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City of Westminster

Committee Agenda

Title:	**Health & Wellbeing Board**
Meeting Date:	**Thursday 17th November, 2016**
Time:	**4.00 pm**
Venue:	**Rooms 3 and 4, 17th Floor, City Hall, 64 Victoria Street, London, SW1E 6QP**

Members:

Councillor Rachael Robathan (Chairman)	Cabinet Member for Adults & Public Health
Dr Neville Purssell	Central London Clinical Commissioning Group
Councillor Danny Chalkley	Cabinet Member for Children and Young People
Councillor Barrie Taylor	Minority Group
Eva Hrobonova	Tri-borough Public Health
Liz Bruce	Tri-borough Adult Social Care
Melissa Caslake	Tri-borough Children's Services
Barbara Brownlee	Housing and Regeneration
Dr Philip Mackney	West London Clinical Commissioning Group
Janice Horsman	Healthwatch Westminster
Sarah Mitchell	Westminster Community Network
Dr David Finch	NHS England

Members of the public are welcome to attend the meeting and listen to the discussion Part 1 of the Agenda

Admission to the public gallery is by ticket, issued from the ground floor reception at City Hall from 3.30pm. If you have a disability and require any special assistance please contact the Committee Officer (details listed below) in advance of the meeting.

An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter. If you require any further information, please contact the Committee Officer, Toby Howes, Senior Committee and Governance Officer.

Tel: 7641 8470; Email: thowes@westminster.gov.uk
Corporate Website: www.westminster.gov.uk

Note for Members: Members are reminded that Officer contacts are shown at the end of each report and Members are welcome to raise questions in advance of the meeting. With regard to item 2, guidance on declarations of interests is included in the Code of Governance; if Members and Officers have any particular questions they should contact the Head of Legal & Democratic Services in advance of the meeting please.

AGENDA

PART 1 (IN PUBLIC)

1. MEMBERSHIP

To report any changes to the Membership of the meeting.

2. DECLARATIONS OF INTEREST

To receive declarations of interest by Board Members and Officers of any personal or prejudicial interests.

3. MINUTES AND ACTIONS ARISING **(Pages 1 - 20)**

I) To agree the Minutes of the meeting held on 15 September 2016.

II) To note progress in actions arising.

4. UPDATE ON THE NORTH WEST LONDON SUSTAINABILITY TRANSFORMATION PLAN AND WESTMINSTER'S JOINT HEALTH AND WELLBEING STRATEGY **(Pages 21 - 60)**

To consider updates on the North West London Sustainability Transformation Plan and Westminster's Joint Health and Wellbeing Strategy.

5. LOCAL SAFEGUARDING CHILDREN BOARD DRAFT ANNUAL REPORT 2015-16 **(Pages 61 - 120)**

To consider the Local Safeguarding Children Board annual report for 2015-16.

6. SAFEGUARDING ADULTS EXECUTIVE BOARD ANNUAL REPORT 2015-16 **(Pages 121 - 152)**

To consider the Safeguarding Adults Executive Board annual report for 2015-16.

7. OPTIMISING OLDER PEOPLE HUBS **(Pages 153 - 156)**

To consider a report on the Older People hubs.

8. DEMENTIA JOINT STRATEGIC NEEDS ASSESSMENT PROGRESS REPORT **(Pages 157 - 164)**

To consider a report on progress on the Dementia Joint Strategic Needs Assessment.

9. CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH TRANSFORMATION PLAN UPDATE AND NEXT STEPS **(Pages 165 - 260)**

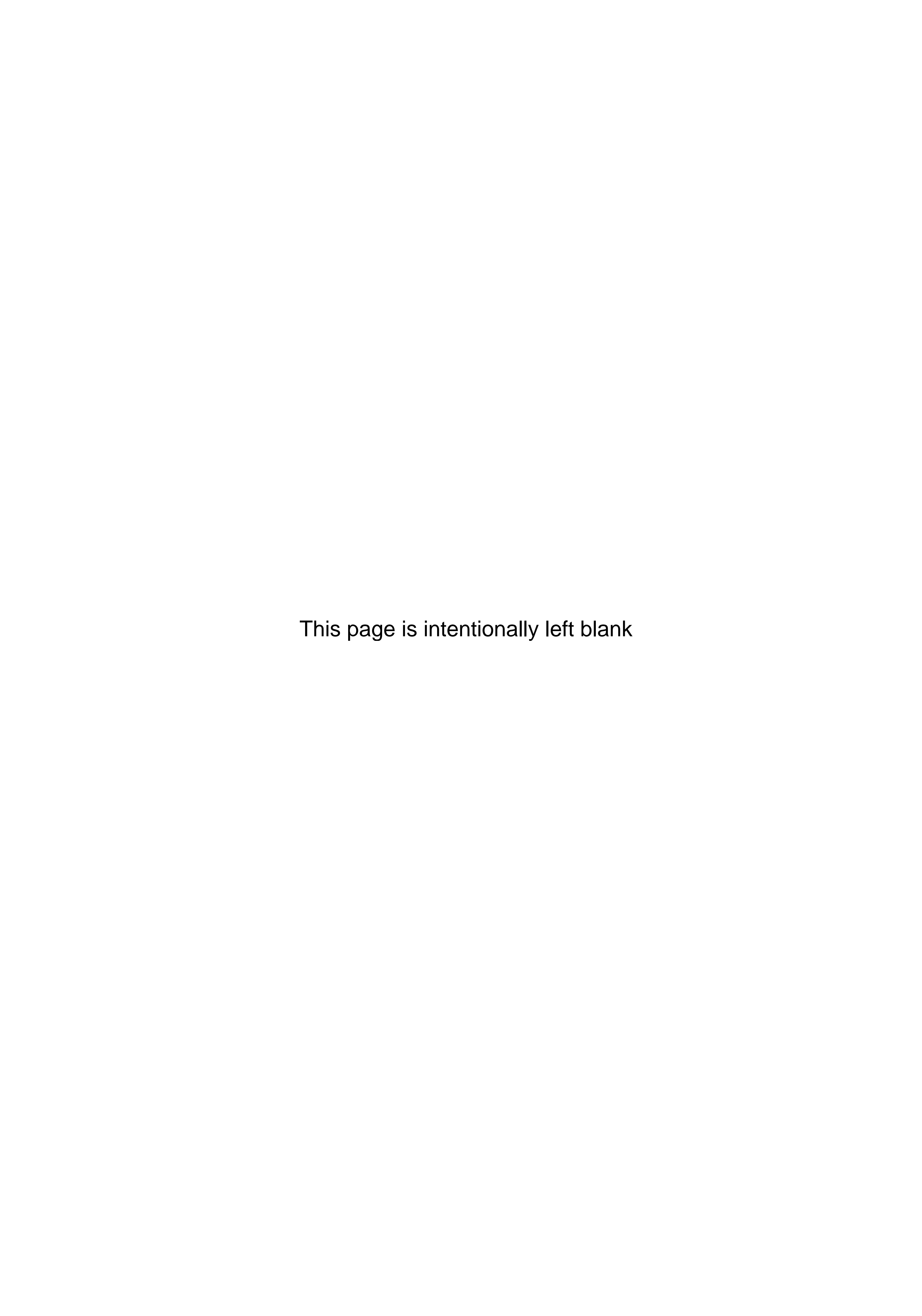
To consider an update on the Children and Young People's Mental Health Transformation Plan.

10. WORK PROGRAMME **(Pages 261 - 262)**

To consider the Work Programme for 2016/17.

11. ANY OTHER BUSINESS

Charlie Parker
Chief Executive
8 November 2016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CITY OF WESTMINSTER

MINUTES

Health & Wellbeing Board

MINUTES OF PROCEEDINGS

Minutes of a meeting of the **Health & Wellbeing Board** held on **Thursday 15th September, 2016**, Rooms 3 and 4, 17th Floor, City Hall, 64 Victoria Street, London, SW1E 6QP.

Members Present:
Chairman: Councillor Rachael Robathan, Cabinet Member for Adults and Public Health
Clinical Representative from the Central London Clinical Commissioning Group: Dr Neville Purssell
Cabinet Member for Children and Young People: Councillor Karen Scarborough (acting as Deputy)
Minority Group Representative: Councillor Barrie Taylor
Deputy Director of Public Health: Eva Hrobonova
Tri-Borough Director of Adult Services: Liz Bruce
Tri-Borough Children's Services: Melissa Caslake
Director of Housing and Regeneration: Barbara Brownlee
Clinical Representative from West London Clinical Commissioning Group: Dr Philip Mackney
Westminster Community Network: Janice Horsman
Chair of Westminster Community Network: Lainya Offside-Keivani (acting as Deputy)

1 MEMBERSHIP

1.1 Apologies for absence were received from Councillor Danny Chalkley (Cabinet Member for Children and Young People) and Sarah Mitchell (Westminster Community Network). Councillor Karen Scarborough (Deputy Cabinet Member for Children and Young People) and Lainya Offside-Keivani (Westminster Community Network) attended as their respective Deputies.

2 DECLARATIONS OF INTEREST

2.1 Janice Horsman (Healthwatch Westminster Representative) declared that in respect of item 10 on the agenda, Housing Support and Care Joint Strategic Needs Assessment, she is the Chief Executive of Wandsworth and Westminster Mind, who provide counselling services. However, she did not regard this as a prejudicial interest and remained present to consider this item.

3 MINUTES AND ACTIONS ARISING

3.1 **RESOLVED:**

1. That the Minutes of the meeting held on 14th July 2016 be signed by the Chairman as a correct record of proceedings; and

2. That progress in implementing actions and recommendations agreed by the Westminster Health and Wellbeing Board be noted.

4 UPDATES ON THE NORTH WEST LONDON SUSTAINABILITY TRANSFORMATION PLAN AND WESTMINSTER JOINT HEALTH AND WELLBEING AND STRATEGY

4.1 The Chairman introduced the item and stated that although the North West London Sustainability Transformation Plan (STP) and the Westminster Joint Health and Wellbeing Strategy were separate pieces of work, they were strongly interlinked with each other. She advised Members that the STP paper was at its first stage and a more detailed submission would be available in October.

4.2 Meenara Islam (Principal Policy Officer) then updated the Board on the draft Westminster Joint Health and Wellbeing Strategy. She advised that there had been 44 consultation responses to date and two consultation events had taken place. The first event, a Health and Care Providers Roundtable held on 8th September, and the second, ‘Everyone’s Business’ on 14th September, an event for businesses to discuss improving health and wellbeing, had both provided fruitful discussions and the importance of preventative work and early intervention had been emphasised. Meenara Islam advised that the next consultation event was a Public Drop-In Health Fair on 5 October where local health and wellbeing organisations and voluntary and community sector organisations would be invited to participate and Board Members were also welcome to attend. Meenara Islam advised that the consultation would end on 16 October and following this, a redrafted strategy would be presented to the Board on 17 November and would also be considered by both the NHS Central London Clinical Commissioning Group (CCG) and the NHS West London CCG. The strategy would then be put to Cabinet for formal approval, prior to its publication by 23 December, with a view to implementing the strategy in January 2017.

4.3 During Members’ discussions, it was suggested that Queens Park Community Council be engaged in the strategy consultation, whilst the views of the Neighbourhood Forums should also be sought. It was asked whether the Cabinet had been briefed about the strategy consultation and had the Westminster Parents Participation Group been consulted. Lainya Offside-Keivani advised that a South Westminster resilient families meeting targeting the needs of vulnerable children was taking place on 22 September at the Abbey Community Centre and she suggested that the strategy be made available for consultation at this meeting.

4.4 In reply to the issues raised, Meenara Islam advised that Queens Park Community Council and the Neighbourhood Forums had been written to at the beginning of the consultation, however she would remind these organisations about the consultation and the events taking place. She confirmed that Cabinet had been briefed about the strategy consultation and would consider arrangements for the strategy to be available for consultation at the South Westminster resilient families meeting.

4.5 The Chairman drew the Board's attention to the timetable of consultation events and welcomed Members' attendance of these and any further suggestions on other organisations that could be approached and other meetings that could be arranged. She thanked those who had been involved in organising the events and confirmed that the final detailed strategy would be presented to the Board at its next meeting on 17th November.

4.6 Louise Proctor (Managing Director, NHS West London Clinical Commissioning Group) then provided an update on the North West London STP and advised that a draft STP had been submitted in June 2016 that had highlighted areas in need of being developed, the investment needed and setting out the change offer. She confirmed that eight CCGs and six local authorities, including Westminster City Council, had supported the draft submission and views were being sought before the final submission of the STP on 21st October. The STP sought to integrate the Shaping a Healthier Future programme, the Better Care Fund, mental healthcare services and out of hospital care. It also sought to address the economic and financial challenges faced at local, North West London and national level. Members noted the STP's triple aim challenges, these being improving and health and wellbeing, improving care and quality and improving productivity and closing the financial gap.

4.7 Liz Bruce (Tri-Borough Director of Adult Social Care) added that the six London boroughs involved in the STP played a system leadership role and the individual local joint health and wellbeing strategies would reflect this. The bidding process for commissioning of services would involve the CCGs and local authorities going through a single gateway together which would present challenges for both groups. Efforts would be made to align budgets and planning cycles across the local authorities and CCGs which would provide obvious benefits. Liz Bruce commented that the STP would bring together cultural changes in providing services and she advised that Westminster City Council was taking a lead in respect of financial and estate issues.

4.8 During discussions by the Board, a Member remarked that the STP had been a major item of discussion at the Imperial College Healthcare NHS Trust Annual General Meeting, with a number of questions from residents. In respect of financial aspects and budgets, he felt that it should be set out more clearly what Westminster was putting in, how the resources would be allocated and used and what the likely impact on services would be. He suggested that further information be provided on the implications of the prospect of the London Borough of Hammersmith and Fulham not being involved in the STP. He asked what the public should be looking out for to measure what the STP was trying to achieve and he emphasised the

importance of the public perception, suggesting that public communication should be continuous because of the way the changes to services had been planned.

4.9 The Chairman advised that only broad financial figures were available presently, however Westminster City Council was taking the lead in respect of the finance stream. She acknowledged that a lot of work needed to be undertaken in respect of finance and resources prior to the submission of the STP and some aspects would need to be place marked. The Chairman advised that the estates stream was an even bigger piece of work and the Council was also taking a lead on this, with Guy Slocombe (Director of Property Investments and Estates) heading this workstream. Members noted that the timescales for the STP were challenging and that the Adults, Health and Public Protection Policy and Scrutiny Committee was also being updated about the STP. The Chairman stated that it was disappointing that the London Borough of Hammersmith and Fulham and the London Borough of Ealing had not signed up to the STP, however these boroughs were keen to work jointly in other areas. She advised that although the STP was a North West London Plan, local delivery would be through the health and wellbeing boards' respective joint strategies. There would also be a specific item on the CCGs' commission intentions in respect of the STP to be considered at the next Board meeting.

4.10 Liz Bruce advised that one of the main objectives of the STP was to prevent unnecessary visits to hospitals. An example of this included an older adult receiving professional support in the community. Neville Purssell (Clinical Lead, NHS Central London Clinical Commissioning Group) added that the STP would provide a shining light in providing more effective planning, however it would involve a journey until this was fully achieved.

4.11 Louise Proctor then provided a verbal update on the CCGs' commissioning intentions and advised that between September to November, consideration would be undertaken as to what to focus on in the first year. Central and West London CCGs would work collaboratively and there would now be joint reports on the CCGs in respect of their commissioning activities. Members noted that a document in respect of the CCG's commissioning activities in Westminster, informed by the STP, would be produced.

4.12 The Chairman welcomed the approach to the CCG's commissioning intentions and these being accountable to their priorities.

5 FAMILY HUBS

5.1 Melissa Caslake (Tri-Borough Children's Services) presented the report and advised that the proposed Family Hubs would provide a virtual network of providers working with children 0 – 19 years with the aim to provide a more streamlined and effective service. The proposed key outcomes included reducing referrals to higher level interventions, preventing family breakdowns that result in children and young people being received into care or entering the criminal justice system, promoting strong and resilient parents and improving outcomes for children and young people across health and

wellbeing indicators. Training would be offered to frontline staff to facilitate this. Melissa Caslake then referred to the core offer to achieve these outcomes in the report through integrating Children's Services, Public Health and CCG activity. This included a one-stop access for universal services, such as birth registrations, to reinforce the hub as the place to go, and providing housing advice to tackle this issue early.

5.2 Melissa Caslake advised that a considerable amount of hard work lay ahead in delivering the family hubs, however a shared vision and shared values, and working more collaboratively and effectively together, would help achieve the desired outcomes. She then requested the Board's support and endorsement of the Family Hubs Programme.

5.3 Members came forward in welcoming the report and made a number of further comments. It was asked whether the programme would involve developing peer pathway support. Members welcomed the programme's focus on prevention, however lessons needed to be learnt from Sure Start and there were also issues about how to get GPs more involved. It was commented that Community Care for Children Programme had not been mentioned in the report and it was suggested that the Family Hubs Programme should join up its work with this programme. A Member welcomed the housing advice initiative in the programme and stated that around 30% of homeless had separated from their families. She asked whether it was possible to place workers within GP practices to help patients access the Family Hubs Programme and emphasised the importance of organisations and departments in sharing information and taking a joined-up approach. Another Member suggested that GP registrars could also be involved to help improve sign posting to the Family Hubs Programme.

5.4 A Member suggested that the programme offered the opportunity to consider issues such as vulnerable families. She stated that a recent survey of 100 families undertaken by her organisation had identified that their key concerns were welfare dependency, fear of moving and wishing to receive financial advice. Another Member felt that consideration should be given as to what the public perception would be of describing the programme as a virtual network of providers and he suggested that an alternative way of describing the programme be considered. He added that registered social landlords and housing associations would be keen to be engaged with the programme as they encountered such issues the programme sought to address on a daily basis.

5.5 The Chairman expressed her support for the programme and its focus on providing integrated, joined-up services and in reaching out to children in need at an earlier age. She concurred that the programme should work jointly with the Connecting Care for Children Programme.

5.6 In reply to some of the issues raised, Melissa Caslake also agreed that the programme should work jointly with the Connecting Care for Children Programme and that more work was needed in involving GPs in the programme. She welcomed any further suggestions from the Board and added that there were also other programmes providing an early help offer.

5.7 The Chairman advised that an update on the programme would be provided at a future meeting. The Board endorsed the report.

6 CHILDREN AND FAMILIES ACT IMPLEMENTATION AND PREPARATION FOR LOCAL AREA INSPECTION

6.1 Ian Heggs (Tri-Borough Director of Schools Commissioning) presented the report and advised that the Children and Families Act was now in its third year of implementation. He advised that the Act had replaced Special Educational Statements (SEN) with Education, Health and Care (EHC) plans, meaning local authorities needed to undertake transfer reviews of all SEN statement children and young people to EHC plans. Although Westminster had only completed 1.1% of the transfer reviews as of December 2015, good feedback had been received on the EHC plans completed to date, and additional resources were being put in place to ensure all transfer reviews were completed by the April 2018 deadline. Ian Heggs advised that a key issue to be addressed jointly by the Council and its health partners was in reducing the time taken by paediatricians to provide health advice for the 20 week EHC assessment process, however he was hopeful that this could be achieved.

6.2 Ian Heggs advised that a Commissioning Strategy was being developed to include plans for areas such as speech and language therapy and occupational therapy where demand had risen, although there were no additional resources for this. He added that autism was a key area of demand. Members noted that a narrative judgement would be given in respect of preparation for the Local Area Inspection. Ian Heggs informed Members that there had been a positive discussion with Ofsted on 15th September about the inspection.

6.3 During discussions, a Member commented on the reduction of services in diagnosing autism and asked whether this would make completing EHC plans more difficult. Another Member stated that personality disorder was a big issue and no statutory laws were in place to enable intervention and support and he suggested that this matter be raised.

6.4 In reply to the issues raised, Mandy Lawson (Tri-Borough Assistant Director, Special Educational Needs and Vulnerable Children's Services) advised that there was national guidance in respect of diagnosing autism and that there needed to be further consideration of the impact of autism on a person's daily life. Ian Heggs advised that under the local offer, the issue of personality disorder could be looked at in the context of mental health.

7 PRIMARY CARE MODELLING

7.1 The Board received a verbal update on the Primary Care Modelling project. Damien Highwood (Evaluation and Performance Manager) began by advising that there had been considerable progress in respect of comparing projected model demand against registered population with NHS Central London CCG. In respect of the supply aspect and estates, this had been discussed at a

meeting on 9th August, although no further update on this matter was available at this stage.

7.2 Rufus Fearnley (NHS North West London Collaboration of Clinical Commisioning Groups) advised that there was considerable variation between the sets of data in some areas, with the figures for cancer and dementia for the registered NHS Central London CCGs population being considerably higher than the modelled data. The registered data also suggested that the Westminster population was not as healthy as the modelled data had assumed, with GPs suggesting that around 70% of the population was healthy, compared to the modelled assumption of around 80%. Louise Proctor added the West London CCG was in the process of obtaining data from its West London GPs, which may further impact upon the results.

7.3 The Chairman stated that a clearer picture would emerge about the current supply and demand balance once more data was available.

8 PUBLIC HEALTH VISION STATEMENT

8.1 Ann Ramage (Bi-Borough Head of Environmental Health – Commercial) presented the report and advised that the Public Health Vision Statement aimed to pull together all the main public health focuses. Work was being undertaken to explain to the public what these focuses are and what the intended outcomes would be. The Chairman added that the Vision Statement was Westminster specific. The Board noted the report.

9 DRAFT ROUGH SLEEPING STRATEGY 2017-20

9.1 Members received a presentation on the Draft Rough Sleeping Strategy 2017-20. Richard Cressey (Principal Policy Officer) began by advising that the strategy was about to go to consultation and he then highlighted the strategy's three priorities, these being:

- Preventing rough sleeping and providing a rapid response
- Supporting people to rebuild their lives
- Tackling anti-social behaviour and keeping the city safe.

9.2 Focusing on supporting people to rebuild their lives, Richard Cressey advised that a key objective of this priority was improving rough sleepers' health and wellbeing, with a particular focus on addressing mental health and substance misuse issues. He advised that the Rough Sleepers Joint Strategic Needs Assessment in 2013 had identified that rough sleepers have more health needs and suffered from greater health inequalities than the general population, with their life expectancy around 30 years shorter than the average population. Rough sleeping was also associated with 'tri-morbidity', involving physical and mental health issues and substance misuse, as well as complex health needs and premature death. Members heard that rough sleepers were more than four times more likely to use Accident and Emergency Services and their secondary healthcare costs were at least five times more expensive than the general population. In addition, there were

specific barriers in accessing services for rough sleepers and hospital discharge was not always managed well.

9.3 Jennifer Travassos (Senior Manager of Rough Sleeping) then informed Members of the initiatives taken to take to tackle rough sleeping to date. This included an Integrated Care Network to provide physical and mental health bed spaces in hostels for those rough sleepers needing extra support, such as those patients discharged from hospital, and this also helped reduce hospital admissions. Homeless health peer advocates were also being used to help break down barriers and navigate rough sleepers through the health system. A new Common Health Assessment Tool had been introduced to the rough sleeping pathway and there had been 100% completion of this for all residents in 2015/16. Jennifer Travassos added that 99% of people in the rough sleeping pathway and over 90% of core rough sleepers were now registered with a GP. A Homeless Coordination Project in partnership with Public Health had also been commissioned.

9.4 Jennifer Travassos then informed Members about the proposed actions for the new strategy. As well as building on the achievements of the last strategy, the new strategy sought to increase the percentage of people in the Council's accommodation services with mental health needs who are engaging with mental health services from 64% to 80%. In respect of substance misuse, dual diagnosis was proposed to explore new routes into treatment services for rough sleepers in accommodation services, focusing on areas such as users of novel psychoactive substances, including 'Spice'. Initiatives would also be undertaken in addressing patients discharged from hospital in becoming homeless. Jennifer Travassos advised that the strategy would also seek to join up with Joint Health and Wellbeing Strategy and to work closely with the Board to ensure effective strategic oversight in delivering this priority.

9.5 During discussions, a Member remarked that two growing areas of difficulty were those being discharged from hospitals or prisons becoming homeless. In addition, as those who had remained homeless aged, hostels were increasingly becoming an unsuitable type of accommodation and these issues needed to be addressed. The Greater London Authority also depended on the Council in coordinating providers and this demonstrated the key role it played in London in tackling homelessness and rough sleeping. Another Member highlighted the importance of data sharing and consulting with homeless charities. It was noted that the voluntary sector was providing both commissioned and non-commissioned services for homeless people. A Member emphasised the need for prevention measures and early intervention to prevent younger people from becoming homeless.

9.6 The Chairman advised that the proposed strategy had Cabinet support and indicated her support on behalf of the Board in welcoming the proposed new strategy.

10 HOUSING SUPPORT AND CARE JOINT STRATEGIC NEEDS ASSESSMENT

10.1 Anna Waterman (Strategic Public Health Adviser) presented the report and stated that it was recognised that better quality housing could help improve health outcomes, whilst poor quality housing could exacerbate existing health problems. The Housing Support and Care Joint Strategic Needs Assessment (JSNA) was a deep dive JSNA that sought to provide integrated solutions to integrated problems and to explore ways in which collaboration can improve customer journeys and value for money. It also sought to complement and support the draft Joint Westminster Health and Wellbeing Strategy, the North West London STP, the Whole Systems Integrated Care and the Like Minded CCG programmes. Anna Waterman then referred to the seven themes underpinning the JSNA:

- Joint commissioning and pooled budgets
- IT data sharing protocols and information governance
- Smooth customer journeys supported by referral rights and referral pathways
- Quality services and facilities, appropriately tailored and targeted
- Asset based approaches (for individuals and for communities)
- Workforce development
- Local intelligence

10.2 Anna Waterman referred to the 12 recommendations in the JSNA, many of which included a range of opportunities for consideration by partners for local implementation. She asked the Board to agree the recommendations in the report.

10.3 During Members' discussions, Louise Proctor commented that commissioning needed to be looked at in practical terms and informed choices need to be made taking into account budget limitations. The Board agreed to the Chairman's suggestion that JSNA be looked at in more detail by Members and that the recommendations in the report be supported, subject to any concerns raised by Members in the next two weeks.

11 WORK PROGRAMME

11.1 Meenara Islam advised that the Westminster Health and Wellbeing Strategy would be presented to the Board at the next meeting for approval, prior to its submission to Cabinet on 12th December 2016 for final approval. She added that there would also be an update on the implementing the recommendations of the JSNA on dementia at the next meeting.

12 ANY OTHER BUSINESS

12.1 There was no other business.

The Meeting ended at 6.04 pm.

CHAIRMAN: ______________________ **DATE** ____________________

WESTMINSTER HEALTH & WELLBEING BOARD
Actions Arising

Meeting on Thursday 15th September 2016

Action	Lead Member(s) And Officer(s)	Comments
Draft Westminster Health and Wellbeing Strategy Refresh		
Final strategy to be put to the Board at the next meeting.	Meenara Islam	To be considered at the 17 November meeting.
Housing Support and Care Joint Strategic Needs Assessment		
Board to look at the Housing Support and Care Joint Strategic Needs Assessment in more detail and to support the recommendations, subject to any concerns raised by Members in the next two weeks.	All Board Members / Anna Waterman	Comments to be made by 29 September.

Meeting on Thursday 14th July 2016

Action	Lead Member(s) And Officer(s)	Comments
Draft Westminster Health and Wellbeing Strategy Refresh		
Meenara Islam then referred to the various consultation events and meetings and stated that she would to circulate to Members the dates that the consultation events and meetings are taking place.	Meenara Islam	Members to provide comments by 30 June.
Tackling Childhood Obesity Together		
Progress on the programme to be reported back to the Board in a year's time.	Eva Hrobonova	
Health and Wellbeing Hubs		
Details of the children's workstream to be reported to the Board at the next meeting.	Melissa Caslake	To be considered at the 15 September meeting.

Meeting on Thursday 26th May 2016

Action	Lead Member(s)	Comments

	And Officer(s)	
Draft Westminster Health and Wellbeing Strategy Refresh		
Members to provide any further input on the strategy before it goes to consultation at the beginning of July.	All Board Members	Members to provide comments by 30 June.

Meeting on Thursday 17th March 2016

Action	Lead Member(s) And Officer(s)	Comments
Westminster Health and Wellbeing Strategy Refresh Update		
Members requested to attend Health and Wellbeing Board workshop on 5 April.	All Board Members	Workshop to take place on 5 April.
Meenara Islam to circulate details of proposals discussed at an engagement plan meeting between Council and Clinical Commissioning Group colleagues.	Meenara Islam	
NHS Central and NHS West London Clinical Commissioning Group Intentions		
Clinical Commissioning Groups to consider how future reports are to be presented with a view to producing reports more similar in format and more user friendly.	Clinical Commissioning Groups	On-going.

Meeting on Thursday 21st January 2016

Action	Lead Member(s) And Officer(s)	Comments
Commissioning Intentions: (A) NHS Central London Clinical Commissioning Group; (B) NHS West London Clinical Commissioning Group		
Update on the Clinical Commissioning Groups' intentions to be reported at the next Board meeting.	Clinical Commissioning Groups	To be considered at the 17 March 2016 meeting.
Westminster Health and Wellbeing Strategy Refresh		
Draft proposals for the strategy refresh to be considered at the next Board meeting	Adult Social Care, Clinical Commissioning Groups and Policy, Performance and Communication	To be considered at the 17 March 2016 meeting.

Meeting on Thursday 19th November 2015

Action	Lead Member(s) And Officer(s)	Comments
Westminster Health and Wellbeing Hubs Programme Update		
Update on the Programme to be reported at the next Board meeting.	Adult Social Care	To be considered at the 21 January 2016 meeting.
Like Minded – North West London Mental Health and Wellbeing Strategy – Case for Change		
Board to receive report on Future In Mind programme to include details of how it will impact upon Westminster and how the Board can feed into the programme to provide more effective delivery of mental health services.	Children's Services	To be considered at earliest opportunity.
Board to receive report on young people's services, including how they all link together in the context of changes to services.	Children's Services	To be considered at earliest opportunity.

Meeting on Thursday 1st October 2015

Action	Lead Member(s) And Officer(s)	Comments
Central London Clinical Commissioning Group – Business Plan 2016/17		
West London Clinical Commissioning Group to circulate their Business Plan 2016/17 to the Board.	West London Clinical Commissioning Group	
Westminster Health and Wellbeing Hubs Programme Update		
Board to nominate volunteers to be involved in the Programme and to be on the Working Group.	Meenara Islam	
Update on the Programme to be reported at the next Board meeting.	Adult Social Care	To be considered at the 19 November 2015 meeting.
Dementia Joint Strategic Needs Assessment – Commissioning Intentions and Sign Off		
Board to receive and update at the first Board meeting in 2016.	Public Health	To be considered at the 21 January 2016 meeting.

Meeting on Thursday 9th July 2015

Action	Lead Member(s) And Officer(s)	Comments
Five Year Forward View and the Role of NHS England in the Local Health and Care System		
That a document be prepared comparing NHS England's documents with the Clinical Commissioning Groups to demonstrate how they tie in together.	Clinical Commissioning Groups/NHS England	To be considered at a forthcoming meeting.
Board to receive regular updates on the work of NHS England and to see how the Board can support this work.	NHS England	To be considered at future meetings.
Westminster Housing Strategy		
Housing Strategy to be brought to a future meeting for the Board to feed back its recommendations.	Spatial and Environmental Planning	To be considered at a forthcoming meeting.
Update on Preparations for the Transfer of Public Health Responsibilities for 0-5 Years		
Board to receive an update in 2016.	Public Health	To be considered at a meeting in 2016.

Meeting on Thursday 21st May 2015

Action	Lead Member(s) And Officer(s)	Comments
North West London Mental Health and Wellbeing Strategic Plan		
That a briefing paper be prepared outlining how the different parts of the mental health services will work and how various partners can feed into the process.	NHS North West London	To be considered at a forthcoming meeting.
Adult Social Care representative to be appointed onto the Transformation Board.	NHS North West London Adult Social Care	To be confirmed.
Children and Young People's Mental Health		
A vision statement be produced and brought to a future Board meeting setting out the work to be done in considering mental health services for 16 to 25 year olds, the pathways in accessing services and the flexibility in both the setting and the type of mental health care provided, whilst embracing a multidisciplinary approach.	Children's Services	To be considered at a forthcoming meeting.
The role of pharmacies in Communities and Prevention		
Public Health Team and Healthwatch Westminster to	Public Health	Completed

liaise and exchange information in their respective studies on pharmacies, including liaising with the Local Pharmaceutical Committee and the Royal Pharmaceutical Society.	Healthwatch Westminster	
Whole Systems Integrated Care		
That the Board be provided with updates on progress for Whole Systems Integrated Care, with the first update being provided in six months' time.	NHS North West London	First update to be considered at the 19th November 2015 Health and Wellbeing Board meeting.
Joint Strategic Needs Assessment		
Consideration be given to ensure JSNAs are more line with the Board's priorities.	Public Health	Report being considered 9th July 2015
The Board to be informed more frequently on any new JSNA requests put forward for consideration.	Public Health	On-going.
Better Care Fund		
An update including details of performance and spending be provided in six months' time.		Update to be considered at the 19th November 2015 Health and Wellbeing Board meeting.
Primary Care Co-Commissioning		
Further consideration of representation, including a local authority liaison, to be undertaken in respect of primary care co-commissioning.	Health and Wellbeing Board	In progress
Work Programme		
Report to be circulated on progress on the Primary Care Project for comments.	Holly Manktelow Health and Wellbeing Board	Circulated.
The Board to nominate a sponsor to oversee progress on the Primary Care Project in between Board meetings.	Health and Wellbeing Board	To be confirmed.
NHS England to prepare a paper describing how they see their role on the Board and to respond to Members' questions at the next Board meeting.	NHS England	To be considered at the 9th July 2015 Health and Wellbeing Board meeting.

Action	Lead Member(s) And Officer(s)	Comments
Pharmaceutical Needs Assessment		
Terms of reference for a separate wider review of the role of pharmacies in health provision, and within integrated whole systems working and the wider health landscape in Westminster, to be referred to the Board for discussion and approval.	Adult Social Care	Completed

Meeting on Thursday 22nd January 2015

Action	Lead Member(s) And Officer(s)	Comments
Better Care Fund Plan		
Further updates on implementation of the Care Act to be a standing item on future agendas.	Adult Social Care	Completed.
Child Poverty		
Work to be commissioned to establish whether and how all Council and partner services contributed to alleviating child poverty and income deprivation locally, through their existing plans and strategies – to identify how children and families living in poverty were targeted for services in key plans and commissioning decisions, and to also enable effective identification of gaps in provision.	Children's Services	In progress.
To identify an appropriate service sponsor for allocation to each of the six priority areas, in order to consolidate existing and future actions that would contribute to achieving objectives.	Children's Services	In progress.
Local Safeguarding Children Board Protocol		
Protocol to be revised to avoid duplication and to be clear on the different and separate roles of the Health & Wellbeing Board and the Scrutiny function.	Local Safeguarding Children Board	Completed.
Primary Care Commissioning		
A further update on progress in Primary Care Co-Commissioning to be given at the meeting in March 2015.	Clinical Commissioning Groups. NHS England	Completed.

Meeting on Thursday 20th November 2014

Action	Lead Member(s)	Comments

	And Officer(s)	
Primary Care Commissioning		
The possible scope and effectiveness of establishing a Task & Finish Group on the commissioning of Primary Care to be discussed with Westminster's CCGs and NHS England, with the outcome be reported to the Health & Wellbeing Board.	Clinical Commissioning Groups NHS England	Completed
Work Programme		
A mapping session to be arranged to look at strategic planning and identify future agenda issues.	Health & Wellbeing Board	Completed.

Meeting on Thursday 18th September 2014

Action	Lead Member(s) And Officer(s)	Comments
Better Care Fund Plan 2014-16 Revised Submission		
That the final version of the revised submission be circulated to members of the Westminster Health & Wellbeing Board, with sign-off being delegated to the Chairman and Vice-Chairman, subject to any comments that may be received.	Director of Public Health.	Completed.
Primary Care Commissioning		
The Commissioning proposals be taken forward at the next meeting of the Westminster Health & Wellbeing Board in November	NHS England	Completed.
Details be provided of the number of GPs in relation to the population across Westminster, together with the number of people registered with those GPs; those who are from out of borough; GP premises which are known to be under pressure; and where out of hours capacity is situated.	NHS England	Completed.
Measles, Mumps and Rubella (MMR) Vaccination In Westminster		
That a further report setting out a strategy for how uptake for all immunisations could be improved, and which provides Ward Level data together with details of the number of patients who have had measles, be brought to a future meeting of the Westminster Health & Wellbeing Board in January 2015.	NHS England Public Health.	To considered at the forthcoming meeting in May 2015. This has been pushed back to later in 2015

Meeting on Thursday 19th June 2014

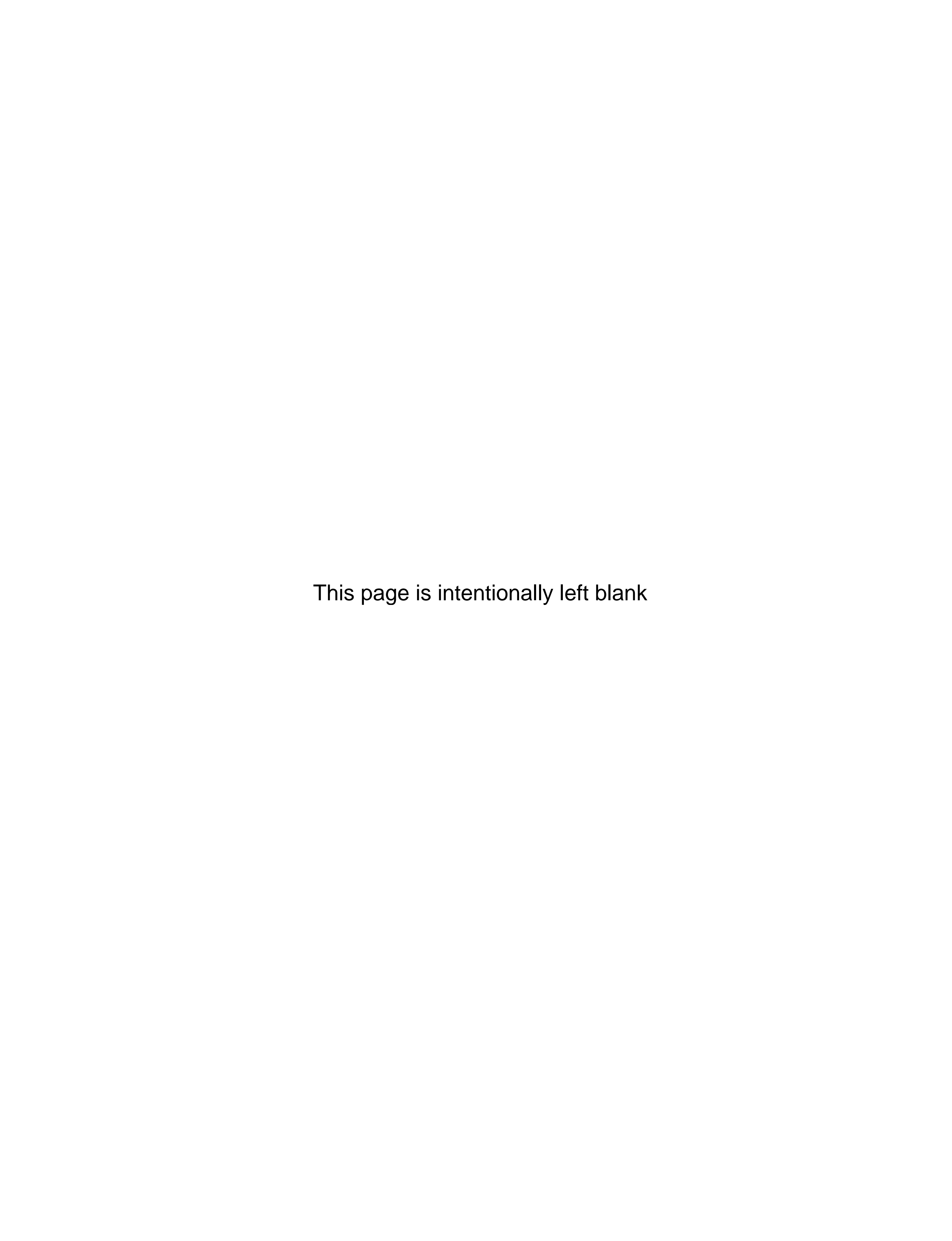
Action	Lead Member(s) And Officer(s)	Comments

Whole Systems		
Business cases for the Whole Systems proposals to be submitted to the Health & Wellbeing Board in the autumn.	Clinical Commissioning Groups.	Complete.
Childhood Obesity		
A further report to be submitted to a future meeting of the Westminster Health & Wellbeing Board by the local authority and health partners, providing an update on progress in the processes and engagement for preventing childhood obesity.	Director of Public Health.	To be considered at a forthcoming meeting
The Health & Wellbeing Strategy		
A further update on progress to be submitted to the Westminster Health & Wellbeing Board in six months.	Priority Leads.	Completed
NHS Health Checks Update and Improvement Plan		
Westminster's Clinical Commissioning Groups to work with GPs to identify ways of improving the effectiveness of Health Checks, with a further report on progress being submitted to a future meeting.	Clinical Commissioning Groups	Completed
Joint Strategic Needs Assessment Work Programme		
The implications of language creating a barrier to successful health outcomes to be considered as a further JSNA application. *Note: Recommendations to be put forward in next year's programme.*	Public Health Services Senior Policy & Strategy Officer.	Completed

Meeting on Thursday 26th April 2014

Action	Lead Member(s) And Officer(s)	Comments
Westminster Housing Strategy		
The consultation draft Westminster Housing Strategy to be submitted to the Health & Wellbeing Board for consideration.	Strategic Director of Housing	Being considered at the 9th July 2015 Health and Wellbeing Board
Child Poverty Joint Strategic Needs Assessment Deep Dive		
A revised and expanded draft recommendation report to be brought back to the Health & Wellbeing Board in September.	Strategic Director of Housing Director of Public Health.	Completed.
Tri-borough Joint Health and Social Care Dementia Strategy		
Comments made by Board Members on the review and initial proposals to be taken into account when drawing up the new Dementia Strategy.	Matthew Bazeley Janice Horsman Paula Arnell	Completed

Whole Systems		
A further update on progress to be brought to the Health & Wellbeing Board in June.	Clinical Commissioning Groups	Completed.



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Westminster Health & Wellbeing Board

Date:	17 November 2016
Classification:	General Release
Title:	Update on the North West London Sustainability Transformation Plan and Westminster's Joint Health and Wellbeing Strategy
Report of:	Councillor Rachael Robathan, Cabinet Member for Adults and Public Health and Chair of the Health and Wellbeing Board Dr Neville Purssell, Vice-chair, Health and Wellbeing Board
Wards Involved:	All
Policy Context:	-
Financial Summary:	NA
Report Author and Contact Details:	Meenara Islam, Principal Policy Officer, Westminster City Council (mislam@westminster.gov.uk) Emma Playford, Central London Clinical Commissioning Group (emma.playford@nhs.net)

1. Executive Summary

1.1 This paper updates the Health and Wellbeing Board on the North West London Sustainability and Transformation Plan and the joint health and wellbeing strategy refresh process.

2. Key Matters for the Board

2.1 The Board is requested to:

- Consider the update on the Sustainability and Transformation Plan;

- Note the summarised engagement and consultation process (appendix A); and
- Consider and provide feedback on the post-consultation draft strategy (appendix B).

3. Background

3.1 In December 2015, NHS England requested that every local health and care system must produce a multi-year Sustainability and Transformation Plan (STP). The purpose of the plan is to demonstrate how local services will evolve and become sustainable over a five year period.

3.2 An STP covering the population of 16 local authorities and Clinical Commissioning Groups (CCGs) in North West London, including Westminster City Council, is being developed. STPs are expected to be submitted to NHS England by the end of 2016 and could attract national transformation funding. The quality of the STP will determine the amount and timing of the release of funding.

3.3 The STP aims to deliver North West London's joint vision of creating a preventative health and wellbeing system. This includes developing high quality primary and community based services, while concurrently supporting the clinical and financial sustainability of the health and care system.

3.4 Westminster's refreshed joint health and wellbeing strategy (expected to be published by the end of the year) will act as the local delivery mechanism for the objectives of the North West London STP. Both documents have been developed in parallel since January 2016 resulting in the linking of themes and principles such as prevention, early intervention and improving mental health and wellbeing for adults and children.

4. North West London Sustainability and Transformation Plan (STP) update

4.1 In June 2016, the North West London Alliance submitted a draft plan to NHS England for early feedback. This draft plan set out five delivery areas:

1. Radically upgrading prevention and wellbeing;
2. Eliminating unwarranted variation and improving long term condition management;
3. Achieving better outcomes and experiences for older people;
4. Improving outcomes for children and adults with mental health needs; and
5. Ensuring we have safe, high quality and sustainable acute services.

4.2 These delivery areas are to be underpinned by an effective and agile workforce, robust digital infrastructure and multi-purpose and community based estates. The STP consortium has been undertaking extensive engagement on the plan

through an online forum and public events. In Westminster, the consultation process and findings from the health and wellbeing strategy has fed into the STP engagement work.

4.3 A further update to the STP was submitted to NHS England in October 2016. There is ongoing engagement and dialogue about the plan between partners and key stakeholders. The key areas of development that are still required are around the out of hospital strategy and the funding required to support more care and support in the community.

4.4 Westminster City Council, under the stewardship of the Cabinet Member for Adults and Public Health, the Chief Executive and Executive Director of Adult Social Care and Health, is leading on the finance and estates planning on behalf of the North West London STP Alliance.

5. Refreshing the Joint Health and Wellbeing Strategy

5.1 Westminster's health and wellbeing strategy is a joint responsibility of the Council, Central London and West London Clinical Commissioning Groups. It responds to local challenges around health inequalities, financial sustainability of health and care services, the changing demography, and the needs and expectations of people who live in, work in and visit the city. The strategy, through its link to the North West London STP, will be addressing the sub-regional challenges around joining up estates, developing multi-skilled health and care teams and joining up health and care services to improve people's experiences of services as well as their lives.

5.2 The draft strategy is based on robust local evidence, early engagement with partners, and local residents. Cllr Rachael Robathan (Cabinet Member for Adults and Public Health and Chair of the Health and Wellbeing Board) and Dr Neville Purssell (Chairman of Central London CCG and Vice Chair of the Westminster Health and Wellbeing Board) jointly led an extensive engagement programme which included events with businesses, health and care providers, patient and service user representatives, the voluntary and community sector, and members of the public. In parallel, an online consultation was undertaken for a period of 14 weeks, ending on 16 October 2016. **Appendix A** provides a summary of the engagement process.

5.3 In summary, the feedback from the online consultation and engagement programme demonstrated strong support for the preventative and early intervention direction as well as the four headline themes of the strategy which include:

1. Improving outcomes for children and young people;
2. Reducing the risk factors for, and improving the management of, long term conditions, with a spotlight on dementia;
3. Improving mental health through prevention and self-management; and

4. Creating and leading a sustainable and effective local health and care system.

5.4 Some of the feedback focused on the role of the broader "determinants of health and wellbeing", including infrastructure, planning, air quality and transport in the city. Other respondents supported the strategy's promotion of nutrition and diet, and physical activity as well the transformation of services of the future which are more holistic and tailored to the needs of our communities. A summary of feedback and proposed changes to the strategy is set out in **appendix A.** A revised draft of the Joint Health and Wellbeing Strategy, taking account of the comments received, is attached at **appendix B**.

6. Governance

6.1 The West London CCG Governing Body received an update on the engagement around the joint health and wellbeing strategy on 2 November 2016. Central London CCG will also be provided with an update at its meeting on 9 November 2016.

6.2 The Health and Wellbeing Board will discuss the revised version of the strategy on 17 November 2016. Following feedback from the Board, the revised strategy will be submitted to the Policy and Scrutiny Committee for the Adults and Public Protection for them to consider it at their meeting on 23 November 2016. Westminster City Council's Cabinet will then review the final version of the draft strategy on 12 December 2016. The final strategy is expected to be published by the end of 2016.

7. Implementation

7.1 A joint implementation plan setting out the focus of each priority, timelines and performance framework will be developed over in the coming months to be presented at the Health and Wellbeing Board meeting on 2 February 2017.

8. Legal Implications

8.1 The duty in respect of Joint Health and Wellbeing Strategies is set out in s116A of the amended Local Government and Public Involvement in Health Act 2007.

8.2 Legal Services have confirmed the Joint Health and Wellbeing Strategy and the STP as being a lawful process that discharges the Council's public and stakeholder's engagement responsibility to consult.

9. Financial Implications

N/A

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

Meenara Islam (mislam@westminster.gov.uk)

APPENDICES:

Appendix A – Summary of the Joint Health and Wellbeing Strategy consultation and engagement process.

Appendix B – Revised Draft of Westminster's Joint Health and Wellbeing Strategy

Appendix A – Summary of the Joint Health and Wellbeing Strategy consultation process and feedback

Online and postal consultation responses

An online feedback platform was open between 6 July and 16 October 2016. The forum was publicised widely through partners, social media and at events. Over 100 responses were received from a range of individuals, organisations and businesses.

Discussions and presentations at partner events

Officers attended and presented at partner and community events and meetings including the below:

North Westminster Community Network	Healthwatch Central West London
Westminster Community Network	Central London CCG's Locality Meetings (North, Central and South)
Central London CCG AGM	West London CCG's Patient Reference Group & Central London CCG's User Panel meeting
Paddington Festival (Queen's Park Community Festival)	Community Champions Summer Health Fair
South Westminster Action Network	Older People's Forum
South West London Health and Wellbeing Network	BME Health Forum

Consultation events

Officers organised three events with the following stakeholders:

- **Health and care providers roundtable at CCG offices, 8 September**
  The meeting was attended by representatives of over 15 provider organisations including Central and North West London Hospital Trust, Imperial College Healthcare Trust, Central London Community Healthcare, Open Age, and Notting Hill Housing.

- **Health is Everyone's Business at Somerset House, 14 September**
  The meeting was attended by representatives from over 60 businesses, and there were presentations from The Crown Estate, Impact Hub Westminster, Marylebone Cricket Club Lords and WSP Group. The event also included a marketplace with community and voluntary organisations.

- **Open House with the public – Church Street Library, 5 October**
  Over 40 members of the public attended our event at Church Street library which included a marketplace with representatives from a range of voluntary and community sector organisations. During the event there were presentations from Central and North West London Healthcare Trust Talking Therapies and Recovery and Wellbeing College, as well as activities hosted by Paddington Development Trust and Penfold Street Hub.

- **Westminster Open Forum – Victoria, 6 October**
  The priorities of the draft Joint Health and Wellbeing Strategy were discussed at a public event run by the Leader of the Council and Cabinet Members. 160 members of the public took part and provided feedback.

Summary of feedback

The following are the most prominent points of feedback received throughout the engagement process. People asked for the strategy to consider:

- The feedback received has been overwhelmingly positive. Strong support has been received for the preventative and community asset-based approach, and the focus on the wider determinants of health in the Strategy.
- The four headline priorities received widespread support from respondents.
- Comments received indicated that the council and partners are already doing a lot to improve and support health and wellbeing but wanted the Health and Wellbeing Board to do more jointly to communicate our good news stories and signpost to available support and services. An example of this was supporting people with disabilities to participate in activities in their local areas.
- The majority of responses were concerned with the “wider determinants” of health and wellbeing and demonstrated how crucial it will be to take a system-wide approach to deliver the strategy. This included: working with partners in housing, transport and public health to tackle air quality, make walking and cycling safer, provide accessible modes of transport, and make physical activity opportunities available.
- There were calls to use data to target services at the vulnerable and those most at risk to prevent escalation of problems and intervening early when there are signs of problems – particularly relating to mental health.
- There was significant support for more opportunities to be physically active.
- People wanted care closer to them – whether they are helped to access services or services are increasingly based and delivered in the community

Feedback on overarching approach of the draft strategy:

- There is support for a preventative approach to ensure people stay as healthy as possible for as long as possible, but some would welcome defining what we mean by prevention – primary (e.g. stopping people starting smoking), secondary

(e.g. stopping people who already smoke) and tertiary (e.g. reducing or stopping smoking after a health event related to smoking).

- There should be more of a focus on the wider role of all members of the health and care system and why collaboration amongst the public sector, commissioners, providers, the voluntary and community sector, businesses and individuals is beneficial for everyone. Providers discussed the importance of ensuring individuals are aware of their responsibilities as patients within a free-at-point-of-service NHS including attending appointments, finishing courses of treatment etc.

- Many respondents commented on the need for improved access to information and signposting to services – the majority of people indicated that they receive their health information from family, friends, the internet and their GP.

- Respondents related a desire to maintain their independence for as long as possible, and prioritised the role of wider determinants – their social networks, their housing, and access to transport – in supporting this.

- Respondents generally supported for new methods of communication with health and care professionals e.g. phone/video calls with GPs, but wanted this to be supported by good access to in-person services when needed.

Changes to the draft strategy post-consultation

The draft strategy has been updated to incorporate feedback received during the public consultation period. The main changes were:

- Stronger references to the wider determinants of health (e.g. the Greener City Action Plan, which contains actions around improving air quality and promoting active transport) and the importance of housing issues.
- Making clear in priorities 1 and 2 that the strategy includes health and care support and services explicitly include people living with physical and learning difficulties.
- Emphasising the role of families in priority 1.
- Emphasising that commitments under priority 1 include all children and young people, from the point of conception.
- Strengthening commitments to promote opportunities for physical activity and information about availability of community facilities and places.
- In priority 2, we ensured that our commitment to helping people into and maintaining employment includes people who are living with chronic conditions.

Joint Health and Wellbeing Strategy for Westminster 2017-2022

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Executive Summary

Our local health and care system (consisting of Westminster City Council, Central and West London NHS Clinical Commissioning Groups, health and care providers, the voluntary and community sector, individuals and communities) **has come together with a single vision*: that all people in Westminster are enabled to be well, stay well and live well, supported by a collaborative and cohesive health and care system.*** This is an opportunity to transform the wellbeing of people who live, work and visit Westminster.

This vision is a response to the unique challenges and opportunities Westminster has as a result of its location at the centre of a national and global economic hub. The City is a destination for people seeking a new life both domestically and from abroad, and is therefore a home to a vibrant and diverse set of communities. It hosts numerous businesses, workers and visitors, often only for short periods of time, leading to high levels of population 'churn'. Some of the complex challenges we face include:

- **Services funded on the basis of resident population,** not reflecting the realities of a place with a changing population which can be up to four times larger during the day than the number of people who reside in Westminster;
- **Urban environment issues such as congestion and air quality,** high levels of road traffic accidents, and parts of the City which are among the worst performers in air quality tests in Europe;
- **Health outcomes are increasingly dependent on lifestyle choices and environmental factors;** and
- **The highest level of rough sleepers of anywhere in the country** with over 2,570 people being identified in 2014/15[1].

Against this backdrop, our mission **is to focus on prevention and early intervention.**

When people experience mental or physical ill health we will come together to ensure timely, high quality, person-centred care is delivered with dignity and respect at all stages, including at the end of life.

Over the next five years, **we intend to achieve this by focusing our efforts on the following four priorities:**

1. Improving outcomes for children and young people;
2. Reducing the risk factors for, and improving the management of, long term conditions such as dementia;
3. Improving mental health through prevention and self-management; and

[1] (St. Mungo's Broadway, 2015/16)

4. Creating and leading a sustainable and effective local health and care system for Westminster.

Our vision to transform health and care is our way of delivering on the national policy shift toward greater devolution of control to local communities. For each priority, we intend to provide improvements in areas such as quality of life, quality of care, financially sustainable health and care, unrivalled professional experience and efficient operational performance of services across the City.

We understand that we need to work together to put in place the leadership and governance arrangements which will allow us to deliver this transformation. We will identify how we will jointly put into action our priorities working on key system enablers such as workforce, estates, information and data.

This strategy focuses on the most complex and critical needs identified by (and for) our communities, where we can all take action quickly and effectively over the next five years to transform the wellbeing and quality of life of people who live, work and visit Westminster. We welcome your input and active participation in the consultation and subsequent delivery of these aims.

Health and wellbeing is everyone’s business, working in partnership with you.

Introduction

Our local health and care system consists of Westminster City Council, Central and West London Commissioning Groups, health and care providers, the voluntary and community sector, communities and individuals. It is a system with many moving parts, with different functions but with one sole purpose – to support and enable us all to live well, be well and stay well.

Our local health system is facing some of the greatest challenges it has ever faced. There are various and complex pressures – a burgeoning population (a small but increasing proportion of which is elderly, frail and living alone); growing numbers of people with long term conditions; and changing and increasing expectations of the public about how and when they can access care and support. Looking to the future, we know that these trends will only continue and doing nothing is not an option.

This strategy represents the whole system's commitment to prioritising prevention and early intervention. When anyone in our population experiences mental or physical ill health and requires support, the whole system will come together to work with them to ensure they experience high quality care delivered by an integrated, talented and diverse workforce in a setting that is appropriate and convenient.

The NHS Five Year Forward View[2] signalled a shift in attitude toward supporting prevention in health and care and called for local areas to work together and experiment with new models of care. The devolution agreement for London[3] encourages ambitious localities, such as Westminster, to prepare for potentially greater flexibilities, powers and responsibilities in the future.

The North West London Sustainability and Transformation Plan (STP)[4] will bring the NHS Five Year Forward View to life and set out the vision for health and care of eight Clinical Commissioning Groups and corresponding local authorities including Westminster. It will help us to implement an integrated system that is oriented towards upstream prevention, early intervention and care in the community by 2021. This Strategy is our local plan setting out how we will meet national commitments, including those in the STP and the North West London Transforming Care Partnership (TCP) plan[1], and deliver local priorities for the population of Westminster. This Strategy will be underpinned by a detailed implementation plan, and regular monitoring by the Health and Wellbeing Board.

Organisations alone can only do so much. Our most significant and most valuable asset to achieve the mission of this strategy is not buildings or budgets – it is the coming together of talented, knowledgeable and passionate people, staff and local community groups. Working with local people, community groups and professionals to design local services is crucial to ensuring those services are meeting local needs.

It is important that our health and care system treats everyone with dignity and respect. This particularly applies to our vulnerable populations. For our large homeless and rough

sleeping population, providing services that address their needs, proactively engage and empower them to make healthy choices is important. We will do all we can to ensure everyone in Westminster has fair access to health and care services to support and improve their health and wellbeing.

This strategy focuses on four targeted priorities which are based on evidence of local need and what we have heard from partners, local groups, communities and people. They are:

1. Improving outcomes for children and young people;
2. Reducing the risk factors for, and improving the management of, long term conditions such as dementia;
3. Improving mental health through prevention and self-management; and
4. Creating and leading a sustainable and effective local health and care system for Westminster.

We will deliver our priorities by addressing quality of life, people's experiences of services and the financial sustainability of our health and care system[5]. Outcomes for each priority set out our aspiration for health and wellbeing in Westminster. We will develop a detailed joint delivery plan that will identify how we will put our commitments into action. The delivery will be overseen by the Health and Wellbeing Board as the leader of the City's health and care system bringing together the Council, our two Clinical Commissioning Groups, voluntary and community groups and Healthwatch.

Our four priorities will be areas of focus for the Westminster Health and Wellbeing Board for the next five years. However, this does not mean that other issues and challenges are not important or will not be addressed during this time. The Strategy puts a spotlight on the most complex and critical needs identified in Westminster where the Health and Wellbeing Board can take action rapidly and effectively.

The Health and Wellbeing Board, on behalf of everyone living in, working in and visiting Westminster, will implement and monitor the commitments in this Strategy and the North West London STP. The Board will review and report on progress annually.

Health and wellbeing is everyone's business, working in partnership with you.

[5] (Healthier North West London, 2016)

Our communities

Westminster is a global city at the heart of the nation's capital and home to a highly diverse resident population of around 242,299 people. The population during the daytime is approximately 900,000 which is the highest daytime population of any London Borough, including residents, employees and visitors[6].

We have the highest level of international migration of any place in England. Just over half of our resident population was born outside of the UK. Black, Asian, Arabic and other minority ethnic groups comprise 30% of our population and there are estimated to be over 10,000 lesbian, gay, bisexual or transgender (LGBT) people in the City.

Our resident population has a high proportion of younger people, with 49% of our resident population aged between 18 and 44 years old. Almost half of households are single person households, the third highest proportion in London. We have the fourth highest proportion in the country of households that are occupied by lone pensioners.

