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Committee Agenda

City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Title:	**Health & Wellbeing Board**
Meeting Date:	**Thursday 28th March, 2019**
Time:	**4.00 pm**
Venue:	**British Land Offices, York House, 45 Seymour Street, Marble Arch, London, W1H 7LX (3rd Floor, Rooms 3.11 & 3.12)**

Members:

Cllr Heather Acton (Chair)	WCC - Cabinet Member for Family Services and Public Health
Councillor David Lindsay (Chair)	RBKC – Lead Member for Healthy City Living
Cllr Emma Will	RBKC - Lead Member for Families, Children and Schools
Cllr Sarah Addenbrooke	RBKC - Lead Member for Adult Social Care
Cllr Nafsika Butler-Thalassis	WCC - Minority Group
Melissa Caslake	Bi-Borough Children's Services
Olivia Clymer	Healthwatch Westminster
Angeleca Silversides	Healthwatch RBKC
Dr David Finch	NHS England
Jo Ohlson	NHS England North West London
Bernie Flaherty	Bi-Borough Adult Social Care
Houda Al-Sharifi	Interim Director of Public Health
Toby Hyde	Imperial College NHS Trust
Philippa Johnson	Central London Community Healthcare NHS Trust
Dr Andrew Steeden	Chair of West London CCG
Dr Naomi Katz	West London CCG
Detective Inspector Iain Keating	Metropolitan Police
Detective Inspector Seb Adjei-Addoh	Metropolitan Police
Dr Neville Purssell	Central London CCG

Hilary Nightingale	Westminster Community Network
Maria O'Brien	Central and North West London NHS Foundation Trust
Jennifer Travassos	Housing and Regeneration
Angela Spence	Kensington & Chelsea Social Council representative
Iain Cassidy	Open Age representative

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

Admission to the public gallery is by a pass, this will be issued from the ground floor reception. If you have a disability and require any special assistance please contact the Committee Officer (details listed below) in advance of the meeting.

If you require any further information, please contact the Committee Officer, Tristan Fieldsend Committee and Governance Officer.

Tel: 7641 2341; Email: tfieldsend@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 Director of Law in advance of the meeting please.

AGENDA

PART 1 (IN PUBLIC)

1. WELCOME TO THE MEETING

Kensington & Chelsea and Westminster Chairs to welcome everyone to the first joint Kensington & Chelsea and Westminster Health and Wellbeing Board meeting.

2. MEMBERSHIP

To report any changes to the Membership of the meeting.

3. DECLARATIONS OF INTEREST

To receive declarations of interest by any Board Member or Officer who has any interests to declare in respect of the items to be discussed.

4. MINUTES **(Pages 7 - 22)**

I) To agree the Minutes of the Royal Borough of Kensington & Chelsea and Westminster Health & Wellbeing Board sovereign meetings held on 12 September 2018 and 13 September 2018 respectively.

II) To agree the minutes of the concurrent Royal Borough of Kensington & Chelsea and Westminster Health & Wellbeing Board meeting held on 24 January 2019.

5. BRITISH LAND PRESENTATION ON HEALTH AND WELLBEING

To receive a presentation on British Land's work to support health and wellbeing.

PART A - HEALTH AND WELLBEING BOARD PRIORITIES

6. SUGAR - APPROACH TO ORAL HEALTH AND OBESITY **(Pages 23 - 30)**

Kate May and Sarah Crouch, Bi-Borough Public Health, to present on RBKC and Westminster's ongoing work to tackle poor oral health and obesity in Kensington & Chelsea and

Westminster, particularly amongst children.

7. DEMENTIA STRATEGY

To receive a verbal update from Anne Pollock**,** Principal Policy Officer, on the progress of the Dementia Strategy.

PART B - OTHER IMPORTANT ITEMS SPONSORED BY THE BOARD

8. IMMUNISATIONS AND FLU VACCINATIONS **(Pages 31 - 66)**

Sarah Crouch**,** Interim Consultant, Bi-Borough Public Health, to provide a contextual overview of immunisations and vaccinations in the bi-borough.

Dr Catherine Heffernan**,** Principal Advisor for Commissioning Immunisations and Vaccination, NHS England, to present an update on the level of uptake of immunisations and flu vaccinations in Kensington & Chelsea and Westminster.

9. VIOLENCE AGAINST WOMEN AND GIRLS STRATEGIC PARTNERSHIP LINK WITH THE HEALTH & WELLBEING BOARD

To receive a verbal update from Shabana Kauser (Bi-Borough Strategic Lead for VAWG) on of the work of the VAWG Partnership and how it can work more closely with the Health & Wellbeing Board in future.

PART C - MONITORING - STATUTORY ITEMS/OTHER

10. CENTRAL LONDON CCG GOVERNING BODY COMMISSIONING ARRANGEMENTS **(Pages 67 - 88)**

Neville Purssell, Chair of Central London CCG, to present Central London CCG's update on future commissioning arrangements, and progress on the North West London Health & Care Partnership.

11. BETTER CARE FUND UPDATE **(To Follow)**

To receive an update from Senel Arkut (Bi-Borough Adult Social Care)

12. LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT

(Pages 89 - 134)

Emma Biskupski, Local Safeguarding Children Board Business Development Manager, to present the latest Children's Safeguarding report.

13. ANY OTHER BUSINESS

The Board to consider any other business which the Chair considers urgent.

Stuart Love
Chief Executive, City of Westminster

Barry Quirk, RB Kensington & Chelsea
20 March 2019

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Minutes of a meeting of the Kensington and Chelsea Health and Wellbeing Board held at Kensington Town Hall at 2.00pm on Wednesday 12 September 2018

PRESENT

Members of the Board

Councillor David Lindsay (Chair, Lead Member for Healthy City Living)
Councillor Sarah Addenbrooke (Lead Member for Adult Social Care)
Professor John Ashton (Interim Director of Public Health)
Bernie Flaherty (Bi Borough Executive Director of Adult Social Care and Health)
Holly Holmes (Strategic Commissioner, Children's Services) (Deputy for Annabel Saunders)
Angeleca Silversides (Central and West London Healthwatch)
Dr Andrew Steeden (Vice-Chair, Acting Chair of West London CCG)
Spencer Sutcliff (Borough Commander for Kensington and Chelsea, London Fire Brigade)

Also in attendance *(including deputies attending **in addition to** primary representatives and officers presenting to the committee or observing)*

Senel Arkut (Interim Director of Health Partnerships)
Dr Oisin Brannick (Clinical Lead, North Kensington Recovery, West London CCG)
Iain Cassidy (Director of Open Age)
Olivia Clymer (Chief Executive Officer, Healthwatch Central West London)
Dr Edward Farrell (GP Lead on the Memory Service, West London CCG)
Councillor Robert J. Freeman (Health Scrutiny)
Mona Hayat (Director, North Kensington Recovery, West London CCG)
Councillor Pat Healy (Health Scrutiny)
Louise Proctor (Managing Director, West London CCG)
Claire Simmons (Chair, St Andrew's Square Residents' Association)
Angela Spence (Chief Executive, Kensington and Chelsea Social Council)
Nafsika Thalassis (BME Health Forum)
Jane Wheeler (Interim Associate Director for Mental Health, West London CCG)
Councillor Charles Williams (Health Scrutiny)
Gareth Ebenezer (Governance Services, Clerk to the Board)

A G E N D A

A1. MEMBERSHIP

The Board welcomed new members Professor John Ashton (Interim Director of Public Health) and Spencer Sutcliff (Borough Commander for Kensington and Chelsea, London Fire Brigade).

A2. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Emma Will (Lead Member for Families, Children and Schools); Reneta Charles (Central and

West London Healthwatch) and from Annabel Saunders (Assistant Director for Commissioning and Innovation).

A3. DECLARATIONS OF INTEREST

In respect of Minute A6 (Progress delivering the West London CCG Integrated Care Strategy) both Mr Cassidy and Ms Spence declared an interest as both worked for voluntary organisation active in RBKC.

A4. MINUTES OF THE PREVIOUS MEETING, HELD ON 11 JULY 2018

The minutes of the meeting held on 11 July 2018 were confirmed as a correct record and signed by the Chair.

A5. NORTH KENSINGTON HEALTH RECOVERY PROGRAMME UPDATE

From the CCG Mona Hayat introduced her report; her commentary concentrating on paragraph 4 (Health and Wellbeing in the Longer Term (from September 2018)). She stressed that the local community would continue to influence the provision of services. It was hoped that there would be a first draft of the North Kensington Health Recovery Plan ready to come to this Board in the New Year.

Action by: *Governance Administrator (to note future agenda item)*

In subsequent questions a number of individual cases known to Board members were alluded to. The point was reinforced that Central and North West London (CNWL) NHS Foundation Trust was both the general mental health provider and the Grenfell area provider. Ms Hayat empathised the role of local primary care and Ms Proctor added that the local Healthwatch often assisted in individual cases.

Ms Hayat confirmed to Councillor Williams that NHS England had been very supportive and appeared to share West London CCG's plans for future services.

The Board noted the report and asked Ms Hayat to keep it informed of future developments.

A6. PROGRESS DELIVERING THE WEST LONDON CCG INTEGRATED CARE STRATEGY

Jane Wheeler introduced the main points of the report. RBKC was lucky to have a number of vibrant community organisations. My Care My Way (MCMW) was the flagship project.

In subsequent questions, Dr Steeden confirmed that West London CCG was leading the pace here and that other authorities were learning from West London CCG. In broader discussion Mr Ashton confirmed that Finland was regarded as the long term international leader in this field.

A7. REDESIGNING MEMORY ASSESSMENT SERVICES IN KENSINGTON AND CHELSEA

Once again Jane Wheeler introduced the main points of this report which described the collaborative work between Central and North West London NHS Foundation Trust (CNWL) and West London CCG. She was assisted in

her introduction by Dr Edward Farrell, who specialised in memory assessment services. Ms Wheeler stressed that there had been a significant reduction in waiting times.

In subsequent discussion Ms Flaherty welcomed the move to a joined up memory service. The Chair broadened the debate by asking what this Board needed to do to be classified as 'dementia friendly'. Members of the Board were sympathetic to this overall aim although recognised that it was an ambitious goal. Mr Cassidy added that the voluntary sector had a significant role to play here.

RESOLVED-

That the Board has the stated ambition to be 'dementia friendly' and undertakes to coordinate all necessary activity to achieve this status.

Action by: *ASC officers*

(in collaboration with West London CCG and CNWL)

A8. FUTURE AGENDA ITEMS

The contents of the report on the agenda were received and noted.

The Chair asked Board members what they would like to see as future agenda items. General discussion ensued. Councillor Freeman called for a greater stress on actions and outcomes.

The Chair wondered if some form of follow up report on previous items could be produced for each meeting.

Action by: *ASC officers*

The Board noted that there was a likelihood of closer future coordination with the Westminster Health and Wellbeing Board.

A9. ANY OTHER URGENT MATTERS

None.

A10. EXCLUSION OF THE PRESS AND PUBLIC

The Board did not take any such resolution as there were no items on the agenda, and no urgent matters, for consideration in private session.

The meeting ended at 3.45pm.

Chair

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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 13th September, 2018**, Rooms 3.6 and 3.7, 3rd Floor, 5 Strand, London, WC2 5HR.

Present:

Councillor Heather Acton: Chairman and Cabinet Member for Family Services and Public Health
Councillor Nafsika Butler-Thalassis (Minority Group Representative)
John Ashton (Interim Director of Public Health)
Hilary Nightingale (Chair of Westminster Community Network)
Bernie Flaherty (Bi-Borough Executive Director of Adult Social Care)
Jennifer Travassos (Head of Prevention)
Olivia Clymer (Healthwatch Westminster)
Maria O'Brien (Central and North West London NHS Foundation Trust)
Annabel Saunders (Assistant Director for Commissioning and Innovation)
Holly Manktelow (Central London CCG)
Niamh McLaughlin (Central London CCG)
Senel Arkut (Director of Health Partnerships)
Christine Mead (WCC Strategic Commissioner)
James Benson (Central London Community Healthcare NHS Trust)
Jon Lear (Imperial College NHS Trust)
Peter Armfield (CityWest Homes)

1 MEMBERSHIP

1.1 Apologies for absence were received from Dr Neville Purssell (Clinical Representative from the Central London Clinical Commissioning Group), Basirat Sadiq (Central London Community Healthcare NHS Trust), Dr Naomi Katz (Clinical Representative from West London Clinical Commissioning Group), Clare Robinson (Imperial College NHS Trust), Louise Proctor (Managing Director – NHS West London Clinical Commissioning Group), Melissa Caslake (Bi-borough Director of Children's Services), Dr David Finch (NHS England) and Detective Inspector Iain Keating (Metropolitan Police).

