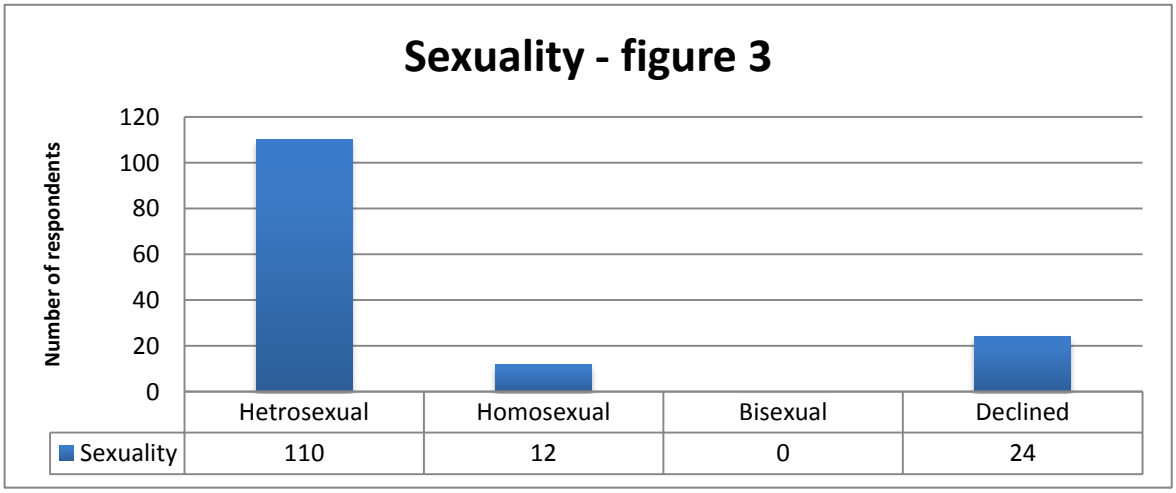
5. Do you have any experience of local sexual health services? (perhaps do this bit one to one and discretely)
    - What was it?
    - Was it good?
    - Was it bad?

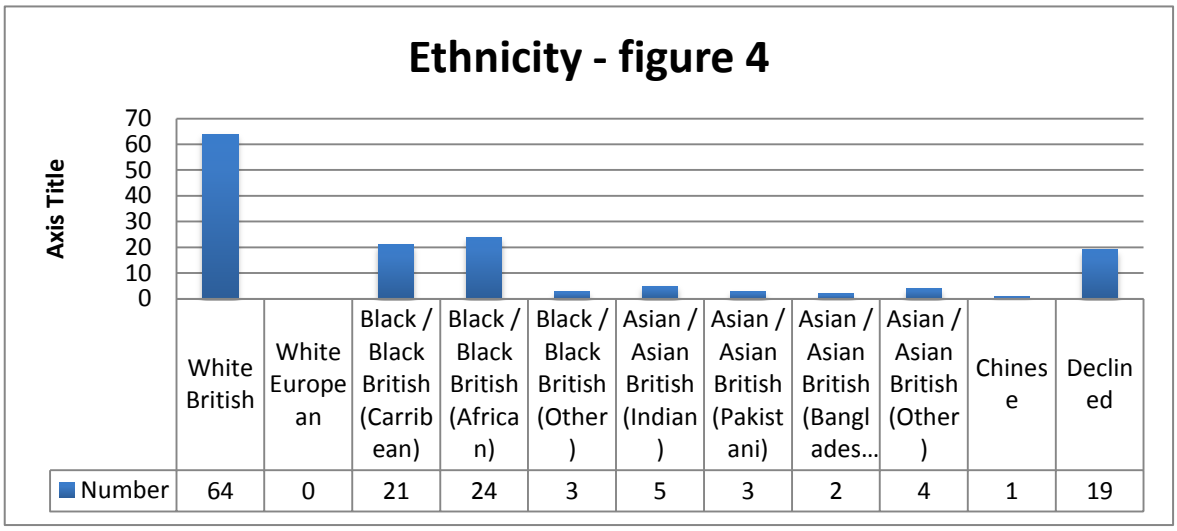
6. Don you know about or used any of the following?
    - Txt M8
    - Youth Projects International
    - Standing Together
    - Outside Chance
    - Any other third sector sexual health organisation.

Appendix 3 – Respondent demographics charts

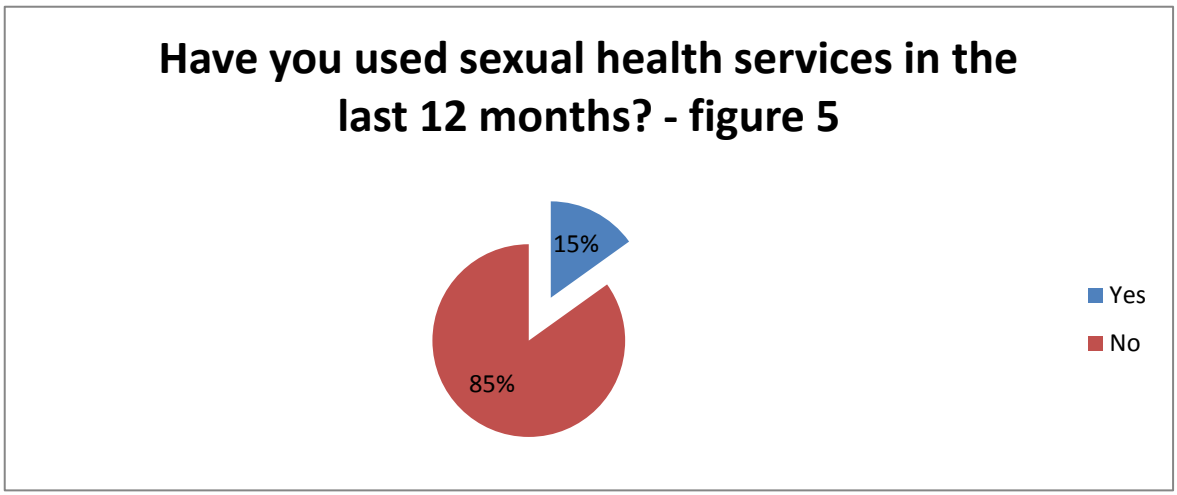


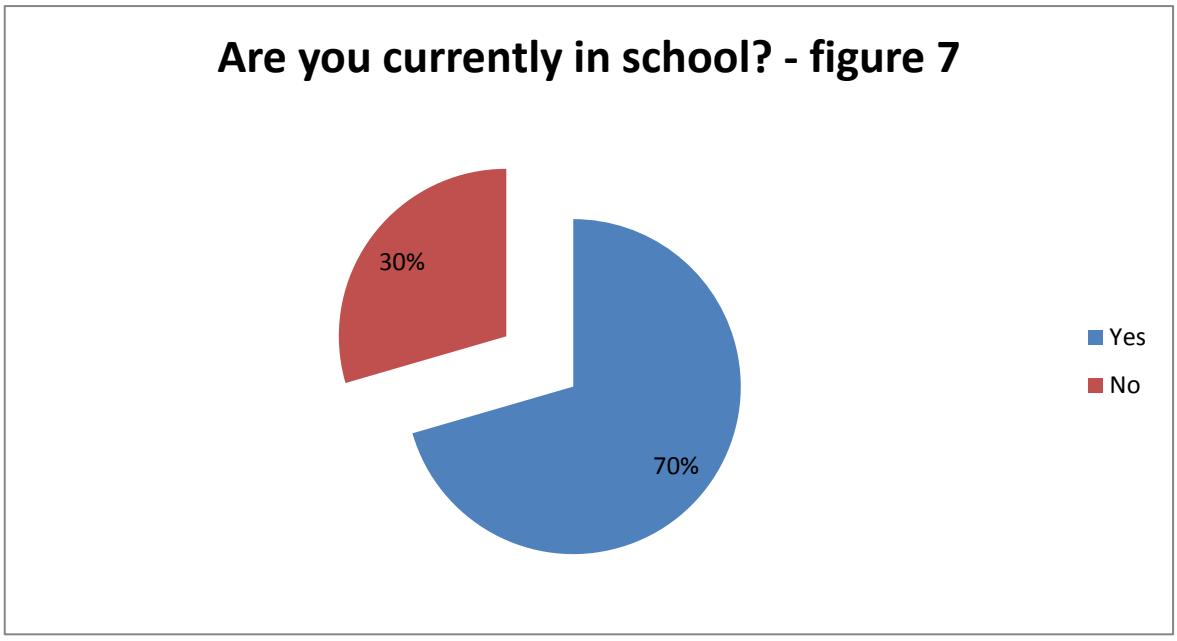


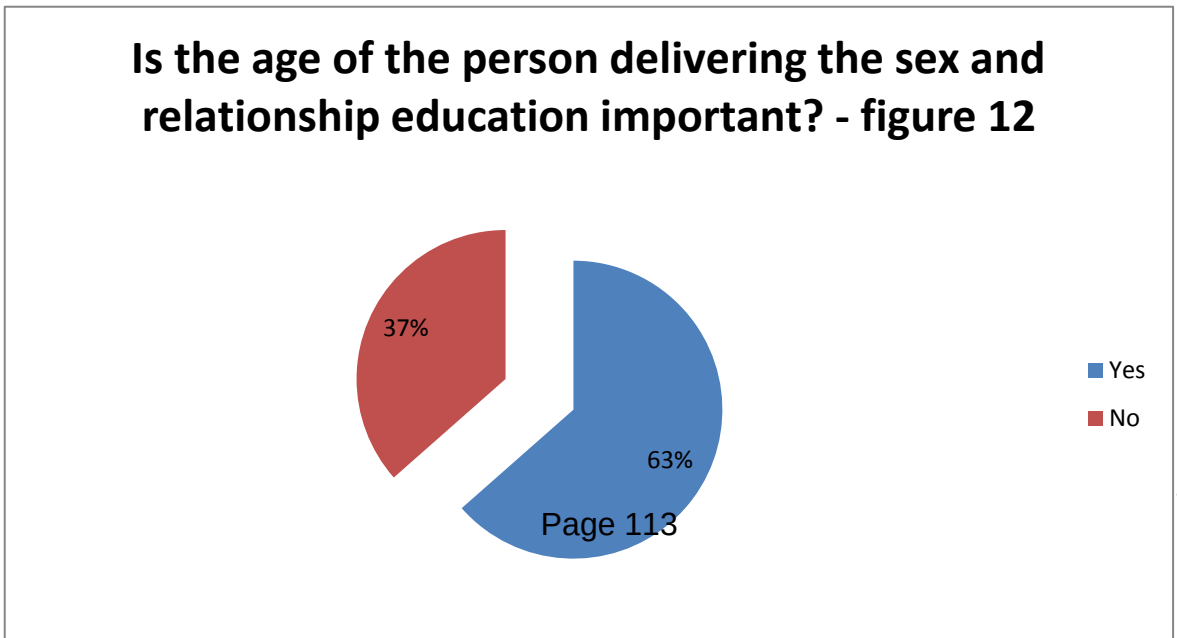



Ethnicity - figure 4
Axis Title
70
60
50
40
30
20
10
0
White British
White European
Black / Black British (Caribbean)
Black / Black British (African)
Black / Black British (Other)
Asian / Asian British (Indian)
Asian / Asian British (Pakistani)
Asian / Asian British (Banglades...
Asian / Asian British (Other)
Chinese
Declined
Number
64
0
21
24
3
5
3
2
4
1
19

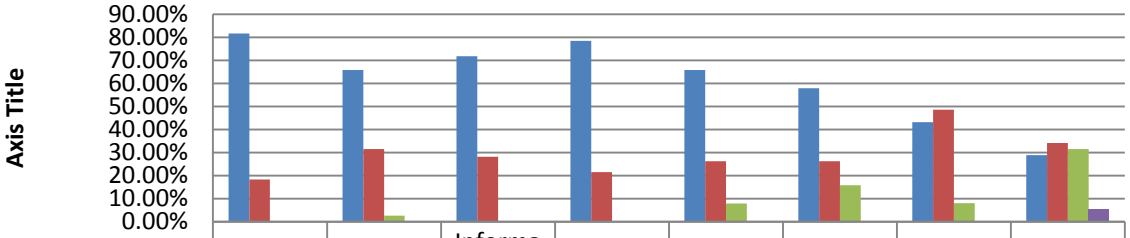
Appendix 4 – Survey results – remaining charts





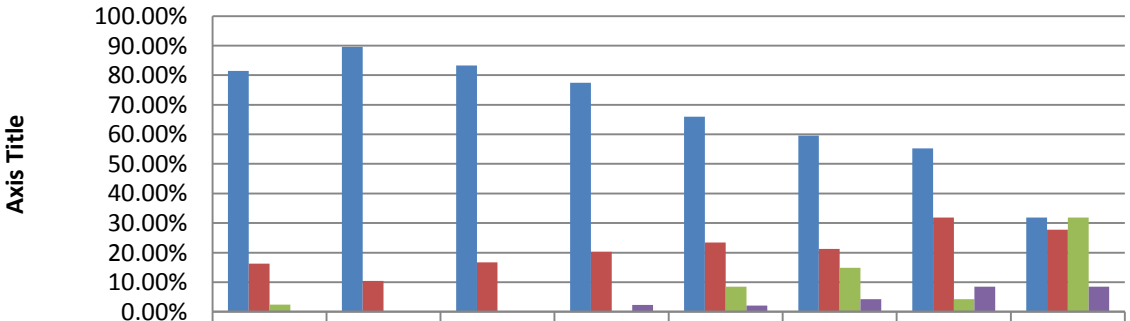


How important is it to have the following in SRE - Male respondents - figure 14b

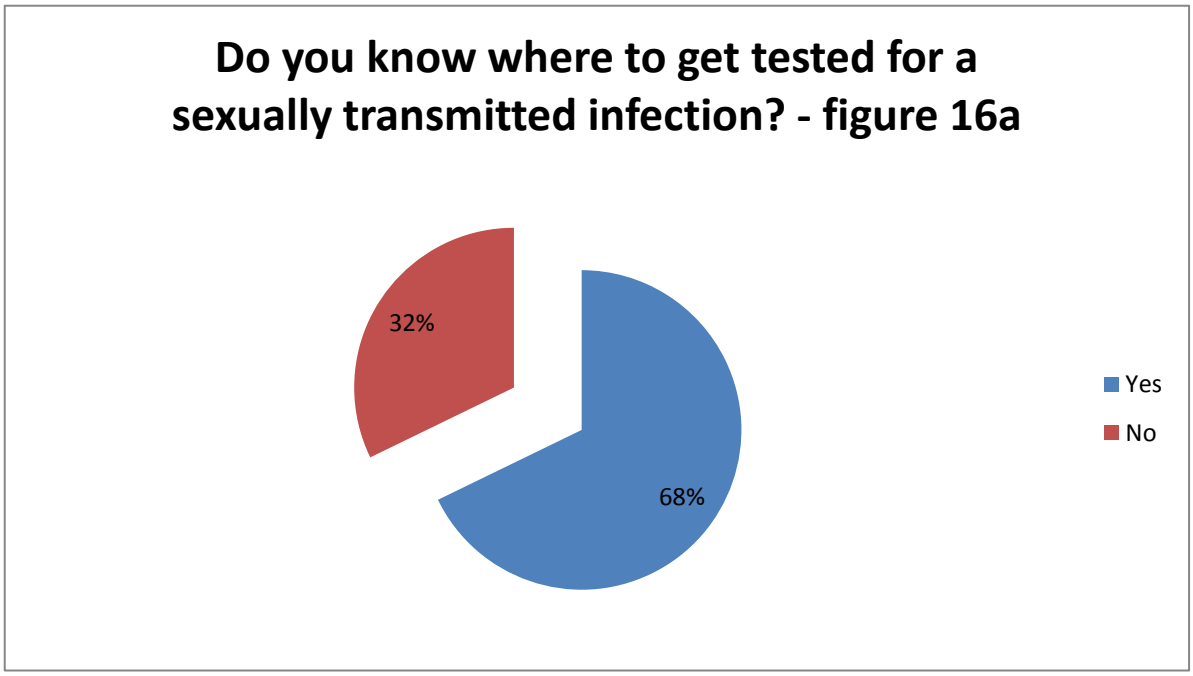


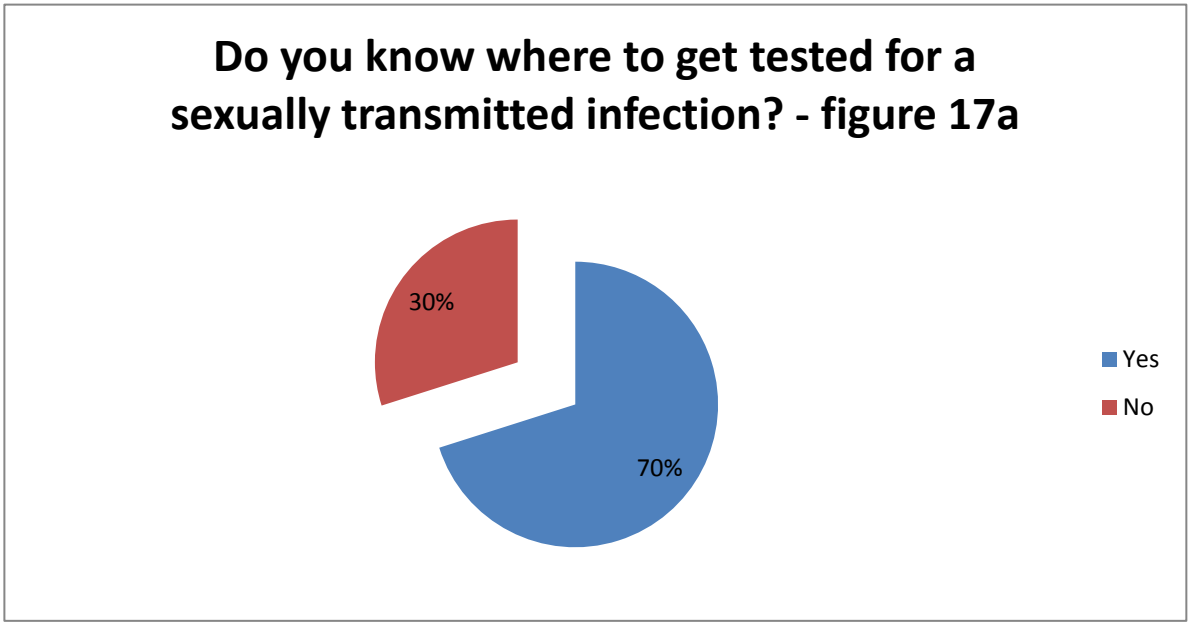
	Signposting to sexual health services	Information about contraception	Information about sexually transmitted infections	Information about safe sex	Information about healthy relationships	Information about domestic violence	Emotional Support	Information about pornography
Very Important	81.60%	65.80%	71.80%	78.40%	65.80%	57.90%	43.20%	28.90%
Important	18.40%	31.60%	28.20%	21.60%	26.30%	26.30%	48.60%	34.20%
Not important	0%	2.60%	0%	0%	7.90%	15.80%	8.10%	31.60%
Don't know	0%	0%	0%	0%	0%	0%	0%	5.30%

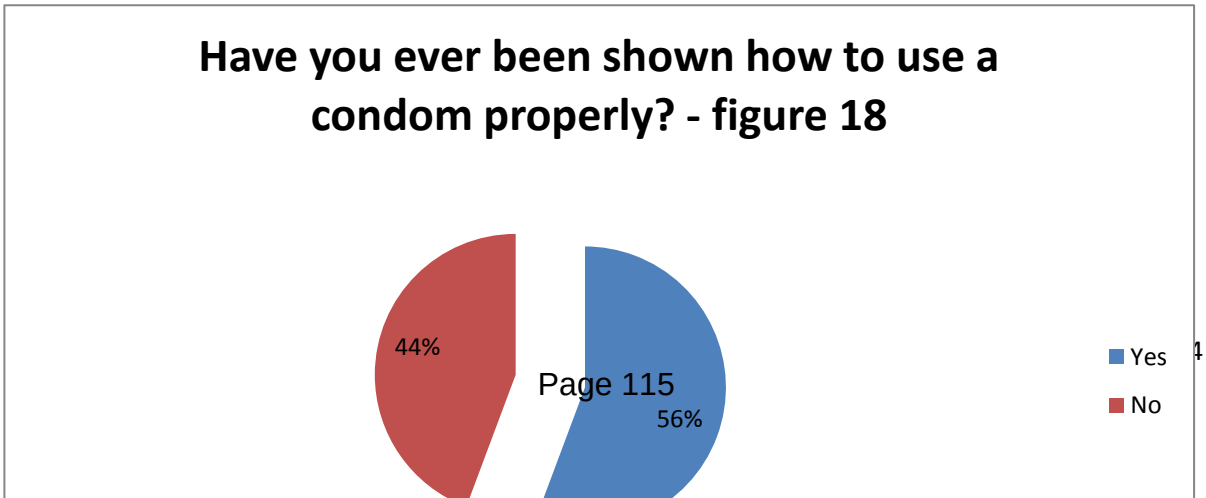
How important is it to have the following in SRE? - Female respondents - figure 14c



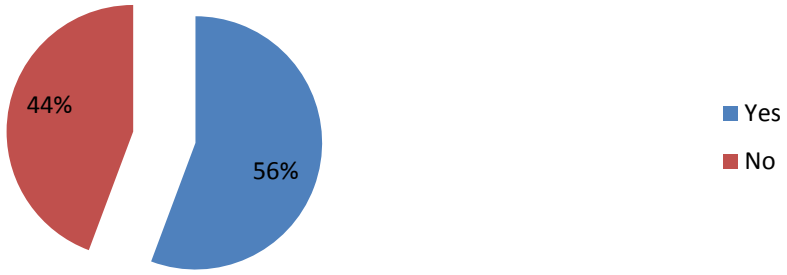
	Signposting to sexual health services	information about contraception	Information about sexually transmitted infections	Information about safe sex	Information about healthy relationships	Information about domestic violence	Emotional support	Information about pornography
Very important	81.50%	89.60%	83.30%	77.40%	66.00%	59.60%	55.30%	31.90%
Important	16.30%	10.40%	16.70%	20.30%	23.40%	21.30%	31.90%	27.70%
Not important	2%	0%	0%	0%	8.50%	14.90%	4.30%	31.90%
Don't know	0%	0%	0%	2.30%	2.10%	4.20%	8.50%	8.50%