Westminster has the highest level of rough sleepers of anywhere in the country with over 2,570 people being identified in 2014/15[7]. There are also tens of thousands of people who live in the City for short periods or on a part-time basis. The Westminster population is more changeable than any other area.

Looking at likely demographic, economic and social trends over the next 15 years, we estimate that the following changes will affect how people live and work in Westminster and in turn their health and wellbeing needs:

- There will be a projected 16% increase in the number of people aged over 85 years[8] living in Westminster. While a large proportion of this group will age in good health, there will be a significant rise in the number of older people living with long term conditions that will cause both minor and severe impacts on their mobility, health and care needs, and wider role in their communities. Over the next five years alone we expect the annual cost of care for older people living with severe physical disabilities and long-term conditions such as dementia to grow by £10.4m[9].

- There will be a smaller proportion of children and young people living in Westminster by 2036 with the proportion of people aged less than 16 years as part of the overall population expected to decline from 16% to 14%[10].

- If nothing changes, more young people will be growing up with long term health conditions, (particularly obesity and mental health related conditions) that will likely follow them into adulthood. This could have significant impact on their ability to make

[6] (Greater London Authority, 2016)
[7] (St. Mungo's Broadway, 2015/16)
[8] (Greater London Authority, 2015)
[9] (Westminster City Council, 2015)
[10] (Greater London Authority, 2015)

the most of the opportunities of a changing social, economic and technological landscape[11].

- The City will be busier than ever with more commuters coming to work in Westminster every day, putting tremendous pressure on transport and public spaces[12]. While these people will be less likely to drive and will make more use of walking, cycling and taxis we do not expect a reduction in the number of vehicles on the roads. This is due to factors such as increasing use of taxis and ride-sharing transport, increasing need for movement of goods (logistics) driven by public expectation of rapid 'just in time' delivery of goods[13].

Westminster has much to celebrate and be proud of. However, we have challenges that we must tackle in partnership with everyone in the City. We want to support everyone to live healthy and fulfilled lives as active participants in their families, communities and workplaces. This involves tackling a range of issues that can be barriers to finding and maintaining long term occupations (including volunteering). Evidence tells us that good quality work or an equivalent meaningful occupation can alleviate some of the physical and mental symptoms of ill health[14].

In Westminster we are proud of our range of libraries, leisure centres, community centres, attractive open and green spaces, visitor-friendly cycling and walking routes and world class heritage sites. These community assets can help people to remain well, healthy and connected. We will work to ensure that everyone knows about and can access and enjoy these throughout their time in Westminster as a resident, worker or visitor.

We will do all we can to ensure that the built environment enables people to make choices that support their health and wellbeing. This includes aiming to ensure that housing is appropriate for different needs and life stages. We will work with schools and other educational establishments to support children and young people, and families to be well and stay well through educating and enabling them to make healthy choices and ensuring they are provided with and enabled access to regular physical activity.

Through Westminster's Greener City Action Plan, we will tackle poor quality and develop a sustainable transport system which delivers health and wellbeing benefits, reducing pollution while keeping the city on the go. We will do this, in part, through promoting active travel – walking and cycling – as alternative modes of transport and making the public realm safer and accessible for all.

The socio-economic and environmental factors that can affect health and wellbeing cannot be tackled alone through public sector interventions. It requires businesses and communities to play their part to, for example, improve air quality to reduce pollution levels

[14] (Waddell & Burton, 2009)

so that the neighbourhoods we live in are clean, accessible and welcoming, and that we all support and look out for those vulnerable people in our communities.

[14] (Waddell & Burton, 2009)

Our unique health challenges

The vitality of Westminster is part of its appeal, but this can sometimes be a challenging landscape in which to help people to be well and stay well.

The life expectancy of our population can vary dramatically depending on where people live. Men living in the least deprived areas live nearly 17 years longer than men living in the most deprived areas. For women this gap is nearly 10 years. Additionally, the most deprived 20% of the population are likely to begin experiencing long-term disability 10 years earlier than the least deprived. This is because our population's health is not just related to the services they can access but also to the wider factors which can influence people's health and wellbeing, such as housing, education, employment and the environment.

We have unique challenges as a result of our being at the centre of a national and global economic hub. Westminster falls within the worst 20% of areas nationally for road traffic accidents, and parts of the City are among the worst performers in air quality tests in Europe[15].

Our large business and visitor populations are significant parts of the local, regional and national economy. However, these groups also put pressure on services and the wider urban environment. Services are often funded on the basis of resident population and so do not reflect the realities of our place where our population increases each day from 250,000 residents to over 900,000 people.

Westminster has a high level of population "churn" as people enter and leave the City rapidly. Every year over 20,000 people leave and approximately the same number of new people move in. This high level of population turnover and can make it more difficult for people to access services and for services to deliver the best outcomes.

The economic, cultural and social attractiveness of Westminster, and the restrictions on space that come with a dense urban environment, mean that the demand for housing is high[16]. The majority of people live in rented accommodation (both private and social housing)[17]. Some of these people can be more exposed to housing cost volatility and the potential to experience deprivation and poverty than people who own their own homes[18].

Westminster has the highest recorded population of rough sleepers of any local authority in the country. This population has higher rates of physical and mental health problems compared to the general population[19], and are at higher risk of complicating alcohol and or

[15] (Westminster City Council, 2015)
[16] (Westminster City Council, 2014)
[17] (Westminster City Council, 2014)
[18] (Joseph Rowntree Foundation, 2013)
[19] (St. Mungo's Broadway, 2015/16)

drug dependency[20]. Rough sleepers attend accident and emergency approximately seven times more often than the general population, and are also generally subject to emergency admission and prolonged hospital stays more often[21]. However, Westminster also has a wealth of knowledge and expertise in supporting and treating homeless people and rough sleepers. We aim to build on this expertise and deliver better health and wellbeing outcomes for those individuals and groups who are not in, or do not have, access to stable and appropriate accommodation.

Children and young people in Westminster live, grow and learn in an international hub of culture, heritage and opportunity. However, to focus on the opportunities alone would be to ignore the real challenges that will face children and young people as they grow and transition into adulthood. We will support them to have healthy relationships with their families, peers and communities and make positive decisions about their lives and be confident to seek help when they need it.

Westminster is blessed with an increasing older population. Retaining their life experience and knowledge adds immense value to our communities. People over 65 are economically, culturally and socially engaged, and often make up a largely unrecognised workforce in their provision of volunteering, caring (for partners and grandchildren and others) and civic support. Working with older people, the voluntary and community sector, carers and professionals, we want to empower everyone over 65, particularly those at risk of isolation, to maintain their independence and their health and wellbeing. We will do this through encouraging and supporting lifestyle changes and enabling self-management of conditions.

[20] (Joint Strategic Needs Assessment, 2013)
[21] (Joint Strategic Needs Assessment, 2013)

Our vision and goals

Overall vision: all people in Westminster are enabled to be well, stay well and live well, supported by a collaborative and cohesive health and care system.

Mission: to focus on prevention and early intervention. When people experience mental or physical ill health we will come together to ensure timely, high quality, person-centred care which is delivered with dignity and respect at all stages, including at the end of life.

Building on the principles set out in the Marmot Review (2010) and the long term goals set in our *Healthier City, Healthier Lives (2013)* for 2013-2028, we will be focusing on the following four priorities over the next five years:

Strategic Priorities 2017-2022	1) Improving outcomes for children and young people; 2) Reducing the risk factors for, and improving the management of, long term conditions such as dementia; 3) Improving mental health through prevention and self-management; and 4) Creating and leading a sustainable and effective local health and care system for Westminster.			
Long Term Goals (2013-2028)	Improving the environment in which children and young people live, learn, work and play	More people live healthily for longer and fewer die prematurely	A safe supportive and sustainable Westminster where all are empowered to play as full a role as possible	People living with injury, disability, long-term conditions, and their carers have quality of life, staying independent for longer

These priorities will steer and challenge the way we deliver local health care to address and realise better outcomes for our population. Instead of focusing on how to cure ill health and poor wellbeing, we are taking a strategic approach to move our collective energy and assets to focus on prevention and early intervention.

For each priority we will aim to deliver improvements in:

- Quality of life;
- Quality of care;
- Financial sustainability for health care;
- Professional experience; and
- Operational performance and collaboration of services.

Our commitments:

We have framed the outcomes from an individual perspective so people can see our aspirations for their health and wellbeing. The following overarching outcomes and expectations are common for all themes:

- I have access to appropriate and timely information required to make the right decisions and choices for my health and wellbeing;
- I am aware of the services, spaces and facilities available and accessible to me, my carer and my family to maintain or improve health and wellbeing;
- There is no “wrong door” for when I need care and support;
- When I am experiencing mental or physical ill health, the services and support I receive are high quality, joined up and delivered in an appropriate setting;
- All my needs are viewed holistically, including both mental and physical health; and
- I am treated with sensitivity, dignity and receive care and support that is tailored according to my needs and preferences.

PRIORITY 1: Improving outcomes for children and young people

PRIORITY VISION: All children and young people live healthy active lives and are supported to transition into healthy active adults who contribute to society and share their positive learning and experiences with their families, friends and neighbourhoods.

The importance of focusing on children and young people

Children in Westminster are on average more likely to be overweight, have poor dental health, and experience poor mental health than their peers in London and the country[22]. This means that they are more likely to transition to and continue through adulthood in poor health, and they are less able to take advantage of the economic and social opportunities of living and learning in the City.

Our approach

This strategy will seek to address the holistic mental and physical health and wellbeing of all children and young people. We want the services they interact with to support them and treat them and their families as capable of making decisions about their lives, health and care.

We will work with and support children and young people and their families, to ensure that they have a safe and healthy childhood from conception to adulthood. We want to ensure that every child and young person, including those who are living with long term physical or mental conditions and those with learning or physical disabilities, in Westminster are equipped with the skills and connections necessary to remain healthy, well and active.

Working with families from the stage of conception is crucial. We know that parenting patterns can impact on the choices children and young people make and we want to work with families right from the start to establish and develop healthy foundations for children and young people. This includes maternity advice and support, and early help family services which engage and enable parents to improve and maintain their wellbeing and form positive relationships with their children. We will also continue to raise awareness of universal and preventative services that children and young people, and their families could benefit from

Evidence in Westminster shows that child poverty (which is a large determinant of the health and wellbeing of children and young people) is directly related to the ability of parents to enter and maintain employment[23]. Working with families to improve outcomes for children and young people, we will support parents to access training and work opportunities that enable them to re-enter and maintain flexible employment that supports their parenting.

We will build on the North West London *Like Minded*[24] strategy and the Children and Family Act 2014 improvements for young people with special educational needs (SEN) and disabilities. They both recognise the role of wider determinants of the mental and physical

health and wellbeing of children and young people. We value the role of schools and communities in supporting prevention and early intervention in mental health for children and young people. We will also work with schools and families to ensure that the professionals children and young people usually interact with are equipped with the knowledge and information to signpost and refer them to the right support at the right time. There is a continued need for local collaboration and joint working to address the wider determinants of health for children and young people, and families, such as housing and education (including Special Educational Needs (SEN)).

We want to prevent children and young people from becoming ill wherever possible. However, if they do experience poor or declining mental and physical health or disabilities we want to empower children and young people and their families, to access appropriate and reliable information, advice and expert care in ways that are convenient and tailored to them. Children and young people will have a diverse range of experiences and attitudes to accessing information, support and care and we will work with them to develop new or improved channels of access and support.

How we want to improve the outcomes for children and young people

We know that being active is important for the physical and mental health of children and young people, and their families[25]. There are links between increased physical activity and a reduction in depression and anxiety for children and young people. It is also important for self-esteem and has been shown to improve academic performance[26]. Studies show a strong link between poor mental health and sedentary behaviour[27].

We will ensure that the range of physical activity opportunities that can be enjoyed either in or out of schools are communicated to children, young people, their families and schools. We will also address barriers (real or perceived) that some children, young people and their families might face to accessing physical activity including cost, transport, availability of supportive and permissive spaces and places such as streets, parks, open and green spaces and other community facilities. We want to encourage children and young people to engage in physical activity every day by enabling them to feel that they can find a type of physical activity they enjoy.

We will continue to encourage and enable children and young people, and families to use our range of community assets and nationally renowned cultural institutions in Westminster to maximise their physical and mental health and wellbeing. These include our libraries, leisure centres, parks and open and green spaces, and facilities based in estates where we offer at least 130 hours per week of free access to activities,. We will enable access to space for physical activity and sports in community spaces and schools after hours through community use agreements such as all-weather sports pitches.

Our commitments:

To ensure that all children and young people are given the best start in life and supported to grow intohealthy and well adults we commit to:

- ensuring that Westminster's young people's emotional wellbeing and mental health is supported by accessible and joined up local services;
- promote the activities and opportunities for physical activity, sport and cultural experiences for children and young people and their families to participate in and enjoy;
- engage with prospective, new and current families to provide information and signposting, and identify early opportunities to provide further targeted support where needed;
- ensuring front line staff (e.g. health visitors, GPs, housing and children's services staff) are working together to support families to access advice services, employment, education and training opportunities;
- promoting and supporting opportunities for families to support each other and learn about their children's health and wellbeing;
- empowering and enabling children and young people to monitor and find sources of support to improve and maintain their own health;
- supporting, encouraging and rewarding children and young people who volunteer and engage in civic activities through Spice Time Credit Schemes and other programmes; and
- involving children and young people in co-designing mental and physical health services to ensure they are relevant, convenient, acceptable and accessible forthem.

Outcome Domain	Population	Outcome
Quality of life	Children and young people	I have a healthy diet, am physically active, am a healthy weight and I have a safe and healthy place to live.
		At school I learn a variety of skills that integrate my social, emotional and educational development.
		I can access green and open spaces and attend physical and social activities and I am given
		I understand how to provide support to my peers about their emotional and physical health and where to direct them for further support.
		I am able to sustain a good level of mental health through self- management and accessing appropriate and timely information and support at school, in the community and at home if needed.
Quality of experience		My general health and wellbeing needs are recognised and supported to sustain a good level of health and I am referred on to specialist services where appropriate.
		I have, and am made aware of, opportunities to be involved in the design, delivery, and/or review of services, spaces and places that I use or would like to use

		I feel respected, valued, and supported by family/carers, and professionals.
Quality of life	Working age adults	I feel able to access community services and resources to support myself and my children, including opportunities to socialise at local libraries, community centres and outdoors in local parks and open spaces.
		As a prospective parent I have access to information and support (including health visitors and midwives) to help me to prepare for parenthood and develop and maintain a healthy lifestyle during my pregnancy.
		I am supported to provide a safe, healthy and stable home for my family.
		As a parent I am supported to maintain my own health and wellbeing, and understand how to model healthy behaviours for my children.
		I am supported to access employment training and flexible, accessible and affordable childcare.
Quality of experience		As a carer for a child with mental or physical health needs, I am supported to understand my child's needs. My needs as a carer are assessed and addressed by services.
		As an educator, I have been trained to recognise, support and refer mental and physical health issues of children in my care.

PRIORITY 2: Reducing the risk factors for, and improving the management of, long term conditions such as dementia

PRIORITY VISION: People remain health, well and independent and the likelihood of developing long-term conditions is reduced, through the management of risk factors such poor diet and insufficient physical activity. People, carers, communities and professionals work together to ensure people living with long term conditions (and their families and carers) receive high quality health and care, and other public services to improve their quality of life. When nearing the end of life, people, their families and carers are supported to plan their care that is dignified and honours their personal preferences.

The importance of tackling long term conditions

The largest expected growth in prevalence and costs to the health system relate to long- term conditions (both mental and physical) particularly for adults aged over 65. Nationally, people with long term conditions account for approximately 50% of all GP appointments, 64% of all outpatient appointments and 70% of all inpatient beds. Treatment for people with long-term conditions is expected to cost £7 in every £10 of health and care spend[28].

People over 65 with long-term conditions are more likely to experience other multiple and complex and long term conditions. Such conditions could significantly impact on quality of life, and restrict economic and social opportunities. Long-term conditions (such as dementia, diabetes and cardio-vascular diseases) are often linked to the quality and appropriateness of housing, social isolation, lifestyle (including behaviours such as alcohol or substance misuse), diet and physical activity either as risk or aggravating factors of long term conditions

Our approach

Our approach is three-fold:

1) reducing the risk factors associated with long-term conditions;
2) reducing the risks of developing complications from long-term conditions; and
3) improving care and support, and outcomes for people with long-term conditions.

We want to, where possible, prevent long term conditions for all ages by intervening early to reduce risk factors through awareness raising, facilitating and encouraging behaviour change and proactive support where possible. We will also work with people to fulfill medical appointments, prescriptions and maximise the take-up of services, such as Health Checks, to make the best use of resources.

Some long-term conditions in themselves can often lead to the developing further long term

and complex conditions. Local evidence tells us that those who experience mental health conditions and those living in areas of deprivation are more likely to suffer multiple long term and complex conditions. This affirms our belief that we need to do more to reduce the risk and aggravating factors of long term conditions. Participating in and maintaining appropriate levels of physical activity and a balanced diet is a significant part of preventing risk factors for and the aggravation of long term conditions. We will work with communities and partners to maintain and promote physical activity opportunities and facilities to all adults in Westminster – whether they live in, work in or visit the city. In parallel, we will continually improve the infrastructure they are surrounded by (including transport, urban environment, housing) to create a supportive environment for good health and wellbeing.

Westminster has a high number of homeless households and the highest population of rough sleepers in the country, many of which include people with complex and multiple mental and physical long-term conditions[29]. Evidence shows that 42% of people who sleep rough in Westminster have one or more support need, including alcohol and drug dependency, and/or mental health conditions[30]. Rough sleeping is a unique challenge to Westminster's health and care system and one that we can best understand and address through collaboration and integration. We will work across organisations as part of the forthcoming Westminster City Council Rough Sleeping Strategy to prioritise the complex health conditions associated with rough sleeping and homelessness.

Safe and secure housing supports people to lead healthy and fulfilled lives. Conversely, unstable, poor or inaccessible housing can have a detrimental effect on health and wellbeing, including leading to the development or aggravation of long term conditions. We will continue to tackle poor living conditions in both social and private accommodation in Westminster.

Actively contributing to communities can help make some people feel engaged and invested in the place where they live, work or learn. It can also help to prevent and alleviate short and long term mental and physical conditions, as well as build community pride and resilience. We will work to ensure that there are a range of employment, adult education and volunteering opportunities for people with long term conditions to engage in their city and communities. We know that some people with long term conditions (whether mental or physical) and disabilities may experience barriers to engaging with their neighbourhoods and local communities or accessing local community facilities such as libraries due to mobility issues and low confidence. We will ensure that people who have such barriers are made aware of the range of support available to them.

A spotlight on dementia

Dementia is an umbrella term used to describe symptoms resulting from diseases and conditions that affect the brain. There are many types of dementia but common types include Alzheimer's disease and vascular dementia. Regardless of type, dementia can have

significant effects on the lives of those who experience it, their carers, families, friends and communities. Dementia can reduce life expectancy for sufferers - someone diagnosed between ages 70-79 loses on average 5.5 years of life[31].

Westminster has a rapidly ageing population. Our recent Joint Strategic Needs Assessment on Dementia[32] found that diagnoses of long term conditions associated with ageing, such as dementia and Alzheimer's, will see an increase of 56% between 2013 and 2033. As of 2015 we have a diagnosed population of 1,806 people. Over 2,600 people in the City will have dementia by 2030. This trend will continue beyond 2030 with over 760 new cases of dementia yearly[33].

There are a number of risk factors for vascular dementia. These are largely factors that result in poor cardiovascular health, such as unhealthy weight, low levels of physical activity and smoking. Improving overall physical health can have an impact on reducing the likelihood of developing vascular dementia, and itself improves quality of life as it relates to general physical health[34]. A study linked improved healthy lifestyles among men to a 20% decrease in the predicted incidence of vascular dementia amongst men over 65[35].

People with dementia are over three times more likely to die during their first admission to hospital for an acute medical condition[36]. Westminster has a high rate of emergency and inpatient admissions for people with dementia, accounting for a quarter of acute hospital beds. People with dementia are likely to have significant physical and mental co-morbidities, such as depression, congestive heart failure and Parkinson's disease. Four out of the five most common co-morbidities for which dementia sufferers are admitted to hospital are preventable, such as broken/fractured hips and bladder and chest infections[37].

[31] (International Longevity Centre UK, 2016)
[32] (Joint Strategic Needs Assessment, 2015)
[33] (Joint Strategic Needs Assessment, 2015)
[34] (Alzheimer's Society)
[35] (Matthews, et al., 2016)
[36] (International Longevity Centre UK, 2016)
[37] (International Longevity Centre UK, 2016)

Our commitments:

Where people are suffering from ill health, we will act early to tackle risk factors and ensure that they receive the best care and support that is tailored to their needs. We will:

- support working age adults to develop and/or retain active lifestyles and mitigate those risk factors that contribute to the development of long-term conditions;
- create the conditions for dementia-friendly communities, where an understanding of dementia supports communities to value the contributions of people experiencing the condition and their carers;
- consider the experiences and needs of people with long-term conditions and their carers by working with them when developing services and plans;
- support community resilience and ensure that a range of local services and community and voluntary organisations are available to support social engagement which acknowledge the diversity of experience and background of people with dementia and their carers;
- support and encourage retired people to volunteer and contribute their knowledge and expertise to Westminster through the Spice Time Credits scheme, which incentivises and rewards participants for community activity; and
- support the development of a workforce that is agile and responsive and which delivers joined up and high quality services. This will include an exploration of hybrid roles across specialisms, social prescribing and multi-disciplinary and multi-sector team working. This will also include ensuring health and care services continue to work closely together and integrate where it makes sense and is possible.

Outcome Domain	Population	**Outcome**
Quality of life	Whole population	I/my carer feel that the wider community has an understanding of my long-term condition and my/our experiences and I feel included in my community.
		I am empowered to live a healthy lifestyle and make healthy choices, including about my diet, physical activity and risk behaviours (such as smoking).
		I/my carer can access advice and support to remain independent and engaged in my/our community (e.g. dementia cafes and befriending services).
		I and/or my carer know what to do to keep myself/ourselves active and well, including understanding how to improve my physical and mental health through diet, physical activity and lifestyle choices.
		I/my carer feel able to access community services and resources, including opportunities to socialise at local libraries, community centres and outdoors in local parks and open spaces.
Quality of Experience	All age groups	I can access services which address my needs as an individual and have an awareness of how my lifestyle (including my housing situation) impacts my health and my access to services. My wider health needs, including accessing opportunities for physical activity, are addressed and supported.
		I/ my carer have developed

		my care plan in conjunction with my family (as much as I want) and my carers are supported to care for me and have their own needs recognised.
		I/my carer have a named point of contact who understands me/us and my conditions. I/my carer feel that the services and workers I/we engage with have been trained to understand my/our specific needs and listen to me/us.
		I/my carer believe that the professionals involved in my care talk to each other and work as a team.
		I am supported to remain independent and stay at home where possible.

PRIORITY 3: Improving mental health outcomes through prevention and self-management

PRIORITY VISION: People are to maintain good mental wellbeing. Those with short or long term mental health illnesses receive the timely and effective support to reduce the impact of and manage their condition where possible, and are treated with dignity and respect.

The importance of tackling poor mental health

Poor mental health can affect our ability to maintain relationships, employment and housing. It also affects our quality of life and life expectancy. Our mental health can be impacted by a range of factors – genetics, deprivation, employment or family stress, social isolation and education. Nearly half of all ill health for under-65s is related to mental illness, and one in six people in the past week in the UK experienced a common mental health problem[38]. We all have the potential to experience poor mental health during our lifetime; however there remains stigma around discussing and seeking treatment for mental health issues.

There are some groups of people who are at a higher risk of experiencing poor mental health. This includes people in vulnerable or excluded groups such as the homeless or rough sleepers and those experiencing deprivation are often more likely to experience severe mental health conditions and they are also more likely to experience related poor physical health conditions[39]. Mental health can have varying degrees of impact on an individual's relationships and employment. The effects of poor mental health are far reaching and can be potentially devastating to individuals and those around them.

Our approach

Most people with common mental health conditions (such as anxiety and depression) have the capacity to self-manage if they have timely access to information and support. Low-level support such as talking therapies can support people to develop the skills to monitor and manage their mental health independently. We will improve access to information and signposting to support for common mental health issues, such as community and peer support.

Improvng the quality of life and life expectancy for people with severe and enduring mental health conditions requires us to treat and support them as whole individuals, and this means looking at the wider issues that may affect them. This includes their housing, employment, relationships, diet, physical activity, and risk behaviours (such as smoking and alcohol consumption). People with severe mental health conditions often receive poorer acknowledgement and treatment of their physical health conditions. Similarly, people with long-term physical conditions also often receive poorer treatment of their mental health[41]. We must ensure that as a health and care system, we are joining up mental and physical health treatment and treating people as individuals.

People with severe mental health conditions often come into contact with multiple public services. For example staff in education, police and fire services, housing and probation often encounter people with severe mental health conditions in the course of their work. It is

important that there is an awareness of mental health issues across public service commissioners, providers and staff to ensure that we can refer and support each other to provide the most effective interventions and .

Compared to neighbouring areas, Westminster has more people receiving mental health social care services[42]. However, there is evidence that support for Westminster carers of people with SMI is lower than in neighbouring boroughs, with fewer carers receiving assessments[43]. We will work to ensure that everyone is aware of their entitlements and the availability of public sector and community organisations that are there to support their needs.

We are not only focused on delivering services, but also on ensuring that these services are effectively supporting and enabling everyone experiencing a mental health condition to lead active and fulfilling lives. By looking at mental health within a wider context, and recognising the complex interaction of factors such as relationships, housing, education, and lifestyle, we will not only improve health and wellbeing, but reduce the stigma associated with mental health conditions.

How we will improve mental health outcomes

The Westminster Health and Wellbeing Board has endorsed and supports the implementation of *Like Minded,* a sub-regional strategy spanning eight boroughs and their corresponding CCGs in North West London. The delivery of the *Like Minded* Strategy depends on partnership working to deliver high quality and joined up mental health services to improve the quality of life for individuals, families and communities.

The Westminster Health and Wellbeing Board is not seeking to replicate the work on mental health that has been set out in *Like Minded.* The Board will instead focus on, and supplement, the ambitions embodied in *Like Minded* including:

"We will improve wellbeing and resilience and prevent mental health needs where possible by:

- *supporting people in the workplace*
- *giving children and young people the skills to cope with different situations*
- *reducing loneliness for older people."*

The Board, in its local leadership role, will use its collective influence and energy to accelerate progress of this ambition in Westminster through prioritising and embedding prevention, early intervention and a whole systems approach to stop and reverse the negative trends of poor mental health and wellbeing.

Mental health and employment

Unemployment and worklessness is a known cause for poor mental health in Westminster and poor mental health can also be a barrier to employment and meaningful occupations (such as volunteering). Stress and mental health disorders are one of the biggest causes of long-term absence and is increasing as a reason for short-term absence in employment[44]. We will work to champion a range of activities, from volunteering to part-time and full-time work, that are welcoming and supportive to people with mental health conditions. We will also work with

employers to embed positive mental health messages and activities to alleviate work-related stress and build resilience in the workplace.

Loneliness and isolation

Positive social interactions are crucial to mental and physical health and wellbeing. Older adults tend to suffer more from long term and multiple conditions which can reduce mobility and limit social interaction. Sustained loneliness and lack of interaction with others can lead to poor mental health and subsequently poor physical health. We will work closer together with partners and communities to minimise loneliness and isolation.

Our commitments:

Working with individuals, communities, professionals and employers we will improve mental health for Westminster people by:

- addressing the stigma associated with all types of mental health conditions;
- recognising and addressing the wider determinants of mental health, including housing, employment, education and networks;
- ensuring that statutory and voluntary and community organisations continue to work closely together to identify early on people who require support, provide advice services, and provide and signpost to health and care services;
- treating and caring for people as individuals and recognising the complex factors that impact mental health;
- supporting people in the workplace and tackling barriers into work;
- working with communities to develop peer support, resilience and cohesion so that individuals, families and neighbours can support and look out for each other; and
- providing information through various mediums that is tailored for people of all ages and situations to access and use.

Population Group	Outcome domain	Outcome
Children and young people	**Quality of life**	I am educated and supported to understand and maintain my mental health as a child and young person.
		My transition from care for children and young people to adult care is planned and supported with my involvement.
Working Age Adults	**Quality of experience**	I am supported to maintain and improve my mental health and wellbeing, and to understand how to access information and support when I need it.
		I am involved in the design, delivery, management or review of services that I use and I have a level of control over the support I receive.
		I feel that the services I use understand my specific needs as an individual, including my cultural background.

		I am treated and cared for as an individual and I feel that my unique challenges and skills are recognised and acknowledged in plans for my care.
	Quality of life	I am supported to engage in my wider community through meaningful occupation (including volunteering and employment).
		I am supported in my workplace to maintain my mental health or seek information and care when necessary.
		I feel comfortable discussing my mental health with my employer.
		I feel an increased ability to manage instances of mental distress.
		I am able to manage and improve my mental and physical health and I can take regular and appropriate physical activity.
		I/my carer feel able to access community services and resources, including opportunities to socialise at local libraries, community centres and outdoors in local parks and open spaces.
Adults over 65 years / Adults over 85 years	**Quality of experience**	I feel that my mental health needs are assessed separately from any preconceptions about conditions that may be associated with my age.

PRIORITY 4: Creating and leading a sustainable and effective local health and care system for Westminster

PRIORITY VISION: We will be an integrated and collaborative health and care system using our collective resources (such as data, technology, estates and workforce) to deliver person-centred information and care in the right place at the right time.

The health and care system has made significant improvements in patient care, experience and outcomes by joining up services and working together. But we could do more. People can often go to different places to receive care relating to single conditions, and medical records may not be transferred between health and care providers in a way that would support efficient and effective care. Furthermore, budgets do not usually follow patients in a way that would support more patient choice.

Westminster has a bold vision for health and care - we want to transform the wellbeing of people who live, work and visit Westminster and in parallel, support a clinically and financially sustainable model of health and care. This vision will require commitment from everyone in Westminster.

The Health and Wellbeing Board is already engaged in determining the way resources are directed and spent in health and care. It sees the transformation of primary care, the bedrock of the current and future health and care system, as fundamentally important to achieving our aims.

To realise the Westminster vision we need to change the way we think about health and care locally and implement a shift in culture to move to a shared responsibility for health and wellbeing.

Leadership and Finance

The London Health and Care devolution agreement[45] sets out a vision of local people and their representatives taking greater control over decisions on matters that affect them.

One of our first tasks will be to put in place the leadership and governance arrangements necessary to make these important and strategic decisions in a robust, transparent and equitable way. We need to be able to share executive decision making across our organisations and position the Health and Wellbeing Board to continue to have the central coordinating and stewardship role on behalf of local people and communities.

To encourage integrated care, payment incentives and business planning cycles need to be aligned. There is an urgent need for changing the nature of tariffs for NHS care to enable greater investment in prevention. Commissioners also need to increase the use of pooled budgets as a way of enabling closer health and care collaboration. Using quality based incentive payments for providers across pathways of care might incentivise best practice models and partnership working, while ensuring that providers are encouraged to make a

contribution to the health and wellbeing of the whole population. Personal health budgets would enable some patients and service users to commission their own care in ways that better meet their needs.

Our implementation priorities:

- Delivering the priorities of this Joint Health and Wellbeing Strategy.
- Putting in place the governance and accountability arrangements which will help us to deliver our strategy, building on Westminster's strong history of joint working across health and care. A priority for us will be to involve local people as active contributors to the decision making process.
- Viewing our budgets and services "as one" in the same way as we have begun to view our priorities as common challenges. We will do this by modelling our spend and priorities over the lifetime of this strategy, setting out how much we anticipate we will spend over this period and on what. We will then need to consider how best we can incentivise our whole system to deliver on this by learning from best practice elsewhere.

Workforce

The changing nature of needs and demands of our population means that we need to transform a workforce that has been trained to work on individual instances of ill health into one that is trained and equipped to work in integrated and multi-disciplinary teams in community settings to prevent and intervene before ill health occurs.

We need to invest in multi-skilled training of nurses and associated health professionals to deliver person-centred care in the community. There is a large and growing mismatch between the demand and expectations of care and the supply of health and care workers who will be able to deliver this, including a large undersupply of GPs.

We also need to review social and economic trends that might affect our workforce in the future, including the cost of living in central London. Improved connections into the City as a result of infrastructure projects, such as Crossrail, may mean more of our workforce will be able to commute into the City. We need to work together to create the conditions that will ensure that Westminster remains an attractive and viable place for health and care workers to live and work in.

Our early implementation priorities:

- Mapping our current workforce to understand gaps in our workforce now and in the future, as well as the skills required to meet changing needs. We have begun to map our demand in the future as part of the Primary Care Modelling project undertaken by the Health and Wellbeing Board[46] and we will use this tool alongside long-term scenario planning (including looking at the potential impact of technology) to understand a range of potential future issues and develop solutions.
- Considering how to capitalise on new technologies and ways of working. Technology has the ability to place more power in the hands of patients to self-manage their own conditions outside of hospital settings and tele-care (remote consultations through

mediums such as live interactions via computers and tablets) will enable greater remote monitoring of patients by specialists.

- Working with partners to redesign the training and development system to facilitate career progress and development of skills and qualifications in work. Working with Royal Colleges, Health Education England and other teaching institutions to refocus local health and care worker training programmes towards the workforce characteristics and practices needed for the future. This is likely to include more specialist skills in primary and community care, more generalist skills in hospital care and more collaboration across hospital and community and mental health and physical health workers. We need to change the training curriculum to develop the skills to care for people with multiple conditions that span physical and mental health.
- Providing the right reward structures and contract flexibility to incentivise the creation and retention of the right workforce, including in pressure areas such as caring and nursing staff. Greater flexibility that allows staff to work at a city-wide and North-West London level must be addressed to incentivise the supply of staff where demand is greatest.
- Recognising, supporting and harnessing the power of the informal workforce by creating a 'social movement' to support those in need, including a more strategic approach to the support and development of volunteers.
- Looking after the mental and physical health and wellbeing of our workforce. The health and wellbeing of our workforce is just as important as that of the people for whom they deliver services. We will support and deliver programmes such as the Workplace Charter to support employers to improve the health and wellbeing of their staff.

Estates

People have changing needs and demands for how they want to access health and care services and our estates need to support people to access services in the community when they need to. We also need to address that the rising cost of space in Westminster which means that models of care built around individual locations for specific services are unsustainable. Partners in Westminster need to work together to share space and build the estate required to respond to the changing needs and demands of our population.

Our implementation priorities:

- Increasing the value of our estate in Westminster - better strategic management of our estate could realise multiple benefits including reducing and sharing fixed running costs, releasing land for housing for our workforce and reinvesting proceeds back into the local health and care system.
- Developing the estate required to facilitate new models of care and support - a new approach is needed that looks across the whole system and brings services together to improve access and experience for people and opportunities for provider innovation and collaboration. This includes, for example, multi-functional hubs that can provide a range of services in a community setting. A more flexible approach involving co-

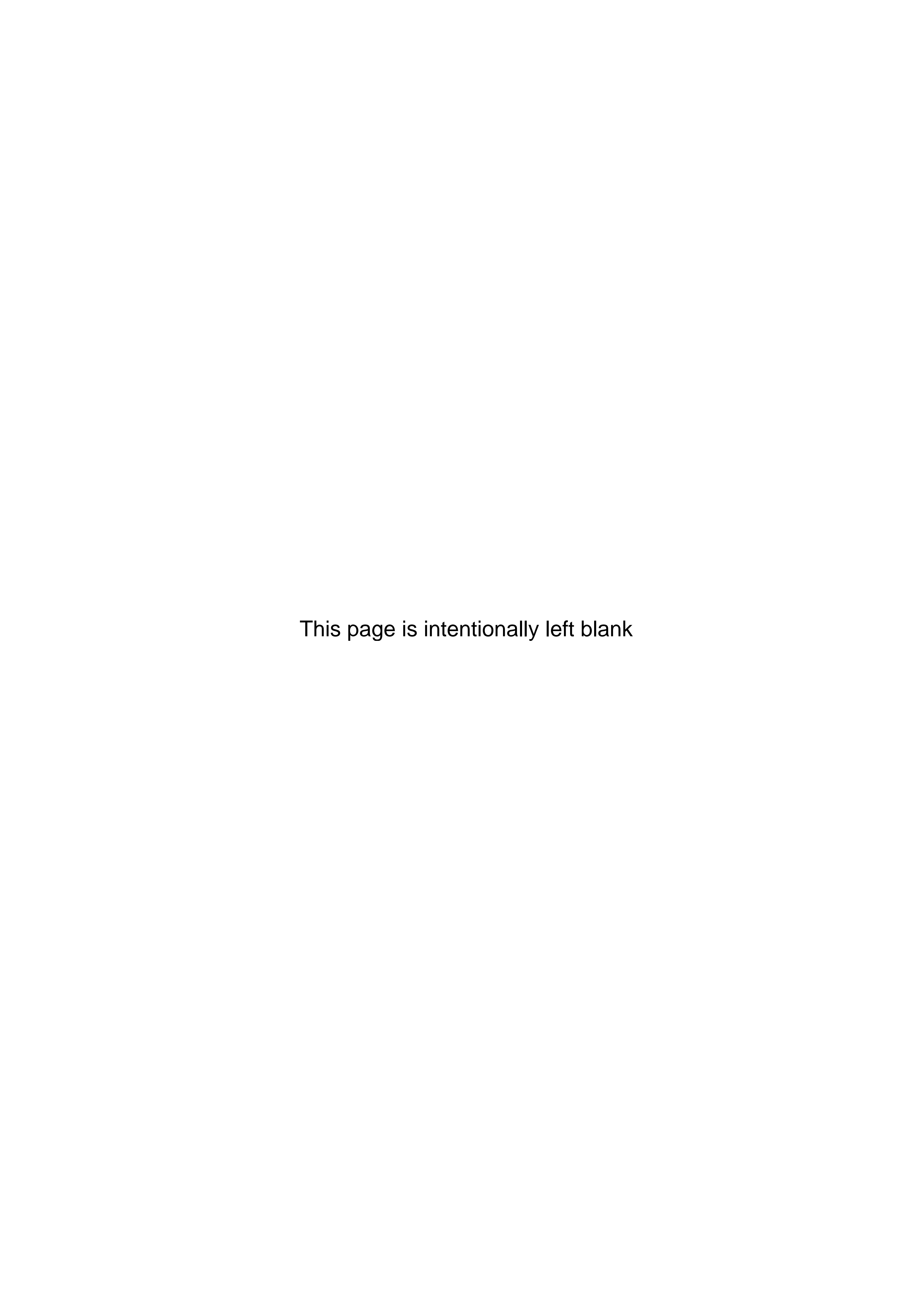
location of NHS and social care staff would make services more accessible and could release savings to be reinvested in patient care, staff and technology.

Technology and Information

Investing in information technology and data analytics will be crucial to enabling a successfully integrated health and social care system in Westminster that provides everyone with a good experience of care. Ensuring that we work with people and partners to secure appropriate consent of people to use their data will be integral. We must work together to facilitate and enable information exchange between organisations in a way that respects people's preferences for how we handle their information. Not doing so could hinder inter-organisational collaboration and innovation.

Our implementation priorities:

- All partners across Westminster must agree to share and pool information in a way that links data at an individual level and organise it into a format which enables better analysis, collaboration and decision making by all organisations. Sharing data also includes sharing with patients and carers to enable them to become more digitally empowered and support their self-management.
- We must continue to use data and evidence to inform our service delivery decisions. This includes identifying residents and communities at risk of poor health so that we can plan effective and targeted interventions.
- Supporting the role of technology in enabling people to manage their own care. The extent to which a person has the skills, knowledge and confidence to manage their own health and care ("patient activation") is a strong predictor of better health outcomes, reduced healthcare costs and satisfaction with services. As little as a 5% increase in self-care could reduce the demand for professional care by 25%[47].



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Westminster Health & Wellbeing Board

Date:	17 November 2016
Classification:	General Release
Title:	Local Safeguarding Children Board Draft Annual Report 2015-16
Report of:	Jean Daintith, Independent Chair of the Local Safeguarding Children Board
Wards Involved:	All
Policy Context:	Statutory requirement to publish an Annual Report (Working Together to Safeguard Children 2015) on the effectiveness of child safeguarding and promoting the welfare of children in the local area. The report should be submitted to the chair of the Health and Wellbeing Board amongst others.
Financial Summary:	No financial implications
Report Author and Contact Details:	Steve Bywater, Service Manager, Strategy Partnership and Organisational Development. steve.bywater@rbkc.gov.uk

1. EXECUTIVE SUMMARY

1.1 A draft version of the Annual Report for the Local Safeguarding Children Board (LSCB) 2015/16 has been provided for consideration by the Health and Wellbeing Board. The publication of such a report is a requirement of the LSCB following statutory guidance. The report includes key details about the demographics of local children, safeguarding responsibilities and activities of agencies which are represented on the LSCB, an overview of the LSCB priorities, activities and details of its budget; a review of the outcomes of Serious Case Reviews and learning that has resulted from these.

2 BACKGROUND

2.1 The independent chair of the LSCB is required (through Working Together to Safeguard Children 2015) to publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area.

2.2 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. The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period.

2.3 The annual report for the LSCB for Westminster, Kensington and Chelsea and Hammersmith & Fulham is currently being finalised and so what is currently a draft version has been provided to be considered by the Westminster Health and Wellbeing Board. It was also circulated to LSCB members prior to its most recent meeting on 11 October 2016. The Health and Wellbeing Board will be advised at its meeting on17 November of any significant changes that have since been made to the draft presented.

3 CONTENTS OF THE REPORT

3.1 The report includes details of:

- The local background and demographics of Westminster and the other two local authorities covered by the LSCB.
- Statements of the activity of key partner agencies in relation to safeguarding children and self- assessments of their effectiveness.
- Details of core activities of the LSCB (including "Section 11" audits of arrangements agencies make to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children; multi-agency audits; the Child Death Overview Panel and others).
- Governance and accountability arrangements and a report on activity and progress made by the various sub-groups which report to the LSCB. This includes a summary of Westminster's "Partnership Group" activity and developments this has resulted in, particularly in the areas of serious youth violence, child sexual exploitation, female genital mutilation and radicalisation of young people.
- An overview of serious case reviews initiated in the course of the year and a summary of serious case review reports which were concluded, some of which focused on cases with connections to Westminster.
- A review of the priorities of the LSCB and progress made and the priorities identified for 2016/17.
- Details of the LSCB budget (income and expenditure).

4 CONTEXTUAL INFORMATION

4.1 The Health and Wellbeing Board may wish to note two key developments which have influenced the current and future developments of local LSCB arrangements. Firstly the LSCB was reviewed by Ofsted as part of the inspection of services for children in need of help and protection and care leavers which took place in January and February 2016. The inspectors found the LSCB to be "good". Approximately a third of the 109 LSCBs to have been reviewed to date have received this judgement with only one recently found to be "outstanding". In the review of our LSCB, Ofsted recognised the "significant benefits for young people and for all partner agencies" resulting from the shared arrangement with the "right balance between shared and local functions" which "ensures that children are effectively safeguarded."

4.2 In May 2016, the government published a national review of LSCBs led by Alan Wood, a former Director of Children's Services. This made a number of recommendations regarding future arrangements to coordinate safeguarding activity at the local level. Many of these were accepted by the government and these are expected to be enacted through the Children and Social Work Bill currently progressing through Parliament. The government has announced its intention to introduce a more flexible statutory framework that supports local partners to work together more effectively to protect and safeguard children. The framework is expected to set out clear requirements for the key local partners, while allowing them freedom to determine how they organise themselves. The key local partners will be the local authority, the police and health (Clinical Commissioning Groups).

4.3 There is some appetite among partner agencies to review and, where possible, improve local arrangements. There is a variety of views about how to proceed, often informed by the size of agencies who participate in our LSCB. Some board members need to represent their agency in LSCB arrangements across numerous other local authority areas as well as the shared LSCB while some other smaller agencies see the LSCB and its sub-group structure as a key way to participate in and stay informed about local safeguarding developments. There is also some overlap in the membership of the LSCB and Health and Wellbeing Board with some areas of common interest across the two Boards. There is a desire to review the overall purpose of the LSCB across the three boroughs and the way that we involve and have an impact upon frontline staff, children, families and the wider community. The LSCB is considering messages from the review and has started to assess opportunities for developing local arrangements to meet the needs of all partner agencies. Options will be considered and developed alongside developments at the national level.

5 FUTURE PRIORITIES OF THE LSCB

5.1 Informed by progress made in 2015/16 and the wider views of partners, the Annual Report summarises the LSCB priorities for the current year. These include:

To build on partnerships to improve safeguarding practice with a particular focus on increasing the capacity of vulnerable parents to safeguard their children effectively
This seeks to continue to focus the Board's attention on the key reasons why children need protection from significant harm, i.e. as a result of parental mental health difficulties, parental substance abuse and domestic abuse. There is an aim to improve engagement with other partnerships which have a role in coordinating and addressing such issues as they affect adults.

Improving communication and engagement
There is an ongoing need to continue to find ways to effectively involve frontline staff from all agencies, children and families and the wider community in the activity of the Board.

Demonstrating our impact and knowing where more effective practice is required
This seeks to make better use of data to target activity and increase the coordination of learning and action plans resulting from serious case reviews. There are also important areas of practice such as the Focus on Practice programme, the tackling of Neglect and development of early help which the Board need to maintain its overview of.

Improving the effectiveness of the Board
As well as ongoing forward planning and work to analyse the effectiveness of multi-agency training, this priority will also be informed by local developments resulting from the Alan Wood Review and the government's response.

6 RECOMMENDATIONS

6.1 It is recommended that the Health and Wellbeing Board considers the degree to which the report provides them with sufficient information to understand and assess the effectiveness of multi-agency safeguarding arrangements in Westminster.

6.2 It is also suggested that the Health and Wellbeing Board identifies additional information that it would find helpful to include in this or future Annual Reports.

6.3 The Health and Wellbeing Board may also wish to identify any priorities it shares with the LSCB and request a coordinated review of these as part of its forward plan.

7 EQUALITY IMPLICATIONS

7.1 As this report is for information only, there are no equality implications to be considered at this stage.

8 LEGAL IMPLICATIONS

8.1 As this report is for information only, there are no legal implications to be considered at this stage.

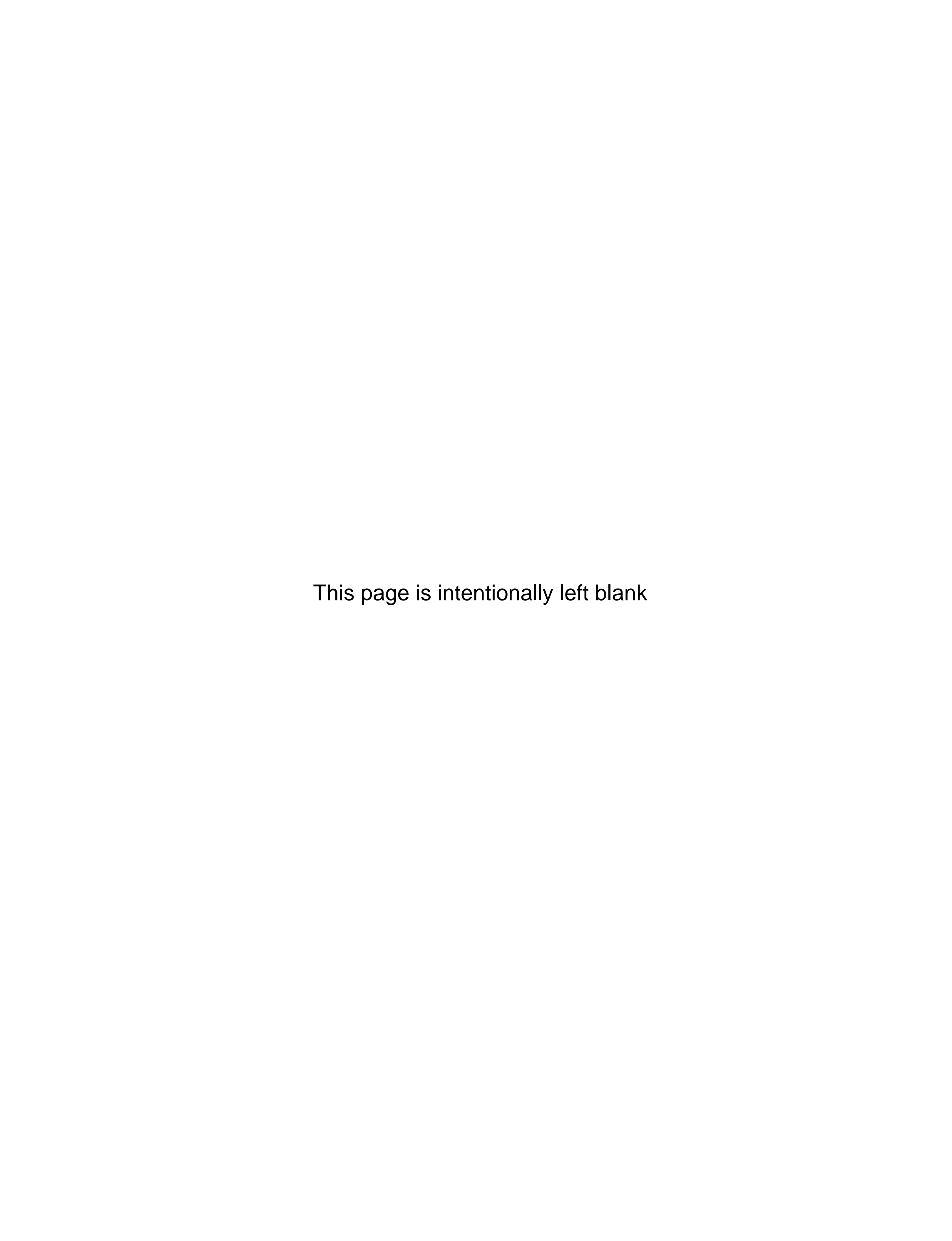
9 FINANCIAL AND RESOURCES IMPLICATIONS

9.1 As this report is for information only, there are no financial and resources implications to be considered at this stage.

If you have any queries about this Report or wish to inspect any of the Background Papers, please contact:

Steve Bywater, Service Manager, Strategy, Partnership and Organisational Development

Email: steve.bywater@rbkc.gov.uk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Hammersmith & Fulham | Kensington and Chelsea | Westminster

DRAFT ANNUAL REPORT

2015 / 2016

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FOREWORD BY LSCB INDEPENDENT CHAIR

I have been the Independent Chair of the Local Safeguarding Children Board for the three boroughs of Hammersmith & Fulham, Kensington and Chelsea and Westminster since it was established in April 2012. This is my fourth report, covering the year April 2015 to March 2016.

The LSCB is a statutory body and is a partnership comprising statutory partners who are charged with compliance with 'Working Together' (the statutory guidance underpinning LSCBs) and other partners, including lay members. We meet as a Board four times a year; but, the LSCB comprises a number of subgroups and a range of activities. The Board is responsible for the strategic oversight of child safeguarding arrangements by all agencies. It is not accountable for delivering child protection services - but it does need to know how well things are working.

This year the annual report presents information about what we know about children in our area, key partner agencies' activities in relation to safeguarding, the activities of the Board, the governance and accountability arrangements, an overview of serious case reviews and a review of the priorities for the coming year as well as some additional information on budget. The report refers to the 2016 Ofsted review of the LSCB (a judgment of Good') and the impact of resources - a reality for all agencies. The priorities for 2016/17 are included in the report.

An early start is being made to consider future options for making the local arrangements more effective. This needs to align with the changes that will be introduced nationally by government for multi-agency safeguarding leadership. 2016/17 is my final year chairing the Board and so I am working with others towards the handover, anticipating the national changes.

Once again I want to thank staff for the difference they continue to make to the lives of those with whom they work. Safeguarding is at the forefront of all that they do.

Jean Daintith, Independent Chair

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EXECUTIVE SUMMARY

This report, as required of the Independent Chair through “Working Together to Protect Children 2015”, provides an overview of the effectiveness of child safeguarding and promoting the welfare of children in the areas of Hammersmith & Fulham, Kensington and Chelsea and Westminster in 2015/16. It includes a self-assessment of the performance and effectiveness of many of the local and regional agencies represented on the LSCB and identifies a number of areas where improvements are required. The report also summarises a number of reports that have been published following reviews of incidents where children have died or been seriously injured and where abuse or neglect is thought to have been involved. The learning that has resulted from such reviews and how these have been communicated to those who work with children is also included.

The Safeguarding Plan for 2015/16 is reviewed with an overview of where progress has been made as well as areas where further work or attention is required. The Report concludes with an Assurance Statement provided by the Independent Chair and outline of the priorities of the LSCB for 206/17.

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LOCAL BACKGROUND AND CONTEXT

The Local Safeguarding Children Board covers three inner London local authority areas. A total of 579,420 people live in the area, of which 110,240 or 18% are children aged 0-18[1].

Local Population Profile * *(mid year 2015 population estimates)*	**LBHF**	**RBKC**	**WCC**	**Total**
All ages resident population	179,410	157,711	242,299	579,420
0 to 4 years	11,601	8,981	13,927	34,509
5 to 10 years	11,990	9,989	14,616	36,595
11 to under 19 years	12,154	10,683	16,299	39,136
Total 0 to under 19 years	35,745	29,653	44,842	110,240

As with many boroughs in London, there are areas with high levels of affluence but also localities where there are significant levels of deprivation. The three boroughs' rates of child poverty after housing costs were (in 2014):

Hammersmith & Fulham 31%
Kensington and Chelsea 28%
Westminster 39%

These figures do not show the variations in levels of poverty within wards. For example, using the Her Majesty's Revenue and Customs (HMRC) measure of child poverty, the ward with the highest rate in London was Church Street in Westminster where 50% of children were classified as being in poverty[2]. 10 wards across the three boroughs have child poverty rates of over 40%.

As with many London boroughs, the three areas covered by the LSCB have highly diverse populations. The 2011 Census identified a BAME (black, Asian and minority ethnic) population of 188,969 people living in the area (58,271 in Hammersmith & Fulham, 46,632 in Kensington and Chelsea and 84,066 in Westminster).

The profile of the most vulnerable children in the LSCB area is summarised below.

Children subject to a child protection plan at 31 March 2016 (and comparative figures since 2011-12)

	2011-12	**2012-13**	**2013-14**	**2014-15**	**2015-16**
Hammersmith & Fulham	134	142	161	169	133
Kensington and Chelsea	79	74	92	61	85
Westminster	97	96	99	113	100
Total	310	312	352	343	318

[1] ONS Mid-Year Estimates 2014
[2] End Child Poverty 2014

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Following increases in the numbers of children subject to a child protection plan increased in Hammersmith and Fulham and Westminster in 2014-15, over the course of 2015-16, planned reductions in the numbers of children with plans were achieved in both boroughs. In Kensington and Chelsea, numbers increased by 7%. These changes are linked to fewer child protection plans starting in the year in Hammersmith and Fulham and Westminster and a higher number of plans ceasing. Kensington and Chelsea saw a similar number of plans starting in each of the two years, but fewer plans ended in 2015-16. The numbers of children with plans fluctuated considerably from month to month in all three boroughs.

Children in care at 31 March 2016
(and comparative figures since 2011-12)

	2011-12	2012-13	2013-14	2014-15	2015-16
Hammersmith & Fulham	224	236	200	185	198
Kensington and Chelsea	139	98	98	105	105
Westminster	208	188	176	179	166
Total	571	522	474	469	469

The numbers of looked after children have increased in Hammersmith and Fulham, reduced in Westminster and remained constant in Kensington and Chelsea over the course of 2015/16. Over the last three years, the number of unaccompanied asylum seeking children has increased by 73%. This trend has had an impact upon overall numbers of children in care which have otherwise been generally decreasing over time.

THE OFSTED REVIEW OF THE LSCB

In January 2016 Ofsted reviewed the LSCB as part of its inspection of the three inspections of Children's Services. The LSCB was reviewed as one body and reported on in all three reports on children's services, with the only variation in the three reports being in relation to the borough-based local partnership groups of the LSCB. The overall judgement of the LSCB was that it was 'Good'. This placed the LSCB in the top third of Boards reviewed at that time.

Ofsted commented on the strengths of the LSCB:

- Amalgamation under a single LSCB creates significant benefits for young people and for all partner agencies.
- The tri-borough achieves the right balance between shared and local functions, and this ensures that children are safeguarded effectively.
- Robust links are in place between the LSCB and other statutory bodies and this allows the board to make sure that children's safeguarding stays high on everyone's agenda.
- The Chair promotes safeguarding issues across the partnership and community, and provides appropriate challenge. As a result, extensive engagement by partners has been secured across the full range of safeguarding work. Partners are encouraged and enabled by the Chair to raise issues and challenges constructively.
- Through systematic analysis of audits under Section 11 of the Children Act 2004,

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the LSCB has assured itself that safeguarding is a priority for all partner agencies. (but see recommendation 3 below).

- Effective monitoring by the Child Sexual Exploitation/Missing sub-group enables the board to have a robust understanding of missing children and their behaviour across the tri-borough.
- An established case review sub-committee ensures that lessons learnt from reviews are disseminated promptly across the tri-borough (but see recommendation 4 below).
- A clear and detailed learning and improvement framework incorporates the learning from Serious Case Reviews (SCRs), themed audits and performance monitoring by the board. The learning and development sub-group of the LSCB undertakes its role across the tri-borough and ensures that sufficient safeguarding training is provided across all partner agencies.
- A wide range of activity to tackle the board's priorities and any lessons from SCRs is appropriately included in the LSCB annual report. A comprehensive safeguarding plan covers all of the board's priorities.

Ofsted made 5 recommendations for the LSCB

1. Review the extensive dataset to ensure that it is aligned to the board's priorities.

2. Devise a system for ensuring that actions arising from data scrutiny are carried out in the individual boroughs.

3. Ensure that recommendations from multi-agency themed audits are carried out and analyse their impact on improving practice.

4. Develop an overarching SCR action plan to track the progress of work arising from individual case reviews.

5. Devise a system to escalate concerns about infrequent partnership attendance at the board.

Ofsted also noted two changes of Business Manager for the LSCB in the previous year and the need for coordination of activities and work arising from the LSCB so that it is evident to others; the limited time available for the Independent Chair to maintain all the links across three separate boroughs; a need for a formal analysis of the impact of training either across the tri-borough partnership or at borough level; and an annual report that could be stronger on explaining the difference the LSCB has made to children's lives.

All these issues have been fed into the 2016/17 Business Plan and are being monitored during the year.

THE EFFECTIVENESS OF LOCAL SERVICES

London Borough of Hammersmith & Fulham

The Borough's Family Services directorate coordinates a range of services for vulnerable children including statutory social work for children and families and early help. A number of services are provided by shared arrangements with the Royal Borough of Kensington and Chelsea and Westminster City Council. This includes specialist support for children involved in the criminal justice system via the local Youth Offending Team which is

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managed by a single management team across three boroughs. There is also a single Fostering and Adoption service which recruits, approves and supports foster carers, connected persons and adoptive parents who care for children from all three boroughs. The borough's services for children in need of help and protection, children looked after and care leavers were inspected by Ofsted under its unannounced single inspection framework in January and February 2016. This resulted in a "Good" judgement by Ofsted. The inspection report[3] included a sub-judgement of "Good" regarding the experience and progress of children needing help and protection.

Ofsted made six recommendations following the inspection in relation to children who go missing, access to independent advocates, out-of-hours services for children, care planning, opportunities for care leavers and pathway plans. The local authority has produced and reviewed progress on an action plan to address these recommendations which has been submitted to Ofsted.

Royal Borough of Kensington and Chelsea

As is the case with Hammersmith & Fulham, the Royal Borough's Family Services directorate coordinates a range of services for vulnerable children including statutory social work for children and families and early help and also shares the same services. The Royal Borough's services for children in need of help and protection, children looked after and care leavers were inspected by Ofsted under its unannounced single inspection framework in January and February 2016. This resulted in an "Outstanding" judgement by Ofsted, one the first of two authorities to have received this judgement to date. The inspection report[4] included a sub-judgement of "Good" regarding the experience and progress of children needing help and protection.

Ofsted made four recommendations following the inspection in relation to children who go missing, out-of-hours services for children, engaging partner agencies in strategy discussions and access to independent advocates. The local authority has produced and reviewed progress on an action plan to address these recommendations which has been submitted to Ofsted.