2 DECLARATIONS OF INTEREST

2.1 No declarations were made.

3 MINUTES AND ACTIONS ARISING

3.1 **RESOLVED:**

That the minutes of the meeting held on 12 July 2018 be signed by the Chairman as a correct record of proceedings.

3.2 The Chairman was pleased to announce that Jennifer Travassos had been shortlisted for the Women in Housing Award 2018 and expressed the Board's congratulations.

3.3 The Chairman expressed the Board's concern that the Central London CCG was withdrawing funding from the Children's Joint Commissioning Plan. In response, a letter setting out the Board's concerns would be issued.

3.4 The Chairman invited Peter Armfield, Quality and Sustainability Manager for CityWest Homes, to join the meeting and provide an update on the housing initiatives he was leading on. The Board was informed that a budget had been allocated to help CityWest Homes tenants whose properties suffered from mould and condensation issues. Information on how the programme operated was provided along with an overview of the extensive number of site visits undertaken. These visits were intended to offer advice and help improve the ventilation and insulation of properties. A large public information campaign was also being undertaken and this proactive approach combined with the site visits was having a positive effect. The Board suggested that due to its positive impact it could potentially be useful to quantify the benefits of the project and consider whether it could be a purchased product for non-CityWest Home tenants. The Board thanked Peter Armfield for the update and the positive effects the project was having in combating mould and condensation issues in the local area.

4 ACTION ON SUGAR REDUCTION, ORAL HEALTH AND CHILDHOOD OBESITY

4.1 Christine Mead, (Community Resilience Manager) introduced the item which set out the actions being taken at local and national levels to address rising levels of sugar consumption and its associated health outcomes amongst children and young people. The Board noted that levels of tooth decay for 5 year olds living within Westminster were higher than the London and England averages. It was also noted that the number of children aged 4 to 5 in Westminster had increased levels of obesity linked to sugar consumption than the London and England averages.

4.2 As a consequence the Board was informed of the various campaigns and initiatives that had been developed to reduce sugar consumption and promote healthier eating. An update was provided on the local oral health campaigns 'Big Bites and Pearly Whites' and 'The Tale of Triumph Over Terrible Teeth' which had been established to improve children's, parents and carers knowledge regarding oral health. The Board was pleased to note that an

initiative involving a number of local dentists visiting local schools to provide talks on oral healthcare to pupils was also being established.

4.3 Efforts to reduce sugar consumption and promote healthy eating formed a central part of the Tackling Childhood Obesity Together (TCOT) programme. The various components of the programme were detailed along with work being undertaken to identify opportunities to better integrate and co-ordinate activities between the Council and partners. This included developing a system wide approach to engage with communities and co-produce and run coordinated events and campaigns that aligned with local needs.

4.4 The Board noted the report and welcomed the proposed plans to integrate sugar reduction messages within a system wide obesity prevention approach. It was suggested that NHS England be invited to participate in this approach as they could potentially support the proposed plans.

5 WESTMINSTER PLANNING FOR INTEGRATED CARE AND THE MCP

5.1 Dr Niamh McLaughlin (Vice Chair, Central London CCG) and Holly Manktelow (Associate Director of Commissioning, Central London CCG) presented a report which provided an update on the local health system's delivery of the Primary Care Strategy and Integrated Care Strategy. In particular, the report detailed progress with the procurement of a Multi-Speciality Community (MCP) provider for Westminster.

5.2 The Chairman confirmed that whilst the Board agreed with various aspects of the report, concern was expressed regarding some of the details contained within it and also the speed with which it was proposed to initiate the changes. The Board was of the opinion that before implementing any changes further consultation was required with the Council and other partners.

5.3 Dr Niamh McLaughlin and Holly Manketlow explained that no decisions had yet been taken on the MCP programme and discussions with partners had taken place to explore the various options available. It was recognised that some partners had voiced concerns and, as such, the Central London CCG hoped to have further discussions regarding how to deliver an integrated system for joined-up care. Following a concern raised regarding the MCP approach being taken the Board was advised that whilst at this early stage it seemed the most attractive model, work would be undertaken on the options available to assess their potential impact on the local market and current providers before any decisions were made.

5.4 Maria O'Brien from the Central and North West London NHS Foundation Trust advised the Board of the health providers' deep concerns regarding the approach. They were committed to providing integrated services, but there was no agreement with the Central London CCG on how this could be achieved. Concerns were expressed over the details in the report, the approach being taken and how this would impact on patients and the delivery of services. Further concern was raised over the proposed timelines and whether they were achievable. Maria O'Brien advised that the health

providers had requested that the report be withdrawn in order for further discussions to take place.

5.5 The Board then held a detailed discussion on the report that covered the following areas:

- The financial aspects of the MCP;
- The levels of engagement undertaken, with a particular focus on commissioning intentions ; and
- The need to introduce an agreed integrated system.

5.6 Following this discussion, the Board noted the report. The Board also noted that its comments would be fed back to the Central London CCG which was requested to review its commissioning approach. The Board also requested that a report detailing the Central London CCG's commissioning intentions be presented at their next meeting scheduled for 29th November 2018.

6 LEARNING DISABILITIES JOINT COMMISSIONING STRATEGY

6.1 The Board was reminded that the deadline to receive comments on the strategy was the end of September 2018.

7 FLOW DIAGRAM OF HEALTH & SOCIAL CARE ORGANISATION RELEVANT TO WESTMINSTER

7.1 The Board noted the flow diagram explaining the local Health and Social Care governance system and members were requested to forward on any comments.

8 ANY OTHER BUSINESS

8.1 The Chairman provided the Board with the following updates:

i) Westminster City Council had prepared a programme of activity ahead of the 3 October 2018 launch of Stoptober, Public Health England's annual 28-day stop smoking campaign.

ii) The Director of Public Health's Annual report would be shared with the Board in autumn for comment ahead of the next Board meeting in November 2018. The paper would then be included on the agenda for the November Board meeting, highlighting elements of the report linked to the Health and Wellbeing Board priority of loneliness.

iii) Officers were exploring the possibility for an alternative venue for the next Board meeting, which would be themed around the Health and Wellbeing Board priority of loneliness.

The Meeting ended at 5.34 pm.

CHAIRMAN: _____ **DATE** _____

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MINUTES

CITY OF WESTMINSTER

THE ROYAL BOROUGH OF
KENSINGTON
AND CHELSEA

Health & Wellbeing Board

MINUTES OF PROCEEDINGS

Minutes of a concurrent meeting of Westminster City Council's and the Royal Borough of Kensington & Chelsea's **Health & Wellbeing Boards** held at 4pm on **Thursday 24 January 2019**, at The Town Hall, Hornton Street, London, W8 7NX.

Present:

Councillor David Lindsay (RBKC - Lead Member for Healthy City Living)
Councillor Heather Acton (WCC - Cabinet Member for Family Services and Public Health)
Councillor Sarah Addenbrooke (RBKC – Lead Member for Adult Social Care)
Councillor Nafsika Butler-Thalassis (WCC - Minority Group Representative)
Councillor Lorraine Dean (WCC – Member of the Family and People Services Policy and Scrutiny Committee)
Councillor Christabel Flight (WCC – Deputy Cabinet Member for Family Services and Public Health)
Senel Arkut (Bi-borough Director of Health Partnerships)
Colin Brodie (Knowledge Manager, WCC – Public Health)
Louise Butler (Interim Bi-Borough Head of Service, Adult Safeguarding and Learning and Development)
Andrew Carpenter (Dementia Programme Lead)
Iain Cassidy (Open Age)
Olivia Clymer (Healthwatch Westminster)
Robyn Doran (CNWL Chief Operating Officer)
Elizabeth Dunsford (Public Health Business Partner, WCC - Public Health)
Bernie Flaherty (Bi-Borough Executive Director of Adult Social Care)
Neil Hales (Deputy Managing Director, Central London CCG)
Andrew Howe (Interim Director of Public Health)
Toby Hyde (Imperial College NHS Trust)
Hilary Nightingale (Westminster Community Network)
Anne Pollock (Principal Policy Officer)
Louise Proctor (Managing Director, West London CCG)
Dr Neville Purssell (Clinical Representative from the Central London CCG)
Katherine Reid (Strategy and Business Planning Manager, WCC - Public Health)

Annabel Saunders (Assistant Director for Commissioning)
Angeleca Silversides (Healthwatch RBKC)
Angela Spence (Kensington and Chelsea Social Council)
Dr Andrew Steeden (West London CCG)
Spencer Sutcliff (London Fire Brigade)
Jennifer Travassos (Head of Prevention)
Jane Wheeler (Acting Deputy Director, Mental Health, North West London Collaboration of CCGs)

1 MEMBERSHIP

1.1 With the approval of both Boards it was agreed for the RB Kensington and Chelsea Health and Wellbeing Board Chair (Councillor David Lindsay) to lead the meeting.

1.2 Apologies for absence were received from Maria O'Brien (Central and North West London NHS Foundation Trust), Dr David Finch (NHS England), Wayne Haywood (Programme Lead for the Better Care Fund) and Paul Kavanagh (London Fire Brigade).

1.3 A Membership Change was noted - Robyn Doran replaces Maria O'Brien (Central and North West London NHS Foundation Trust).

2 MINUTES OF THE PREVIOUS MEETING HELD ON 29 NOVEMBER 2018

2.1 The Minutes of the concurrent meeting held on 29 November 2018 were signed by both Councillor Acton (for Westminster) and Councillor Lindsay (for RBKC).

3 DECLARATIONS OF INTEREST

3.1 No declarations were made.

4 PROPOSED MEMORANDUM OF UNDERSTANDING FOR JOINT RB KENSINGTON AND CHELSEA AND WESTMINSTER HEALTH AND WELLBEING BOARD

4.1 Anne Pollock (Principal Policy Officer) introduced the report. There was general enthusiasm for joint Board meetings. Councillor Lindsay suggested that all meetings be joint with the possibility of sovereign single borough meetings afterwards (it was noted there needed to be at least one sovereign Board meeting annually). It was recognised that in respect of these sovereign meetings (after the joint Boards) there would be accommodation and officer availability issues (if needed at both sovereign meetings) to resolve.

4.2 The Board accepted the suggestion of Louise Proctor that it would make sense to have a few joint meetings and check that they work. It was agreed to review the arrangements at the Joint Board meeting in September 2019.

4.3 The next Joint Board meeting would be on 28 March (at a Westminster venue). The draft meeting schedule contained in Appendix D of the report would need to be revised by officers.

RESOLVED:

1. That the Westminster Board approves the proposals to establish a joint HWBB with the Royal Borough of Kensington and Chelsea (RBKC).

2. That the Westminster Board approves the draft constitution of the proposed Joint HWBB (including the membership), as set out in Appendix C of the report.

3. That the Westminster Board approves that the next meeting of the Joint Board take place on 28 March 2019 (at a Westminster venue) with a full meeting schedule (with venues alternating between Westminster and RBKC) to be drawn up thereafter.

4. That the RBKC Board approves the proposals to establish a joint HWBB with the Westminster Board.

5. That the RBKC Board approves the draft constitution of the proposed joint HWBB (including the membership), as set out in Appendix C of the report.

6. That the RBKC Board approves that the next meeting of the Joint Board take place on 28 March 2019 (at a Westminster venue) with a full meeting schedule (with venues alternating between Westminster and RBKC) to be drawn up thereafter.

7. That these arrangements be reviewed at the Joint Board meeting in September 2019.

5 DISCUSSION ABOUT DEMENTIA TO FEED INTO THE BI-BOROUGH DEMENTIA STRATEGY UNDER DEVELOPMENT

5.1 The Board recognised that we were in the early stages of developing a Dementia Strategy. Anne Pollock (who introduced this report) referred to the Expert Panel being drawn up and confirmed this would include service users. It was noted that the strategy would cover not just health and care but other services as well (e.g. housing).

5.2 Andrew Carpenter (Dementia Programme Lead) and Dr Neville Purssell both agreed with the emphasis on prevention and living well with dementia. However, Dr Purssell made the point that dementia was a progressive disease and he would like to see the strategy contain greater reference to End of Life Care. Councillor Dean spoke from her personal experience of a family member receiving excellent care in Westminster.

5.3 Toby Hyde confirmed that Imperial was very keen to support early diagnosis and Bernie Flaherty also agreed with the importance of diagnosis. Healthwatch colleagues indicated their support of this initiative and Ms Silversides was interested in cultural implications. Dr Steeden spoke of the value of My Care,

My Way. Mr Sutcliff pointed out that people with dementia were at greater risk of danger from fire and had a more limited ability to escape.

5.4 The experiences of persons in the Public Gallery were noted. A number of both Westminster and RBKC Councillors were due to receive dementia training. Any further comments on the report were to be circulated to Anne Pollock.

6 MENTAL HEALTH AND WELLBEING JSNA FIRST DRAFT

6.1 Colin Brodie (Bi-Borough Public Health Knowledge Manager) assisted by Elizabeth Dunsford (Public Health Business Partner, WCC - Public Health) introduced this report. It was confirmed that consultation on this first draft would continue until 3 February.