Do you know where to get tested for a sexually transmitted infection? - figure 16a
32%
68%
Yes
No

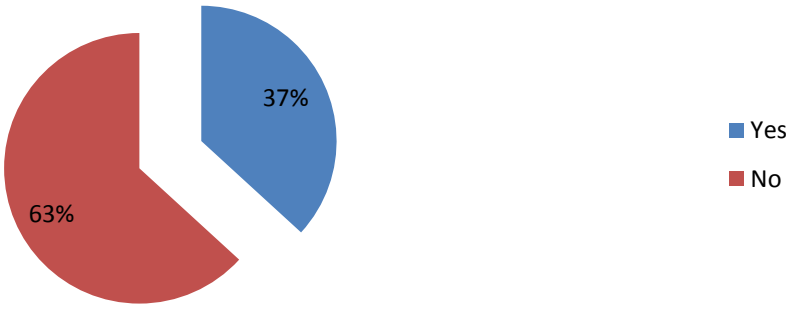

Do you know where to get tested for a sexually transmitted infection? - figure 17a
30%
70%
Yes
No


Have you ever been shown how to use a condom properly? - figure 18
44%
56%
Yes
No

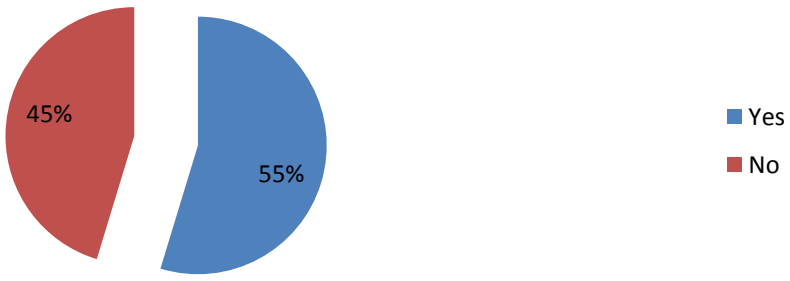
Do you know where to get free condoms from? - figure 19a

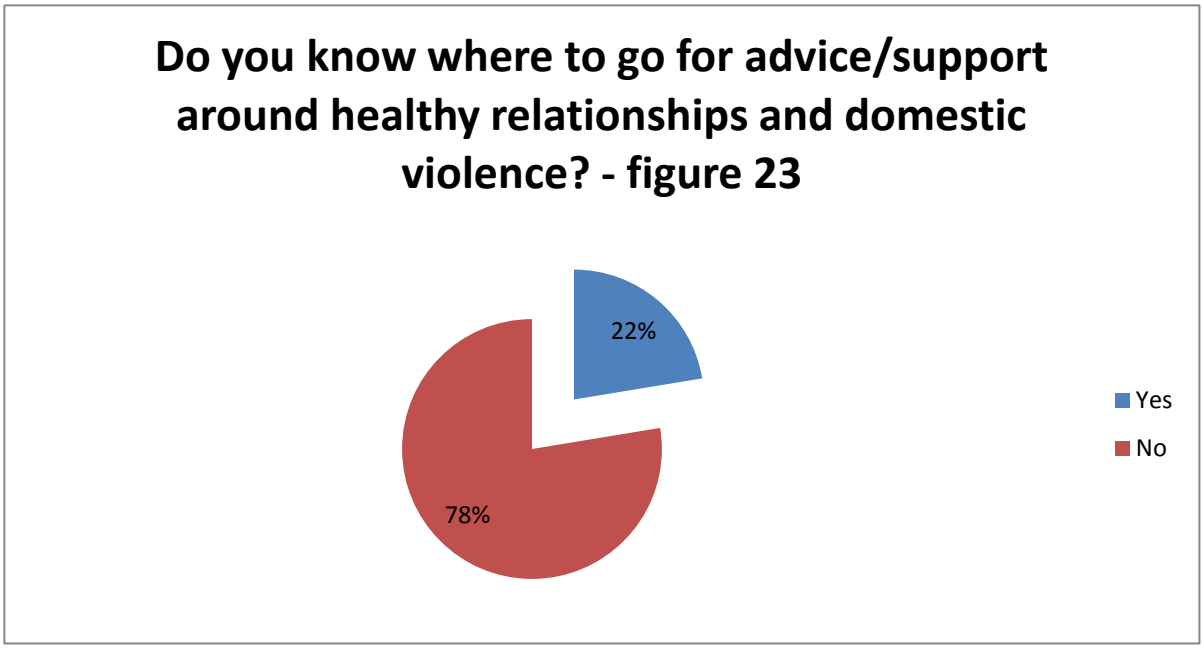


Do you know where to access emergency contraception? - figure 21



Do you know where to go for pregnacy testing? - figure 22a




Do you know where to go for advice/support around healthy relationships and domestic violence? - figure 23
22%
78%
Yes
No

	London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **10 November 2014**
LOCAL SAFEGUARDING CHILDREN BOARD'S ANNUAL REPORT 2013-2014	
Report of the Independent Chair of the LSCB	
Open Report	
Classification – For Review & Comment **Key Decision:** No	
Wards Affected: All	
Accountable Executive Director: Andrew Christie, Tri Borough Executive Director of Children's Services	
Report Author: (name and title) Tim Deacon (LSCB Manager) Victoria Jones (Policy Officer, Triborough Children's Services)	**Contact Details:** Tel: 020 8753 5140 E-mail: tim.deacon@lbhf.gov.uk

1. EXECUTIVE SUMMARY

Working Together (2013) places a requirement on the Local Safeguarding Children Board to send its Annual Report to the Chairman of the local Health and Well Being Board. The report sets out the achievements of the LSCB (2013/2014) against its four key priorities, evaluates the effectiveness of the LSCB overall, describes its activities, and future priorities and comments on the linkage to the Health and Wellbeing Board.

2. RECOMMENDATIONS

2.1. That the Health and Wellbeing Board considers the report and makes recommendations to the Independent LSCB Chair as appropriate.

3. REASONS FOR DECISION

The Health and Wellbeing Board is asked to consider the LSCB Annual Report. The Independent Chair of the LSCB would welcome any response/comment that will help the work of the LSCB and the HWBB.

4. INTRODUCTION AND BACKGROUND

4.1 Local Safeguarding Children Boards have a statutory obligation to compile and publish an Annual Report. This report provides an assessment of the effectiveness of local arrangements to safeguard and promote the welfare of children. It recognises the achievements and progress that has been made in the Local Safeguarding Children Board (LSCB) covering the areas of Hammersmith and Fulham, the Royal Borough of Kensington and Chelsea and the City of Westminster as well as providing a realistic assessment of the challenges that lie ahead. The report illustrates the extent to which the functions of the LSCB as set out in Working Together 2013 are being effectively discharged.

4.2 The Annual Report details both the core functions of the LSCB as well as the priorities that were established in April 2012.
In order to establish the effectiveness of local safeguarding arrangements and of the LSCB itself, the report evaluates standing work of the Board such as training, case reviews and the safeguarding of priority groups. It also measures progress against the LSCB priorities for 2013-14: early help and prevention of harm; better outcomes for children subject to child protection plans and those looked after; practice areas to compare, contrast and improve together; continuous improvement in a changing landscape.

4.3 Safeguarding children requires all agencies working with children and their families to work together – by identifying children who may be at risk of harm, by pooling information to ensure that the clearest possible picture of family functioning and risk to children is obtained, by providing services to reduce the risk of harm to children and by monitoring children to ensure that the risks are reducing. The LSCB key functions are to ensure that the work of key agencies is coordinated and effective and to hold all agencies to account for the quality of their work to safeguard children.

4.4The commitment to ensure that local as well as national priorities are addressed has shaped the work of the LSCB in the past year. The agenda has been progressed successfully through active short life improvement groups and sub groups of the Board. Borough-based partnerships have included a proper focus on local activities and there are developing relationships with the Children's Trust and each of the Health and Well-Being Boards. Increasingly there is a linkage to the Health and Well-Being Boards' priority themes for children, and duplication is avoided, whilst shared priorities are acknowledged. This linkage is key to the LSCB being seen as effective in both governance and partnership.

4.5 This Annual Report was presented to the Hammersmith and Fulham Children and Education Policy and Accountability Committee on the 3rd September .

5. PROPOSAL AND ISSUES

5.1 The report considers the local safeguarding needs of children and how these are met by agencies working together, across the areas of Hammersmith and Fulham, the Royal Borough of Kensington and Chelsea, and the City of Westminster. Agency representation at the LSCB includes several members of the Health and Well-Being Board.

6. OPTIONS AND ANALYSIS OF OPTIONS

6.1 This does not apply

7. CONSULTATION

7.1 All member agencies of the LSCB have contributed to the report which is now a public document.

8. EQUALITY IMPLICATIONS

8.1 No Comment

9. LEGAL IMPLICATIONS

9.1 No Comment

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1 No Comment

11. RISK MANAGEMENT

11.1 Section 13 of the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals (other than the local authority) that should be represented on LSCBs. An LSCB must be established for every local authority area. The LSCB has a range of roles and statutory functions including developing local safeguarding policy and procedures and scrutinising local arrangements. The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area (this is a statutory requirement under section 14A of the Children Act 2004). The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the health and wellbeing board. In producing this report this meets the following risks identified on the Strategic Tri-borough Risk Register, risk number 5 managing statutory duty, risk number 6 standards and delivery of care and 8 maintaining reputation and service standards.

Comments provided by Michael Sloniowski, Bi-borough Risk Manager ext 2587.

12. **PROCUREMENT AND IT STRATEGY IMPLICATIONS**

12.1 No Comment

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	None		

LIST OF APPENDICES:

Appendix 1 – the Annual Report of the Local Safeguarding Children Board

Tri-borough Local Safeguarding Children Board

Annual Report 2013/14 for Hammersmith & Fulham, Kensington and Chelsea, and Westminster

Foreword

This is the second report of the work of the local multi-agency arrangements for safeguarding and promoting the welfare of children and young people across the areas of Hammersmith and Fulham, Kensington and Chelsea and Westminster. The Local Safeguarding Children Board was established as a tri-borough board in April 2012. This report covers the period April 2013 to March 2014.

The LSCB is a statutory body and partnership. It is responsible collectively, as a Board, for the strategic oversight of child safeguarding arrangements by all agencies. It does this by leading, coordinating, developing, challenging and monitoring the delivery of effective safeguarding practice by all agencies across the tri-borough areas. Whilst it is not responsible or accountable, as a Board, for *delivering* child protection services, the LSCB does need to know whether or not systems are working well in each of the agencies so that children and young people are safe and that the services are delivered in a way that makes a positive difference to their lives. That is why it is so important that we continue to build on the mechanisms we established last year to consult and engage with children and young people on the difference services are making.

Members of the Board are very senior managers in each of the statutory and other agencies represented on the Board. There are also four lay members of the Board. I am an independent Chair of the Board and this is my second year in this role. One of the Board's strengths is the commitment and engagement of each of the agencies and the open and honest participation of senior people in the Board's work. All members of the Board want to make sure there are better outcomes for children and young people from both single-agency and multi-agency work; they understand that this will require change and challenge as well as commitment and a continued investment in best practice by front-line staff.

In the conclusion of this annual report you can read about many of the strengths and achievements from the last year. You will also see that there are many areas where we can do even better. The LSCB wants to make sure that the' journey' children and young people take is a safe one and one that equips them well for adulthood. That is why in the next year we will work with other partnership groups so that "safeguarding is everyone's business".

This is a busy LSCB, covering a large and diverse part of London. There are many opportunities for children to thrive and do well and many chances for young lives to be badly affected by circumstances and abusive relationships. The role that front-line work plays in intervening and mediating must be timely and focussed on securing positive outcomes for children. The LSCB takes very seriously learning from case-work, ensuring there is strong management oversight and that there is accountability at all levels for work with children.

So whilst the LSCB is a strategic body, the operational work undertaken by all agencies, singly and together, must deliver on our ambitions for children and young people across the three boroughs. Whilst we focus on early help, child protection and looked after children, we will continue to prioritise an outward focus on learning from others and anticipating key areas for improvement as we develop and deliver on safeguarding in 2014/15.

Jean Daintith
Independent Chair

Contents

Executive summary

This is the second annual review of the effectiveness of the Tri-borough Local Safeguarding Children Board (LSCB) for Hammersmith & Fulham, Kensington and Chelsea, and Westminster.

Working Together 2013 requires each LSCB to publish an annual report on the effectiveness of safeguarding and the promotion of the welfare of children in the local area. The report recognises the achievements and progress that has been made in the three boroughs as well as providing a realistic assessment of the challenges that remain.

The role and scope of the Tri-borough LSCB is considerable. Agencies working with children and families across the three boroughs work well together and have made significant developments to strengthen local safeguarding practice. Key achievements from 2013/14 include:

- ✓ The publication of the Threshold Guidance and a Local Assessment Protocol, for staff in all agencies working with children, to assist in decision making about how to help families with different levels of need.
- ✓ The roll out of the Multi-Agency Safeguarding Hub (MASH) across all three boroughs to help improve decision making at the point of referral, through rapid and rigorous information sharing.
- ✓ Improved multi-agency response to children at risk of sexual exploitation through the development of a Child Sexual Exploitation (CSE) strategy – setting out how agencies will work together – and the introduction of the Multi-Agency Sexual Exploitation (MASE) panel which provides a strategic overview of cases and quality assurance in respect of investigations, case work, and outcomes for children.
- ✓ Strengthening of local safeguarding networks, including better links with voluntary and community sector, through the three local Partnership groups.
- ✓ Establishment of Section 11 panel which has promoted improved standards of safeguarding within partner agencies.
- ✓ Development of the LSCB's training program that includes E learning and new specialist courses, based on local priorities and need.
- ✓ The publication of a regular LSCB Newsletter which is promoted across all agencies.
- ✓ The strengthening of the LSCB's relationship with the community, faith and voluntary sector and specific work on areas such as female genital mutilation and translating services.
- ✓ Young people contributing more significantly to the safeguarding work of the Borough.

Areas for development, or where progress is not as good as the LSCB would want it to be, are highlighted throughout the document and summarised in section 14. Going forward into 2014/15 the Board has agreed that neglect is a cross-cutting theme that needs to be highlighted across all the other priorities. Responding to national issues at a local level, such as female genital mutilation, will also be high on the LSCB's agenda as will getting the local multi-agency response right regarding child sexual exploitation, gangs, missing young people, and suicide risk.

1. Introduction

1.1 This is the second annual review of the effectiveness of the Tri-borough Local Safeguarding Children Board (LSCB) for Hammersmith & Fulham, Kensington and Chelsea, and Westminster.

1.2 Working Together 2013 requires each LSCB to publish an annual report on the effectiveness of safeguarding and the promotion of the welfare of children in the local area. The report will be publically available and submitted to the Chief Executive and Leader of the three local authorities, the local Police and Crime Commissioner and the chairs of the three borough's Health and Wellbeing Boards.

1.3 The annual report should:

- Provide an assessment of the effectiveness of local arrangements to safeguard and promote the welfare of children;
- Recognise the achievements and progress that has been made in the three boroughs as well as providing a realistic assessment of the challenges that remain;
- Demonstrate the extent to which the functions of the LSCB are being effectively discharged
- Include a clear account of progress that has been made in implementing actions from individual Serious Case Reviews.

1.4 In order to establish the effectiveness of local safeguarding arrangements, and of the LSCB itself, the report will evaluate the standing work of the Board – such as training, case reviews, and Child Death Overview Panel – and the safeguarding of priority groups. It will also measure progress against the LSCB priorities for 2013/14 as set out in its Business Plan.

2. Background and Context

2.1 The three local authority children's services within the London Borough of Hammersmith & Fulham (LBHF), Royal Borough of Kensington and Chelsea (RBKC) and the City of Westminster created a Tri-borough Children's Service in 2012 under one Director of Children's Services. This led to the formation of a single LSCB in April 2012. This report therefore looks at safeguarding practice across all agencies in the three boroughs.

2.2 The Board is chaired by the Independent Chair of the LSCB and meets four times a year. The Board includes a range of local agencies which are outlined in Appendix A. In addition to the quarterly meetings, the Board has two half-day development sessions or extra-ordinary meetings and holds special events for members' learning from case reviews. Much of the business of the Board is taken forward by its subgroups which meet between Board meetings. Each borough also retains a partnership group which has an important role in channeling issues up to, and disseminating messages from, the main Board.

2.3 In addition to the standing subgroups the LSCB create short-life improvement groups which consider specific issues of concern to agencies; in 2013/14 the LSCB managed two groups on children missing from home and care and prevention of suicide amongst young people.

2.4 The Board, and the wider work of the LSCB, is supported by a small team lead by the LSCB Manager. The team includes a business support function, Training Officer, and two recently recruited Community Development workers. The LSCB outturn figures for 2013/14 are provided in appendix B. These indicate the financial contributions received from partner agencies and detail the reserves carried forward from the former three borough-based Boards. The expenditure, largely relating to salary costs is shown for 2013/14.

2.5 The LSCB manages its work through its annual Business Plan. The Business Plan is structured around four themes: early help and prevention of harm; better outcomes for children subject to child protection plans and those looked after; practice areas to compare, contrast and improve together; and continuous improvement in a changing landscape.

Priorities for action by the LSCB are informed by the continuous review of performance information and case review, local issues and practice, and emerging regional and national priorities, and agreed through dialogue with all agencies.

2.6 This annual review captures the work of the Tri-borough LSCB in its second year of operation. As the LSCB has continued to established itself as a Tri-borough board, further children's services have been merged across the three boroughs, such as those for Looked After Children. The LSCB has ensured that partners can continue to focus on specific local issues through the borough-based partnership groups whilst retaining oversight.

2.7 The LSCB serves children across three boroughs located in the centre of London where there is a diverse population with extremes of poverty and wealth.

- Between the 2001 and the 2011 Census the population of Hammersmith & Fulham and Westminster has risen. The population of Kensington and Chelsea has declined. The population is LBHF: 182,500 (+10%), RBKC: 158,600 (-0.2%), WCC: 219,400 (+21%).
- Kensington & Chelsea is the country's second most densely populated area (Islington is the most densely populated) Hammersmith & Fulham is sixth and Westminster is seventh.
- The population turnover (churn) is high in all three boroughs: Westminster is the highest in London, Hammersmith and Fulham is the fourth and Kensington and Chelsea is the sixth.
- In Hammersmith & Fulham 20% of the population are aged 0 to 19 years, 19% in Kensington and Chelsea and Westminster.
- An estimated 86,600 children under 16 in the tri-borough: LBHF (+9%), RBKC (-2%), WCC (+33%).
- 23% of all households in LBHF contain dependent children; 19.5% in RBKC and 19% in WCC.
- 15,000 (46%) children in LBHF are from Black and Minority Ethnic (BAME) group; 10,300 (38%) in RBKC and 20,500 (57%) in WCC.
- WCC has seen a 73% increase in the non-Christian under 16s population; 41% in LBHF and 2% in RBKC.
- 17% of LBHF children have other (non-British) national identities; 28% in RBKC and 23% in WCC.
- Foreign-born children made up 14% of all children in LBHF; 21% in RBKC and 19% in WCC.
- All three boroughs have a higher percentage of lone parents not in employment than national (40.5%) and London (47.8%) rates with Westminster ranked second highest nationally (Tower Hamlets has the highest percentage)

2.8 As at the 31 March 2014, across the three boroughs there were:

- 354 children subject to child protection plans. 163 were in Hammersmith and Fulham, 92 in Kensington and Chelsea and 99 in Westminster. Compared with previous years this is a reduction in numbers.
- 476 Children were in Care across the three boroughs. Hammersmith and Fulham (204), Kensington and Chelsea (99), Westminster (178).
- 400 Children became subject to a child protection plan across the three boroughs during 2013-14. Hammersmith and Fulham (195), Westminster (106) and Kensington and Chelsea (99).
- 5,751 referrals were received across the three boroughs Hammersmith and Fulham (1,801), Westminster (2,342) and Kensington and Chelsea (1,808).

2.9 A Tri-borough LSCB works well for partners, in particular Health agencies, who report favourably on the Tri-borough arrangements; in particular in reducing the duplication of senior managers having to attend three different LSCBs. This has also had a positive impact on attendance and strength of input. It is more problematic for the Police at the level of Borough Command and the challenge of this is significant, especially as there have been changes in personnel during the past year. However, for the Metropolitan Police Child Abuse Investigation Team (CAIT) it is an advantage to attend only one LSCB rather than three, especially as the same CAIT covers seven boroughs.

2.10 As a Tri-borough LSCB there is a significant advantage in having best practice, learning and resources from the three boroughs shared across agencies. Three geographically small boroughs would be challenged in having the resources to run three boards with the attendant costs of having specialist posts to take forward some of the work of the Board. For example, it is probable that three single LSCBs would not have the funding to support the part-time development workers for faith and voluntary sector, and children and young people's participation.

3. Governance & Accountability

3.1 The Tri-borough Local Safeguarding Children Board was established in April 2012, so this review accounts for the work of the Board in its second year of operation. Governance arrangements continue to be embedded and were given additional momentum by the publication of Working Together 2013. The guidance highlighted the need for the LSCB to revisit a number of documents that support the Board's governance arrangements. As a consequence, the Terms of Reference of the Board and its subgroups have been refreshed as well as the 'Roles and Responsibilities' of members of the Board. The effectiveness of these new arrangements should be reviewed in 2014/15.