Westminster City Council

As is the case with Hammersmith & Fulham and Kensington and Chelsea, Westminster's Family Services directorate coordinates a range of services for vulnerable children including statutory social work for children and families and early help and also shares the same services. Westminster's services for children in need of help and protection, children looked after and care leavers were inspected by Ofsted under its unannounced single inspection framework in January and February 2016. This resulted in an "Outstanding" judgement by Ofsted, one of the first two authorities to have received this judgement to

[3] London Borough of Hammersmith and Fulham - Inspection of services for children in need of help and protection, children looked after and care leavers Ofsted 2016

[4] Royal Borough of Kensington & Chelsea - Inspection of services for children in need of help and protection, children looked after and care leavers Ofsted 2016

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date. The inspection report[5] included a sub-judgement of “Good” regarding the experience and progress of children needing help and protection.

Ofsted made four recommendations following the inspection in relation to children who go missing, out-of-hours services for children, evaluation of children in need cases and support for care leavers who are in custody. The local authority has produced and reviewed progress on an action plan to address these recommendations which has been submitted to Ofsted.

Metropolitan Police

A combination of individual Borough Commands and specialist teams provide policing across the LSCB area. All of these units prioritise children’s safeguarding with their wider priorities informed by the Mayor’s Office for Policing and Community (MOPAC). MOPAC identified 7 key neighbourhood crime types for particular attention between 2013 and 2016 including violence with injury. The future strategies of the Metropolitan Police will focus increasingly on key risks to vulnerable people, including children, for example, those who go missing, are at risk of sexual exploitation and victims of modern slavery.

The Child Abuse Investigation Team (CAIT) is one of 15 such teams covering all 32 boroughs and has responsibility for providing support, advice and assistance with any serious safeguarding issues relating to children. CAIT also investigate abuse committed within families as well as by professionals and carers. Such investigations take place in cooperation with local authority services and include recent and historical allegations of offences against children. Locally, the Borough police have focused particularly on children who go missing or are at risk of child sexual exploitation, domestic abuse and serious youth violence or gang activity. As more specialist secondary teams often rely upon borough police officers to detect and refer on such crime, it is important that frontline officers have the necessary levels of awareness and knowledge. Therefore, a continuous programme of training is provided to officers on these issues and safeguarding in general. Current pressures for the police service include needing to respond to high levels of children being reported as missing and meeting the needs of people who have significant mental health difficulties. In the LSCB area there are also additional pressures resulting from needing to provide initial responses to significant numbers of young people for whom there are concerns but who are the responsibility of other local authority areas.

The report following a “PEEL” inspection of the Metropolitan Police’s effectiveness across London in response to vulnerable people was published in December 2015. It concluded that a good response was provided by the force to missing and absent children and that it had made a good start in ensuring it was well prepared to tackle child sexual exploitation. Meanwhile its response to victims of domestic abuse was good, clear and well understood by officers and staff across the force. However, the overall conclusion was that the force required improvement. There were recommendations to develop understanding of the nature and scale of the issue of missing and absent children through assessment of available data, including that of partner organisations. It was also recommended that it should be ensured that specialist staff receive appropriate training in relation to safeguarding and understanding how to prevent repeat instances which could lead to

[5] Westminster City Council - Inspection of services for children in need of help and protection, children looked after and care leavers Ofsted 2016

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harm. In 2016, Her Majesty's Inspectorate of Constabulary carried out an inspection of the Metropolitan Police's response to child protection issues, the results of which are yet to be published

Multi-Agency Safeguarding Hub (MASH)

The Tri-Borough MASH acts as the focal point for all police generated safeguarding referrals for both children and vulnerable adults. Excellent partnerships exist across all the agencies represented within the MASH ensuring consistency in the application of thresholds and informed risk based decision making. The team also shares all reports created in relation to missing children maintaining a productive working relationship with the Tri-Borough Missing Persons Co-ordinator. The officers within the MASH now have responsibility for the investigation of Category 1 CSE concerns across the LSCB area. This dedicated response has seen a significant increase in police attendance at strategy meetings and improved oversight of the links between missing children and CSE. Oversight for CSE across the area is managed via the Multi-Agency Sexual Exploitation (MASE) panel which enables a strategic overview of the effectiveness of interventions made with victims and disruption tactics employed with perpetrators. MASE is well attended by a range of partners who are supportive of the aims of the group which reports quarterly to the LSCB subgroup. The work of the MASH, MASE, and overall response to CSE were commended in the reports published by Ofsted following inspections in all three boroughs of services for children in need of help and protection, children looked after and care leavers. Arrangements have also been subject to a recent Her Majesty's Inspectorate of Constabulary inspection the results of which are yet to be published.

NHS England (NHSE)

NHS England London Region is responsible for ensuring that the commissioning system in London works effectively to safeguard children at risk of abuse or neglect. One of its outcomes is to ensure that NHS England London Region directorates are aware of their responsibilities with regard to safeguarding and are appropriately engaged with the Local Safeguarding Boards and key partners such as the Metropolitan Police across London.

Key activity for London Region in 2015/16 included carrying out a CCG Safeguarding Deep Dive Assurance and the development of a risk matrix outlining key safeguarding risks across London. This was partly based on the "Section 11 audit" used by LSCBs to assure themselves that agencies placed under a duty to co-operate are fulfilling their responsibilities to safeguard children. While the self assessment concluded that the theme of "The culture of safeguarding within the organisation" was fully met, the outcomes for "A safe organisation" and "Assurance and system leadership" were assessed as "partially met". This has led to planned actions to improve training for staff and to improve linkages between CCGs, local authorities and NHS London in relation to primary care assurance. The need for work with London Councils in relation to the Alan Wood Review (a government initiated review of the role of LSCBs published in 2016) was also highlighted.

Significant challenges for health agencies in London include the recruitment and retention of safeguarding professionals; effective working with CCGs, Care Quality Commission (CQC) and safeguarding boards to recognise and understand key safeguarding risks in primary care; keeping up with the challenge of complexity, particularly in relation to new and emerging risks including Female Genital Mutilation (FGM), Modern Slavery, counter terrorism, unaccompanied asylum seeking children and CSE. Activity in 2015/16 which has specifically impacted upon the area covered by the LSCB includes the implementation of

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the Child Protection-Information Sharing project (CP-IS). This is a national system that connects children's Social Care IT systems with those used by in unscheduled care settings across England. The system went live in Kensington and Chelsea in 2015/16 with Hammersmith & Fulham and Westminster due to go live by the end of 2016.

Priorities for 2016/17 include improving training numbers in the region; leading work on FGM and modern slavery; working with partners to understand the impact of the Alan Wood review; and improving the CH-IS roll out and to work on priorities identified from the CCG deep dives.

Clinical Commissioning Groups (CCGs): West London CCG, Hammersmith and Fulham CCG and Central London CCG

CCGs are statutory NHS bodies with a range of statutory duties – including the safeguarding of children. They are membership organisations that bring together General Practices to commission services for the registered populations and unregistered patients who live in their area.

CCGs as commissioners of local health services need to assure themselves that the organisations they commission have effective safeguarding arrangements in place. They are responsible for securing the expertise of Designated Professionals on behalf of the local health system. These professionals undertake this role across the health economy and actively participate in the work of the LSCB. During 2015-16 Designated Professionals played an integral role in all parts of the commissioning cycle, from procurement to quality assurance, ensuring appropriate services are commissioned that support children at risk of abuse or neglect, as well as effectively safeguarding their well-being.

During 2015 the three CCGs undertook an NHSE Assurance Safeguarding "Deep Dive" exercise. The CCGs were assessed against four components namely: Governance, Systems and Processes; Workforce; Capacity Levels; and Assurance

The table below details NHSE's assessment of the CCGs against these components.

Safeguarding Deep Dive Review Components		Outcome
1	Governance / Systems / Processes	Assured as Good
2	Workforce	Limited Assurance
3	Capacity Levels within CCGs	Assured as Good
4	Assurance	Assured as Good

Beneath these four high level components are a number of more detailed areas. The CCGs were assured as being **Outstanding** on the following areas:

- Engagement around FGM.
- The work being undertaken with Buckinghamshire New University to develop an educational tool to support practitioners in the application of the Mental Capacity Act (2005).

Components that were rated as providing Limited Assurance are being addressed at a CCG level. These predominately relate to the uptake of training.

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Imperial Hospital NHS Trust

Imperial College Healthcare NHS Trust has a well-established children's safeguarding service led by a Designated Doctor, Nurse and Midwife. Specialist staff are based in maternity, children's services and the A&E department and a quarterly safeguarding children meeting is held. Strong links have been established with organisations and charities, to provide joined up support in areas such as domestic violence (Standing Together) and youth gang violence and child sexual exploitation (Red Thread). Red Thread workers are based in the A&E department and sexual health clinic at St Mary's Hospitals. Close working has also been developed with adult safeguarding services to ensure that children are protected in situations where there are adult safeguarding concerns. An extensive programme of training and supervision has been established to ensure that staff are prepared and supported when dealing with safeguarding issues.

Chelsea and Westminster Hospital NHS Foundation Trust

Within Chelsea & Westminster Hospital there is a full safeguarding children's team – liaison health visitor, Designated Nurse, Midwife and Doctor, supported by an administration post. The Designated Doctor for the area works within the Trust and offers additional support. Quarterly Children's Safeguarding Boards are chaired by the Director of Nursing, and there is also an annual Joint Adult and Children's Safeguarding Board within the Trust. A social work team based within the hospital supports children's safeguarding. Child Protection medicals are undertaken within the hospital, and there is good attendance at case reviews by the safeguarding team along with the lead nurse for paediatrics.

The team has worked with the Designated Nurses and Tri-borough safeguarding leads in a number of SCRs with learning shared across the organisation and with other agencies. The relationships developed through the LSCB enable the organisation to provide best practice, up to date safeguarding training, supervision, and care to children and families. Domestic violence continues to be a theme within SCRs and training within this area has been a priority, led by our Domestic Violence lead. We are delighted to have an Independent Domestic Violence Advocate in post to offer support and advice to families and staff.

Child and Adolescent Mental Health Services (CAMHS) are an ongoing concern due to the lack of tier 4 beds (specialist in-patient care for children who are suffering from severe and/or complex mental health conditions), but senior staff within the hospital are working with the CCG, mental health providers and NHSE to bring about improvements for patients within this area.

The Director of Nursing is a member of the LSCB and this is an essential partnership to enable sharing of learning, best practice, and support across agencies.

Central and North West London NHS Trust (CNWL) and West London Mental Health Trust

Both Trusts have continued to work closely with children's social care across the three local authorities, referring cases appropriately whilst responding to MASH or Front Door enquiries as to whether parents are known to mental health services when safeguarding is a concern. There has been good feedback about the service provided by Trust link staff. We have worked hard to promote the "Think Family" agenda within adult mental health

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services and this has contributed to a demonstrable increase in referrals from adult mental health services to children's social care.

An audit on the joint protocol was included in our Commissioning for Quality and Innovation (CQUINs) payments framework. This showed good joint working across the partnership, but with no room for complacency. We have also tried to stress that mental health is not just about mental health services and this year have encouraged primary care to explain to service users the services that they provide to those with minor mental health problems or stable severe conditions.

In 2015/16 both Trusts were subject to CQC Inspections and there were no actions that were identified in relation to safeguarding children arising from either inspection.

CNWL has undertaken work in relation to the two Serious Case Reviews that it was involved with and is now in the process of implementing the action plans and embedding the learning across its services. This has also been shared with West London Mental Health Trust so that both Trusts can learn from incidents.

New reporting guidance on FGM has been implemented. New guidance on modern slavery has also been promoted and used effectively with a specific case so that a vulnerable adult was kept safe. The Prevent agenda also continues to be promoted with both agencies having internal targets to contributing to a three year target which is on track to be achieved. Both Trusts have been involved with a Mayor's Office for Policing and Crime (MOPAC) funded project. This includes join work with Standing Together to run sessions for mental health staff on raising awareness of domestic abuse and to improve compliance with procedures.

Probation

The National Probation Service (NPS) London continues to work with partner agencies to safeguard children within the three boroughs. NPS contributes to MASH, the Multi-Agency Risk Assessment Conference (MARAC), MASE and Multi-Agency Public Protection Arrangements (MAPPA) to ensure that issues of child safeguarding are at the forefront of all our work with service users. NPS undertakes an audit of a sample of cases every month and safeguarding aspects of casework are always considered when appropriate. Court teams are currently developing closer links with safeguarding agencies to ensure more effective and faster sharing of information to protect children of those who appear in our local courts. All staff are trained and are encouraged to take part in the opportunities for further learning provided by the LSCB training programme.

Community Rehabilitation Company (CRC)

Since December 2015, London CRC's offender managers have adopted a new approach which works with groups of offenders who have similar rehabilitation needs. The aim of this new way of working to deliver tailored services that tackle the underlying causes of offending. Young people receiving services are now assigned to one of six cohort groups including those who are 18 to 25 year old males, those who have mental health and learning disabilities (as the primary presenting need) and those who are women. Through this model, operational staff can spend more time working face-to-face with offenders. The CRC also continues to fulfil its Community Safety (Integrated Offender Management) and Safeguarding (MASH) responsibilities. The CRC has re-launched its performance framework which monitors the volume of responses and whether someone is known to

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children's social care. Meanwhile staff in the separate Rehabilitation, Partnerships and Stakeholders directorate are focusing on developing partnership relationships. This work is led by a Head of Stakeholders and Partnerships who attend this and other LSCBs.

Children and Family Court Advisory and Support Service (Cafcass)

Cafcass is a non-departmental public body, sponsored by the Ministry of Justice. It works in the family courts in circumstances where children have experienced or are at risk of experiencing abuse, neglect or trauma. Cafcass also work with families in circumstances where there is a dispute about where a child should live or with whom they should spend time, often following divorce or separation. The role of Cafcass is to make recommendations to the court about the right courses of action for children and young people. Cafcass was inspected by Ofsted in 2014 and judged to be good with outstanding leadership and management. Since then Cafcass continues to prioritise safeguarding activity and internal audit reveals that the organisation is making good progress. Cafcass's recent annual report detailed work with 116,104 children and young people across England. Cafcass's key performance indicators were met 2015-2016 despite a 10.3% increase in demand in private law and a 14.2% increase in public law cases.

Community Safety

Across the three local authority areas, Community Safety provides significant focus around prevention and a range of activity in support of safeguarding. Through the Channel and wider Prevent safeguarding processes, the Prevent Team works closely with different Council departments across the three local authorities and with other agencies to support and safeguard individuals potentially vulnerable to extremism or radicalisation.

Channel is a statutory, early intervention, multi-agency process designed to safeguard vulnerable people from being drawn into violent extremism and/or terrorism. Channel works in a similar way to other safeguarding partnerships such as case conferences for children in need. It is a pre-criminal process that is designed to support vulnerable people at the earliest possible opportunity, before they become involved in illegal activity. Safeguarding leads from within child protection and Children's Services also sit on the panel. Alongside this, other multi-agency partners, including all those involved in any specific case, are brought together to collectively assess the risks in relation to an individual and decide whether a support package is needed. If the panel feels that an individual would benefit from support; a bespoke package will be developed, based on their particular needs and circumstances. The value of this work across the three boroughs was recognised in the early 2016 Ofsted inspection of services for children in need of help and protection, children looked after and care leavers.

Significant work has taken place to address youth violence within and across the three boroughs. Westminster's Integrated Gangs Unit (IGU) has also delivered multi agency work to safeguard young people. Examples include the provision of intensive support for those involved in gangs (100 referrals per year), prevention in schools (3074 pupils took part in sessions in 2015), joint workshops to support women in the BAME community (Prevent and IGU) and work to safeguard those at risk of being exploited by potential child sexual exploitation perpetrators.

Housing and Housing providers

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The range of housing services across the three boroughs is very broad comprising the provision of tens of thousands of homes owned and/or managed by the three councils with similar numbers of affordable housing properties owned by Registered Providers (Housing Associations). Advice is provided to thousands of households in housing need and across the three boroughs. Accommodation is also provided for over 6000 homeless households and supported housing services to care-leavers and other vulnerable young people to support them to live independently. High priority has been given to ensuring front-line staff across all types of housing service have an excellent understanding of safeguarding, are able to identify risk and know the appropriate action to take. There has also been a strong focus from the LSCB on ensuring that the most vulnerable homeless families are prioritised for suitable housing within their home borough and that the use of non-self-contained bed and breakfast accommodation for households in need only happens in emergencies. At any one time there have not been any more than 10 such placements across the three boroughs. Reviews of young people's hostel accommodation have included a significant focus on safeguarding and the findings of such reviews were very positive with the overwhelming majority of young people feeling safe and knowing action to take following any incidents.

Voluntary / Faith Sector

The LSCB has benefited from a Community Development Worker post working closely with key safeguarding agencies from across the three boroughs, such as Prevent, the safeguarding in schools lead, and the FGM lead. In 2015-16, joint safeguarding sessions have been delivered to community groups, Imams, supplementary school teachers, and community forums. This joint working has helped to safeguard children more effectively in an LSCB area of significant diversity because of the increased face-to-face contact enabled with key community leaders who are often gate-keepers to the communities themselves. We have provided such leaders with key safeguarding contacts, an enhanced understanding of what safeguarding is, and some insight into signs and symptoms of abuse. This increased awareness amongst communities and groups can only strengthen safeguarding arrangements of children and young people. The Ofsted inspection in early 2016 provided very positive feedback regarding the work carried out with male members of FGM practising communities, particularly in reference to the support provided for key community leaders, including an Imam, in addressing this challenging issue amongst the wider community.

Schools

As at January 2016[6], there were there was a total of 255 schools across the three boroughs. 160 of these were state funded including 12 nursery schools, 104 primary schools, 30 secondary schools, 9 special schools and 5 settings which were either pupil referral units or alternative provision. 43 of these schools were academies or free schools. There is a significant independent sector across the three boroughs. In all there are 94 independent schools, 21 in Hammersmith & Fulham, 44 in Kensington and Chelsea and 29 in Westminster.

Ofsted Inspections of Schools 2015/16

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[6] DfE "Schools, pupils and their characteristics: January 2016"

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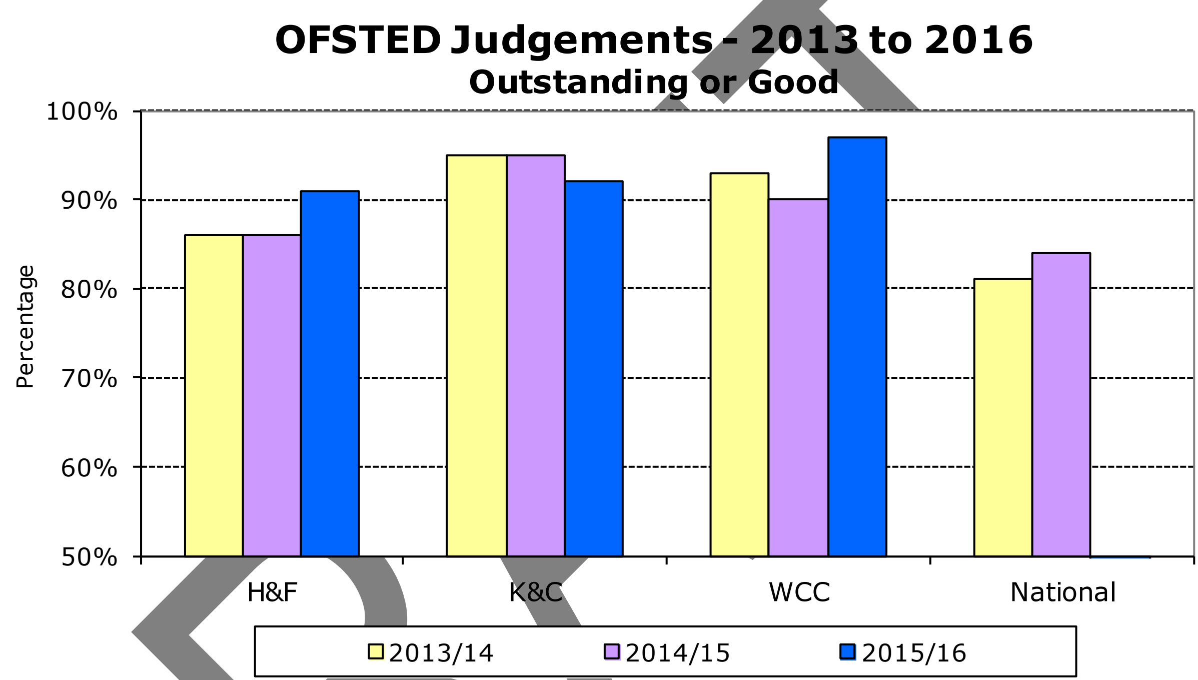
The percentages of schools in the tri-boroughs which are rated outstanding or good by Ofsted inspectors have remained consistently high during the last three academic years. Only three schools are currently judged inadequate (Hurlingham Academy and Phoenix, in Hammersmith & Fulham, and Wilberforce in Westminster) while seven of the 155 schools are judged to require improvement.

The percentages ranked outstanding or good at the end of the last three academic years is shown below; overall judgements for all three boroughs were considerably above the national average.



During 2015/16 to date there have been twelve full inspections of schools across the three local authorities. There have also been short inspections of a further four schools.
The reports from such inspections include specific commentary from Ofsted regarding the effectiveness of safeguarding arrangements in individual schools and these reports are all publicly available.

Children's Homes

The Royal Borough of Kensington and Chelsea maintains two children's homes in the area (Olive House and St Marks). St Mark's has a current Ofsted rating of Good following an inspection in June 2016. Olive House received a rating of Good with "declining effectiveness" in an interim inspection in February 2016. No recommendations were made for specific actions for Olive House and the "declining effectiveness" issue was linked to the registration status of the home's manager. An application for registration has subsequently been submitted to Ofsted.

Both Olive House and St Mark's continue to provide detailed risk assessments for all the young people placed with them. These identify areas of concern and actions taken to address them. All staff undertake relevant training including bespoke training as the needs arise. Specific training was commissioned to support staff around working with CSE and to

respond more effectively to those people who go missing. St Mark's Ofsted inspection did note the lack of opportunity for young people to be seen by an independent person when returning after going missing and an action plan is in place to address this.

The Haven in Hammersmith & Fulham is a local authority children's home registered for up to seven children with learning disabilities and physical disabilities. The home mainly provides short breaks, but can also provide interim emergency and longer-term placements. It was last inspected in July 2016 and judged by Ofsted to be "good" across all three sub-judgements. An area identified for improvement was the "safeguarding knowledge" of staff. Managers advise that this refers particularly to temporary staff which have been needed to meet demands for longer-term placements. This demand has resulted from a planned strategy to ensure more children with complex needs can be placed locally with good access to their family networks and local support services. Managers have provided assurance that permanent staff have a good understanding of safeguarding and that these staff take lead responsibility for each shift. Further actions are being taken to increase recruitment to permanent positions and to ensure training needs of all staff are identified and met.

HM Prison Wormwood Scrubs

Safeguarding comprises a significant part of the work carried out by HM Wormwood Scrubs Prison with families and children of inmates. A lead officer, who is also an attending statutory member of the LSCB, is in place for safeguarding. Her role includes liaison with social workers, schools and families regarding children's visits to the prison and discussing any safeguarding issues. There are also links between the prison and external Multi-Agency Public Protection Arrangements (MAPPA).The officer has attended Level 3 multi-agency safeguarding training provided by the LSCB and the Academy of Justice and. Furthermore she provides a basic training to the officers who supervise visits and there are plans to recruit a family officer.

The prison's Visitor Centre has provided safeguarding training for the staff working there and can make referrals or consult with the lead officer where there are any safeguarding issues for families attending the centre.

A recent Justice Inspectorate inspection in December 2015 noted that public protection procedures were adequate and that applications for contact with children were assessed appropriately and suitable levels of contact approved where possible.

Section 11 Audits

Section 11 of the Children Act 2004 details the responsibilities that agencies have for safeguarding children. The LSCB carries out bi-annual audits of all member agencies. In 2015-2016, a working group, including one of the LSCB lay members, reviewed the pan-London audit tool in use and revised the questions in it to make it both more user friendly and helpful for agencies completing it. The audit tool questions were also updated to include new and emerging safeguarding concerns such as radicalisation and child sexual exploitation. The audit tool is now accessed online and once completed in full, allows users to generate an action plan to address any areas that need improvement. Following the development of the revised audit tool, a small number of agencies were selected to

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complete it at the end of the year. A wider range of agencies, including schools and voluntary sector providers are expected to complete it in 2016-2017.

ANNUAL REPORTS

Child Death Overview Panel (CDOP)

The 2015/16 Annual Report for CDOP provides analysis of the child deaths reviewed during 2015-16 in the boroughs of Westminster, Kensington and Chelsea and Hammersmith and Fulham, rather than those deaths notified during the same period. Between April 2009 and March 2016 there have been 226 child death reviews completed with 25 reviews in 2015- 16.

The panel has focused on reviewing all child deaths that have occurred across the 3 boroughs identifying factors that may have contributed to the deaths along with any modifiable factors.

The panels are themed to enable more effective learning from cases and do not review unexpected deaths until other forms of investigations or Serious Case Review has been undertaken.

In addition, the timing of reviews is subject to:

- The information available from agencies involved
- Other processes such as police investigation, serious case review or inquest
- Number of cases relation to particular themes

Of the 25 deaths of children, reviewed by the Child Death Overview Panel (CDOP) 10 were assessed as unexpected. The key themes for the unexpected deaths were related to life limiting disease and perinatal events. As a consequence, the main category of death has been those with life limiting disease.

The Clinical Commissioning Groups have continued to lead on the work of CDOP on behalf of the LSCB. Quarterly updates are given to the Board and progress has been made in strengthening links with other subgroups in particular the Case Review Subgroup.

The panel is chaired by the Deputy Director of Public Health for Westminster. A Specialist Nurse is being recruited to take responsibility for the management of the CDOP process working alongside the Designated Doctor for Child Death.

A number of recommendations were made for the work of CDOP in 2016/17 including

- To improve the communication process between CDOP and the parents of children who have died. Parents should receive a letter to inform them of the CDOP process along with appropriate leaflets.
- Identification of topics for research and to develop a work stream to support this.
- To work with the LSCB to develop web pages on the LSCB website so that families and professionals have access to information and resources in relation to the child death process and how to access support.
- To establish links with the Learning and Development subgroup secondary and primary care, education and the police to ensure that learning from the child

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death reviews is disseminated and that agencies are aware of the CDOP process.
- The learning from CDOP to inform the Joint Strategic Needs Assessment for the three boroughs.

Local Authority Designated Officer (LADO) – Safer Organisations

The LADO has provided a report regarding the management of allegations against adults working with children across the LSCB over the course of the past year.

The procedures used for managing allegations are as set out in the London Child Protection Procedures. The procedures are invoked when there is an allegation (whether historic or current) that a person who works with children has:
• behaved in a way that has harmed a child, or may have harmed a child;
• possibly committed a criminal offence against or related to a child; or
• behaved towards a child or children in a way that indicates they may pose a risk of harm to children

These behaviours should be considered within the context of the four categories of abuse (i.e. physical, sexual and emotional abuse and neglect). These include concerns relating to inappropriate relationships between members of staff and children or young people. If concerns arise about the person's behaviour to her/his own children, the police and/or children's social care must consider informing the employer or organisation in order to assess whether there may be implications for children with whom the person has contact at work / in the organisation, in which case this procedure will apply.

All staff should be made aware of their organisation's whistle-blowing policy and feel confident to voice concerns about the attitude or actions of colleagues; learning from Serious Case Reviews indicates that early reporting of low level concerns around rule breaking and boundary keeping can help to prevent the abuse of children.

In 2015/16, the local LADO service has been strengthened and developed. Child protection advisors in each of the boroughs handle incoming cases on a duty basis with support from the Safe Organisation manager /LADO lead. The majority of Child Protection Advisors are now permanent members of staff which means practice is embedded and there are opportunities to take advantage of discussing emerging themes and thresholds across the three boroughs. This is particularly important where there have been similar changes in the arrangement in place for the Child Abuse Investigation team.

Safe Recruitment and leaning from Serious Case Reviews
The LADO has continued to offer accredited safe recruitment training as part of the LSCB training programme. This has been well attended as have sessions on learning from SCRs and 'meet the LADO' events.

Raising the profile of the LADO role
The LADO has worked closely with the Safeguarding Lead for Schools and Education officer and the LSCB Training Officer to raise the profile of the role with schools and in particular in the independent school sector (in part prompted by the learning from the Southbank International School SCR). There is further work to be done academies, particularly those which belong to larger trusts and where in-house HR services for such schools do not have specialist knowledge of safeguarding.

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Origin of Referrals

Overall the volume of cases reported to the LADO service is increasing – this appears to be reflected across the London boroughs. More organisations are making contact for consultation and reassurance on risk assessment. The majority of cases still emanate from early years settings and schools.

It would appear that more historic cases are coming to light and this could partly reflect the influence of the Independent Inquiry into Child Sexual Abuse at a national level. All LADOs have been instructed to retain and secure records of previous concerns and it is possible that a local case will be called in during the course of the Inquiry.

It is notable that there has been a decline in the number of referrals from the voluntary sector. Whilst acknowledging that this is not a homogenous group of organisations, some consideration should be given to further outreach work to raise the profile of safeguarding and to ensure that the sector is well-supported amongst the wide range of organisations in this sector.

In contrast there has been an increase in referrals from a broad range of sports organisations. Whilst some bodies like the Rugby Football Union do have a regulatory role, many other such bodies are membership organisations, meaning that anyone can pay their fee and join. This can give users the false impression that sports providers are accredited and vetted and it can be very difficult to hold some small scale providers to account in these circumstances. A similar situation applies to other service providers – for example therapists who do not need to be registered with the Health Care Professionals Council (HCPC).

Private Fostering

The social worker responsible for the coordination of private fostering arrangements across the LSCB area provided a report to the LSCB in October 2015. The report showed an increase in notifications of such arrangements at that point of 2015/16 compared with the previous year. Notifications tended to come from agencies such as school admissions, the Benefits Agency, schools, local authority Children's Services and self-referrals. A programme of awareness-raising had taken place including with GPs, Health Centres, and Youth Hubs with some initial indications of this having an impact upon referrals. Other publicity and guidance had led to an increase in queries and consultations. The effectiveness of this coordinating role including awareness raising and impact on referrals was confirmed in the reports following the Ofsted inspections in all three boroughs in January and February 2016.

The report notes that a high number of private fostering arrangements had recently ended, largely because children and young people had either returned to the care of close family members, made the transition into adulthood or moved to other areas. Appropriate referrals have been made to the relevant boroughs to inform them of the likelihood that children were moving into their area subject to private fostering arrangements. Support had also been explored with carers of young people as they reached the age of 16, and appropriate referrals made where required.

Further work was planned including a formal communication and awareness raising strategy across the LSCB area including a single website; engagement with external special interest groups to ensure access to best practice; development of a local, shared

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Private Fostering Protocol and improvements to common recording and assessment processes.

Independent Reviewing Officers (IRO)

Independent Reviewing Officers chair reviews for individual looked after children and have an important role in the care planning and safeguarding of such children. They therefore hold significant information regarding the overall experiences of children in the care of the three local authorities covered by the LSCB.

Over the course of 2015/16, the IROs have been working as part of a unified service. The teams have remained relatively stable, with caseloads within the recommended limits set in the IRO Handbook. This allows IROs to know their children well, and to monitor cases between reviews. They have continued to work in collaboration with the social work teams to resolve issues and concerns about children's care plans in an informal manner wherever possible. There is a positive working relationship between IROs and front line teams across the three authorities, and this has kept the need for recourse to the formal Resolution Protocol to a minimum.

The role of the IROs was noted in the inspections of the three local authorities by Ofsted in 2016 with commentary including "Outstanding services for children looked after are characterised by robust arrangements in place for reviewing care plans by a dedicated team of independent reviewing officers", "Independent reviewing officers know children and young people well, and provide positive support outside of the reviewing process. There is a culture of informal and formal challenges to care plans" and that IROs "have manageable caseloads ..., enabling them to drive permanency planning vigorously. They routinely attend permanency planning meetings and are committed, knowledgeable and passionate about their work. They know the young people well."

51% of the children looked-after at 31st March 2016 had been in the care system for less than 12 months. This indicates a continued high turnover of children in the care system over the 12 month period. 78% of looked-after children across the three authorities are aged ten and over. This presents particular challenges for achieving stable and permanent placements for some of these young people, as their needs are likely to be more complex as a result of their late entry into the care system. 22% of looked-after children were placed outside of the London area. Progressing permanent and stable placements for these children close to their home authority wherever possible remains a challenge and the LSCB has reviewed the reasons behind children being placed at distance from a perspective of being able to provide consistent health services for them.

Across the three local authorities 91% of looked after children reviews were held within statutory timescales. Over 97% of looked after children participated in their review meetings over the year. They have also been involved in key service development initiatives through their Children and Young People's Panel / Children in Care Councils. These included engagement activities as part of the development and implementation of the Looked After Children and Care leavers Strategy, recruitment of senior Officers, and a number of events to celebrate key achievements

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Violence Against Women and Girls (VAWG) Partnership[7]

The three local authorities covered by the LSCB established have maintained a shared services response to VAWG commissioning, governance and strategy since 2014. Mayor's Office for Policing and Crime (MOPAC) London Crime Prevention Funding, matched by Council funding has been used for this purpose from 2013 with the current funding due to end in 2017. From April 2015 to March 2016 the three previously sovereign borough Domestic Violence/VAWG arrangements were brought within a single governance structure with a Strategic Board, chaired by the Tri-Borough Executive Director of Children's Services, and supported by six operational groups. Joint working protocols have been established with the partnerships including the LSCB in recognition of the cross cutting range of harms included in the scope of VAWG.

The VAWG strategy is configured around seven priorities including one which focuses on children and young people. The priority is that children and young people are supported if they witness or are subject to abuse and understand healthy relationships and acceptable behaviour in order to prevent future abuse. The Partnership prioritises both prevention of violence and abuse and direct provision of support for Children and Young People.

Specialist VAWG professionals within eight different children's services settings were co-located through the Partnership in 2015/16. Professionals in specialist services now work alongside colleagues from children's services to strengthen pathways and knowledge-sharing between them to support high risk families in the short term but also to undertake longer term work to prevent future abuse and increase safety in families.

Priorities for 2016/17 include a focus on whole school and whole family approaches and networks of lead professionals across the children's sector. Additionally, there is a plan to roll out the #SpeakSense campaign for young people alongside the young person's version of the VAWG Strategy.

Specialist support for children remains a significant gap in all three boroughs. There is no specialist advocacy support for children and young people under 13 years old who have been affected by domestic abuse in any of the three boroughs. The Partnership aims to address this gap with a needs assessment and joint commissioning strategy.

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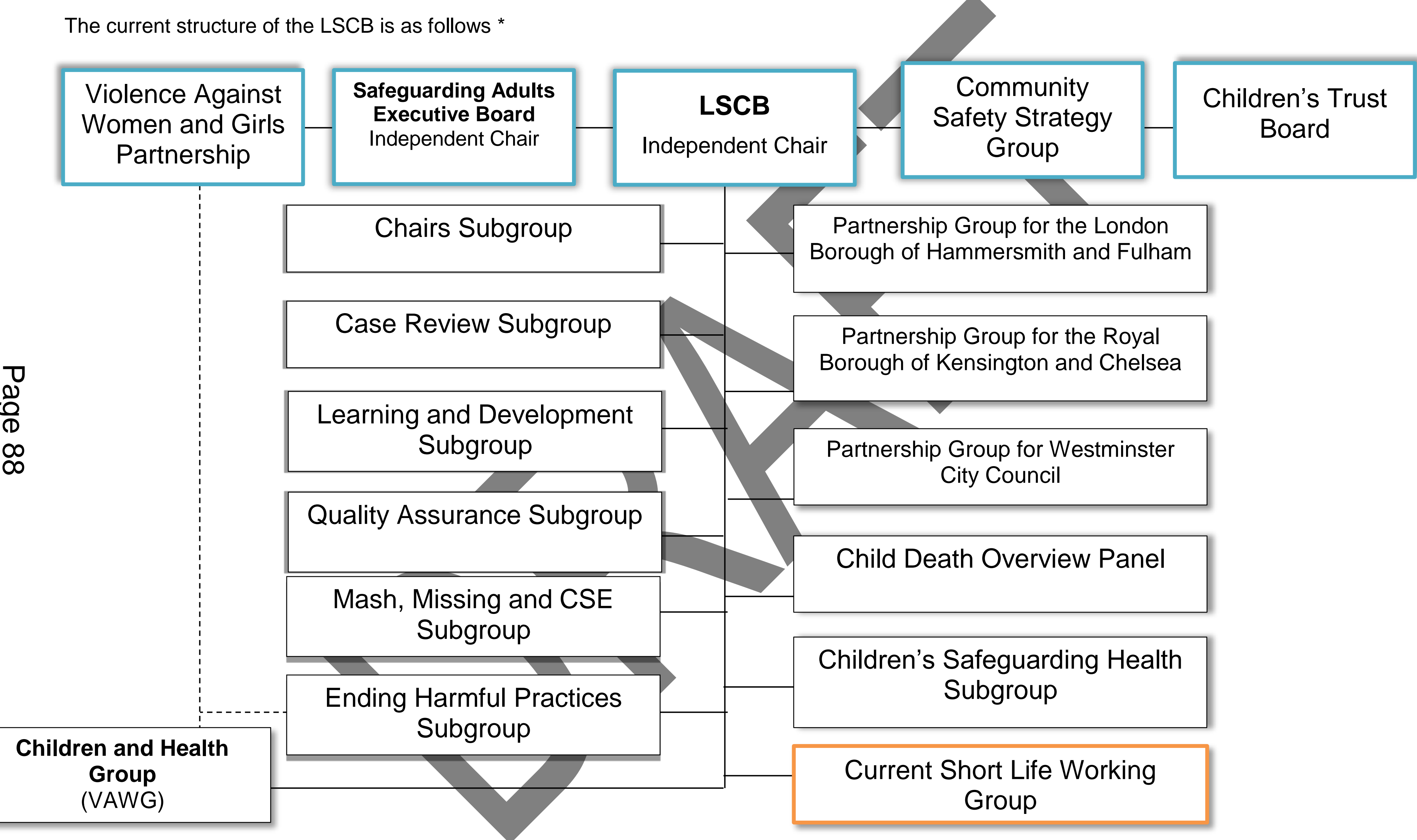
[7] https://www.rbkc.gov.uk/pdf/Violence%20against%20women%20and%20girls%20Partnership%20Annual%20Report%202015-16.pdf

GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

The current structure of the LSCB is as follows *



* LSCB membership on LSCB website https://www.rbkc.gov.uk/sharedservices/lscb/aboutus/boardmembersandadvisers.aspx

Version 6 20/10/16

PRIORITIES OF THE LOCAL SAFEGUARDING CHILDREN BOARD – 2015/16

The headline priorities of the Local Safeguarding Children Board for 2015/16 were as follows**:**

Continue to deliver the core business of the Board at high quality

- Evaluation and challenge of the role of Early Help in safeguarding children
- Engagement with diverse communities
- Effective child protection plans
- Multi-agency responses to neglect
- Ensure safeguarding practice meets the needs of children with mental health concerns, who are disabled or affected by domestic abuse

Improve the Board's effectiveness in reducing harm to children

- Learning from each other in a context of organisational change
- Increased learning from case reviews
- Ensuring that the needs of children from marginalised groups are scrutinised by the Board
- Effective communication with a multi-agency workforce
- Holding each other to account - challenge that improves outcomes
- Maximising our wider partnerships to better influence impact on the ground

Ensure effective, proportionate, multi-agency responses to safeguarding issues which affect children & young people with high levels of vulnerability

- Female Genital Mutilation
- Sexual exploitation
- Addressing perpetrators of abuse and exploitation
- Involvement with gangs
- Going missing
- Substance misuse
- Radicalisation of young people

Informed by the voice of the child & the experience of our looked after children

Summary of outcomes and progress made

The Safeguarding Plan was developed to identify a series of outcomes through which progress could be measured. The following section lists the outcomes and evidence of activity that supports each of the outcomes.

1. **We know the impact of our early help framework in identifying and supporting children and young people who are at risk of neglect and/or have high levels of vulnerability.**
    - The LSCB was provided with an assessment from each borough of measured impacts of council early help services upon children and families.
    - A Focus on Practice impact report was provided showing initial indications of the positive effects of the programme on rates of children becoming looked after, those with child protection plans and re-referrals.
    - The LSCB Neglect Strategy was published which is now informing a series of tools and awareness raising developments across the three boroughs.
    - An integrated ante-natal offer and 2 year old check has been implemented across all three boroughs with Information Sharing Agreements in place.
    - Schools are increasingly engaged with addressing eSafety issues, including through linking with parents.

2. **Our performance framework identifies areas of concern which are challenged and addressed through the Board.**
    - The Board has consistently received performance reports with exceptions identified. There have been challenges which have been discussed at the Board including in relation to the numbers of looked after children placed out of borough.

3. **Partners have a shared overview of the effectiveness of safeguarding of disabled children and agree actions to address any concerns.**
    - Learning in relation to the specific needs of disabled children from relevant Serious Case Reviews has been reviewed and shared across the multi-agency workforce.

4. **We have reviewed the structure of the LSCB to maximise the contribution of our partners and the Board's impact upon wider practice.**
    - Ofsted's Review of the LSCB found the shared structure created significant benefits for young people through the rationalisation of time and secure involvement of senior representatives from partner agencies. The balance achieved between shared and local functions ensured that children are safeguarded effectively. Additional points of relevance to this outcome included:
        1. Although Ofsted recommended that the Board should devise a system to escalate concerns about infrequent attendance at the board by

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partners, there has been effective follow-up in relation to this by the Independent Chair and others. There has also been effective action to ensure departing members are replaced. The sub-groups are chaired by leads from a range of agencies. The LSCB now includes stronger input from Public Health, Health, Adults Services and Prevent.

ii. A Health Overview sub-group has been meeting since April 2015.

iii. A new system has been implemented to enable Section 11 audits to be carried out virtually with a phased programme to make this accessible to different agencies.

5. **A Communications Strategy is agreed which reflects the views of children and young people on how best to raise their awareness of our priority safeguarding issues; successfully disseminates key learning to practitioners in all partner agencies; identifies missing stakeholders/partners and strategies to engage them.**
    - A shared website went live in 2015 and has been regularly updated with further developments planned. A Twitter feed is driving visits to the site.
    - The “Young Humans” project regarding feelings of young people about being Muslim in West London has been hosted on the website.
    - The LSCB worked with young people during Youth Takeover Day to design anti-bullying resources.
    - Our communications are encouraging increasing numbers of independent schools to seek advice about safeguarding issues.

6. **Our training programme is targeted to reflect the priorities of the LSCB and address current challenges for frontline workers.**
    - The annual training programme was published with a plan in place to measure the impact on delegates at intervals after training was completed, as well as mystery shopping exercises.
    - Feedback from consultation has influenced training content, e.g. a VAWG consultation of young people led to key messages being stressed in LSCB core training. LSCB has facilitated advertising of Prevent WRAP training to increase uptake by the children’s multi-agency workforce.

7. **LSCB members have a clear understanding of the role and challenges of other partner agencies including the impact of ongoing significant change.**
    - LSCB member agencies have publicised changes to service offers via the Board with challenges where it is felt that such changes could have an impact on safeguarding. This aspect of the Board’s activity will be formalised through LSCB meeting agendas in 2016/17.

8. **All partner agencies are effective in identifying children and young people affected by gangs and serious youth violence and refer them on for effective support.**
    - There have been effective services and processes in all three boroughs as follows:

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i. Hammersmith & Fulham: Street Outreach Service operating as an autonomous service with referrals from police, children's services and probation following concerns about serious youth violence or emerging tensions.
ii. Kensington and Chelsea: Good working relationships between key agencies concerned with serious youth violence facilitate information sharing and effective meetings following London Child Protection guidelines. The local police gangs team work with all agencies on managing individual or groups of young people.
iii. Westminster: The multi-agency Integrated Gangs Unit located in the MASH meets daily to share information with strong partnership working with schools, Redthread and Child and Adolescent Mental Health Services.

9. **Frontline practitioners are aware of the signs of child sexual exploitation and are confident in supporting children who are affected.**
   - There is a high level of assurance about the effectiveness of a wide range of strategies to tackle CSE in the three boroughs. Ofsted noted a "robust and well-coordinated response…informed by the effective sharing of information and intelligence between all key agencies." The Review of the LSCB noted that "Effective monitoring by the child sexual exploitation and missing sub-group enables the board to have a robust understanding of missing children and their behaviour across the tri-borough partnership."
   - LSCB general and specialist training courses address CSE with additional training provided for Family Services staff by CSE leads. Training has been reviewed and revised where appropriate e.g. to make some generic training more specific to local situations. Staff from local authority Children's Services, health, the voluntary sector and probation have participated in the training offered.
   - Training and awareness videos have been published on the LSCB website.
   - Profiles of CSE activity have been produced and shared with partners through the MASH/Missing/CSE sub-group.

10. **The wider community has an increased awareness of young people vulnerable to sexual exploitation, gang activities, domestic violence and female genital mutilation.**
    - Operation Makesafe has been implemented across the three councils with a Stakeholder Group led by the Director of Children's Services reporting to the LSCB. This has engaged businesses including hotels, licensed premises and taxi companies in awareness of and responses to CSE
    - Awareness of CSE amongst young people has been addressed through the Healthy Schools Partnership and School Improvement Team which promotes this in schools through the Personal, Health and Social Education (PHSE) curriculum.

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- Young people in targeted schools have received training from the Integrated Gangs Unit and the police on consent and rape as well as additional training from Barnardo's and VAWG.
- Ofsted noted the effectiveness of awareness-raising regarding FGM which had led to referrals to children's social care increasing along with the effective role of the tri-borough female genital mutilation project in engaging fathers and husbands and from particular communities.

11. **Multi-agency planning addresses the behaviour of perpetrators of CSE and Domestic Abuse.**
    - Ofsted noted the role of information sharing through the Multi-Agency Sexual Exploitation panel (MASE) and other local panels and mapping arrangements in ensuring a focus on both victims and perpetrators.
    - Reports to the MASH/Missing/CSE Sub Group now include summary information about perpetrators and locations of concern.
    - There is reciprocal attendance at key risk management groups such as MAPPA and Serious Youth Violence panels with good examples of "mapping" meetings in the boroughs sharing information about perpetrators from different agency perspectives.
    - Anonymised examples of effective action to disrupt perpetrators and address locations of concern have been shared with the LSCB and the Sub Group.
    - All three boroughs have well performing MARACs that safety plan for families where there is high risk domestic abuse

12. **Agencies are aware of and able to respond to young people affected by domestic abuse perpetrated by peers**
    - A report has been presented by VAWG representatives to the LSCB with a commitment to regular updates going forward.
    - Professionals from specialist services are now working alongside colleagues from children's services to strengthen pathways and knowledge-sharing between them to support high risk families and to provide longer term work to prevent future abuse and increase safety in families.
    - Parenting Programmes have been introduced which support wider relationships and their impact on child well-being, in addition to developing additional components to early intervention parenting programmes that offer VAWG support. This includes *Talking Without Fear*, which focuses on offering extra support to non-abusive parents post separation as they are recovering from the trauma of abuse, and the *Healthy Relationships Healthy Babies* pilot, both of which have happened in Westminster.
    - Children and young people have been identified as a priority in all of the VAWG's operational groups

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13. **Practitioners are increasingly able to identify children at risk of female genital mutilation and respond appropriately to safeguard them.**
    - A pilot project involving local authority and health services has introduced an innovative approach in identifying and working with potential and current FGM victims. A specialist social worker co-located and embedded within a health setting has contributed to strong multi-agency working which is enhanced by joint development work with Midaye, a Somali Development Network.
    - The project has led to a substantial increase in the number of families where FGM has been identified to be an issue, enabling a proportionate response at an early help stage or Child in Need or Child Protection services where required. From May 2014 to March 2016, 77 women from the three boroughs have been referred and seen in both clinics. All women who have daughters or are going to give birth to girls have agreed to social work visits.
    - At St Mary's weekly FGM clinic, the team see approximately 10-12 women per clinic. 3-7 of these are residents of the three boroughs. At Queen Charlotte's Hospital where an FGM clinic operates fortnightly, the team sees 5-10 women per clinic, with 4-5 women of these from the three boroughs.
    - The LSCB provides FGM training to a range of practitioners who have contact with girls across different age groups. "Learning Events" have been planned to support schools with addressing FGM.
    - The LSCB community worker has built strong links with Mosques and Madrassahs to build capacity to recognise and respond to safeguarding issues

14. **The LSCB has identified how best to work with other key partnerships to better address safeguarding issues resulting from the radicalisation of some young people.**
    - A major conference took place involving local schools and including presentations on responding to threats of radicalisation,
    - The Channel Panel has been expanded to include safeguarding representatives from Children's Services in all three boroughs and specific schools, determined by what is on the agenda.
    - Following training and awareness raising, an increasing number of schools and colleges are raising the issue through school councils, PHSE, assemblies and using the support and advice available from Prevent.

15. **The LSCB has ensured that local multi-agency responses to national safeguarding issues are proportionate and target the communities or localities most affected.**
    - There are good examples of tailored support being provided to specific communities, raising awareness of safeguarding in response to local needs while ensuring an appropriate range of other issues are addressed through this contact.

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Conclusions following the review of the 2015/16 Safeguarding Plan

1. While there have been significant developments in many service areas and improved processes, in some areas of LSCB activity, there is an ongoing need for a greater emphasis upon outcomes and clearer indications of impact upon children which result.
2. While we are now clearer about the impact of local authority Early Help services, there is less clarity about preventative services provided by other sectors and their contribution to effective safeguarding.
3. There is a need for the Board to consider the safeguarding needs of disabled children. While the recent Ofsted review and the simultaneous inspections of the three local authorities did not identify any specific concerns about disabled children, there is still a need for the LSCB to consider their safeguarding needs in more detail.
4. While there have been initiatives to involve young people in the work of the board and consult them about safeguarding, this has involved limited numbers of children. A more comprehensive understanding of how we assess the impact of safeguarding upon the lives of children and young people and how the Board has acted upon their views is required.
5. While we have made progress with communicating more regularly and in different ways, we are not always clear about the degree to which key messages are received and responded to by the large multi-agency workforce. Further developments could also be considered as to how the LSCB might best receive feedback from frontline staff about how safeguarding is working in practice.
6. There is an ongoing need for the LSCB needs to continue to develop its links with a range of partnerships with which we share a common agenda or priorities.

VIEWS OF CHILDREN AND YOUNG PEOPLE

With support from the LSCB Community Development Officer for Children and Young People we undertook a range of activities this year. In July, we hosted a workshop for school children aged 9-10 years old for the Children's Choice Conference for schools in Hammersmith and Fulham, and Kensington and Chelsea where we asked children to tell us about what worried them most. The children were asked 1) what worried them about a particular safeguarding topic, 2) how they could keep themselves and their friends safe and 3) what adults could do to keep them safe.

One of the main themes identified was bullying at school, and we subsequently planned an activity around this and e-safety for Youth Takeover Day in November. For this event, we challenged a number of young people from Phoenix High School in Hammersmith and Fulham to produce with a short stop motion film about keeping safe online which was used on the LSCB Twitter feed to promote Safer Internet Day in February.

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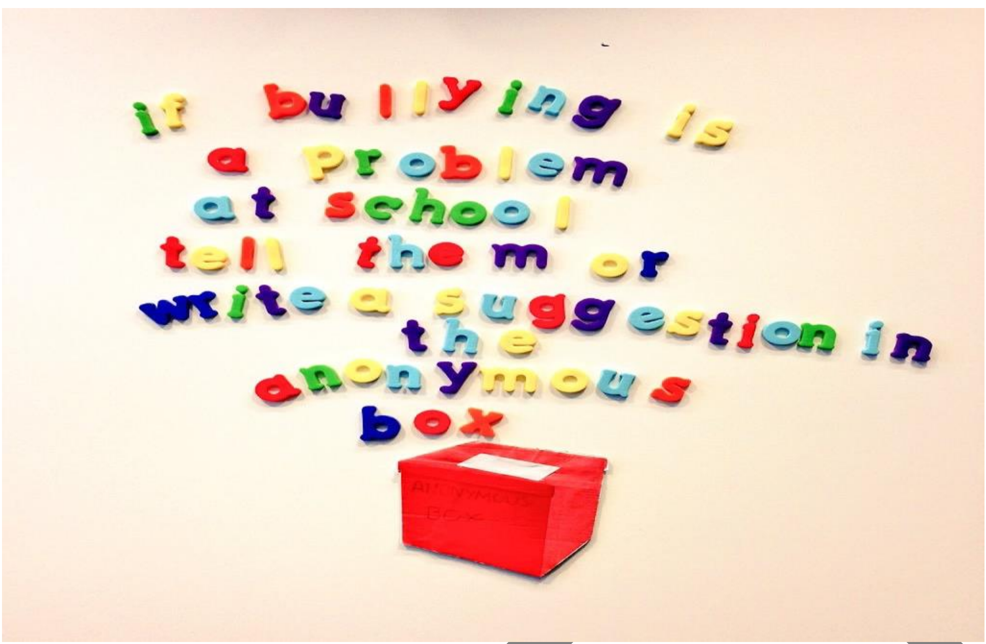

In 2015 we also worked with a group of young people in Westminster who formed our Young People's Panel. They identified 'sexting' and staying safe online as two issues they wanted to explore further during our workshops with them.

KEY ACHIEVEMENTS FROM LSCB SUBGROUPS

Hammersmith and Fulham Partnership Group

The Partnership Group has continued to develop strong partner relationships. There has been good and consistent attendance and contribution by a wide range of agencies. Key issues such as child sexual exploitation, domestic abuse, substance misuse and adult mental health have remained high on the agenda and are standing items for discussion. The Partnership Group has continued to engage the community and voluntary sector and has sought to strengthen collaboration and partnerships by bringing them into the core of safeguarding work. A range of voluntary sector partners have engaged with the partnership group, including Queens Park Rangers Football Club to develop relationships and strengthen their understanding, knowledge and response to safeguarding issues.

The Partnership Group now has a representative from education as a permanent member, which provides an essential link to the head teachers' forum and ensures that key education issues are brought to the attention of the LSCB.

The Partnership Group has routinely sought to encourage challenge between partners in a measured and proactive way. The LSCB is kept informed about all challenges that are raised. Challenges are recorded on the "challenge log", which is regularly reviewed to measure outcomes and the impact of any action taken. This has led to changes to protocols, pathways and responses. For example, a review led to improvements to the protocol and pathways in relation to pregnant refugee women presenting at maternity units for delivery who are homeless and have no recourse to public fund.

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‘What are you concerned about’ remains a standing agenda item of the Partnership Group. This facilitates the raising of key safeguarding issues which can then be escalated to the Board. Members consider safeguarding in the wider context and can prompt particular actions, e.g. sexual health clinics noted a rise in CSE concerns in schools and younger children engaging in sexual activities. A multi-professional meeting was arranged to explore the concerns and developed a more robust approach to the assessment of the safeguarding concerns for each child, an assessment of the response of schools and a strengthening of communication pathways between agencies.

The Partnership Group has been central in maintaining the link between front line services and the LSCB. Feedback has been actively sought from front line practitioners across all services through questionnaires or team/service discussions. The group has led on the dissemination of information to front line staff, including the LSCB newsletter and Learning Review. Exercises have also taken place to measure the impact of the Partnership Group on front line staff’s knowledge, understanding and practice following the dissemination of information about referral pathways, thresholds and Early Help and child sexual exploitation.

Kensington and Chelsea Partnership Group

The Partnership Group has a committed and long standing core membership. Members seek to investigate proactively safeguarding issues of relevance to local need and issues, reflect and debate, and take action where required to improve the quality of interagency working and the quality of service provision to the children, young people and families in Kensington and Chelsea.

The group has met formally on a quarterly basis, with additional work taking place as required. This is supported by a comprehensive Business Action Plan which guides the group’s focus and promotes the opportunity for reflection on local safeguarding issues.

Over the course of the year the Group considered a range of thematic subjects of relevance to local children, families, communities and professionals working at the frontline. These included; ending harmful practices such as FGM, early help services, organisational change and its impact, learning from serious case and management reviews, private fostering, child sexual exploitation, serious youth violence and gang activity. The Group members contribute to the delivery of information through papers, research and presentations on a range of issues. The opportunity to discuss and debate is actively pursued.

A range of speakers were invited to broaden the knowledge and the agenda. Guests discussed thematic issues, e.g. the Asian Resource Centre have presented their partnership work on ending harmful practices. Annual reports have been presented including those of the Child Death Overview Panel, Local Authority Designated Officer, Private Fostering, Multi Agency Risk Assessment Conference (MARAC) report considering domestic abuse, and the Multi Agency Public Protection Arrangements (MAPPA) report of the London Probation Service.

Guidance and signposting to specialist tools have been disseminated through members including FGM and CSE vulnerability assessment tools, and guidance

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resulting from the Southbank Serious Case Review in understanding the 'grooming' of the environment and how to ensure a positive safeguarding culture and leadership in organisations.

Organisational changes and the impact upon local safeguarding arrangements have continued to be a theme with opportunities to provide updates, ask questions, raise challenge and debate safeguarding issues and implications. A significantly beneficial aspect has been to focus on collectively how we may support colleagues and promote a positive interagency working arrangement, promoting the opportunity to form professional relationships and address the emergence of issues at the earliest stage. This has had direct benefits for effective working together arrangements and safeguarding matters in relation to children and their families.

The partnership group remains committed to the Board's work on Neglect and a number of members are committed to the continuing partnership with the NSPCC to deliver the Neglect Campaign across the three Boroughs into 2016-2017.

Westminster Partnership Group

The partnership group has had a productive year including the Ofsted inspection of children's services which took place in January 2016. The final report included a Review of the LSCB which was positive about the contribution and quality of Westminster's Partnership Group.

Achievements this year included the collation and dissemination of a comprehensive list of Westminster supplementary schools. These are education establishments that may not be registered with Ofsted because they offer homework clubs, religious studies and other provision out of usual school hours and therefore are not subject to a regulatory framework. The Community Development Worker undertook some effective relationship building to enable input with those running schools and institutions. This has meant the profile of issues such as FGM, child sexual exploitation, private fostering and the safeguarding aspects of the 'Prevent' agenda are raised directly with communities who may be affected.
The Community Development Worker has offered advice about making referrals to children's social care and therefore this work had a direct impact on the well-being of young people. She enabled discussions about the issues listed above to take place within the institutions which would not have happened otherwise. The list of supplementary schools was compiled with input from the group to ensure a comprehensive gathering of intelligence across the multi agency safeguarding spectrum.

The Children's Services and Housing Panel was promoted at the partnership group to ensure agencies are aware of the referral pathways and the work that can be done to intervene early, preventing homelessness for children and families.
The Partnership Group identified a low take up of training from multi agency staff about how to use interpreters, which led to a discussion about interpreters' understanding of safeguarding and the complications that can arise when using interpreters with families where there are safeguarding concerns. Subsequently the interpreting and translation contract for children's services is being re-commissioned and this feedback was incorporated into the new specifications, ensuring that

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interpreters and users of the service will have clear expectations and quality standards.

The Group heard challenges about the quality of the emergency out of hours social work service, and this was subsequently recognised through self-assessment and the Ofsted inspection. The challenges raised by our Lay Member and Appropriate Adult volunteer resulted in a number of detailed meetings and examination of the processes. The position now is that although further work is required, additional social work resource has been agreed for the out of hours service in Westminster to improve its quality.

The Partnership Group also identified the need for young carers to receive a better service this year. The Young Carers contract with a voluntary sector provider subsequently came to an end with the decommissioning decision influenced by the partnership group. The service is now provided in-house by Westminster Children's Services. There is now a target within Westminster City Council to report on the numbers of young carers identified as a proportion of early help cases. Such cases will therefore have significant multi agency input.

A series of themed workshops were planned to address the priorities the partnership group identified for itself at the start of 2015-16. These were informed by the wider Safeguarding Plan of the LSCB as follows:

- Serious Youth Violence
- Child Sexual Exploitation
- Female Genital Mutilation
- Radicalisation and Prevent

This led to a number of examples of the direct, positive impact of the partnership group on outcomes for children:

A workshop was held with group members and additional invitees on each of the themes outlined resulting in actions to be taken in each area. For example, Redthread attended and gave a presentation at the serious youth violence workshop about their work in hospitals with young people who have been the victim of violence. This was at the suggestion of a safeguarding health lead and led to actions including Redthread attending a safeguarding briefing for GPs. The Tri-Borough Alternative Provision (TBAP) schools were also invited to the Integrated Gangs Unit meetings in order to create better information sharing and closer working as some young people attending such provision would be at risk of or perpetrating serious youth violence.

The workshop on CSE resulted in increased input at the Multi Agency Sexual Exploitation Panel from probation and housing, and a commitment from colleagues in the Safeguarding, Review and Quality Assurance section in Children's Services to ensure that child protection plans for children who were considered at risk of CSE contained specific actions that would increase their safety.