6.2 Robyn Doran notified a number of points of detail. Olivia Clymer and others were concerned about suicide prevention and it was noted that the suicide prevention strategy was also coming to the Board's next meeting. Andrew Carpenter hoped there would be content on autism in the suicide prevention strategy and he would speak to Andrew Howe on this. Annabel Saunders repeated points relating to education and young people.

6.3 Councillor Butler-Thalassis spoke of the particular nature of mental health problems and Dr Purssell agreed as to the importance of preventative work.

6.4 Jane Wheeler saw this as a good opportunity to join up existing services. She wondered if the recommendations contained in the report needed to be adjusted with the six priority areas (listed in paragraph 5.3) assigned to groups that were already in place.

7 ADULT SAFEGUARDING FINAL REPORT

7.1 Louise Butler (Interim Bi-Borough Head of Service, Adult Safeguarding and Learning and Development) presented the Annual Adult Safeguarding Report. Her introductory remarks stressed the mechanisms in place to learn from past cases.

7.2 In subsequent questions and answers Ms Butler confirmed the existence of a clear training programme, pathways for referrals, strong community engagement, and key performance indicators. At the suggestion of Neil Hales Ms Butler would speak to Trading Standards about email scams.

8 ANY OTHER BUSINESS

8.1 CCG Budgets

Councillor Acton mentioned that both of the CCGs were experiencing significant financial pressures. Bi-borough Adult Social Care would continue to work closely with both CCGs to acknowledge and deal with these pressures. The Better Care Fund may also come under severe pressure. There would be an update to the Board's next meeting.

8.2 **NHS England Health and Wellbeing Strategy**

NHS England had sought the views of the Boards.

8.3 **Westminster's Care Awards**

Noted the ceremony was taking place on 25 March with the deadline for nominations being 8 February.

The Meeting ended at 5.45pm.

CHAIR: _____ **DATE** _____

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City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Westminster Health & Wellbeing Board

RBKC Health & Wellbeing Board

Date:	*28th March 2019*
Classification:	**General Release**
Title:	***Oral Health and Obesity Update***
Report of:	*Director of Public Health*
Wards Involved:	*N/A*
Financial Summary:	*N/A*
Report Author and Contact Details:	*Kate May Public Health Business Partner* *Kmay@westminster.gov.uk*

1. Executive Summary

1.1 Oral health and obesity continue to be key public health issues in Westminster and RBKC. The local authorities have a key role in championing action, given five-year-old children are at higher risk of tooth decay than London and England and rates of obesity in year 6 children are higher than England averages.

1.2 This paper outlines the Council's activity to promote oral health including integrating oral health within the health visiting service, the healthy schools and healthy early years programme. It also provides an animation to promote key oral health messages.

1.3 Oral health is seen as a marker of wider health and social care issues including nutrition and obesity. Interventions that reduce sugar have an impact on obesity and tooth decay as sugar is a risk factor for both tooth decay and obesity. There is a comprehensive programme of work underway across both boroughs to address obesity. As result, rates of childhood obesity are starting to reduce across both boroughs for younger children.

2. Key Matters for the Board

2.1 This paper provides the board with an update on oral health and obesity across Westminster and RBKC and asks for the Board's continued support in promoting NHS General Services to families to increase access and promote consistent healthy eating messages across all settings.

3. Background

3.1 Dental decay among children remains an important public health issue, as it leads to pain and distress, sleepless nights for children and parents and time off school and work. Oral health is therefore an important aspect of a child's overall health status and of their school readiness.

3.2 Oral health is seen as a marker of wider health and social care issues including nutrition and obesity. Interventions that reduce sugar have an impact on obesity and tooth decay as sugar is a risk factor for both tooth decay and obesity. Local action to address childhood obesity is outlined in section 6.

3.3 In addition, tooth decay is the top cause of non-emergency hospital admissions for children aged 1-18 across the Bi-borough and represents a fifth of all hospital admissions. It should be noted that data suggests that hospital admissions for dental carries are reducing from 211 (2012/13-14/15) to 158 (2014/15 -2016/17). This is due to the Community Dental service treating more children in the community.

3.4 Tooth Decay is caused by plaque. Plaque is made of traces of food, saliva and natural bacteria found in the mouth that turn food to acid. The main risk factor for tooth decay is sugar. When sugar is consumed it is absorbed by plaque/bacteria on the surface of teeth. These convert sugar to acid which weakens the surface of the teeth causing decay. The top 3 interventions for reducing tooth decay[1] are:

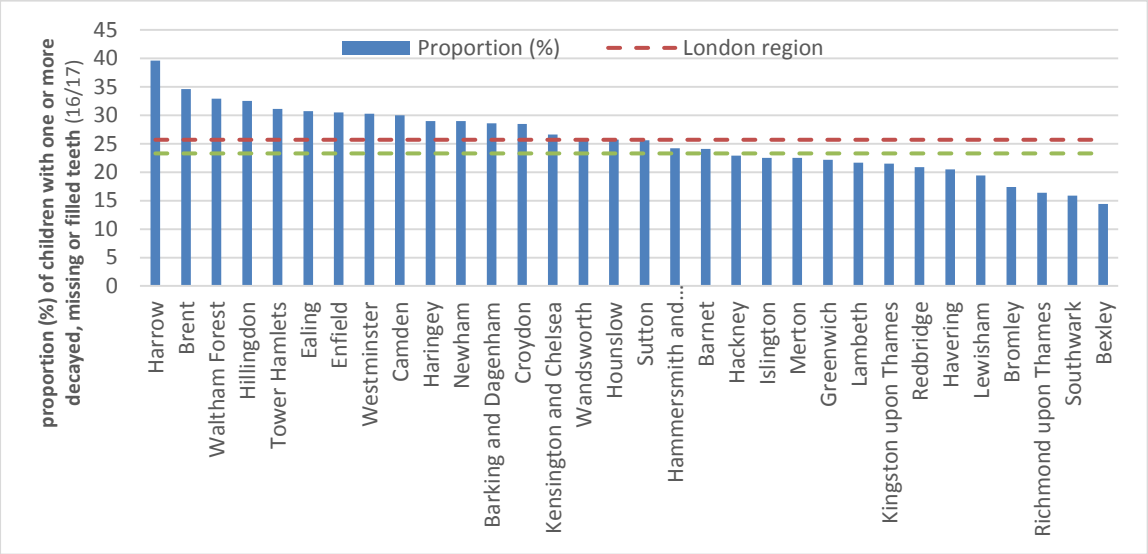
-Reducing the consumption of food and drinks that contain sugar;

-Brushing teeth twice daily with fluoride toothpaste;

-Taking your child to the dentist when their first tooth erupts;

[1] Public Health England Child Oral Health Applying All Our Health

3.5 In Westminster 30.3% of 5 year old children suffer from tooth decay and in RBKC 26.6%. This is higher than London (25.1%) and England (23.3%)[2].



3.6 In Westminster the mean number of decayed missing or filled teeth in five year olds is 0.93 and in RBKC 0.83. This is lower than the London average (0.95) but higher than the England average (0.78).

3.7 The prevalence of being overweight and of obesity is measured on an annual basis in reception and year six. In Westminster 18.4% of reception children are overweight or obese and 20.6% in RBKC which is lower than London (21.9%) and England (22.4%). In year 6, 39.1% of children in Westminster are overweight or obese and in RBKC 36.7%. The London average for year six is 37.7% and for England is 34.3%.

3.8 Data from PHE indicates that 4% of two-year-olds in Westminster and 3.6% of two-year-olds in RBKC have visited the Dentist.

3.9 Nationally children from deprived backgrounds have higher levels of decay than those from the least deprived. Prevalence among the most deprived children is 33.7% and for the least deprived is 13.6%.

3.10 Children in particular ethnic groups have higher levels of decay prevalence. Among children from Eastern Europe, the prevalence was 49.4% compared to 19.6 % for black/black British (National data).

3.11 Children from black and minority ethnic families are more likely than children from white families to be overweight or obese: for example in Westminster over the last three years 39% of year six Asian pupils are overweight or obese, compared to 28% of year six white pupils. Nationally and locally dental decay levels are reducing and there are signs that inequalities are beginning to reduce, but the inequalities gap remains high.

[2] Public Health England Oral Health Survey of 5 year old children 2017

4. Mechanisms to improve oral health for children and young people

4.1 Local authorities' PH directorates have a lead role in championing oral health. A major report, 'Commissioning for better oral health'[3] recommends that oral health improvement should be integrated within existing projects such as the healthy child programme. It also recommends that programmes should be evidence based, include policy approaches, interventions at organization level and individual behavioral approaches.

4.2 'Commissioning better oral health' included an evidence review, which recommended the following interventions:

a) Integration of oral health into targeted home visits by health/social workers.

b) Targeted provision of tooth brush and toothpaste to encourage parents to adopt good oral health practices from when their children are very young.

c) Targeted community-based fluoride varnish programmes.

d) Supervised tooth brushing in targeted settings to ensure children are brushing twice a day using fluoride toothpaste and the correct technique.

e) Healthy food and drink policies in childhood settings to reduce consumption of sugars.

f) Targeted peer support groups/peer oral health workers.

4.3 Public Health England[4] estimates that after five years, targeted supervised tooth brushing can result in an extra 2,666 school days gained per 5,000 children and £3.06 for every £1 spent.

4.4 In addition, it is estimated that targeted provision of toothbrushes and paste by post and by health visitors increases the cost effectiveness. After five years the return on investment from every £1 spent is £4.89, increasing to £7.34 after ten years. Combining postal provision of toothbrushes with support from health visitors can result in 2,566 school days gained per 5,000 children after five years.

4.5 The Return on Investment of targeted fluoride varnish programs is £2.29 per pound spent after five years, increasing to £2.74 after ten years, and can result in an extra 3,049 school days gained.

5. Current activities to promote good oral health for children and young people

5.1 NHS England commissions the CLCH oral health promotion team to deliver a range of interventions on behalf of Westminster and RBKC. Oral health is currently integrated within health visiting with health visitors receiving oral health training from the CLCH Oral Health Promotion Team as part of their induction and on an annual basis. Health visitors also distribute brushing for life packs and free flowing cups.

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[3] Local authorities improving oral health: commissioning better oral health for children and young people

[4] Health Matters – Child Dental Health

5.2 The oral health promotion team support work with looked after children, Early Help, Family Hubs, and children with special educational needs. In addition, oral health training is offered to all health staff who work with children with physical and learning disabilities.

5.3 Oral Health is an integrated part of our healthy schools' programme and the healthy early years programme. Schools applying for their bronze healthy schools award must demonstrate a whole school Food and Drink Policy (including a sugar reduction statement). These must show examples of how the school ensures free, clean palatable drinking water is available at all times e.g. at lunch times, in the classroom, in the playground (including any examples of working towards a 'water only' policy). Eleven Westminster schools and twelve schools in RBKC have achieved silver healthy schools award covering healthy eating (Including sugar reduction) / or oral health. Three of these schools in Westminster and five in RBKC have achieved Gold Healthy Schools awards specifically related to oral health.

5.4 The oral health promotion team also delivers the Keep Smiling programme annually in twelve schools in Westminster and ten schools in RBKC on an annual basis. This is targeted at schools at high risk of tooth decay. This programme involves two sessions of supervised brushing and one fluoride varnish application. In addition, supervised brushing is being trialled in five early years setting in North Kensington and Chelsea.

5.5 The oral Health team is also supporting a Dental Buddying scheme. This is an initiative for dental practices to adopt local schools and family hubs to increase dental attendance. To date, three dental practices are currently involved in this initiative with two more expressing interest.

5.6 The team supports the development of oral health champions in different settings.

5.7 In Westminster, "The Tale of Triumph over Terrible Teeth" campaign was run in 2018. This was promoted via schools, libraries, dentists, GP surgeries and through other resident communication channels. Feedback around this has been positive. The animation has been viewed 1,517 times on YouTube.

5.8 We are funding work in Chelsea and Westminster hospital (Big Bites and Pearly Whites) where an oral health promotion initiative has been developed to improve oral health across the hospital. In addition, PHE is trialling programmes of supervised brushing at both St Mary's and Chelsea and Westminster Hospitals.

6. Current activities to address childhood obesity

6.1 Given the important link between oral health and obesity, highlighted in 3.2 above, it is anticipated the Board may appreciate a brief update on work to prevent childhood obesity across Westminster, Kensington and Chelsea.

6.2 Preventing childhood obesity is a key national and local priority. Obesity is associated with multiple adverse health outcomes and significant costs to the NHS and wider economy. In 2015 Public Health introduced a focused programme of work that aimed to halt and reverse levels of childhood obesity across Westminster, Kensington and Chelsea in partnership with the NHS and wider Council. This programme, entitled Tackling Childhood Obesity Together (TCOT), involved the

commissioning of new prevention and treatment services, cross-council action to create healthier local environments, and the development of a pilot project entitled Go Golborne to engage the community across the RBKC Golborne area in actions to promote healthy eating and physical activity.