3.2 Over the course of 2013/14 the Board utilised the newly recruited four Lay Members, a representative from Wormwood Scrubs (the local Category B men's prison in Hammersmith and Fulham), and improved the commitment from schools. The four Lay Members have brought independent thinking to the Board as well as input to sub-groups, one of the short-life working groups, the scrutiny panel for Section 11 reports and ideas for web development. Three of the Lay Members have private sector experience and one of them contributes to the community safety arrangements at a local level with the Police. This wider membership has expanded the basis for engagement of local agencies but also presents a challenge to ensure that each is able to contribute and demonstrate their impact at Board meetings.

3.3 The Board has identified the need to be more rigorous in respect of monitoring the attendance of individual agencies and their contributions. Formal arrangements to monitor attendance, at the main Board and subgroups, are being developed, so that there is more formal evidence to present to challenge partners on non-attendance. There were concerns that there was a lack of regular strategic representation at the Board from the Police and Schools. Schools now have three Headteacher representatives and the Police representative attended meetings until the end of the year when she was promoted. It is important that safeguarding is not lost with Policing models changing at a local level. At a subgroup level, the Police have had a lead role in the development of MASH and have been a significant partner in addressing concerns for Missing Children.

3.4 During 2013/14 the Board and Chair have encouraged agencies to challenge each other at the Board meeting. There are various examples of this happening – for example regarding the drop in numbers of children going onto Child Protection plans and challenge towards Health on referrals of female genital mutilation – but on more occasions the Board has questioned, rather than directly 'challenged'. To some extent, this questioning style is indicative of the close relationship between partners operating across the three small boroughs but is also a result of significant day to day challenge outside of meetings and in other informal and formal ways. However, more explicit challenge at Board level is an area for development in 2014/15, with specific actions including:

- Promoting the expectation that individual agencies will evidence where they have made a challenge and for this to be updated in a 'challenge log';
- Subgroups to ensure a robust framework of challenge to improve practice;

- Child protection chairs to evidence their challenge of agencies and how this has made a difference to effective multi-agency working;
- Safeguarding Review Unit to provide the LSCB Quality Assurance Group with data on agency participation at Child Protection Conferences, including provision of reports and attendance;
- Training Subgroup to highlight performance of agencies attendance at training and provision of trainers
- Attendance of agencies at subgroups will be more closely monitored and followed up by chairs and brought to the attention of Chair and Chairs' group.
- LSCB chair will evidence the difference she has made following conversations with senior leaders

3.5 Other opportunities for agencies to challenge partners include through the multi-agency case audits, conducted by the Quality and Assurance Subgroup, which are brought to the Board for scrutiny, and development sessions about the learning from case and serious case reviews.

3.6 The Independent Chair of the LSCB meets regularly with key leaders in the Local Authority, including the Director of Children's Services, Lead Members for Children's Services and the two Chief Executives of the councils (one for Westminster and one joint CE for Hammersmith & Fulham and Kensington and Chelsea), to ensure that the Chair is held to account for the effectiveness of the board. To ensure the robustness of these arrangements a protocol of joint working has been drafted between the LSCB and key partners and partnerships. This document, and steps to secure these arrangements, needs to be agreed by the Board at the earliest opportunity in 2014/15. Opportunities for senior officers outside of the three local authorities, to challenge the LSCB and Chair, at other agencies' board meetings have not been fully utilised. However, the recent work with the Health and Wellbeing Boards gives an impetus to mutual challenge.

3.7 A Joint Working Protocol between the LSCB and the three Boroughs' Health and Wellbeing Boards (H&WB) has also been developed; at the time of drafting this report the protocol has been agreed by Kensington and Chelsea's H&WB but not Hammersmith & Fulham's or Westminster's H&WB. This should be a priority for action. Representatives from the LSCB and H&WBs have met to discuss their respective governance arrangements, priorities and future plans and have started to work together on a H&WB priority regarding parental mental health.

3.8 Demonstrating the impact of both the LSCB and its subgroups on local safeguarding outcomes is an area that needs further work. Although there has been a strengthening of the Terms of Reference of subgroups there needs to be greater challenge of their effectiveness .The subgroups largely meet on a quarterly basis with the focus being on activities such as training ,case review and quality assurance, rather than the priorities of the LSCB .It is intended that the revision of their terms of reference will provide the opportunity for groups to be more challenging and focused on the priorities of the board and business plan.

3.9 The Business Plan for 2014/15 will also be more rigorous in setting SMART targets and specifying the intended impact and outcomes of the LSCB's work. There needs to be greater evidence of clear improvement priorities that deliver improved outcomes. This will be crucial to ensuring that the effectiveness of the board is easier to measure and partners are able to clearly articulate the value of the board.

3.10 LSCB partners should also be able to assess whether they are fulfilling their statutory responsibilities to help, protect and care for children and young people. Holding members to account is evidenced through Section 11 auditing, but this needs to have greater prominence at the whole Board meetings.

3.11 In order to secure the effective engagement of and communication with local partners, a multi-agency Partnership Group has been maintained in each of the three local authorities. The focus of these partnership groups is primarily early help/prevention of harm. Each of the partnerships are in differing stages of development and it would be useful for the chairs of the three partnerships to review the strengths and weaknesses of their groups and share learning and best practice. The chairs of LBHF and RBKC's groups should also consider adopting a clear programme of work, such as that operated in Westminster.

Hammersmith and Fulham's local partnership group was refreshed in November 2012. The group's purpose has been to raise the profile of safeguarding and welfare issues with local staff and practitioners working with children and families.

The group struggled to gain real commitment from all members, but this has improved and members now feel that the group has its own identity. In the past year the group has secured representation from the voluntary and community sector which has improved relationships and ensured their key involvement in the development of the FGM strategy and their contribution in the consideration of other important safeguarding issues i.e. domestic violence. Good engagement with the Safeguarding GP for Hammersmith & Fulham has improved local GP's understanding and response to risk issues.

The group is chaired by the Safeguarding, Review and Quality Assurance Manager for LBHF which means the agenda is often social care focused. The Chair has asked for a co-chair from another agency but this position is still vacant.

The most successful piece of work during 2013/14 for the group has been the development of a local multi-agency strategy on Female Genital Mutilation. Other areas of focus for the group during 2013/14 have been domestic violence and the impact of welfare reform.

Westminster Prevention of Harm

The Director of Family Services chairs Westminster's local partnership group titled 'Prevention of Harm'. The group has clear terms of reference and a good representation from a wide range of agencies. Each year the group sets itself a number of priorities for action which provides clarity of focus for the group. Additionally, the priorities ensure that the contribution of different agencies is clearly identified and this has in turn helped to build and sustain links between partners. The POH group has taken a lead role in developing Tri-borough initiatives around a range of safeguarding issues including early help, parental substance misuse, sexual exploitation, and work in the area of faith and culture.

During 2013/14 the Prevention of Harm partnership group focused on the following priorities: Housing and benefit changes; safeguarding across faith and cultures; parental mental health; parental substance misuse; sexual exploitation; and safeguarding in schools. All workstreams have 'smart' objectives set and are required to report on progress to the group at each meeting. The chair has plans to strengthen the robustness of the group's work by being more rigorous in specifying the outcomes that are to be achieved.

At the start of 2013/14 the chair introduced a 'what is causing you concern?' standing item on the group's agenda. This has given members an opportunity to pause, reflect and raise other issues not on the agenda if they felt that they were of concern and to probe for weaknesses in local safeguarding practice. Although many of the concerns raised are often resolved via signposting the process has raised a number of issues escalated for action by the chair and LSCB.

A key focus for **Kensington and Chelsea's local partnership** has been to understand organisational change and the impact on local safeguarding practice. During 2013/14 a number of partners have made presentations to the group including the Early Help Service, Health Services, and the Probation Service. These presentations have aided local practitioner and manager understanding of the changes and the impact on practice.

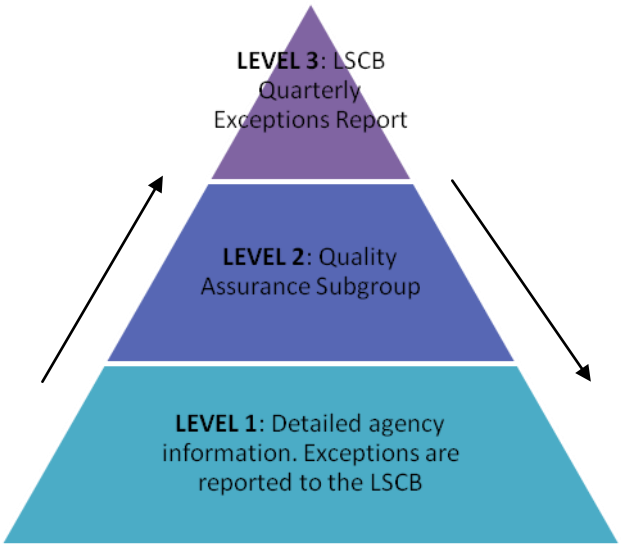
RBKC's partnership is chaired by the Joint Head of Safeguarding, Review and Quality Assurance. A constant core membership, with over ten agencies represented, has been maintained. Representation from the voluntary and community sector has been recently strengthened through the recruitment of a further member from this sector.

Key achievements of the group include:

- The development of a private fostering communication strategy and action plan for 2013-2016. This has informed the development of a Tri Borough strategy.
- Increased knowledge base for partners, and consultation discussion routes into safeguarding team.
- Securing regular attendance at the RBKC GP forum to keep local GPs informed of safeguarding developments and social work practice. One outcome of this improved collaborative working has been the design of a specific GP Report form for Child Protection Conferences to ensure that reports are focused and include the information the network requires.
- As a result of connections through the board, partners are more confident in reviewing multi agency interventions undertaken with families and formulating recommendations for improvement. Anonymously, the cases have been brought back to the Partnership for practice discussions and learning.
- Through the partnership safeguarding issues have been raised, and in particular cases direct challenge has been raised.

4. Quality and Effectiveness

4.1 The Quality Assurance (QA) subgroup takes a lead role in fulfilling the LSCB's scrutiny functions. At the start of 2013, under the direction of a new chair, the QA subgroup launched their Quality Assurance Framework. The framework provides the LSCB with an opportunity to scrutinise key information from agencies across the partnership, incorporating quantitative data, information about the quality of services, and information about outcomes for children, asking: how much, how good, and what difference. Exceptions are escalated up the different levels (see diagram) of reporting, for discussion and decision, with the results fed back down and action followed up by the QA subgroup or individual agencies.



4.2 All members of the QA group have a responsibility to report any concerns about the process of scrutiny undertaken within their agencies and share an ambition to challenge each other and improve the way agencies work together. Engagement by agencies at the subgroup is good; however, sometimes agencies, in particular education and schools, are not represented at the group. A recent initiative to improve attendance at the group has been undertaken by the chair.

4.3 The Quality Assurance subgroup examines a range of safeguarding information in a large data set designed to demonstrate "how much, how good, what difference". The data set has been effective in identifying patterns and themes within interagency safeguarding work. For example, the low child protection rates in Westminster were noted by the board in the July 2013 QA report. As a result, an analysis of child protection trends was undertaken and a report explaining the reasons was submitted to the Independent Chair of the board.

4.4 Some agencies have had difficulty in providing information because: the agency in question collects information regionally or with alternative boundaries and it is hard to distil on a tri or single borough basis; some agencies' systems to collect safeguarding data are still developing, for example aligning the definitions of 'missing' children so that each agency is using common criteria. There are also logistical issues with collating a data set from such a wide range of sources and the supply of regular information, which allows issues to be responded in a timely way. As a result, the QA subgroup has agreed to take agency information in the form that is provided within their organisations. The report includes information about a range of issues including those families in temporary accommodation, crime data, information about MASH activity and health data.

4.5 In addition to the general exceptions report provided to the LSCB, the QA subgroup has conducted a number of multi-agency themed audits of front-line practice concerning specific

Board priorities: in 2013/14 this included domestic violence, children at risk of self-harm and suicide, and children returning home following a period in care. The focus of audits has been closely aligned to topics on the agenda of the Board meetings and short life groups, thus enabling audit findings to supplement other topic related information presented to the Board. The audits have been led by officers independent and external to the LSCB and usually involve up to 15 cases from the three boroughs. The QA subgroup review the audits to identify strengths and weaknesses in current practice.

Spotlight on..... *children and young people returned home having been Looked After*

The majority of children in England enter care as a result of abuse or neglect. The most common outcome for them is to return home to a parent or relative. Research indicates that between a third and a half of children returning home to parents become looked after again for similar reasons and that about a third of those that stay at home still experience poor standards of care, including abuse and neglect.

An audit of 15 children and young people across the three boroughs who had returned home, having been Looked After, during the previous year identified a correlation in factors leading to episodes of care, in particular mental ill health in parents, parental alcohol and/or substance misuse and associated domestic violence. The audit also found that outcomes for children were variable; and concern that in a minority of cases there was evidence that there had not been enough improvement in home circumstances.

The audit demonstrated many aspects of good practice and effective partnership working to return children home from being looked after. It also highlighted potential deficits in direct work to help children make sense of what is happening, the provision of advocacy services, and the early identification of vulnerable children by adult mental health and substance dependency services.

In response to the audit, the LSCB has asked the Tri-borough Family Services leads to undertake further work to ensure there is a more structured framework for multi-agency involvement and sufficient focus on the reunification plan for children who are returning home from care.

4.6 The audits have been instrumental in providing insight into strengths and weaknesses in practice across the three boroughs. Arising from the audits, the LSCB has:

- Established a multi-agency short life working group to examine work with domestic violence victims and their children across the Tri-borough. A separate specific group has looked at the social work response to domestic violence, focusing on two key areas: improved engagement of male partners; building a trusted relationship with the women who are victims in order to avoid situations where they feel they have to lie to social workers.
- Learned lessons about services to children who may be victims of self harm or suicide. The key messages from the audit included a need to focus on early intervention work, not just those children who present at tiers three and four. More positively this audit found that there was good practice in the voice for the child being heard by professionals. The board recommended that multi-agency

networks were effective in ensuring good communication between professionals and members agreed to ensure such meetings take place when children are subject to self harm or suicide.

- The audit looking at young people who were subject to child sexual exploitation contributed to the work being undertaken to adopt a multi-agency response to such young people. As a result of this work, the LSCB endorsed the development of Multi Agency Sexual Exploitation (MASE) meetings, a monthly partnership group meeting led by Police and Social Care.

4.7 Audits identified for 2014/15 will focus on themes of sexual exploitation and neglect.

4.8 The LSCB has held a program of section 11 audits. The Quality and Assurance subgroup also review the outcomes of Section 11 audits that agencies undertake to assess whether they are fulfilling their statutory duties in relation to safeguarding. Members of the QA subgroup have met as a panel to scrutinise the Section 11 agency reports and provide peer challenge to the agency presenting the report. Results are reported to the Board but these could be given more prominence. Examples of good data collection and review through Section 11 audits include:

- Housing has worked collaboratively on Section 11 Audits and now provide specific information in respect of families living in temporary accommodation.
- The Police now provide quarterly returns through the London Safeguarding Board
- Probation has provided Section 11 feedback, which has included audit information.
- The establishment of a Section 11 panel to scrutinise agency S11 reports which reports to the Q&A Subgroup.

4.9 The LSCB only has looked at findings from local authority inspections but there is no systematic collation of inspection information from other partner agencies. (see also sections 11.1-11.4)The LSCB should consider whether to utilise the information from on-going school inspections, and from other agency inspections such as the police and those from the Care Quality Commission.

4.10 Individual agency developments to improve data and information about safeguarding (Level One of the LSCB Quality Assurance Framework) include:

- During 2013/14 Housing Commissioning has developed a 'Safeguarding Action Plan' which includes a number of actions to strengthen quality assurance, improve data intelligence and information sharing across agencies. Safeguarding is also now a standard agenda item at quarterly contract performance meetings with providers and discussed at the wider Strategic Housing Forum.
- During 2013/14 NSH England (NWL Area Team) has set up a Safeguarding Governance Group to monitor risks in the system. This group is chaired by the Chief Nurse. The group considers information supplied by health providers through the Safeguarding Health Outcomes Framework.
- The West London Mental Health Trust has developed and strengthened its quality and performance metrics for all safeguarding functions and embedded feedback mechanisms into governance structures. This has allowed the Trust Board to have greater knowledge of frontline safeguarding and clinical services are better able to reflect on how they discharge safeguarding responsibilities.

- The WLMHT has also developed a reporting mechanism to establish figures for the numbers of adult service users with dependents. This allows teams to narrow its focus on identifying and supporting children living in households where parents have mental illness.

5. Learning and Development

5.1 The learning and Development Group oversees the Tri-borough LSCB multi-agency training programme ensuring that the local children's workforce is equipped with the skills, knowledge and competencies to deliver services to children, young people and families which is based on sound safeguarding practice responsive to local priorities and national developments and learning. During 2013/14 the group has agreed a new Terms of Reference and developed a Learning and Improvement Framework and Strategy.

5.2 The LSCB training programme aims to use the expertise and knowledge of professionals working within the Tri -borough area to design and deliver the majority of the courses. However external trainers are commissioned for some specialist courses. Over the course of the 2014 there have been some changes in the membership and key roles of this subgroup. There is a new chair of the L&D Sub-group and LSCB Training Officer. In order to ensure continuity of the work of this subgroup these changes were managed through robust handover between the outgoing subgroup member and the new appointee.

5.3 As well as running the day to day LSCB training programme a number of projects have been completed during 2013/14, including:

- A review of Multi-Agency Safeguarding and Child Protection (Level 3) course. The purpose of this is to ensure the level 3 training continues to reflect local and national developments, initiatives and learning. Additional updates around MASH, as well as MASE and CSE risks, have been included and refreshed scenario exercises added.
- The development and commissioning of Joint Investigation Training for specific groups of professionals so promoting effective working between police and social professionals.
- The development of an Impact Evaluation Process, which will seek to measure the effectiveness of LSCB training in influencing and improving practice and so outcomes for children and young people. The LSCB is considering adopting the LSCB training evaluation schedule which measures knowledge prior to the course, immediately after the course, and three months afterwards.
- Introduction of a new and improved online Booking System from April 2013 which is more accessible and efficient
- The development of seven e-Learning modules which will be launched in September 2014, including the following modules:
    - ✓ Introduction to Safeguarding Children (Level 1)
    - ✓ Multi-agency Safeguarding and Child Protection (Level 3)
    - ✓ Domestic Abuse
    - ✓ Female Genital Mutilation
    - ✓ Private Fostering
    - ✓ Parental Mental Health and Safeguarding Children
    - ✓ Parental Substance Misuse and Safeguarding Children

5.4 The e-modules were developed to offer a more flexible approach to the delivery of training and to better prepare the delegates attending a course when undertaken prior to attendance. The e- learning modules have been trialed by partner agencies prior to been launched and will be further evaluated in relation to uptake and feedback from delegates. Some e-learning courses will be mandatory prior to face-to-face training and others will be recommended.

5.5 A total of 1697 practitioners and managers undertook training commissioned or delivered by the LSCB during 2013/14. The most popular courses continue to be the mandatory safeguarding courses at level 1 and level 3. Health and Local Authority Children's Services delivered the most courses, totaling 71% of courses across the L&D programme.

5.6 Local Authority Children's Services staff had the highest attendance rate across the programme, accounting for 31% of all attendances. The voluntary sector (13.5%), early years settings (13%) and Central London Community Healthcare (11%) had the next highest attendances. These attendance rates roughly reflect the makeup of the children's workforce. The Police and Probation were underrepresented on LSCB training programmes and the reasons for this will be explored with partners on the L&D Subgroup.

5.7 Feedback from delegates, in relation to mandatory courses is very positive, with 95% of delegates stating that the course objectives were met. Delegates also rated their trainers highly in terms of their subject matter knowledge and understanding. Feedback from delegates is more variable for the specialist courses with responses varying from 90% to 60% stating the course objectives were met. There will be a review of the specialist modules to ensure that all course objectives match the course specifications. There will also be a review of managerial courses to ensure that the right balance between delivery and activities can be established. A planned development for 2014/15 is to conduct 'mystery shopping' of LSCB, and in particular internal agency, training courses to ensure they meet standards.

5.8 The LSCB training offer is continually reviewed to ensure that it responds to local priorities and demands. The L&D team has convened a number of focus groups with training participants, managers, subgroup members, trainers and safeguarding specialists to review the training offer. As a result the content of Safeguarding Training level 3 has been reviewed, and will include information on MASH and MASE arrangements, as well as the LSCB threshold document and local protocol. The focus group also identified that supervisors wanted more in-depth training on specific issues - such as gangs and working with male perpetrators of domestic abuse – and how to supervise practitioners who are working on cases which feature them.

5.9 In response to issues identified in the Faith and Cultures short life working group (potential child protection risks where there are language barriers) the L&D subgroup commissioned a 'interpreting project'. The main focus of the project has been to review how professionals engage interpreters for direct work, case conferences and other multi-agency meetings. The first session with workers will be held in July 2014.

5.10 As a result of national and local serious case reviews three learning events have been held for staff working across the three boroughs. In particular, there has been a focus on chronic neglect, disguised compliance in neglect cases, and the early identification and help for neglect. These workshops are generally very well attended and received by participants. In 2014/15 the LSCB are considering running additional lunch and learn workshops across different venues to engage staff around lessons learned and LSCB priorities for the year ahead.

5.11 A further case review workshop was held in November 2013 for head teachers and school staff regarding the learning from the Daniel Pelka serious case review in Coventry. As a result of the workshop staff from more schools are developing or strengthening a 'Team around the School' approach, identifying children where there are emerging patterns of potential chronic neglect through assessment of risk factors, consideration around thresholds for safeguarding and child protection and improving timely referrals to Early Help Services and/or safeguarding Services. This specific workshop complemented the ongoing safeguarding/CP training at an individual school level, for Designated Teachers and Designated Governors which also incorporated the learning from the Daniel Pelka SCR.

5.12 Information from Section 11 and multi-agency audits has helped to ascertain levels of compliance with safeguarding training and where additional support is required. In particular, the audits identified that most agencies had appropriate induction plans for staff, and signposted appropriate staff to the LSCB training programme. However, many agencies found it more challenging to demonstrate the impact of their training package and how to measure the effectiveness of their in-house training. The L&D subgroup has begun to look at ways to measure the impact of training and will cascade its findings to member agencies once further results are obtained.