The FGM workshop ensured a greater profile for FGM prior to the summer holiday break in 2016, which we know is a crucial time to identify girls who may be at risk.

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Finally the Prevent workshop enabled an overview of the ‘reach’ of the current training offer for Prevent, offering reassurance that staff across the partnership have accessed the training and are making referrals where appropriate.

Case Review Subgroup

The Case Review Subgroup considers new child care incidents (of serious injury or death to children) and makes recommendations to the chair of the LSCB on whether a decision on holding a formal Serious Case Review (SCR) or another type of review should be held.

The sub group also receives completed reports commissioned within the three boroughs so that learning can be identified and disseminated to the LSCB workforce. The sub group considers national or other local authority review reports where there are potential lessons for our local services.

New child care incidents: Recommendations from Case Reviews

During the year two SCRs have commenced, one initiated by the shared LSCB and another by Luton LSCB involving a family which had prior involvement from services in Hammersmith & Fulham. Both reports will be completed in 2016/17.

The case initiated by the shared LSCB (known as “Baby Rose”) involved a young mother who gave birth abroad and returned to the UK four months later with the intention of taking the baby to Moorfield Eye Hospital for an operation. The mother informed her parents, who lived abroad, that Children’s Services had removed the baby from her care, and they were so concerned that they came to the UK immediately and took their daughter to the Police to report the baby missing. Following a police investigation the mother was charged and convicted of murder. Police advised that she had accepted that she suffocated and disposed of the body.

In the Luton case a baby died of severe physical injuries when cared for by a young mother and her new partner; the use of drugs by both parents influenced the care they provided for the baby. Hammersmith & Fulham Children's Services were involved at the time of the baby’s birth, before the family moved out of the area. Children's Services and Hammersmith & Fulham’s Housing Department are both engaged in the serious case review.

COMPLETED REPORTS RECEIVED AND REVIEWED

A number of completed reports were received by the sub group and the key lessons reported to the LSCB and to the wider multi agency workforce through training, learning events and the Learning Review newsletter.

The key reports and lessons were as follows:

CD – Case Review

CD was a 21 year old care leaver who died as a result of drug misuse. She had a long history in care with multiple placements. The review noted that the services she was offered were provided by highly committed staff; despite the high level of input

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the services did not sufficiently change her pattern of substance use or other life choices

The report identified the following lessons:

a. The LSCB should note the need for the care leavers' teams to have and/or have access to specialist substance misuse knowledge and should ask the Tri Borough Assistant Director for looked after children to review the position in the three care leaver's services and take appropriate action as necessary.

b. The borough's care leaver service should consider how to make available a drop-in opportunity for young people not able to keep to regular appointments.

c. Peer mentoring should be made available to engage hard to reach young people.

d. Pathway plans for young people leaving care should have a wider multi agency input into them.

e. Consideration should be given to a career pathway for personal advisors to ensure that the more complex young people can be allocated to the most experienced staff.

Sofia – Serious Case Review

In December 2015, the LSCB published the serious case review regarding baby Sofia. Sofia was a 13-month old baby who died as a result of neglect. Her mother had a history of moving between boroughs. As far as can be ascertained, Sofia and her mother lived in seven different areas prior to the baby's death.

The report identified the following lessons:

a. There was a pattern, particularly across London, whereby the complex nature of housing and benefits legislation (as it applies to foreign nationals) meant that professionals are ill-equipped to explore all options open to families.
b. There was a pattern in Westminster Children's Social Care at the time not to assess the needs of pregnant women where housing needs were the primary problem. This potentially placed unborn children at risk
c. Systems to share information between GPs and Health Visitors need to be more robust so that reliable oversight of babies' health is not undermined.
d. There was a pattern in London whereby strategy discussions had become diluted to a brief telephone communication between Police and Children's Social Care, which resulted in other agencies not being included in the discussion, even where they have the greatest knowledge of the family.
e. There was a pattern of professionals over-focusing on physical manifestations of neglect, such as weight loss and failing to identify more complex, less visible indicators.
f. There was a tendency to assess risk from the parent's perspective and not to focus on the child's experience. This meant that destitution, and resulting transience, were not seen as potential child protection issues.

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g. Children's Social Care being unable to complete an assessment because a family is 'avoidant' at point of transfer may lead to children inappropriately being described as 'in need' rather than 'in need of protection'.

JJ – Serious Case Review

In January 2016, the LSCB published the serious case review for JJ. JJ was a 3-year-old boy who lived in Westminster with his mother. He died in the care of his father while having overnight contact in another local authority area. The post mortem outcome was that this was an unexplained tragic accident; further specialist medical advice concluded that the injuries did not match the reported description of events and suggested force had been used. Because the child had died and abuse or neglect was suspected, a serious case review was held.

The review could not identify any information regarding what had happened the evening JJ died – this had been carefully investigated by the police. No agencies were involved in any plans for JJ's overnight stays with his father; this was organised informally between his parents. However there were lessons which emerged for agencies which arose from the interactions his mother had had with health agencies.

The report made the following recommendations

a. The health visiting service should review the assessment and recognition of support needs when mothers are presenting with low level mental health issues or anxiety.
b. Communication needed to be stronger to primary health services regarding presentations of children to Accident & Emergency services. This should include not just the transmission of information, but the aggregation of patterns of presentations and understanding the potential issues that might lie behind them.
c. Agencies should ensure that fathers are an important part of their thinking, assessments and intervention.

Southbank International School Serious Case Review

The sub group received the report on the abuse at Southbank International School, which occurred over a period of four years, perpetrated by a teacher, William Vahey, who is now known to have been a prolific sex offender.

The report concluded that: "William Vahey, an American citizen, joined Southbank School from the international school in Venezuela, having worked in several countries during his teaching career. It is significant that he had a conviction for sexual offences against young boys in California in 1969 and this conviction resulted in a 90-day jail sentence and five years' probation with a condition that he should be supervised in the company of males younger than 16 during that time. This conviction was not picked up at the point he qualified as a teacher in the United States or by any subsequent employer."

Recruitment processes which were not compliant with expected standards resulted in his appointment as a teacher at Southbank International School. Vahey had quickly established himself as a teacher who had an informal, unconventional teaching style but was popular with many pupils. He specialised in residential trips

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and ran the ‘travel club’ which involved him selecting pupils and teachers to accompany him on overseas trips.

The review has found that “aspects of Vahey’s behaviour should have alerted senior staff at the school to the possibility that he was sexually abusing pupils; at no point was this given any formal consideration”.

The key recommendations identified were:

a. There is a need to ensure that all staff in the multi agency workforce are able to use the report resulting from the SCR to further develop their understanding of the modus operandi of sex offenders.
b. The LSCB to consider how it can promote learning in agencies regarding the establishing and maintenance of a safeguarding culture that restricts opportunities for offenders, promotes identifications and ensures effective follow up when issues are raised.
c. The need for effective recruitment practice, and where possible, overseas checks to be implemented in all agencies so as to minimise the chances of offenders gaining access to employment and to children.

Family C - Serious Case Review to be published in 2016-17

In February 2015, the mother of two young children aged 4 and 18 months, killed her oldest child as well as the children’s father and also seriously injured the youngest child, whilst she was experiencing an acute psychiatric disorder. The family had been known to local statutory agencies but had never met the criteria for any formal child safeguarding interventions. The mother was seen by adult services but left before formal assessments could be completed.

The SCR findings will be published in a full report, alongside the publication of a domestic homicide review (DHR), commissioned by the Community Safety Partnership. The timescale for publication of the SCR has not delayed sharing learning from it with practitioners and introducing some service changes in adult health services in order to improve communications.

External Serious Case Reviews

The sub group also considered two serious case reviews from other LSCBs where children had been harmed in other local authority areas. In one case a local authority foster carer had sexually abused children placed in his care over a 10 year period. Another SCR focused on a teenager who had suffered severe neglect over a long period of time. Local review of these cases and learning led to actions to ensure this was shared with relevant groups (e.g. the local Fostering Panel, services responding to school attendance concerns and Early Help services) as well as informing the content of training and conferences.

Communication of the Lessons

As a matter of routine all three local partnership groups in the three local authorities take the review reports to their meetings to ensure there is wide dissemination of the lessons. The LSCB’s Learning Review newsletter includes a summary of the

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lessons. The LSCB training offer is amended where required to incorporate learning. In addition, all LSCB members are expected to communicate and cascade lessons back to their agency networks as appropriate.

Quality Assurance Subgroup

The Quality Assurance (QA) subgroup takes a lead on the LSCB's role in examining information including quantitative data, information about the quality of services, and information about outcomes for children. This is done by examining performance data from a number of key agencies, multiagency audits, section 11 audits and informal exception reporting. This is scrutinised to consider any unusual patterns or themes and compared with local and national data where possible. The subgroup has met quarterly to explore the above drawing conclusions and potential recommendations relevant for each sector.

In 2015/16 there were a number of achievements led by the QA subgroup. Section 11 audits are now completed using a virtual tool and the questions redesigned to ensure the document is user friendly and to increase agency participation. This has been trialled by several agencies with positive results tracked by the LSCB.

Multi-agency audits are now led by the local authorities' Quality Assurance Manager where previously an independent consultant was commissioned. In this period the subject chosen by the subgroup for audit was 'Safeguarding and Parental Mental Health' and the report was completed in January 2016. The process included agencies across a number of services completing individual case audits followed by a workshop to consider the findings. The information was analysed and contributed to a final report which was communicated to the LSCB meeting themed around mental health. The following findings cover a number of recommendations in the full report:

1) Challenges Associated with Information Sharing
This report has highlighted different examples of where information sharing has worked and where it is hindered. This ranges from parental consent/openness with practitioners to information sharing barriers between agencies. This is inclusive of private providers. The importance of taking a curious and proactive approach to safeguarding is essential.

2) The Importance of Robust and Purposeful Planning and Interventions
The inclusion of families and the importance of multiagency working is an important aspect of achieving good outcomes for families. There were examples where well attended network meetings had led to good discussions and planning to support families. However, there were examples where network meetings had not taken place and were therefore recommended within the audits.

3) Relationships
Relationships are central to working with families and the professional network to achieve positive outcomes and change. How we strengthen these relationships and utilise them is essential to continued development across services.

In November 2015, in response to a challenge from a voluntary sector partner agency, the Local Children Safeguarding Board was requested to review Children's

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Services use of the Barnardo's Domestic Violence Risk Identification Matrix (DVRIM) where domestic abuse is identified in the home. The audit also explored the other types of tools that may be contributing to the Social Work assessment of risk and also made wider observations related to the quality of practice.

Whilst use of the Risk Identification Matrix was not evident on any of the cases reviewed, the audit identified evidence of multi agency approaches to assessments and interventions with families. Social Workers had a good understanding of risk to the child or children and parents and considered these in detail. The drive of systemic practice across Children's Services in the three local authorities was also being utilised in a number of these cases both with Social Workers that were on the 'Focus on Practice' course and those who had not yet started demonstrating that this too is becoming embedded.

Planned multiagency audits will now occur twice a year with the flexibility to complete further audit work where agencies raise potential practice challenges as demonstrated above.

CSE, Missing and MASH Sub-group

The subgroup met on three occasions over the course of the year. As a multi-disciplinary partnership it considered strategic plans to deliver on LSCB safeguarding priorities in this area. The membership of the group continued to represent the wider spectrum of partnership agencies working with children and their families affected by child sexual exploitation, children who are missing from home, care and education. It also reflected the systems in operation through the Multi Agency Safeguarding Hub (MASH) to effective identified and manage the information flow when assessing risk for some of the most vulnerable families.

The MASH has now been in operation for a number of years, and its activity has been overseen by this sub-group. This included the regular scrutiny of activity data as well as an exploration of practice issues and workload demands. The communication flow back to agencies which have been consulted as part of the initial checks made by MASH remained a challenge for the Hub and professionals. This led to a clear statement which noted that professionals and agencies will not be contacted following initial checks unless there was a concern that needed to be communicated. The sub-group acknowledged that the MASH would not have capacity to provide any additional feedback and approved a decision that Family Services would provide this where appropriate as part of any assessment carried out.

With an expanding knowledge of child sexual exploitation (CSE), its signs, impact and the need to increase awareness, the sub-group has overseen a multi agency strategic approach to address this safeguarding priority. There have been significant developments in the last year which the LSCB has been instrumental in leading, including the development of the CSE strategy and oversight of the Multi Agency Sexual Exploitation (MASE) panel which considers the cases of significant vulnerability and concern. A CSE Screening Tool has been developed and the six month pilot and results reported back into the sub-group. The outcome of the screening pilot was a confirmation of good levels of local understanding of risks, the levels of vulnerability and the decision making which had taken place.

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Missing children and young people continue to be a priority of the LSCB's safeguarding plan. The last year saw an increased multi-agency understanding of the connecting factors of concern for children who go missing from home, missing from education, CSE, gang activity and criminal behaviour. The local authority Missing Coordinator has worked closely with social work practitioners and multi-agency partners to improve practice and safeguarding responses. The sub-group has been instrumental in refocusing the work of partners onto key issues of practice and effective interventions, leading to increased understanding about why children go missing and how they can be supported to not go missing in the future.

Harmful Practices Steering Group

The Harmful Practices Steering Group was formed in June 2015 as part of the new governance structure to deliver the 2015-2018 Shared Services Violence Against Women and Girls (VAWG) Strategy and regularly reports to the VAWG Strategic Board and the LSCB. The Steering Group is chaired by the VAWG Strategic Lead and the Deputy Chair is the Joint Head of Safeguarding, Review and Quality Assurance for Children's Services.

The main functions of the Steering Group have been to ensure that the Project for Ending Harmful Practices Pilot (PEHPP) is delivering its objectives and outcomes, and highlight and address any issues arising regarding the delivery of the pilot at the earliest available opportunity. It has also overseen the delivery of the FGM pilot at St Mary's Hospital and Queen Charlotte's Hospital.

Ending Harmful Practices Training

The PEHPP has overseen the roll out of a range of training opportunities on topics including FGM, forced marriage, honour based violence and faith based abuse. The training was delivered in stages, with half day multi-agency workshops open to staff from all agencies, followed by a two day specialist workshop open only to social workers, police and health staff. Staff who completed the two day specialist workshops were then invited to attend a series of half day follow up sessions to enable them to tackle the subjects in more depth.

Attendance in the first year of the training programme was good, although there was a high drop-out rate from bookings (overbookings were taken to compensate for this) with a good representation of practitioners from a variety of agencies. Evaluations from the earlier courses were taken into consideration to shape the following workshops and improvements were made in the delivery of subsequent workshops and evaluations continued to show good results as practitioners understanding of the subjects grew. The roll out of the training also coincided with the introduction of the FGM Mandatory Reporting Duty and the LSCB practice note on this topic was widely shared and discussed in training.

Educator Advocates:
The PEHP Pilot has also seen Educator Advocates deployed in all three local authorities, initially in Children's Services offices. Their role has been to assist children's social care professionals in effective case management where FGM, Honour Based Violence, Forced Marriage or Faith Based Abuse is a concern. The

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advocacy service was also available to support and offer guidance to victims of harmful practices. There were some initial barriers in getting this part of the project to work smoothly (e.g. access to system records, building trust with colleagues in children's social care) but these have gradually been overcome and the result is a steady growth in consultations that the advocates have carried out. The Educator Advocates have been proactive in visiting a range of offices where children's social care staff are based to reach a wide audience and extend the reach of this part of the programme.

Community Engagement:
The PEHP Pilot has also delivered a range of community engagement activities across the three local authorities. This includes work done in local schools to engage families during coffee mornings. A local organisation has been set up by men (mostly from Somali and Sudanese communities) and a session was held with them to explore ways we could engage men in the conversations around FGM. Our male FGM worker also co-ordinated the delivery of a training session on FGM to a local school for 120 boys which was very well received.

Female Genital Mutilation Early Intervention Project:
A partnership approach to the early identification of girls' at risk of FGM has been running at St Marys and Queen Charlotte's hospitals for a full year. This included a multi-disciplinary team of a specialist mid-wife, a specialist social worker, health advocates from the voluntary sector, a male worker and trauma therapists working together to deliver holistic maternity care to mother's who have suffered FGM, while working with those families to offer early help or safeguarding services to prevent FGM occurring to future generations. In the course of the year 139 families were worked with and 76 received further assessment and support from Children Services. This is compared to the baseline figure which was that no children at risk of FGM had been identified. The project will continue until December 2016.

Safeguarding Children Health Subgroup

The Subgroup is chaired by the Designated Professionals and meets on a quarterly basis. The purpose of this group is to provide a strategic focus across health agencies to safeguarding children, quality improvement and sharing of learning. During 2015-16, the group met four times although quoracy was not always met owing to competing priorities of health providers.

Key achievements of the group

- Implementation of the "Child Protection-Information Sharing" (CP-IS) project has progressed. This will improve the way that health and social care services work together to protect vulnerable children. NHSE have met with the NHS providers who provide unscheduled care and support is to be given regarding implanting CP-IS across different Information Technology systems within health.
- Links have been made between the Homeless Outreach Worker, wider health services and other vulnerable women's groups. Although many of the health providers are aware of risks within this particular group they tend not to be

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aware of the services being offered. This has reduced the risk of pregnant homeless women not accessing appropriate healthcare services.

- Work has taken place to identify "bed blocking" in maternity wards by mothers who are subject to delayed discharge for social reasons such as homelessness or awaiting court orders. An audit was undertaken to ascertain the level of bed blocking and the impact on emergency cases. Results of the audit will be presented to the sub-group and appropriate actions agreed.
- An audit has commenced on an apparent trend for increasing numbers of children attending Accident & Emergency units following falls from high rise buildings

The outcomes of these pieces of work will identify service areas that need improving and will strengthen the partnership working between health, social care and housing.

Priorities of the Safeguarding Children Health Subgroup for 2016/2017

- To improve the group's quoracy by identifying the key organisational representatives who should attend, rotating meeting days and setting dates for the year ahead to enable the right participants to attend.
- To revise the agenda setting process to ensure meeting outcomes are robust and relevant to members and to allow the group to feedback any issues to the LSCB and wider health partners in a timely manner
- To ensure serious case reviews are a standing agenda item so that recommendations for health agencies and action plans are incorporated into practice at the earliest opportunity so learning can be embedded
- To carry out self-audits and "deep dives" to measure how learning from SCRs impacts upon practice.
- To develop a standardised referral form to children's social care. This aims to alleviate staff anxiety and delays in acceptance of referrals as well as enabling enable professionals to have a common language and to facilitate the challenge and escalation of decisions where required.
- Increase the role of Designated Professionals in providing more scrutiny on health providers' Section 11 audits and where required, working with providers on activity relating to the national inquiry into historical child sexual abuse.

Learning and Development Subgroup

The LSCB has continued to provide a wide ranging training offer. This year, a total of 15 Introduction to Safeguarding Children workshops and 34 Multi-agency Safeguarding and Child Protection courses were offered. In response to demand from practitioners we introduced a half day refresher multi-agency safeguarding and child protection workshop.

New specialist workshops added to the programme included a session on the 'toxic trio' (domestic abuse, parental mental health and parental substance misuse) and

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also working with difficult and evasive families. In partnership with the Women and Girls Network, we have also offered a series of seven workshops on child sexual exploitation.

The LSCB facilitated the roll out of the Partnership for Ending Harmful Practices Pilot (PEHPP) training. This included twelve half day multi-agency workshops (open to all agencies) covering FGM, forced marriage, honour based violence and faith based abuse. These were followed by two-day specialist workshops for health staff and social workers for more in depth information to be explored. A series of half day follow on sessions were also offered to delegates completing the two day specialist workshops, however, attendance at these was significantly lower as practitioners found it challenging to take so much time away from work.

Working in partnership with the Safer Organisations Manager and Tri-Borough LADO, we hosted accredited Safer Recruitment Workshops and Meet the LADO workshops to raise awareness of this important role.

The LSCB published an e-learning course on private fostering and continued to signpost to free external e-learning on FGM, Forced Marriage and CSE.

Evaluation of the training courses is carried out by a pre and post workshop evaluation form, to show how much learning has taken place on the day. A selection of delegates was then asked to complete a further online evaluation some months later, once they had had a chance to put their learning into practice.

Our priorities for 2016-17 include improving the way we evaluate training workshops, by holding focus groups to further measure the impact of training. The specialist course offer will be reviewed and additional workshops on the toxic trio and parental mental health and e-safety will be explored. A learning event for schools on the Southbank International School serious case review is also being developed.

SHORT LIFE WORKING GROUPS

Parental Mental Health Short Life Working Group

Central North West London Mental Health Trust and West London Mental Health Trust have been meeting regularly with representatives from children's social care regularly and more recently have engaged primary care in this short life working group. Participation of other agencies has been more sporadic. The working group has reviewed the challenges that issues of parental mental health and safeguarding pose for the multi-agency network and have identified key themes for the LSCB to consider at its Board meeting when the working group's final report will be presented. Themes focus on:

- Challenges for primary care
- The role of specialist adult mental health services
- The development of perinatal mental health services
- Information sharing
- Training

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The group has also contributed to the development and completion of two multi-agency audits which have provided assurance on joint working and compliance with safeguarding policies. Findings from the audits will also be addressed in the final report.

Neglect Short Life Working Group

Neglect continues to be a key priority for the Board and in late 2014, a decision was taken to commence a short life working group (SLWG), tasked to consider:

- the needs of frontline professionals in the recognition of the signs of neglect
- how to increase understanding of the impact of neglect
- the identification of tools or guidance that might best increase professional capacity to work with families to address neglect and the harm to children.

The group has considered and reflected on a wide range of issues, including the needs of a wide range of stakeholders and the different nature of their relationships with families which impact upon their understanding of neglect.

First actions of the SLWG included:

- a review of a range of tools already used by other agencies nationally;
- development of the neglect pages on the LSCB website
- consideration of the National Society for the Prevention of Cruelty to Children (NSPCC) core programme on neglect, and development of in-house resources to aid the understanding of how a child or young people lives day to day when neglect may be an issue.

It was recognised that the family practitioners' access to the Focus on Practice programme within Children's Services has done much to assist frontline social workers to work more effectively with families, and that new sets of formal procedures or assessment models were not what was required.

The SLWG also concluded that schools and early years provisions are key to understanding the lived experience of children and their families' experience. Therefore more valid recognition needs to be placed on the information and understanding which such agencies bring to the wider professional understanding of this. These agencies are most likely to have a long term connection with a family and may also have a sibling group in attendance for many years. Some of these agencies have expressed difficulties at times in communicating their concerns when referring to statutory social work services. Locality social work teams acknowledge this, particularly in relation to the application of thresholds for interventions.

Recently published SCRs on the children Sofia and Leon recognised that such thresholds can be too high, and do not always evaluate the impact of chronic neglect, its "drip-drip" effect and its emotional impact which is difficult to measure. All agencies and practitioners recognised that this needs to be reviewed and improved where required.

Additional developments instigated by the SLWG include the development and piloting of two set of tools which have been developed and trialled across the three

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Family Service Directorates and in a number of schools. The purpose of these tools is to improve understanding of neglect, communication of concerns, focusing more on the 'lived experience' of children.

In collaboration with the NSPCC the Board agreed to the initiation of a Neglect Campaign into 2016-2017, with the launch being delivered through a multi-agency conference in May 2016. The aim of the conference was to increase awareness and recognition of neglect, with presentations from a number of prominent researchers and highly qualified professionals.

The work of the SLWG has increased professional awareness of neglect, improved the environment for professional discussion and debate and ensured that all practitioners working with families have access to a variety of tools to inform their work, supported by enhanced information on the LSCB website.

ASSURANCE STATEMENT

This year LSCB can take some assurance from the review by Ofsted that it is 'Good', as well as from the two 'Outstanding' and one 'Good' judgements from the inspections of the local authority children's services. Areas where the LSCB has to be assured of the range of services and their effectiveness - adoption, fostering, care leavers, early help, social work services - were inspected, as were areas where we share key responsibilities e.g. CSE, missing children. Some areas of joint work, FGM, were highlighted as particularly notable. Reviews of local health services' safeguarding arrangements, described in this report, also give a high level of assurance that services are good. In addition the strong relationships in the LSCB and across local partnerships enable challenge and problem-resolution and there is good 'working together'.

Children's services commit more resources and time to the LSCB than any other partner and in 2015/16 chaired all three partnership groups and all sub-groups with the exception of the Health sub-group. Whilst partners are committed to participation in sub-groups, it is notable that no sub-group or short life working group has been chaired by the Police. During 2016/17 the Police have agreed upon a SLWG that they wish to chair. This is welcomed as is the stronger leadership by the police at a local borough level and across the three boroughs. In relation to funding, the local authority input – both financial and 'in kind' for the LSCB – is way beyond what any other partner commits. All London LSCB Chairs have noted that the Metropolitan Police continues to choose to fund partnership safeguarding in London 45% less than all the other large urban Metropolitan Police Forces in England. Safeguarding is a complicated and demanding partnership arrangement that needs appropriate resourcing if it is to be effective.

However, the organisational arrangements for the LSCB, commented upon by Ofsted, have continued to be under pressure with the new Business Manager recently covering her previous role of training manager as well as her own work. A 'move' of the managerial arrangements of the small safeguarding 'team' to Children's Commissioning coincided with increasing demands on the remaining staff – and it has been through strong competence and willingness of staff that the arrangements have 'held' sufficiently for the Board's work to continue. The support for multi-agency work across the LSCB relies on the small business support team and the

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LSCB will not be able to maintain its momentum without this. The LSCB has met its statutory responsibilities in 2015/16.

The LSCB comprises all the required statutory partners and has strong and effective relationships with other partnership bodies across the three boroughs. Lay persons are engaged with the Board's work. The Board works closely with the Adult Safeguarding Executive Board for the three boroughs. All leaders and professionals, as well as voluntary organisations, prioritise safeguarding children. There could be a stronger link with front-line staff so that information from them directly informs the Board's work: the current emphasis upon relationships between and developments led by senior, strategic managers could be improved by a more genuine engagement of frontline workers, children and their families and the wider community. A multi-agency focus on and improvement of multi-agency practice should be the key means through which better outcomes can be realised and impact measured.

The national review by Alan Wood of the role and functions of LSCBs published with a response from government at the end of May 2016 will lead to national changes (currently being debated in parliament) for LSCBs in future years. I will complete my term as Independent Chair in 2016/17. National changes, which will place safeguarding responsibilities (yet to be defined) on local authorities, health and the police – as the three 'local leaders' – will pave the way for the current roles and functions operating at a local level to be re-defined and the structures to be reshaped. Early work by the LSCB to anticipate these changes is underway. New legislation and statutory guidance will be published during 2017. In the meantime, holding onto key staff and partnership working is imperative.

LSCB PRIORITIES FOR 2016-17

Following a review of progress with previous priorities by the Board and consideration of developing needs across the three areas, the following four priorities with associated outcomes and actions have been agreed through the LSCB's Safeguarding Plan for 2016/17:

1. **Build on partnerships to improve safeguarding practice with a particular focus on increasing the capacity of vulnerable parents to safeguard their children effectively**

   Outcome: More children are effectively safeguarded in families where parents have complex problems.

   The actions to achieve this priority and outcome are as follows:

- Maximise partnership arrangements to evaluate and increase their impact upon safeguarding children where parents are affected by domestic violence and abuse, mental health problems and substance misuse.

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- Improve links and, where appropriate, hold to account key partnerships[8] to demonstrate that strategic work has a positive impact upon frontline practice and outcomes for children.

2. Improving communication and engagement

Outcome: those who should benefit from the work of the LSCB are aware of and have an influence on what the Board is seeking to improve

The actions to achieve this priority and outcome are as follows:

- Develop a comprehensive communications strategy for all Board activity.
- Listen to and review issues raised by multi-agency staff about safeguarding and confirm action taken by the LSCB in response.
- Listen to feedback from vulnerable children, young people and parents about the impact of safeguarding issues upon their lives (including issues such as radicalisation, CSE, missing children and FGM) and ensure the Board responds to this where required.
- Build upon progress and further develop an interactive LSCB website.

3. Demonstrating our impact and knowing where more effective practice is required

Outcome: The Board is clear where improvements are required and can demonstrate actions which have made a positive difference to practice and children's lives.

The actions to achieve this priority and outcome are as follows:

- Streamline and improve the use of multi-agency data to better measure our impact and progress as well as identifying where we need to improve.
- Ensure the work of sub-groups and short life working groups informs and delivers the LSCB's Safeguarding Plan
- Maximise impact and of learning from serious case reviews across the three boroughs by coordinating subsequent action plans.
- Review how the impact of the Focus on Practice programme is experienced by agencies responsible for safeguarding children and the opportunities for multi-agency learning from the programme.
- Promote the best outcomes for children who have experienced neglect.

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[8] To include Health and Wellbeing Boards, VAWG, Safeguarding Adults Board, Children's Trust Board, Crime and Disorder Partnerships, MARAC and MAPPA.

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- Assess the effectiveness of multi-agency early help partnership work at a borough level in improving outcomes for children, ensuring the LSCB is sighted on service changes that may impact on safeguarding.

- Review multi-agency action and planning to improve outcomes for children and young people whose needs are difficult to meet, and who may pose risks to other children.

- Develop links with commissioners in all relevant agencies to be able to identify where improvements in safeguarding are needed.

4. Improving the effectiveness of the Board

Outcome: All partners are consistently aware of and engage with the priorities of the Board

The actions to achieve this priority and outcome are as follows:

- Continue to monitor attendance of partners at Board meetings taking effective action when attendance is infrequent or turnover of key members is anticipated.

- Develop a Forward Plan to include key Board activities and scheduling in other required reports.

- Develop a work plan for the LSCB business support team that coordinates activities arising from the Board and partnership groups and drives through the priorities for children.

- Ensure there is an analysis of the impact of multi-agency safeguarding training at a tri-borough level.

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LSCB BUDGET

	LBHF	RBKC	WCC	FORECAST
Contributions received in 201516				
Sovereign Borough general fund (BUDGET at Period 13)	-87,369	-67,612	-69,926	**-224,907**
Partner Contributions in 2015/16				
Metropolitan Police	-5,000	-5,000	-5,000	**-15,000**
Probation	-2,000	-2,000	-2,000	**-6,000**
CAFCASS	-550	-550	-550	**-1,650**
CCG (Health)	-40,000	-40,000	-40,000	**-120,000**
Total Funding excluding reserves 2015/16	**-134,919**	**-115,162**	**-117,476**	**-367,557**
Forecast Expenditure in 2015/16	**LBHF**	**RBKC**	**WCC**	**FORECAST**
Salary expenditure	83,200	83,145	82,527	**248,872**
Independent Chair	5,153	5,153	5,153	**15,459**
Training	3,016	3,016	3,016	**9,048**
Peer review/consultancy	1,625	1,625	1,625	**4,875**
Multi-agency Auditing	3,333	3,333	3,333	**10,000**
Other LSCB costs	409	109	109	**627**
Total expenditure	**96,736**	**96,381**	**95,763**	**288,881**
Serious Case Review related expenditure in-year	1,750	2,224	4,354	
Forecast variance 2015/16 excluding Serious Case Review expenditure	**-36,433**	**-16,557**	**-17,358**	**-78,676**
Moved to B/S for partner income	**36,433**	**16,557**	**17,358**	
Final outturn	**0**	**0**	**0**	
LSCB Reserves as at Period 1 2015/16				
	LBHF	**RBKC**	**WCC**	**FORECAST**
Reserves Brought Forward into 15/16	-5,500	-72,835	-90,579	**-168,914**
Adjustment in year 2015/16	5,500	-16,557	-17,358	**-28,415**
Contribution to LSCB balance sheet accounts	-36,433	0	0	**-36,433**
Reserves to take forward into 2016/17	**-36,433**	**-89,392**	**-107,937**	**-233,762**

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GLOSSARY OF TERMS

BAME	Black, Asian and Minority Ethnic
CAFCASS	Children and Family Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Services
CDOP	Child Death Overview Panel
CRC	Community Rehabilitation Company
CCG	Clinical Commissioning Group
CQUIN	Commissioning for Quality and Innovation (payments framework)
CP-IS	Child Protection-Information Sharing project
CSE	Child Sexual Exploitation
FGM	Female Genital Mutilation
HCPC	Health and Care Professions Council
HMRC	Her Majesty's Revenue and Customs
IGU	Integrated Gangs Unit
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MASE	Multi-Agency Sexual Exploitation meeting
MASH	Multi-Agency Safeguarding Hub
NHSE	National Health Service England
NPS	National Probation Service
NSPCC	National Society for Prevention of Cruelty to Children
PHSE	Personal, Health and Social Education
Ofsted	Office for Standards in Education
SCR	Serious Case Review
SLWG	Short Life Working Group
VAWG	Violence Against Women and Girls (partnership)

CONTACT DETAILS

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Telephone: 020 8753 3914

Website: https://www.rbkc.gov.uk/subsites/lscb.aspx

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APPENDIX A: LEGISLATIVE AND STATUTORY CONTEXT FOR LSCBS

Section 14 of the Children Act 2004 and Working Together to Safeguard Children 2015 outlines the statutory obligations and functions of the LSCB as below:

(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
(b) to ensure the effectiveness of what is done by each such person or body for those purposes.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that the functions of the LSCB, in relation to the above objectives under section 14 of the Children Act 2004, are as follows:

1(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:
(i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
(ii) training of persons who work with children or in services affecting the safety and welfare of children;
(iii) recruitment and supervision of persons who work with children;
(iv) investigation of allegations concerning persons who work with children;
(v) safety and welfare of children who are privately fostered;
(vi) cooperation with neighbouring children's services authorities and their Board partners;
(b) communicating 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;
(c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;
(d) participating in the planning of services for children in the area of the authority; and
(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

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APPENDIX B: LSCB BOARD ATTENDANCE 2015-2016

LSCB Main Board Attendance 2015-16

Role	21st April 2015	14th July 2015	13th October 2015	24th November 2015	19th January 2015
LSCB Chair	y	y	y	y	y
Executive Director of Children's Services (Tri-borough)	y	y	y	y	y
Director of Family Services (H&F)	y	y	y	y	y
Director of Family Services (RBKC)	y	x	y	y	y
Director of Children's Services (WCC)	y	y	y	y	x
Director of Schools	y	y	y	x	y
Head of Combined Safeguarding & Quality Assurance	y	y	y	y	y
LSCB Business Manager	y	y	x	y	y
Director of Adults Safeguarding	y	y	y	x	y
Housing	y	y	y	y	x
Borough Command	y	y	y	y	y
CAIT	y	y	y	y	x
Probation	y	x	y	x	y
Community Rehabilitation Company	y	y	o	o	o
CAFCASS	x	x	x	y	y
Prisons	y	x	y	x	y
Ambulance Service	y	y	y	x	x
Voluntary Sector	y	y	y	y	y
Lay member	y	y	y	y	y

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NHS England	x	x	x	x	x
Health CCGs	y	y	y	y	y
Designated Doctor	x	y	y	y	y
Designated Nurse	y	y	y	y	y
Head of Safeguarding, CLCH	y	y	y	y	o
CLCH Director of Nursing	x	y	y	x	y
Imperial Director of Nursing	y	x	x	x	x
Chelwest Director of Nursing	x	y	y	x	y
WLMHT	y	y	y	x	x
CNWL	y	y	y	y	y
Public Health	x	y	y	x	x
Community Safety Team (Commissioning)	y	y	y	x	y
Policy Team (Commissioning)	y	y	y	y	y
Head Teachers	x	x	x	y	y
Cabinet Member for Children's services, H&F	x	x	y	x	x
Cabinet Member for Family and Children's Services, RBKC	y	y	x	y	y
Cabinet Member for Children's Services, WCC	x	x	x	y	y

Please note for the purpose of this table 'y' means attendance of the LSCB Member of a representative, 'o' means a representative was not expected and 'x' that no representative attended. Please see the minutes of individual meetings for more in depth information.

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This report was prepared by the LSCB Independent Chair, Jean Daintith, with support from Emma Biskupski (Interim LSCB Business Development Manager) and Steve Bywater (Service Manager, Strategy, Partnerships and Organisational Development).

We would like to thank the many members of the LSCB who also made contributions to the report.

Draft Reviewed by LSCB: 11 October 2016

Published on (tbc) 2016

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Agenda Item 6

Westminster Health & Wellbeing Board

Date:	17 November 2016
Classification:	General Release
Title:	Safeguarding Adults Executive Board Annual Report 2015-16
Report of:	Mike Howard, Independent Chair of the Safeguarding Adults Executive Board
Wards Involved:	All
Policy Context:	From 1st April 2015, there is a statutory requirement to publish an Annual Report (Schedule 2 of Care Act 2014) on the effectiveness of Safeguarding Adult Boards in preventing and abuse and neglect; and responding in a way that support's people's choices and promotes their well-being, when they have experienced abuse or neglect. The Board must send a copy of the report to the chair of the Health and Wellbeing Board, amongst others.
Financial Summary:	No financial implications
Report Author and Contact Details:	Helen Banham, Strategic Lead Professional Standards and Safeguarding hbanham@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1 This is the third Annual Report of the Safeguarding Adult Executive Board (SAEB). The multi-agency Board provides leadership of adult safeguarding across the London Borough of Hammersmith & Fulham; the Royal Borough of Kensington and Chelsea; and the City of Westminster.

1.2 It is the first year that the Board is operating under Schedule 2 of the Care Act 2014, and overseeing the statutory duties of conducting Safeguarding Adult Enquiries (Section 42) and Safeguarding Adults Reviews (Section 44). The Board is required to report on progress on its strategic priorities, and particularly, on the work it has carried out reviewing deaths and serious harm, of people with care and support needs, as a result abuse and neglect, and where agencies may have worked better together to prevent harm or death.

1.3 The published report, in the section: 'What are the numbers telling us?' show comparative data for the three boroughs served by the Board. The report provided for the Health and Well-being Board also includes a section on 'What are the numbers telling us?' in Westminster.

2. RECOMMENDATIONS

2.1 The Health and Wellbeing Board is invited to consider the report and the arrangements that are in place to meet the requirements of the Care Act 2014, including discharging its S44 responsibility to review death and serious incidents.

2.2 The Health and Wellbeing Board is invited to reflect on the strategic direction adopted by the Board and its priorities for 2016-17.

2.3 The Health and Wellbeing Board is invited to suggest to the Board priority areas that it may wish the Board, or the member agencies of the Board, to consider for inclusion in its work plan.

4. LEGAL IMPLICATIONS

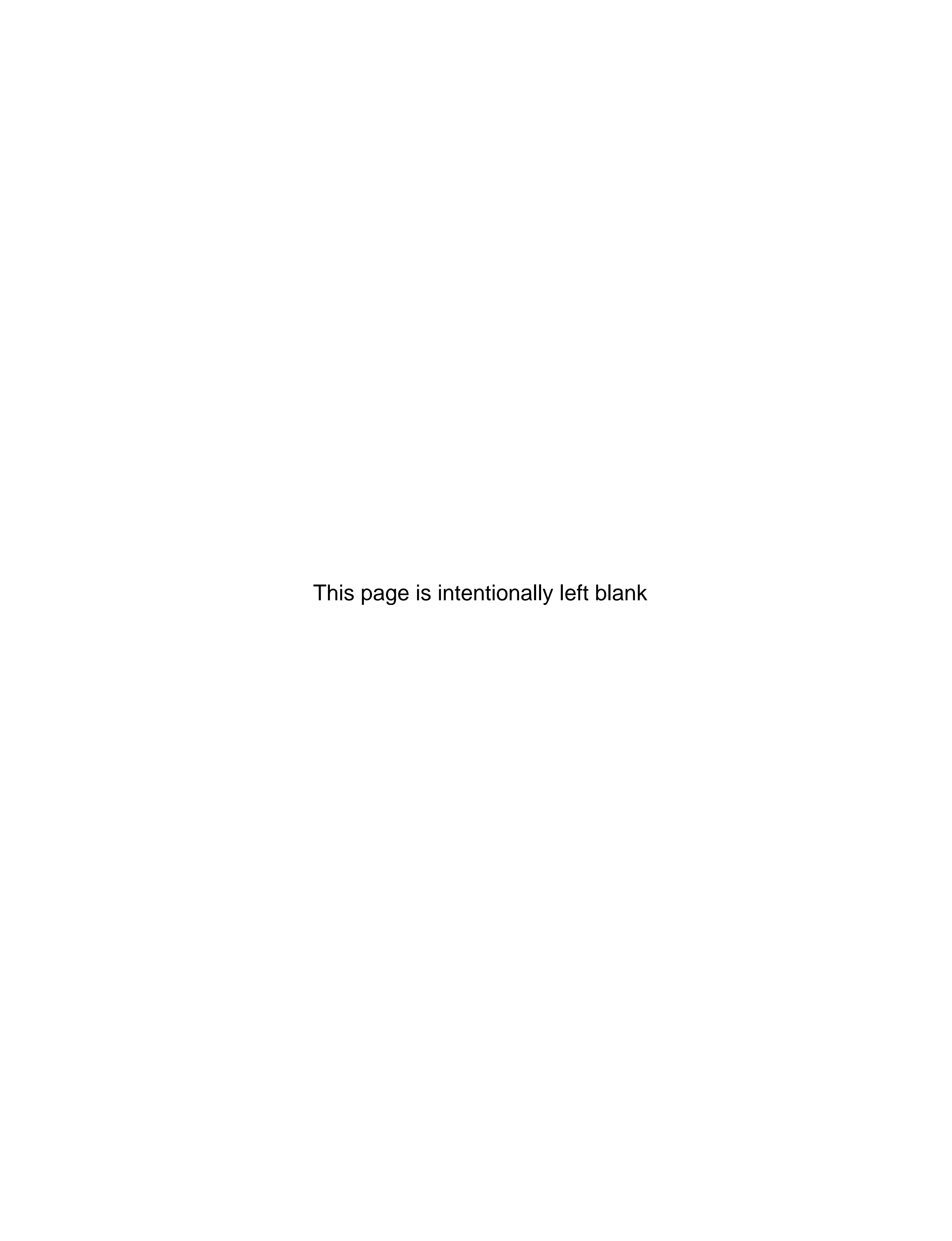
This report is for information only. There are no legal implications.

5. FINANCIAL AND RESOURCES IMPLICATIONS

This report is for information only. There are no financial and resources implications.

If you have any queries about this Report or wish to inspect any of the Background Papers, please contact:

Helen Banham, Strategic Lead Professional Standards and Safeguarding **Email:** hbanham@westminster.gov.uk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Safeguarding Adults Executive Board
Annual Report 2015-16

Courage, Compassion, and Accountability

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Foreword

Mike Howard, Independent Chair of the Safeguarding Adults Executive Board

I am pleased to present the third annual report of the Safeguarding Adults Executive Board (SAEB) for Westminster, Kensington and Chelsea, and Hammersmith and Fulham. It is in a similar style and format to last year's report which was well-received. Much work goes into its compilation and it is gratifying to receive such positive comments.

The report describes how the Board's agencies, both jointly and independently, work to ensure the safety of those adults within the Boroughs who are deemed to be most at risk of harm through the actions of other people. In last year's report, I outlined the impact of the Care Act 2014 which gave a wider ranging definition of vulnerability. I also mentioned the establishment of a Safeguarding Adults Case Review Group. This group has developed over the past year and now has good representation from most Board agencies and is chaired by the Police Commander from Kensington and Chelsea.

The report focuses on the Group's work; they examine cases from a number of agencies working with local residents in the greatest need of protection but who, in some cases, have been let down by the 'system'. We do not seek to allocate blame, but rather look for opportunities for learning and to change practice. Some examples are summarised within the report.

The highest profile case involved a death in a care home, and led in September 2015 to the commissioning of a Safeguarding Adult Review from an independent reviewer from the Social Care Institute of Excellence. Mindful that such reviews can take many months, I set a deadline and the draft report was presented to the Board three months later. Work has taken place since January to act upon the findings of the Review. The report will be published in the autumn 2016 and a summary of strategic gains made will feature in next year's annual report.

After voicing criticism last year about the lack of funding, the Board now has received money from the Metropolitan Police; the London Fire Brigade; and the Clinical Commissioning Groups, with 'payment in kind' from the Central and North West London Mental Health Trust through use of meeting rooms.

The Board has done much over the past year to reach out to people living in the three boroughs. The Community Engagement work-stream is co-chaired by representatives from registered charities and they convened a consultation

workshop on 25th November 2015. The Care Act requires us to consult with the community and at the consultation event many of the eighty participants stressed the need for simple language. From this we developed the 'house' strategy which expresses in simple language what people said they wanted the Board to focus on for the next three years. We held a similar event this September to explain how we have acted upon the views expressed last year.

In the past, the Board has concentrated on the physical injury and neglect of local people. A major initiative for 2016 is to examine the mental and emotional harm caused by financial abuse or 'scams'. The Board now has a representative from Trading Standards, and examples of their work are mentioned in this report.

We also want to develop closer links with the network of Community Champions sponsored by Public Health. The Champions have an important role in creating local awareness about safeguarding matters, and we in turn can learn from them what really matters to people living in the three boroughs.

The case studies cite the difference that a safeguarding intervention makes to the life of an individual. Whilst the emphasis is rightly upon quality, there are some statistics about the safeguarding journey. The purpose is to show the number of concerns, and enquiries that result in some form of action and outcome for the person. It is important to show context so the data shows the size of the eligible adult population living in the three boroughs, together with those adults who have care and support needs.

Space precludes detailed mention of other projects championed by the Board in the past year; these include the production of a handbook to assist agencies to safely recruit staff for caring jobs; the on-going promotion of the principles and practice of Making Safeguarding Personal; and various training initiatives.

I am pleased that the Board continues to be well-supported and members have highlighted our work to other London Safeguarding Adults Boards as good practice.

I would like to end by thanking everyone for their contributions to the work of the Board. I am impressed by the commitment shown by all members and their common sense of purpose to ensuring the safety and well-being of residents in the three boroughs who are in need of care and support.

M Howard

Mike Howard, Independent Chair October 2016

What is the Safeguarding Adults Executive Board and is it doing what it is meant to do?

The Care Act 2014 says that the local authority must have a Safeguarding Adults Board from 1st April 2015.

The Safeguarding Adults Executive Board was set up in 2013 and provides leadership of adult safeguarding across the London Borough of Hammersmith & Fulham; the Royal Borough of Kensington and Chelsea; and the City of Westminster.

The Board is a partnership of organisations working together to promote people's right to live in safety, free from abuse or neglect. Its purpose is to both prevent abuse and neglect, and respond in a way that supports people's choices and promotes their well-being, when they have experienced abuse or neglect.

The Board believes that adult safeguarding takes **COURAGE** to acknowledge abuse or neglect is occurring, and to overcome our natural reluctance to face the consequences for all concerned of shining a light on it.

The Board promotes **COMPASSION** in our dealings with people who have experienced abuse and neglect, and in our dealings with one other, especially when we make mistakes. The Board promotes a culture of learning rather than blame.

At the same time, as members of the Board, we are clear that we are **ACCOUNTABLE** to each other, and to the people we serve in the three boroughs.

The Care Act says key members of the Board must be the local authority; the clinical commissioning groups; and the chief officer of police.

The Director of Integrated Care Adult Social Care and Health; the Deputy Director of Quality, Nursing and Safeguarding, Central Westminster Hammersmith Hillingdon and Ealing (CWHHE) Clinical Commissioning Groups Commissioning Collaborative; and the Borough Commander of the Metropolitan Police in the Royal Borough of Kensington and Chelsea; are the three statutory members of the Safeguarding Adults Executive Board.

The Care Act says these three must appoint a chair person who has the required skills and experience.

Mike Howard has been confirmed as the Independent Chair of the Safeguarding Adults Executive Board for a further two years.

The Care Act says the Board can appoint other members it considers appropriate with the right skills and experience.

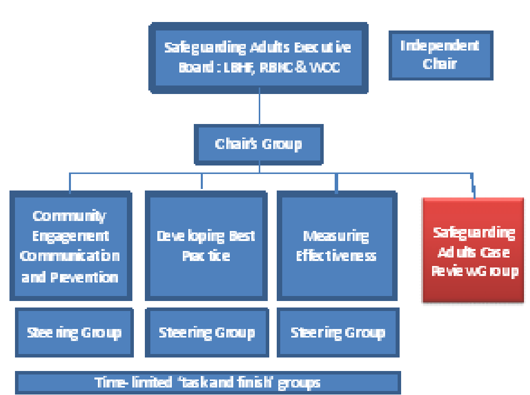
There are representatives on the Board, from the following organisations:

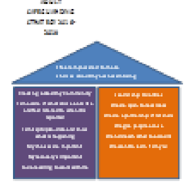
Imperial College Healthcare NHS Trust; Chelsea and Westminster Hospital foundation NHS Trust; The Royal Marsden NHS Foundation Trust; Central London Community Healthcare Trust; Central North West London NHS Foundation Trust; West London Mental Health Trust; London Ambulance Service; Healthwatch, Central West London; London Fire Brigade; London Probation Service; Children's Services; Elected members; Community Safety; Housing; Trading Standards; NHS England; HM Prison, Wormwood Scrubs; Public Health; Royal Brompton and Harefield NHS Foundation Trust.

There is now a senior 'go to' person in each of these organisations with responsibility for adult safeguarding. Their role as members of the Board is to bring their organsation's adult safeguarding issues to the attention of the Board, and to promote the Board's priorities, and disseminate lessons learned in their organisation.

An even wider group of people, including voluntary sector organisations; housing and homelessness agencies; advocacy and carers' groups ; and members of the public; all contribute to the four work-streams of the Board: Community Engagement; Developing Best Practice; Measuring Effectiveness; and Safeguarding Adults Case Review group.

The Safeguarding Adults Executive Board and work-streams





The Trust introduced a new operational model from September 2015 which has resulted in clear roles and responsibilities at a sector level, increasing representation at local authority Safeguarding Board meetings.
London Ambulance Service Safeguarding Annual Report 2015-16

The Board meets four times year and provides leadership and direction for adult safeguarding in the three boroughs. The work-streams meet more regularly. The Board is always mindful that the challenging work of preventing and responding to abuse and neglect is carried out by hard-working staff in all these organisations, every day of the year.

The Care Act says members may make payments for purposes connected with the Board.

The Local Authorities and the Clinical Commissioning Groups mostly fund the Board and its work-streams. This year, the Metropolitan Police Service contributed £5,000 per borough from the London Mayor's Fund; and the London Fire Brigade allocated £1,000 per borough to be shared between the Safeguarding Adults Board and the Local Safeguarding Children's Board. These contributions pay for the Board's administration costs; the independent chair; and externally commissioned Safeguarding Adults Reviews. The Board is planning to use these contributions to recruit a Board Business Manager to further improve its effectiveness and efficiency in 2016-17.

The Care Act says members may provide staff, goods, services, accommodation or other resources for purposes connected with the Board.

All the member organisations free up staff with the right skills and experience to contribute to meetings and to carry out the work of the four work-streams. Attendance is good and members are committed, and work hard to safeguard adults at risk of harm. Member organisations, in particular the Central North West London NHS Trust, have provided venues for Board meetings.

The Act says the Board must publish a report of what it has done during that year to achieve its objectives, including findings of the reviews arranged by it under Section 44 of the Act.

Despite the London Fire Brigade's non-statutory status on local safeguarding adult boards, to demonstrate its commitment to safeguarding the Brigade has made an offer of a £1,000 voluntary contribution to each of the 32 safeguarding adult boards (to be shared with children's safeguarding boards). In order to access this funding each borough is required to sign a Memorandum of Understanding agreeing to improve the lives of vulnerable persons within the borough by making appropriate safeguarding referrals when a concern is raised by the Brigade in carrying out its fire safety function; to agree to consider arranging and holding case conferences on particular cases when a Brigade representative requests following a fatal fire; and agreeing to make referrals of vulnerable persons to the Brigade to carry out Home Fire Safety Visits.
Extract from the London Fire Brigade Safeguarding Adults at Risk Audit Tool 2016-2017

This is the Annual Report of the Safeguarding Adults Executive Board. It is an account of what the Board set out to do in 2015-16 and what it has achieved.

This is the first full year that the Board has carried out its Section 44 duties to undertake Safeguarding Adults Reviews. These reviews are a legal requirement where a person with care and support needs has died, or suffered serious harm, as a result of neglect or abuse, and there is reasonable cause for concern about how agencies worked together to safeguard the person.

Cases that might meet the criteria for a review are considered by the Safeguarding Adults Care Review Group. This group is made up of representatives of organisations represented on the Board. The group recommends to the Chair of the Board the type of review that will provide a proportionate response to the concern, and the opportunity for most learning.

The report includes some of the learning from these Reviews and some of the changes that have been made to systems and practice as a result what has been learned.

In 2015-16 the first ever joint working protocols were agreed between the Violence Against Women and Girls Board; The Local Safeguarding Children's Board; and the Safeguarding Adults Executive Board.
The Violence Against Women and Girls Board has been working to strengthen relationships and improve referral pathways between specialist and statutory organisations.
The success of this is evident through the variety of sources of referral to the Angelou Partnership, and to the Multi-Agency- Risk Assessment Conferences, and joint working with the Metropolitan Central police to address trafficking for sexual exploitation and prostitution.

Extract from the Violence Against Women and Girls Strategic Partnership Annual Report 2015-16

Aspirations for 2015-16

In its 2014-15 Annual Report the Board made the following commitments for the year ahead:

There will be more opportunities for people who have direct experiences of services, and their families and carers, to be involved in safeguarding adults work, and the work of the Board, including:

- consulting on the Board's strategic plan;
- reviewing adult safeguarding information and advice;
- involving families in monitoring the quality of provision in the three boroughs;
- Making Safeguarding Personal in response to all concerns raised about abuse and neglect.

Agencies represented on the Board will continue to work together to ensure local services are safe, respectful, and of a high standard, including:

- Adopting safer recruitment practices;
- Learning from case reviews to inform health and adult social care commissioning, working with the Health and Well-being Boards;
- Building on the Compassionate Leadership Programme;
- Sharing information about local provider performance, including the views of customers and their families, in order to support continuous improvements and prevent market failure;
- Aligning the work of the Board to the Local Children's Safeguarding Board, and the Violence Against Women and Girls Board, to make sure agencies working with children and adults, who are experiencing different kinds of harm, are responsive, well-co-ordinated and the best use is made of resources.

Board members will continue to work together to develop better information-sharing, to assist with the requirements, from 1st April 2015, to conduct Safeguarding Enquiries conducted under Section 42 of the Care Act 2014, and Safeguarding Adults Reviews, under Section 44 of the Care Act 2014, including:

- Exploring the possibility of an adult Multi-Agency-Safeguarding-Hub (MASH).

We also said:

"In next year's Annual Report (2015-16), having consulted more widely on the Board's strategic priorities, we will be reporting what YOU SAID: and what WE DID".

The things people told us are most important to them at the consultation event on 24th November 2015 that will shape the Board's priorities for the next three years

ADULT SAFEGUARDING STRATEGY 2016- 2019

I feel empowered to make choices about my own well-being

Creating a Healthy Community

I am aware of what abuse looks like and feel listened to when it is reported

I am kept up-to-date and know what is happening

My choices are important

My recovery is important

You are willing to work with me

Leadership Qualities

We are open to new ideas

We are a partnership of listeners

We give people a voice

We hold each other to account

We want to learn from you

Achievements in 2015-16

More opportunities for people who have direct experiences of services, and their families and carers, to be involved in safeguarding adults work, and the work of the Board

Consulting on the Board's strategic plan
On 25th November 2015, the Community Engagement Group held a very successful consultation event attended by eighty delegates, mostly members of housing, advocacy, and voluntary organisations, and local residents.

Delegates were asked what safeguarding meant to them, and what they wanted the Board to work on in the next three years. Everyone's ideas were captured on graffiti boards. From these ideas, we distilled the key themes which are in the **'house'**. These themes are deceptively simple, but challenging for organisations to consistently deliver. We are using these themes from the Consultation to guide the work of the Safeguarding Board and work-streams from now until 2018.

The **'house'** has two strands. The first is those things that people valued most in their dealings with statutory agencies, and which lead to **Creating a Healthy Community**. The second strand is what people said are the **Leadership Qualities** they expected from the Board and the organisations represented on it.

Leadership Qualities

You said: *I want to be listened to and for you to be willing to work with me.*
We said: *We are a partnership of listeners. We want to learn from you and we are open to new ideas.*

What WE DID
In addition to the consultation, we are involving more families and, where a person does not have friends or family, representatives, in monitoring people's experience of local provision in the three boroughs. This includes encouraging care and nursing homes to set up residents and relatives groups, which in some homes are called **'Quality Boards'**.

People are telling us that there is more to do to restore confidence in provision of care at home. A **Homecare Board** has been set up to oversee improvements in the delivery of care at home, and one of the measures of success will be **fewer safeguarding concerns being raised**.

The new **duty of candour** has seen an increase in patient involvement in enquiries into incidents in hospitals and community and mental health trusts that have led to significant harm. This 'duty of candour' has also been adopted in the Board's approach to Safeguarding Adults Reviews, as demonstrated in the 'Learning from Safeguarding Adults Reviews' section of this report.
The growing concerns reported in the media, and through local councillor surgeries, of 'scamming' and financial

abuse of older people, has led the Board to put new emphasis on tackling **financial abuse** together. The Trading Standards team are making an invaluable contribution to the work of the Board. Below are two examples of how the Board has initiated joint work that is helping people escape the clutches of people who systematically aim to defraud them.

A Good Outcome

Adult Social Care asked advice from the Trading Standards team about a man of 75 years who had lost all his money (in excess of £200,000) on a fake lottery. He was facing eviction due to large rent arrears. Together, Adult Social Care and Trading Standards submitted a letter of support with his housing benefit application, and are pleased to report his arrears of £6000 have been paid off. They are working closely with his bank to ensure he is not loaned any more money and that his priority bills are paid. Of concern is that after six years of making payments to one lottery, and despite continued best advice, he remains convinced he has won the US lottery.

A Sad Outcome

A repeat victim on the priority referral list who a member of the Trading Standards had been working closely with, and had just signed up to the Mail Marshal scheme died at the end of August. He had been spending on average £50 per month over a five year period (£3000) and had only won £30. His sister said that he had lost far more than that but had not disclosed the real sum.

You said: *'We need to hold each other to account'*

What WE DID

As promised, we published the **Safer Recruitment Guide** which is available to organisations in printed and electronic copy, and to people who may be recruiting personal assistants to provide their care.

Safeguarding Adult Reviews have provided opportunities for change and improvement, and there is also a growing sense of trust and transparency between agencies; and hopefully families, with timely **information sharing** (subject to usual information governance arrangements); and a genuine desire to work together to improve people's experiences of safeguarding and prevent further deaths and serious harm, caused by abuse or neglect.
To date, it has not been necessary to invoke Section 45 of the Care Act 2014

which gives the Board the authority to formally request information, if an organisation is unwilling to share information in the course of a safeguarding enquiry or review.

The Board continues to explore the value of creating an adult **Multi-Agency Safeguarding Hub** as part of the front door to adult services, including mental health services. A number of possible options are being considered, together with the resource implications of each. This year, the Board signed up to working protocols which have strengthened the working arrangements with the **Local Safeguarding Children's Board** and the **Violence Against Women and Girls Board,** and these boards' relationship with the Health and Well-being Boards.

The joint work with **Violence Against Women and Girls Board** has been particularly important in ensuring that if someone is experiencing domestic abuse, or modern day slavery, they are directed quickly and confidentially to the agency that can best assist them. The success of this joint work is evident through the variety of sources of referral to the commissioned providers specialising in Domestic Abuse; and to the Multi-Agency-Risk Assessment Conferences; and working with the Metropolitan Central police to address trafficking for sexual exploitation and prostitution.

Creating a Healthy Community

You said: *"I want to feel empowered to make choices about my own well-being. My choices are important."*

What We DID
Through staff training we are promoting the Care Act principle that each of us is the expert in our own life, and this applies equally when we are making choices about our health and well-being, and when we have experienced harm or abuse. Staff in our organisations are being trained to always ask people who have experienced abuse or neglect, or where appropriate their representative, *'What is important to you?'* and *'What would you like to happen next?'* This is what is meant by **Making Safeguarding Personal.** We are now recording whether or not each person has achieved what they hoped to achieve, as a result of safeguarding work.

We are developing a directory for use at service front doors that will make sure that people are directed to the most appropriate source of information and advice, to meet their needs.

You said: *"I want to be aware of what abuse looks like and feel listened to when it is reported."*

What WE DID
The safeguarding information leaflets **'Say NO to abuse'** have been up-dated and a new leaflet, '**Keeping safe from abuse and neglect: what happens after**

you report abuse' has been published this year. Both of these and other information and advice about safeguarding adults are available on the **People First website**. Printed copies are also available on request.