6.3 As result of our collective efforts, rates of childhood obesity are starting to reduce across both boroughs for younger children. Efforts to target preventative action in the Golborne ward have so far led to a small but significant reduction in obesity amongst children in the area.

6.4 Whilst this is positive news, inequalities are widening and there is a need for increased focus on improving outcomes for children living in the most deprived areas.

6.5 In May 2019, Public Health will launch a refreshed approach to accelerate local efforts called the 'change 4 life' programme. This will focus on the active promotion of change 4 life at a local level and delivery of innovative new services and policy initiatives to help children and families to put messages about healthy eating and physical activity into practice.

6.6 For further information, please see the background documents.

7. Conclusions

7.1 Though the prevalence and severity of tooth decay in Westminster and Kensington & Chelsea is reducing, it is still higher than the London and England average and inequalities remain.

7.2 There is no silver bullet for reducing tooth decay. However, further work needs to be done to increase access to general dental practices by promoting these services to families across all settings. Work also needs to be done to reduce sugar consumption, and this will be embedded within the bi-borough change 4 life programme which will include a network to align local services for children and young people in campaigns and actions to promote healthy living. It will also include a cross council action plan to maximise the use of policy levers and opportunities to create healthy environments for children.

7.3 We will continue to work with CLCH to evaluate the distribution of toothbrushes and tooth paste and the supervised brushing and targeted fluoride varnish programme.

If you have any queries about this Report please contact:

Contact Officer: Houda Al Sharifi, Interim Director of Public Health

E-mail: halsharifi@westminster.gov.uk

Background documents

For further information about the status of childhood obesity and approach to tackling it in Westminster please see the Family and People Services Policy and Scrutiny Committee report
https://committees.westminster.gov.uk/documents/s30841/160119%20Obesity%20Scrutiny%20paper.pdf

Kensington and Chelsea Adult Social Care and Health Scrutiny Committee is due to receive a thematic report on childhood obesity at the meeting on 1 April 2019
https://www.rbkc.gov.uk/committees/Meetings/tabid/73/ctl/ViewMeetingPublic/mid/669/Meeting/7841/Committee/1553/Default.aspx

Both reports will be circulated with Health and Wellbeing Board minutes.

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City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Westminster Health & Wellbeing Board

RBKC Health & Wellbeing Board

Date:	March 28th 2019
Classification:	**General Release**
Title:	Immunisation Programmes in RBKC and Westminster
Report of:	Bi-Borough Public Health – Cover Paper NHS England – Immunisations Paper
Wards Involved:	All wards in RBKC and WCC
Financial Summary:	There are no financial implications currently
Report Author and Contact Details:	Anna Cox – Bi-Borough Public Health Business Partner acox1@westminster.gov.uk Lucy Rumbellow – NHS England Immunisations Commissioner NW London lucy.rumbellow@nhs.net Dr Catherine Heffernan, Principal Advisor for Commissioning Immunisations and Vaccination, NHS England catherine.heffernan@nhs.net

1. Executive Summary

1.1 This cover paper from Bi-Borough Public Health accompanies a detailed report from NHS England giving an overview of Immunisation uptake across Westminster and Kensington and Chelsea.

1.2 The National Immunisations programme includes a range of vaccines to protect against a number of diseases and covers neonates, pre-school children, primary and secondary school aged children, pregnant women and adults.

1.3 Uptake of most vaccines in the Bi-Borough is generally lower than the national and London average and has been in decline over the last decade, giving rise to concerns about the collective immunity of the community (known as 'herd immunity') and the resulting risk to the population and individuals in the event of a disease outbreak.

1.4 The NHS England report attached provides an update and overview of current uptake across the immunisations schedule and outlines data issues and possible reasons for variance in uptake, alongside actions that are being taken at a national, London wide and local level.

1.5 At the Bi-borough level there is little localised research to explain the low uptake and variance at population level within our communities.

1.6 Building on the work covered in the NHS England paper and to fulfil their role in quality assurance, Public Health are proposing to facilitate collaborative workshops on key local issues with partner organisations and specialists. These will draw on the data and evidence to help understand local variance, identify inequalities and explore priorities for local action.

1.7 The workshops and dissemination process will result in an Implementation Plan, developed and owned by local partners, proposing a set of actions for moving forward towards a greater understanding of what is driving uptake and variance in immunisation rates in the Bi-Borough, and, ultimately towards improving vaccination cover in our communities.

1.8 The Health and Wellbeing Board are invited to consider the reports submitted, provide comment and to review future progress as part of the local assurance process.

2. Key Matters for the Board

2.1 The Bi-Borough Health and Wellbeing Board are requested to note and provide comment on:

- The paper provided by NHS England giving an overview of Immunisation uptake in the Bi-borough
- Local Authority Public health proposals for next steps in creating a local implementation plan

And to

- Consider and agree to proposals to return to the Health and Wellbeing Board in 6 months (September 2019) with completed partnership Implementation plan and in a further 6 months (March 2020) to review progress.

3. Background

Roles and Responsibilities

3.1 The Health and Social Care Act 2012 introduced new sets of responsibilities for the delivery of public health services. For Immunisations the responsibilities outlined are as follows:

- NHS England – To commission and co-ordinate national immunisation programmes according to national service specifications under the section 7a agreement.

  " *NHS England are accountable for ensuring that local providers of services will deliver against national service specifications and meet agreed population uptake and coverage levels. NHS England are responsible for monitoring providers performance and supporting providers in delivering improvements in quality." (1.2.1 National Delivery Framework)*

- Public Health England (PHE) – To lead response to outbreaks of vaccine preventable disease and provide expert advice in cases of immunisation incidents.

- Local Authority – Is the leader of the local public health system and is responsible for improving the improving and protecting the health of local people and communities. They will provide independent scrutiny and challenge of the arrangements of NHS England, PHE and providers. This function may be carried out through agreed local mechanisms such as the Health and Wellbeing Board.

- CCGs have a role in quality improvement, including the delivery of primary medical care services delivered by GP practices.

- Providers of immunisations services deliver programmes under contractual arrangements.

All the arrangements above are outlined in detail in the Immunisation and Screening National Delivery Framework and Local Operation Model document – included here under 'Background Documents'.

Immunisations

3.2 The current National Immunisations programme offers protection against the following diseases:

- Diptheria, Tetanus, Pertussis (Whooping cough) (DTaP)
- Polio (IPV)
- Haemophilus influenzae type b (Hib)
- Hepatitis B (Hep B)
- Pneumococcal (PCV and PPV)
- Meningococcal groups B and C (Men B and Men C)
- Rotavirus gastroenteritis
- Cervical cancer caused by human papillomavirus (HPV)
- Meningococcal groups A,C, W &Y (Men ACWY)
- Shingles
- Seasonal influenza

In addition, BCG vaccine to protect against Tuberculosis is offered to neonates under a London wide programme.

Full details, including eligibility and age groups are covered in the Complete routine immunisation schedule included here under 'Background Documents'.

Immunisations in the Bi-borough

3.3 Immunisation rates in the Bi-Borough have historically been lower than national and London averages for most vaccinations and have declined considerably since 2010. These continuing low rates have raised concern within the Bi-Borough Local Authorities and Public Health and therefore NHS England have been asked to provide a paper to the Health and Wellbeing Board to examine to current position.

3.4 The resulting paper presented here and included as Appendix 1 covers

I. Immunisation coverage data
II. Headlines for London
III. Routine Childhood immunisation programme (0-5 yrs)
IV. School age vaccinations (5-18 yrs)
V. Challenges and What is being done to increase uptake?
VI. Outbreaks of Vaccine preventable diseases
VII. Next steps

3.5 To further understand the local issues Public Health are proposing a series of collaborative workshops to examine the issues raised in the NHS England paper in more detail with key partners. These workshops will be an opportunity to work with NHS England and delivery partners to investigate ways to improve the data issues identified, identify where there may be inequalities in vaccine uptake and engage all local stakeholders in a systems approach to further understanding the local issues with the ultimate aim of improving vaccine uptake.

3.6 The workshops will result in a partnership implementation plan, co-ordinated by Public Health, in which priorities for action will be identified and owned by participants.

3.7 The workshops are currently being scoped and are likely to include sessions on Data, General Practice, Children's Services and Communications.

3.8 A draft version of the NHS England paper has been shared for comment with colleagues in Primary Care and Quality and Performance in both Central and West London CCGs. Proposals for the development workshops have been well received by CCG colleagues who have provided initial comment and suggested participants.

3.9 Wider dissemination of the implementation plan is envisaged with proposed presentations to the Primary Care and Quality and Performance Committees at both CCGs for further discussion and comment and also via Primary Care Networks.

4. Options / Considerations

4.1 The Health and Wellbeing Board are asked to:

- Note that the available data shows that immunisations rates in the Bi-Borough are lower than national and London averages for most immunisations and have been for many years.

- Consider the reasons given for current performance variation and populations that are likely to be most affected within the Bi-Borough community.

- Consider and comment upon proposed actions to further understand immunisation uptake rates, investigate reasons for variance and interventions to ultimately improve immunisation uptake rates in the Bi-Borough.

5. Legal Implications

5.1 The roles and responsibilities of organisations in the delivery of National Immunisation programmes is set out in the Health and Social Care Act 2012 and is detailed further in the Immunisation and Screening National Delivery Framework and Local Operating Model.
http://www.legislation.gov.uk/ukpga/2012/7/part/1/enacted
https://www.england.nhs.uk/wp-content/uploads/2013/05/del-frame-local-op-model-130524.pdf

6. Financial Implications

6.1 There are no financial implications arising from this paper. However, should future proposals arise from the implementation workshops for projects with an associated cost implication, finance from an appropriate funding stream will need to be sought. This is likely and will be built in to the implementation plan.

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

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APPENDICES:

1. Report to Health and Well-Being Board on Section 7a Immunisation Programmes in the Royal Borough of Kensington and Chelsea and Westminster 2017/18 – NHS England

BACKGROUND PAPERS:

1. Immunisations and Screening National Delivery Framework and Local Operating Model (NHS England / Public Health England 2013)

2. Complete routine immunisation schedule from Autumn 2018 (NHS)

Report to Health and Well-Being Board on Section 7a Immunisation Programmes in the Royal Borough of Kensington and Chelsea and Westminster 2017/18

Report on Section 7a Immunisation Programmes in the Royal Borough of Kensington & Chelsea and Westminster.

Prepared by: Miss Lucy Rumbellow, Immunisation Commissioning Manager for North West London and Dr Catherine Heffernan, Principal Advisor for Commissioning Immunisations and Vaccination Services
Presented to: Health and Wellbeing Board.

Classification: OFFICIAL

The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Contents

1 Aim

- The purpose of this paper is to provide an overview of Section 7a childhood and school age immunisation programmes in the London Boroughs of Kensington & Chelsea and Westminster for 2017/18. The paper covers the vaccine coverage and uptake for each programme along with an account of what NHS England (NHSE) London Region are doing to improve uptake and coverage.

- Section 7a immunisation programmes are publicly funded immunisation programmes that cover the life-course and the 18 programmes include:
    - Antenatal and targeted new-born vaccinations
    - Routine Childhood Immunisation Programme for 0-5 years
    - School age vaccinations
    - Adult vaccinations such as the annual seasonal influenza vaccination

- This paper focuses on those immunisation programmes provided for 0-5 years under the national Routine Childhood Immunisation Schedule and those programmes provided for school aged children (4-18).

- Members of the Health and Well-Being Board are asked to note and support the work NHSE (London) and its partners such as Public Health England (PHE), the local authority and the CCG are doing to increase vaccination coverage and immunisation uptake in Kensington & Chelsea.

2 Roles and responsibilities

- *The Immunisation & Screening National Delivery Framework & Local Operating Model* (2013) sets out the roles and responsibilities of different partners and organisations in the delivery of immunisations.

- Under this guidance, NHS England (NHSE), through its Area Teams (known as Screening and Immunisation Teams), is responsible for the routine commissioning of all National Immunisation Programmes under the terms of the Section 7a agreement. In this capacity, NHS England is accountable for ensuring that local providers of services deliver against the national service specifications and meet agreed population uptake & coverage levels. NHS England is also responsible for monitoring providers' performance and for supporting providers in delivering improvements in quality and changes in the programmes when required.

- Public Health England (PHE) Health Protection Teams lead the response to outbreaks of vaccine preventable disease and provide expert advice to NHSE screening and immunisation teams in cases of immunisation incidents. They also provide access to national expertise on vaccination and immunisation queries. In Kensington & Chelsea and Westminster, this function is provided by the PHE North West Health Protection Team.