5.13 The Section 11 audits have proved to be a useful tool in challenging agencies on their internal training offer and take-up and identifying potential LSCB wide training opportunities. The LSCB will need to ensure that we follow up with individual agencies at the 6 month review meetings where the quality of their Section 11 audit was poor or needed further clarification.

5.14 The new chair of the L&D subgroup has a number of priorities for 2014, including:

- The promotion of training amongst community and voluntary sector organisations to increase take-up;
- A focus on diversity issues such as forced marriage and FGM;
- Safeguarding issues around social media and internet safety
- Linking across to the training programme offered in adult services;
- Impact of domestic homicide;
- Ensuring all agencies have the highest standards in safer recruitment of staff; and
- Developing the L&D dataset to ensure that data reflects the quality of training not just the quantity.

6. Case Review and Child Death Overview Panel

6.1 The **Case Review subgroup** considers how local agencies can learn from national and local case review findings and oversees the implementation of action plans arising from local case reviews. Case reviews are considered in the event of serious injury or death of a child.

6.2 Over the course of 2013/14 the subgroup has finalised one Serious Case Review (SCR), started one SCR, and finalised one multi-agency review in Westminster. The subgroup will be reviewing if this level of activity is reasonable across the Tri-borough or if it is too low and whether this is possibly as a result of thresholds for investigation being too high or if there are unidentified barriers to the subgroup being informed of potential cases to review. The subgroup has also maintained an overview of case reviews led by other LSCBs, where one of the tri-borough agencies had prior involvement as well as prominent SCRs in other parts of the country.

6.3 The completed review of a teenager fatally stabbed by a group of young men identified the need to develop a formal response to safeguarding risks posed by being in a gang, outside of the child protection and case conference structure. A model for adolescent safeguarding has not yet been developed but is something that the Local Authorities' Safeguarding Review and Quality Assurance team will be piloting in 2014/15. All of those risks are currently formally managed and identified, but there is room for a more creative model that looks at how services engage adolescents more in the process.

6.4 The case also identified the valuable opportunity to engage young people at risk of gangs in A&E settings, called the 'Teachable Moment' in US practice. As a result, the Major Trauma Service and the Safeguarding Team at Imperial NHS Trust is working to raise funding for a pilot project involving embedding youth workings in A&E at St Mary's Hospital site; the workers will support victims of gang-related violence and sexual exploitation, facilitating the early identification and help of potential and actual victims.

6.5 A half day workshop for staff across the three boroughs' was delivered to disseminate the learning from two reviews of cases involving the sudden unidentified death of an infant in Westminster and Hammersmith & Fulham. Small, but significant, issues for practice were identified regarding the importance of reflective social work supervision and creating a culture of challenge, where necessary by schools if they feel that a child 's situation is not improving or no action appears to be being taken and the importance of escalating the concerns in these circumstances to Social Care . This learning point has also been incorporated in to ongoing single agency training with schools and has been reinforced by Statutory Guidance "Keeping Children Safe in Education " published at the start of April 2014.

6.6 These reviews also posed wider questions about the engagement of men in safeguarding work, in particular where the man is the perpetrator of domestic violence. The reviews

highlighted that persistence is critical to engage men who wish to remain peripheral to the intervention but are crucial to addressing the safeguarding issue. As a result of this issue being raised, local authority social care teams, with the support of Standing Together, have considered the use of split case conferences in all situations where domestic violence is an issue. As a result there has been better information sharing in conferences and increased confidence that the assessment of risk from the pooled information in the conference is more accurate.

6.7 A further change, following a recommendation from the work of the Case Review Panel, has been to strengthen the response to children (aged 16 and 17) entering the care system due to homelessness. A case review found that the labeling of 'Southwark Judgement Cases' for these young people had in some incidences meant that best practice established in other LAC work was not always replicated for 'homeless' cases. As a result, for example in Hammersmith and Fulham, practitioners responding to the needs of these young people are now managed within social care rather than early help services.

6.8 Over the course of 2013/14 there have been three events for staff to disseminate the learning from Case Reviews and Serious Case Reviews. In addition, the Case Review subgroup presents a report to each LSCB Board meeting; agencies represented on the subgroup and board are expected to report findings and recommendations to colleagues within their organisation. The Chair of the subgroup has identified that the dissemination of learning, in particular to front-line staff, could be made more robust and at the moment it relies on each agency to take the messages forward to their staff. As a result, the chair will publish a 'key lessons' briefing following all subgroup meetings which will be disseminated to staff and placed on the LSCB websites.

6.9 Working across three boroughs does mean that the Board's case review sub-group is always very casework-heavy. Involvement in SCRs across London and beyond, as well as our own learning reviews and any SCRs, make for a significant workload for members of this group and for its Chair. Such a large geographical and busy area is always going to produce a lot of casework and being so 'busy' will remain a challenge and be resource-hungry.

6.10 The **Child Death Overview Panel** (CDOP), which has been operating as a tri-borough initiative prior to the formation of a Tri-borough LSCB, considers the circumstances relating to the deaths of children from the three boroughs and relevant practice implications. During 2013/14 the Panel reviewed 46 cases.

6.11 One of the themes arising from the cases reviewed at the Panel this year has been sudden deaths in infants and the impact of sleeping arrangements. Following the review of a number of sudden infant-death cases, the Panel recommended that Central London Community Healthcare undertake a stock-take of the advice given to parents on sleeping arrangements. As a result, Health Visitors and the Community Midwifery Team have reviewed the information they give to parents and have piloted a New Birth Information Pack, which includes advice on safe sleeping. This pack will be rolled out across all teams in 2014/15.

6.12 Following the multi-agency review into the death of a child with a life-limiting illness, the panel noted the high number of moves into new housing for the family. The CDOP challenged the Local Authorities' Housing Services on their action in this case and their practice regarding families with children with disabilities. The issue was raised at the LSCB Board, as part of the regular CDOP reporting; follow-up of this sort of challenge can be complex for the LSCB. The Chair of the CDOP has identified that while systems for following up on recommendations for Health agencies are embedded, there is further work to be done to ensure the identified actions for other agencies are followed up.

6.13 During 2013/14 the Panel changed its model to reviewing neo-natal deaths. The benefits of this new model include providing CDOP members with a better understanding of medical and multi-agencies issues.

6.14 The Chair of the CDOP has developed strong links with the Clinical Commissioning Groups across the three boroughs which has created a more robust system to monitor Health agencies. The Chair of the CDOP has also established a strong working relationship with the borough's Partnership Boards and the Case Review subgroup.

6.15 Areas for development in 2014/15 include: Identifying areas for research, including neonatal deaths; review feedback mechanisms to parents; and revisit training programme to ensure all agencies are aware of the CDOP process.

7. Engagement and Participation of Children and Young People

7.1 Work to engage children and young people in the work of the Board has been considerably strengthened in 2013/14 since the recruitment in July 2013 of a dedicated LSCB Community Development Officer for children and young people.

7.2 Much of the focus of the officer's work has been to raise the profile of the LSCB, and safeguarding more generally, with children and young people. Particular projects, to raise awareness of the LSCB and safeguarding issues, have included: Epic Children's Forum Safety Tips which address safety at home, at school, outside and when using the internet; workshops at the Hammersmith and Fulham's 'Take Over Day' where young people discussed issues around online safety and 'sexting'; work with the Westminster City Boy's project debating a number of safeguarding scenarios; the development of a children and young people friendly version of the 2013/14 annual review; and the launch of a 'menu of services' for young people to contact if they have any safeguarding concerns. See also sections 11.5-8 for further detail.

7.3 For those who had been engaged in the projects, young people agreed that their understanding of specific safeguarding issues, and the role of the LSCB, had improved.

However, these young people only represent a small proportion of the total child population. To improve reach the development officer has been exploring how the internet and social media could be used. Plans are in place to conduct an online survey in July 2014 and the worker has been closely involved in the development of the LSCB website to ensure that it is children and young people friendly.

7.4 A new focus for the development worker in 2013/14 has been their involvement in section 11 audits, challenging agencies on how well their service development plans are informed by the views of children and families. The Development Officer has created a tracker to document the action and progression of agencies stemming from the children's collected views.

7.5 Individual agency examples of the engagement and participation of children and young people in safeguarding work include:

- Young people's involvement in a review of hostel provision across the three boroughs. Young people reported that they were able to recognise signs of abuse and felt confident in being about to report concerns to staff, social workers or the Police.
- The Epic Children's Forum in RBKC were asked and part-funded by the LSCB to draft a leaflet of 'top ten tips' for other children to 'stay safe': they produced this and DVD.

8. Equality and Diversity

8.1 The LSCB has enjoyed considerable success in strengthening links with communities following the appointment of a Community Development Worker – with a focus on communities – in May 2013. Tasked with building community partnerships, the worker has conducted a number of projects to enable statutory services to better understand the communities they serve, to strengthen the capacity of local voluntary, community and faith groups to safeguard and protect local children, and to help improve the community perception of statutory services with child protection responsibilities – see sections 10.13-10.25 for more detail.

8.2 Priority has been given to making links with voluntary organisations, faith groups and supplementary schools as anecdotal evidence indicated that local communities feel supported by these bodies and place great trust in them.

8.3 Specific developments include:

- Improving cultural competence of front-line practitioners: Each Borough now has a Lead Child Protection Advisor (CPA), who will develop expertise in the areas of safeguarding related to Faith and Culture. The CPAs will be a point of consultation for front-line practitioners across agencies for safeguarding issues relating to Faith and Culture. The CPAs together with the Community Development worker has also formed a working sub-group to drive forward actions in relation to raising awareness and competence of front-line practitioners when encountered with the above mentioned issues. In Westminster, the CPA now attends visits to families with social workers, where there are safeguarding concerns regarding faith and culture; this has ensured

that social workers have access to specialist expertise and are supported to achieve the best outcomes for children and young people.

- Securing Voluntary sector representation at the borough level Partnership Groups. The representatives are in the early stages of establishing themselves on the board and impact of their membership should be evidenced in 2014/15.
- Cascading information from the LSCB to the Voluntary & Faith sector: Each of the umbrella organisations has agreed to disseminate information from the LSCB to individual organisations through their e-bulletins and distribution lists. A database of Voluntary and Faith organisations is also being compiled that can be used by the LSCB to promote information to the sector directly. Over the past year, the Development worker has held a number of presentations about the LSCB, including at Regents Park Mosque and the Islamic Cultural Centre and Shepherd's Bush Mosque, and held discussions with the Diocese of London and Dean of Westminster. As a result of these discussions there is an increased awareness of safeguarding issues among these agencies and relationships have been strengthened.
- A self-audit tool, designed specifically for the Voluntary & Faith sector to assess safeguarding practice, has been identified. This tool is being promoted amongst organisations already commissioned by the Local Authority and it has been agreed to embed these tools within future contracts. A series of workshops to support organisations to use these tools will also be provided.
- Planning for a number of training sessions for practitioners on the effective use of interpreters to front-line teams. The training will be supplemented by 'Best Practice Guidance' that has also been developed, in relation to the use of interpreters. The training has been developed in response to the identification that insufficient or inappropriate use of interpreters was an area of weakness of statutory services in serious case reviews.

8.4 An event in May 2014 is planned to bring the Voluntary & Faith sector and key agencies in the Statutory sector together to discuss how partnership working can be improved to strengthen safeguarding efforts across both sectors. This will follow a launch of a survey to the sector to assess areas of strengths and challenges that front-line practitioners in the Voluntary & Faith sector and statutory sector face in relation to safeguarding. The results of this survey will be used to inform the action plan for the Community Development worker for the next year.(See section10.22 for further detail)

9. Communication and Awareness raising

9.1 The LSCB communication strategy ensures that the LSCB fully discharges its responsibility to: 'Communicate to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so' (Working Together 2013 chapter 3).This strategy covers both 'reactive' (when the LSCB is approached, for example, by the media) and 'proactive' communication.

9.2 The key communication objectives for 2013/14 have been to:

- Promote awareness amongst frontline practitioners, children and young people and our communities of how everyone can contribute to safeguarding and promoting the welfare of children and young people
- inform children of the work of the Board and partner agencies.

9.3 Currently, information about the Tri-borough LSCB, including learning and development opportunities, key contacts, and publications, are located on the three Council's respective websites. This means (in theory) that there are three 'sovereign' representations of the Tri-borough LSCB on the council's individual websites. However, in practice there is no one multi-agency website which is fully developed and there is much duplication of effort to maintain three websites that do not reflect the multi-agency nature of the one LSCB. There have been continued difficulties in the establishment of a tri-borough LSCB website which has meant that the launch of a single micro-site has been delayed; this is expected now in 2014/15. A single online presence will bring together resources and support for parents, carers and professionals on safeguarding issues, as well as streamline the promotion of the work of the LSCB. This will also help develop a clear brand for the multi-agency LSCB and provide a suitable backdrop for articulating its current priorities.

9.4 The LSCB Newsletter is now published on a regular basis, emailed and placed on the three boroughs' LSCB websites. It needs a redesign by the Communication Team to ensure its likelihood of reaching a wider audience. There has been no evaluation of whether it reaches all front-line staff; this should be included in development priorities for 2014/15. The coordination of information could also be more pro-active and additional help has been requested.

9.5 The LSCB has held a number of themed events that encourages sharing of learning and good practice, including two LSCB development days to consider learning from recent SCIE reviews and the effectiveness of the LSCB, and workshops following short-life working groups for child sexual exploitation and young people at risk of self harm. There are plans for two further workshops in 2014/15 on child deaths and child sexual exploitation.

The key messages of the LSCB for 2013/14 were:

- Safeguarding children and young people is everybody's business
- The LSCB is focused on the priorities that improve outcomes for children and young people and is committed to giving every child the best start to improve their wellbeing
- The LSCB is transparent and open in its activities and will promote the sharing of information in order to safeguard children
- When information cannot be shared, the LSCB will make the reasons clear
- The LSCB will work to ensure that children and young people are included in its activities and decision making
- Communications from the LSCB will have a focus on making information available to frontline staff of all partner agencies and the wider community

9.6 On a day to day basis, LSCB officers provide briefings for interested parties on relevant subjects and on the work of the

LSCB, to raise the profile of the LSCB and awareness of safeguarding issues. During 2014/15 presentations were made to the voluntary sector, private hospitals, as part of training to new councilors, included as part of the Karma Nivarna Roadshow on forced marriage, and twilight training sessions for staff.

10. Early help and prevention of harm

2013/14 Business Plan priorities:

- ✓ Development of outcomes framework for early help, to include a threshold document and protocol for assessment
- ✓ Development of the MASH and improved information sharing
- ✓ Improve safeguarding outcomes for children and young people within Black and minority families
- ✓ to ensure that practice in respect of abuse linked to faith or belief is developed
- ✓ Develop more effective safeguarding links within the voluntary sector and with young people
- ✓ Improve links with adult safeguarding services

10.1 The LSCB has a statutory responsibility to assess the effectiveness of help being provided to children and families, including early help. Early help means providing help for children and families as soon as problems start to emerge or when there is a strong likelihood that problems will emerge in the future. The 2013/14 business plan priorities reflect multi-agency priorities towards improving early help services and the early identification and help of children at risk.

Early Help

10.2 The LSCB has overseen a major service review of early help across the three boroughs during 2013/14. The LSCB has been particularly interested in this work to ensure that it has a clearer oversight of early help services across the three boroughs; that the three boroughs have strong 'step-up' and 'step-down' procedures to and from social care services; and that there are transparent thresholds for assessment and support that are understood by all agencies.

10.3 Phase One of the review, completed in October 2013, was mainly focused on Local Authority early help services and included the development of an Early Help Vision; an Early Help Outcomes Framework - based upon six priority outcome areas for children and young people; an Early Help Offer; and an Early Help Thresholds and Local Assessment Protocol, as required by Working Together 2013. Whilst early help services will continue to be delivered and managed locally, the above aimed to identify the most effective processes and interventions and consistently apply them across the three boroughs.

10.4 The LSCB has developed and disseminated Threshold Guidance and a Local Assessment Protocol to complement the pan-London Child Protection Procedures. These provide the baseline guidance for induction and training of staff across all agencies, and act as points of reference for the multi-agency network. In practice, operational understanding of

consistent and shared thresholds and levels of assessment is delivered through the thread of meetings and working relationships that take place at all levels, with a particular focus upon clear and effective step-up and step-down arrangements.

10.5 In Phase One of the review, six working groups were set up to address the key outcomes areas from the Early Help Vision, in order to produce a report that compared and contrasted activities across the three boroughs to identify similarities, differences, good practice, and gaps, and to then put forward a series of recommendations that focus on improving practice. These outcome areas include: prevention of crime and serious youth violence; children to have strong and effective parents; healthy children who thrive at school; improved participation in education and training; prevention of harm and keeping children safe; and improving outcomes for children on the edge of care. An agreed set of performance indicators has been identified so that progress against these six priority outcome areas can be measured. Phase 2 focused upon implementing these recommendations or carrying out further compare and contrast.

10.6 The progress of the working group on 'prevention of harm and keeping children safe' has been of particular interest to the LSCB. During the year, the working group has narrowed its focus to identifying ways to improve the three borough's approach to responding to parental mental health, parental substance misuse, and domestic violence as significant factors in preventing harm and keeping children safe. This work will be taken forward by the Early Help partnership in 2014/15 with the support of the LSCB and the Health and Wellbeing Boards.

10.7 Where Phase 1 of the Review was inward looking, focusing on improved practice across the three local authorities, Phase two has turned outwards in order to engage with key partners to develop a joint vision and offer. A stakeholder event was held to determine better understand stakeholder contributions to the Early Help agenda, introduce the idea of co-ownership and co-design, obtain contributions and thinking from stakeholders about the Early Help Vision, and agree next steps to co-design an Early Help offer that will be jointly owned.

10.8 The commitment to effective Early Help has been driven jointly by the LSCB, the Health & Well-being Boards and the Children's Trust Board; and leadership has been provided by a number of members of the LSCB Board, as well as through its local borough partnership sub-groups.

Multi-Agency Safeguarding Hub (MASH)

10.9 The Tri-borough Multi-agency Safeguarding Hub (MASH) was initially developed in Westminster and then moved to becoming a full Tri-borough service in October 2013. The Tri-borough MASH is already demonstrating the benefits of improved decision-making at the point of referral - thanks to rapid and rigorous information sharing - so that some children benefit from an escalated child protection response when information indicates a higher level of risk, and other children and families benefit from a de-escalated response

which is focused more on assessment of need and support than an urgent child protection response.

10.10 There has been effective co-location of Social Care, Police, Health, and Education staff, together with good virtual engagement from other services such as Probation, Youth Offending and Housing. The MASH team works closely with the operational services in each borough to ensure good and close communication. As the service establishes itself, officers are now working on the added value that MASH can bring to a more consistent and effective approach to Child Sexual Exploitation and Missing Children.

10.11 A key achievement of the MASH has been to develop a consistent approach to threshold of risk for children across the three boroughs. MASH are able to challenge and focus risk thresholds from a subjective, and intelligence based model ensuring that the child remains paramount and that information held by all agencies inform the risk assessment. MASH ensures that children and families receive targeted services which are necessary and proportionate reducing unnecessary intervention. The LSCB receives quarterly quality assurance reports from MASH: information demonstrates that there has been improved information sharing between agencies' which is reflected in the analysis of referrals, compliance with timescales and tracking of cases.

10.12 There is the potential risk that MASH recommendations are not endorsed by boroughs and intervention/services provision is not in line with risk assessments; a 'One size fits all' could result in borough front doors changing the RAG rating or not endorsing MASH recommendations. To ensure that this risk is managed, the MASH will review the Tri-borough Threshold document regularly and update in line with changes and procedures for each boroughs. MASH and

How MASH has improved information sharing.....

Case example 1:

Confidential information sharing in MASH resulted in a statutory assessment, and a change in rag rating from green to amber, when Probation referred to MASH due to concerns that their client had recently begun a relationship with a mother of two children (aged 7 and 6 months). The client was awaiting attending court following a violent assault on family members. As a result of MASH Police checks on the Police National Database, MASH was informed that the client was also involved in the sexual assault of a 14 year old female child for which he was not subject to the Sex Offenders List. Without this information sharing via MASH risks to the children would not have been identified and managed.

Case example 2:

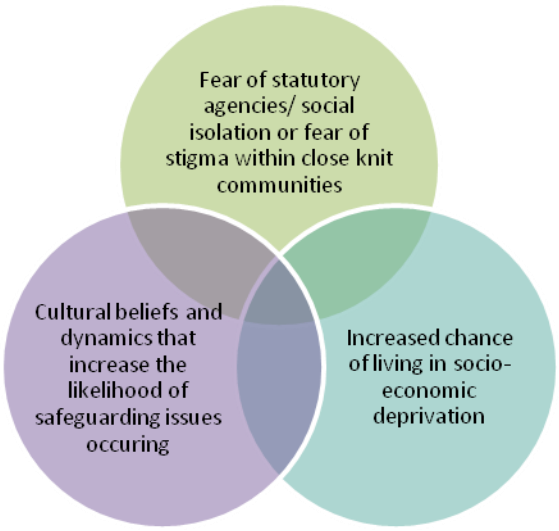
A GP raised concerns to MASH about pregnant mother and 4 yr old child having moved in to the area from Newham fleeing domestic abuse and living in a refuge. MASH was able to ascertain from other professionals details for the unborn baby's father following refusal from mother to give this information. MASH discovered that the father was known to the Police for violence towards previous partners, Robbery and Possession of class A drugs. MASH gave a final rag Amber due to safeguarding concerns for unborn and 4 yr old.

partners continue to build upon relationships and communication to ensure that thresholds are better aligned and any differences are escalated appropriately to relevant managers.

10.13 The LSCB has provided strong scrutiny of MASH as it has developed, with a particular focus upon the performance data in relation to the impact of improved information sharing, the speed with which partner agencies are responding to information requests, and the capacity that the MASH requires from key partners.