The Safeguarding '**Train-the-trainers' programme** is being offered to the Community Champion leaders who will then offer the training to the **300 Community Champions** in 2016 -17. We are already learning from Community Champions how to work more effectively and sensitively with people who may be reluctant to disclose that they are being harmed, to statutory agencies.

You said: '*I want to be kept up-to-date and know what is happening after I have told you about abuse or neglect'.*

What WE DID

This has been a challenge for a number of years. Very often a lot of very good work is happening, but we do not routinely tell the person who has experienced, or reported harm, what we are doing. So we have **redesigned our safeguarding system**, and built in to it the requirement that our enquiry officers talk to the person or their representative about what has happened to you. They will ask you what you hope our enquiries will achieve for you. When we have finished our work, we will ask you if you have achieved what you wanted to achieve. We will be checking that this is happening through our **case audits**.

The **Measuring Effectiveness Group** is also running a **pilot** which will test what sort of responses people have had when they have raised a safeguarding concern. The findings from this pilot will be reported to the Board in the Autumn.

"There are clear safeguarding processes which are well understood and owned across operational teams".

"The three boroughs can seize upon the opportunity and willingness of users, carers, staff and stakeholders to create real involvement, building on the good practice that already exists."

Extract from the Peer Challenge for Adult Social Care Shared Services in London Borough of Hammersmith & Fulham; the Royal Borough of Kensington and Chelsea; and the City of Westminster 12th June 2015

Learning from Safeguarding Adults Reviews in 2015-16

The Safeguarding Adults Reviews that have been undertaken this year have provided insights into how effectively organisations are working together. A successful Review results in learning and improvements to systems and practice. A key lesson learned this year is that working with families, and using enquiries to answer their questions, gives everyone involved a better understanding of the circumstances that led to the serious harm, or death of their relative, and how to act to prevent future deaths or serious harm. It is hoped that this respectful way of working may help families towards recovering from their loss, which is very important to the Board.

In 2015-16 13 cases were accepted by the Safeguarding Adults Case Review Group as meeting the Section 44 Safeguarding Adults Review criteria. A list of the emerging themes from the Reviews is attached as APPENDIX 1.

These are some of the changes that have happened as a direct result of these Reviews:

- The security arrangements in the Accident and Emergency department in an acute Hospital have been tightened to make it more difficult for unaccompanied and vulnerable patients (for example, people with a learning disability, or dementia) to leave unnoticed.
- Delay in discovering the death of a man who had returned to a hostel on leave from hospital has led to a change to the welfare check procedures in the hostel to include daily checks of all unoccupied rooms. The hostel swipe-entry system is now disabled for people when they are admitted to hospital. This is so that when they return home from hospital, they have to check in with staff. Photos of residents are kept in the office to help new and temporary staff identify residents quickly.
- The leave and hospital discharge arrangements for people recovering from mental illness has been reviewed, and work is being done to improve communication and closer working between the Hospital and the hostel accommodation to which people are returning.
- The London Fire Brigade report all fatal fires to the Safeguarding Adults Case Review Group. As a result of a Review, the Brigade are currently working with the London Ambulance Service to pilot the provision of Home Fire Safety Visits to people who are at increased risk of fire from hoarding, as identified by the London Ambulance Service.

- A Homecare Board has been set up to address the local challenges of delivering safe and consistent care at home to residents of the three boroughs. The findings from three Reviews have confirmed that reducing risk and raising customer satisfaction with care at home is a priority area of work for agencies represented on the Board in 2016-17.

These are three examples of how the reviews have been conducted. They are used to illustrate the impact a death or serious incident have on agencies, and how they work together, and on families who have lost a loved one.

Ms. Adam's* was the first death reviewed by the Safeguarding Adults Case Review Group

*(*not her real name)*

Ms. Adam attempted to drown herself in the Thames, but was prevented from doing so by the police and detained in a local (mental health) Hospital. Within 24 hours, she absconded from the Hospital, and on her second attempt, did drown herself in the Thames.

As part of the Safeguarding Adults Review, the police and the Trust met to share what they had learned from this sad death, and agreed what each agency would do to prevent other, similar deaths occurring.

At the recent inquest into Ms. Adam's death, the jury found that Ms. Adam had been able to abscond due to inadequate security systems and processes at the Hospital, at the time.

However, the Coroner decided not to make a Prevention of Future Death report[1] because of the significant work that had been undertaken by the Trust to improve the security arrangements in the Hospital following Ms. Adam's death. The evidence provided by Trust's Chief Executive led the Coroner to reflect on how very difficult it is to get the balance right between creating the right environment (a hospital is not a prison) and the need for proper security.

The Coroner expressed praise for the joint work between the police and the Trust, which has led to the following measurable improvements:

In 2013 the police dealt with 104 mental health patients missing from the Hospital. When the joint work began, in 2014-15 this reduced to 62 missing persons, and by March 2016 was down to 40 patients. This reduction in demand has not only saved lives and made people safer, but has also saved an estimated £220,000 in police time, which can be spent on other aspects of policing.

Whilst escapes from the wards have effectively stopped, escapes during escorted leave have risen. The police, the Trust and hostels, are now working together to reduce the number of patients who put themselves at risk by

[1] Paragraph 7 of Schedule 5, Coroners and Justice Act 2009, provides coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths.

not returning to the Hospital when they should.
This case illustrates what can be achieved when agencies learn the lessons from a very sad and serious incident, and together use what they have learned to make changes to their systems and practices, to save both lives, and use scarce resources as effectively as possible.

The £220,000 has been calculated using the following assumptions:
If the police have a high risk missing person for 24 hours they deploy the following:

4 officers from the Missing Person's Unit (40 hours)
4 officers from Community Safety Unit (early / late and night duty) (120 hours)
1 Police Search Adviser team (12 officers x 6 hours) (72 hours)
4 officers from Emergency Response and Patrol Team (early / late and night duty) (120 hours)
1 officer from Casualty Information Unit (early / late and night duty) (24 hours)
1 member of Senior Leadership Team (2 hours per shift) (6 hours)
2 officers from Safer Neighbourhood Team (24 hours)

This equates to approximately £10,000 which is a conservative amount, and covers only the first 24 hours of officers' time.

Ms. Brewer's* was the first death to be reviewed by an external reviewer, using the Social Care Institute of Excellence (SCIE) Learning Together approach.
*(*not her real name)*
Ms. Brewer was living in residential care home, and was pushed over by a fellow resident. She was admitted into hospital with a broken hip. She also suffered a bleed on the brain as a result of her fall, and subsequently died in hospital.
Although the Review was prompted by the death of Ms. Brewer, the focus of the review was on how the man who caused her harm who, for the purposes of the review was called 'Andrew', came to be in a situation where he was able to inflict serious harm on a fellow resident.
Andrew's story is that the care he received from his partner made it possible for him to live at home, despite his severe dementia. After his partner died, Andrew spent some time in the acute mental health wards of two different hospitals, before being placed in a care home, registered to provide dementia care. Several professionals including social workers, nurses, and consultant psychiatrists, played a part in the decision-making about where Andrew's care and support needs would best be met.
Andrew stayed at the care home for two and a half months. He was removed after

the incident that resulted in Ms. Brewer's death.

The question the Review sought to answer was: *"What can we learn about how placements for people with dementia are commissioned, made and monitored across the three boroughs?"*

As a result of the Review, the recently constituted Joint Health and Social Care Dementia Programme Board is looking at the range and variety of provision for people with dementia, and how this might be commissioned and delivered in a more imaginative way. This includes looking at the experiences of other people with similar needs to 'Andrew' and seeing how well they are being served, and how they might be better served.
Work is being done to increase staff understanding of how placements are made and how in future, health and adult social care processes can become more seamless.
The Board is also exploring how information might be shared more effectively through single 'front doors' and arrangements such as a Multi-Agency-Safeguarding-Hub (MASH) for adults, such as the one that is in place for safeguarding children across the three boroughs.

The review of Ms. Connor's* death confirmed how important it is for communication between teams to be crystal clear, and that families need to have answers to their questions when they have lost a family member
*(*not her real name)*
Ms. Connor was discharged home from hospital and because of a mis-communication between two teams, the homecare package she had been assessed as needing was not put in place. When she died, Ms. Connor was not wearing the call alarm pendant with which she might have been able to summon help.
Although Ms. Connor's family were very much involved in her care, they were not informed of her discharge from hospital. Key learning for all staff involved in the Review is always 'think family'.

An extract from a letter to Ms. Connor's son and daughter.
Thank you for taking the time to meet with us to review the circumstances of your mother's death. Like you, we needed to understand what went wrong. We hope that our meetings have given you an explanation of what happened, and that you know how very sorry we are that we did not provide your mother with the care she needed, that may, or may not have extended her life.
For us, the meetings with you helped us to focus on what is important, and what we need to do to prevent something similar from happening to someone else's mother, father, or family member.
All the agencies involved with providing health and social care to your mother realised as soon as we learned of her death, that this was a serious matter that

needed to be fully investigated. I asked the Head of Service to meet you as soon as possible so that we could understand the questions you needed answering.
Each agency carried out their own internal enquiries, and we used this information to put together the timeline that we shared with you at our first meeting. I hope that sharing the timeline answered some of your questions, and that the second meeting you requested, provided you with a fuller account of what happened on the day your mother died, and the omissions which led to her not receiving the care she was assessed as needing.
In terms of actions, we are reminding all staff to ensure that pendent alarms are continually checked and placed around people necks.
A meeting with the hospital transport team has been called to ensure that all crews are aware of the importance of this and to ensure that when they take people home, the crews locate the pendent alarms and ensure they are within reach.
We are ensuring that all new referrals to the Service are accompanied by a letter confirming any conversations between the teams. This has been reinforced with all staff in the team, not just the person who omitted to confirm the bookings.
We have appreciated the way you have worked with us through this very difficult time for you and your family. We were especially touched by your generosity in the meeting when you said that whilst you felt that the staff involved had been negligent, you understood that they had not meant to harm your mother, and that you did not want them to be burdened by the guilt of what they neglected to do. We have passed your message to the staff involved.
Thank you for giving us permission to reflect with staff on the circumstances of your mother's death, so that we can all learn the lessons, and make changes to way we do things that will reduce the chances of something similar happening again.
Thank you also for giving us a copy of the lovely photo of your mother when she was younger. We will share this with staff in the 'learning together' session. It will remind us all that each person we work with has a story and, for those of us lucky enough to have family, how important our families are to us.
Please let me know if you have any questions that remain unanswered, or we have left anything out that is important to you.

In addition to the learning that Safeguarding Adult Reviews have provided this year, and opportunities for change and improvement, there is also a growing sense of trust and transparency between agencies; improved information sharing; and a genuine desire to work together to improve people's experiences of safeguarding and prevent deaths and serious harm, caused by abuse or neglect.

How we know we are making a difference?

Here are four examples of how the work of the Safeguarding Adults Executive Board is making a difference to people who are residents of the three boroughs.

How safeguarding has provided justice to a woman who had a crime committed against her, and is working to take unsuitable people out of the health and care work-force so that they can no longer take advantage of people for whom they are meant to be caring.

Mrs Smith* is a 93 year old woman who lives in a local care home, and funds her own care. A carer working in in the home stole £4,800 from Mrs. Smith 18 months ago. The carer was caught and was found guilty last week at the Crown Court. She is yet to be sentenced. The care home dismissed the carer under their disciplinary code and referred her to the Disclosure and Barring Service with the intention of preventing her from working in the health or care sector again.
*(*not her real name)*

How the Deprivation of Liberty Safeguards, which often get a negative press, is making a real difference to a person's well-being and quality of life.

Mr. Arnold* told the Best Interest Assessor who had come to assess him for a Deprivation of Liberty Safeguard (DoLS), that he did not mind living in his care home, but did not like sharing his room with strangers. On further enquiry, the Best Interest Assessor found out that the home had put up a curtain across Mr. Arnold's room and were using a second bed in his room for people needing respite care. The care home was told to put a stop to this immediately.
Mr. Arnold also told the assessor that he would like to live near the sea. The Best Interest Assessor made it a condition of the DoLS that Mr. Arnold's request to move to the seaside be explored. Mr Arnold was also given a paid representative to ensure that this happened, as he had no-one to represent him. In her most recent report, the paid representative wrote:
"When I asked Mr. Arnold how he felt about living in his new home, where he has now resided for about five weeks, he said 'I am happy here.' He then gestured

out of his bedroom window and said, 'I like the scenery and I go down the beach.' I said that staff had told me that he goes to the seafront twice a week, and I asked if he felt that twice was enough? Mr. Arnold and replied, 'That's enough for me.' Mr. Arnold is also planning to visit is brother along the coast in Devon where he lived as a child"
*(*not his real name)*

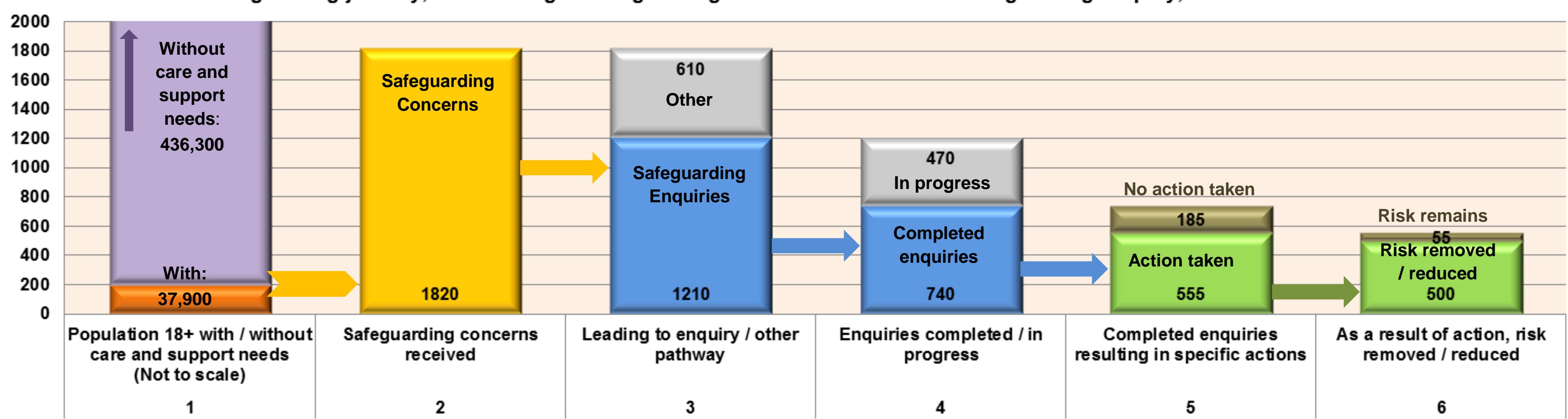
How agencies working together in the three boroughs are protecting people from scams, fraud and other forms of financial abuse that can cause emotional distress, increase social isolation, and can sometimes lead to illness and death.

The social work team were worried about various financial transactions Mr. Price* was involved in, and had a conversation with colleagues in Trading Standards to see if there was any substance to their concerns. Mr. Price has been sending money to a woman living in a West African country, with whom he believes he has been having a relationship for the past 7 years. The amount of money he has sent is in the region of £15,000. Mr. Price manages his own finances, but is beginning to struggle to pay his bills. Trading Standards contacted the organisation through which the money was being transferred. Their enquiries uncovered that another 10 men were transferring money to the same woman, on the same basis as Mr. Price. These transfers have been intercepted, and the money transfer organisation is now investigating the potential fraud with the police. Mr. Price and other victims have not been informed as there are concerns that they might inadvertently tip off the recipient, which could seriously jeopardise any investigations. This decision has been made to protect public interest. The social work team are working with Mr. Price to link him in to some local organisations that will help to address his feelings of loneliness and social isolation, which scammers often exploit.
*(*not his real name)*

"A safeguarding meeting is a very stressful time for a family, and for a GP, however the meeting being so well chaired, so well informed, and so well prepared for, has, I believe, helped the carers and the family, and I, to improve the care we offer Mr. Jones, and made this event have a number of productive outcomes in terms of risk prevention."*
(*not his real name)

Extract from a letter from a local General Practitioner March 2016.

What are the numbers telling us?



Raising of safeguarding concerns

- In mid-2015 the three boroughs (LBHF, RBKC and WCC) had a combined adult population of about 474,200.
- Using the percentage of adults aged 18+ who say in national surveys that they are unable to manage at least one self-care activity, such as washing or dressing, on their own (about 8%) as a proxy measure, we estimate that across the three boroughs about 38,000 adults have care and support needs. This is five times the number of adults who receive on-going support from social services
- In 2015-16 the three boroughs received a total of 1,820 concerns about cases of potential or actual harm or abuse. This is equivalent to about four concerns for every 1,000 adults in the general population, or 48 for every 1,000 adults with care and support needs, or 240 for every 1,000 adults receiving on-going social care (7,565)
- The majority of concerns were raised by health and care

Resulting safeguarding enquiry process

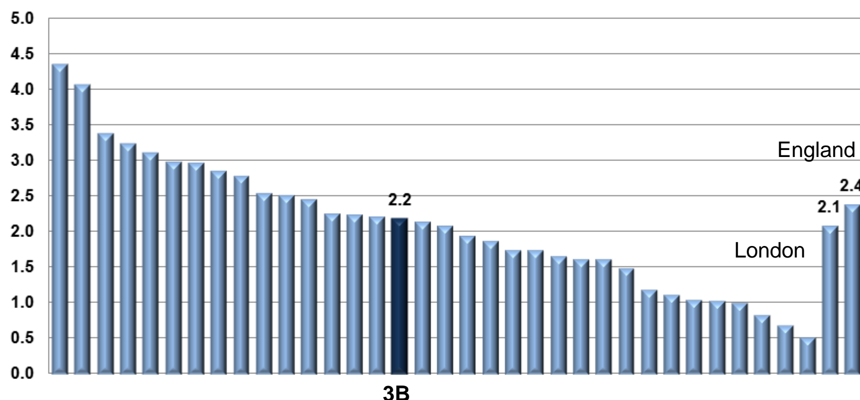
- About two-thirds (1,210) of the concerns received were assessed as requiring follow-up under safeguarding procedures.
- This is because the people involved were assessed as:
  (a) experiencing, or being at risk of, harm or abuse; and
  (b) having care and support needs which prevented them from protecting themselves.
- These concerns became the subject of a safeguarding enquiry to establish *what the person wanted to happen in relation to the risk* and what needed to be done to achieve this
- Those concerns (610) not followed up as safeguarding enquiries were followed up in other ways, for example by referral to trading standards offices, domestic abuse support agencies, the police or the customer services team.

Outcome of enquiry process

- Safeguarding enquiries can take varying lengths of time to complete, depending on the issues and organisations involved. At 31 March 2016 nearly two-thirds (740) of the enquiries that had been started since 1 April 2015 had been completed. The remainder were still in progress.
- Of the safeguarding enquiries which were completed in 2015-16, the majority (555, or about 70%) resulted in specific actions being taken in relation to the risk, such as disciplinary action or removing staff from the situation
- The remaining cases (185) had not resulted in specific actions for a number of reasons, for example because the inquiry had found the risk to be unfounded, or because the adult did not wish any action to be taken
- Where specific actions had been taken, in the great majority of cases (500, or 90%) the risk of harm or abuse was judged by the social worker to have been removed or reduced

A comparison with London and England 2015-16

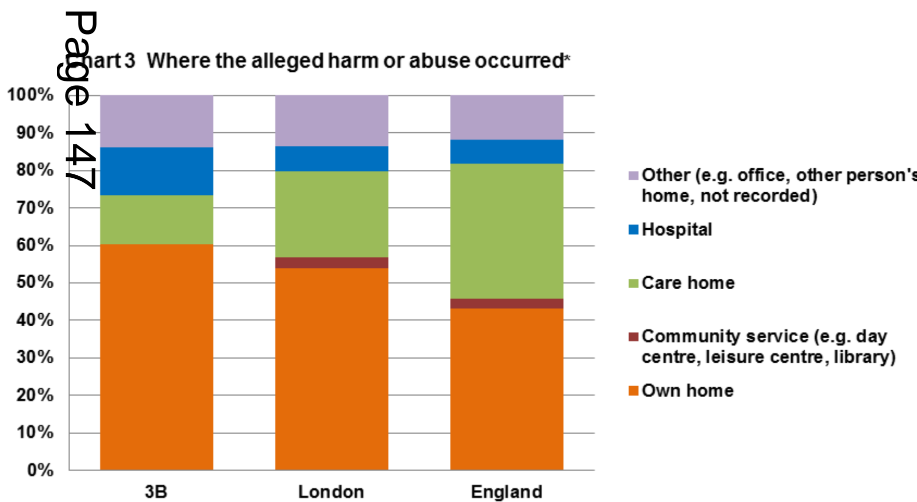
Chart 2 Number of individuals involved in safeguarding enquiries started in 2015-16, per 1,000 population aged 18+ - all London boroughs*



*3B=1,025 individuals; London=13,805; England=103,800.

The number of safeguarding enquiries started per head of population varied considerably across London with 3B in the mid-range close to the London average.

Chart 3 Where the alleged harm or abuse occurred*



*Based on the number of enquiries completed in 2015-16, regardless of when they started. 3B=935; London=13,045; England=108,910

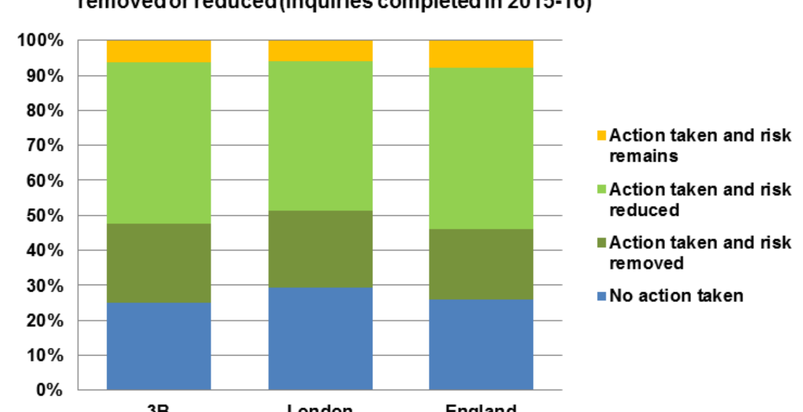
Compared with London as a whole and especially England, a higher percentage of enquires in 3B related to abuse in people's own homes. About half of these involved care professionals and about half relatives, neighbours or strangers.

Chart 4 Types of abuse alleged (enquiries completed in 2015-16)

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
3B
London
England
Discriminatory
Organisational
Neglect / Acts of omission
Financial / Material abuse
Psychol. / Emotional abuse
Sexual abuse
Physical abuse

The frequency with which different types of abuse were reported was similar across the country but in 3B proportionately fewer enquiries involved instances of neglect. These cases nearly always involved care providers.

Chart 5 Whether, following action, the risk of abuse had been removed or reduced (inquiries completed in 2015-16)



In some cases safeguarding inquiries are unable to confirm the occurrence of abuse or identify a source of risk and do not require specific actions. But where they did do in nine out of ten cases the risk of abuse was reduced or removed. Where the risk remained this was with the agreement of the adult at risk.

What the Board will be working on in 2016-17?

The Board will continue to be guided by what people are telling us is important to them, as contained in the 'house'. We continue to work in the coming year on the three key areas of:

- Providing opportunities for people to be involved in safeguarding adults work, and the work of the Board;
- Working together to ensure local services are safe, respectful, and of a high standard;
- Developing better information-sharing.

To achieve these ambitions, the pieces of work we will be completing are:

- We will follow up on the consultation event and check with delegates and members of the public that the Board is doing what we said we would do.
- We will complete the review of our safeguarding systems and training to ensure that staff always ask *'What is important to you?' and 'What would you like to happen next?'* when you have reported a concern. We will also build the prompt to ensure you or the person who has reported the concern, is kept up to date with what is happening.
- We will be rolling out the Community Champions Training-the-training programme and evaluating how it is contributing to the health of the Community.
- We will continue to promote awareness of scams, fraud and financial abuse and tackle fraudsters by working together.

Learning from what the numbers are telling us we:

- We will be ensuring more timely ending of Safeguarding enquiries;
- We will be exploring in more detail what is happening in people's homes where the person causing harm is a relative, neighbour or stranger, and thinking about new ways of working that can help.

Learning from Safeguarding Adults Reviews:

- We will be publishing the Reviews and tracking progress on the changes made as a result of the findings and disseminating the learning;
- We will be tracking the progress made by Joint Health and Social Care Dementia Programme Board in developing the range and variety of provision for people with dementia;
- We will be working together to improve the life chances of people living in hostels, with mental health problems, and those who use substances;
- We will be raising awareness of fire risks, and working together to reduce the incidence of fatal fires;
- We will be working on increasing people's confidence in the provision of care at in their own home.

We will continue to involve people and their families in planning safeguarding enquiries and reviews, to better understand what has happened and learn what might prevent something happening again.

Glossary of terms

Safeguarding means protecting and adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and reduce the risk of abuse and neglect. When people have experienced abuse or neglect, safeguarding is about taking actions that are informed by the person's views, wishes, feelings and beliefs.

Making Safeguarding Personal starts with the principle that you are expert in your own life. Whilst many people do want to be safer, other things may be as, or more, important to you; for example, your relationship with your family, or your decisions about how you manage your money. So, our staff are being encouraged to always ask you *'What is important to you?'* and *'What would you like to happen next?'*

An Outcome is what you hope to get out of the conversations we have, and the work we do with you. Measuring outcomes helps the Board to answer the question "*what difference did we make?"* rather than *"what did we do?"*

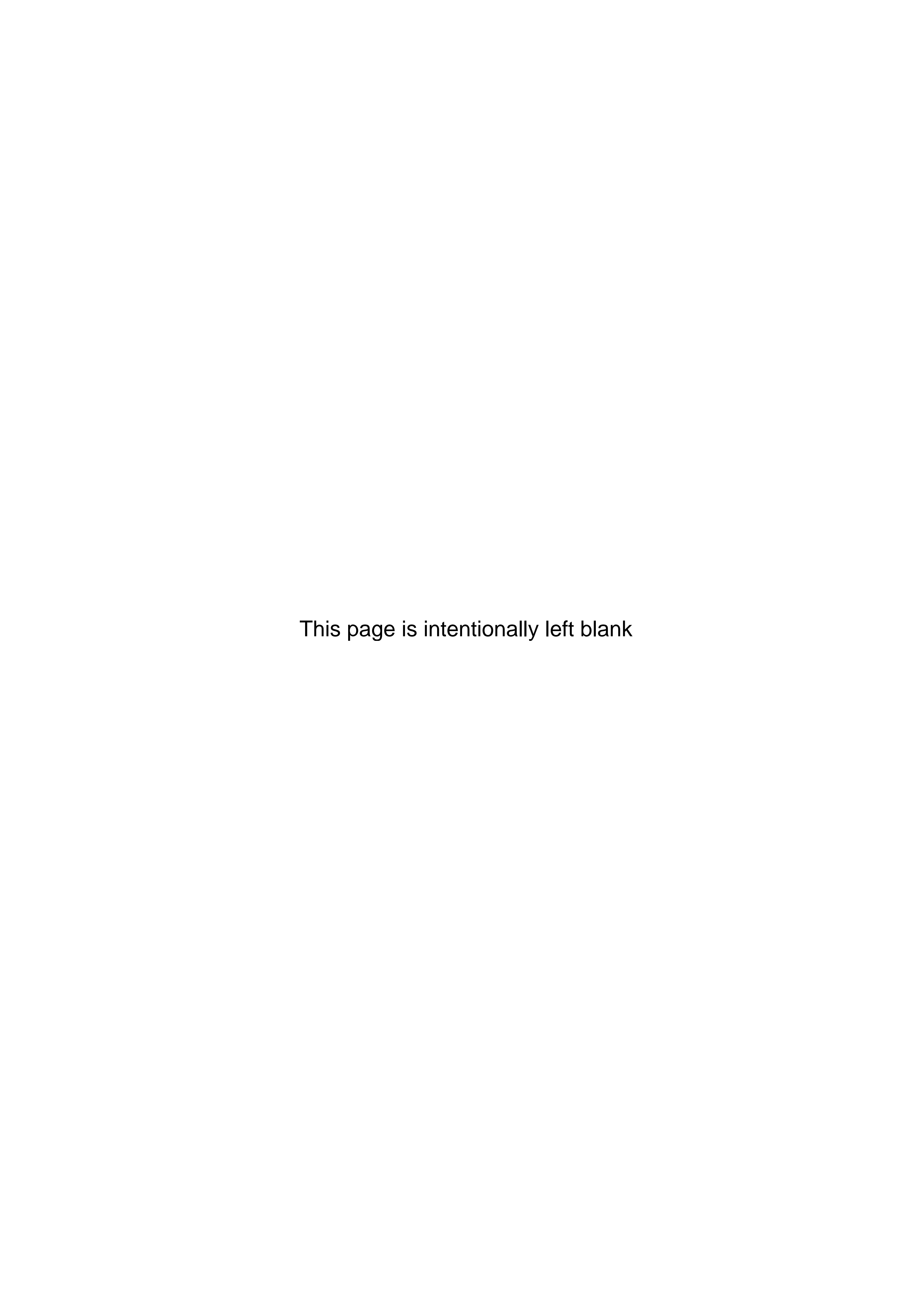
Deprivation of Liberty Safeguards (DOLS)
When a person in a care, or nursing home, or hospital, is subject to continuous supervision and control from staff, and is not free to leave, under the Supreme Court judgement known as 'Cheshire West', they are deprived of their liberty. Once identified, a deprivation of liberty must be authorised either by the Court of Protection order; or under the Deprivation of Liberty Safeguards in the Mental Capacity Act 2005; or under the Mental Health Act 1983. If it is not authorised, under the law, it is an illegal detention.

Multi-Agency-Safeguarding-Hub (MASH)
The purpose of a Multi-Agency Safeguarding Hub (MASH) is to gather information from various professionals in order to make a brief assessment of a child and/or a family, or an adult, who is at risk of harm, to ensure their immediate safety and meet their welfare, or care and support needs. The MASH aims to improve the quality of information sharing between professionals in order to make timely and informed decisions based on accurate and up-to-date information. This assists to ensure that the child, their family or the adult at risk of harm, is provided with the most appropriate offer of supports and services, as soon as possible.

Duty of Candour is a legal duty on hospitals and community and mental health trusts, to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The duty of candour aims to help patients receive accurate, truthful information from health providers.

APPENDIX 1 Cases Accepted for Safeguarding Adults Review in 2015-16 and emerging themes

	Date case to SACRG	Emerging themes from Safeguarding Adults Reviews
1.	06/03/2015	The mismatch between the needs of older people with dementia and the range of appropriate provision to meet those needs ('requisite variety'); information-sharing between agencies. **(Case included because subject to a Review using Social Care Institute for Excellence Learning Together, September to December 2015 and shortly to be published)**
2.	29/05/2015	The challenges of providing suitable housing for a mix of adults with a range of needs, including drugs and alcohol use; mental health problems; physical frailty; age related conditions; and of keeping this mix of people as safe and secure as possible, particularly in hostel accommodation.
3.	10/07/2015	Staff confidence with application of the Mental Capacity Act in complex and life-threatening decision-making and support for staff when a capacitated decision is unwise, and as a result a person dies or suffers serious harm.
4.	10/07/2015	The challenge of how to effectively hold a private General Practitioner to account with regards to their clinical decision-making; and their application of the Mental Capacity Act; and end of life care.
5.	01/10/2015	The challenges of good information sharing, when electronic systems do not talk to each other; the need for secure handover of cases between agencies and teams within agencies; and to prevent the serious consequences of 'dropping the baton'.
6.	02/10/2015	The challenge of working with people with capacity who are reluctant to accept care from statutory services which results in their physical health care needs not being met.
7.	13/11/2015	The review of leave and hospital discharge arrangements for people recovering from mental illness, and the need for improved communication and closer working between hospital and the hostel accommodation people are discharged home to.
8.	13/11/2015	The value of working with relatives and families to prevent harm, and involving them as soon as possible when harm or death has occurred so their questions can help to inform the enquiries and reviews, and provide them with some answers.
9.	05/02/2016	The review of leave and hospital discharge arrangements for people recovering from mental illness, and the need for better communication and closer working between hospital and the hostel accommodation people are discharged home to.
10.	05/02/2016	The challenges of good information sharing, when electronic systems do not talk to each other; the need for secure handover of cases between agencies, and teams within agencies; and the serious consequences of 'dropping the baton'.
11.	05/02/2016	Quality of home care provision and risks associated with transfer of contracts to new providers
12.	18/03/2016	Quality of home care provision and risks associated with transfer of contracts to new providers
13.	18/03/2016	Adequacy of transport arrangements for an older patient between a mental health facility and an acute hospital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Westminster Health & Wellbeing Board

Date:	17 November 2016
Classification:	General Release
Title:	Optimising Older People Hubs
Report of:	Liz Bruce, Executive Director of Adult Social Care
Wards Involved:	All
Policy Context:	Health & Wellbeing Strategy and North West London Sustainability & Transformation Plan Primary care population needs modelling
Financial Summary:	NA
Report Author and Contact Details:	Steven Falvey Steven.Falvey@lbhf.gov.uk Siobhan Herron siobhan.herron@nhs.net

1. Executive Summary

1.1. The Health and Wellbeing Hubs Programme was born out of a desire to develop new models of care that provide better access to preventative services and make more effective use of our assets to improve people's quality of life and reduce reliance on costly public services.

1.2. The Health & Wellbeing Board has initiated three areas of work within the programme which focus on older people (Older People Hubs), children and young people (Family Hubs) and adults with complex needs (Newman Street) to test new models of care for these groups with a view to informing the wider strategic intentions and planning underway through the North West London Sustainability and Transformation Plan (STP).

1.3. Regular updates are brought to the board on the progress made delivering these areas of work. This report provides an update on the progress made between the council, CCGs and voluntary sector in optimising the preventative role of Older People Hubs in the city.

2. Key Matters for the Board

2.1. The Health and Wellbeing Board is asked to note the progress made optimising the preventative role of Older People Hubs in the city and consider how close alignment can be continued and shared learning between this area of work and the wider approach to developing new models of care through the North West London Sustainability and Transformation Plan (STP).

3. Background

3.1. The Health and Wellbeing Hubs programme was initiated to test how best to improve the lives and outcomes of groups and individuals who face a range of social and economic challenges through changing the way we work within the Council and with our partners. The focus is on improving the use of our estates so as to increase access to preventative services for those at risk of experiencing multiple needs. This is to help people to avoid more complex and varied challenges in their lives that negatively affects their wellbeing and are costly to individuals, families and public services to resolve. This ambition aligns fully with the priority areas in the draft North West London Sustainability and Transformation Plan to 'support people who are mainly healthy to stay mentally and physically well' and to 'reduce social isolation' and the draft Westminster Health & Wellbeing Strategy to 'act early to tackle risk factors and ensure that people receive the best care and support'.

3.2. The approach of Health and Wellbeing Hubs is based on the principles of co-location; co-production with our communities, and joint working between multiple sectors and professions to build services around individuals. The goal of the programme is to support people at highest risk of their health and wellbeing deteriorating to prevent them from requiring complex and often costly public services, such as admissions to Accident and Emergency departments or emergency service call outs. We will do this by using existing services but changing the way we work to deliver them, to improve the health and wellbeing outcomes for Westminster residents.

3.3. To test how these principles can best be applied to developing new models of care, the Health and Wellbeing Board has agreed to initiate three areas of work:

1. **Older People**: optimising the preventative role of Older People Hubs in the city

2. **Children and Young People**: improving access to preventative services (both universal and targeted)

3. **Single Adults with Complex Needs**: improving how we target existing services at single people with multiple complex needs living in temporary accommodation in Newman Street through addressing their multiple needs in parallel and proactively taking services to them so we can improve their life chances

3.4. In parallel, the council with Central London CCG and West London CCG, has been progressing the Primary Care Needs Modelling Project which aims to provide an evidence base to inform joint planning aligned to the North West London Sustainability and Transformation Plan around new models of care for our population. The project aims to:

- Provide an understanding of the likely population size and profile for Westminster by 2040 (including consideration of the daytime population), the likely burden of disease of this population by 2040, and how the new models of care being developed within the local health economy may impact on the use of primary care by this population in 2040.

- Overlay the impacts of regeneration, housing and infrastructure plans on the estimates modelled and build a tool that enables the manipulation of these impacts according to a number of variables. This will include the mapping of the existing provision of GP, council and other local services both in terms of numbers of professionals and also physical estate.

- Undertake a joint analysis of how the needs of the Westminster population will impact on the demand for frontline services (including primary care)

3.5. Our goal is to then bring together our local joint planning around new models of care with our analysis of future need, workforce and estates through the North West London Sustainability and Transformation Plan in order to inform the estates strategies for the council, CCGs and other local public services.

4. Optimising Older Peoples' Hubs

4.1. The objective of this work stream is to identify opportunities to reduce duplication; increase integration with partners; and make the best use of the health and wellbeing hubs for older people.

4.2. In Westminster a joint strategic review of the full range of Health and Adult Social Care preventative services for older people is currently nearing completion, the outcome of which will inform the approach for new p contracts being in place from 1 August 2017.

4.3. Officers are continuing to explore opportunities to expand service reach and achieve efficiencies by accessing alternative venues e.g. universal services, such as council libraries.

4.4. Initial findings have highlighted that the current model is aligned with the shared ambition across health and local government to create an integrated health and care system that enables people to live and be well. It directly supports two of the priority areas, and one of the delivery areas, as set out in the NW London Sustainability and Transformation Plan (STP). These are:

STP Priority Area:

PA 1 - Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves.

PA 2 - Reduce social isolation

Delivery Area:

DA 1 – Radically upgrading prevention and wellbeing.

4.5. In line with the need to reduce demand for health and social care services, these cost-effective services already deliver interventions to support people to manage their own wellbeing and make health lifestyle choices, and connect those who feel socially isolated.

4.6. Now is the time to strengthen partnership working to improve the current successful model to meet the Clinical Commissioning Groups' (CCG) and Adult Social Care's (ASC) changing needs. There is an opportunity to work in collaboration with key partners to:

- Improve delivery and experience of local services for older people in Westminster by improving outcomes through prevention, early intervention, and transition back into communities following episodes of ill health.

- Improve efficiencies for CCG and ASC commissioners and providers to strengthen the sustainability of the services.

- Improve existing links and streamline referral routes e.g. utilise Care Navigators and Social Prescribers through the CCGs Care Coordination Service, and City West Homes Housing Managers. These additional referrals routes may identify other services that residents would benefit from to improve their health outcomes, for example there may be sufficient local demand for a cardiac rehab exercise programme. In addition implementing more routine use of measurement tools such as the Outcomes Star.

4.7. A multi-agency project team will be established shortly to shape and agree the service model for the Older People's preventative programme, post July 2017. An update will be brought to the Health and Wellbeing Board in early next year.

5. Legal Implications

5.1. None at this time.

6. Financial Implications

6.1. None at this time.

Westminster Health & Wellbeing Board

Date: 17 November 2016

Classification: General Release

Title: Dementia Joint Strategic Needs Assessment Progress Report

Report of: Executive Director of Adult Social Care and Health

Wards Involved: All

Policy Context: To support the Health & Wellbeing Board statutory duty to deliver a Joint Strategic Needs Assessment

Financial Summary: n/a

Report Author and Contact Details:

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1. Executive Summary

1.1 This report presents the progress made by the Three Borough (Westminster; Hammersmith and Fulham; Kensington and Chelsea) Joint Health and Social Care Dementia Programme Board in response to the 32 recommendations set

out in the Joint Strategic Needs Assessment (JSNA) on dementia. The report covers a six-month period up to September 2016. It aims to give the Health & Wellbeing Board assurance by setting out progress and the programme management approach to facilitate implementation.

2. Key Matters for the Board

2.1 To consider the progress made by the Three Borough Joint Health and Social Care Dementia Programme Board and the wider strategic implications for the three boroughs to develop and commission quality, person centred and cost-effective care.

2.2 To consider and endorse the Three Borough Joint Health and Adult Social Care Dementia 'Plan on a Page' 2016/2017 that is contained in this report.

3. Background & Context

3.1 On the 1st October 2015, the JSNA on dementia and its recommendations was presented to and endorsed by to the Health & Wellbeing Board.

3.2 Since the publication of the JSNA on dementia in 2015, diagnosis rates have been consistently increasing, which will have an impact on the way that health and social care commissions post-diagnostic services, as it is expected that there will be a requirement for more services and a range of services in future. Each of the three CCGs are in the top performing category for diagnosis rates having exceeded the NHS England national target of 67% with Central London CCG at 78.1%, Hammersmith & Fulham CCG at 80.1% and West London CCG at 76.9%.

3.3 NHS England have recently strengthened the Quality and Outcomes Framework (QoF) 2016/2017 indicators on dementia care planning and post-diagnostic support to include the proportion of patients with dementia whose care plan has been reviewed in the preceding 12 months. All three CCGs currently fall within the 'needs improvement' category (<75.6%). However, Central London CCG and Hammersmith & Fulham CCG only require a small increase in the proportion of care plan reviews to meet the performing well target. West London CCG requires a little distance to travel to meet the performing well target and an action plan is in place to achieve improvements in this area.

4. Progress Report

4.1 Membership of the Three Borough Joint Health and Social Care Dementia Programme Board now includes clinicians, patient representatives, safeguarding leads, and subject matter experts, such as, the Alzheimer's Society as in Appendix 1 .

4.2 Considerable work is in progress to implement The Three Borough Joint Health and Adult Social Care Dementia 'Plan on a Page' in Appendix 2 setting out the vision, performance standards and programme deliverables within the financial

year 2016/2017. To achieve this, the programme board agreed to use the NHS England 'Well Pathway': preventing well, diagnosing well, supporting well, living well and dying well, as a framework to better understand the stages in the pathway and the key interdependencies to deliver high quality health and social care.

4.3 Alongside this, the programme board recognised that implementing the 32 Tri-borough JSNA on dementia recommendations within the current financial year would be extremely ambitious given the limited resources and timescales. After in-depth discussion, the programme board agreed that facilitating implementation should be based on common themes across the three boroughs. The five overarching key recommendations are set out in Table 1 below, the aim is to prioritise (5 out 32) nearly 16% this year.

4.4 The programme board acknowledges that only through effective business intelligence gathered and triangulating information to produce the evidence base can effective implementation of the JSNA recommendations be realised. Considerable work is in progress to develop a performance management dashboard to give assurance to the Health & Wellbeing Board to monitor progress against these key deliverables.

Table 1:

Combined Targeted JSNA Priorities		
	Priority	**Progress**
1	• Addressing the supply of local care home beds in future local authority and CCG commissioning intentions.	• A multi-strategy approach has been pursued; this includes building commitment towards the Shared Lives Scheme and undertaking a strategic review to better understand the underlying drivers that contribute to the lack of supply of local care home beds that results in out of area placements.
2	• Ensure there are opportunities for coordinated training and support for people across the pathway to enable recognition of people with dementia and to improve confidence in care for people with complex needs and behaviours that challenge.	• Opportunities are being explored for public sector and private enterprise funding. Exploring partnership working with a range of stakeholders, and opportunities with Skills for Care and Health Education England (HEE). • The establishment of the Three Borough Nominated Dementia Lead Database provides a platform to disseminate information on training and safeguarding, and to receive returns from the care home sector.
3	• Exploit joint working with the police and community partners	• Opportunities are being explored for multi-agency working with the police

	to support appropriate and effective use of assistive technology/telecare with patients/service users with dementia.	and the Alzheimer's Society to pilot a radio frequency Identification (RFID) Wrist Band to locate missing people with a dementia diagnosis.
4	• Establish a joint dementia programme board to facilitate implementation of the JSNA and North West London Strategy.	• The dementia programme board has established a comprehensive Dementia 'Plan on a Page' to set out the direction of travel.
5	• The increasing numbers and needs of people with dementia and their carers are taken into account in the wider local authority and health strategies, especially, care settings and housing.	• Work is in progress to develop and implement patient metrics, I Statements', not only for the care hoe and housing settings, but for the whole system. • Work is progress to strengthen carers respite care to ensure they 'live well'

Source: Combined Target Priorities -2016/2017

5 Legal Implications

5.1 The Health and Social Care Act 2012 placed a joint and equal duty on local Authorities and clinical Commissioning Groups (CCGs) to prepare JSNAs through the Health and Wellbeing Board.

Legal implications completed by Rhian Davies, Chief Solicitor (Litigation and Social Care)

6 Financial Implications

6.1 Westminster City Council:

Any funding implications for ASC arising from the implementation of these recommendations will need to be met from within the Adults revenue budget of £59.7m or the public health budget as appropriate,

Financial implications provided by: Michael Taylor, ASC Finance Manager, Westminster City Council; Tel: 0207 641 1469 email: mtaylor2@westminster.gov.uk.

6.2 Clinical Commissioning Groups:

Any future projects will be contained within the CCG budget

Appendix 1

The Three Borough Joint Health and Social Care Dementia Programme Board Membership			
Organisation	**Designation**	**Function**	**Name**
ASC	3B ASC (London Borough of Hammersmith & Fulham, the Royal Borough of Kensington and Chelsea, Westminster City Council)	Director for 3B ASC Commissioning and Enterprise (SRO)	Mike Boyle
		Head of 3B Head of Complex Needs Older People (Chair)	Ben Gladstone
		Strategic Commissioner, Adult Social Care	Frank Hamilton
		Strategic Lead in Professional Development	Helen Banham
		Head of Quality Assurance and Professioanl Lead	Ann Stuart
		Senior Business Analysis	James Hebblethwaite
		Chair of Safegarding Board	Michael Howard
CCGs	NHS Central London Clinical Commissioning Group	Corporate & Mental Health Project Manager	Chris Longster
	NHS West London Clinical Commissioning Group		
	NHS Hammersmith & Fulham Clinical Commissioning Group	Head of Planned Care and Mental Health	Julie Scrivens
		Planned Care and Mental Health Programme Manager	Jessica Simpson
	3 CCGs	Dementia Clinical Lead	Farukh Malik, Ed Farrell, Calre Graley
Joint Commissioning Older People/Vulnerable Adults (OPVA) Team	Joint Clinical Commissioning Group	Senior Joint Commissioning Manager - Continuing Care and End of Life Care Joint Commissioning	Louise Maile
	Joint Commissioning Group / Adult Social Care	Strategic Dementia Review Lead	Lisa Cavanagh
	Joint Clinical Commissioning Group	Joint Commissioning Officer	Julie Willoughby
Central London, West London, Hammersmith & Fulham, Hillingdon and Ealing (CWHEE)	CWHHE Clinical Commissioning Groups Collaborative	Safeguarding Lead	Molly Larkin
Public Health	Public Health Representative	Mental Health	Marry Russell
Healthwatch	3rd Sector	Interim Director for Healthwatch	Carena Rogers
Alzheimer's	Subject Matter Expert	Delivery Manager	Karen McCrudden
K&C and Westminster (KCW) CNWL	Subject Matter Expert	Consultant Psychiatrists	Claudia Wauld
H&F WLMHT	Subject Matter Expert	Consultant Psychiatrists	Stephen Orleans-Foli

Appendix 2

Three Borough Joint Health and Adult Social Care Dementia 'Plan on a Page' 2016/2017

Strategic context – the scale of the challenge & vision

Vision

The Joint Health and Adult Social Care dementia vision is to develop, commission and deliver high quality, cost-effective services for the local populations of Hammersmith & Fulham, Kensington and Chelsea and Westminster through population based commissioning, and by working in partnership with people living with dementia, carers and local stakeholders.

The vision is underpinned by the Joint Strategic Needs Assessment (JSNA) to:

- Increase understanding of local health and social care needs
- Raise awareness and understanding
- Support early diagnosis and post diagnostic support
- Promote prevention, personalisation, integration, and local services
- Enable sound financial and risk management
- 'Live well' with dementia

Where are the three boroughs now…

- The three boroughs generally perform well on health and social care indicators compared to national benchmarks, although in some aspects there is a distance to travel.
- The prevalence of dementia is due to rise by nearly a third (30%) over the next 15 years.
- The number of older people aged 65 has increased by a fifth (20%) and in the over 85 population it has increased by nearly a third (30%).
- Improvements in early diagnosis across the three boroughs has led to exceeding the NHS England benchmark of 67%.
- There are too many care home placements out of borough as a result of limited in borough capacity.
- Better workforce planning is leading to delivery of higher quality services.

What we want to achieve…

- Raise awareness of healthy lifestyles through public health campaigns on prevention and risk reduction.
- Build capacity to support carers.
- Improve the quality of health and social care services for local people to meet their needs.
- Commission a joint health and social care system using the 'Well Pathway' that is based on local population needs.
- Commission services in the most effective way using the research and the evidence base.

The outcomes we want to deliver are to:

- Improve the patient, service user and carer experience.
- Prevent, reduce or delay people with dementia having hospital admissions, and permanently attending nursing or residential care homes.
- Reduce duplication by effectively working together across the system, with the aim to increase efficiency.

How we will deliver the vision: Priority areas

Combined JSNA Priorities

- Address the supply of local care home beds in future local authority and CCG commissioning intentions.
- Ensure there are opportunities for coordinated training and support for people across the pathway to enable recognition of people with dementia and to improve confidence in care for people with complex needs and behaviours that challenge.
- Exploit joint working with the police and community partners to support appropriate and effective use of assistive technology/telecare with patients/service users with dementia.
- Establish joint dementia programme board to facilitate implementation of the JSNA recommendations and North West London Strategy.
- The increasing numbers and needs of people with dementia and their carers are taken into account in the wider local authority and health strategies, especially, care settings and housing.

Performance Improvement

- Develop a robust performance management tool to track and monitor progress against the combined JSNA priority action plan, while mitigating risks.
- Ensure patient/service user safety and quality underpins every contact with people with a dementia diagnosis in contracts.
- Ensure provider contract schedules and performance requirements are outcome focused.
- Comply with National Institute of Health and Social Care Excellence (NICE) quality standards.
- Promote information sharing and agree minimum dataset (MDS) across the health and social care system.
- Adhere to the national outcome frameworks: Health, Adult Social Care, Public Health and Education.
- Improve triangulation of data across health and social care to produce the evidence base for future commissioning.

Governance

The Joint Health and Social Care Dementia Programme Board will report periodically into the Health and Wellbeing Boards on progress made against the 'Joint Dementia Action Plan', with the aim to give transparency on delivery. This Board will produce a dashboard to give visibility on the programme board's trajectory against deliverables.

Although the aim is to work at scale and pace, each local authority and CCG are subject to their own sovereignty and local governance arrangements for the dementia implementation plan.

Joint Health and Adult Social Care Dementia (JHASCD) Plans for delivery

	Outcomes	Key Joint Dementia Action Plans	Measure
Preventing Well	The risk of people developing dementia is minimised	• Expand the Dementia Action Alliance and dementia friendly campaigns to raise public awareness and understanding of dementia in the wider community. • Review the number of people that have vascular checks as part of NHS Health Checks that are at risk of dementia.	• The number of dementia friendly society registrations against proxy baseline
Diagnosing Well	Timely diagnosis, integrated care plan and review within first year	• Identify commissioning opportunities for hybrid working across care settings to enable staff to recognise dementia signs and symptoms in order to take the most appropriate action. • Ensure people in care homes and supported extra housing are appropriately supported through advice and guidance by the nominated dementia lead.	• The number of bid submissions • The number of care home registrations with dementia leads on the database
Supporting Well	Access to safe, high quality health and social care for people with dementia and carers	• Support and train the health and social care workforce to better support people with a dementia diagnosis in order to care for their physical, mental, and emotional needs. • Review hospital discharge data for people with a dementia diagnosis to improve care planning. • Ensure people with dementia have access to appropriate care and support through personal budgets. • Develop a delivery plan to address the supply of local care home beds in future. • Develop a delivery plan with key stakeholders and community safety partners to increase the use of technology.	• Percentage of the workforce with dementia training • Admissions rates • Percentage of people on personal budgets. • Developed plans
Living Well	People with dementia can live normally in safe and accepting communities	• Conduct audit of people with dementia living in care homes to ensure compliance with safeguarding standards. • Review sample of hospital and community survey results to improve services. • Develop and implement patient metrics, 'I Statements', in care home and housing settings. • Develop appropriate and effective respite care for carers (as and when they need it). • Ensure effective peer support and advocacy for people with dementia and carers to enable them to live well.	• Percentage of care homes compliant with safeguarding standards • Meta-analysis of surveys hospital and community survey data • Condensed set of questions
Dying Well	People with dementia die with dignity in the place of their choosing	• Undertake a review of people with a dementia diagnosis on the end of life care pathway through recording the place of death. • Review integrated advanced care plans and support people with dementia with guidance with the powers of attorney arrangements. • Raise awareness of bereavement support, advice and guidance services for people with a dementia to ensure these people are treated with dignity and respect.	• Percentage of people with a recorded place of death • Sample of interviews

For further information on the Joint Dementia 'Plan on a Page' 2016/2017, please contact Frank Hamilton at frank.hamilton@lbhf.gov.uk or Lisa Cavanagh on lisa.cavanagh@nw.london.nhs.uk

If you have any queries about this Report or wish to inspect any of the Background Papers, please contact:

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Westminster Health & Wellbeing Board

Date:	17 November 2016
Classification:	General Release
Title:	Children and Young People's Mental Health Transformation Plan Update and Next Steps
Report of:	Angela Caulder, CAMHS Tri-Borough Joint Commissioning Manager
Wards Involved:	All wards
Policy Context:	Following a critical report from the House of Common's Health Select Committee on young people's mental health, the Children and Young People's Health and Wellbeing Taskforce was established in September 2014. The Taskforce report, '*Future in Mind*' contained 49 recommendations for improvement, and there was an undertaking from the Government to increase resources for young people's mental health by £1.25 billion over five years.
Financial Summary:	Central London CCG (CL CCG) invests £1,631,347 commissioning young people's mental health services. Additionally, West London CCG provides a further £607,764 to commission mental health services for young people with a GP in the Queens Park and Paddington area. Total historic CCG funding is £2,239,111. Following the government's publication of *Future in Mind* (Feb 2015) CL CCG was allocated £91,557[1] to establish a community eating disorder service for young people and a further £229,176[2] to transform Child and Adolescent Mental Health Services (CAMHS) for 2015-16, these funds arrived with CCG's in December 2015. For 2016-17 an uplift of 24.5%, a further £78,648 has been confirmed. This uplift is for continuing the transformation of CAMHS and for the recurrent Eating

[1] Recurrent funding.
[2] Funding for five years.

Disorders money which remains at 2015-16 levels, giving a new total for 2016-17 at £399,380. [3]

Total CCG funding for 2016-17 is therefore:

Existing funding:	£2,239,111
Transformation funding:	£ 399,380
Total	**£2, 638,491**

Westminster City Council invests **£638,420** in young people's mental health services. The council is currently considering proposals to withdraw or re-direct this funding because of financial constraints.

Report Author and Contact Details: Angela Caulder, CAMHS Joint Commissioning Manager, Children's Tri-borough Joint Commissioning Team. Angela.Caulder@nw.london.nhs.uk

1. Executive Summary

1.1. An update report was provided to the Westminster Health and Wellbeing Board in March 2016 which outlined in some detail the progress since the CAMHS Task and Finish Group report (November 2014); publication of 'Future in Mind' (February 2015) and the submission of the initial Central London CCG and Westminster Young Person's Mental Health Transformation Plan (October 2015).

1.2. The submitted Transformation Plan resulted in additional funds being released to local Clinical Commissioning Groups (CCGs) in December 2015. NHS England have now asked for these plans to be 'refreshed' and revised plans, signed off by the Health and Wellbeing Board Chair must be re-submitted. Cllr Rachael Robathan has approved the plan, pending the agreement of the Westminster Health and Wellbeing Board at its meeting on 17 November. Successful submission of the 'refreshed' Transformation Plan unlocks the next tranche of additional NHS England funding.

1.3. This report summarises the achievements of the last six months and charts the next steps to be taken in Westminster to continue the momentum for improvement that has already been established.

2. Key Matters for the Board

2.1. The Health and Wellbeing Board is asked to note the achievements to date, the progress in implementing the Central London CCG and Westminster Young People's Mental Health Transformation Plan and the challenges ahead in realising

[3] The 'transformation' funding has been included in CCG baseline resourcing so has to be found within CCG 2016-17 budgets.

local ambitions to genuinely 'transform' Westminster's mental health services for children and young people.

3. Background

3.1. As was explained in the March Health and Wellbeing Board report the direction of travel to improve mental health services for Westminster young people was established by the successful CAMHS Task and Finish Group, which reported in 2014. In March 2015 the Government published the national CAMHS Taskforce report which made 49 recommendations for improvements. Furthermore, additional resources were pledged to: a. establish a dedicated specialist community eating disorder service for young people and b. funds to support service 'transformation.'

3.2. To support the 'transformation' of services NHS England required CCG's to submit a 'Transformation Plan' in collaboration with local authorities to improve mental health services for young people. Successful submission of the Westminster Transformation Plan resulted in additional funds being released to Central and West London CCG's and the funding allocations are included in the financial summary above. Additionally, the specifics of the spending commitments for 2016-17 can be found in Appendix 1 entitled 'Annex B: Central London CCG[4].'

3.3. The original Transformation Plan had eight priority areas[5] and this has now been streamlined to four:

- Community Eating Disorder Service
- Service re-design
- Crisis Care
- Learning Disabilities and Neuro-developmental Disorders

3.4 Co-production with young people, improving training and embedding Future in Mind are now incorporated into the delivery of the streamlined priorities set out above. Furthermore, The Anna Freud centre who were commissioned to update the North West London needs analysis for young people's mental health are about to complete their work so this priority has been achieved.

4. Achievements and Projects 2016-17

4.1. As explained above, the Anna Freud Centre has now completed its needs assessment work and held seminars with local stakeholders to sense check their conclusions and have initial discussion about possible recommendations. Early

[4] Central London CCG submission sent to NHS England as part of the North West London CCG's Transformation Plan.
[5] Updating the local needs assessment, Co-production with young people, Training the workforce, Community eating disorder service, CAMHS redesign and pathways review, Learning disability and neuro-developmental services, Crisis Care including the OOH Pilot Project, Embedding Future in Mind

findings suggest that improvements are particularly needed in two areas: Transitions and Learning Disabilities and cross borough seminars are now planned to address these themes.

4.2 Co-production work with young people is well underway and a Young People's Mental Health Conference was held on October 29 2016. Central and North West London Mental HealthTrust (CNWL) have been allocated funds to ensure collaboration with Young Champions supported by ReThink[6].

4.3 Public Health's Healthy Schools co-ordinators are actively engaged with commissioners in planning training for schools in Westminster to develop school based mental health strategies. Furthermore, Tri-Borough Educational Psychology, Westminster MIND and CNWL are delivering multi-agency training for Westminster professionals and school staff.

4.4 In line with national expectations CNWL have developed a community eating disorder service for young people Westminster, Kensington and Chelsea, Harrow, Brent and Hillingdon. The service commenced on the 1st April 2016 and accepts self-referrals from young people, has a one week wait for urgent cases and all referrals regardless of urgency are seen within 4 weeks . The main service hub is at Vincent Square, 1 Nightingale Place, London SW10 9NG[7].

4.5 A Westminster seminar to discuss the Anna Freud Centre findings and ideas for improvements and redesign was held for Westminster stakeholders in September 2016. Suggestions included adopted the 'Thrive Model' of intervention, enabling access to mental health services though 'multiple access points' and encouraging schools to have a designated 'mental wellbeing co-ordinator, similar to a SENCO[8]. The final Anna Freud reports will be available in November.

4.6 Improving access and waiting times into specialist CAMHS for children and young people with a learning disability and autism was a priority in 2016-17. CNWL received additional investment in to the service, £50K for CL CCG, and £30K for WL CCG.

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[6] ReThink Mental Illness is a national mental health charity which has been commissioned locally to support co-production work with Westminster young people

[7] CNWL combined CAMHS and Adult Eating Disorders Service Hub at Chelsea and Westminster Hospital.

[8] Special Educational Needs Co-ordinators (SENCO)

4.7 This has successfully increased activity levels for young people with learning disability with twice as many contacts for young people in 2016-17 than in previous years:

Learning Disabilities Patient Contacts	Central London CCG	West London CCG[9]	Total
2014/15	12	18	30
2015/16	22	16	38
2016/17 (forecast based on M1 to M6 actuals)	30	40	70

4.8 There were also positive improvements in access for children and young people with autism reflected in increased contacts in 2016-17:

Neurodevelopmental patient contacts	Central London CCG	West London CCG[10]	Total
2014/15	403	323	726
2015/16	516	341	857
2016/17 (forecast based on M1 to M6 actuals)	510	980	1490

4.9 Learning Disabilities and Autism pathways are currently under review across the Westminster, Kensington & Chelsea and Hammersmith and Fulham. The objective is to streamline assessment, reduce delays across the whole pathway for all providers including CNWL, West London Mental Health Trust[11], the local authorities, and Central London and Community Healthcare (CLCH) without compromising clinical input. The pathway review will also look at options for improving the current multi-agency model, strengthening psycho-social, post diagnostic and parenting support.