- Clinical Commissioning Groups (CCGs) have a duty of quality improvement, and this extends to primary medical care services delivered by GP practices, including delivery of childhood immunisation services.

- Across the UK, the main providers of childhood immunisation are GP practices. In Kensington & Chelsea and Westminster, all general practices are contracted to deliver childhood immunisations for children aged 0-5 through their primary care contract.

- Central and North West London NHS Foundation Trust (CNWL) are contracted by NHSE (London) to provide the school age immunisations. Central London Community Healthcare NHS Trust (CLCH) are contracted to provide neonatal BCG vaccination.

- Immunisation data is captured on Child Health Information System (CHIS) for Kensington & Chelsea and Westminster as part of the NWL CHIS Hub (provided by Health Intelligence). Data is uploaded into CHIS from GP practice records via a data linkage system provided by Health Intelligence. The CHIS provides quarterly and annual submissions to Public Health England for their publication of statistics on 0-5s childhood immunisation programmes. This is known as Cohort of Vaccination Evaluated Rapidly (COVER) and these are the official statistics.

- Local Authority Public Health Teams (LAs) are responsible for providing independent scrutiny and challenge of the arrangements of NHS England, Public Health England and providers.

- Apart from attendance at Health and Social Care Overview Panels and at Health and Well-Being Boards, NHSE (London) also provides assurance on the delivery and performance of immunisation programmes via quarterly meetings of Immunisation Performance and Quality Boards. There is one for each Strategic Transformation Partnership (STP) footprint. The purpose of these meetings is to quality assure and assess the performance of all Section 7a Immunisation Programmes across the STP in line with Public Health England (PHE) standards, recommendations and section 7a service specifications as prepared by PHE with NHS England commissioning. All partners are invited to this scrutiny meeting, including colleagues from the Local Authority, CCG, CHIS, NHSE, PHE Health Protection and Community Provider service leads. Data for Kensington & Chelsea and Westminster is covered in the NWL STP Immunisation Performance and Quality Boards.

- Directors of Public Health across London also receive quarterly reports from the London Immunisation Partnership and updates via the Association of Directors of Public Health. It is through these communication channels that progress on the Bi-annual London Immunisation Plan (2017-19) and its accompanying annual Flu Plans are shared.

3 What is COVER and how is it produced?

- COVER monitors immunisation coverage data for children in UK who reach their first, second or fifth birthday during each evaluation quarter – e.g. 1st January 2012 to 31st March 2012, 1st April 2012 – 30th June 2012. Children having their first birthday in the quarter should have been vaccinated at 2, 3 and 4 months, those turning 2 should have been vaccinated at 12/13 months and those who are having their 5th birthday should have been vaccinated before 5 years, ideally 3 years 3 months to 4 years. This is an important point to note as often COVER statistics are used to improve uptake in general practice populations or communities. However, the data used is between 6 months and 18 months out of date and opportunities to ensure that those cohorts have been immunised in accordance with the routine immunisation schedule have therefore been missed.

- There are known complexities in collecting data on childhood immunisations. Indeed, since 2013, London's COVER data is usually published with caveats and drops in reported rates are always due to data collection or collation issues for that quarter. Production of COVER statistics in London involves a range of individuals and organisations with different roles and responsibilities.

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3.1 Role of Child Health Information Service (CHIS)

- London has four CHIS Hubs – North East London (provider is North East London Foundation Trust, NELFT), South East London (provider is Health Intelligence), South West London (provider is Your Healthcare CIC) and North-West London (provider is Health Intelligence). These Hubs are commissioned by NHSE to compile and report London's quarterly and annual submissions to PHE for COVER.

- A 'script' or algorithm is utilized to electronically extract anonymous data from the relevant data fields to compile the reports for COVER within the caveats specified. For example, for first dose of MMR, any child who had their MMR vaccination before their first birthday are not included and so appear unvaccinated.

- CHIS Hubs are commissioned to check the reports run and are expected to refresh the reports before final submission to PHE.

- CHIS Hubs are also commissioned to 'clean' the denominator by routinely undertaking 'movers in and movers out' reports. This is to ensure the denominator is up-to-date with the children currently resident in London. They are also expected to account for the vaccinations of unregistered children in London. Historically and currently, there are ongoing issues with CHIS Hubs keeping up-to-date with movers in and removals which is picked up in contract performance meetings with the NHSE (London) commissioners.

3.2 Role of Data Linkage Systems

- Immunisation data is extracted from London's general practices' IT systems and uploaded onto the CHIS systems. This isn't done directly by the CHIS Hubs. Instead data linkage systems provided by three different providers provide the interface between general practices and CHIS. Two of these providers – QMS and Health Intelligence – are commissioned by NHSE whilst 4 CCGs in outer North-East London commission a separate system.

- Since the primary purpose of CHIS is to hold health information on individual children, the immunisation data extracted from general practices is patient identifiable data (PID). As a result, data sharing agreements are required between each general practice and CHIS. In 2017, NHSE (London) Immunisation Commissioning Team and CHIS Hubs worked to ensure that data sharing agreements were signed and agreed. Introduction of GPDR in mid-2018 meant that DSAs had to be resigned and this was reported by the NEL CHIS Hub to their commissioner as having had an impact on their data submission for Q1 2018/19 and again for Q2 2018/19.

- NHS (London) Immunisation Commissioning Team receives data linkage reports from QMS and Health Intelligence. This provides a breakdown by general practice of the uptake of vaccinations in accordance to the COVER cohorts and cohorts for Exeter (for payments). This information is utilized by the team as part of the 'COVER SOP', to check against the COVER submissions by CHIS to question variations or discrepancies.

3.3 Role of General Practice

- While data linkage systems provide an automated solution to manual contact between CHIS and general practices, data linkage does not extract raw data. General practices have to prepare the data for extraction every month. This will vary between practices how automated the process is but it can be dependent upon one person to compile the data in time for the extraction by the data linkage system providers and should this person be on annual or sick leave, there will be missing data.

- General practices have to prepare data for four immunisation data systems – COVER, ImmForm (although this is largely done by their IT provider of Vision, EMIS or TPP SystmOne, all of whom are commissioned by their CCG), CQRS (the payments system run by NHS England for the payment of administration of the vaccine) and Exeter (payments system, whereby practices receive targeted payments for achieving 70% or 90% uptake of their cohorts – these cohorts are different to the COVER cohorts of children). Preparation of data for the systems again will vary between practices but this can be time and resource intensive.

- The aggregated immunisation data in each practice is dependent upon the quality of patient records. When a practice nurse vaccinates a child, the record

of the vaccination should be recorded onto the GP IT system and into the child's hand held personal record (the Redbook). In the past, a duplicate copy was taken from the Redbook and sent to CHIS but this is no longer wide-spread practice. It is anticipated that the e-Redbook will provide that secondary source to triangulate immunisation data going forward. There can be variation in when the nurse inputs the information – can be at the individual appointment or at the end of a clinic. Roll out across London is expected to commence in late 2019 and completed by the end of 2020.

- There is also an array of codes that can be used to code the vaccination (if a code different to what the data linkage system recognises is utilised, it results in the child looking unvaccinated) and there are difficulties with coding children who received their vaccinations abroad or delays in information on vaccinations given elsewhere in UK being uploaded onto the system in time for the data extraction. (During 2015/16, the team visited 300 practices to uncover the issues in vaccinating 0-5-year olds and these were the main factors vocalised by practice managers.)

- Whilst NHSE (London) immunisation commissioning team verify and pay administration of vaccines that are part of the Section 7a immunisation programmes, they do not commission general practices directly. Vaccination services, including call/recall (patient invite and reminder systems) are contracted under the General Medical Services (GMS) contract. This contract is held by primary care commissioning directorates of NHSE. To date, there is a lack of clarity on what levers NHSE (London) Immunisation Commissioning Team (with primary care colleagues) can use to ensure robust high-quality data for extraction for COVER and that practices are undertaking adequate call/recall.

4 Headlines for London

- Historically and currently, London performs lower than national (England) averages across all the immunisation programmes.
- London faces challenges in attaining high coverage and uptake of vaccinations due to high population mobility, increasing population, increasing fiscal pressures and demands on health services and a decreasing vaccinating workforce.
- Under the London Immunisation Partnership (formerly the London Immunisation Board), NHS England London Region (NHSE London) and Public Health England London Region (PHE London) seek to ensure that the London population are protected from vaccine preventable diseases and are working in partnership with local authorities, CCGs and other partners to increase equity in access to vaccination services and to reduce health inequalities in relation to immunisations.

5 Routine Childhood Immunisation Programme (0-5 years)

5.1 The routine schedule for 0-5s

- The routine childhood immunisation programme protects against:
    - Diphtheria, Tetanus, Pertussis (whooping cough), Polio, Haemophilus influenza type b (given as the '6 in 1' DTaP/IPV/Hib/HepB vaccine)
    - Pneumococcal disease, (PCV)
    - Meningococcal group C disease (Men C)
    - Meningococcal group B disease
    - Measles, mumps and rubella (MMR)

- Children aged 1 year should have received 3 doses of 6 in 1 (called the primaries) and 2 doses of Men B. If eligible, they may also be offered the targeted BCG and Hep B.

- At 12 months, they are offered first dose of MMR and the boosters of PCV, Hib/Men C and Men B.

- At 2 years and again at 3 years, children are offered annual child influenza vaccine.

- From 3 years 4 months to 5 years, children are offered 2nd dose of MMR and preschool booster (which is the fourth dose of the diphtheria/tetanus/pertussis/polio course).

5.2 Kensington & Chelsea and Westminster and the challenges

- Kensington & Chelsea and Westminster are affected by the same challenges that face the London region. London has in recent years delivered significantly poorer uptake than the remainder of the country. Reasons for the low coverage include:
    - Complexities in data collection for COVER statistics
    - the increasing birth rate in London which results in a growing 0-5 population and puts pressure on existing resources such as GP practices
    - London's high population mobility which affects data collection and accuracy
    - Inconsistent patient invite/reminder (call-recall) systems across London
    - Declining vaccinating workforce
    - Increasing competing health priorities for general practice

- London's high population turnover is a big factor. There is a 20-40% annual turnover on GP patient lists which affects the accuracy of the denominator for COVER submissions, which in Kensington & Chelsea and Westminster's case inflates the denominator (i.e. number of children requiring immunisation)

resulting in a lower uptake percentage. A 2017 audit by London's CHIS providers showed that by the age of 12 months, 33% of infants moved address at least once.

- However, despite London's percentage uptake being lower than other regions, London vaccinates almost twice as many 0-5 year olds than any other region. If you look at MMR2 as an indicator of completion of programme, London reported 79.5% uptake for 2016/17 compared to England's 87.6%. We vaccinated 100,293 five year olds with MMR2 in 2016/17, down from 104,031 in 2015/16 but more than any other region – South East (the next biggest region) vaccinated 99,434 (86.2% coverage)

- It could be argued that with a bigger denominator, London has a bigger number of unvaccinated children. However, only a proportion of these 'unvaccinated' children are truly unvaccinated, the others have been vaccinated abroad (there are known difficulties recording these) or within UK (records may not be updated in time for the data extraction). These vaccinations have not been captured on data systems. Similarly, there are children who are vaccinated outside the schedule (either early or late) and are not included in the cohorts reported.

- Kensington & Chelsea and Westminster has a high number of private practices within the boroughs, thought to be approximately 100. A number of children may register in the area and therefore show up on the CHIS system but never actually access their GP or just have certain vaccinations and then go privately for some. As private practice data cannot be accessed, it is unknown what numbers this constitutes.