Safeguarding outcomes for black and minority ethnic children

10.14 The short-life working group on safeguarding across Faith and Cultures reported to the LSCB in July 2013. The group highlighted that available demographic and front-line practice information indicated the need to consider that some vulnerable children from Black, Asian and other minority ethnic backgrounds were at increased risk by a mixture of socio-economic and cultural factors.



10.15 The working group recommended that the LSCB prioritised building community partnerships in order to strengthen the capacity of communities to safeguarding and protect local children, and to improve perceptions of statutory services. The LSCB Development Worker, appointed in May 2013, has lead a number of initiatives to build community partnerships including direct work with faith groups to raise awareness of the LSCB, improving voluntary sector engagement at the borough level partnership groups, developing self-audit tools for voluntary and faith groups to evaluate their safeguarding processes, improving the cultural competence of front-line practitioners; and delivering training sessions on the effective use of interpreters (see section 8 for more details). It should be noted that this is a long-term piece of work for the LSCB as, by their nature, relationships and perceptions do not develop and change overnight.

10.16 Following a case review in 2012, which identified the need to improve the assessment of children from families where English is not the spoken language, the LSCB has prioritised improving the quality of interpreting services offered to families. Focus groups with community groups and front-line staff identified that the many families are wary of using interpreters because of a fear that private information will be leaked into the community, that they had a poor quality of English and a lack of knowledge of safeguarding terms, and there was little guidance or training for practitioners on how to use interpreters effectively. Guidance, and training sessions, have now been developed and will be ready to roll- out from October 2014.

Safeguarding in relation to faith or belief

10.17 The Safeguarding Across Faith and Cultures working group identified five areas of child maltreatment affecting children from Black, Asian and minority ethnic backgrounds including: so-called honour based violence, forced marriage, female genital mutilation, accusations of spirit possession and witchcraft, and child trafficking. The LSCB Development worker, with a focus on communities, has been taking forward multi-agency action responding to the recommendations highlighted in the report.

10.18 There is often a high correlation with domestic violence in cases of honor based violence and forced marriage. The Faith and Communities subgroup has developed a toolkit to support social workers where concerns are raised and a leaflet for young girls who may be at risk. Advice is also offered to social workers, where appropriate, in a number of cases across Tri-borough where risks have been identified.

10.19 In regards to spirit possession and witchcraft action has been taken to encourage social workers to look more closely at how faith and culture underpin how a family functions and the role of religion in parental response to accepting issues such as illness, bedwetting, and mental health in their children. A toolkit for practitioners has now been created, following an audit of cases in Westminster, to ensure that social workers have a better understanding of how to assess risk and the different cultural considerations that need to be made. Training has also been commissioned for staff on these issues.

10.20 The LSCB has promoted training in child trafficking issues, and in feedback following the course attendees reported an increased awareness and ability to be able to identify cases. Tracking of potential cases is now in place but numbers are very low. The Community Development worker works closely with the Private Fostering Social Worker to ensure that possible benefit trafficking is identified.

10.21 Child Protection Advisors (CPA) are now tracking social work cases where faith and culture issues are a factor. Putting systems in place to track cases has taken considerable effort and although in its early stages of development the tracking has helped to identify: a baseline for further monitoring; gaps in skills or provision of services through the tracking of agency input; and best practice in addressing issues identified. An area for focus in 2014/15 will be developing the expertise of the CPA role and identifying resources to support this work.

Spotlight on..... Female genital mutilation (FGM)

Until 2013, Female Genital Mutilation (FGM) was an area that had received limited attention in terms of developing inter-agency awareness. The Safeguarding in Faith and Cultures Working Group identified that there had not been any criminal investigations across Tri-borough in relation to FGM and that practitioner understanding of the issue was low.

It is incredibly difficult to estimate prevalence when FGM is so rarely disclosed by survivors or routinely asked about by professionals or community groups. FGM is practiced by a number of ethnic communities; in some countries - Egypt, Ethiopia, Somalia and Sudan - prevalence rates can be as high as 98 per cent of the female population. With high levels of migrants from these communities in the three boroughs this represents a significant challenge for local services to prevent FGM and protect children and young people affected by the practice.

Specific pieces of work regarding FGM have been undertaken by the Westminster and Hammersmith & Fulham partnership boards in 2013/14, with the support of the LSCB Community Development Worker. In Hammersmith and Fulham a local Multi-Agency Strategy has been drafted. In Westminster, action has been taken to raise awareness, develop tracking systems, and create an agreed protocol on the response to FGM. Child Protection Advisors in the three boroughs also provide consultation and advice for front-line staff on FGM.

In March 2014 the LSBC agreed to establish a FGM Implementation group with the aim of coordinating local agencies, across the three boroughs, response to FGM, which will be a significant priority for action for the LSCB in 2014/15. The first phase of the group's work will be 'recognition and referral' which will establish an agreed threshold for referral when victims of FGM are identified through maternity, gynaecological or GP services if they have or are expecting a female child. The group will also ensure that the three boroughs have a consistent system in place for recording and tracking FGM cases and referrals so that patterns and outcomes can be identified. Phase two of the group will be a wider focus on embedding good practice, including the full implementation of the Tri-borough FGM strategy and ensuring that the strategy is embedded as part of working culture and mainstreamed as safeguarding practice.

Links with the voluntary sector

10.22 The Community Development Worker has secured agreement from the three borough's voluntary sector umbrella organisations to disseminate information from the LSCB to individual organisations through their e-bulletins and distribution lists. A database of Voluntary and Faith organisations is also being compiled that can be used by the LSCB to promote information to the sector directly. Over the past year, the Development worker has held a number of presentations about the LSCB, including at Regents Park Mosque and the Islamic Cultural Centre and Shepherd's Bush Mosque, and held discussions with the Diocese of London and Dean of Westminster. As a result of these discussions there is an increased awareness of safeguarding issues among these agencies and relationships have been strengthened.

10.23 An awareness raising module, as part of the LSCB Community Development Worker's role, has been developed for staff from faith, community and voluntary groups. The modules have been designed to raise awareness of 'safeguarding' and improve communities' perceptions of statutory services. So far 3 groups have completed the module (including the BME Health forum, Midaye, and Church Street Library) with a further sessions planned in 2014/15. A questionnaire to all known community, voluntary and faith organisations is planned in May 2014 which will inform the work programme of the Community Development Worker in 2014/15.

10.24 To ensure that faith and voluntary organizations meet safeguarding requirements in relation to working with children and young people a standard tool has been developed that all organizations are being encouraged to adopt. The LSCB and Tri-borough Children's Commissioning team are promoting the use of this tool, within all contracts held with these groups, and in 2014/15 will be tracking the progress of organisations in using this tool. Furthermore, following demand guidance has been produced that supplementary schools, voluntary/faith organisations schools can use when writing their safeguarding policies.

10.25 An event in May 2014 is planned to bring the Voluntary & Faith sector and key agencies in the Statutory sector together to discuss how partnership working can be improved to strengthen safeguarding efforts across both sectors. This will follow a launch of a survey to the sector to assess areas of strengths and challenges that front-line practitioners in the Voluntary & Faith sector and statutory sector face in relation to safeguarding. The results of this survey will be used to inform the action plan for the Community Development worker for the next year.

Strengthening links to the Adult Safeguarding Board

10.26 The LSCB has developed a Joint Protocol with Adult Safeguarding Board which has promoted engagement of both boards with each other's work. In particular, there has been joint working within the short life subgroups on domestic violence and in respect to tri borough responses to women and girls affected by domestic violence. There is also now greater sharing of Section 11 feedback from agencies that work specifically with adults.

10.27 The LSCB Chair and the Chair of the new Tri-borough Safeguarding Adults Board attend one another's Boards on an annual basis. They also meet several times a year to ensure key issues are worked on together. This year they met with a Governor from Wormwood Scrubs to ensure Prison Service linkages were established with both Boards. This led to a Prison Service representative joining both Boards. They also pursued together the linkages with Community Safety and there is now a Community Safety representative on the LSCB. Further joint work led to a protocol with the Health and Wellbeing Board and some shared priorities for 2014/15. (See also Section3.7)

11. Better outcomes for children subject to child protection plans and those looked after

2013/14 Business Plan priorities:

- ✓ Achieve good data collection and review
- ✓ Promote the engagement of children, young people, families and frontline practitioners with the work of the Board and their increased participation in safeguarding practice
- ✓ Increase the effectiveness of safeguarding arrangements and improved outcomes for children subject to child protection plans, ensuring we collaborate well in relation to areas of neglect
- ✓ Ensure learning from OfSTED Inspections, Serious Case Reviews and other case reviews

Data collection and review

11.1 During 2013-14 work has continued on the development of the Quality Assurance Framework based on the 2011 London Safeguarding Children Board and Local Government Improvement and Development guidance on developing a 'Strategic Quality Assurance Framework'. The outcomes framework is considered a way of looking at how multi-agency services contribute to improving outcomes in relation to safeguarding children and is intended to help commissioners and providers in the development of services which promote a culture of safeguarding and evidencing improved outcomes for children and young people.

11.2 The Quality Assurance group has provided quarterly reports to the Board which help to understand multi-agency activity data and a thematic approach has been taken in relation to some of the priority areas, in particular domestic violence. See section 4 for a more detailed overview of the work of the Quality Assurance Subgroup in 2013/14.

11.3 The LSCB quality assurance group has worked towards improving information sharing between agencies to enable multi-agency reporting to the Safeguarding Board, but as highlighted in section 4 there have been a number of hurdles to making information truly multi-agency. A thematic approach to the collection of this information has proved to be a valuable way of agencies being able to contribute to the Quality Assurance Group discussion and the report to the board. The Board may wish to adopt this approach more formally over the coming year by developing a schedule of thematic areas for consideration by Quality Assurance group and reporting on a quarterly basis to the Board.

11.4 As the identity of the QA group has developed over the year, agencies have become more active in submitting data. As well as the routine multi-agency data on child protection planning, the quarterly report has included data from the following agencies: the police who have provided crime statistics; the MARAC in relation to numbers of families for whom this multi-agency forum has been working with; routine reports from the MASH; housing information including numbers of families who are homeless or in temporary accommodation; and health performance data.

Engagement of children, families and practitioners with the work of the board

11.5 Work to engage children and young people in the work of the Board has been considerably strengthened in 2013/14 since the recruitment of a dedicated LSCB Community Development Officer for children and young people (see section 7 for more information). Particular projects, to raise awareness of the LSCB and safeguarding issues, have included: a 'top safety tips' DVD; workshops at the Hammersmith and Fulham's 'Take Over Day' where young people discussed issues around online safety and 'sexting'; work with the Westminster City Boy's project debating a number of safeguarding scenarios; the development of a children and young people friendly version of the 2013/14 annual review; and the launch of a 'menu of services' for young people to contact if they have any safeguarding concerns.

11.6 Further work is needed to ensure that the meetings of the Board and subgroups are at times that are suitable for children and young people to attend. The Board has however attended events and activities that have been specifically set up for children.

11.7 Parents and families are not directly engaged with the Board, although one of the lay members is a local parent; however, through the Section 11 audit process the LSCB has sought to scrutinise agencies' engagement with families and the use of their feedback in the development of services.

11.8 Practitioners have been engaged in the work of the Board though: the LSCB's short-life working groups on CSE, missing children, domestic violence and children at risk of self-harm; local partnership boards; through LSCB feedback and surveys; at learning events; feedback in respect of training; and through engagement in reviews, e.g. case reviews.

Safeguarding arrangements and improved outcomes for children

11.9 The QA subgroup has conducted a number of multi-agency themed audits of front-line practice concerning specific Board priorities: in 2013/14 this included domestic violence, children at risk of self-harm and suicide, and children returning home following a period in care. The audits have been instrumental in providing insight into strengths and weaknesses in practice across the three boroughs. Audits identified for 2014/15 will focus on themes of sexual exploitation and neglect.

11.10 Identifying the early signs of neglect has been a focus for agencies on the Board. As part of this, during 2013/14 Imperial College NHS Trust has reviewed its 'do not attend' policy for children; now GPs and referrers are notified of all children who are not brought for their

out-patient health appointments so that cases of potential neglect can be identified at an early stage. Social workers are also informed when the child is on a child protection plan. A discussion paper on neglect is planned for presentation at the Board in July 2014.

11.11 Achieving better outcomes for children subject to child protection plans and those Looked After is the core business of the three local authorities children's services. During 2013/14 a number of senior appointments have been made to secure further Tri-borough improvements to service delivery and standards, including the Tri-borough Assistant Director for LAC and Care Leavers, and Children with Disabilities. The Safeguarding, Review and Quality Assurance Service is looking to further restructure on a Tri-borough basis, initially at a service management level.

11.12 In addition to the above, the three boroughs' Family Services embarked on a new initiative titled 'Focus on Practice', a major programme for the next two years. The programme, for all tri-borough practitioners, will focus on a range of areas to improve practice and outcomes for children and families, including re-referrals and reducing demand on high need/high cost services. The programme will involve a review of evidence-based practice and will involve identifying opportunities for partners to work together to strengthen and improve practice.

11.13 Within the central Child Abuse Investigation Team (CAIT) there are three Police Conference Liaison Officers (PCLO) who attend initial and repeat case conferences on behalf of the Police. Due to a recruitment freeze the team is currently under-capacity, and while a PCLO attended all initial case conferences, attendance rates at repeat conferences was lower than expected. A priority for 2014/15 will be recruiting two new PCLOs and improve attendance at repeat child protection conferences.

11.14 Individual agency contributions to improving outcomes for children with child protection plans or who are looked after include:

- The production of a DVD for young people, as part of Housing's Homeless Prevention Programme. There has also been a strong focus on mediation to ensure that where possible, and safe, young people can remain at home. This work has fed into edge of care work and has seen a reduction in the number of homeless presentations, particularly for 16/17 year olds.
- Negotiations between NHS England (NWL Team) and prisoner and offender health teams to improve services and support on offer for children becoming looked after through being placed on remand and for LAC who offend.
- The Metropolitan Police Service, with partner agencies, is currently evaluating the effectiveness of the Child Risk Assessment Model (CRAM) in accurately assessing the risk in cases and what improvements can be made, if any. Results will be shared with the LSCB in 2014/15.
- The CCGs have commissioned a review to look at the effectiveness of LAC Health provision in 2014/15. This will build on the review of the LAC Nurse role in 2013. The LSCB should scrutinise the outcome of the review at a future board meeting.

Learning from inspections and case reviews

11.15 The LSCB has held two development days for Board members during 2013/14: one to help the LSCB examine the standards expected of a good children's service, and attended by a member of the Ofsted team; and one to promote learning from case reviews. In the forthcoming year there are two further days planned to learn from Peer Review and work in respect of Children at risk of Sexual Exploitation.

11.16 Over the course of 2013/14 the Case Review subgroup has finalised one Serious Case Review (SCR), started one SCR, and finalised one multi-agency review in Westminster (See Section 6 of the report outcomes from the Case Review Subgroup in 2013/14). Learning from the subgroup is disseminated through learning events, briefings, and messages forwarded within agency newsletters and bulletins. The reach and effectiveness of current communication methods with front-line staff should be reviewed in 2014/15. Key learning from the subgroup has been:

- The development of a formal response to safeguarding risks posed by being in a gang, outside of the child protection and case conference structure;
- The need for embedded youth workers in acute settings to support victims of gang related violence and sexual exploitation;
- The review of advice given to new parents about sleeping arrangements
- The need to improve the engagement of men in safeguarding work, in particular where domestic violence is a significant safeguarding issue.
- Strengthening the safeguarding response to young people presenting as homeless.

11.17 In December 2013 Tri-borough Children's Services Senior Leadership Team commissioned a 'mock' Ofsted Inspection of the three Local Authorities Children's Services as part of their preparation for the real thing – both to evaluate the performance of services in the light of the new single inspection framework and also to test their readiness to handle the demands of an inspection. The LSCB will also undertake a similar exercise in June 2014.

12. Practice areas to compare, contrast and improve together

2013/14 Business Plan priorities:

- ✓ Improve practice in respect of children who go missing
- ✓ Improve practice in respect of children at risk of serious self-harm and suicide
- ✓ Improve the safeguarding of children and young people at risk of sexual exploitation
- ✓ to improve outcomes for children who are vulnerable from adults within the Criminal Justice System

12.1 Since 2012, organisations working across the three boroughs have sought to strengthen practice by using a compare and contrast process, to identify the best practice across and outside the three Local Authorities and where there is a business case for it, to merge services so that they provide a single Tri-borough service. A secondary aim of 'Tri-borough' arrangements has been to preserve front line services in the face of budget reductions through efficiencies generated by shared management, merged services and more effective practice.

Missing children

12.2 At the start of 2013/14 the LSCB initiated a short life working group focusing on missing children. This followed the local and national interest in outcomes for missing children, an Ofsted peer review on practice in Westminster, and work undertaken nationally by ACPO and Ofsted. The initial focus of the group was to agree on a definition of a 'missing' child, identify responses of different agencies to missing children, and suggest improvements to multi-agency working. This phase of work was reported back to the LSCB in January 2014.

12.3 The Group generated a protocol and a new dedicated post for missing children. The Group identified that MASH, on behalf of the LSCB, with their multiagency risk assessment responsibility, is in a strong position to asssist front line staff and the Police Missing Persons Team.The working group suggested that this improvement in multi-agency working as well as other practice initiatives will promote an improvement in the engagement of both police and Social Care with young people and lead to a reduction in the numbers of children at risk of going missing. There has also been effective collaborative work with the Police to ensure good risk assessments and plans for when a child returns.

12.4 The LSCB agreed that the Family Services Director for Westminster would take forward phase two of this work in 2014/15, including the following activities: to agree a tri-borough work flow for missing children; to lead on engagement with the Police and other agencies; to implement a multi-agency Missing Children Protocol; and ensure multi-agency practice

is implemented. It is anticipated that this will create a more robust system for children reported missing from care and home.

Spotlight on..... domestic violence

Following findings from case reviews and a subsequent multi-agency audit of child protection cases during 2013/14 the LSCB initiated a short-life working group (SLWG) on Domestic Violence. While domestic violence has been a long known common theme in safeguarding work, the LSCB agreed that a targeted SLWG would provide focus for progressing change in this important area.

Arising from case reviews, there were questions raised about the need for different practice in child protection conferences given the potential for family members to be silenced or subject to further violence. The review report commented "Case conferences with the perpetrator attending undermined information sharing...because of the risk of triggering further violence". It also raised another issues regarding local agencies policies having the effect of prioritising confidentiality over information sharing. The reviews also raised questions about the role of perpetrators of domestic violence and if it was realistic to include requirements in CP plans that the perpetrator should not be in the home.

The multi-agency audit of nine cases found that in the small sample of children who are at risk of harm from domestic violence, services had demonstrated some improved outcomes, especially in relation to physical health and ability to engage and learn at school. However, in other cases improved protection from violence is yet to be secured. However, the overall approach to work is characterised by an absence of engagement with a key party - that is the abusive partner/ father. This necessarily limits ability to manage risk and certainly to confront and resolve it.

Considering the evidence from the case review, audit and consultation with LSCB members the SLWG will be tasked with: evaluating the impact that multi agency work has on improving the outcomes for children and young people who live with domestic violence; identifying areas for improvement and establish an implementation plan to drive forward these improvements; ensuring that children and young people are included in the work of the group; and considering equality and diversity needs of children and young people living with domestic violence

By October 2014, the SLWG is expected to: present findings to the LSCB outlining areas of practice to develop for 2014-16; develop a brief LSCB Best Practice Guidance document; provide a briefing based on the findings for Partnerships and agencies responsible for commissioning services in relation to domestic violence; and develop a protocol to establish links between Strategic Partnerships for DV, Safeguarding Adult Board and the LSCB to ensure that there is a clear pathway for sharing data collection.

Self-harm and suicide

12.5 In April 2013, the LSCB identified the need for a specific working group to review multi-agency practice in relation to deliberate self-harm and suicide prevention among children and young people. This followed the tragic deaths of two adolescents which had been

reviewed by the Case Review Sub group, and concerns across London in dealing with children exhibiting self harm behaviours with a risk of suicide.

12.6 The SLWG engaged with partners working with CYP to identify good practice, gaps in provision, and identify multi-agency solutions. Particular areas for focus included the review of the outcomes of two incident reviews; the lack of coherent data on local needs in relation to self harm; the rise in deliberate self-harm reported nationally; and the risks to partnership working following various national and local reorganizations in a number of agencies.

12.7 The final report of the working group was presented to the LSCB in April 2014. A number of actions – including the producing of practice guidance, an agreed dataset, engagement with schools, and training package – are being taken forward by the group which is due to report back to the Board on progress made at a 2014 meeting.

Child Sexual Exploitation and sexual violence

12.8 A short-life working group to review multi-agency practice in relation to young people affected by sexual violence and gangs and sexual exploitation provided its final report to the LSCB in June 2013. The group was initiated as local agencies recognised that the three boroughs each had a range of initiatives underway and that the safeguarding needs of adolescents, especially looked-after young people and care leavers, are complex and challenging, requiring a different approach from child protection work in younger age groups.

12.9 The group identified three key strands of work to promote a reduction in youth violence and sexual exploitation across the three boroughs, noting that these strands of work need to be considered alongside other related LSCB workstreams such as children who go missing and children at risk of self-harm. These strands included: a need for improved preventive work through the engagement of schools and local communities; improve multi-agency partnership working around youth violence and sexual exploitation; and improve the wider framework for agencies working together.

12.10 Alongside this, the LSCB commissioned the development of a Child Sexual Exploitation (CSE) Strategy, which was published in early 2014, and agreed to adopt the new Pan-London Child Protocol. This was to ensure that a shared approach to tackling child sexual exploitation was taken across all agencies.