4.10 In terms of improving mental health 'out of hours' support for young people the CNWL service has been reviewed with input from young people. The evaluation demonstrated that the new service[12] has successfully met the aim of providing young people with access to a trained CAMHS professional. This improved the quality of experience for young people and has anecdotally reduced numbers of young people admitted to inpatient beds. Work continues with NHS England Specialist Commissioners to strengthen the relationship between out of hour's community support and avoiding an unnecessary admission to hospital.

[9] 22% of this figure applies proportionately to Westminster children and young people.
[10] 22% of this figure applies proportionately to Westminster children and young people.
[11] Mental Health provider in Hammersmith & Fulham, Hounslow and Ealing
[12] CAMHS trained Psychiatric Nurses working at night, weekends and bank holidays to support young people presenting and A&E in crisis

4.11 Finally, as part of embedding *Future in Mind*, a CNWL pilot project based in a local children's centre, aims to work with parents and young children (0-5 years), offering consultation, assessment and six sessions of mother and child attachment work. This early intervention pilot seeks to address attachment issues for parents which if not addressed, have been highlighted in research as possible indicators of future mental health issues for young people.

5. Future Plans 2017-20

5.1. The outcome, discussion and conclusions that can be drawn from both the Anna Freud Centre's needs analysis and service redesign work will have an important impact on the longer term transformation funding priorities for local mental health services for young people.

5.2. Looking in more detail at the four stream lined priority areas:

Community Eating Disorder Service

5.3. CNWL established a community eating disorder service for Westminster young people in January 2016 in line with national standards[13]. The service has been developed in collaboration with West London, Brent, Harrow and Hillingdon CCGs. The community eating disorder service operates with a base at Chelsea and Westminster Hospital.

5.4. The service offers five day a week support, diagnosis and treatment for young people with:

- anorexia nervosa
- bulimia nervosa
- binge eating disorder
- atypical anorexia and bulimic eating disorder

The service has been operational since February 2016 and currently supports approximately 25 young people with a West or Central London CCG GP. Approximately 62 appointment slots are provided each month with young people on average being seen three times in that period.

5.5 Eating disorder referrals have doubled from previous financial years, on track to receive 100 referrals in 2016-17 across the North West London CCG collaborative. Further investigation into why this has occurred will be undertaken; but it is likely that the wide reaching marketing exercise undertaken for the launch of the service in April 2016, increased the knowledge of GP's and multi-agency partners about the new service:

[13] One week wait for first appointments and provision for self-referrals from young people.

Eating Disorders Referrals Accepted	Central London CCG	West London CCG	Total
2014/2015	17	8	25
2015/2016	7	16	23
2016/17	18	22	40

5.6 The service will be formally evaluated in 2017 with input from young people.

Service Redesign

5.7 The service redesign aspects of the Westminster transformation plan are core to driving change and ideas based on discussions with the Anna Freud Centre and local stakeholders and young people include:

- adopting the ‘Thrive Model’ - an alternative to the current tiered system
- looking at establishing a defined number of Points of Access
- encouraging schools to have Mental Health Co-ordinators (MHCOs)
- considering options for integrating with local authority Early Help services
- strengthening learning disability support through improved multi-agency collaborations
- exploring how the voluntary sector can play a larger role
- developing a ‘tapered approach’ to transitions

5.8 Thrive Model

- Developed by AFC and Tavistock and Portman NHS Trust
- Distinguishes treatment vs. risk management as primary focus
- Focuses on individuals/communities strengths- assets approach
- Input not determined by diagnosis or severity; rather agreed by process of shared decision making whereby children young people and families agree with those seeking to help them which of 5 needs based groupings most relevant
- Noted that only 38% of children clearly in a position to receive NICE guideline focussed work (Wolpert M et al 2015: *Child and Adolescent Mental Health Services Payment System Project: Final Report.* London: http://pbrcamhs.org/final-report/)
- Need to recognise limits of treatment and be explicit about this with those accessing help
- Emphasises role of all sectors
- Moves away from care pathways to systems of help where people from range of sectors all continue to be involved

Crisis Care

5.8 CCGs across North West London have improved out of hours crisis care by increasing investment to fund waking psychiatric nursing staff who work from 4.30pm to 7.30 am (weekdays), weekends and bank holidays. These nurses see young people presenting at emergency departments with a view to providing safe alternatives to admission.

5.9 This new service has been running for almost nine months and has recently been evaluated with input from young people. The evaluation found the service to be

well received by young people but with significant down time after 2.00 am. As a result the current model is being reshaped to enable stronger links with mental health day staff and hospital based psychiatric liaison services.

5.10 CCGs are also waiting for the promised publication of an updated version of the Crisis Care Concordat which is rumoured to include additional requirements and standards for emergency support, both in and out of hours.

5.11 CCGs, CNWL, West London Mental Health Trust and the Priory Group[14] continue to work closely with NHS England as part of the 'New Models of Care Programme' to improve the support provided to young people who are admitted to psychiatric units. Current discussions foresee the commissioning of beds for young people moving from NHS England to local mental health providers with the ambition of developing community home treatment or crisis teams (supported possibly by short term beds).

Learning Disabilities, Neuro-Developmental Disorders and Autism

5.12 The multi-agency service pathways for young people with learning disabilities and autism require urgent review and this is currently underway with workshops planned to take place for mapping and exploring several different good practice clinical models of delivery.

5.13 Short term additional commissioning resource has been agreed to support the CAMHS transformation programme across Central, West London and Hammersmith & Fulham CCGs with a particular focus on learning disabilities and autism, commissioning co-production and the implications of service redesign.

National Issues

5.14 The provision of inpatient beds for young people, commissioned by NHS England, continues to cause considerable concern. Following the publication of a Tier 4[15] Review carried out by NHS England two years ago, it has been apparent that there is an insufficient bed supply. To begin to address this issue NHS England plan to commission additional beds through in 2017-18.

5.15 Furthermore, a joint proposal by CNWL[16] and WLMHT to develop a new model of care to commission London beds for young people has been approved by NHS England. The first meeting of a new NW London Implementation Board with NHS England has recently been held.

5.16 The Westminster Partnership/Alliance will be launched in early 2017. This will bring together the young people's mental health providers, commissioners, social

[14] Private hospital group which provides psychiatric beds for young people at its facilities in Roehampton and North London. These units are frequently used by young people from West London.
[15] Mental health inpatient provision for young people
[16] Central and North West London Mental Health Trust

care, early help and the voluntary sector agencies, with young people and parents, to work together on the delivery, ambitions and challenges ahead for the transformation of child and adolescent mental health in Westminster.

6 Ambitions and Challenges

6.1 A Tapered Transition Model will be developed for all young people from 14-25 years in future years. This approach would allow greater flexibility over transition for young people and their families allowing young people to choose when they transition to adult services, with some vulnerable young people remaining in children's services beyond their 18th birthday.

6.2 Local ambitions also include addressing tightening local authority and NHS budgets, rising demand and expectations, ensuring that services work together to ensure the right young people are matched with the right services and resources is crucial.

6.3 With this objective in mind CCG and LA staff will be exploring where local authority and currently CCG funded services can work together, aligning or integrating their efforts to provide support to families, GPs, primary care and schools. This will include evaluating where there are opportunities for mental health services to be delivered through school sites in combination with Early Help staff or from a young person's service hub.

6.4 The table below shows expected number of additional CYP treated by 2021 based on prevalence data:

			Expected percentage of CYP treated				
			2016/17	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Borough	**Estimated prevalence (2014)**		28%	30%	32%	34%	34%
K&C	1440		403	432	461	489.6	490
Westminster	2417		677	725	773	822	822

7 Options

Option 1

7.1 The Westminster Health and Wellbeing Board to note and support the work being undertaken in relation to transforming mental health services for young people.

Option 2

7.2 The Westminster Health and Wellbeing Board does not support the young people's mental health service Transformation work as summarised above.

7.3 It is recommended that the Westminster Health and Wellbeing Board supports Option1.

8 Legal Implications

8.2 There are no legal implications for Westminster City Council in this report.

9 Financial Implications

9.1 The transformation funding for 2017-18 will be released to CCGs subject to NHS England assurance processes following sign off from the Westminster Health and Wellbeing Board Chair. CCGs have been informed that the transformation funding committed for five years has been added to baseline allocations from 2016-17.

9.2 Westminster City Council funding for young people's mental health services is being reviewed as part of Westminster austerity and efficiency plans. Proposals are being considered to curtail of redirect the current invest from 1 April 2017.

9.3 The Health and Wellbeing Board is asked to note the current expenditure available from the CL CCG and WCC, which may be subject to change, depending on as yet to be defined, future service delivery possibilities.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

Rachael Wright Turner - Director of Tri-Borough Commissioning, Jules Martin-Managing Director Central London CCG

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APPENDICES:

Appendix 1 - Annex B: Central London CCG Local information and implementation plans for Central London CCG and Westminster City Council. October 2016.

Appendix 2 – Central London CCG Transformation Plan Refresh Overview

BACKGROUND PAPERS:

North West London Transformation Plan Refresh (Main Business Case) Document

NHS
Central London
Clinical Commissioning Group

WCC HWBB - APPENDIX 1

ANNEX B: CENTRAL LONDON CCG

Local information and implementation plans for Central London CCG and Westminster City Council

1. Background

In March 2015 the government published *Future in Mind*, their strategy for promoting, protecting and improving our children and young people's mental health. Additional funding was allocated with the guidance to invest in children and young people's mental health services. In order to access this funding, CCGs were tasked with developing local transformation plans which set out a vision for transformation over five years, in collaboration with partner agencies. The original plans were finalised in October 2015 and outlined a sustainable, phased approach to implementation. Across North West London the eight CCG's collaborated, with support from the Like Minded team, to deliver a single plan that defined our joint priorities.

This formal refresh aims to provide assurance, demonstrate how progress is being made, provide evidence on how services are being transformed and ensure funding is being spent as plans develop further.

Our ambition for this transformation plan is that by the end of 2020 the children and young people of Central London CCG will see a transformed service that better suits their needs, and they will be able to access services at the right time, right place with the right offer in a welcoming environment. We want our new model to be sustainable beyond 2020 – to ensure that future children and our future workforce continue to receive and provide the best quality care we know makes a significant difference.

In the original LTP 8 priority areas were specified:-

- Priority 1: Needs Assessment
- Priority 2: Supporting Co-production
- Priority 3: Workforce Development and Training
- Priority 4: Community Eating Disorders Service
- Priority 5: Transforming Pathways and Pathway Redesign Pathways
- Priority 6: Enhanced Support for Learning Disabilities and Neurodevelopmental Disorders
- Priority 7: Crisis and Urgent Care Pathways
- Priority 8: Embedding Future in Mind Locally

From these priorities, local transformation plans in 2015-16 successfully delivered:-

- Co-production work with young people,
- Reduction of waiting times for Specialist CAMHS
- A new Out of Hours Crisis service for young people
- A new children and young people's community eating disorder service.
- Role enhancement of schools in emotional well-being services
- Mental health training to schools and partner agencies

In April 2016, to address Priority 1, the Anna Freud Centre (AFC) was commissioned to undertake a needs assessment across North West London. The aim of the exercise was to:-

- Undertake an in-depth analysis of the mental health needs of children and young people across Central London.
- Evaluate the range of services and supports that are available, including the skills and knowledge of staff working with children and young people.
- Identify the needs of Central London in relation to the provision of services offered.

Following an interim report, a strategic seminar took place for Westminster partners in September 2016. The seminar aimed to facilitate identification of local priorities and promote an integrated approach to service delivery. The findings are scheduled to be delivered in a final report by the beginning of November 2016 to CL CCG CAMHS commissioners. As the needs assessment is almost complete, this is no longer a priority for future years.

Continuing areas of work to progress into future years are:

- To drive forward delivery of the **CYP IAPT** programme. CNWL are already increasing the numbers of staff trained in CYP IAPT evidence based treatments;
- To invest in developing more robust **data capture and clinical systems** to enable commissioners and providers to have a joint clearer understanding of current activity and projections;

As the plans in 2016-17 progressed to address the remaining priorities, it became clear three priorities: co-production, workforce development and embedding *Future in Mind* underpinned the transformation programme as a whole. It was therefore decided at a LTP review meeting in early September to reduce the priority areas from 8 to 4, focussing on the following agreed areas:

- **Priority 1: Community Eating Disorders Service**
- **Priority 2: Transforming Pathways and Redesigning services**
- **Priority 3: Learning Disabilities and Neurodevelopmental Disorders**
- **Priority 4: Crisis and Urgent Care Pathways**

The financial allocation for North West London, and Central London CCG specifically for 16/17 is as follows:

	Eating Disorders 16/17	Transformation Plan 16/17	Recurrent uplift
Brent	£173,000	£420,000	£593,000
Central London	£91,557	£307,823	£399,380
Ealing	£211,543	£630,997	£842,540
Hammersmith and Fulham	£100,744	£328,186	£428,930
Harrow	£121,785	£304,840	£426,625
Hillingdon	£149,760	£374,863	£524,623
Hounslow	£152,983	£382,931	£535,913
West London	£116,621	£369,509	£486,130
Total	**£1,117,993**	**£3,119,149**	**£4,237,141**

The Central London CCG covers the majority of Westminster, GPs in the Queens Park & Paddington area are part of West London CCG. This is acknowledged by a 22% adjustment to budgets so that Westminster young people will benefit from approximately 22% of the Transformation funding allocated to neighbouring West London CCG.

2. Our local offer

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Westminster young people requiring mental health services are supported by Central and North West London Mental Health Trust (CNWL) who deliver both a school focused early intervention community service and specialist CAMHS for diagnosis and treatment of mental health disorders. The CNWL team of approximately 30 staff includes psychiatrists, psychiatric nurses, family therapists, psychotherapists and psychologists. The team actively supports approximately 600 Westminster young people but can often see many more in the course of a year. The CCG also fund a mental health post in the Integrated Gangs Unit which in 2016-17 and beyond will be funded through CAMHS Transformation funds

Westminster City Council fund several mental health clinicians to co-ordinate mental health support for looked after young people[1] and their carers locally, and with placements further afield. The council also supports mental health work with vulnerable young people, for example, with learning disabilities and youth offending needs. Westminster children and young people in schools and children's centres also receive direct support. These current council investments are not guaranteed beyond 31st March 2017. There is a proposal from the local authority that these financial contributions to CAMHS will be reduced.

The local authority also contributes funding to young people's mental health in the borough, by directly employing Systemic Family Psychotherapists. These clinicians are embedded in the social care delivery, to support social workers involved with those children and young people and families who have active social work involvement in their lives.

In-patient psychiatric beds for young people are commissioned by NHS England's Specialist Commissioning and NHS E data indicates that 30 Westminster young people were admitted in 2014-15. As part of NHS E New Models of Programme WLMHT and CNWL are working in partnership with the Priory Group to enable CYP who require access to bedded services can be admitted locally. The programme will also look to develop community services to ensure CYP have access to home treatment programmes.

2016/17 Investment in Children and Young People's Mental Health			
	Clinical Commissioning Group	**NHSE (Tier 4 CAMHS)**	**Local Authority**
Westminster	£1,631,347	£*	£638,420
Total	**£***		

*As NHS England has not yet provided the 2016/17 Tier 4 investment, we are unable to provide the spend. Plans will be updated upon the receipt of the information.

[1] 179 Westminster looked after children (31 March 2015) and 160 care leavers.

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3. Children and young people's mental health transformation plan

The table below outlines the shared components of our plans, as well as local detail specific to Central London CCG and Westminster.

Priority	Priority Description	Implementation Plans	2016-17 Investment
1	Community Eating Disorder Service	**North West London Common Approach:** A new, separate eating disorders service has been developed that has care pathway provision and seamless referral routes to ensure quick, easy access to the service. This service is already delivering the new national specification for eating disorder services, offering a 5 day service for young people aged 0-18th birthday who have a suspected or confirmed eating disorder diagnosis. It accepts referrals from any professional in the local area, and also self-referrals from young people and families. The aim of the service is to see all young people referred within 4 weeks of referral, with a wait of no more than one week for urgent cases. Our intention is to market test this service in 2017/18 and to investigate offering a 7 day service.	**Investment: £91,557** A new community eating disorders service was launched on 1 April 2016. Westminster young people are seen at the CNWL 'hub' at Vincent Square, Chelsea and Westminster Hospital. With minor amendments, the pilot is due to be adopted as business as usual from 1 April 2017 within a two year contract with the Trust.
2	Redesigning Pathways – A Tier free system	**2016-2020 CAMHS Re-design:** We will move away from tiered services to services that meet the needs of the child/young person and the family. Broadly, our new proposed model will be based on the Thrive Model which has been recommended to us by the Anna Freud Centre in the Central London CCG Interim Report.[2]	**2016-17 Investment: £207,000** This includes: *£6K* MIND 'Mental Health First Aid' Programme - trains staff across voluntary sector, education and in the community to deliver early intervention to YP at risk and crisis. *£12K*

[2] Wolpert, M., Harris, R., Hodges, S., Fuggle, P., James, R., Wiener, A., . . . Fonagy, P. (2015). THRIVE Elaborated. London: CAMHS Press http://www.annafreud.org/media/3214/thrive-elaborated-2nd-edition29042016.pdf

	Transforming Pathways – A Tier free system	Getting Advice Getting Help THRIVING Getting Risk Support Getting More Help Signposting, Self-management and one off contact Goals focused evidence informed and outcomes focused intervention Prevention & promotion Risk management and crisis response Extensive treatment This includes: • **A Multiple Access Point model (MAP)** to connect schools, GP's, the local authority and the voluntary sector with a mental health lead for the area.	MIND 'Learn Well' is a 6 module psycho- educational programme in schools which builds resilience, promotes positive practices and adaptive coping skills to reduce stress and increase confidence in YP. *£50K* CNWL's early intervention/prevention programme for parents and infants (0-5) for improving attachment based in a local children's centre. *£5K* Training programme delivered by Educational Psychology for 30 support assistants in schools to become 'Emotional Literacy Support Workers' to improve learning. *£17K* 'Healthy Schools' Public Health programme which supports schools and nurseries to make improvements to health and wellbeing through the development of a mental health strategy and action plan. *£30K* Rethink Recruitment and supervision to support 15 young champions to deliver a young people's conference and service review. Also work with CNWL to deliver 'Collective Voices' training to schools.

	Transforming Pathways – A Tier free system	• **Evidence based treatments** delivered by all CAMHS services. • **School based Mental Health Lead** to develop emotional wellbeing and resilience and to identify and support young people with mental health needs • **Multi-agency risk management approach** to deliver a joined up delivery for agencies working with high risk, hard to engage young people who need further work before they can engage with mental health treatment. • **A Tapered Transition Model** will be developed for all young people from 14 -25 years in future years. This approach would allow greater flexibility over transition for young people and their families. • **A new CYP IAPT programme** to train up lower grade staff at London Universities has been launched. Westminster Specialist CAMHS is interested in being a part of this new initiative which is funded for its first year in 2017, but will need funding from commissioners for future years. • Central London CCG will draw on the work being developed by NHSE and H&F CCG on the **CAMHS School Link Pilot** to inform their transformed CAMHS model. • By 1 April 2017 a **sustainable CAMHS training programme** will be bookable on-line for any professional across the boroughs of Westminster, Hammersmith and Fulham and Kensington and Chelsea. There will also be a parents' programme. • The successful **Co-production training programme, 'Collective Voices'** with Rethink young mental health champions delivering the training jointly with mental health colleagues from CNWL will be rolled out to Westminster schools. • **The Westminster CAMHS Alliance network** will be launched in 2017. This will aim to spread responsibility and knowledge of young people's mental health across agencies, improve collaborative working and plan local quality improvements and transformation with champions and young people.	*£10K* MIND 6- 12 month 'mentoring' programme to improve YP confidence and motivation in colleges and sixth forms. *£10K* Educational Psychology and CNWL led multi agency training in CAMHS available for all tri-borough professionals. *£25K* 'Schools/CAMHS pilot'. Mental Health named Leads in schools linking with CNWL clinicians who offer each school 2 hours input each week. *£10K* MIND educational support offered to YP aged 14 to 25 yrs who are transitioning in their lives. Email, telephone and 1:1 sessions can be accessed via self-referral.

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3	Enhanced support for Learning Disabilities and Neuro Development Disorders	**North West London Common Approach:** Work is underway across NW London to align to the adult learning disability programme workstream to ensure smooth transition and consistency of care. **Central London CCG/Westminster City Council Local Approach:** CL CCG will invest in additional capacity across the whole system for LD and ND pathways. This will be in collaboration with CNWL, the Local Authority Children with Disability and Learning Disability teams; child development service and voluntary sector providers. ▪ **Map local care pathways** and reconfigure services ▪ Develop an **effective strategic link** between CAMHS Learning Disabilities/Neurodevelopmental (LD/ND) services and special educational needs (SEN) departments, ▪ **Enhance the capacity of CAMHS** to meet the increasing demand for ASD and ADHD assessments. ▪ **Provide advice and support to special schools and specialist units** ▪ Connect with **local voluntary sector services** and support groups for young people with LD/ND and their families (e.g. parent-run ASD support group).	**Investment: £80,360** This includes: *£30,000* CCG staffing – project manager to review LD and ND pathways across 3 CCG's with partner agencies. To produce options paper leading to recommendations for commissioners for redesign of pathways and models for LD, ASD and ADHD.. *£30,000* CNWL project to reduce waits, improve skills of broader staff to be able to take on LD/ND work, and smooth out pathways between agencies.
4	Crisis and Urgent Care Pathways	**North West London Common Approach:** We aim to ensure that our local offer of support and intervention for young people reflects the Mental Health Crisis Care Concordat. We will also implement clear, evidence-based pathways for community-based care, including where resources allow, home treatment teams and crisis response services to ensure that unnecessary admissions to inpatient care are avoided. As part of NHSE New Models of Programme WLMHT and CNWL are working in partnership with the Priory Group to ensure CYP who require	**Investment: £20,000**

		access to bedded services can be admitted locally. The programme will also look to develop community services to ensure CYP have access intensive treatment programmes which deliver high quality effective care at home. **Central London CCG/Westminster Local Approach:** The implementation of an out of hours crisis pilot was initiated in January 2016 by CNWL across Westminster, Kensington and Chelsea, Hillingdon, Harrow and Brent. This was not funded by transformation monies but by each of the eight CCG's separately. For future years a new service will comprise crisis response and home treatment services and will build on existing work to develop a complete urgent care pathway. We will also work with colleagues in locality authority, public health, and schools to ensure that the prevention of self-harm and crisis avoidance via good mental health promotion forms part of this pathway. Where possible, we will look to work with existing home treatment teams to incorporate CAMHS skills and training into existing services.	In 2016-17 CNWL will be offered *£20,000* to accommodate in-hours crisis work as a pilot to prevent this work impacting on routine waits for assessment and treatment. If successful, this can be incorporated into the wider crisis pathway re-design for future years.

City of Westminster | NHS Central London Clinical Commissioning Group

APPENDIX 2

CENTRAL LONDON CCG Transformation Plan Refresh Overview

NWL and Local information and implementation plans for Central London CCG and Westminster City Council

Overview

In March 2015 the government published *Future in Mind*, their strategy for promoting, protecting and improving our children and young people's mental health. CCGS developed NWL and local transformation plans in October 2015 which set out a vision for transformation over five years, in collaboration with partner agencies. The plans were further refreshed, in October 16, as per the Five Year Forward View guidance.

Comparison of 2015 and 2016 Transformation Plan

The Transformation Plan consists of a) the central business case Transformation Plan and b) the individual CCG annexes which contain more local and detailed information. The main difference between the October 2015 Transformation plan and the October 2016 plan refresh are below:

- NWL CCGs decided, as part of the refresh process, to reduce the number of priorities from 8 to 4. The remaining four former priorities are now referred to as 'enablers.'
- The Transformation plan and annexe refresh further demonstrates a) progress since the last plan submission in October 2015 c) Further plans from 2017 - 2020
- An overview of how Westminster and the other 7 CCGS have worked with a) Like Minded, who provide a project management coordination function for transformation across NWL and b) the Anna Freud Centre who have undertaken a Needs Analysis and strategic seminars to provide recommendations for the transformation of CAMHS (due November '16).

Funding

The below table details the proposed investment into CAMHS for 2016/17

2016/17 Investment in Children and Young People's Mental Health			
	Clinical Commissioning Group	**NHSE (Tier 4 CAMHS)**	**Local Authority**
Westminster	£1,631,347	£389,130 (Central London CCG)	£638,420
Total	**£2,658,897**		

Priority 1 – Eating Disorder Service

<u>Transformation Plan October 2015:</u>

This plan sets out the ambition for dedicated community Eating Disorder services. Historically, across the 8 CCGS individuals with Eating disorders were seen in core CAMHS services/ within small hubs.

<u>Transformation Plan October 2016:</u>

New Community Eating Disorder service launched in April 2016; provides care pathway provision and seamless referral routes to ensure quick, easy access to the service. Aim that CYP waiting time

guideline standards are met. With minor amendments the pilot is due to be adapted as business as usual from 1st April 2017. Investment for 2016/17: £91, 557

Priority 2- Re-designing Pathways – A Tier Free System

Transformation Plan October 2015:

This plan set out local and NWL ambitions for re-designing and re-aligning pathways. The document outlines plans to ensure clear navigation of the pathway, reducing duplication and gaps in services, collaborative working with partners, flexible engagement with CYP, strong links with schools and further engagement with the voluntary sector.

Transformation Plan October 2016:

Provides an overview of milestones achieved. The Westminster annexe further outline progress within Central London CCG inclusive of: **MIND Mental Health First Aid** programme for staff across voluntary sector, education and in community; **Mind Learn Well programme** for schools, **CNWL's Early Intervention programme** for parents and infants (0-5); **Training Programme** delivered by Education Psychology for Support Assistants; **Healthy Schools Public Health programme** that supports schools an nurseries to make mental health and wellbeing improvements; MIND 6-12 month mentoring programme, **Ed. Psychology and CNWL Multi-agency training** in CAMHS for professionals; **Schools/CAMHS pilot** with CNWL clinicians offering input to schools; Mind Educational support for 14-25yr olds who are transitioning in lives.

CL (Westminster) CCG further plan to move away from the tiered CAMHS services approach. CCGS have worked with the Anna Freud centres who have proposed the Thrive Model as approach to move away from dividing service provision into tiers. Total Investment for 2016/17: £207, 000

Priority 3 – Enhanced Support for Learning Disabilities and Neuro Development Disorders

Transformation Plan 2015:

The proposed ambition was to align (or re-design where required) the CAMHS LD/ND pathway and to further integrate with the adult learning disability programme workstream to ensure smooth transition and consistency of care. Commencement of the proposal would need to be undertaken in collaboration with CNWL, the Local Authority Children with Disability and Learning Disability teams; child development service and voluntary sector providers.

Transformation Plan 2016:

Reports the following updates: CL CCG invested in additional capacity across the whole system for LD and ND pathways to reduce waits, improve skills of broader staff and smooth pathways between agencies. A project manager has also been appointed to review LD and ND pathways across the 3 CCGs with partner agencies. Options paper will be produced to provide recommendations to commissioners for re-design of pathway models for LD, ASD and ADHD. Investment for 2016/17: £80,360.

Priority 4 – Crisis and Urgent Care Pathways

Transformation Plan 2015:

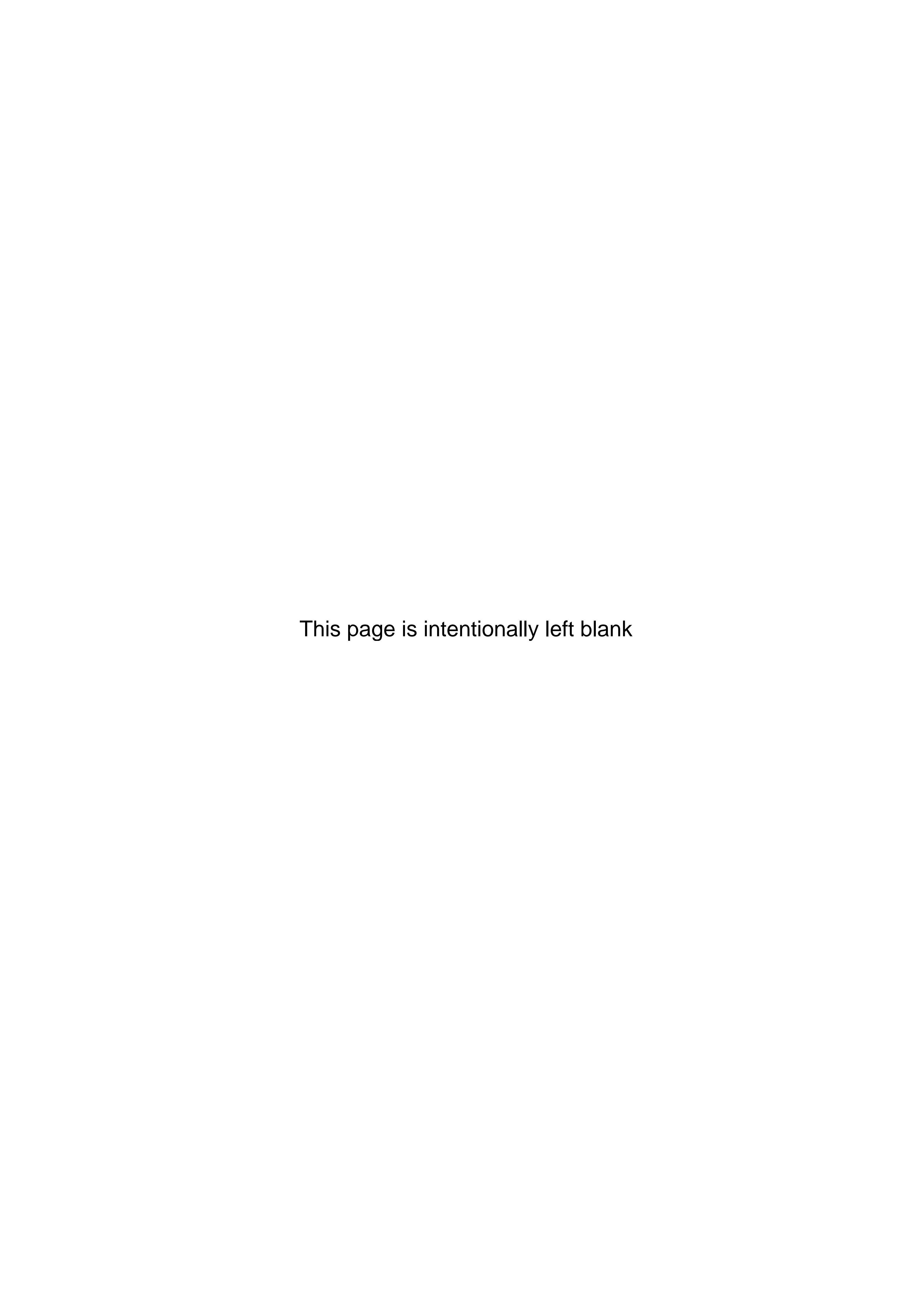
An aim was outlined to ensure that local offer of support reflects the Mental Health Crisis Concordat. There was a proposal for the implementation of clear evidence based pathways for community based care, including where resources allow, Home Treatment Teams and crisis response to ensure that unnecessary admissions to inpatient care are avoided.

Transformation Plan 2016:

Reports the following updates: In January 2016 – An Out of Hours Pilot Service was initiated across Westminster, RBKC, Hillingdon, Harrow and Brent (not utilising Transformation funds). In 2016/17 Westminster CCG plans to further invest £20,000 (using Transformation funds) to accommodate dedicated in-hours crisis service provision. Furthermore WLMHT and CNWL are working in partnership with the Priory group to ensure that CYP who require access to bedded services can be admitted locally. The programme will also look to develop community services around crisis response. This New Model of Care programme is funded directly via NHS E. Investment for 2016/17: £20,000

Our Enablers

1. **Needs Assessment:** Needs Assessment undertaken by Anna Freud Centre in collaboration with UCL Partners. Paper will be available in Nov' 2016 and will aid to inform the re-design of pathways.
2. **Co-Production:** Rethink Recruitment and supervision to support 15 young champions to deliver a young people's conference and service review. Also work with CNWL to deliver 'Collective Voices' training to schools.
3. **Workforce Development:** Aim for 34% of CYP MH need (access to services and treatment) by 2020; this will include bringing down waiting times. CYP IAPT framework shall also need to be embedded by training a select number of staff and supervisors. The latter are part of national government initiatives and further funding will be provided, via NHS E, in October 2016 to bring down waits. CL CCG are working with CNWL towards these goals.
4. **Embedding Future in Mind:** Like Minded provide a strategy and transformation coordination function to aid CCGs across NWL to align pathways (whilst considering local needs and service variations). The Anna Freud Centre was also commissioned to undertake Needs Assessment, Workforce analysis, focus groups and subsequently provide recommendations for the transformation of CAMHS across NWL and local CCGs.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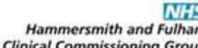


NHS Hillingdon Clinical Commissioning Group

NHS Hounslow Clinical Commissioning Group

NHS West London Clinical Commissioning Group

North West London Clinical Commissioning Groups

Children and Young People's Mental Health and Wellbeing Strategy and Transformation Plan

In response to *Future in Mind*

October 2015
Revised January 2016 following NHS England feedback
Refreshed October 2016

Supported by Like Minded – The Mental Health and Wellbeing Strategy for North West London

Declarations of Support

Brent

Name: Position/Organisation: Date:	Name: Position/Organisation: Date:

Central London

Name: Elizabeth Campbell Position/Organisation: Deputy Chair Health and Well-being Board Date: 20.10.16	Name: Position/Organisation: Date:
Name: Position/Organisation: Date:	

Ealing

Name: DR MOHINI PARMAR Position/Organisation: CHAIR, NHS EALING CCG Date: 28.10.2016	Name: Cllr Julian Bell Position/Organisation: Leader, London Borough of Ealing; Chair, Ealing Health & Well-being Board Date: 25/10/2016

Hammersmith and Fulham

Name: Cllr Lukey Position/Organisation: Chair Health and Well-being Board. Date: 27.10.16	Name: Position/Organisation: Date:
Name: Position/Organisation: Date:	Name: Position/Organisation: Date:

Harrow

Name: Position/Organisation: Date:	Name: Position/Organisation: Date:

Hillingdon

Name: Position/Organisation: Date:	Name: Position/Organisation: Date:
Name: Position/Organisation: Date:	

Hounslow

Name: Susan Jeffers Position/Organisation: Managing Director Hounslow CCG Date: 25th October 2016	Name: Position/Organisation: Date:

West London

Name: Mary Weale Position/Organisation: Date: 28.10.16	Name: Position/Organisation: Chairman Health and Well-being Board Date:

Preface

Following guidance from NHS England, all local areas are to refresh their Children and Young People's Mental Health and Wellbeing Transformation Plans to demonstrate work done to date, the impact of this work, and the revised trajectories that are expected from on-going transformation. All plans are to be refreshed and published by 31st October 2016, and incorporated into each area's Sustainability and Transformation Plans. The eight North West London (NWL) Clinical Commissioning Groups (CCGs) and Local Authorities have worked together to produce this refreshed Transformation Plan to reflect updates to work completed in 2015/16 and in 2016/17 and planned refinements to ensure alignment to the Five Year Forward View for Mental Health.

To reflect the work done on transformation of children and young people's mental health services, refreshed Transformation Plan now includes the following:

- An aspiration to increase access to services with at least 35% of those with diagnosable mental health conditions accessing NHS community based treatment by 2020/21;
- Plans for the training and expansion of workforce to meet the increase in access for mental health services;
- Allocation of the new funding for children and young people's services to support delivery of the Local Transformation Plans and wider improvements to services;
- Baseline data to further map 'how' 95% of children and young people with eating disorders will receive treatment within 1 to 4 weeks;
- A plan on how by 2020/21 there will be a reduction in inpatient stays (only where clinically appropriate). The plan will include 24/7 crisis resolution and liaison mental health services;
- Insight into how CYP IAPT staff training targets will be reached;
- A commitment to work towards implementing evidence based treatments pathways.

It should be noted that we are still awaiting NHS England confirmation of new uplift amounts. These will be confirmed in November 2016 and the Transformation plans will be further updated where required.

1.0 Supporting improved mental health and wellbeing for children and young people in North West London

The eight Clinical Commissioning Groups (CCGs) in North West London (NWL) are committed to improving mental health and wellbeing for their local communities. In February 2015 the CCGs launched '*Like Minded*' – the NWL strategy for mental health and wellbeing. The publication of the Government's mental health strategy for children and young people, '*Future in Mind',* was timely and the CCGs have framed their work on children and young people to focus on ways of implementing '*Future in Mind'* across our eight boroughs.

To support both the local and national strategy we are submitting a single plan which defines where we have joint priorities, and where we will undertake specific projects to respond to local needs and current service configuration. Through working together we can learn from good practice, ensure best value and develop flexible services for our populations.

The priorities outlined in this document are the key steps to transforming current services. In combining our joint vision, resources, expertise and working with our stakeholders we can develop collaborative solutions and services together.

We have agreed shared priorities – but also principles for how we work: addressing inequalities and responding to specific needs across our diverse populations, co-producing, working jointly where possible and focusing on clear outcomes.

Collaboration is at the core of how we work – but we recognise that each borough has specific local needs, set up and infrastructure. For clarity we are not proposing that there is any cross-subsidisation across NWL. The funding outlined in this Plan is ear-marked for each CCG, and will be invested in the children and young people in local area of that CCG.

We have joined together as a collaboration of eight CCGs in NWL as we see a number of clear benefits from working together on our mental health priorities. These include:

- An over-arching perspective of the picture across NWL: instead of reviewing the health needs and services available for young people in one borough, we can get a clear picture of the situation across our wider geographical area. This gives us a richer understanding of the demands on our services, the challenges we face, and the different areas in which we can benefit from working closely with our neighbouring boroughs with similar needs.
- Economies of scale: allowing us to pool our resources and jointly invest in project management, commissioning of needs assessments, and buying of services such as communication campaigns.
- Sharing of learning: we can draw on the experience of other CCGs, learning from Harrow and Hillingdon's recent needs assessments, and from the Child and Adolescent Mental Health Services (CAMHS) school link pilot in Hammersmith and Fulham.

- Reduction of duplication: instead of each borough developing draft specifications for new CAMHS services, we can work as one to develop services that reflect the needs of all our children and young people which reduces duplication and ensure consistency of approach across boroughs. This is particularly beneficial for our transient young population.
- Equity in provision across NWL: by working together to ensure our CAMHS services, crisis response, and eating disorder (ED) services are all working to the same specifications, we can ensure that young people in NWL receive good quality mental health care and support, irrespective of which borough they live in.
- Collaborative working with our two mental health trusts: working together to develop ED services that cover several boroughs not only makes sense in terms of footprint coverage, but also frees up time and resource for our trusts to deliver services rather than negotiate contracts and performance management with eight different CCGs.
- Links to the '*Like Minded'* mental health strategy for NWL: working in collaboration with the Like Minded Strategy and Transformation Team, we can ensure that any of the developments we are planning for children and young people are both informed by, and also inform the development of the NWL strategy.

Alongside our collaborative approach, we continue to keep a local focus to ensure the specific needs of each borough are reflected in our overall plans. The four priorities of our Transformation Plan are shared across our CCGs; the individualised approaches to delivering these priorities are summarised in each section of this report and in further detail in each CCG's local annex. For more detail on each CCGs local plans, please refer to:

- Annex A: Brent CCG
- Annex B: Central London CCG
- Annex C: Ealing CCG
- Annex D: Hammersmith and Fulham CCG
- Annex E: Harrow CCG
- Annex F: Hillingdon CCG
- Annex G: Hounslow CCG
- Annex H: West London CCG

Following the recent report from the Children and Young People's Mental Health Taskforce, '*Future in Mind'*, the Government announced increased funding for children's mental health services to the total of £1.25 billion over five years.

2.0 <u>Our ambition and vision for the future</u>

We want to be bold about the need for change for our children and young people. We recognise the unique opportunity to design a new system which, in five years, looks substantially different from our current services – and addresses the needs and issues our young people tell us currently exist. We want to resist being constrained by traditional boundaries – of tiers, organisations, funding mechanisms and criteria – and develop clear, co-ordinated, whole system pathways that improve co-ordination between agencies and stop young people falling through the gaps.

We are working in partnership across NWL to capitalise on shared learning, improve co-ordination, and benefit from economies of scale. Jointly we believe that our plans will mean that by the end of 2020 the children and young people of NWL will see a transformed service that better suits their needs, and they will be able to access services at the right time, right place with the right offer in a welcoming environment. We want our new model to be sustainable beyond 2020 – to ensure that future children and our future workforce continue to receive and provide the best quality care we know makes a significant difference.

The core principle of our single Transformation Plan has been to work together on a joined up approach, whilst always ensuring we recognise and build on specific local needs and differences in current service provision across health, education and social care. In taking a new and ambitious approach we have been asking some challenging questions:

- About the age of young people within our services – can we extend services to young people up to 25 years of age?
- About the provision of inpatient beds currently funded via NHS England – can we ensure that our inpatient beds are used only by our local young people?
- About the potential for smoother pathways through joined up commissioning and management – can we work together to remove the barrier between organisations and funding streams?
- About the extent to which Local Authorities (LAs) continue to fund the range of services to which they have historically committed – can we ensure that our CCGs and LAs work together on these plans to develop new, innovative approaches rather than plugging funding gaps created by budget cuts?
- Do we have the right data systems in place to capture the data that we require for contractual and quality monitoring purposes?

We have asked ourselves these questions and developed our plans to reflect our shared commitment to a co-ordinated, whole system pathway for children and young people's mental health.

Our priority areas reflect both some short-term immediate areas of impact – and a commitment to an ambitious programme of transformational change. We provided detailed plans for our work in 2015/16 and into 2016/17. We have further reviewed our plans for 2017/2018. This work will continue to inform our future models and our proposed funding and associated resource will be further refined for future years as we continue to co-produce new ways of working across the system.

We will firstly get the basis right – embedding co-production, refreshing our needs assessments and undertaking workforce needs analysis. We will then reduce the waiting times for specialist CAMHS, ensure a crisis and intensive support service is in place in each borough, develop a comprehensive learning disability (LD) service for children with challenging behaviour and autism, and improve access to community ED services.

We will maximise the role of schools and further education establishments in emotional well-being and commissioning services such as counselling, to support

them in their role as the first line response to many children and young people in need.

In combination we will take large strides to deliver a fundamental change – as described in *Future in Mind* – and reiterated in the voices of our children and young people in NWL.

3.0 Understanding local needs; Our Starting Point

Knowing and understanding the local needs of our boroughs was pertinent to understanding the changes and transformations required across North West London. Our initial needs assessment provides the backdrop to understand what is working and where the gaps were within our boroughs. We have commissioned Anna Freud Centre to undertake needs assessment for each of our CCG area and we have used the initial findings to inform our priorities going forward. The final analysis will be completed in January and we will review our local plans to ensure alignment with needs.

In NWL, ensuring good mental health and wellbeing for our children and young people is a priority. We know there is a need to reach out to more young people and to improve the services children and young people receive when they have mental health needs. A snapshot of mental health needs across the UK shows us that:

- 1 in 10 children and young people aged 5 - 16 suffer from a diagnosable mental health disorder - that is around three children in every class[1];
- 75% of mental health problems in adulthood (excluding dementia) start before 18 years[2];
- Between 1 in 12 and 1 in 15 children and young people deliberately self-harm[3];
- More than half of all adults with mental health problems were diagnosed in childhood. Less than half were treated appropriately at the time[4].

Our children and young people population can be seen in the below table. For six of our eight boroughs, the boundaries are coterminous. West London CCG covers the borough of Kensington and Chelsea, and the Queens Park and Paddington areas of Westminster. Central London CCG covers the remainder of Westminster.

Key population details

[1] Green, H., McGinnity, A., Meltzer, H., et al. (2005). *Mental health of children and young people in Great Britain 2004*. London: Palgrave.
[2] Future in Mind (2015)
[3] Mental Health Foundation (2006). *Truth hurts: report of the National Inquiry into self-harm among young people.* London: Mental Health Foundation.
[4] Kim-Cohen, J., Caspi, A., Moffitt, TE., et al (2003): *Prior juvenile diagnoses in adults with mental disorder*. Archives of general psychiatry, Vol 60, pp.709-717.

	CLCCG	WLCCG	H&F	Ealing	Hounslow	Hillingdon	Brent	Harrow	TOTAL NWL
Number of children [5]	27,480	40,175	33,705	80,520	61,945	69,860	73,325	57,200	444,210
	W'minster	**K&C**	**H&F**	**Ealing**	**Hounslow**	**Hillingdon**	**Brent**	**Harrow**	**TOTAL NWL**
Number of children[6]	35,288	27,322	33,328	80,520	61,945	69,860	73,325	57,200	438,788
Number of school children[7]	22,460	25,935	20,071	57,682	43,273	53,993	50,142	38,316	311,872
Rate of LAC[8]	46	36	60	49	53	55	48	30	48

We have invested our Transformation Plan funds into six out of our eight boroughs, to gain up to date information on the mental health and emotional well-being of our children and young people. In 2015/16 based our initial proposals and priority areas for 2015/16 and 2016/17 based on our understanding of local needs from consulting with our children, young people, parents, and professionals, and drawing on prevalence data. We now have interim reports that provide us with up-to date data on the local needs of our children and young people.

Estimates for NWL suggest that around 25,000 5-16 year olds will have a mental health disorder[9]. The most common mental health issues in boys are conduct and hyperkinetic disorders, whereas emotional disorders are more common amongst girls. We are committed to ensure that by 2020 35% of children with a diagnosable mental health disorder receive treatment.

Estimated Numbers of Mental Health Disorders (Public Health England, 2014)									
	Brent	**Ealing**	**H&F**	**Harrow**	**Hillingdon**	**Hounslow**	**K&C**	**West-minster**	**TOTAL NWL**
Any mental health disorder	4572	4692	1828	3171	4051	3468	1440	2417	**25639**
Emotional Disorders	1763	1819	723	1232	1560	1327	569	964	**9957**
Conduct Disorders	2842	2877	1104	1909	2466	2123	852	1482	**15655**
Hyperkinetic Disorders	781	798	307	533	688	593	239	408	**4347**

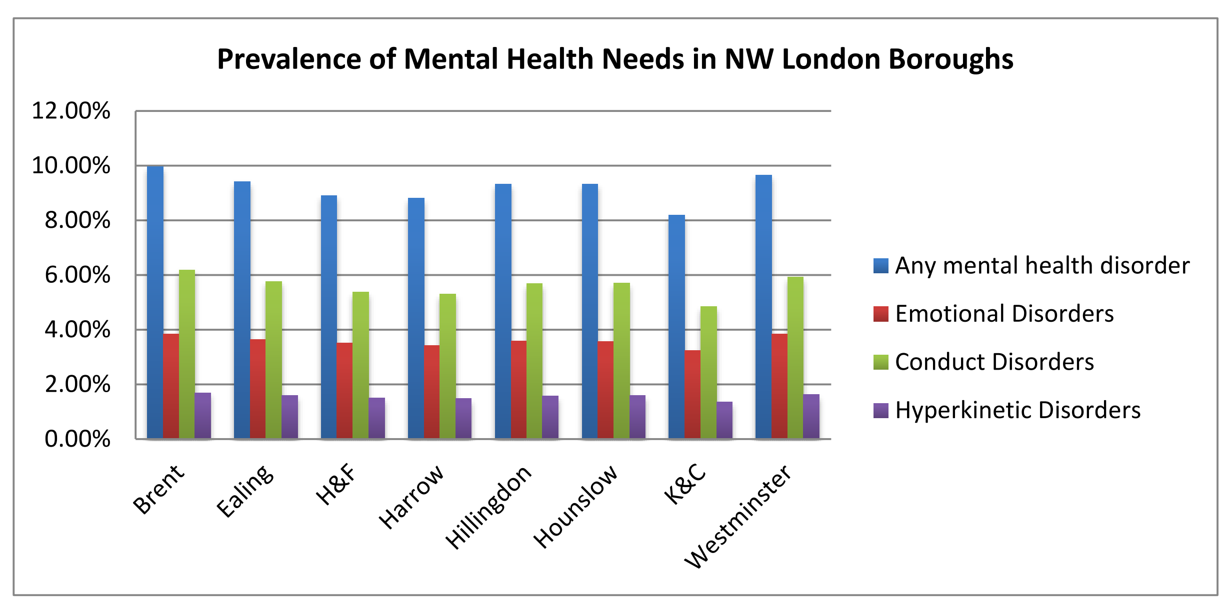
[5] ONS 2012 based population projection for 2015, children aged 0-17

[6] For Westminster, K&C and H&F: ONS mid-year projections: Table SAPE15DT8: Mid-2013 Population Estimates for 2013 Wards in England and Wales, by Single Year of Age and Sex (experimental statistics). For all other boroughs: ONS 2012 based population projection for 2015, children aged 0-17

[7] For Westminster, K&C and K&F: DfE School rolls 2015. For all other boroughs: DfE SFR16/2015 pupils by Local Authority January 2015 Census

[8] DfE SFR36/2014 Number of looked after children aged 0-17 per 10,000

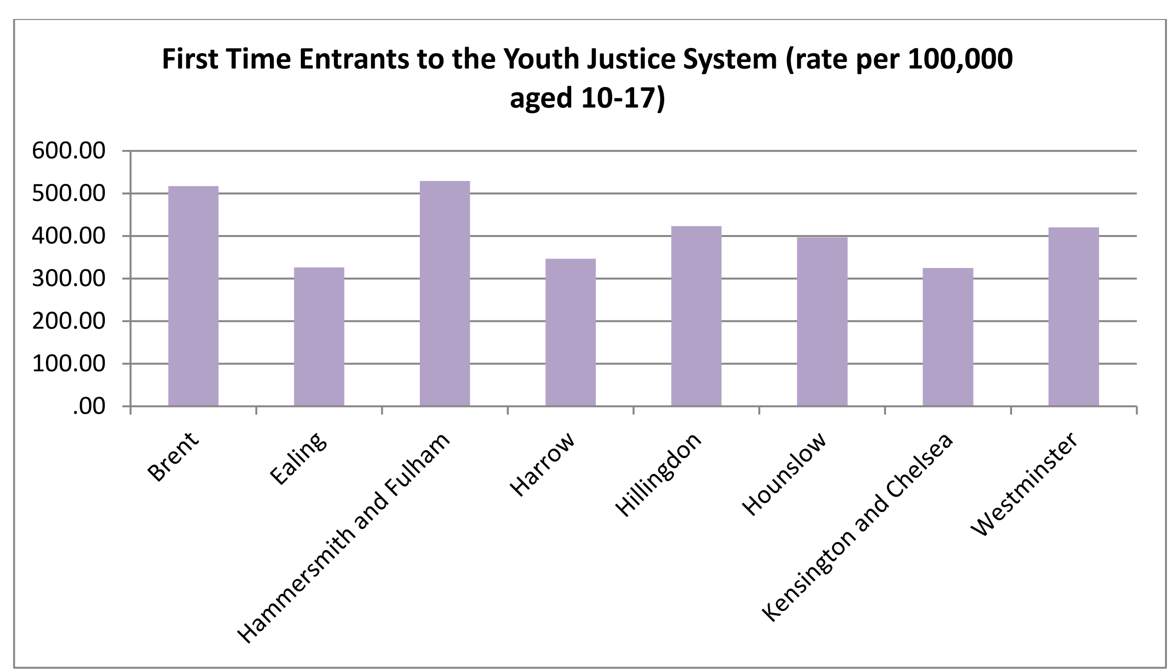
[9] Public Health England Fingertips Tool (2014). Accessed at http://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/data#page/9/gid/1938132753/pat/6/par/E12000007/ati/102/are/E09000005



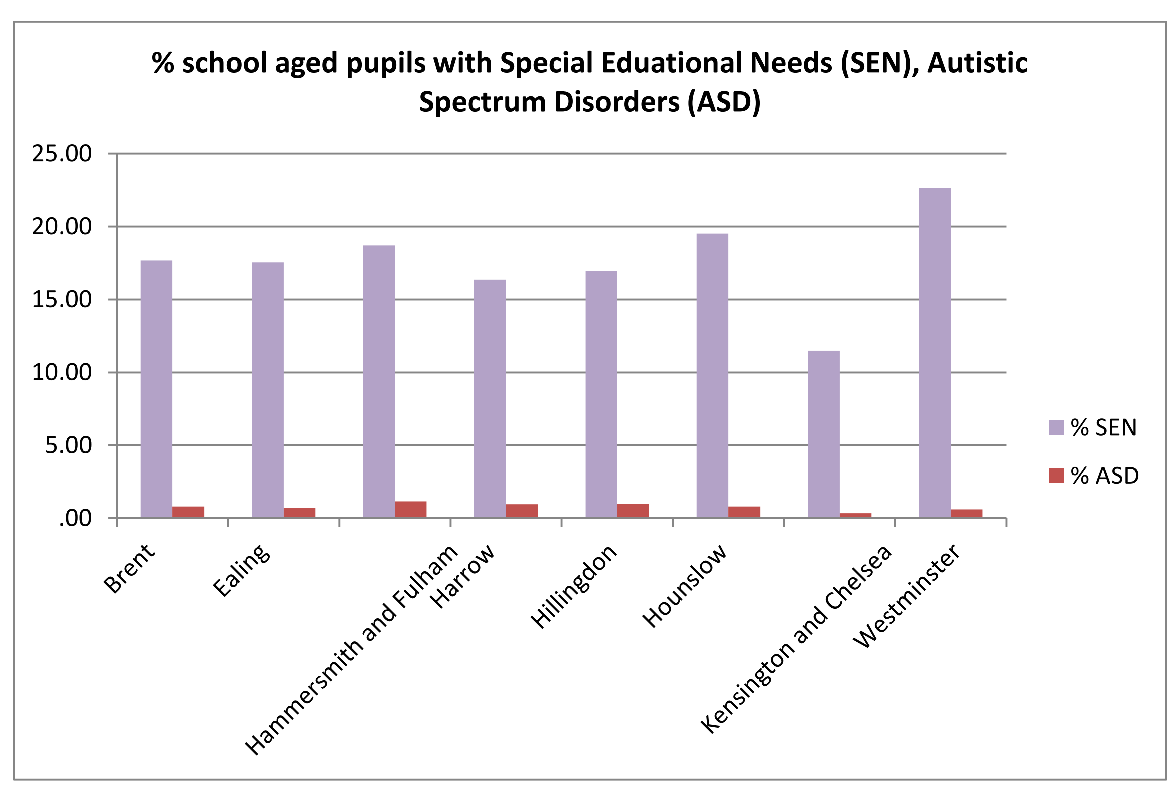
Self-harm is also more common amongst young people with mental health needs. Among 11-16 year olds, over a quarter of those with emotional disorders and around a fifth of those with conduct or hyperkinetic disorders or depression said that they had tried to harm themselves[10]. Deliberate self-harm is more common among girls than boys[11]. Between 2001/02 to 2010/11, rates of hospital admission due to deliberate self-harm have increased nationally by around 43% among 11-18 year olds (to around 17,500 in 2010/11)[12].

There are a number of specialised areas of mental health needs that are relevant in certain areas of NWL. For example, some areas have large number of looked after children. The rates of looked after children vary by borough from 55 in Hillingdon to 30 in Harrow; the national rate is 60 and for inner London is 64[13]. National research has found that among Looked After Children, 38%-49% (depending on age) have a mental health disorder. Mental health problems are also more common among young offenders. This is thought to be associated with the offending behaviour, in over three-quarters of the young people who had a full assessment in 2014/15. Rates for first time entry to the youth justice system across NWL are shown in the graph below.

[10] ONS (2005). Mental Health of Children and Young People in Great Britain. Accessed at http://www.hscic.gov.uk/catalogue/PUB06116/ment-heal-chil-youn-peop-gb-2004-rep2.pdf.
[11] Royal College of Psychiatrists (2015). http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/depression/self-harm.aspx
[12] Hospital episode statistics. Sourced from chimat.org.uk.
[13] DfE SFR36 2014 Number of Looked After Children aged 0-17 per 10,000



Children with special educational needs may be at higher risk of developing emotional and mental health needs. Across NWL, the percentage of school aged children with special education needs, including autistic spectrum disorders, ranges widely as demonstrated in the graph below.[14]



[14] Public Health England Fingertips Tool (2014). Accessed at http://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/data#page/9/gid/1938132753/pat/6/par/E12000007/ati/102/are/E09000005

4.0 Service Provision

4.1 Services: Our Starting Point

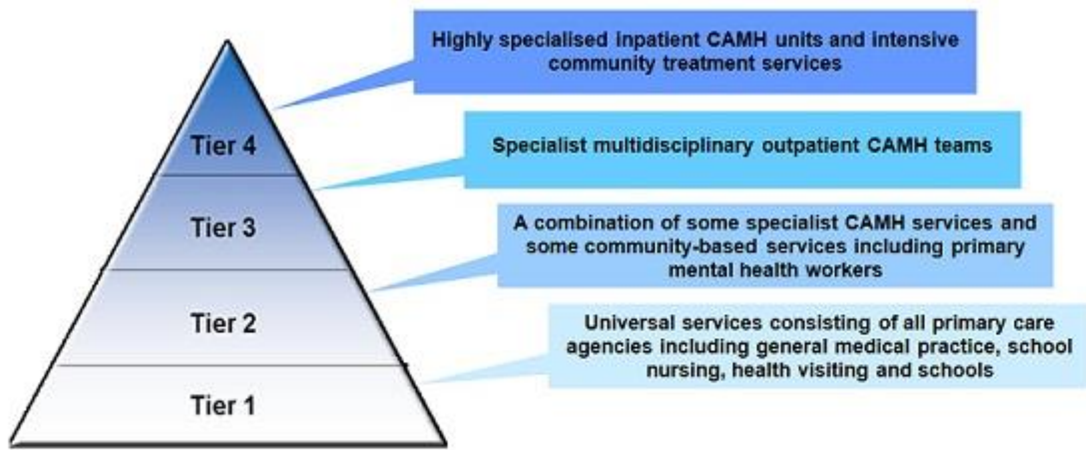
The below details provide a background to services prior to the implementation of the transformation of our CAMHS services. This information has been used as a baseline to identify what was working and where changes in needed.

4.1.1 Core Service – Specialist Children and Adolescent Mental Health Services (CAMHS)

Specialist CAMHS provides an assessment and treatment specialist service for children and young people up to the age of 18 years where there is likelihood that the child or young person has a severe mental health disorder and/or where symptoms, or distress, and degree of social and/or functional impairment are severe. Specialist CAMHS services assess and treat children and young people who are experiencing serious risks to their emotional and psychological wellbeing and development. The current threshold for referral to specialist CAMHS is that the suspected mental health difficulties are urgent, persistent, complex or severe.

CAMHS teams are multidisciplinary and consist of consultant child and adolescent psychiatrists, clinical psychologists, child psychotherapists, systemic family therapists, clinical nurse specialists and junior doctors from the CAMH medical training scheme. The teams provide a range of therapeutic and psycho-pharmacological interventions, consultation and liaison with other services including the paediatric liaison, and out of hours services. Referrals can be made to specialist CAMHS by any professional working with a child, young person or their family.

CAMHS have traditionally been described in four 'tiers', which have primarily been defined by how the service is provided. Tier 4 includes highly specialised inpatient CAMH units, commissioned by NHS England.



Increasingly this approach is seen to promote a dis-integrated approach to service provision. Alternative models have been proposed which are framed around needs and resources rather than services. Although we refer to tiers within this paper, we will, however, be aiming to move away from a tiered structure; with plans to fulfil this goal in 2017/2018.

4.2 Other Support for Mental Health

In NWL we have a number of other providers and services that support our CAMHS teams, providing community and schools based support for mental health needs. The full offer in each borough is outlined in annexes A-H.

In addition to the CAMHS described above, other local mental health support[15] includes:

- Early intervention in psychosis services to offer quick identification of the first onset of a psychotic disorder and appropriate treatment including intensive support, crisis intervention, assertive outreach and home treatment in the early phase.
- Specialist learning disability services
- Looked After Children (LAC) services
- Youth Offender Team (YOT) services

Across NWL, the provision of these services differs from borough to borough; further information can be found in the annexes of local services.