5.3 Kensington & Chelsea and Westminster's uptake and coverage rates

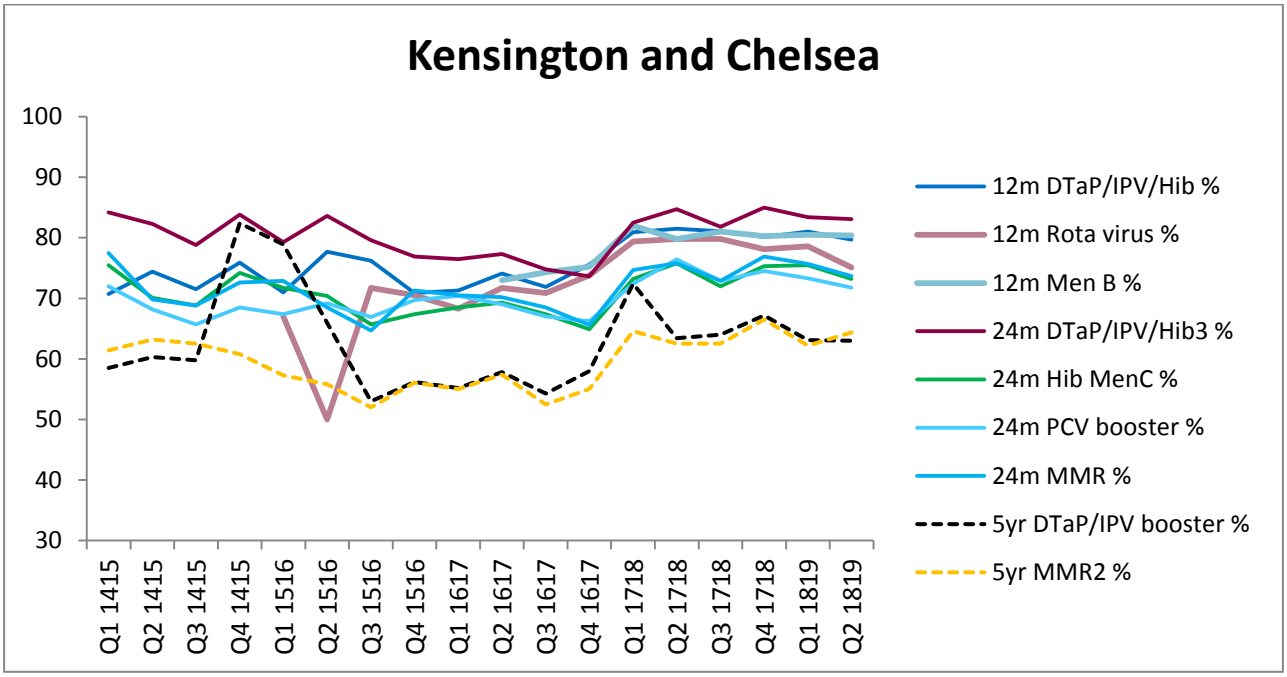
- COVER monitors immunisation coverage data for children in UK who reach their first, second or fifth birthday during each evaluation quarter – e.g. 1st January 2012 to 31st March 2012, 1st April 2012 – 30th June 2012. Children having their first birthday in the quarter should have been vaccinated at 2, 3 and 4 months, those turning 2 should have been vaccinated at 12/13 months and those who are having their 5th birthday should have been vaccinated before 5 years, ideally 3 years 3 months to 4 years.

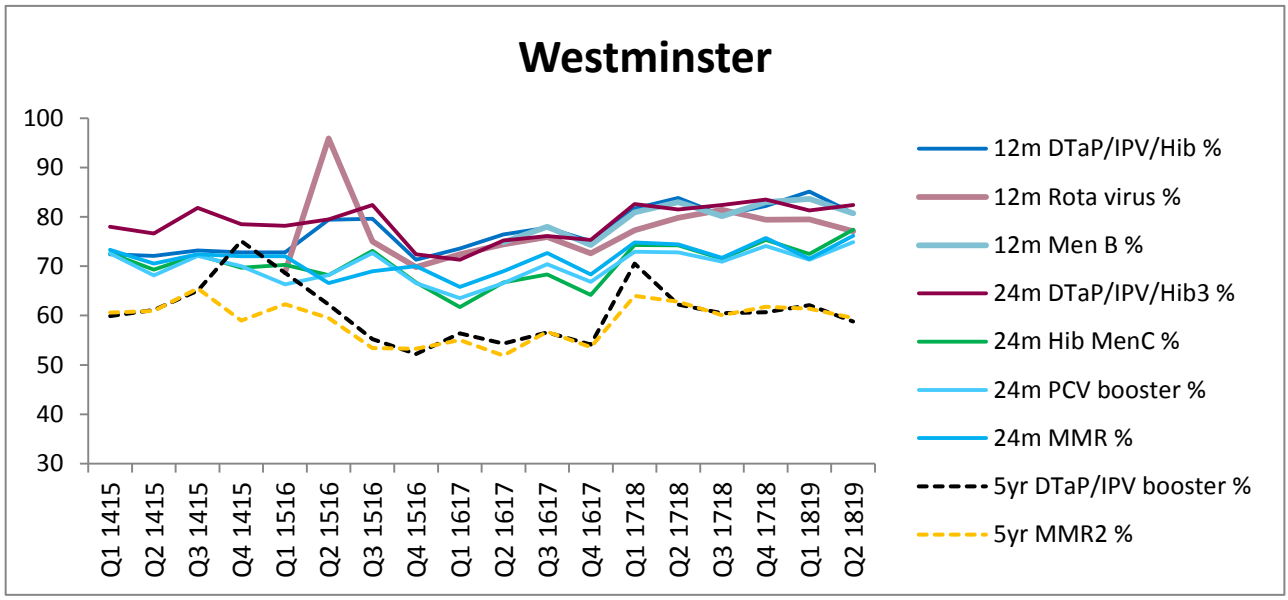
- Like many other London boroughs, Kensington & Chelsea and Westminster has not achieved the World Health Organisation recommended 95% coverage for the primaries and MMR to provide herd immunity (i.e. the proportion of people that need to be vaccinated to stop a disease spreading in the population).

- For immunisations, uptake is usually compared with geographical neighbours as immunisation uptake is affected by service provision and neighbouring boroughs in NWL historically have similar general practice provision and thereby provide a better comparison than statistical neighbours.

- Figure 1 provides a snapshot of all Kensington & Chelsea and Westminster's 0-5 immunisation programmes. It can be seen that the uptake of vaccinations are close together indicating a good quality of service provision (drop off between age 1 and age 2 and again by age 5 indicates system ability to call/recall and track children).

Figure 1
Uptake rates of 0-5 vaccinations for Kensington & Chelsea and Westminster Q1 2014/15 – Q2 2018/19



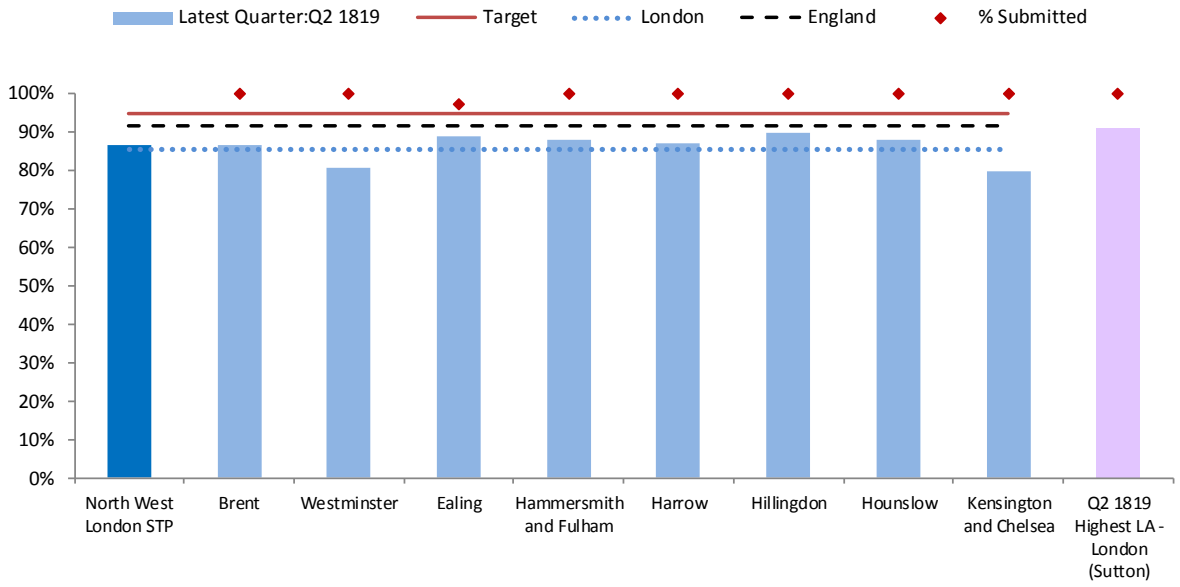


Source: PHE (2019)

- Figures 2-5 illustrate the comparison of Kensington & Chelsea and Westminster to other North West London boroughs using quarterly COVER statistics for the uptake of the six main COVER indicators for uptake. These are
    - The primaries (i.e. completed three doses of DTaP/IPV/Hib/HepB) are used to indicate completion of age one immunisations
    - PCV and Hib/MenC boosters and first dose of MMR for immunisations by age 2
    - Preschool booster and second dose of MMR for age 5.

- Quarterly rates vary considerably more than annual rates but are used here so that Quarter 2 data from 2018/19 (the latest available data) could be included.

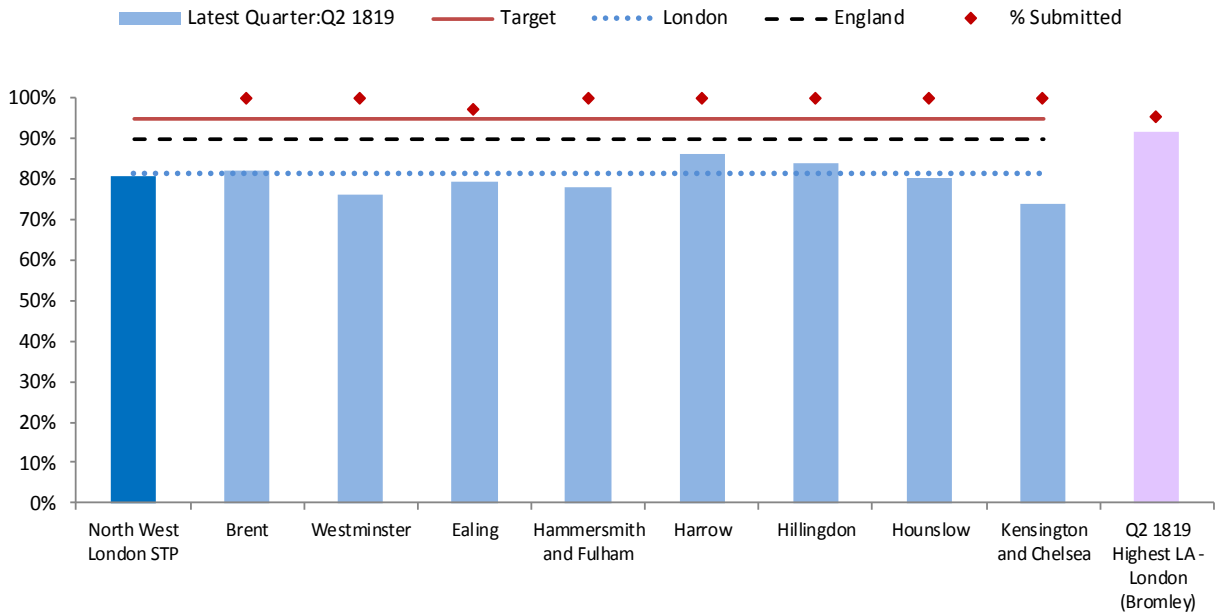
Figure 2
DTAP/IPV/ Hib/Hep B Vaccine – 1 year (quarterly data Q2 17/18 to Q2 2018/19)



	Eligible	Vaccinated	Q2 1718	Q3 1718	Q4 1718	Q1 1819	Q2 1819	Eligible	Vaccinated	Trendline
ENGLAND	**170,151**	**158,581**	**93.2%**	**93.1%**	**92.6%**	**0.0%**	**91.6%**	**168,144**	**154,020**	
London	**31,157**	**27,738**	**89.0%**	**88.9%**	**89.1%**	**86.3%**	**85.5%**	**32,267**	**27,592**	
North West London STP	**7,434**	**6,466**	**88.7%**	**88.8%**	**89.1%**	**88.4%**	**86.8%**	**7,434**	**6,456**	
Brent	1,256	1,086	89.4%	90.7%	90.1%	89.6%	86.5%	1,256	1,086	
Westminster	538	434	83.8%	80.3%	82.2%	85.1%	80.7%	538	434	
Ealing	1,339	1,190	90.1%	89.6%	91.7%	90.3%	88.9%	1,339	1,190	
Hammersmith and Fulham	599	528	88.2%	87.8%	88.5%	86.4%	88.1%	599	528	
Harrow	876	762	90.0%	88.9%	90.3%	88.1%	87.0%	876	762	
Hillingdon	1,125	1,009	91.7%	93.6%	91.9%	90.8%	89.7%	1,125	1,009	
Hounslow	1,075	947	88.8%	90.0%	90.0%	89.2%	88.1%	1,075	947	
Kensington and Chelsea	626	499	81.5%	81.1%	80.1%	81.0%	79.7%	626	499	
Q2 1819 Highest LA - London (Sutton)							91.3%	596	544	

Source: PHE (2019)

Figure 3
MMR Vaccine Dose 1 measured at 2 years of age (quarterly data Q2 17/18 to Q2 2018/19)