12.11 The work plan arising from the short-life working group is now being coordinated through the Multi-Agency Safeguarding Hub (MASH) & CSE Sub-Group (of the LSCB). Since being established, the group has developed and published guidance on CSE referral pathways and the role of the newly created Multi-Agency Sexual Exploitation (MASE) Panel meetings. The MASE Panel, which started to meet monthly from January 2014, is jointly chaired by the Police and Tri borough sexual exploitation lead within social services; the panel has a strategic over view of cases and provides quality assurance in respect of investigations, case work and outcomes for children and young people.

12.12 Multi-agency training on CSE has been incorporated into the LSCB training and development schedule to ensure staff have an improved awareness of to identify and respond to cases. Individual briefing sessions on CSE have also been held for staff working in Housing.

12.13 The Metropolitan Police Service has created a dedicated Child Sexual Exploitation team to deal with the most serious allegations of CSE. The team works closely with partner agencies and employs a number of tactics to protect children. These include full intelligence and background profiling, disruption techniques to thwart those trying to exploit children, interviews with victims and provision of support and safeguarding, as well as the prosecution of offenders.

12.14 The first Tri-borough 'Problem Profile' has been produced to provide the LSCB with a clearer analysis of the prevalence and nature of CSE that local services are currently addressing.

Outcomes for children who are vulnerable from adults within the Criminal Justice System

12.15 Children are vulnerable to adults within the criminal justice system (CJS) in generally two ways: first, and most common, children of adults involved in the CJS may be more vulnerable to poverty, abuse and poor life chances. The siblings of those involved in serious youth violence and gang activity may be vulnerable by association. Secondly, children may be vulnerable to adults who target children for the commission of offences, often of a sexual nature, and may either be known to the offender or randomly targeted through circumstance.

12.16 Outcomes for the first group of children are improved when the agencies working with a family unit communicate well and openly and that there is face to face liaison between the agencies. By working with the adults and seeking to improve their life circumstances, the Probation Service can also improve the prospects for the children involved. The key to improved outcomes for children in these circumstances is:

- Effective identification of the children involved with adults in the CJS
- Competent and comprehensive assessment of the risks posed
- Identification and liaison with other agencies involved with the children and their families
- Effective intervention with the adults to improve their circumstances and by association those of the children.

12.17 For the second group of children, the victim may be a random selection and therefore protection of the child relies on good management of the perpetrator concerned. Most of these offenders will be subject to the local Multi-Agency Public Protection Arrangements (MAPPA) facilitated by the Local Authority, Police, Probation Service and Prison Service. A management plan will be in place for each MAPPA case and the risks are assessed on a sliding scale. Those cases with the most serious risks are managed at Level 3 and this involves a regular review at a minimum of every six weeks with all agencies involved meeting together. Where specific children are identified as being at risk, liaison with relevant LA services can take place.

12.18 A continued gap in the effective identification of children involved with adults in the CJS is the Probation Service's case recording systems; at present the case record system does not quantify how many cases are flagged for a contact with children's services nor how many cases have contact with children. The Assistant Chief Officer of London Probation is raising this with the national probation service as a priority area for addressing.

13. Continuous improvement in a changing landscape

2013/14 Business Plan priorities:

- ✓ Good representation of all agencies at LSCB and within its subgroup activities. This should include the strengthening of links between the LSCB and the local partnership boards, Health and Well Being Boards, Public Health and with the Judiciary
- ✓ To strengthen links with Youth Offending Services and develop an understanding of the issues for children in the secure estate
- ✓ Continue to identify and respond to the safeguarding implications of Housing Reform on vulnerable children
- ✓ Establish and respond to changes in the local safeguarding arrangements for Probation and Police
- ✓ promote improved safeguarding practice in schools, ensuring learning from case reviews, and the development of quality assurance, support, challenge and training

13.1 The landscape of services delivered and commissioned locally for children and families has gone through unprecedented change over the past few years. Understanding the implications of and identifying any risks for the safeguarding of children, which are presented by these changes, is complex and ever evolving. The LSCB has prioritised a number of activities within its business plan to ensure that the LSCB plans and continually reviews the quality of services, and that risks presented by the changing landscape are mitigated.

Good representation and strengthening of links

13.2 Over the course of 2013/14 the Board recruited four Lay Members, a representative from Wormwood Scrubs (the local Category B men's prison in Hammersmith and Fulham), and improved the commitment from schools. This wider membership has expanded the basis for engagement of local agencies but also presents a challenge to ensure that each is able to contribute and demonstrate their impact at Board meetings.

13.3 The three Clinical Commissioning Groups' (CCGs) membership of the LSCB has been strengthened through the presence of the Director of Quality and Patient Safety and the Associate Director for Safeguarding. The CCGs' Safeguarding Team development has also increased capacity of health representation at the LSCB subgroups. The CCG Safeguarding Team host a range of health groups focusing on safeguarding children at operational and strategic levels. The key purpose of these meetings is to disseminate LSCB messages, challenge Health response to LSCB priorities, and consider wider national safeguarding priorities.

13.4 The Board has identified the need to be more rigorous in respect of monitoring the attendance of individual agencies and their contributions. Formal arrangements to monitor attendance, at the main Board and subgroups, are being developed, so that there is more formal evidence to present to challenge partners on non-attendance.

13.5 The well established Westminster 'Prevention of Harm' partnership group is led by Westminster's Director of Family Services and has a strong business plan. It has taken a lead role in developing Tri-borough initiatives including early help, parental substance misuse, sexual exploitation, and work in the area of faith and culture The Kensington and Chelsea and Hammersmith & Fulham partnership groups are well represented multi-agency groups that discuss and disseminate key LSCB documents. It is expected that the Partnership groups will share best practice and review their terms of reference to ensure that they are more challenging and focused on the priorities of the main LSCB.

13.6 To ensure the robustness of governance arrangements a protocol of joint working has been drafted between the LSCB and key partners and partnerships. This document, and steps to secure these arrangements, needs to be agreed by the Board at the earliest opportunity in 2014/15. Opportunities for senior officers outside of the three local authorities, to challenge the LSCB and Chair, at other agencies' board meetings have not been fully utilised. However, recent work to engage Health and Wellbeing Boards gives an impetus to mutual challenge and will need to be followed up by HWBBs as well as the LSCB.

Strengthen links to Youth Offending Service and issues for children in the secure estate

13.7 The LSCB Independent Chair, the Youth Offending Service (YOS) Manager, and one of the Directors for Family Services met with the Governor, and several of their team, at Feltham (Young Offenders Institute). The LSCB Chair had requested this meeting to be organised by the Chair of Hounslow LSCB, specifically because of the fact that the Tri-borough LSCB covers an area that has the highest number of young people in Feltham of any other LSCB. The outcome has been not only an improvement in engagement about young offenders from the YOI but better planning for transfer and release. The YOS was concerned about gang-related activity by young offenders in the YOI and has now delivered training programmes for staff at the YOI about 'handling' this with our young offenders.

Responding to Housing Reform

13.8 Safeguarding vulnerable children and families has had a strong focus across the wide range of housing services provided across the tri-borough. This includes all boroughs having robust protocols in place to work with Children's Services for the most vulnerable households in housing need, providing young people leaving care with a wide range of housing and support options, using bed and breakfast accommodation now only as a last resort, providing a co-ordinated service providing housing advice and employment services to those households affected by welfare reform, ensuring all front-line staff are trained in safeguarding practice and prioritising overcrowded households for moves into larger accommodation.

Spotlight on housing.....

There is an acute shortage of accommodation across the three boroughs which is affordable to households on low or modest incomes. House prices and private sector rents have risen dramatically over the last few years and the three authorities are the most expensive places in the country to live. This has intensified the pressure on the limited affordable accommodation available and on the three housing services. To this has been added the impact of the Government's welfare reform programme;

- Local Housing Allowance and caps on Housing Benefit payments which have restricted the benefit available to private sector tenants, with the effect that many of these tenancies have become unsustainable;
- The Introduction of the Overall Benefit Cap of £500pw for families and couples and £350pw for single people, with the difference between these amounts and previous entitlement being made up effectively by reductions in Housing Benefit;
- Removal of the Spare Bedroom Subsidy for social housing tenants, which for those deemed to be under-occupying their home has led to a reduction of 14 % (1 spare room) or 25% (2 spare rooms) in their Housing Benefit;
- The imminent introduction of Universal Credit (a limited rollout has already started in LBHF) which will replace a number of different benefits and credits with one single monthly payment and will eventually affect tens of thousands of households in the three boroughs.

In Housing terms, the combined impact over the last few years of the housing market position and the welfare reform programme has been:

- The loss of private sector tenancies by households on low incomes;
- Increased pressure on the homelessness services of the three authorities;
- Increased difficulty in securing good quality temporary accommodation in-borough and the need to procure it primarily in other parts of London;
- Increased difficulty in avoiding the use of Bed and Breakfast accommodation for homeless families;
- Greater demands from social tenants to downsize and to move overcrowded families into more suitable accommodation.

13.9 Provisions for safeguarding vulnerable children and families across the wide range of housing services provided within the three boroughs have been sustained against a background of challenging changes in the local housing environment. In response to these pressures the three Housing services in 2013/14 have:

- Dramatically reduced or (in two cases) eliminated the use of B&B for families;
- Reached a position in which there are no families in B&B which have been there for over 6 weeks;
- Adopted systems of suitability assessments in which before placements of families are made into either temporary or permanent accommodation there is a full assessment of the suitability of the offer in terms of its quality, type, size, location and cost, taking into account the needs of the family, including children; Adopted

protocols which involve Childrens and Adults services in decisions about individual households affected by welfare reform;

- Implemented moves for under-occupying and overcrowded households;
- Sustained programmes for the provision of supported accommodation for people with particular housing requirements, e.g. children leaving care, people with mental health issues or people with a physical or learning disability.

Establish and respond to changes in the local safeguarding arrangements for Probation and Police

13.10 The Probation Service has provided a number of updates to the Board during 2013/14 concerning the split of the service into two separate organizations. From 1 June 2014 the National Probation Service (NPS) will manage all court work, any high risk offenders and those subject to MAPPA. The Community Rehabilitation Company (CRC) will manage medium and low risk offenders. Currently both organisations are in public ownership but the Government plans to sell the CRC to the private sector and the tendering and bidding process is underway. This sell off is likely to occur at the end of 2014 with an effective start date of April 2015.

13.11 Both new organisations are currently working to the policies of the former Probation Trust but in time both will need to develop their own. This split will present challenges for safeguarding and child protection as the LSCB and three local authorities will have to develop liaison arrangements with both organisations. Both organisations will be managing cases where work with children is necessary. Indeed it is expected that many domestic violence perpetrators will be managed within the CRC.

13.12 Locally, within the Tri-Borough, it is expected that all Probation staff responsible for case management of offenders will partake in the training programmes offered through the LSCB. This expectation is written into the appraisal planning cycle. These arrangements will need to be developed with both new organisations (CRC and NPS).

13.13 The Health Service has also undergone a year of establishing itself, following significant changes in its structure. The key lesson for CCGs has been to develop leadership across the health economy in an increasingly complex commissioning environment. This is a recognised challenge for the CCGs in ensuring that appropriate links and influences are maintained in order to continue to develop the golden thread of safeguarding throughout the whole health system. This should be reviewed by the LSCB in 2014/15.

Promote improved safeguarding practice in schools

13.14 The Tri-borough Safeguarding in Schools and Education Officer has taken a lead role in promoting improved safeguarding practice in schools.

13.15 A number of maintained and independent schools have conducted audits of their safeguarding practice during 2013/14. Maintained Schools are participating in self-audits

(Section 175) regarding the effective delivery of their safeguarding responsibilities. This provides the opportunity to share good practice across schools and to pick on any emerging themes or gaps to inform future training. The audit programme also includes Independent Schools (section 157). The outcomes are being reported back to the LSCB via the Q&A Subgroup. To promote the use of the audit tool, and to improve the number of schools engaging in this agenda, the Safeguarding in Schools and Education Officer will be focusing on a different phase of schools each school term during 2014/15. All schools will be asked to complete the audit tool which will then be followed up with learning events to share best practice, identify gaps or where further support is needed, and to share current guidance and information on priority areas for the LSCB, such as FGM, CSE, e-safety and work around faith and culture.

13.16 A case review workshop was held in November 2013 for head teachers and school staff regarding the learning from the Daniel Pelka serious case review in Coventry. As a result of the workshop staff more schools are developing or strengthening a Team Around the School approach, identifying children where there are emerging patterns of potential chronic neglect, through assessment of risk factors, consideration around thresholds for safeguarding and child protection and improving timely referrals to Early Help Services and /or Safeguarding Services. This specific workshop complemented the ongoing safeguarding /CP training at an individual school level, for Designated Teachers and Designated Governors which also incorporated the learning from the Daniel Pelka SCR.

13.17 The Team Around the School approach has also afforded the opportunity to consider more complex issues across a particular school population regarding risk factors associated with eating disorders, social networking, cyberbullying and suicidal ideation through an enhanced Team Around the School approach by extending the agency representation to include CAMHs and streamlining referral pathways.

13.18 Representatives from MASH have contributed to single agency training for Child Protection training for schools. Schools have very much valued this input and have reported a much clearer idea of the role of MASH which has in turn strengthened schools' engagement and communication with the MASH.

14. Conclusion and future priorities

14.1 This information submitted and presented in this annual review demonstrates that the LSCB for Hammersmith & Fulham, Kensington and Chelsea, and Westminster fulfils its statutory responsibilities in accordance with Children Act 2004 and the Local Safeguarding Children Board Regulations 2006. This Review is evidence that the LSCB has coordinated the work of agencies, represented on the Board, for the purposes of safeguarding and promoting the welfare of children in the area. The review also captures the mechanisms the LSCB has in place to ensure and monitor the effectiveness of what is done by agencies to safeguard and promote the welfare of children across the three boroughs.

14.2 The role and scope of the Tri-borough LSCB is considerable. Key achievements from 2013/14 include:

- ✓ The publication of the Threshold Guidance and a Local Assessment Protocol.
- ✓ The roll out of MASH across all three boroughs.
- ✓ Development of CSE strategy and MASE panel.
- ✓ The work to strengthen agencies response to missing children and child sexual exploitation.
- ✓ Strengthening of local safeguarding networks through the three local Partnership groups.
- ✓ Establishment of Section 11 panel which has promoted improved standards of safeguarding within partner agencies.
- ✓ Development of training program that includes E learning and new specialist courses.
- ✓ LSCB Newsletter promoted across all agencies.
- ✓ The strengthening of relationships with the community, faith and voluntary sector.
- ✓ Young people contributing more significantly to the safeguarding work of the Borough.
- ✓ Publication of SCR in January 2013 with associated learning events.

14.3 Areas for development, or where progress is not as good as the LSCB would want it to be, are highlighted throughout the document. Below is a summary of these development points and other observations captured while compiling this report.

Governance arrangements:

- Safeguarding is a priority for statutory members of the LSCB; this is evidenced by the strong commitment and contribution to subgroups and short-life working groups. Actions for improvement have been identified where individual agencies have not fully engaged in the past.
- There is evidence that partners hold each other to account for their contribution to the safety and protection of children and young people but there is no formal way in

which this is collated. The Chair prioritised this for action during 2013/14 and further initiatives during 2014/15 will see challenge better promoted and evidenced.

- The Tri-borough Board and subgroup structure enables partners to assess whether they are fulfilling their statutory duties to help, protect and care for children and young people. The Board wants to capitalise on joint working with the three Health and Wellbeing Boards, and this should be strengthened during 2014/15 following the agreement of a joint working protocol. Relationships with other partnerships also need to be articulated.
- The LSCB Business Plan should be made more 'SMART' in future. In particular the business plan should identify what impact it intends to have on improving outcomes for children and young people. Consideration should also be given to streamlining the number of actions to make the Board more focused. This needs to be balanced with ensuring the LSCB does not overlook key areas of importance for children and young people's well-being.
- The LSCB should consider commissioning a Joint Strategic Needs Analysis (JSNA) of local safeguarding needs - that is owned and shared by partners - to strengthen the LSCB's priority setting process.
- There should be a concerted effort by all standing and short-life subgroups of the board to evidence the impact the LSCB is having on outcomes for children and young people. This could be supported by a review of how groups report to the Board and how the subgroups manage and evidence their work.
- It would be useful for the chairs of the three local partnerships groups to review the strengths and weaknesses of their groups and share learning and best practice

Quality and Effectiveness:

- The Quality Assurance Framework is now established which is starting to evidence 'how much, how good, and what difference'; however the 'what difference' aspect of this needs further development so that the LSCB is able to evidence with some confidence the impact it is having on outcomes for children and young people.
- The case audits undertaken by the Quality and Assurance Subgroup demonstrate that the LSCB is able to understand the quality of practice and areas for improvement.
- The LSCB should develop its performance monitoring to focus more on outcomes and the impact of services on outcomes. Adopting a more 'thematic' approach may help strengthen this focus on outcomes.
- There are continuing challenges to data collection and performance monitoring from some partner agencies, this should be escalated to the Board for discussion and action.
- The 2014/15 audits on sexual exploitation and neglect are likely to inform future LSCB priorities.
- Section 11 reporting could be made more prominent at the Board.

Learning and development:

- The LSCB has a comprehensive framework of learning opportunities for staff working with children in the three boroughs as evidenced through the training programme and learning from case review and audits. The LSCB training offer is regularly reviewed and demonstrates that it is quick to respond to local demands

- The evaluation of training is mainly focused on the take-up and quality of training; the Learning and Development Subgroup should develop mechanisms to evaluate its effectiveness and impact on improving front-line practice and the experiences of children, young people and families as soon as possible.
- The LSCB needs to assure itself that key messages and lessons from case review and audits are reaching frontline staff across all agencies.

Communication and dissemination:

- The development of the standalone LSCB website should help to ensure that the LSCB has a strong identity and that it is able to effectively communicate the local 'safeguarding story'.
- The LSCB needs to assure itself that key messages and lessons from case review and audits are reaching frontline staff across all agencies.

LSCB Priorities:

- Neglect is a cross-cutting theme that needs to be highlighted across all the other priorities.
- Child sexual exploitation, gangs, missing young people, suicide risk are linked further high priorities
- Responding to national issues at a local level, such as female genital mutilation, will also be high on the LSCB's priorities.

Early help

- The LSCB ensures that high quality policy and procedures and in place, as evidenced by the publication of the Threshold Guidance and a Local Assessment Protocol. The LSCB should assure itself that policies and procedures are regularly monitored and evaluated for their effectiveness and impact, possibly through a rolling audit programme.
- There should be further consideration given to how the Board will monitor and challenge the effectiveness of early help services, including MASH, in the future.
- The work around faith and culture is a significant; further work by the LSCB is required to ensure that this is fully embedded and its effectiveness evaluated. Further resources may need to be identified to support this work long-term into the future.
- Female Genital Mutilation is an area that has been consistently raised by partners as a priority for further action. The work of the standing (implementation) group, set up in March 2014, should be included in the business plan for 2014/15, and challenged by the Board.
- Shared priorities for action between the LSCB and Adult Safeguarding Board should be identified – this may be a good forum to take forward priorities around domestic violence, parental mental health and parental substance misuse.

Better outcomes for children subject to child protection plans and those looked after

- The impact of the LSCB in this area is not as clear as other priority areas of the Business Plan. Further consideration should be given to the added value the LSCB can bring to improving the impact of services on outcomes for children and young people and how it should hold agencies to account in this priority area.

- An audit of cases regarding practice in relation to neglect is planned for 2014/15. Recommendations for the LSCB should be incorporated into the Business Plan in this section.

Compare and contrast

- The close relationship between partners ensures that the LSCB understands the nature and extent of local issues for children and young people. Significant developments have taken place over the past year to progress work on missing children and sexual child exploitation and further work is planned on FGM.
- In order to avoid any drift in any of the working groups (in regards to scope and timescales) stronger project management support needs to be put in place, with more clearly defined timescales, purpose and specified outcomes of work. The LSCB will need to ensure that it has the appropriate resources to support this activity.
- Probation and the CRC should take steps to ensure that children involved with adults in the Criminal Justice System are identified in recording systems.

Changing landscape

- The LSCB and Chair has demonstrated challenge to agencies – such as Health, Police and Probation – in regards to the effectiveness of safeguarding during structural change. The LSCB should ensure that it continues to challenge the Local Authority following structural change.