Public mental health services are also commissioned by local authorities across NWL, focusing on health promotion.

Many agencies and providers – and many of our universal services have contact with children and young people who may have risk factors for mental illness or have mental illness. This includes primary care, schools, leisure services, voluntary sector providers, acute hospital services, health visiting etc. The support offered by each of these agencies and providers also contributes to the local mental health support network across NWL.

4.3 Activity Levels Prior to the Start of Our Transformation Plans

The table below outlines the activity data for our core mental health support services in NWL, providing an indication of the demand for services in each NW London borough or CCG area. Our core services provide the majority of local activity, and hence this activity data is used to give an indication of local demand prior to the start of our Transformation plans for NWL.

[15] West London CCG – Young people over the age of 16+ are seen at the Adult IAPT and Adult Community Living Well Service

	CLCCG	WLCCG	H&F	Ealing	H'slow	H'don	Brent	Harrow	TOTAL NWL
Number of admissions for mental health conditions 2014/15 [16]	26	33	45	51	31	55	66	31	338
Admission rate per 10,000 children	9.5	8.2	13.4	6.3	5.0	7.9	9.0	5.4	7.6
Referrals made 2014/15 [17]	579	975	897	1741	1213	1114	1548	936	9003
Referrals accepted 2014/15[18]	467	808	748	1533	856	785	1137	784	7118
Referrals per 10,000 children	211	243	266	216	196	159	211	164	203
First Attendances	606	850	662	824	627	689	1,280	1,207	6,745
Follow Up Attendances	4,118	6,052	5,156	7,181	6,088	4,546	5,066	4,309	42,516
Total Attendances [19]	**4,724**	**6,902**	**5,818**	**8,005**	**6,715**	**5,235**	**6,346**	**5,516**	**49,261**
First Attendances per 10,000 children	221	212	196	102	101	99	175	211	152
Follow Up Attendances per 10,000 children	1,499	1,506	1,530	892	983	651	691	753	957
Total Attendances per 10,000 children	**1,719**	**1,718**	**1,726**	**994**	**1,084**	**749**	**865**	**964**	**1,109**

[16] SUS 2014/15. Patients aged 0-17 admitted with a primary diagnosis in ICD Chapter F (Mental and Behavioural Disorders)

[17] WLMHT and CNWL Referrals dataset. Includes rejected referrals.

[18] WLMHT and CNWL Referrals dataset.

[19] All attendance data source: Trust Minimum Data Set.

CAMHS Waiting Times June 2015[20]									
	CLCCG	WLCCG	H&F	Ealing	H'slow	H'don	Brent	Harrow	TOTAL NWL
Referral – Assessment: Under 4 weeks	26 (66.7%)	17 (60.7%)	15 (55.6%)	3 (25%)	2 (7.7%)	10 (21.3%)	16 (29.6%)	8 (18.6%)	97 (35.1%)
Referral – Assessment: 5 - 11 weeks	7 (17.9%)	10 (35.7%)	10 (37%)	4 (33.3%)	9 (34.6%)	9 (19.1%)	16 (29.6%)	28 (65.1%)	93 (33.7%)
Referral – Assessment: over 11 weeks	6 (15.4%)	1 (3.6%)	2 (7.4%)	5 (41.7%)	15 (57.7%)	28 (59.6%)	22 (40.7%)	7 (16.3%)	86 (31.2%)
Assessment – Treatment: Under 4 weeks	30 (83.3%)	12 (60%)	17 (68%)	6 (66.7%)	8 (57.1%)	11 (45.8%)	23 (79.3%)	5 (83.3%)	112 (68.7%)
Assessment – Treatment: 5 - 11 weeks	5 (13.9%)	6 (30%)	5 (20%)	1 (11.1%)	6 (42.9%)	9 (37.5%)	3 (10.3%)	0 (0%)	35 (21.5%)
Assessment – Treatment: over 11 weeks	1 (2.8%)	2 (10%)	3 (12%)	2 (22.2%)	0 (0%)	4 (16.7%)	3 (10.3%)	1 (16.7%)	16 (9.8%)

We recognise that the data above is affected by the inclusion of waiting times for some specialist CAMHS clinics such as neurodevelopmental disorder assessments. Therefore we have provided more detail on the waiting time (in days) for general CAMHS clinics and for neurodevelopmental assessments. Please note that the table above shows numbers and percentages of cases that are seen within 4 weeks of referral, 5-11 weeks of referral, and over 11 weeks from referral whereas the data below is shown in days from date of referral.

CURRENT WAITING TIMES – SPECIALIST/URGENT CARE SERVICES IN CAMHS[21]***					
CNWL					
	Brent	CLCCG	Harrow	Hillingdon	WLCCG
Referral to treatment time (in days) for GENERAL CAMHS	93	25	39	30	26
Referral to treatment time (in days) for NEURODEVELOPMENTAL DISORDER assessment	49	77	35	35	42
Referral to treatment time (in hours) for EMERGENCY referrals	82	8	NA	NA	0.3
Referral to treatment time (in hours) for URGENT referrals	315	52	160	72	80
Number of CYP on CAMHS tier 3 waiting list	472	159	120	200	153
Number of CYP on NEURODEVELOPMENTAL assessment waiting list	98	1	0	0	9

***NOTE: This data was refreshed by CNWL in January 2016 and shows some different trends to the data originally submitted in October 2015. We are working with CNWL to understand the discrepancies and trends over time.

[20] CNWL and WLMHT Monthly Information Return, June 2015

[21] Data reports provided by Trusts, January 2016

CURRENT WAITING TIMES – SPECIALIST/URGENT CARE SERVICES IN CAMHS[22]			
WLMHT			
	Ealing	Hammersmith and Fulham	Hounslow
Referral to treatment time (in days) for GENERAL CAMHS	28	14	28
Referral to treatment time (in days) for NEURODEVELOPMENTAL DISORDER assessment	365	182.5	365
Referral to treatment time (in hours) for EMERGENCY referrals	4	4	4
Referral to treatment time (in hours) for URGENT referrals	24	24	24
Number of CYP on CAMHS tier 3 waiting list	39	44	115
Number of CYP on NEURODEVELOPMENTAL assessment waiting list	97	25	222

Within both of our existing CAMHS providers there are small teams providing specialised support for children and young people with eating disorders. Their current activity and staffing levels are outlined below.

CENTRAL & NORTH WEST LONDON NHS FOUNDATION TRUST (CNWL) – EATING DISORDER SERVICE[23]						
	Brent	CLCCG	Harrow	Hillingdon	WLCCG	TOTAL
Current number of patients with ED on caseload (month snapshot)	9	11	15	22	12	**69**
Number of appointments use for children and young people with ED (month snapshot)	11	25	23	31	37	**127**
Monthly average number of appointments per patient	1.2	2.3	1.5	1.4	3.1	**1.8**

WEST LONDON MENTAL HEALTH NHS TRUST (WLMHT) – EATING DISORDER SERVICE[24]				
	Ealing	Hammersmith and Fulham	Hounslow	TOTAL
Current number of patients with ED on caseload (month snapshot)	26	11	17	**54**
Number of appointments use for children and young people with ED (month snapshot)	56	24	36	**116**
Monthly average number of appointments per patient	2.2	2.2	2.1	**2.15**
Current number of referrals per annum to children and young people's ED services	24	6	16	**46**

[22] Data reports provided by trusts, January 2016
[23] Data reports provided by trusts, November 2015
[24] Data reports provided by trusts, November 2015

5.0 Equality and Health Inequalities

Our approach to defining our common priorities has been bottom-up, meaning they are based on locally identified need reflected in shared solutions. We acknowledged that our assessments of needs (and the prevalence of risk factors that can drive need) were mostly out of date and we emphasised the importance of better understanding our populations – and their needs. The Anna Freud Centre has been commissioned to undertake a Needs Assessment; initial reports have been used to shape the refresh of this Transformation Plan and the final reports will be published in the latter part of 2016. This will enable our teams across the eight CCGs to more accurately commission and provide services targeted at those with the greatest need.

That not-withstanding, we do have good local intelligence on the needs of our communities and the groups that our current services under-serve. We know this because of what our partners tell us – from schools, voluntary sector and of course from young people themselves. We know that good mental health and flourishing mental wellbeing are not equally distributed across our population. Similarly, mental health problems and mental illness are not randomly distributed across populations. We have benefited from good input from our public health teams to develop our plans – ensuring we build on assets within our community and reflect the need to develop resilience across our population as much as expanded service provision.

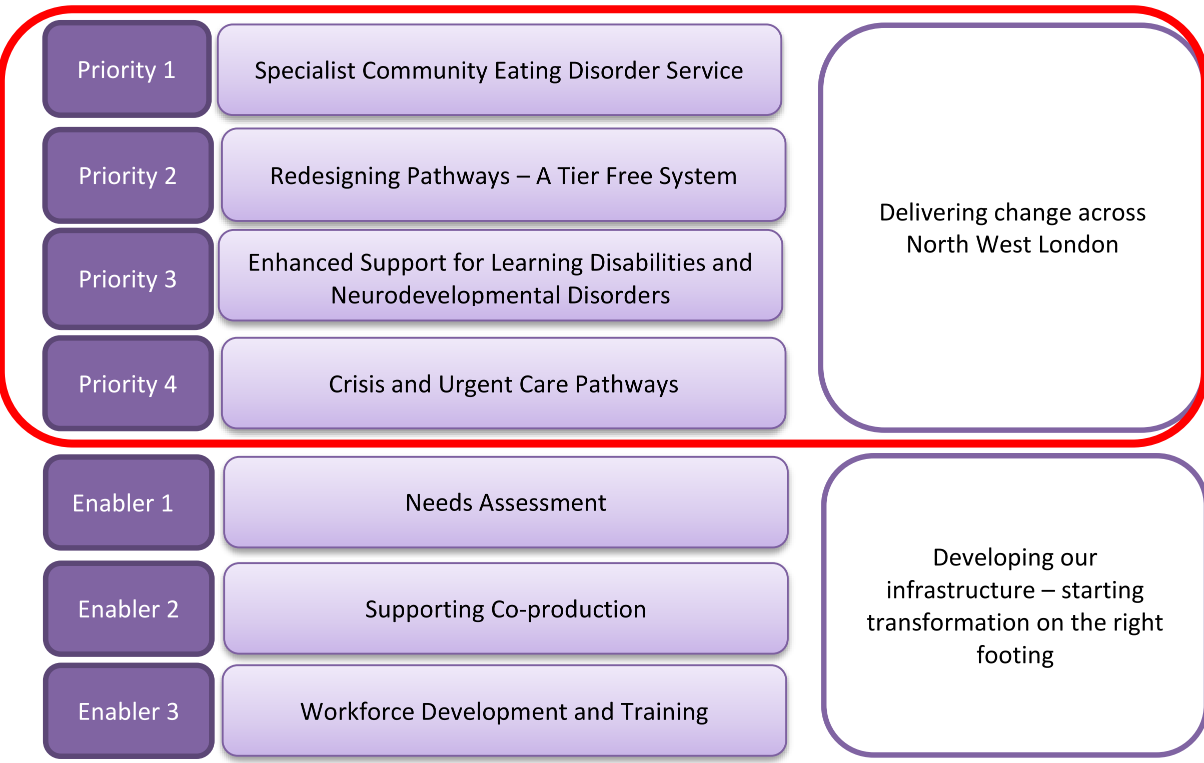
To engage with our population in its widest sense, we have worked via local groups building on existing work (with Health Watch, schools via the Healthy Schools Partnership and current service providers' user groups). We know this does not enable us to reach a representative view of our wider population, and so our second priority reflects our commitment to support and further develop local co-production.

Across NWL we undertake Equalities Impact Assessments when we undertake large change programmes. At this stage in the programme we have completed the screening phase of this process which provides a structure to address firstly who our changes will impact and any gaps in our plans, and secondly how we have worked with a representative community to develop our plans (as outlined above).

Our assessments reflect the needs of certain groups, but also highlights that some of the real challenges are hidden within our available data; bulimia prevalence in Brent, the increased migrant population in Hounslow and challenges specific to deprivation across all our boroughs. We recognise that our boroughs have specific groups of young people who are more vulnerable to mental health concerns, including young offenders and looked after children. Our plan outlines how our universal services respond to the specific needs of vulnerable groups.

6.0 Our Shared Priorities Across NWL

Through a process of understanding specific local needs and shared priorities we identified considerable overlap in the areas we want to develop. This originally resulted in the formulation of 8 priority areas. It was originally sensible to ensure that priority areas such as Needs Assessment, Supporting Co-Production, Workforce Development and Training, and Embedding Future in Mind, were seen as stand-alone priorities. This was to ensure that prime attention was paid to these areas. Following the work completed so far and informed by our learning, it has become clear that these areas are key enablers to ensure service transformation and design priorities and as such we now revised our strategic framework to support the delivery.



It needs to be noted that the detailed plans for year on year spend will continue to be formulated over the coming months with confirmation of increased funding.

6.1 Priority One: Community Eating Disorders (ED) Service

Specialist community eating disorder services for children and young people

6.1.1 Why We Have Chosen This Area

Prior to the Transformation of our services, there was limited access to services for people with eating disorders across NWL. We did not have implicit Eating Disorder teams; instead CYP with suspected or diagnosed eating disorders were seen by local CAMHS teams. There was also variable provision of lower intensity specialist Eating Disorders services for residents. Well-regarded specialist multidisciplinary tertiary and inpatient services were funded for residents at various locations; however, the distance by public transport made the service inaccessible for many and somewhat impractical for the provision of outpatient treatments.

Although there is a good local support is available, the new national specification outlined the best practice service provision that the NWL Collaboration need to aspire to.

The initial analysis and review of ED service provision, in 2014/15, outlined a number of issues and gaps as outlined below:

- A lack of a community ED services
- Inconsistent input from Paediatricians
- Lack of capacity for work with atypical eating disorders, which are one of the most common presentations in young people;
- Lack of capacity to provide cognitive behavioural therapy and family interventions, both are which are indicated by the National Institute for Health and Care Excellence (NICE) as effective interventions;
- Limited capacity for input from dieticians;
- Provision on weekdays only

6.1.2 The Ambition

We want to provide the right pathway for children, young people and their families – based on need, provided locally and with the right escalation for those children who need it. As with all our CYP services, ensuring a safe transfer from into suitable adult services will be an important part of this pathway.

We want to have consistent standards and outcomes for our population - against the measures in the recent guidance, but also using patient reported measures.

Access is critical and a core part of our new model will be ensuring that the wider system knows about the availability of support – for all levels of need – and that services are available at times and locations that work for the children, young people, and parents who need them.

We will be working towards ensuring that 95% of children and young people with eating disorders are to receive treatment within 1 to 4 weeks. Local areas will

baseline their current performance against new waiting time standards for eating disorders and plan for improvement. They will be measured against the standards from 2017/18.

We are keen to ensure that we offer a choice of NICE Guidelines treatment options which the child/young person will want to access whilst also improving the support to parents/carers

6.1.3 <u>Where We Are Now</u>

In March 2016 both trusts, WLMHT and CNWL, developed two separate pilots for a new Eating Disorders service. They provide care pathway provision and seamless referral routes to ensure quick, easy access to and from the current CAMHS service providers, and from referrers outside of CAMHS. These services reflect the new national specification for eating disorder services. It currently provides 5 days of service for young people aged 18 or under who have a suspected or confirmed eating disorder diagnosis of:

- anorexia nervosa,
- bulimia nervosa,
- binge eating disorder,
- atypical anorexic and bulimic eating disorder

The current and new model includes:
- Family interventions as a core component of evidence based treatment required for eating disorders in children and young people.
- Cognitive behavioural therapy (CBT) and enhanced CBT (CBT-E) for the treatment of anorexia nervosa, bulimia nervosa and related adolescent presentations.

Both services are fully staffed and in the 8th month of the pilot timeline. The services now provide:
- A rapid single point of low-threshold access to community eating disorder service
- Accessibility – within waiting time guidance (1 week for urgent and 4 weeks for routine)
- Comprehensive assessment and care planning for people with suspected / confirmed eating disorders guide in line with the providers.
- Evidence-based treatments for people with anorexia nervosa, bulimia nervosa and binge eating disorder who can be treated safely and effectively close to home and without recourse to the specialist multidisciplinary team.
- Advice, information and sign-posting to people with eating problems who do not wish to access treatment services (or who are not eligible for treatment under the current funding arrangements).
- Specialist consultancy to GPs whether or not the service is able to offer treatment.
- Seamless onward referral to treatment services for people whose needs cannot be met within a primary care-based service (e.g. those at higher risk or requiring multi-disciplinary treatment and care).
- A service compliant with NICE Guidance (CG9).
- The service will liaise effectively with other providers and partners to ensure joined-up care.

CNWL and WLMHT have been able to provide us with data to reflect current staffing models, activity and current waiting and referral times for the two new Eating Disorder pilots. We will be evaluating the services in March 2017, however, the current data sets provides us with useful baseline information; particularly around waiting time standards. An overview of current baseline data is below.

CNWL Eating Disorder Service

The service has a WTE of 7.71 staff, including family therapists and psychiatry input.

Eating Disorders WTE	Brent CCG	Central London CCG	Harrow CCG	Hillingdon CCG	West London CCG
2014/2015	0	0	0	0	0
2015/2016	0	0	0	0	0
2016/17	1.96	1.10	1.46	1.79	1.40

Referrals into the new service have doubled from previous financial years and on track to receive 100 referrals in 2016/17. Analysis will be required to determine why referral rate has doubled. It should be noted, however, that we have undertaken an extensive new service marketing exercise which we can assume may have increased the referral rate.

Eating Disorders Referrals Accepted	Brent CCG	Central London CCG	Harrow CCG	Hillingdon CCG	West London CCG	Total
2014/2015	8	17	12	18	8	63
2015/2016	7	7	11	8	16	49
2016/17	24	18	20	22	22	106

Activity has remained consistent from previous years. However this is expected to increase in the second half of 2016/17 now the service is fully recruited and refers become more aware of the service.

Eating Disorders	Brent CCG	Central London CCG	Harrow CCG	Hillingdon CCG	West London CCG	Total
2014/2015	51	343	223	247	227	1091
2015/2016	157	258	349	217	168	1149
2016/17	192	230	308	194	136	1060

Waiting times performance are submitted monthly to commissioners and are in line with national and local targets for seeing urgent referrals (one week) and routine (four weeks). This is also submitted nationally each month on Unify to NHS England. Overall, 70% of the waiting time targets have been met.

Eating Disorders Urgent Waiting Times	Under 1 Week	Over 1 Week	Grand Total	Performance
Central London CCG	3	0	3	100%
Brent CCG	2	2	4	50%
Harrow CCG	0	1	1	0%
Hillingdon CCG	0	1	1	0%
West London CCG	2	0	2	100%
Grand Total	**7**	**4**	**11**	**64%**

Eating Disorders Routine Waiting Times	Under 4 Week	Over 1 Week	Grand Total	Performance
Brent CCG	6	2	8	75%
Harrow CCG	6	3	9	67%
Hillingdon CCG	7	3	10	70%
West London CCG	7	2	9	78%
Central London CCG	6	0	6	100%
Grand Total	**32**	**10**	**42**	**76%**

WLMHT Eating Disorder Service

The WLMHT trust service has a dedicated staffing model as below:

CAMHS Eating Disorders Service

The newly developed CAMHS Eating Disorders Service has been operational since 1st April 2016. This service covers Ealing, H&F and Hounslow and data is now recorded under one work-unit on RiO. Due to the merging of data to reflect the new service, it is not possible to provide information for 2014/15 or 2015/16 as historically cases were not recorded in a specific EDS work-unit, but across the work-units (teams) teams in each Borough.

Staffing Model

Eating Disorders WTE	Service Description	Hounslow	Ealing	Hammersmith and Fulham
2014/15	Separate Services	N/A	N/A	N/A
2015/16	Separate Services	1.4wte but not dedicated resource	3.55wte dedicated resource	Cases were picked up but no dedicated resource
2016/17	Integrated Service	8 WTE – multi-disciplinary team across the three boroughs		

MDT team that is fully recruited to, as of October 2016, consists of Consultant Psychiatrist and Staff Grade Psychiatrist, Family Therapy, Psychology, Nursing, Psychotherapy, Dietician and admin. The current service comprises of 8WTE.

Referrals into the service

Eating Disorders referrals accepted	Hounslow	Ealing	Hammersmith and Fulham	Total
2014/15*	N/A	N/A	N/A	N/A
2015/16*	N/A	N/A	N/A	N/A
2016/17	6	17	9	32 received 30 accepted

*As above not able to provide historic data due to merging of all cases under new EDS work-unit on RiO. This would require manual data review – resource not currently available to support this

Activity

Eating Disorders Urgent Waiting Times	Under 1 Week	Over 1 Week	Grand Total	Performance
Ealing CCG	3		3	100%
H&F CCG	2		2	100%
Hounslow CCG	2		2	100%

All urgent referrals seen within 1 week as per access and waiting times specification

Eating Disorders Routine Waiting Times	Under 4 Week	Over 4 Weeks	Grand Total	Performance
Ealing CCG	13		13	100%
H & F CCG	5	1	6	95%
Hounslow CCG	4		4	100%

Average waiting time – referral to assessment – only 1 case out of 23 waited for more than 4 weeks

Funding

	2015/16	2016/17	2017/18	2018/19	2019/20
Central	£91,557	£91,557	£91,557	£91,557	£91,557
West	£116,621	£116,621	£116,621	£116,621	£116,621
H&F	£100,744	£100,744	£100,744	£100,744	£100,744
Ealing	£211,543	£211,543	£211,543	£211,543	£211,543
Hounslow	£152,983	£152,983	£152,983	£152,983	£152,983
Hillingdon	£149,760	£149,760	£149,760	£149,760	£149,760
Harrow	£121,785	£121,785	£121,785	£121,785	£121,785
Brent	£163,584	£163,584	£163,584	£163,584	£163,584

6.1.4 <u>Our Next Steps</u>

2015/16	2016/17	2017/18	2018/19	2019/20
Review of the current services and pathways. Commence recruitment and delivery of new service	Market testing. Procurement and mobilisation (of required). On-going implementation stage Nov 16 - Create plan with a focus that 95% of waiting times for Eating Disorders are met.	Implement plan to ensure that 95% of waiting times for Eating Disorders are met. Evaluate.		

Our next steps will primarily focus on evaluating our current pilot service models and furthermore reviewing our waiting time procedures so that we can meet the national standard waiting time guidelines.

Service Model

Though the current two services are within pilot stages there is an on-going plan to ensure that we have an Eating Disorder service for the on-going future.

To ensure that the services are fit for purpose, meet the needs for children and young people, adhere to waiting national standard guidelines and meet NICE guidelines we will undertake a comprehensive evaluation of the service in March 2017. We will also need to ensure that the evaluation of the service is co-produced. As such Hammersmith and Fulham have commissioned Young Champion from Re-think to be involved in the evaluation of the service.

Parameters of the evaluation will be set in January, commencement of the evaluation in March, and the final evaluation report will inform what is working and what service changes are required.

In conjunction to the above we will begin to create strategy plans to:

- Develop a recruitment and retention strategy and robust training plans
- Undergo a service re-model exercise with view of providing appointments outside of current core operating hours (9am-5pm) and further enhancing accessibility by providing a seven day service.

Waiting Times

We have identified baseline waiting time data which will be used to further map how 95% of children and young people with eating disorders will receive treatment within 1 – 4 weeks. At present CNWL are meeting 70%, and WLMHT 100%, of waiting time targets. We propose the following milestones by 2020.

Milestones	2016/2017	2017/2018	2018/2019	2019/2020
No. of children being seen between 1 to 4 weeks.	85% of children are currently being seen within 1-4 weeks	89%	92%	95%

Our trusts will work together with CCGs to identify a written strategy to ensure that we meet 95% of referrals. Strategies may include:

- Increasing workforce to meet need (based on modelling)
- Review waiting time policies and procedures
- Flag and investigate any waiting time breaches
- Review operating hours with view of extending to evening and weekend opening hours
- Plot external circumstances that may impact on reaching national waiting times goals.

6.2 Priority Two: Redesigning Pathways – (including a tier free system)

6.2.1 Why We Have Chosen This Area

The single greatest cause of concern amongst our young people and the professionals they interact with is about the barriers between different parts of the system – the unnecessary hurdles to get to the support needed and the lack of a clear understanding about what is available, and where.

In recent years we have sought to augment the current system; we have schools commissioning a wide variety of counselling and other support; local authorities funding on a non-recurrent basis different 'add-ons' to address particular needs; and health services seeking to improve – both face to face care and also the data we have available.

What Future in Mind tells us, is that this tinkering is not going to be enough – rather we need to start a fresh with an approach which is meaningful for children and young people.

The Five Year Forward View for Mental Health further tells us that evidence based treatment needs to be developed to cover the journey from referral to recovery. These will include expectations of referral to treatment times, interventions provided and outcomes measured.

6.2.2 The Ambition

In this significant piece of work we seek to address:

- How we can keep prevention and reduction of risks factors at the core of our approach
- How adult and children's services need to work differently to get transition right
- Whether we need to review the 'transition age' and we extend the age of young people's service to 25 years
- Explore 'no-wrong door' concept – and how the whole community respond to needs
- Review and agree our access strategy and points
- How we work differently with critical partners in schools and primary care
- Review and consider opportunities digital solutions can provide
- How we address parental and family needs when we think about children's needs
- Determine whether the current funding approaches help or hinder joined up working and how we can be more innovative and collaborative
- How we can redesign the inpatient care to ensure it is an integral part of the joined up pathway

Ultimately we want children and young people to convey a substantially better experience of their mental health care and support. And more boldly we want to shift

where we prioritise funding to invest in early interventions and prevention, where we know we can most impact on the whole life experience of our population as a whole and individual children and their families.

We will take a whole systems approach to CAMHS and connected services – meaning we need to think differently about how we commission across education, social care and health. Importantly we will also think about the wider context and impact on children, young people and their families – access to leisure services and parental mental health for example.

We will move away from tiered services to services that meet the needs of the child/young person and the family. To do this we will need to address particular pinch points - as well as building a new overall model without tiers. Broadly, our proposed model will include:

- A single point of access (SPA) across each CCG area or where there is a common provider across several CCG areas, a central SPA or Multiple Points of Access
- Referral, assessment, treatment, discharge that is evidence based
- School based work – both to develop emotional wellbeing and resilience and to identify and support young people with mental health needs
- Maintenance – it is crucial to include continued maintenance even after discharge to prevent a young person being re-referred into a CAMHS service

The redesigned service will seek to address existing quality and capacity concerns regarding **access** and **transition**. Providing for a seamless provision a young person is more likely to remain engaged in the service, which will enable them to participate further in education, training or employment.

More importantly there will be **'no wrong front door'**, with clear pathways between services and an ethos of working together to meet the needs of children and young people, particularly during transition to adult services.

We will continue the roll out of **CYP IAPT training programme** across NWL through the collaborative (including CNWL and WLMHT), ensuring that all young people have the opportunity to outcome based measures to evidence effectiveness of their assessment and treatment. We will ensure that our pathways and referral routes incorporate all CAMHS providers. All assessment and treatment options will be evidence based, and delivered by a trained and competent workforce who specialise in working with children and young people.

We can intervene earlier to **prevent the development** of more serious or chronic mental health problems by working with families in partnership with a wide range of universal services, including across schools, children's centres, youth services, GP surgeries and voluntary and community sector organisations. We will also link up with the work underway on early years/early help initiatives commissioned by our NWL local authorities. Alongside this, children and young people with a higher level of need, including looked after children, should be provided with immediate access to specialist services.

Young people who do not meet the threshold for adult mental health services may be best **supported by primary care**, other agencies such as youth counselling services,

or may be discharged with a clear plan which tells them and their families what to do if they become unwell. Currently, many receive no such plan and are left to re-contact primary care services if further advice, treatment or care is required.

We recognise that further joint working with our Health and Justice teams would strengthen our plan and we welcome recent offers of input from the central team. By working with specialist colleagues, we want to develop models of care and support that are fully integrated with key justice services including Liaison and Diversion, Feltham Young Offenders Institute (and other all ages sites such as Wormwood Scrubs), and police custody units.

Based on our planning to date, we expect our new model to include:

- **Clear navigation** and pathway referrals with simple access to the appropriate service;
- **A tierless model** that reflects need rather than unintentionally creating barriers between services or/and embed service division or fragmentation of care;
- **No duplication** of services or gaps between services;
- **Common pathways and standards** across all services to reduce variation in quality of services;
- Service providers **working together** effectively in support of individual needs whilst continuing to recognise the statutory duties of each organisation and ensuring that these are met;
- More people **avoiding unnecessary hospital admissions** by being supported in the community and those that do go into hospital are supported to return home quickly following admission;
- Adequate staffing to support a **flexible engagement** and appointment approach to young people (extended evenings and Saturday mornings);
- A strong and well defined **school service out reaching into local schools and colleges** with the flexibility to integrate with local authority 'early help' services, which may be based within Education;
- **Increased clinical capacity** to respond to young people with complex and life threatening conditions
- Support for **new roles** within the young people's community mental health service;
- Strengthening the prevention and early intervention support available to young people by in collaboration with Local Authorities and Public Health, commissioning the **voluntary sector** to provide easy access services aimed at providing emotional support to young people, but with clear and active links to the community mental health service, should young require additional expertise.

6.2.3 Where We Are Now

CCGS have begun to work on local level and across NWL to begin to further re-align services and pathways to provide seamless care and support for children and young people with mental health challenges. In some areas new services have been commissioned (see local annexes). Details of NWL system changes can be viewed below.

Clear navigation of Services

CNWL have proposed a Single Point of Access service and have provided a business plan to this effect. CCGs are currently reviewing the model to further decide on what will be feasible within the financial envelope and to consider options.

Other options include integrating the CYP SPA with the current adult function (which provide an assessment, referral and signposting mechanism)- and having Multiple Access Points – as suggested by the Anna Freud Centre whereby different access points can provide shared responsibility of access points.

It should be noted that at current the WLMHT OOH service is accessed through the adult SPA telephone number.

Tierless System

One of the initial recommendations specified in the interim needs assessment carried out by the Anna Freud Centre, suggests how we can work together to deliver a system without tiers. Recommended is THRIVE, a needs based person centred conceptual framework which looks to ensure children young people and their families receive the right intervention at the right time. The THRIVE Framework is a collaborative initiative developed in partnership by the Anna Freud Centre and the Tavistock and Portman NHS Foundation Trust.

Attempts have been made to conceptualise CAMHS, the most long-lasting and influential of which is a model dividing service provision into four tiers as outlined and described below:(6)

Tier 1: consists of non-specialist primary care workers such as school nurses and health visitors working with, for instance, common problems of childhood such as sleeping difficulties or feeding problems. Tier 2: consists of specialised Primary Mental Health Workers (PMHW's) offering support to other professionals around child development; assessment and treatment in problems in primary care, such as family work, bereavement, parenting groups etc. This also includes Substance Misuse & Counselling Services. Tier 3: consist of specialist multidisciplinary teams such as Child & Adolescent Mental Health Teams based in a local clinic. Problems dealt with here would be problems too complicated to be dealt with at tier 2 e.g. assessment of development problems, autism, hyperactivity, depression, early onset psychosis. Tier

4: consists of specialised day and inpatient units, where patients with more severe mental health problems can be assessed and treated.

No duplication

An alignment mapping exercise has been undertaken to reflect current and proposed services. CCGs on a local level are also undergoing processes to develop asset maps incorporating existing services, undertaking service reviews and making commissioning decisions based on community borough needs. Details can be found in local annexes. Anna Freud Centre has also undertaken an asset mapping exercise – details of which will be available in November 2016.

Working together

Our Steering Group provides the forum for our main providers, our trusts, to work together across the eight boroughs. The New Model of Care further enhances the opportunity for our current trusts to work together.

Avoiding Unnecessary Hospital Admissions

Our current Out of Hours service model provides the opportunity to aid the process of avoiding unnecessary hospital admissions.

All current transformational community CAMHS and workforce development initiatives are geared with a focus with decreasing likelihood of a mental health challenge escalating to the point of needing hospital admissions. Details of local priorities can be found in the annexes.

Flexible Engagement

CNWL now provide appointments outside of core hours (9am-5pm) which provides the opportunity for CYP and parents to be able to access services within more flexible hours. This thus increases capacity.

6.2.4 <u>Our Next Steps</u>

2015/16	2016/17	2017/18	2018/19	2019/20
Commence SPAs Develop Whole Systems approach to CAMHS	Anna Freud Centre needs assessment and recommendations to inform reconfiguration across NW London to deliver needs based, person-centred integrated intervention for CYP Implement increased capacity to underpin future change Agree ways of working across NHSE for Tier 4 integration CCGs to create Local Funding cuts risk minimisation strategy protocols.	Implement and evaluate		

We have had a number of developments over the last 12 months and furthermore need to review feedback from Anna Freud Centre, as well as, to ensure that our services align.

It is envisioned that in February 2017 a Transformation Seminar will be held with our colleagues to begin to further develop our current plans for the following:

Clear Navigation of Services

We will identify options and develop business cases. This is will include analysis of the sustainability of having a SPA and MAPs. If models are viewed as feasible, implementation will be aimed for 2017/18.

No Duplication

Within our Implementation meetings and Steering Group we will continue to evolve our services whilst providing clears maps of 'where we are' which in essence inform 'where we want to get to.'

We will also provide increased time for local CCGs to align and share their current local priorities and developments. Like Minded Strategy & Transformation Team will oversee this process with the alignment exercise a core focus of the Transformation Seminar in February 2017.

Working Together in Partnership with NHSE on the Health and Justice/ Specialised Commissioning CYP Mental Health Workstream

We are working in partnership with NHSE on the Health and Justice/Specialised commissioning CYP Mental Health workstream. A key aim of this workstream is to improve the health and justice outcomes of young people in the borough who are in or at risk of the justice system. NHSE have allocated central funding to this borough for the purpose of commissioning liaison and diversion services and enhancing the health and wellbeing pathway for this group. We plan to conduct a needs analysis and mapping exercise in partnership with the Youth Offending team and other relevant partners in the borough to identify needs and gaps in provision. Once these are understood we will formulate a commissioning proposal to NHSE by 31st December outlining the development of the pathway and what services we plan to commission with the central allocation.

Avoiding Unnecessary Hospital Admissions

Proposed Out Of Hours Service models will be confirmed in November 2016. We will to undertake an impatient activity modelling exercise to provide a comparative analysis of the impact of the OoH service on the New Models of Care.

WLMHT will also outline their plans to implement the New Models of Care including the how to avoid unnecessary hospitals admissions, as well as, plans as to how funding can be shifted from savings to decrease in number of tier 4 beds.

Flexible Engagement

We will be working with WLMHT in February 2017 to review the current staffing model and propose plans to extend working hours as a first step towards a seven day service. CNWL currently provide flexible working hours from Monday to Friday; in February 2017 we plan to review the model with a proposition that weekend appointments are offered.

Understanding Local Authority Reductions

Our local authority partners face significant funding challenges which result in service reductions. We are keen to understand how those decisions affect our priorities, pathways and services and will be working very closely with our partners to monitor the impact of those on children and young people. We recognise the importance of not utilising the Transformation funds to address the gaps through these reductions.

Funding

	2015/16	2016/17	2017/18	2018/19	2019/20
Central	£60,000	£207,045	£187,045	£187,045	£187,045
West	£88,000	£244,509	£195,509	£195,509	£195,509
H&F	£56,000	£189,026	£189,026	£189,026	£189,026
Ealing	£206,700	£328,765	£318,514	£318,514	£318,514
Hounslow	£127,930	£246,902	£199,846	£199,846	£199,846
Hillingdon	£120,000	£140,000	£140,000	£140,000	£140,000
Harrow	£170,000	£270,000	£270,000	£270,000	£270,000
Brent	£154,468	£166,000	£166,000	£166,000	£166,000

6.4.5 Localising Priorities

In **Ealing** pathways are being designed which include a 'consultancy' element which offers advice and support to a wide range of professionals and ensures children and young people are sign posted to the most appropriate help, support and intervention.

Central London, Hammersmith and Fulham and **West London** are rolling out several training packages for schools including an Emotional Literacy Support Assistants (ELSA) training package which facilities early intervention in schools for CYP with attachment disorder; and work with schools to develop their own mental health strategy and action plans.

Hounslow are implementing a Mental Health in Schools programme to improve mental health promotion and early intervention. The programme is being delivered in partnership with 8 schools from September 2016 until April 2017. The aim is to build capacity at through consultation, training and support from Specialist CAMHS practitioners.

Hillingdon CCG and London Borough of Hillingdon are proposing to work towards developing an integrated pathway moving away from 'Tiered Model' to ensure CYP receive the right intervention at the right time. This initiative will firstly focus on emotional wellbeing, support to schools and parents before considering more specialised services.

Harrow CCG in partnership with Harrow Council has commissioned a CYP Pilot emotional health and wellbeing service delivering flexible short to medium term intervention together with a targeted service model offering early intervention.

6.3 Priority Three: Enhanced Support for Learning Disabilities (LD) and Neurodevelopmental (ND) Disorders

6.3.1 Why We Have Chosen This Area

As outlined in our introduction, learning disabilities and neurodevelopmental disorders such as autistic spectrum disorders (ASD) and attention deficit hyperactivity disorder (ADHD) are prevalent in NWL to varying degrees across our eight boroughs. People with learning disabilities who have mental health needs experience a wide range of problems and therefore require a wide range of services. They can have the full range of mental illnesses seen in the general population such as schizophrenia, bipolar disorder, depression, anxiety disorders, specific phobias, agoraphobia, obsessive compulsive disorder and dementia.

Some of the main drivers for change include:

- The increased prevalence of mental health problems among people with learning disabilities, compared to the general population;
- The large number of people with LD and mental health problems that have behaviours described as challenging, developmental disorders, or other conditions;
- The critical need for improvements in services for people with learning disabilities;
- The current limited capacity of LD services to cope with increasing demand;
- The significant cost of current LD/ND services to health, social care and education providers and commissioners

6.3.2 The Ambition

We will develop an enhanced service within our eight boroughs, streamlining the current service offering and filling the gaps. The design of the service locally will vary because the starting position is different and the needs of each borough differ somewhat based on prevalence and population. The NWL approach will ensure consistent quality and shared learning.

We are currently mapping local care pathways for children and young people with learning disabilities and mental health difficulties to ensure a seamless experience of care for all children in their local area. This may involve reconfiguring services or commissioning additional local provision where there are gaps, commissioning an integrated service from CAMHS and Community Paediatrics.

As well as working closely with Community Paediatrics when screening referrals and undertaking assessments, there should be an effective strategic link between CAMHS LD/ND services and special educational needs (SEN) departments, to ensure coordinated assessment and planning of education, health and care (EHC) plans where necessary, and effective transitions for young people with LD/ND across health and education. Multi-agency agreements and monitoring arrangements will be

defined with close working amongst frontline services, clearly defined lead professionals and shared care plans.

We will enhance the capacity of CAMHS to meet the increasing demand for ASD and ADHD assessments. In some areas this will involve adding additional staffing resource to specialist neurodevelopmental teams.

Specialist support embedded in the network - In some areas such as Ealing the model of co-located services for children with disabilities enables fast access to specialist mental health practitioners for advice, consultation and joint working. This model will be explored in other areas and if physical co-location of entire services is not feasible, we will consider embedding mental health practitioners in services that work closely with children and young people with LD.

We will be considering recommendations from the Anna Freud Centre particularly recommendations for pathway re-configuration as well as transition mechanisms to enhance the link between child LD/ND services and adult LD/ND services.

We will consider models where specialist mental health practitioners will be available to provide advice and support to special schools and specialist units to support early identification of mental health difficulties, advise on behavioural management strategies, and signpost to specialist support if needed.

Vulnerable groups including those with disabilities can find it more difficult to access specialist services when they need them, so we will take all measures in our wider plan to improve accessibility of specialist mental health services (such as single point of access, user involvement etc.) apply equally to young people with LD and neurodevelopmental difficulties.

We will ensure that specialist services for children and young people with learning disabilities, neurodevelopmental disorders and mental health difficulties are sufficiently resourced to enable efficient access in line with national waiting time targets, to a workforce with the right expertise to meet their needs.

The crisis pathway (Priority 2) developed through this NWL Transformation plan will ensure access to support from staff who are appropriately trained to work with young people with LD, whether through direct access or a consultation model. This will ensure that admissions to residential care are avoided wherever possible and that discharge back to the community is well supported.

There will be clear agreements in place between specialist services and primary care to support shared care for young people with LD/ND who require medication.

CCG commissioners will connect with local voluntary sector services and support groups for young people with LD/ND and their families (e.g. parent-run ASD support group).

As part of our redesign of LD and ND services, we will ensure that the principles of ‘Transforming Care’ are incorporated into our new pathway and service models. We have furthermore been liaising with adult commissioners to ensure that our pathways align. Explicitly, we will develop pathways that ensure that when a hospital admission

is required for a person with LD or ND, all providers will first ensure that there is no other alternative to admission. Once this challenge has been passed, the person will have an agreed discharge plan developed at the point of admission to ensure they are discharged into community settings as soon as possible. We will also ensure that care and treatment reviews form a fundamental part of our LD and ND pathways and services.

Service Users, providers and commissioners recently came together at an all day workshop to look at adults Learning Disability provision – a key theme of the day is the need to ensure transition is well managed and supported. 35 of the participants volunteered to be part of a network addressing transition issues – reflecting the commitment to change.

6.3.3 Where We Are Now

Current Services

In 2015/16 the current services and interdependencies were mapped out in detail. A number of workshops were arranged including workshops with CNWL and CCGS, WLMHT and CCGS and an Anna Freud Centre LD/ND workshop. All the workshops were successfully co-produced with different agencies, such as health, social care, education and parents attending.

The original aim was to create uniform standards across the eight boroughs, however, this has been deemed challenging considering that different boroughs are at different starting points.

We did find, however, that CCGs wanted to work towards the same vision (as outlined below):

- Children and young people access assessment and treatment for LD and ND in a timely manner.
- Children and young people with LD or ND achieve improved health and educational outcomes.
- Children, young people and parents report an improved experience of engaging with LD or ND services.

It has thus been agreed that the boroughs will work on a local level (though the inner London group of CCGs will work collectively) to align their current service provision with the collective vision.

Referrals, Patient Contact and Waiting Times

Our waiting times from referral to assessment were considered concerning. Extra workforce was required to bring down referral to assessment times waits. Each CCG allocated transformation funds to decrease waiting times. An overview of impact can be seen below.

CNWL LD/ND Waiting Times 2015/2016/2017

CNWL have received additional investment into CAMHS services to manage patients with Learning Disabilities and Neurodevelopmental conditions. CNWL have recruited to these posts in early 2016/17 and there has been a positive impact on the children with these conditions.

Funding for Waiting Times

Additional funding (£)	Brent CCG	Central London CCG	Harrow CCG	Hillingdon CCG	West London CCG	Total
2016/17	96,000	52,000	118,0000	155,155	30,000	614,084

Due to the additional funding into CAMHS, and the ability to provide the service to a wider cohort of children, there has been a 50% increase in referrals for children with Learning Disabilities in 2016/17 compared to the previous financial year.

Learning Disabilities Referrals	Brent CCG	Central London CCG	Harrow CCG	Hillingdon CCG	West London CCG	Total
2014/15	49	11	37	18	13	128
2015/16	33	10	41	29	12	125
2016/17 (forecast based on M1 to M6 actuals)	38	6	78	56	6	184

Furthermore there has been a clear increase in activity levels with twice as many contacts with Learning Disability patients in 2016/17 than in previous financial years. This is expected to increase further in the second half of 2016/17 as not all newly recruited staff started at the beginning of the financial year.

Learning Disabilities Patient Contacts	Brent CCG	Central London CCG	Harrow CCG	Hillingdon CCG	West London CCG	Total
2014/15	33	12	59	24	18	145
2015/16	35	22	67	33	16	172
2016/17 (forecast based on M1 to M6 actuals)	61	30	131	91	40	353

The Harrow Learning Disabilities School Pilot has commenced at the beginning of the new academic year, and detailed performance information will be shared shortly with commissioners to allow evaluation of the pilot.

There have also been positive improvements in access for children with Neurodevelopmental conditions. This is reflected in activity levels which have increased by 60%. However the increase is not reflected in referral numbers as children with Neurodevelopmental conditions are coded on our clinical system following diagnosis, not at referral. This can take multiple appointments for a Neurodevelopmental disorder is diagnosed. Therefore the referral numbers below for 2016/17 is lower than reality as a number of children have been seen but not coded as Neurodevelopmental on the system yet.

Neurodevelopmental patient contacts	Brent CCG	Central London CCG	Harrow CCG	Hillingdon CCG	West London CCG	Total
2014/15	578	403	862	269	323	2435
2015/16	666	516	733	289	341	2545
2016/17 (forecast based on M1 to M6 actuals)	1258	510	1002	396	980	4146

Neurodevelopmental referrals	Brent CCG	Central London CCG	Harrow CCG	Hillingdon CCG	West London CCG	Total
2014/15	67	19	79	39	32	236
2015/16	65	21	49	19	29	183
2016/17 (forecast based on M1 to M6 actuals)	16	12	30	4	20	82

There has also been a significant reduction in waiting times for children with Learning Disabilities and Neurodevelopmental conditions with minimal waiting lists at the time of reporting with 11 children waiting to be seen in Brent, 0 in Harrow, 4 in Hillingdon, 3 in West London and 0 in Central London. In September all children with both LD and ND waiting were seen within three weeks of referral with the exception of Brent who had two children from the backlog before funding waiting to be seen.

WLMHT LD/ND Waiting Times

There has been a decrease in the number of new appointments on a like for like comparative basis.

Funding for Waiting Times

Additional funding (£)	Ealing CCG	H&F CCG	Hounslow CCG
2015/16	91,729		
2016/17	16,166 (Q1)		

LD ND

Due to the additional funding into CAMHS, and the ability to provide the service to a wider cohort of children, there has been an increase in the number of children seen with Learning Disabilities / Neurodevelopment conditions, which in turn has had an impact on waiting lists. Funding into WLMHT to date has focused on waiting list initiatives into the ND element of the pathway; LD has not had additional resource to date.

To note that in H&F the work for ND team is currently recorded under one work-unit which includes all Tier 3 referrals and therefore it has not been possible to separate out the waiting time averages, referral to treatment times and number on waiting list as this would require manual data sorting.

In Ealing the waitlist initiative reduced the waiting list by 20% with clinicians seeing over fifty new contacts. In recognition of the demand placed on the services and the transformation work commenced in 2015/16, the CCG has approved funding for an additional two sessions of consultant time, caring for families whose children have a learning disability.

Hounslow Neurodevelopmental Services

Investment: 16/17 funds to reduce waiting time, caseloads and improve accessibility:

Implementation:

- Q1: 4 x Saturday morning clinics: Consultant Psychiatrist, B8a Family Therapist, B6 Nurse, B5 Administrator - Completed
- Q1: B8a WTE 0.8 Agency Clinical Psychologist - Completed
- Locum Psychiatric trainee WTE 0.4 (April-Aug) - underway
- B7 WTE 1.0 Clinical Psychologist – Appointed, HR clearance underway.

Impact:

Activity Data	May-16	Jun-16	Jul-16	Aug-16
Avg wait to Assessment (wks)	48	35	36	34
No of Accepted Referrals	27	43	44	16
No of Discharges	30	19	20	27
No of Contacts (F2F / TC)	306	320	298	130
No of Patients on Waiting List	162	231	258	246
No of First Assessments	19	12	8	15
Longest Wait (wks)	50	48	50	51

- Number of contacts fell in August due to annual leave.
- Number of patients on the waiting list and longest wait is unchanged.

	Ealing CCG	H&F CCG	Hounslow CCG
ND referrals 2015/16	328 accepted	Not able to report due to set-up on clinical system	299 accepted

CYP IAPT

No. of proposed staff (supervisors and clinicians separately) to be trained with new initiative	1 Supervisor (CBT) 1 Trainee ((CBT)

6.3.4 Our Next Steps

2015/16	2016/17	2017/18	2018/19	2019/20
Map current provision and identifiable gaps. Develop service specification.	Revise current services and provide business plans for new services	Develop and commence new services. Embed the model, develop sustainability, evaluate and further refine.		

Between November 2016 and March 2017 CCGs will work with partners including trusts, health, education, and local authorities to re-design their current pathways. CCG commissioners will also connect with local voluntary sector services and support groups for young people with LD/ND and their families (e.g. parent-run ASD support group). Within this period of time an analysis will also be undertaken to determine how we can further decrease waiting times whilst increasing access to services.

Like Minded Strategy and Transformation Team will also aid to coordinate an adult and CYP LD/ND transitions workshop in Q4 of 2016/17. CCGs will need to work with our adult commissioners to define the transition pathways; this will be joint work with the Transforming Care Plan programme of work. Business plans will need to be drawn to propose how we can use shared funds to aid sustain and coordinate the transition process.

One of the most advisable models, for transitions, as recommended by the Anna Freud Centre, is the Transitions Model which provides a backdrop to transitions to adult services identified as early as 16 years of age with support provided, where required, up until the age of 25. The below model reflects the process of tapered transitions.

It is expected that CCGs will begin to finalise their commissioning intentions in March 2017.

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Tapered Transitions

Proposed development of 'tapered' transition period between CAMHS and AMHS between ages of 16 - 25

- Between ages of 16 – 25, young people would have a choice as to whether they wanted to access services in adult or child mental health.
- Young people already receiving services would have the choice as to when they might transition over to AMHS – if this were needed.
- This would allow greater flexibility for transitions led by the needs and wishes of the young person.

Funding

	2015/16	2016/17	2017/18	2018/19	2019/20
Central	£52,000	£60,778	£60,778	£60,778	£60,778
West	£30,000	£85,000	£70,000	£70,000	£70,000
H&F	£79,174	£99,160	£99,160	£99,160	£99,160
Ealing	£91,729	£64,916	£66,000	£66,000	£66,000
Hounslow	£91,000	£61,028	£61,028	£61,028	£61,028
Hillingdon	£100,000	£100,000	£100,000	£100,000	£100,000
Harrow	£54,840	£20,000	£20,000	£20,000	£20,000
Brent	£96,000	£60,000	£60,000	£60,000	£60,000

6.3.5 Localising Priorities

Central London, Hammersmith and Fulham and **West London** are working together with community partners to develop an integrated model with pooled budgets and virtual team services.

Hounslow are increasing the workforce capacity within the CAMHS Neurodevelopmental Service to reduce waiting times.

A full overview of local priorities can be found in the annexes (A-H)

6.4 Priority Two: Crisis and Urgent Care Pathways

Development of a new 24/7 crisis and urgent care pathway

6.4.1 Why We Chose This Area

Even with the best possible mental health care and support, there will always be children and young people who experience mental health crises. During a crisis, quick access to support and treatment is vital to improve mental health outcomes.

Evidence from the UK suggests that families benefit from having an alternative choice to inpatient admission; European evidence suggests that treatment effectiveness can be equivalent to inpatient care in some cases, and that costs are lower for those cases[25]. Although there are no direct financial savings to the CCG, we recognise that the ability to offer seven-days-a-week CAMHS capacity as part of the local home treatment rapid response service would reduce inappropriate admissions to adult wards, and provide less restrictive care options for children.

There have been issues identified for service users in accessing mental health services. This is an on-going issue and NHSE have identified that despite policies and protocols being in place, these often do not appear in practice. Across NWL, we are committed to improving urgent care and support options for children and young people experiencing a mental health crisis, at any time of the day.

By 2020/21, inpatient stays for CYP will only take place where clinically appropriate. This will be achieved through improved access to CYP appropriate 24/7 crisis resolution and liaison mental health services.

6.4.2 The Ambition

We aim to ensure that our local offer of support and intervention for young people reflects the Mental Health Crisis Care Concordat (whereby we are broadly compliant). We will also implement clear, evidence-based pathways for community-based care, including home treatment and crisis response services to ensure that unnecessary admissions to inpatient care are avoided.

NWL has recently agreed a new urgent care and assessment pathway for adults. This demonstrates an excellent collaborative approach across commissioners and providers, with service user input and involving wider stakeholders such as the LAS and Metropolitan Police.

We want to ensure that we build on our learning – to ensure we have a robust and sensitive approach for any child or young person in crisis. To avoid unnecessary duplication, and to make best use of the learning from the recent adult service redesign, where clinically appropriate, the CAMHS crisis and urgent care pathway will be aligned or part of the adult mental health teams.

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[25] Boege, I., Corpus, N., Schepker, R., Kilian, R., & Fegert, J. M. (2015). Cost-effectiveness of intensive home treatment enhanced by inpatient treatment elements in child and adolescent psychiatry in Germany: A randomised trial. European Psychiatry: *The Journal Of The Association Of European Psychiatrists*, **30**(5), 583–589.

We will develop an enhanced service across all eight boroughs to prevent a crisis leading to inpatient admission and deliver home treatment to children and young people, streamlining the current service offering and filling the gaps.

The overall plan is to develop a new service which will comprise of crisis response and home treatment services and will build on existing work to develop a complete urgent care pathway. It is vital that we also work with colleagues in local authority, public health, and schools to ensure that the prevention of self-harm and crisis avoidance via good mental health promotion forms part of this pathway. Where possible, we will look to work with existing home treatment teams to incorporate CAMHS skills and training into existing services. This would reduce unnecessary duplication, and ensure child/parent issues were effectively covered.

The CAMHS, adult mental health services (AMHS) and early intervention services (EIS) services will work together to benchmark themselves against the processes and standards below. They will be expected to identify new policies and procedures where required and an action plan to work towards having the processes in place.

- Co design the care pathways with the Mental Health Trusts, CAMHS, EIS and AMHS young people and families and the receiving service in designing and reviewing the transition pathway to ensure timely referral needed for a safe and smooth access and transition;
- Ensure that the crisis services are appropriately aligned;
- Include GPs in the pathway development to ensure GPs have the relevant information to support people (and their parent carers) during and after treatment;
- Agree the aim and goal of interventions with service user or parent and carer, where appropriate and monitor the changes to agreed and shared goals and to symptoms, amending therapeutic interactions as a result to deliver the best possible outcome;
- Provide information at all stages of the pathway about interventions or treatment options to enable service users and families to make informed decisions about their care appropriate to their competence and capacity;
- Co-produce the care plan and ensure a copy is given to the service user /parent / carer. The care plan should include clear written information not only on their current care plan and named professional contacts but also how to access the services routinely and in a crisis;
- Provide written assessments, care plans etc. that are jargon free (where any technical terms defined);
- Ensure that people leaving the service have a written and agreed discharge plan that supports self-management where possible and explains how to access help if this becomes necessary;
- Where a person is moving to another service, whether to adult mental health services or to a different service, the provider will ensure that the agreed transition protocol is followed with, as a minimum, a joint meeting between the provider and new service that includes the service user and/or family member, a written discharge summary, followed up after six months to check the transition has proceeded smoothly.

6.4.3 Where We Are Now

CCGS and trusts have been working collaboratively within a number of different areas related to the crisis pathway model. Below is an overview of current services and plans.

Out of Hours (OOH) Service

We recognised the need for an OOH service to provide a 24/7 crisis response to our children and young people in NWL. Subsequently the eight CCGs commissioned 2 pilot Out of Hours across NWL. The pilots provided different service structures as seen below.

	CNWL OOH Service	WLMHT OOH Service
Operating Hours	4pm – 8am	4pm – 12am
Staff	2 WTE	2 WTE
CCG Areas Covered	Hillingdon, Harrow, WL, CL, Brent	H&F, Ealing, Hounslow

The services have now been evaluated and anecdotal evidence implies a decrease in inappropriate paediatric admissions and decreased anxieties in the system. At present, however, it is not possible to calculate a direct impact on decreasing inappropriate specialist service inpatient stays, and, we plan to further undertake an analysis as an extended part of our evaluation processes.

Both OOH staff and paediatric staff have also self-reported that the service has decreased service level anxieties and provides an excellent resource to streamline assessment and support for children and young people in crisis. Children and young people report that although there has been an improvement for children and young people they would like to see communication training improvements.

CQUIN

A bed management CQUIN service has been devised by CNWL and CCGs with funding from NHS England. The plan is to utilise the service to streamline process when aiding children and young people, who require a bed, to access inpatient services.

Collaborative Commissioning with NHSE: New Models of Care

WLMHT have been awarded a New Model of Care Pilot site which has been designated to aid map out the pathway from identification of crisis, to assessment of need, access to specialist beds (tier 4), followed by discharge back to CAMHS. This mapping will enable trusts and commissioners to identify new and creative ways of managing an integrated crisis pathway. WLMHT are also currently working collaboratively with CNWL with a further plan to procure beds in NWL.

Whole Systems Crisis Pathway

CCGs have been keen to ensure that the whole crisis pathway model is reviewed to ensure that children and young people can access services 24/7 when in a crisis, as well, as a system that support this mechanism.

Funding

CCGS had originally allocated the below funding for re-designing the crisis model prior to receiving transformation funds. As such it should be noted that the OOH pilot service was funded from savings gained in previous years, however, going forward further funding will need to be allocated to ensure that the necessary crisis provisions can be met.

It should also be noted that it is deemed that the New Model of Care pilot and OOH will ideally decrease expenditure, by 2020, at the inpatient level (by proper management of crisis) and thus shifting funding down from tier 4 (specialist services) with an aim that this will fund a crisis response or home treatment team services. Modelling is required in 2017 to provide accurate projections of trajectories of clients into and out of crisis services, expenditure and how we can move resources to better meet the needs of children and young people.

	2015/16	2016/17	2017/18	2018/19	2019/20
Central	£0	£40,000	£60,000	£60,000	£60,000
West	£65,000	£40,000	£104,000	£104,000	£104,000
H&F	£0	£32,600	£70,000	£70,000	£70,000
Ealing	£32,000	£237,316	£145,000	£145,000	£145,000
Hounslow	£34,000	£75,000	£122,056	£122,056	£122,056
Hillingdon	£100,000	£100,000	£100,000	£100,000	£100,000
Harrow	£40,000	£14,840	£14,840	£14,840	£14,840
Brent	£10,000	£108,000	£108,000	£108,000	£108,000

6.4.4 Our Next Steps

2015/16	2016/17	2017/18	2018/19	2019/20
Scope current provision and identifiable gaps.	Design and consult on new service. Commence service. Embed new OOH Model New Models of Care Programme will begin to aid map out how to decrease inappropriate inpatient admission	Evolve OOH Model to create include a crisis pathway Begin to review the potential need for a Home Treatment/ Crisis Service Procurement of beds in NWL	Implement a pilot crisis model that provides a 3.5 tier crisis response team	Review and mould the model.

CCGS are committed to ensure:

- A clear plan on the reduction of inappropriate admission of under 18s to adult wards when CAMHS beds are unavailable, and reduced demand for CAMHS beds.
- A viable alternative to inpatient care for some cases.
- Supported discharge from CAMHS beds by allowing contingency plans to include crisis team response.
- Children and young people in crisis or with significant needs remain at home where possible.
- Parents and other carers are supported to look after young people in crisis.
- Reduction of A&E attendances and admissions acute hospital due to deliberate self-harm or overdose.

We plan to deliver the above through the following strategies:

Collaborative Commissioning: OOH and Crisis Model – A 24/7 service

CNWL and WLMHT facing CCGS plan to utilise November 2016 to January 2017 to draw together a new OOH service model.[26]

CCGs will then plan to evolve the model over a one year period from 2017 to 2018 to meet the above commitments. CCGs will be reviewing best possible models to achieve their proposed aims.

We propose to continue with a 24/7 model to ensure that our children and young people have access to CAMHS services. We have found, however, that the number of children and young people seen after 2am in the morning rapidly declines. As such, we will be altering (through our pilot) our OOH service operating hours, however will ensure CYP access to crisis services through our night time SPR function.

Collaborative Commissioning: New Models of Care/ Tier 4/Tier 4.5

August 2016 – August 2018 will provide the opportunity for WLMHT, in collaboration with CNWL, to pan out requirements needed for an enhanced service model to decrease the number of inappropriate inpatient (paediatric and inpatient beds) stays, streamline the process of admission to discharge with clear plans for CYP back into the community, and to ensure that CYP and their parents are involved in their care. WLMHT will further be advancing in procuring beds within NWL as we currently do not hold any inpatient beds in London – which is not conducive of the needs of CYP, in NWL, and their families. NHS England currently holds the funds to commission beds nationally for our CYP in NWL; the aim is for bed procurement funds to be released to our trusts.

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[26] This will include Hammersmith and Fulham, in the short term, joining with CNWL, rather than WLMHT, to deliver the service. This is following evaluation reports identifying that children and young people from Hammersmith and Fulham have been presenting to Chelsea and Westminster hospital.