	Eligible	Vaccinated	Q2 1718	Q3 1718	Q4 1718	Q1 1819	Q2 1819	Eligible	Vaccinated	Trendline
ENGLAND	**160,960**	**146,635**	**91.1%**	**91.1%**	**90.8%**	**0.0%**	**89.9%**	**173,769**	**156,218**	
London	**30,990**	**25,868**	**83.5%**	**83.7%**	**84.3%**	**81.6%**	**81.2%**	**32,911**	**26,726**	
North West London STP	**7,459**	**5,813**	**81.2%**	**80.9%**	**82.3%**	**80.7%**	**80.7%**	**7,459**	**6,017**	
Brent	1,143	938	81.1%	83.0%	82.2%	81.4%	82.1%	1,143	938	
Westminster	501	382	74.4%	71.7%	75.7%	71.5%	76.2%	501	382	
Ealing	1,329	1,057	82.3%	82.0%	83.2%	81.7%	79.5%	1,329	1,057	
Hammersmith and Fulham	624	486	79.6%	80.5%	80.8%	75.7%	77.9%	624	486	
Harrow	909	785	82.6%	83.8%	85.2%	82.7%	86.4%	909	785	
Hillingdon	1,137	952	85.1%	82.6%	86.3%	83.7%	83.7%	1,137	952	
Hounslow	1,189	955	82.3%	82.3%	82.3%	83.2%	80.3%	1,189	955	
Kensington and Chelsea	627	462	75.8%	72.9%	76.9%	75.7%	73.7%	627	462	
Q2 1819 Highest LA - London (Bromley)							91.7%	1,153	1,057	

Source: PHE (2019)

Figure 4

Hib/MenC Vaccines uptake at 2 years (quarterly data) (2017/18 - 2018/19)

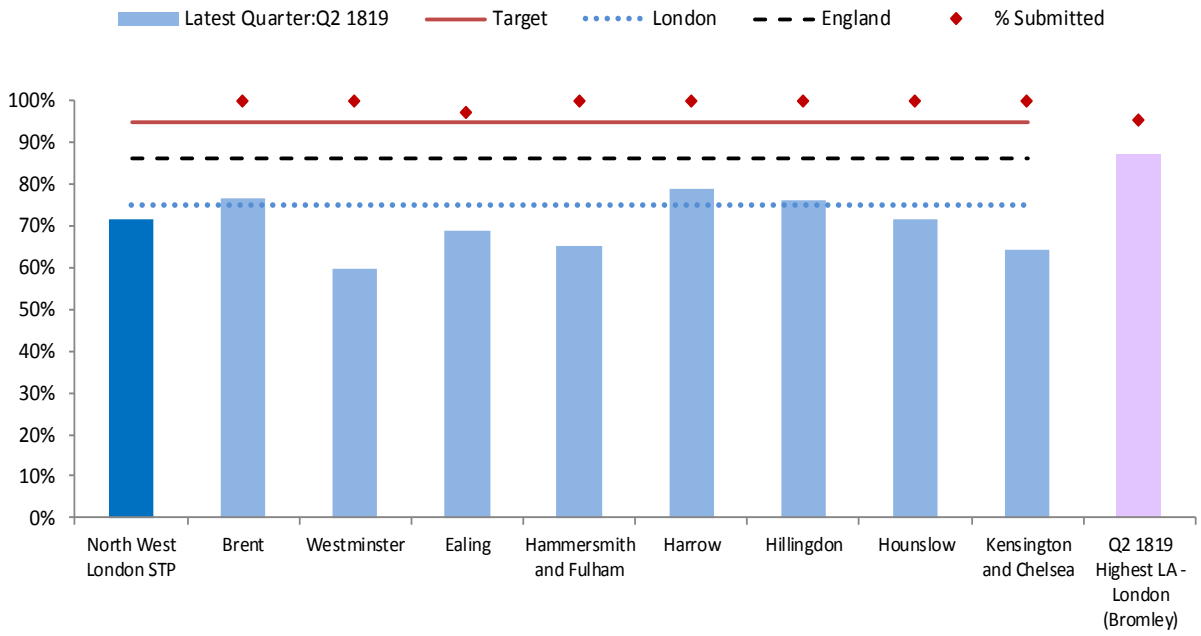
	Q3 1718	Q4 1718	Q1 1819	Q2 1819
ENGLAND	**91.3%**	**91.2%**	**0.0%**	**90.2%**
London	**84.2%**	**85.2%**	**82.2%**	**81.8%**
LA with highest uptake - London	**91.1%**	**92.1%**	**92.7%**	**92.0%**
North West London STP	**81.3%**	**83.4%**	**81.5%**	**81.8%**
Brent	**83.5%**	**84.8%**	**83.7%**	**83.5%**
Ealing	**83.3%**	**84.7%**	**82.9%**	**80.6%**
Hammersmith and Fulham	**81.1%**	**81.9%**	**76.5%**	**80.9%**
Harrow	**83.5%**	**84.6%**	**82.8%**	**86.8%**
Hillingdon	**83.1%**	**88.7%**	**84.7%**	**85.1%**
Hounslow	**82.8%**	**83.3%**	**83.3%**	**81.2%**
Kensington & Chelsea	**72.0%**	**75.3%**	**75.5%**	**73.2%**
Westminster	**71.5%**	**75.3%**	**72.5%**	**77.4%**

PCV Vaccine uptake at 2 years (quarterly data) (2017/18 - 2018/19)

	Q3 1718	Q4 1718	Q1 1819	Q2 1819
ENGLAND	**91.3%**	**91.2%**	**0.0%**	**90.0%**
London	**84.0%**	**84.7%**	**81.8%**	**81.3%**
LA with highest uptake - London	**91.2%**	**92.3%**	**92.0%**	**91.7%**
North West London STP	**80.2%**	**81.4%**	**80.1%**	**80.0%**
Brent	**82.3%**	**83.2%**	**82.8%**	**81.9%**
Ealing	**81.8%**	**82.4%**	**81.3%**	**79.0%**
Hammersmith and Fulham	**79.9%**	**80.3%**	**74.7%**	**78.8%**
Harrow	**82.5%**	**82.6%**	**82.4%**	**84.6%**
Hillingdon	**82.6%**	**86.9%**	**83.0%**	**84.3%**
Hounslow	**79.9%**	**79.6%**	**81.1%**	**78.5%**
Kensington & Chelsea	**72.9%**	**74.5%**	**73.3%**	**71.8%**
Westminster	**70.9%**	**74.1%**	**71.3%**	**74.9%**

Source: PHE (2019)

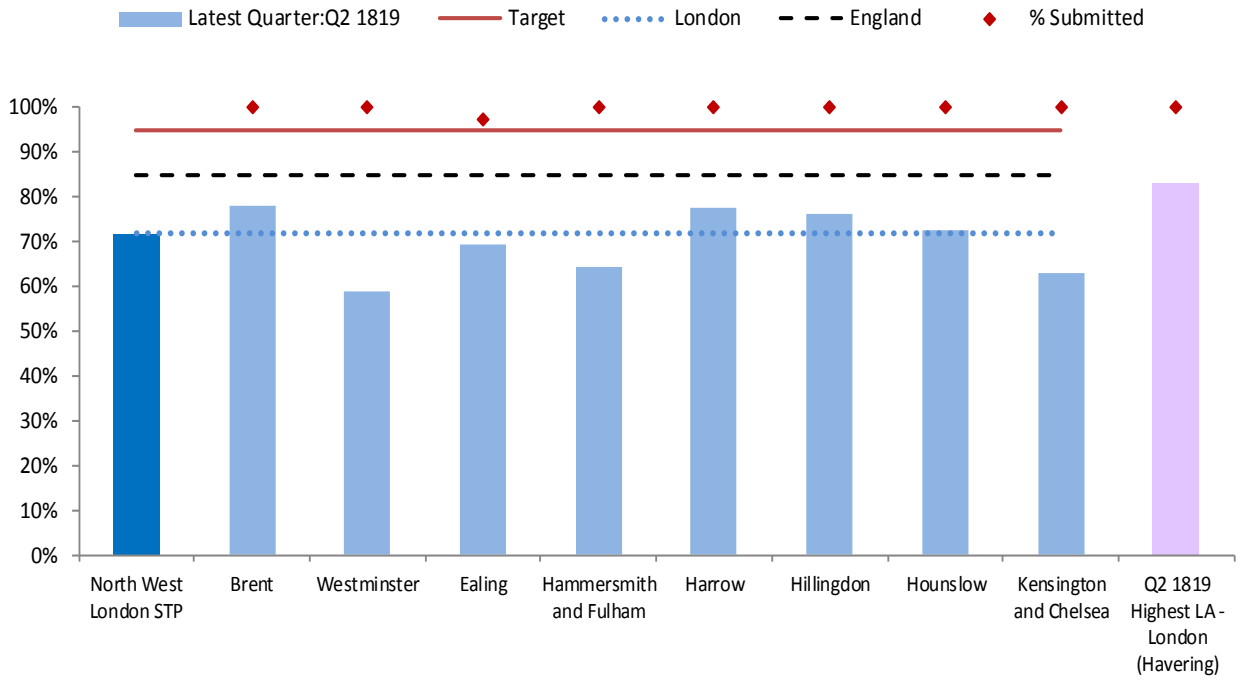
Figure 5
MMR Vaccine Dose 2 – measured at 5 years of age (quarterly data Q2 17/18 to Q2 2018/19)



	Eligible	Vaccinated	Q2 1718	Q3 1718	Q4 1718	Q1 1819	Q2 1819	Eligible	Vaccinated	Trendline
ENGLAND	**171,013**	**149,807**	**87.6%**	**87.3%**	**87.2%**	**0.0%**	**86.4%**	**179,348**	**154,957**	
London	**31,452**	**24,192**	**76.9%**	**77.1%**	**77.6%**	**72.2%**	**74.8%**	**32,095**	**24,000**	
North West London STP	**7,493**	**5,615**	**75.1%**	**73.3%**	**75.3%**	**71.5%**	**71.7%**	**7,493**	**5,370**	
Brent	1,246	954	81.2%	79.6%	80.0%	76.8%	76.6%	1,246	954	
Westminster	452	269	62.8%	60.1%	61.8%	61.4%	59.5%	452	269	
Ealing	1,398	962	75.3%	73.2%	75.6%	71.1%	68.8%	1,398	962	
Hammersmith and Fulham	575	374	71.6%	68.2%	71.2%	61.6%	65.0%	575	374	
Harrow	889	700	80.3%	80.9%	79.9%	79.4%	78.7%	889	700	
Hillingdon	1,193	909	77.0%	76.3%	76.6%	76.5%	76.2%	1,193	909	
Hounslow	1,156	827	75.5%	71.8%	77.1%	69.4%	71.5%	1,156	827	
Kensington and Chelsea	584	376	62.5%	62.5%	66.5%	62.2%	64.4%	584	376	
Q2 1819 Highest LA - London (Bromley)							87.0%	1,141	993	

Source: PHE (2019)

Figure 6
DTAP/IPV (Pre School Booster) Vaccine – measured at 5 years of age (quarterly data Q2 17/18 to Q2 2018/19)



	Eligible	Vaccinated	Q2 1718	Q3 1718	Q4 1718	Q1 1819	Q2 1819	Eligible	Vaccinated	Trendline
ENGLAND	**171,013**	**147,413**	**86.2%**	**85.9%**	**85.5%**	**0.0%**	**85.0%**	**179,348**	**152,446**	
London	**31,452**	**24,236**	**77.1%**	**75.0%**	**75.5%**	**69.2%**	**71.8%**	**32,095**	**23,058**	
North West London STP	**7,493**	**5,675**	**75.9%**	**73.5%**	**75.4%**	**72.1%**	**71.8%**	**7,493**	**5,379**	
Brent	1,246	973	81.8%	80.3%	80.5%	79.0%	78.1%	1,246	973	
Westminster	452	266	62.2%	60.5%	60.7%	62.1%	58.8%	452	266	
Ealing	1,398	967	75.7%	71.7%	74.9%	70.2%	69.2%	1,398	967	
Hammersmith and Fulham	575	369	71.1%	70.1%	70.3%	60.5%	64.2%	575	369	
Harrow	889	690	82.4%	80.9%	80.4%	80.7%	77.6%	889	690	
Hillingdon	1,193	909	78.1%	76.6%	77.7%	77.6%	76.2%	1,193	909	
Hounslow	1,156	837	76.9%	72.3%	77.4%	69.8%	72.4%	1,156	837	
Kensington and Chelsea	584	368	63.4%	64.0%	67.2%	63.1%	63.0%	584	368	
Q2 1819 Highest LA - London (Havering)							83.1%	955	794	