Appendix A

Members of the Tri-borough Local Safeguarding Children Board (2013/14)

Name	Position	Organisation
Jean Daintith	Independent Chair	n/a
Andrew Christie	Executive Director of Children's Services	Tri-borough Children's Services
Liz Bruce (deputy for Board was Gill Vickers)	Executive Director of Adults' Services (DASS) Director for Operational Adults' Services	Tri-borough Adults Services
Cllr Heather Acton	Deputy Cabinet Member for Children & Young People	Westminster City Council
Cllr Helen Binmore	Cabinet Member for Children and Education	Hammersmith and Fulham Council
Cllr Elizabeth Campbell	Cabinet Member for Family and Children's Services	Royal Borough Kensington and Chelsea
Clare Chamberlain	Director of Family Services	Royal Borough of Kensington and Chelsea
Steve Miley	Director of Family Services	Hammersmith & Fulham
James Thomas	Director of Family Services	Westminster City Council
Debbie Raymond	Head of Safeguarding, Review and Quality Assurance Service	Tri-borough Children's Services
Tim Deacon	LSCB Business Manager	Tri-borough Children's Services
Will Jones	Assistant Chief Officer	London Probation Trust
Paul Monk	Chief Inspector	Metropolitan Police (CAIT)
Lucy D'Orsi	Chief Superintendent	Metropolitan Police (LBHF)
Peter Harwood	Head Teacher of Special school	Woodlane School
Sally Whyte	Secondary Head Teacher	Lady Margaret School
Wayne Leeming	Primary Head Teacher	Melcombe School
Ian Heggs	Director for Schools Commissioning	Tri-Borough Children's Services
Greg Roberts	Housing Services	Westminster City Council
Adam Taylor	Community Safety Partnerships	Westminster City Council
Liz Royle	Head of Safeguarding	Central London Community Health Care, Chair of L&D Group
Dr Louise Ashley	Director of Nursing, Quality and Assurance,	Central London Community Health Care
Eva Hrobonova	Deputy Director for Public Health	Tri-borough Councils
Nicky Brownjohn	Associate Director for Safeguarding	Central London ,West London, Hammersmith and Fulham, Hounslow and Ealing Clinical Commissioning Groups (CWHHE)
Senga Steele	Deputy Director of Nursing	Imperial Healthcare NHS Trust
Zafer Yilkan		CAFCASS

Andrea Goddard/Paul Hargreaves	Designated Doctor for Safeguarding	Central London, West London, Hammersmith and Fulham CCGs Medical Adviser to LSCB
Patricia Grant / Sarah Hamilton/ Sian Thomas	Designated Nurse for Safeguarding	Central London, West London, Hammersmith and Fulham CCGs Health Adviser to LSCB
Libby McManus (deputy for Board is Vanessa Sloane)	Director of Nursing and Quality.	Chelsea and Westminster Hospital
Jonathan Webster	Director of Quality, Patient Safety and Nursing	CWHHE CCG Collaborative representative for Central London/ West London/ Hammersmith and Fulham CCGs
Catherine Knights	Associate Director of Operations	Central North-West London Mental Health Trust
Johan Redelinghuys	Director of Safeguarding	West London Mental Health Trust
Denise Chaffer (previously Janet Shepherd)	Director of Nursing	NW London Area Team NHS England
Steve Lennox	Director of Quality and Health Promotion	London Ambulance Service
Sally Jackson	Voluntary sector representative	Standing Together
Elizabeth Virgo, Tola Dehinde, Poppy Scott-Plummer, Andrea Andriou	Lay Members	n/a
Mark Emmett	Head of Safer Prisons, Equalities and Diversity.	Wormwood Scrubs Prison

Appendix B

Tri-borough LSCB Statement as at 31st March 2014 for 2013/14 Financial Year

	LBHF	RBKC	WCC	Total
Reserves 13/14	(72,000)	(67,370)	(167,635)	(307,005)
Reserves available 13/14	**(29,050)**	**(110,320)**	**(167,635)**	**(307,005)**
Total Partner Contributions	**(88,950)**	**(82,290)**	**(85,250)**	**(256,490)**
LSCB Expenditure in 2013/14				
Salary expenditure	86,156	82,721	83,355	252,232
Training	14,236	4,290	5,652	24,178
Case Reviews	10,151	0	25,125	35,275
Multiagency Auditing	5,781	5,781	5,781	17,343
Other Expenditure	3,955	0	0	3,955
Total expenditure	**120,279**	**92,792**	**119,913**	**332,983**
1314 Outturn Variance	**31,329**	**11,422**	**7,840**	**50,590**
Reserves Closing balance	(29,050)	(111,240)	(140,812)	(281,102)

The considerable reserves (totalling £307k) was carried forward from 2012/13 from the three previous Boards, with a previous agreement for these fund to be used to resource case reviews, and where sufficient funds exist in the respective reserves, on cross-borough LSCB projects. In 2013/14, the Board decided to fund the Community Development Worker post, resource multi-agency LSCB audits and to fund a number of case reviews.

	**London Borough of Hammersmith & Fulham** **HEALTH & WELLBEING BOARD** **10 November 2014**
TITLE OF REPORT: Hammersmith & Fulham Clinical Commissioning Group Contracting Intentions: Progress Update	
Report of the H&F Clinical Commissioning Group	
Open Report	
Classification - For Review & Comment **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: n/a	
Report Author: Rachel Stanfield Head of Organisational Development & Governance NHS Hammersmith & Fulham CCG	**Contact Details:** Tel: 0203 350 4559

EXECUTIVE SUMMARY

This report updates the Board and facilitates discussion on where members can still help shape the commissioning plans.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	None		

Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Developing commissioning priorities beyond 2014 – conversation with Hammersmith & Fulham Health & Wellbeing Board

Dr Tim Spicer

November 2014

Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Purpose, objectives and outcomes
… or why are we here today?

Purpose

- To have a conversation with you about our commissioning plans and how you can influence their development

Objectives

- Share with you the work to date on our commissioning plans
- Highlight the specific areas where our plans are still being formed
- Get your feedback on which areas we should prioritise going forwards

Outcomes

- Greater clarity for us on your views on our commissioning plans so that we can move towards a robust set of priorities

Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Our commissioning plans: an update

Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

How we develop our commissioning plans

- We develop commissioning plans for our overall vision
- ‘Commissioning’: reviewing need, to service design & re-design, procurement and evaluation
- Evolving cycle of commissioning and different areas of our work at different stages of the cycle
- Patients and the public are at the heart of all stages of the cycle

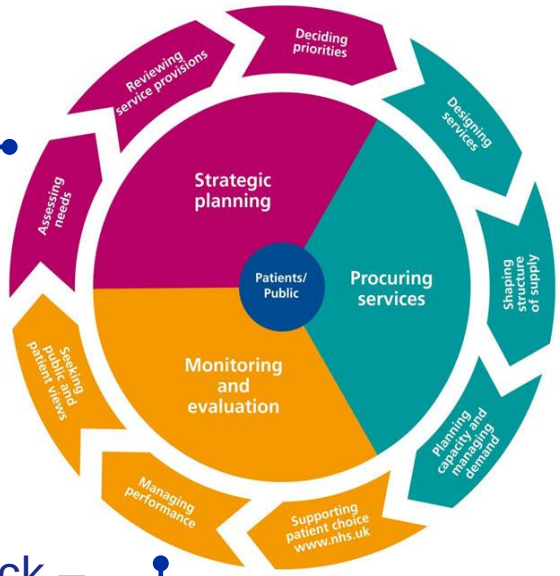
Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Our conversations with you

Inviting you to join our strategic planning groups and project steering groups

On-going conversations to understand patient need



Specific projects and working groups to co-design local pathways

Asking for your contribution to the development of service specifications and provider selection

Gathering your feedback – directly and via the VCS – to understand service quality and performance

Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Developing Commissioning Intentions

Headlines for this year

Key points about developing the intentions this year (2015/16)

- **A move away from the 'annual' approach to commissioning intentions to drawing on conversations with staff and patients throughout the year to inform our commissioning intentions**
- **We issued specific "contracting intentions" to providers on 30 September 2014 to set the tone for our expectations from providers with more detailed commissioning intentions to follow**
- **We continue to develop wider commissioning plans for 2015/16**
- **A separate public facing document will be produced for the end of the year**

Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Developing Commissioning Intentions

Decision making

We aim to make our decisions about services based on a combination of:

- **Public health information**
- **Patient experience**
- **Contract monitoring**
- **Co-production with patients and service users**
- **Potential for achieving best value for money**
- **Fit with our overall strategy**

Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Developing Commissioning Intentions

Where you can influence

Our plans fall into three broad areas, and your input is needed to help us take each one forward

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Hammersmith and Fulham
Clinical Commissioning Group

Developing Commissioning Intentions

Services we have decided to buy for 2015/16

Some commissioning decisions have already been made, in consultation with stakeholders, and are being implemented

- **MSK**
- **Ophthalmology**
- **Community gynaecology**
- **Community dermatology**
- **Community Independence Service Plus**
- **Wheelchair repair**
- **Diagnostics**
- **NHS 111 & UCCs**
- **Perinatal mental health**
- **Primary care memory service**
- **Expert Patient Programme**
- **Homecare**
- **Tissue viability**

How can we recruit local people to help us procure these services?

There is more information on these procurements in the supporting information at the back of this pack

Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Developing Commissioning Intentions

Services we buy now: will review 2015/16

There are some services that we already buy, but may need to review, for a number of reasons including quality, equity, and value for money

- **Retinal screening**
- **Diabetes**
- **Podiatry**
- **Foot care**
- **End of life care**
- **TB**
- **Chronic kidney disease (CKD)**

There is more information on these pathways in the supporting information at the back of this pack

What is your view on which of these we should prioritise?

Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Developing Commissioning Intentions

Services we need to decide whether to buy:

There are some services that we don't currently buy for the local population – we need to make a decision about how we approach these for 2016/17

- **Cardiology, to include heart failure**
- **Community ENT (ear, nose & throat)**
- **Community gastroenterology**
- **Neurology**
- **Urology**
- **Paediatric continence**

What is your view on which of these we should prioritise?

There is more information on these pathways in the supporting information at the back of this pack

Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Supplementary questions

We would value your views on the following:

- **How can we identify and engage individual Hammersmith & Fulham patients in different stages of our work, e.g. service design, specification development, selection of bidders, and evaluation?**
- **We are developing more services for patients in the local community. How can we ensure that this information is shared with local people?**

Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Appendix 1

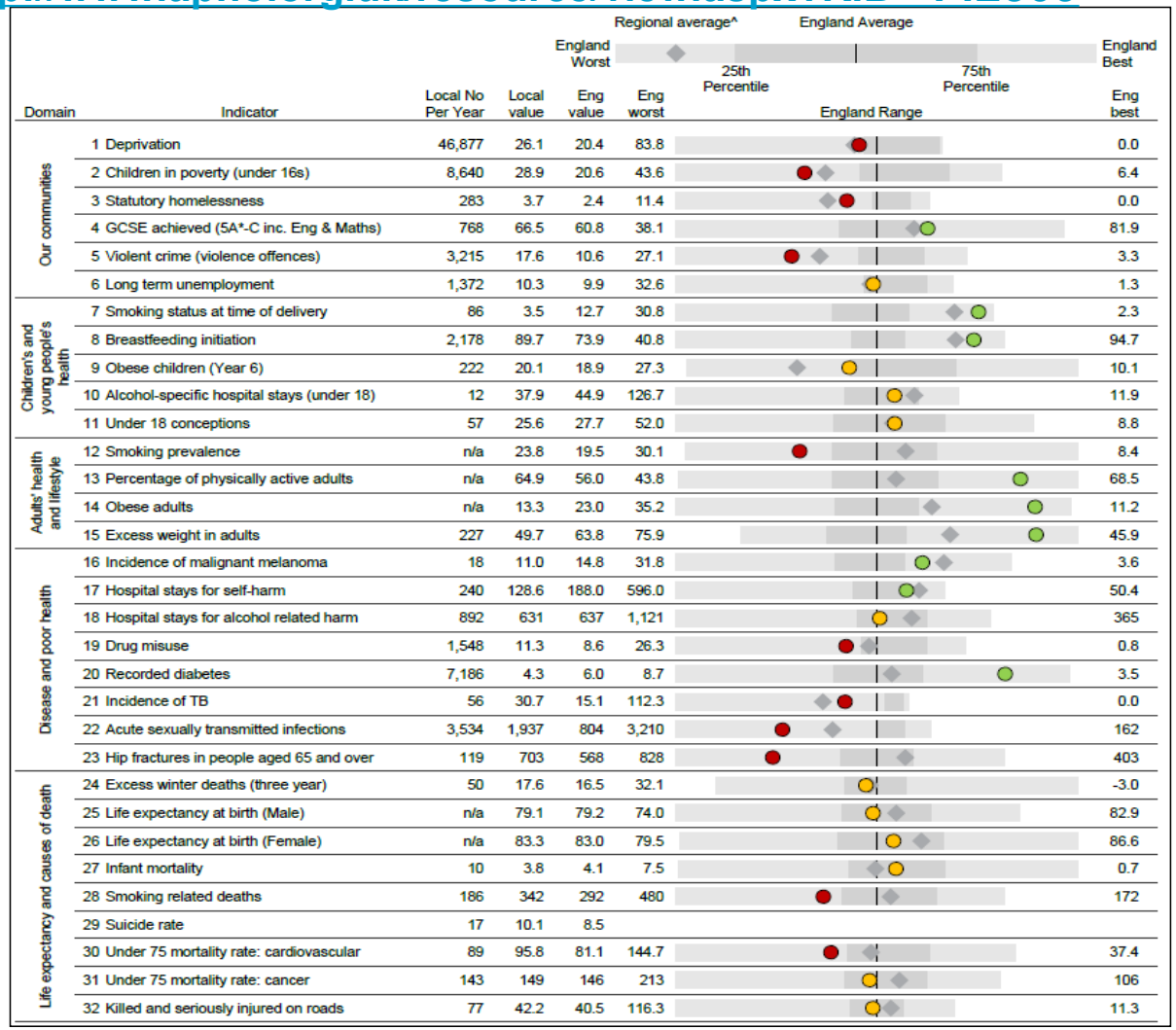
Public health view on commissioning intentions

Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Health Profile 2014

http://www.apho.org.uk/resource/view.aspx?RID=142309



Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	Regional average^ / England Average / England Range	Eng best
Our communities	1	Deprivation	46,877	26.1	20.4	83.8		0.0
	2	Children in poverty (under 16s)	8,640	28.9	20.6	43.6		6.4
	3	Statutory homelessness	283	3.7	2.4	11.4		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)	768	66.5	60.8	38.1		81.9
	5	Violent crime (violence offences)	3,215	17.6	10.6	27.1		3.3
	6	Long term unemployment	1,372	10.3	9.9	32.6		1.3
Children's and young people's health	7	Smoking status at time of delivery	86	3.5	12.7	30.8		2.3
	8	Breastfeeding initiation	2,178	89.7	73.9	40.8		94.7
	9	Obese children (Year 6)	222	20.1	18.9	27.3		10.1
	10	Alcohol-specific hospital stays (under 18)	12	37.9	44.9	126.7		11.9
	11	Under 18 conceptions	57	25.6	27.7	52.0		8.8
Adults' health and lifestyle	12	Smoking prevalence	n/a	23.8	19.5	30.1		8.4
	13	Percentage of physically active adults	n/a	64.9	56.0	43.8		68.5
	14	Obese adults	n/a	13.3	23.0	35.2		11.2
	15	Excess weight in adults	227	49.7	63.8	75.9		45.9
Disease and poor health	16	Incidence of malignant melanoma	18	11.0	14.8	31.8		3.6
	17	Hospital stays for self-harm	240	128.6	188.0	596.0		50.4
	18	Hospital stays for alcohol related harm	892	631	637	1,121		365
	19	Drug misuse	1,548	11.3	8.6	26.3		0.8
	20	Recorded diabetes	7,186	4.3	6.0	8.7		3.5
	21	Incidence of TB	56	30.7	15.1	112.3		0.0
	22	Acute sexually transmitted infections	3,534	1,937	804	3,210		162
	23	Hip fractures in people aged 65 and over	119	703	568	828		403
Life expectancy and causes of death	24	Excess winter deaths (three year)	50	17.6	16.5	32.1		-3.0
	25	Life expectancy at birth (Male)	n/a	79.1	79.2	74.0		82.9
	26	Life expectancy at birth (Female)	n/a	83.3	83.0	79.5		86.6
	27	Infant mortality	10	3.8	4.1	7.5		0.7
	28	Smoking related deaths	186	342	292	480		172
	29	Suicide rate	17	10.1	8.5			
	30	Under 75 mortality rate: cardiovascular	89	95.8	81.1	144.7		37.4
	31	Under 75 mortality rate: cancer	143	149	146	213		106
	32	Killed and seriously injured on roads	77	42.2	40.5	116.3		11.3

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Conclusions

- Deprivation
  - especially Child Poverty
- Smoking prevalence and Smoking related deaths
- Drug use
- Sexual health
- Hip fractures 65+
- CVD mortality

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Public Health Outcomes Framework

Healthcare and premature mortality				
4.01 - Infant mortality	3.46	4.3	4.3	2009 - 11
4.02 - Tooth decay in children aged 5	1.15	1.23	.94	2011/12
4.03 - Mortality rate from causes considered preventable	169.0	137.6	146.1	2009 - 11
4.04i - Under 75 mortality rate from all cardiovascular diseases	66.5	62.7	60.9	2009 - 11
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	42.5	39.3	40.6	2009 - 11
4.05i - Under 75 mortality rate from cancer	116.9	103.3	108.1	2009 - 11
4.05ii - Under 75 mortality rate from cancer considered preventable	73.7	59.3	61.9	2009 - 11
4.06i - Under 75 mortality rate from liver disease	24.4	15.1	14.4	2009 - 11
4.06ii - Under 75 mortality rate from liver disease considered preventable	20.4	12.9	12.7	2009 - 11
4.07i - Under 75 mortality rate from respiratory disease	25.1	21.9	23.4	2009 - 11
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	13.8	10.8	11.6	2009 - 11
4.0 - Mortality from communicable diseases	32.8	31.7	29.9	2009 - 11
4.1 - Suicide rate	7.4	6.8	7.9	2009 - 11
4.1 - Emergency readmissions within 30 days of discharge from hospital, persons	13.3%	12.0%	11.8%	2010/11
4.11 - Emergency readmissions within 30 days of discharge from hospital, male	14.4%	12.5%	12.1%	2010/11
4.11 - Emergency readmissions within 30 days of discharge from hospital, female	12.2%	11.4%	11.4%	2010/11
4.12i - Preventable sight loss - age related macular degeneration (AMD)	102.9		110.5	2011/12
4.12ii - Preventable sight loss - glaucoma	23.3		12.8	2011/12
4.12iii - Preventable sight loss - diabetic eye disease	3.8		3.8	2011/12
4.12iv - Preventable sight loss - sight loss certifications	31.2		44.5	2011/12
4.14i - Hip fractures in people aged 65 and over	452.0	434.0	457.2	2011/12
4.14ii - Hip fractures in people aged 65 and over - aged 65-79	297.8	217.5	222.2	2011/12
4.14iii - Hip fractures in people aged 65 and over - aged 80+	1145.8	1408.1	1514.6	2011/12
4.15i - Excess Winter Deaths Index (Single year, all ages)	15.8	17.3	17.0	Aug 10-Jul 11
4.15ii - Excess Winter Deaths Index (single year, ages 85+)	14.8	22.2	21.2	Aug 10-Jul 11

Worse than London and England | Between London and England | Better than London and England

Bold *Significantly worse*

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Conclusions

- CVD mortality <75
- Cancer mortality <75
- Liver disease mortality <75
- Respiratory mortality <75
- Suicide rate
- Hospital readmissions
- Sight loss – glaucoma
- Hip fractures 65-79

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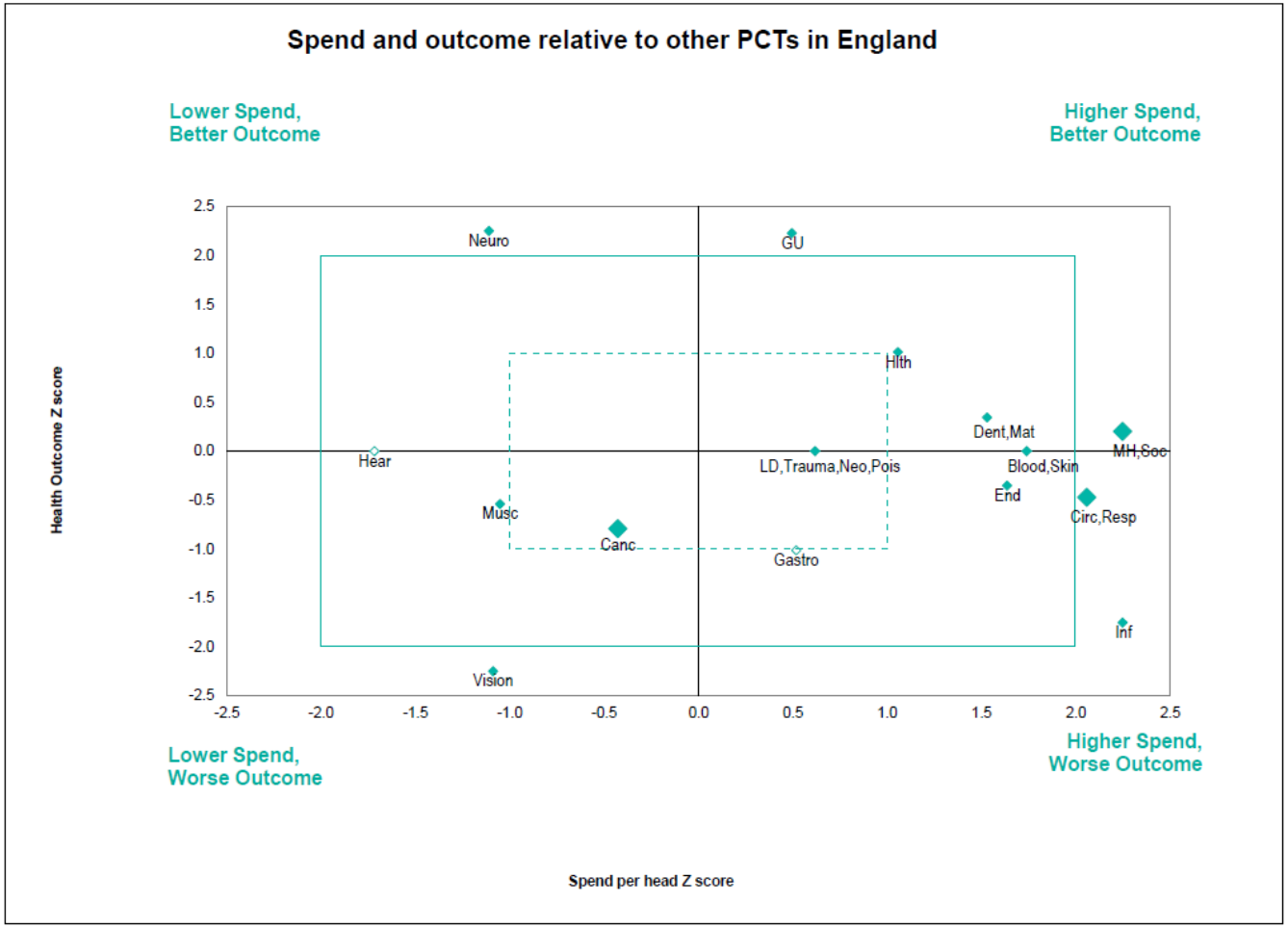
Spend and outcome relative to other PCTs in England