2017 will see the CCGS decide on the most suitable model to provide a crisis treatment response. The proposed plans have been; a Home Treatment Team, team around the child, and a tier 3.5 service (for example, a crisis house). The eventual service will need to meet the needs of CYP in NWL whilst being cost-effective, sustainable and in alignment with our other services available.

A clear plan on how by 2020/21 there will be a reduction in inpatient stays (only where clinically appropriate). The plan will include 24/7 crisis resolution and liaison mental health services.

Like Minded Strategy & Transformation Team will continue to provide project management capacity for this aim.

Collaborative Commissioning Networks: Health Justice

We are working in partnership with NHSE on the Health and Justice/Specialised commissioning CYP Mental Health workstream. A key aim of this workstream is to improve the health and justice outcomes of young people in the borough who are in or at risk of the justice system. NHSE have allocated central funding to this borough for the purpose of commissioning liaison and diversion services and enhancing the health and wellbeing pathway for this group. We plan to conduct a needs analysis and mapping exercise in partnership with the Youth Offending team and other relevant partners in the borough to identify needs and gaps in provision. Once these are understood we will formulate a commissioning proposal to NHSE by 31st December outlining the development of the pathway and what services we plan to commission with the central allocation.

How We Further Plan to Reduce Tier 4 Bed Stays

In order to reduce the number of inpatient beds stays we recognising that we:

a) Need to catch mental health challenges early
b) Provide the opportunity for children and young people to receive intervention at the best possible earliest stage
c) Ensure that we liaise with our partners to provide them with the skillset to aid our children and young people to address mental health challenges.

We have dedicated ourselves to this aim as seen in our ‘Re-designing Pathways’ priority which focuses on:

a) Ensuring that our local Early Interventions teams are intervening at the earliest possible stage
b) Providing Nice Guideline training for professionals, including in the extended network, who work with children and young people (e.g. in schools)
c) Providing training and parental intervention for parents and care givers of children and young people with mental health challenges
d) Aiming to provide access points for CYP – e.g. through implementing a Single Point of Access or Multiple Points of Access
e) Review the possibility of having MENCOS in our schools; we recognise that teaching teachers how to recognise early signs of mental health, intervention

skills and sign-posting mechanisms may reduce the impact of mental health challenges in children and young people.

6.5 Enabler One: Supporting Co-production

Supporting service users, carers and family members to engage with and co-produce support services.

6.5.1 Why We Have Chosen This Area

The importance of co-production is widely recognised across the full range of public services, not just social care and health in NWL. This demonstrates the widespread acknowledgement that each individual has a vital role to play in achieving positive outcomes from public services; especially mental health services.

Emerging outputs of the National Mental Health Taskforce demonstrate the benefits of fully engaging with our population to develop services – as well as supporting on-going monitoring of quality and experience.

Implementing co-produced service redesign is challenging and complex. It involves looking at every aspect of how an organisation works from a wide variety of perspectives. This approach enables the views from a wide range of sources including managers, practitioners, people who use services and carers to shape and develop mental health services that are accessible and achieve the outcomes that stakeholders have identified as important.

6.5.2 The Ambition

Our ambition is to continue to develop a mental health support offer for NWL that has been designed by the children, young people, and parents who will use it and reflects the opinions of the clinicians and professionals who will work within it. Each borough will now also aim to have at least one young persons' Mental Health representative at relevant NWL meetings to ensure co-production is embed in on-going service evaluations and future commissioning. We will consider how best to do this for children of different ages. We will continue to seek advice and specialist input into the most effective approaches to engaging all our stakeholder groups, especially our vulnerable groups including young offenders, looked after children, and care leavers.

6.5.3 Where We Are Now

Local organisations have been funded across the eight boroughs with particular relevance to local needs, and needs of specific under-served groups, to support young people, parents, and other key stakeholders to be involved in co-production.

There have also been a number of local initiatives that feed into the NWL collaborative services. For example, Re-think, funded by the Tri-borough have undertaken an evaluation of the Out of Hours service (details can be found in the Crisis Evaluation section) to ensure that feedback from children and young people, as well as staff, is captured to further improve the service.

We have also had a number of conferences and workshops which have been attended by young people and their parents. This has enabled us to further co-

produce our project such as the Out of Hours Crisis service and our upcoming children's conference.

6.5.4 Our Next Steps

2015/16	2016 - 2021
Scope potential support partners + procure	As co-production underpins the transformation programme as a whole it has been incorporated into the remaining 4 priorities.

Local annexes are able to provide the finer detail regarding how co-production with continue to be embedded into the strategy and transformation of services from 2016 – 2020. CCGs are committed to continue to ensure that:

- Children, young people and parents are engaged with the development of new pathways and services.
- Co-design arrangements are understood and used effectively by all stakeholders.
- Children, young people, parents, and professionals know about support options for children and young people's mental health needs, know how to access them, and feel confident and comfortable in seeking support when it is needed.
- Children, young people and parents report improved experience in using mental health support services.
- Young people and parents are invited to attend NWL CCG Steering and Implementation Groups

Whilst we have been engaging with our key user groups to redesign services and produced this Plan, we have agreed that upon the publication of the Transformation Plan we will provide an opportunity for key stakeholders, including children and young people, to further feedback on the transformation of services.

Our Steering Group provides the opportunity for a number of professionals to meet and steer the transformation of services collaboratively and locally across NWL. We want to further open up the remits of invite to children and young people and to further provide a solid process to ensure that they are invited, and that their views are captured at each meeting. This will aid our ambition to work jointly with our shared service providers to deliver co-production, where appropriate, on a large scale to reduce duplication.

Funding

At the beginning of the Transformation Plan CCGs allocated the following funds to ensure the embedding of co-production into the strategy behind the transformation of local and NWL plans. CCGs will continue to allocate funds to the transformation of services; however, these monies have now been embedded and allocated to support the four main priorities for 2017-2021.

	2015/16	2016/17
Central	£14,175	£27,175
West	£24,913	£34,913
H&F	£28,000	£28,000
Ealing	£13,601	£28,8000
Hounslow	£10,000	£35,000
Hillingdon	£25,000	£25,000
Harrow	£20,000	£10,000
Brent	£32,000	£12,000

6.6 Enabler Two: Needs Assessment

Needs Assessment to update understanding of the populations we serve.

6.6.1 Why We Have Chosen This Area

It was vital to ensure that we captured the needs of each borough, across North West London, to review the data for children and young people's mental health trends. The data could then provide a backbone to potential gaps in the commissioning of services.

6.6.2 The Ambition

The ambition is to utilise Needs Assessments to underpin effective commissioning of both health and non-health services, including those from education, children's services and public health with robust data. This will enable us, year on year, to map need, commission more effectively and monitor outcomes and impact.

We can also commission support on a larger scale across several boroughs, we can take a more strategic view of services that cover several boroughs and continue to develop a clearer NWL picture to support collaborative delivery of our transformation plans.

6.6.3 Where We Are Now

The Anna Freud Centre was commissioned to map out, in detail, current prevalence, demand, services and interdependencies. UCL Partners have further provided individual Needs Assessments, which will be used to analyse local need and provision. The analyses also provide focus on the needs of emerging vulnerable groups such as refugees and asylum seekers are addressed in this assessment.

Upon publication - the Needs Assessments will further enable the individual CCGs and boroughs to further develop and refine service requirements for the remainder of the plan including:

- Local and community CAMHS provision
- How we can extend support to our multi-agencies who work with children and young people
- Informing our commissioning intentions

6.6.4 Our Next Steps

2015/16	2016 - 2021
Scope potential support partners + procure	CCGs to utilise the Needs Assessment to underpin transformation of CAMHS services across NWL.

Upon publication of the Needs Assessment CCGs will work collectively to see how we can further align a pan-borough response to issues (such as suicide prevention, child sexual abuse and exploitation and child neglect) whilst ensuring access to

mental health services for these cohorts in alignment with the Five Year Forward View for Mental Health.

We will furthermore use the needs assessment as a basis to inform our understanding of joined up services and gaps in joint working where collaborative commissioning approaches between CCGs, local authorities and other partners can enable all areas to accelerate service transformation.

The Needs Assessment should also shed light on understanding the requirements of transitional services.

Funding

CCGs had allocated funds to 2015/16 (not including Harrow and Hillingdon as they had already commissioned recent Needs Assessments) to ensure that they accommodated the assessment of currents needs within local boroughs. There will be no further funding allocated by each CCG as this priority has now been met.

	2015/16
Central	£25,000
West	£25,000
H&F	£25,000
Ealing	£21,656
Hounslow	£25,000
Hillingdon	£0
Harrow	£0
Brent	£36,000

6.7 Enabler Three: Workforce Development and Training Strategy

Developing training and support for parents and all professionals in contact with children and young people to identify and respond to mental health needs.

6.7.1 Why We Have Chosen This Area

In developing this plan and working with local young people, CAMHS Teams, GPs and schools, the common theme we heard was that there is a need for development – in the broadest sense. This includes non-specialist training to support greater awareness of mental illness, and the ways to identify and support early signs. It also spans more specialist needs for particular teams – for example following the development of the community eating disorder service ensuring that all members of CAMHS teams have the required competence to support eating disorders within lower tier services.

We also know from work with our public health colleagues that the evidence base for investment in certain development activities is strong (below we demonstrate the long term savings of interventions per £1 spent).

Intervention	Total return for every £1 spent27	Savings to public sector (excluding NHS)	Saving to non-public sector28	Saving to NHS
School based social and emotional learning programmes	£84	£17.02	£57.29	£9.42
GP training for suicide prevention	£44	£0.05	£43.88	£0.08

Recent research carried out by Amplify (the Children's Commissioner's young people's advisory group) highlighted that although most young people seek support from their friends for mental health worries, other common sources of support are parents (43.7%), mental health professionals (40.9%), teachers (20.2%) and school nurses (18.1%)[29]. Teachers and staff in the voluntary sector tell us that they often lack confidence in broaching the subject of mental health and emotional difficulties partly due to stigma and partly due to lack of expertise and support.

The Department for Education has recently issued guidance (Counselling in schools: A blueprint for the future)30 for the appointment of counsellors in schools highlighting the importance of teaching coping skills for those with sub-clinical emotional health and wellbeing issues and increased effectiveness of a whole school approach. In our

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[27] Rounded to nearest pound

[28] E.g. voluntary sector, victim and crime costs not attributable to public sector, workforce productivity

[29] Children's Commissioner (2015). *Everyone has a mental health: A project looking at what young people want if they, or someone they know, have a mental health need or worry.* Accessed at http://www.childrenscommissioner.gov.uk/sites/default/files/publications/amplify-mental-health-report.pdf.

[30] Department for Education (2015). *Counselling in schools: A blueprint for the future.* Accessed at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/416326/Counselling_in_schools_-240315.pdf.

schools locally there are great examples of close working with specialist teams – there are also gaps and challenges as the workload on teachers can be challenging.

Our two local mental health trusts have recently worked closely with their service user groups to redesign their websites and the information available; there is however no comprehensive communication strategy in NWL around how to access CAMHS, or information on mental health for children more generally.

Health Education England NWL (HEENWL) is also very involved in considering, planning, and delivering health service training in a number of areas related to CAMHS, including GP leadership programmes. HEENWL support our proposals and will be a key player in the delivery of this work stream. Also in NWL, the Imperial College Health Partners Academic Health Science Network will be involved in monitoring and evaluating the impact of different training approaches. There is much interest in developing a local offer that can meet the needs of professionals who work with young people, and parents, to improve mental health outcomes.

6.7.2 Our Ambition

In line with implementing the Five Year Forward View by 2020/21, we should be meeting the need of at least 35% of children and young people with a mental health diagnoses. This means we will need to increase our workforce accordingly to meet this need. All services should also be working within CYP IAPT, resulting in at least 3,400 staff (nationally) being trained in specific therapies, supervision, organisational change and team development. We are currently working with our trusts to ascertain the number of staff in NWL who should be trained in CYP IAPT.

Our ambition is to ensure that our partners who work with children and young people with mental health diagnoses are also trained based on NICE guidelines. We are keen that our training not only focuses on professionals, but also on those who have a relationship (whether personal or professional) with children and young people with mental health.

As such we know (from research and work undertaken with Anna Freud Centre) that we need to ensure that training is not limited to the following persons:

- CAMHS professionals
- School staff
- Children's centre staff
- Social care staff
- Youth services staff
- Parents/carers
- GPs
- Allied health professionals including school nurses and health visitors
- Agency leaders – CCG Managing Directors, Councillors, Social Care directors
- Voluntary sector

Workforce Strategy for CAMHS Professionals

In line with the Implementing the Five Year Forward we want to ensure that we increase the training and expansion of the workforce by recruiting and training new therapists and supervisors. On a national level this will be a target of 1,700 new therapists and 334 supervisors by 2020/21.

CYP IAPT

By 2020/21, all services should be working within the CYP IAPT framework, resulting in at least 3,400 staff (nationally) being trained in specific therapies, supervision, organisational change and team development. On a NWL level this means identifying, year on year, staff for CYP IAPT training and subsequently working with trusts and other services to ensure that staff can be released (with NHS E/ CCG backfill allocations) to ensure that this target is met.

Other Training Types

We are ambitious in supporting a step change in the way services are delivered for children and their young people by supporting our workforce to work differently, using their specialist knowledge and skills in more joined up ways. Our aim is to review our current available training packages and draw upon existing evidence base for mental health training in CAMHS

Other Professionals

Each day we have a number of other professionals who come in contact with children and young people. We feel that in many circumstances professionals benefit from relevant training, for example youth teams and drug and alcohol teams. We are committed to analysing the need, at a local level, and furthermore filling the training need gap. In some circumstances this may be CCG funded training or the provision of an available menu of training options that can be 'brought in' by services.

Parents

We are keen to consult with parents and provide, where required, suitable training programmes and intervention support. These packages will include items such as:

- how to recognise signs of children and young people requiring mental health and well-being support, what services are available and how to access them, different referral and acceptance criteria
- how to cope and support children/young people who have challenging behaviour
- how and where to access parenting support programmes

6.7.3 <u>Where We Are Now</u>

CCGs undertook the following steps: Pin-pointing common concerns across NWL, as well as, addressing local gaps in training and development.

A common concern across NWL were the extended waiting times for referral to assessment for children and young people with learning disabilities. CCGs worked closely with trusts to work towards bringing down waiting times. This involved the re-modelling of staff structure, as well as, the employing additional workforce across the boroughs.

6.7.3.1 Overview of Training Investments in Trusts

The impact of the workforce changes on staffing can be seen below:

Investment for Brent and Harrow CYP IAPT in the first year was £355k. As at month 6 2016/17 there is £55k remaining. This is projected to be all spent during 2017/18. The year 2 investment was £80k which as at month 6 there is £45k remaining, is expected to be all spent during 2017/18.

CNWL

Investing training (2016 – current)	Number of Staff
CBT	6
Supervisors in Parenting Interventions	1
Parenting Interventions	1
Systemic Family Practise for Eating Disorders	1
Systemic CYP IAPT	2
Management Course	3
IPTA	1

Planned Training for 2016/2017	Number of Staff
IPTA	1
CBT	1
Systemic Trainee Course	1

We are awaiting information from WLMHT regarding overview of current workforce training investments. This data will be received in October 2016.

6.7.3.2 Training Investments Locally

CCG have also responded to local gaps in training. A full view of interventions and training plans can be found in local annexes.

6.8 Our Next Steps

2015/16	2016/17	2017/18	2018/19	2019/20
Undertake Training Needs Analysis Begin to implement local training plans for professionals	Sep ’16 – Nominate staff for CYPIAPT Training Oct/Nov ’16 – Create 5 year plan for no. of staff who will be trained in CYP IAPT Nov’16 – Utilise AFC Training Needs Analysis to identify local 5 year staff and professionals training plans	2017 – 2018 Scope available providers – working with HEE and HENWL, professional bodies and procure providers Implement and evaluate Increase workforce to meet 35% of need (from 28%) by 2020.		

6.8.1 Joint Agency Workforce Plans: Development and Training

The Anna Freud Centre were commissioned to undertake a number of strategic seminars, with multiple agencies and stakeholders, to further pin down borough training and workforce development requirements.

These reports will be available in November 2016 and will further enhance commissioner knowledge and complement on-going plans in alignment with past and current workforce developments.

The Anna Freud Centre has also drafted a workforce analysis and the final version will include workforce training recommendations based on best practise and NICE guidelines. These recommendations will thread into commissioning intentions, as well as, inform us what training packages we should pre-dispose our staff, agencies and parents to, to further capitalise on ensuring that individuals are appropriately trained to recognise signs of mental health and to further support children and young people with mental health.

6.8.3 Increasing Workforce to Meet 35% of Need By 2020

We know, from the Five Year Forward View (August 2016) that we need to meet 35% of mental health need (based on prevalence) by 2021. We further know that we will need to expand our workforce to match this need. We will work together, with trusts, by December 21st to draw and map out plans to increase workforce to meet needs of CYP with Mental Health diagnoses. The chart below shows expected numbers of children who will receive treatment by 2021. We will be calculating current need met (by asking our providers to provide data) and subsequently calculating workforce expansion needs required to meet this need. We will be using the £25million to help us to begin to meet this need. We will also utilise part of these funds to further bring down waiting times.

The table below shows expected number of additional CYP treated by 2021 based on prevalence data.

			Expected percentage of CYP treated				
			2016/17	2017/18	2018/19	2019/20	2020/21
Borough	**Estimated prevalence (2014)**	**Current no. of CYP Treated**	28%	30%	32%	34%	34%
Brent	4572		1280	1372	1463	1554	1554
Ealing	4692		1314	1408	1501	1595	1595
H&F	1828		512	548	585	622	622
Harrow	3171		888	951	1015	1078	1078
Hillingdon	4051		1134	1215	1296	1377	1377
Hounslow	3468		971	1040	1110	1179	1179
K&C	1440		403	432	461	489.6	490
Westminster	2417		677	725	773	822	822

CCGs are currently working with trusts to identify both a) the number of which the workforce will need to increase by and b) the plan to increase the workforce to meet the needs of 35% of children and young people by 2020. We will create a Local Workforce Action Board (LWAB) as a mechanism to help us to reach our aims. This modelling exercise will be completed in November 2016 and trusts have provided NHS England data to this effect. NHS will further be confirming additional funds for waiting times initiatives.

6.8.4 CYP IAPT

By 2020/21, all services should be working within CYP IAPT, resulting in at least 3,400 staff (nationally) being trained in specific therapies, supervision, organisational change and team development.

In November 2016 CCGs will be further working with trusts and the Anna Freud Centre to determine how many staff needs to be trained in CYP IAPT by 2020. Staff training backfill is at a cost of £10k per staff member. It is essential that CGGS are able to ensure that they are able utilise their transformation funds to support staff support funds.

7.0 Governance and Risks

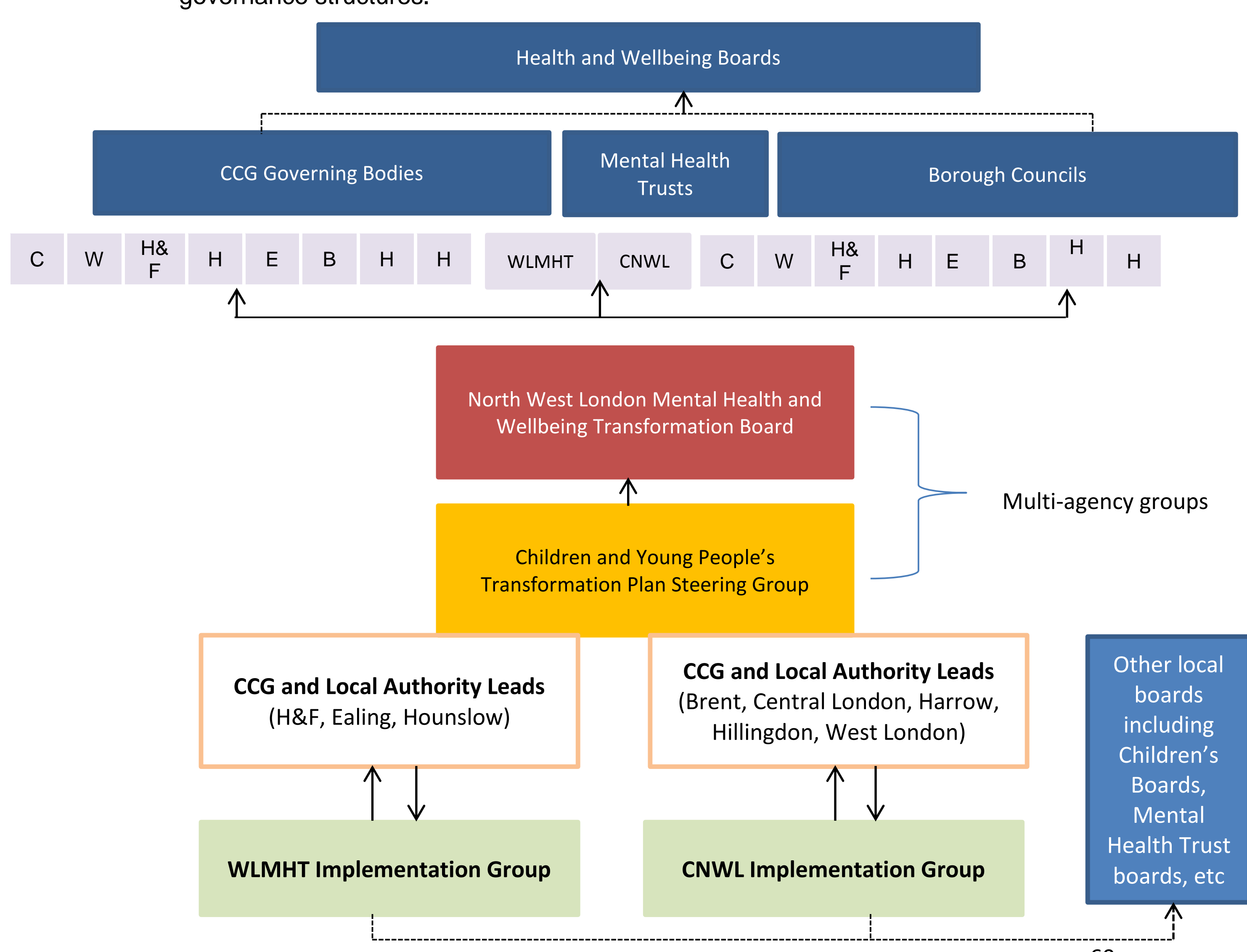
The Steering Group supporting the development of this plan has brought together the key representatives from the eight CCGs – as well as tasking the leads to engage locally with the wider teams not represented at the table. The Steering Group reports formally to the NWL Mental Health and Wellbeing Transformation Board – which is accountable to its constituent CCGs and Health and Wellbeing Boards. The Board is multi-agency and has oversight of the entirety of mental health and wellbeing strategic development across NW London.

We propose that this Steering Group continues to meet to oversee the transition from developing plans into implementation – and quickly onto business as usual.

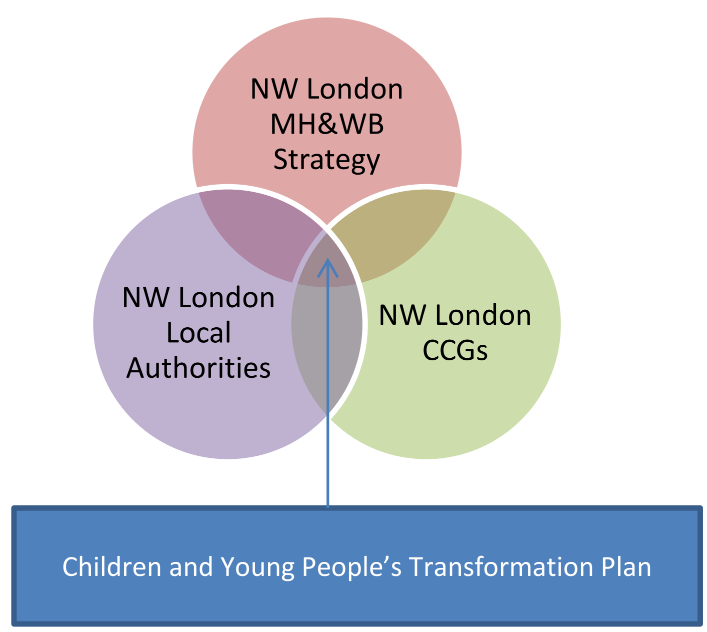
We have also formed (or re-started) 2 dedicated multi-agency implementation groups to support the development and delivery of projects with our local mental health trusts:

- WLMHT facing CCGs (Ealing, Hammersmith & Fulham and Hounslow)
- CNWL facing CCGs (Brent, Central London, Harrow, Hillingdon and West London)

As well as reporting to the Steering Group, these groups will have a clear link to local governance structures.



Our over-arching governance model links the NWL Mental Health and Wellbeing Strategy with the 8 NWL CCGs and Local Authorities, with clear governance and reporting to ensure shared ownership of delivery of our transformation plans (as shown below).

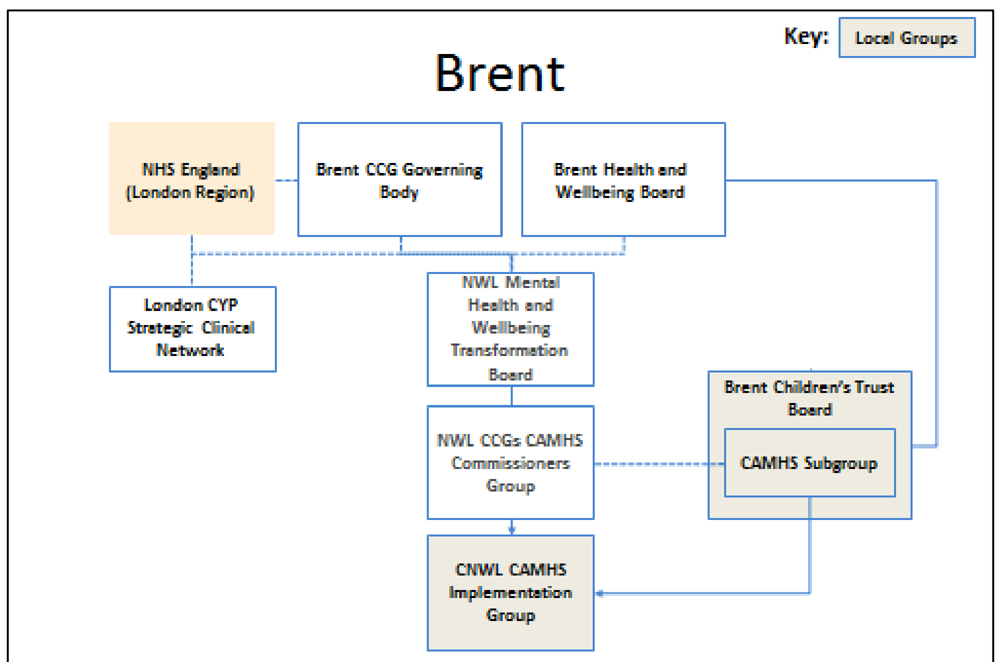


In developing our plans – and in ensuring we continue to work collaboratively across North West London - we have a clear governance structure at the NWL level. We also know that transformation happens at the local level and much of our plans will be delivered locally. Each CCG has a clear structure for engaging different agencies in delivering change – these ensure connections to local decision making bodes in CCGs and Local Authorities as well as the right links to wider children's work and mental health developments:

The Transformation Board at a NWL level has NHS England representation providing a clear link to specialist commissioning and Health in Justice teams.

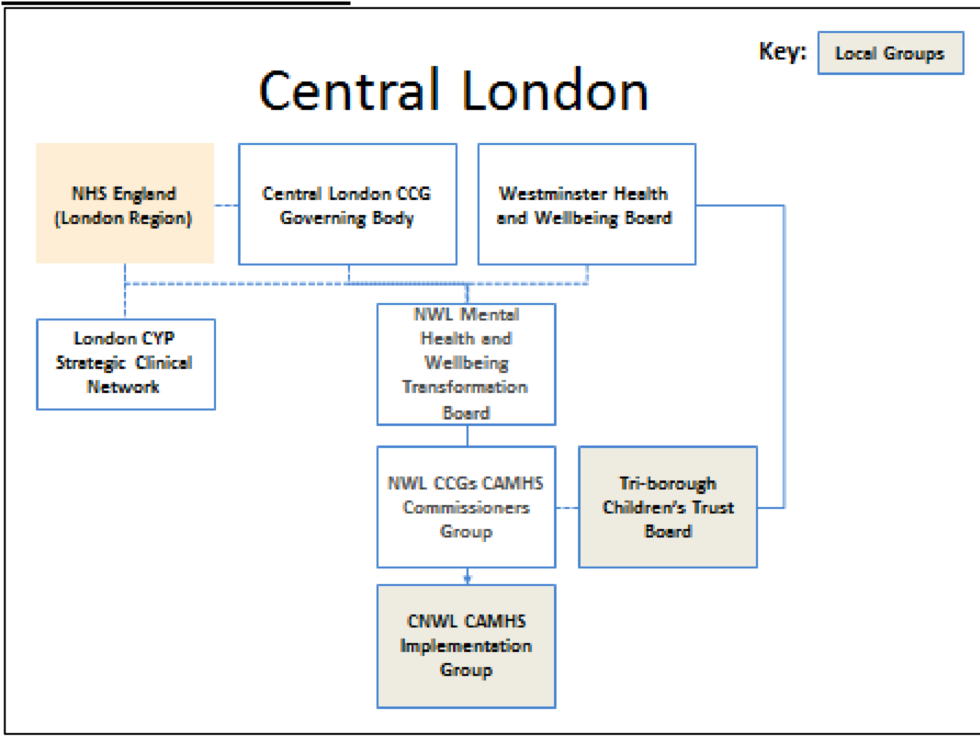
Further to our over-arching governance arrangements, the governance structures of each CCG are outlined in detail below.

BRENT CCG



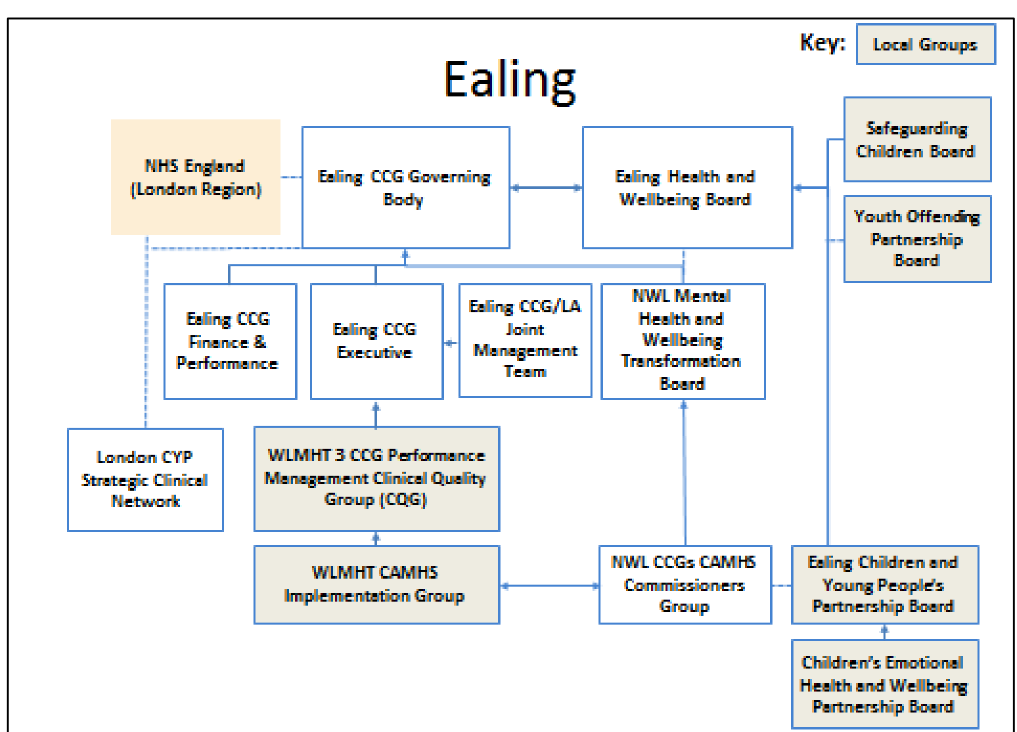
Brent's Children's Trust Board provides a multi-agency governance structure for coordinating work on children's services, and has agreed to establish a new sub-group for CAMHS to deliver the local Transformation Plan. A reviewed commissioning framework has been agreed. The Health and Well-being Board members contributed to the development of the plan, and have formally recognised the need to make mental health (all ages) an area of focus.

CENTRAL LONDON CCG



EALING CCG

Ealing CCG is represented by the Health of Children's Commissioning (Maggie Wilson) on the local performance management board and has worked with the team to devise health action plans.



HAMMERSMITH AND FULHAM CCG

Key:
Local Groups

Hammersmith & Fulham

NHS England (London Region)

Hammersmith & Fulham CCG Governing Body

Hammersmith & Fulham Health and Wellbeing Board

London CYP Strategic Clinical Network

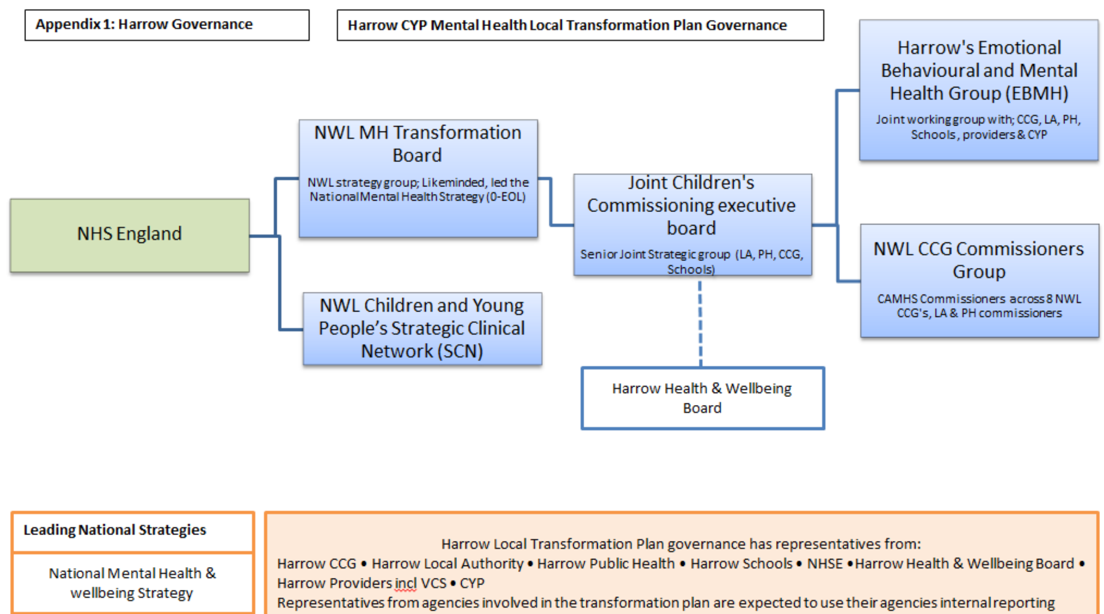
NWL Mental Health and Wellbeing Transformation Board

NWL CCGs CAMHS Commissioners Group

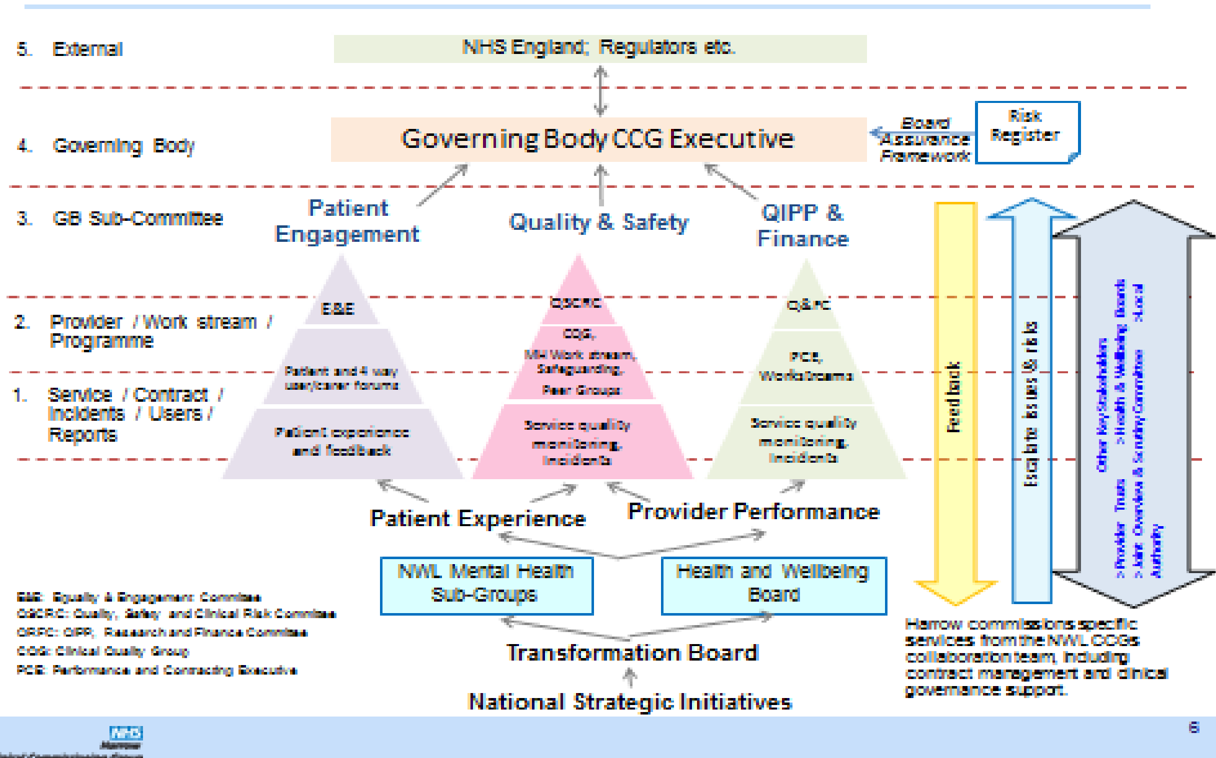
Tri-borough Children's Trust Board

WLMHT CAMHS Implementation Group

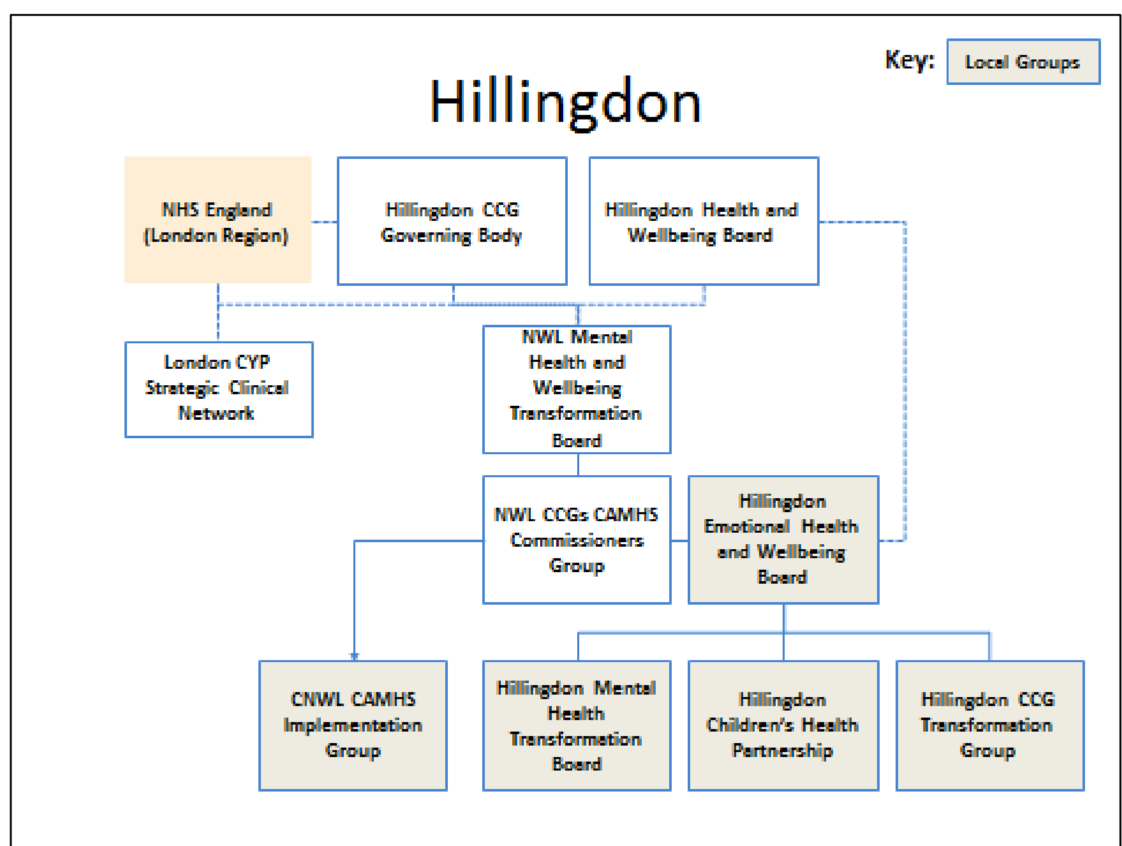
HARROW CCG



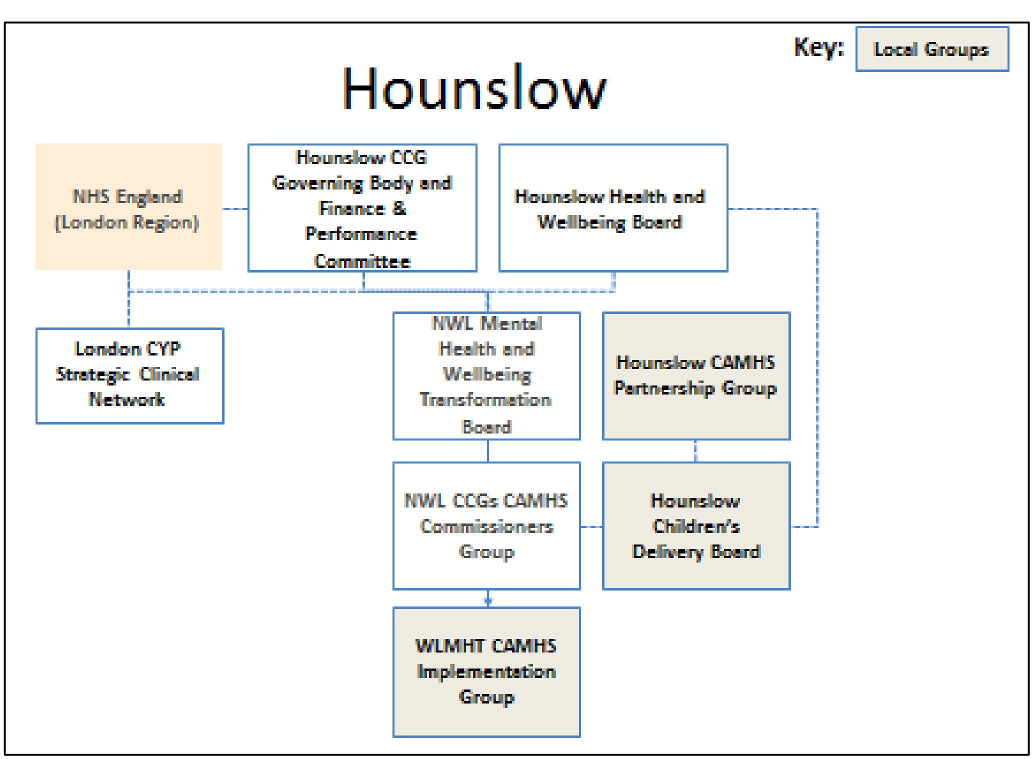
Quality and Safety



HILLINGDON CCG



HOUNSLOW CCG



8. RISK MANAGEMENT

As with the wider NWL transformation programmes, we will continue to focus on a robust process of risk management. Our current risks are outlined in the table below:

RISK REGISTER					
	Description	**Impact**	**Inherent Risk Rating**	**Avoidance / Mitigation**	**Residual Risk Rating**
R1	The wider context of risks of funding cuts to CCGs and LAs will impact on activity and resource for Transforming mental health services for children and young people.	We will not achieve the level of transformational change required to improve the quality of care for children and young people whilst ensuring financial sustainability across the system.	12	Working with multi-agency colleagues to ensure we describe a joined up approach but ensuring we do not dilute the ambition through funding gaps in service rather than transformation.	12
R2	Need to commence Eating Disorders service in 2015/16	Doing so requires dedicated resource and quick implementation	6	Both trusts already working with local commissioners to commence work. TP should enable additional funding for this work. A single tender waiver sought to enable continued work with current providers and rapid service development.	6
R4	Short timescales for spending 2016/17 financial allocation means we don't secure maximum benefit from 15/16 funding.	If we do not access all available funds, we may not set appropriate foundations for transformation in the coming years.	12	We are working with existing providers to agree arrangements for funding projects in year and agreeing tender waivers with our CCGs and have commenced early planning for new work in 15/16.	9

ANNEX A: Brent CCG (attached as a separate document)

ANNEX B: Central London CCG (attached as a separate document)

ANNEX C: Ealing CCG (attached as a separate document)

ANNEX D: Hammersmith and Fulham CCG (attached as a separate document)

ANNEX E: Harrow CCG (attached as a separate document)

ANNEX F: Hillingdon CCG (attached as a separate document)

ANNEX G: Hounslow CCG (attached as a separate document)

ANNEX H: West London CCG (attached as a separate document)

ANNEX I – Engagement Log

In the development of this plan we have consulted widely with our Children and Young people, their parents and carers, our and key partners across schools, social care and health teams. Evidence can be supplied on request. The table describes the key groups and populations we have actively engaged with – however at a local level our developments have been informed by on-going discussions with a far greater range of people.

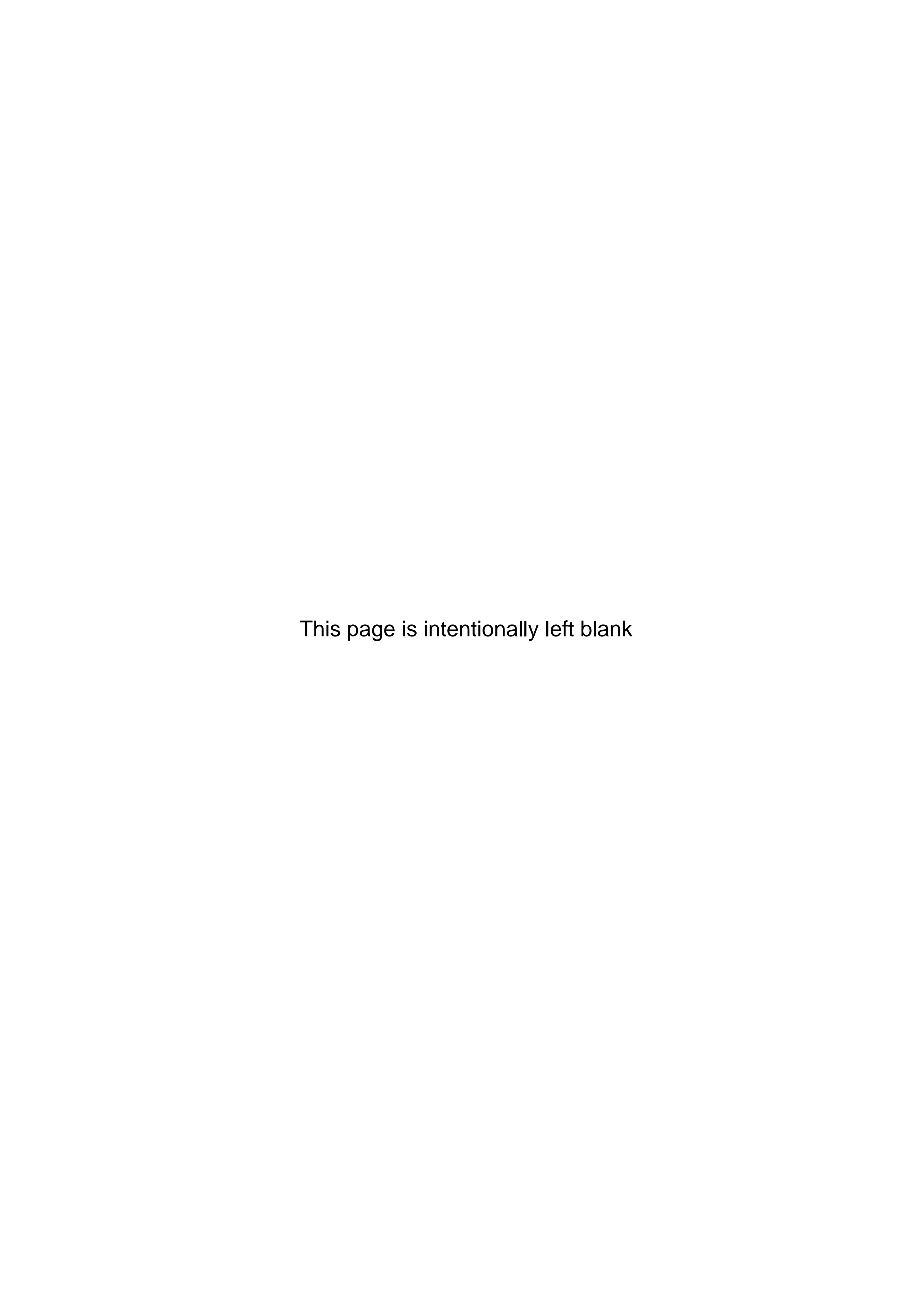
Brent CCG
Central London CCG
Ealing CCG
Hammersmith & Fulham CCG
Harrow CCG
Hillingdon CCG
Hounslow CCG
West London CCG
NHS England Specialised Commissioning (CAMHS)
NHS England Mental Health Team
Brent Council
Westminster City Council
The Royal Borough of Kensington and Chelsea
The London Borough of Hammersmith and Fulham
Ealing Council
Harrow Council
The London Borough of Hillingdon
The London Borough of Hounslow
Healthwatch Brent
Healthwatch Central London
Healthwatch Ealing
Healthwatch Hammersmith and Fulham
Healthwatch Harrow
Healthwatch Hillingdon
Healthwatch West London
Central and North West London Mental Health Trust
West London Mental Health Trust
Health Education North West London
Youth Justice Teams
Healthy Schools Partnerships
Rethink Young People
Imperial College Healthcare NHS Trust
Central London Community Healthcare NHS Trust

ANNEX J – Glossary of Terms

ADHD	Attention deficit hyperactivity disorder	A group of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness.
ASD	Autistic spectrum disorders	A condition that affects social interaction, communication, interests, and behaviour.
CAMHS	Child and adolescent mental health services	Services that work with children and young people who have difficulties with their emotional or behavioural wellbeing.
CBT	Cognitive behavioural therapy	A talking therapy that can help you manage your problems by changing the way you think and behave.
CCG	Clinical commissioning group	Groups of local GPs and other health professionals who commission most of the hospital and community NHS services in the local areas for which they are responsible. Commissioning involves deciding what services are needed and ensuring that they are provided.
CLCCG	Central London clinical commissioning group	The clinical commissioning group responsible for commissioning health care services for the residents of the borough of Westminster (excluding the areas of Queens Park and Paddington).
CNWL	Central and North West London NHS Foundation Trust	An NHS provider of mental health, sexual health, physical health, addictions, eating disorder and learning disability services.
CORC	CAMHS outcome research consortium	A group of mental health providers, schools, service users and researchers to work together to develop and improve the effective and routine use of outcome measures in work with children and young people (and their families and carers) who experience mental health and emotional wellbeing difficulties.
CQUIN	Commissioning for quality and innovation	A payment framework that enables commissioners to reward excellence, by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals.
CYP IAPT	Children and young people's increasing access to psychological therapies	A service transformation programme delivered by NHS England that aims to improve existing child and adolescent mental health services working in the community.
DBT	Dialectical behaviour therapy	A type of talking therapy based on cognitive behavioural therapy (CBT) that has been adapted to meet the particular needs of people who experience emotions very intensely.
DfE	Department for Education	The government department responsible for education and children's services in England.
ED	Eating disorder	A mental health condition characterised by an abnormal attitude towards food that causes someone to change their eating habits and behaviour. The most common eating disorders are anorexia nervosa, bulimia, and binge eating

		disorders.
ESCAN	Ealing service for children with additional needs	A joint initiative between Ealing Primary Care Trust and Ealing Council, working towards a single point of information with improved access to referral, assessment and appropriate interventions for children and young people with disabilities in the borough.
Future in Mind	The Department of Health's policy on promoting, protecting and improving our children and young people's mental health	The policy makes a number of proposals the government wishes to see by 2020 including tackling stigma and improving attitudes to mental illness, introducing more access and waiting time standards for services, establishing 'one stop shop' support services in the community and improving access for children and young people who are particularly vulnerable.
GP/s	General Practitioner/s	Doctors who deal with a whole range of health problems and provide health education, offer advice on smoking and diet, run clinics, give vaccinations and carry out simple surgical operations.
H&F	Hammersmith and Fulham	The London borough of Hammersmith and Fulham.
JSNA	Joint strategic needs assessment	A process by which local authorities, clinical commissioning groups, and other public sector partners jointly describe the current and future health and wellbeing needs of its local population and identify priorities for action.
LA	Local authority	An administrative body in local government responsible for providing a range of services for local residents including children and family services and health and adult social care.
LAC	Looked after children	A child who is accommodated (which means that the council is looking after them with the agreement, at the request or in the absence of their parents) or subject to a Care Order made by the Family Courts.
LD	Learning disability	A reduced intellectual ability and difficulty with everyday activities – for example household tasks, socialising or managing money – which affects someone for their whole life.
Like Minded	The mental health and wellbeing strategy for North West London	A strategy that encourages working in partnership to look at how we can deliver excellent, joined up services that improve the quality of life for individuals, families and communities who experience mental health issues.
MDT	Multidisciplinary team	A team of professionals with different qualifications and experience who work together to provide a total package of care.
ND	Neurodevelopmental disorder	Disorder that can affect children and young people's development, including their intellectual, motor, communication, behaviour

		and / or social development. The most common neurodevelopmental disorders are attention deficit hyperactivity disorder (ADHD) and autistic spectrum disorder (ASD).
NHS	National Health Service	The universal healthcare system in the United Kingdom.
NHSE	National Health Service England	The leadership organisation of the National Health Service (NHS) in England. They set the priorities and direction of the NHS and encourage and inform the national debate to improve health and care.
NICE	National institute for health care and excellence	A non-departmental public body, accountable to to but independent of government that provides national guidance and advice to improve health and social care.
NWL	North West London	The north west region of London that includes the London boroughs of Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and Westminster.
OOH	Out of hours	Outside of normal business hours of 9am to 5pm Monday to Friday.
ROMS	Reported outcome measures	Measures that provide a means of gaining an insight into the way patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life.
SAFE	Situational awareness for everyone	A two year programme led by the Royal College of Paediatrics and Child Health which, in partnership with 12 hospitals, is developing and trialling a suite of quality improvement techniques.
SEND	Special educational needs and disabilities	Learning difficulties or disabilities that make it harder for them to learn than most children and young people of the same age.
TAMHS	Targeted mental health in schools	A national project to transform the way that mental health support is delivered to children aged 5 to 13, to improve their mental well-being and tackle problems more quickly
WLCCG	West London clinical commissioning group	The clinical commissioning group responsible for commissioning health care services for the residents of the boroughs of Kensington and Chelsea and the Queens Park and Paddington areas of Westminster.
WLMHT	West London mental health NHS trust	An NHS provider of mental health services for a range of conditions or illnesses affecting people's psychological wellbeing.
WTE	Whole time equivalent	A unit that indicates the workload of a full time employed person.
YOT	Youth offending team	Teams of professionals that work with young people that get into trouble with the law, are arrested, or taken to court, and help them stay away from crime.



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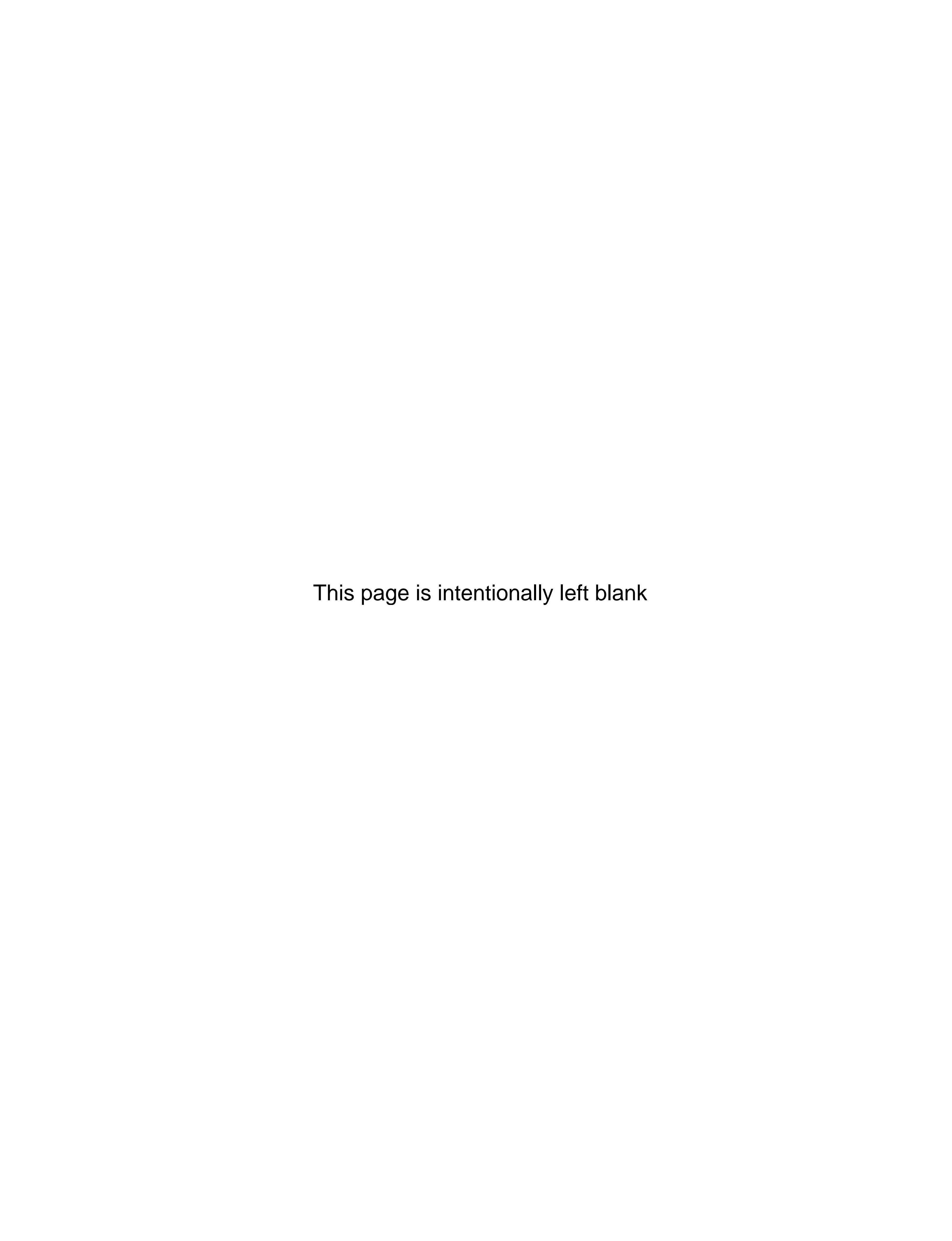
Westminster Health & Wellbeing Board
Work Programme
2017

Agenda Item	Item
2 FEBRUARY 2017	
BETTER CARE FUND PLANNING UPDATE + ALLOCATIONS 2017/18	For decision
JOINT HEALTH AND WELLBEING STRATEGY IMPLEMENTATION	For decision
HEALTH HUBS	For discussion
UPDATE ON SUSTAINABILITY TRANSFORMATION PLANS	For discussion
PHARMACEUTICAL NEEDS ASSESSMENT	For discussion
CCG COMMISSIONING INTENTIONS	For discussion
JSNA Highlights report	For discussion
27 MARCH 2017	
HEALTH + SOCIAL CARE INTEGRATION PLANS	For decision
LEARNING FROM THE LONDON DEVOLUTION PILOTS	For discussion
JOINT HEALTH AND WELLBEING STRATEGY IMPLEMENTATION	For discussion
CCG OPERATING PLANS 2017/18	For discussion
HEALTH HUBS	For discussion
PHARMACEUTICAL NEEDS ASSESSMENT	For discussion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