◇ No outcome indicators readily available
◆ Outcome indicators available

Programme Area Abbreviations

Infectious Diseases	Inf	Hearing	Hear	Disorders of Blood	Blood
Cancers & Tumours	Canc	Circulation	Circ	Maternity	Mat
Respiratory System	Resp	Mental Health	MH	Neonates	Neo
Endocrine, Nutritional & Metabolic	End	Dental	Dent	Neurological	Neuro
Genito Urinary System	GU	GI System	Gastro	Healthy Individuals	Hlth
Learning Disabilities	LD	Musculoskeletal	Musc	Social Care Needs	Soc
Adverse effects & poisoning	Pois	Trauma & Injuries	Trauma		

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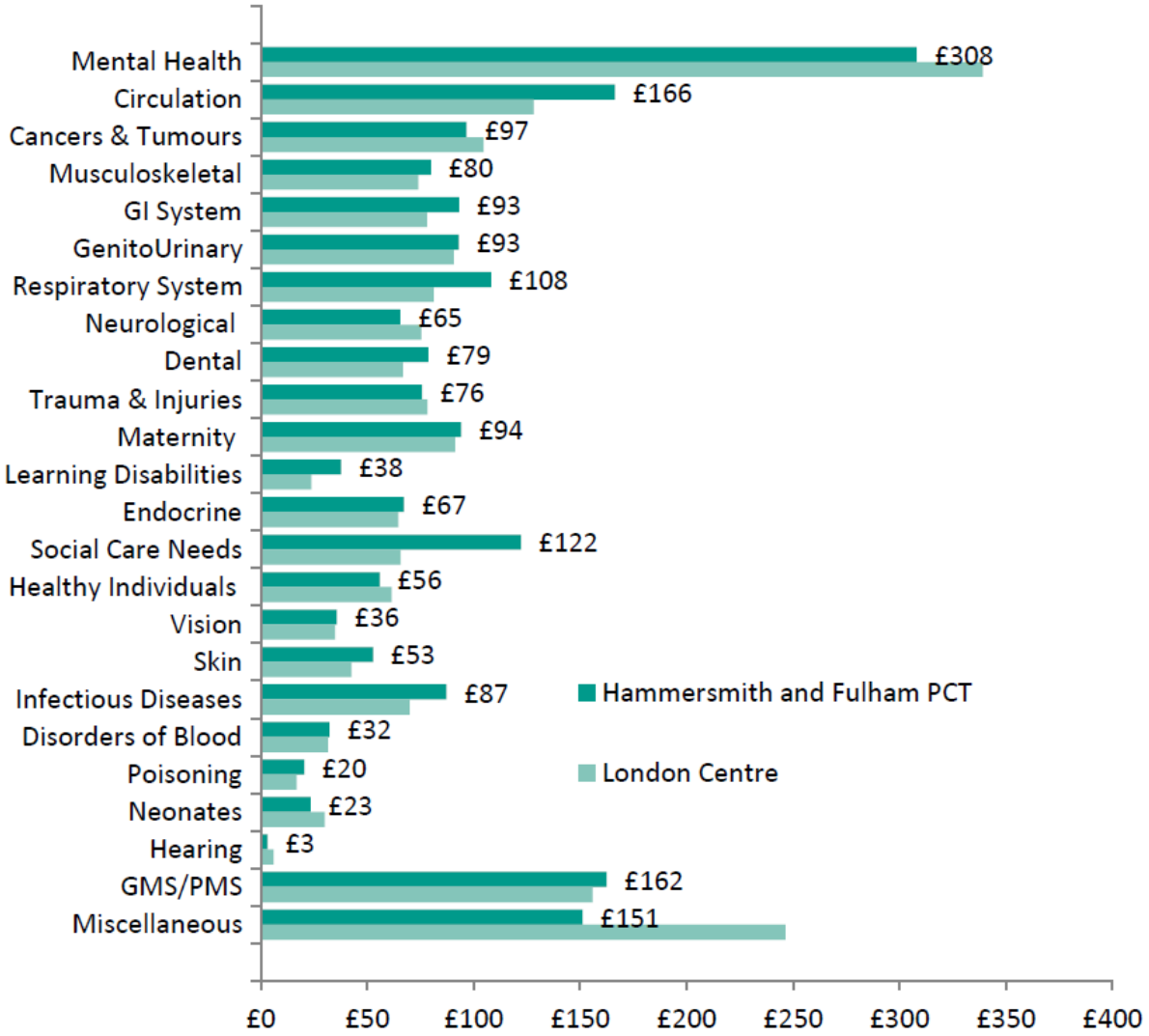
Spend compared to ONS Cluster



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Conclusions

- Outliers on spend areas:
  - Infectious disease
  - Mental Health
  - Circulatory
  - Respiratory system
  - Neurological
  - Vision
  - Genito-urinary system
  - Social Care Needs

Source: H&F Spend and outcome factsheet 2011/12

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Overall conclusions – what are the local health priorities?

CCG Priorities identified	Mapping to CIs
– CVD mortality <75	– Heart Failure, Diabetes (?)
– Cancer mortality <75	– ?
– Liver disease mortality <75	– ?
– Respiratory mortality <75	– ?
– Suicide (Mental Health)	– ?
– Hospital readmissions	– District/community nursing?
– Sight loss / Vision – glaucoma	– Ophthalmology, Retinal screening
– Hip fractures 65-79	– MSK
– Infectious disease	– TB
– Neurological	– ?
– Genito-urinary system	– Paediatric continence

Where are the gaps?

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Appendix 2

Some further information on services/pathways

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Services we have already committed to buying

Procurement timelines

Procurement	Expected to be live and seeing patients
MSK	TBC
Community ophthalmology	July 2015
Community gynaecology	April 2015
Community dermatology	April 2015
Community Independence Service Plus	April 2015
Wheelchair repair	TBC
Diagnostics	October 2015
NHS 111 & UCCs	September 2015
Perinatal mental health	July 2015
Primary care memory service	July 2015
Expert Patient Programme	April 2015
Homecare	April 2015
Tissue viability	TBC

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Developing Commissioning Intentions

Services we currently buy, but need to review

Pathway	Current evidence/knowledge about service
Retinal screening	We are not currently meeting national guidance in this area; NHSE commissions diabetic eye screening; there is a drive to move to pan-London commissioning and we need to respond to this driver; we currently also commission CLCH to provide a diabetic service that includes screening - therefore we need to understand where we could be double paying and where the current service overlaps with other pathways, e.g. ophthalmology
Diabetes	We have done a lot of work to improve the diabetes pathway already, e.g. recommissioning patient education in response to feedback; we now need to review services to ensure equity of service provision across CWHHE, and ensure there is alignment across the new primary care contracts and the diabetes services in acute and community settings; we need to review the current CLCH contract. We believe we can do the necessary work by 31 March 2015
Podiatry	The Joint Commissioning team asked CLCH to review the current service specification and we awaiting the results of that review
Foot care	This area should be reviewed as part of ensuring a robust diabetes service
End of life care	We have already done a lot of work on end of life pathways and communication with patients about it; we still have more work to do to develop this work
TB	A public health JSNA deep dive across the Tri-borough showed that NICE guidance is not being met; there is also disparity in the services offered across the Tri-borough; there is believed to be the potential for financial savings in reviewing the services; CLCH are keen to progress this. We believe we can do the scoping work by early 2015
CKD	Small numbers affected; we need to streamline the patient pathway across existing services in primary & secondary care rather than commission a new service

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Developing Commissioning Intentions
Services we don't currently buy

Pathway	Current evidence/knowledge about service
Cardiology, including heart failure	Public health analysis shows this should be a priority because we have high mortality from CVD and we also have high spend and low outcomes; there is believed to be a strong evidence base for financial savings (British Heart Foundation) through reduced hospital admissions and outpatient attendances; we know there is appetite amongst patient groups to be part of working in this area; we are also the only Tri-borough CCG with no heart failure service
Community ENT (ear nose and throat)	Raised by local GPs as a potential area for developing a community service
Community gastroenterology	Raised by local GPs as a potential area for developing a community service
Urology	This is a gap in service for us and other CCGs are working on this area
Neurology	Public health analysis shows this could be a priority for us because we are an outlier in terms of spend; we are currently scoping this area to see what could be provided in terms of a community service
Paediatric continence	Continence services are adult-focused, and we are exploring bringing a stronger focus on children. There are some specific proposal around some additional nursing support, and these are being discussed across the Tri-borough.

	**London Borough of Hammersmith & Fulham** **HEALTH & WELLBEING BOARD** **10 November 2014**
The London Health Commission report summary	
Report of the Health and Wellbeing Board support team and Hammersmith and Fulham CCG	
Open Report	
Classification - For Information **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: n/a	
Report Author: Chris Swoffer, Policy Officer	**Contact Details:** Tel: 020 7641 5146 E-mail: cswoffer@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. This report gives a brief overview of the main recommendations of interest to the London Borough of Hammersmith and Fulham (LBHF) Health and Wellbeing Board, from the London Health Commission report, 'Better Health for London'.

2. RECOMMENDATIONS

2.1. The London Borough of Hammersmith and Fulham Health and Wellbeing Board are asked to note the recommendations of interest from the London Health Commission report.

3. REASONS FOR DECISION

3.1. This report is for information only.

4. INTRODUCTION AND BACKGROUND

4.1 On Wednesday 15th October 2014, The London Health Commission, an independent inquiry chaired by Lord Darzi, reported to the Mayor of London on how to improve health and wellbeing in London.

4.2 The full report[1] includes 64 recommendations. This briefing focuses on the areas of the report which will be of particular interest to the LBHF Health and Wellbeing Board.

5. PROPOSAL AND ISSUES

5.1 The London Health Commission report is wide ranging in its scope and covers a whole variety of issues around the health and wellbeing agenda, from active lifestyles to air quality.

5.2 This briefing sets out the recommendations (R) of particular interest to the LBF Health and Wellbeing Board under the following headings:

- Better health for children and young people
- Making care more personal
- Information, investment and reform

Better health for children and young people

5.3 The second chapter of the report entitled 'better health for London's Children' focuses on child poverty, childhood obesity, healthier schools, mental and physical health services.

5.4 On **better parenting**, the report recommends that health and care commissioners should jointly develop a new model to improve support for parents of vulnerable children under three years of age (R13).

5.5 The report points out that only 53% of London's children reach a good level of development at age 5, with wide variation within London linked to deprivation and place. Health and Wellbeing Boards have an important role to play in driving this agenda and there is already progress being made locally through the Early Help review across Tri-borough.

5.6 The report also calls for better **children's mental health services and physical health services,** recommending that health commissioners and

[1] http://www.londonhealthcommission.org.uk/wp-content/uploads/London-Health-Commission_Better-Health-for-London.pdf

providers should launch a process to address the variation in quality of care for children and to propose actions to improve outcomes (R16).

5.7 Health and Wellbeing Boards can take a leading role in facilitating conversations around effective early intervention and prevention at a strategic level, ensuring that the mental health needs of the population are met through the most appropriate accessible channels. Health and Wellbeing Boards should learn from innovative best practice examples both nationally and internationally and consider whether these can be effectively implemented locally.

5.8 The Children, Young People and Mental Health Task and Finish group which have been considering the future vision for children and adolescent mental health services locally is a good example of where the Health and Wellbeing Board can have a positive impact in setting the strategic direction and ultimately improve outcomes for children and young people across the borough.

Making care more personal

5.9 The third chapter of the report focuses on 'Better Care' with a particular focus on personal care based on the needs of the individual.

5.10 On **personalised care and empowering people**, the report recommends that health and care commissioners should commission holistic, integrated physical, mental and social care services for population groups with similar needs, with clearly defined outcomes developed by listening to people who use services (R17).

5.11 Health and Wellbeing Boards will have a particularly important role to play in relation to this recommendation, with Healthwatch providing an invaluable link to the patient through their voice on the Board.

5.12 On **GP care**, the report says that NHS England and CCGs should promote and support GPs working in networks (R24) and allow patients to move freely within GP networks (R25). In addition to this, the report recommends that NHS England and CCGs should put in place arrangements to allow existing or new providers to set up new GP services in areas of persistent poor provision in London (R26).

5.13 GP practices in Hammersmith and Fulham have been working as part of commissioning networks since around 2010, and relationships between practices are well developed. Since May 2014, Hammersmith & Fulham CCG has also been actively supporting all practices to join together

formally as a single provider federation. We expect the Hammersmith and Fulham GP Federation to become a legal entity in November 2014; this organisation will provide a vehicle for offering equitable primary care to all Hammersmith and Fulham residents, and will support the movement of patients between practices. Initially, the CCG expects to be able to contract with the Federation for a range of specified Out of Hospital (OOH) services from early 2015.

5.14 On **the GP estate** in London, the report recommends that NHS England should reform the rent imbursement system for GP Premises (R51).

5.15 Hammersmith & Fulham CCG is working closely with NHS England and NHS Property Services to take forward plans to modernise existing GP premises across the borough. During 2013/14 we have already re-housed four GP surgeries into a state-of-the-art facility in White City, Parkview Centre for Health and Wellbeing. However, there remain a number of practices operating out of buildings which are not fit for purpose for 21st century healthcare. As such, the CCG welcomes this recommendation, which would further incentivise local GPs to move to more suitable premises.

5.16 On **primary care investment**, the report says that NHS England should rebalance expenditure from specialised services to primary and community services, and launches a five-year £1 billion investment programme in GP premises (R21). Health commissioners should increase the proportion of total London NHS spending dedicated to GPs and primary and community services and facilities (R22).

5.17 The report also covers better care for **marginalised groups** and recommends that health and care commissioners should ensure that all Londoners have access to digital mental health support, in the languages that they speak, and using the latest technology (R28).

<u>Information, investment and reform</u>

5.18 On **better health information**, the report recommends that health and care commissioners should embrace advanced data analytics to better understand care needs and to commission high quality care (R44).

5.19 On **CCG funding and payments**, the report recommends that London CCGs and Strategic Planning Groups should consider developing local initiatives to promote greater equity in financing the health and care system (R46). The report also recommends that NHS England should

make clear the budget for the London Region of NHS England and for London CCGs for the duration of future spending review periods (R47).

5.20 The CCGs across NWL have developed a joint financial strategy to reflect the inter-connectedness of the local health economy and the need to work closely together to deliver a whole-system transformation of health services. This strategy allows for the promotion of equity in financing across the CCGs. Hammersmith and Fulham CCG would welcome greater certainty on future allocations to enable us to make long-term plans for improving services for local residents.

5.21 On **integrated care,** the report points out the drawbacks of having the NHS budget distributed to care providers through multiple different payment mechanisms. It recommends that NHS England should work with CCGs and local authorities to trial capitated budgets for specific population groups, such as elderly people with long-term conditions (R49).

5.22 The Health and Wellbeing Board will continue to have an important role to play in developing integrated care through the Better Care Fund. There may be an opportunity for the Health and Wellbeing Board to trial capitated budgets in the future through working with NHS England as set out in the recommendation.

5.23 The Whole Systems Integrated Care Steering Group for Finance, Analytics and Informatics has been meeting fortnightly since July 2014 to agree a common methodology for the calculation and implementation of capitated budgets in North West London. There are three reasons for taking a common approach to capitated budgets across North West London. The first is that these calculations will be more accurate the bigger the population that they are based on, the second is providers will benefit from being recipients of a common payment mechanism across the geography and the third is that this will help ensure equality in the offer to patients. There is representation on the group from CCGs and Local Authorities across North West London, including lay members.

5.24 On **local leadership**, the report recommends that NHS England should further empower CCGs to work together – with their local authority partners – to improve care across multiple boroughs, by devolving further decision making powers to strategic planning groups (R62).

5.25 An opportunity exists for the Health and Wellbeing Boards to become the driver for this change, with partners working together to improve the

health and wellbeing of residents across boundaries where need and priorities are shared.

	London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **10 November 2014**
HEALTH AND WELLBEING BOARD LEARNING AND DEVELOPMENT SESSIONS	
Report of the Corporate Director	
Open Report	
Classification - For Information **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Tri Borough Executive Director of Adult Social Care	
Report Author: Chris Swoffer, Policy Officer, Health and Wellbeing Board support team	**Contact Details:** Tel: 020 7641 5146 E-mail: cswoffer@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1 The London Borough of Hammersmith and Fulham, Royal Borough of Kensington and Chelsea, and Westminster Health and Wellbeing Boards have received funding from the LGA and London Councils Local Facilitation Development Fund to run a series of facilitated sessions to support the continued development of the Boards.

1.2 This briefing sets out the benefits for Health and Wellbeing Board members in participating in these sessions and the suggested approach for delivery.

2. RECOMMENDATION

2.1. The Health and Wellbeing Board are asked to note the proposed training and development plan and provide input and ownership into the sessions once they have been confirmed.

3. PROPOSAL AND ISSUES

3.1 It is proposed that members of the LBHF Health and Wellbeing Board participate in two development sessions in the New Year to reflect on its experience to date and consider wider system leadership and the Boards role in driving improvements to health and wellbeing outcomes at a place level. One of these sessions will be delivered collectively to all three Boards. Ideas and input from Health and Wellbeing Board members in helping to develop these sessions are very welcome.

3.2 It is proposed that further sessions are arranged to inform and engage providers on the role of the Health and Wellbeing Boards across Tri-borough and a public engagement event is developed to share the journey of the Health and Wellbeing Board and gather ideas to inform future planning.

3.3 Health and Wellbeing Board members will also be invited to a series of individual briefings over November and December to increase knowledge around subjects of specific interest. Details for all of these sessions will be confirmed shortly.

4. OPTIONS AND ANALYSIS OF OPTIONS

4.1 These sessions will lead to improved partnership working across the LBHF Health and Wellbeing Board; improved engagement with providers and stakeholders; and more effective coordination with the Health and Wellbeing Boards in the Royal Borough of Kensington and Chelsea and Westminster where similar aims are shared.

4.2 The individual Health and Wellbeing Board sessions will require ownership and input from all members to strengthen the Board's leadership at a place level.

4.3 By participating in these sessions, it is expected that the LBHF Health and Wellbeing Board will develop an improved understanding of the pressures, priorities and agendas of the individual organisations and members represented on the Health and Wellbeing Board, a combined understanding of the Board's role within the health, care and wellbeing system, and an increased knowledge of best practice that will benefit the Board in its future development.

	London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **10 November 2014**
WORK PROGRAMME AND FORWARD PLAN 2014-2015	
Report of the Director of Law	
Open Report	
Classification - For Scrutiny Review & Comment **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Tri-borough Executive Director of Adult Social Care and Health	
Report Author: Holly Manktelow	**Contact Details:** Tel: 020 7641 2757 Email: hmanktelow@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1 The Committee is asked to give consideration to its work programme for this municipal year, as set out in Appendix 1 of the report.

2. RECOMMENDATIONS

2.1 The Committee is asked to consider and agree its proposed work programme, subject to update at subsequent meetings of the Committee.

3. INTRODUCTION AND BACKGROUND

3.1 The purpose of this report is to enable the Committee to determine its work programme for this municipal year 2014/15.

4. PROPOSAL AND ISSUES

4.1 A draft work programme is set out at Appendix 1, which has been drawn up, having regard to actions and suggestions arising from previous meetings.

4.2 The Committee is requested to consider the items within the proposed work programme and suggest any amendments or additional topics to be included in the future

5. OPTIONS AND ANALYSIS OF OPTIONS

5.1. As set out above.

6. CONSULTATION

6.1. Not applicable.

7. EQUALITY IMPLICATIONS

7.1. Not applicable.

8. LEGAL IMPLICATIONS

8.1. Not applicable.

9. FINANCIAL AND RESOURCES IMPLICATIONS

9.1. Not applicable.

10. RISK MANAGEMENT

10.1. Not applicable.

11. PROCUREMENT AND IT STRATEGY IMPLICATIONS

11.1. Not applicable.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	None		

LIST OF APPENDICES:

Appendix 1 - List of work programme items

Hammersmith and Fulham Health & Wellbeing Board
Work Programme 2014/15

Agenda Item	Issue and/or decision	Lead
Meeting Date 10th November 2014		
CHILDREN AND YOUNG PEOPLE MENTAL HEALTH AND WELLBEING	Discussion and endorsement of Final Report and recommendations from the Task and Finish Group	Task and Finish Group Chair
SCHOOL NURSING	Results of the review of school nursing services and options relating to service design and future commissioning intentions	Public Health
SEXUAL HEALTH AND EDUCATION	Findings of a Healthwatch report with young people and views from the commissioners	Healthwatch Public Health
LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT	LSCB presentation on their annual report and areas where the HWB might need to take action	LSCB (and Children's)
CONTRATING INTENTIONS	Note progress of 2015/16 H&F CCG contracting intentions.	CCG
LONDON HEALTH COMMISSION	A for information report on the findings of the London Health Commission report.	CCG/HWB support team
Meeting Date 19th January 2015		
CHILD POVERTY	Development of a strategy to tackle Child Poverty which will meet the need identified in the recent JSNA deep dive	Executive Director of Children's Services
OUT OF HOSPITAL STRATEGY	Consider progress in delivering Out of Hospital Strategy	CCG
CCG CONTRACTING INTENTIONS	Review and endorse final version of the CCG Contracting intentions	CCG
HEALTH VISITING	Consider the preparations underway for the transfer of health visiting from NHS England to the local authority	Public Health
CARE ACT	Consider the implementation of the Care Act	Adult Social Care
EQUALITIES	Report on the demographics of LBHF and discrimination through the lens of equalities	Healthwatch
MENTAL HEALTH TRANSFORMATION PROGRAMME	Update on the development and implementation of the programme	NWL CCG

SOCIAL INCLUSION	*Consider current work underway to promote social inclusion and identify areas for improvement*	*tbc*
Meeting Date 23rd March 2015		
PHARMACEUTICAL NEEDS ASSESSMENT	Endorse final Pharmaceutical Needs Assessment for publication	PNA Task and Finish Group
H&F JSNA Highlight report 2014/15	Consider key messages from the highlight report and endorse for publication	Public Health
HEALTH AND WELLBEING STRATEGY	Report on progress and further development	All Board Sponsors