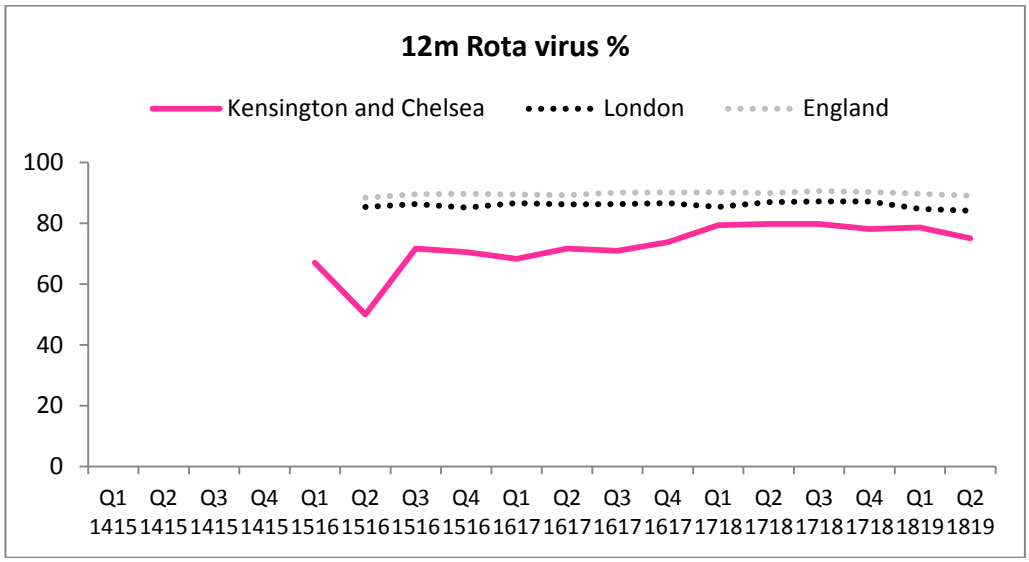
Source: PHE (2019)

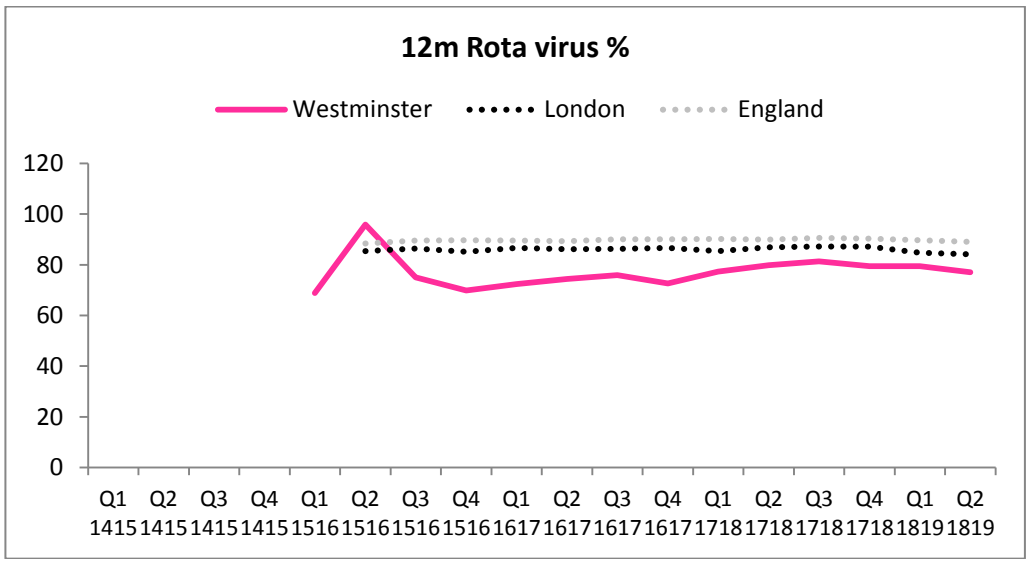
5.4 Rotavirus

- Rotavirus is a contagious virus that causes gastroenteritis.
- Rotavirus vaccine was introduced into the Routine Childhood Immunisation Schedule in 2013/14 and has been reported as part of COVER since 2016.
- In Kensington & Chelsea and Westminster, coverage (i.e. the 2 doses) of Rotavirus is below London averages and England averages (Figure 7) and was

75.1% and 77.1% respectively in Q2 2018/19 compared to London's 84.7%. Figure 8 illustrates how Kensington & Chelsea and Westminster has been doing compared to its geographical neighbours up to Q1 2018/19.

Figure 7
Coverage of Rotavirus at 12 months in Kensington & Chelsea and Westminster compared to London and England Averages





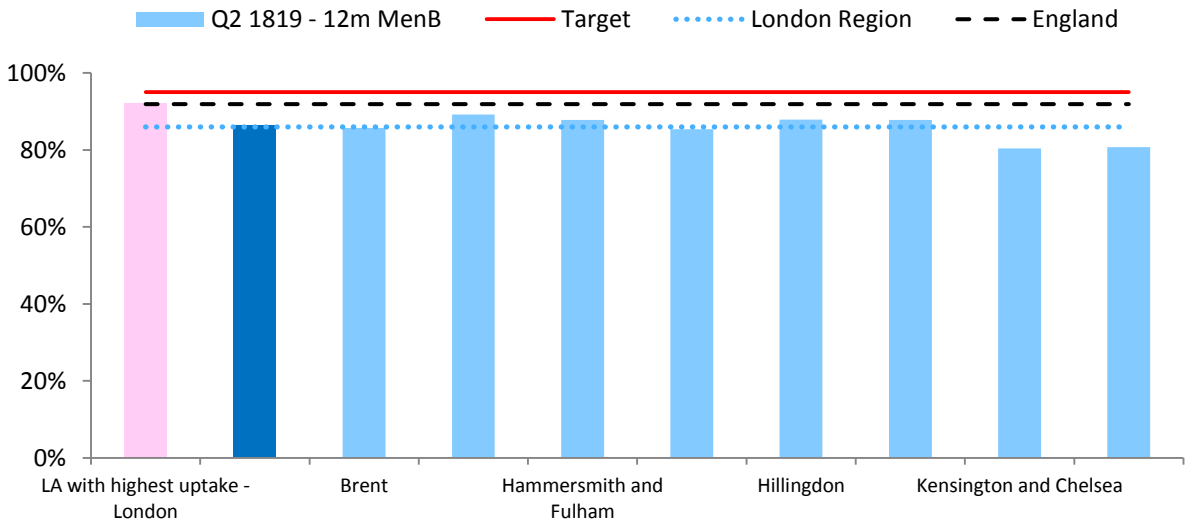
**please note that the vaccine reporting was only introduced in 2015/16*

Source: PHE (2019)

Figure 8
Uptake of Rotavirus at 12months in NWL

	Q3 1718	Q4 1718	Q1 1819	Q2 1819
ENGLAND	**90.6%**	**90.3%**	**0.0%**	**89.1%**
London	**87.2%**	**87.2%**	**84.7%**	**84.1%**
LA with highest uptake - London	**93.8%**	**92.5%**	**91.7%**	**90.3%**
North West London STP	**87.2%**	**86.1%**	**85.7%**	**84.8%**
Brent	**86.5%**	**86.8%**	**86.7%**	**85.8%**
Ealing	**89.7%**	**87.9%**	**87.2%**	**87.5%**
Hammersmith and Fulham	**88.3%**	**87.1%**	**85.4%**	**86.5%**
Harrow	**85.7%**	**87.5%**	**85.1%**	**84.1%**
Hillingdon	**91.7%**	**89.1%**	**88.8%**	**88.5%**
Hounslow	**88.1%**	**86.4%**	**87.5%**	**85.8%**
Kensington & Chelsea	**79.8%**	**78.1%**	**78.6%**	**75.1%**
Westminster	**81.4%**	**79.4%**	**79.5%**	**77.1%**

**please note that the migration of GP data to the NE London CHIS hub has affected coverage estimates for many of the LAs reported by this hub. As a consequence, London-level coverage figures are under-estimated in quarter 1. Due to the impact London data has on national figures, England estimates have not been calculated for quarter 1.*

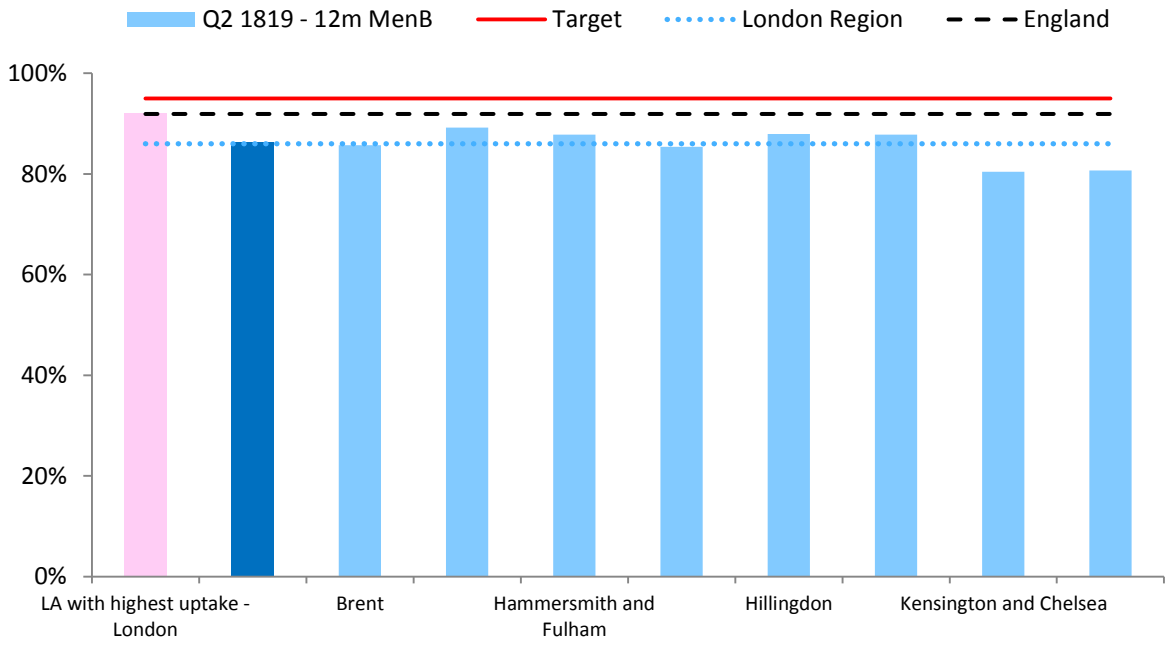


Source: PHE (2019)

5.5 Meningococcal B vaccination

- Since September 2015, all infants are offered a course of meningococcal B (men B) vaccine as part of the Routine Childhood Schedule. Eligible infants were those babies born on or after 1st July 2015.
- Kensington & Chelsea and Westminster performs below the London average.

Figure 9
Uptake of two doses of Men B vaccination by 12 months in Kensington & Chelsea and Westminster compared to London and England



	Q3 1718	Q4 1718	Q1 1819	Q2 1819
ENGLAND	**93.0%**	**92.5%**	**0.0%**	**91.9%**
London	**88.0%**	**88.5%**	**86.1%**	**86.0%**
LA with highest uptake - London	**94.4%**	**93.0%**	**92.7%**	**92.1%**
North West London STP	**87.8%**	**88.0%**	**87.5%**	**86.3%**
Brent	**89.0%**	**88.6%**	**87.6%**	**85.7%**
Ealing	**89.2%**	**90.6%**	**89.9%**	**89.2%**
Hammersmith and Fulham	**88.1%**	**88.3%**	**86.6%**	**87.8%**
Harrow	**87.7%**	**88.2%**	**86.9%**	**85.4%**
Hillingdon	**91.4%**	**89.3%**	**90.2%**	**87.9%**
Hounslow	**89.0%**	**89.1%**	**88.8%**	**87.8%**
Kensington & Chelsea	**81.0%**	**80.3%**	**80.5%**	**80.4%**
Westminster	**80.1%**	**83.0%**	**83.6%**	**80.7%**

Source: PHE (2019)
**please note the vaccine was only introduced in 2015 so this is the first available data*

5.6 Child 'flu vaccination

- There is a national ambition for 40-60% and London achieved these in 17/18 for the school age groups.

- Our goal in London was to achieve 40% uptake rates in 2 and 3 year olds and 50% in School Years 1, 2 and 3 and 40% in reception and School year 4
- Age 2 and 3 remain under 40% but the 2017/18 figures reflect the highest ever proportion of children vaccinated with child flu vaccine in these age groups.
- Figure 10 displays the comparison of London's 2017/18 rates to the previous year whilst Figure 11 compares Kensington & Chelsea and Westminster with the rest of its geographical neighbours and London and England averages. Kensington & Chelsea and Westminster performs well across the age groups, particularly when the vaccine is given in the school setting by the community provider CNWL, where they achieve the highest rates in the North West area. There are also year on year improvements in each cohort. This can be seen in Westminster where the 51.3% of reception children being vaccinated, which is higher than the original child 'flu group of Year 4 (they've been receiving the vaccination since Year 1), where 37.1% were vaccinated.

Figure 10
Child 'Flu vaccination rates for London 2016/17 and 2017/18

	Age 2	Age 3	Reception	Year 1	Year 2	Year 3	Year 4
London 17/18	33.1%	33.1%	51%	49%	48%	45%	41%
London 16/17	30.4%	32.5%	n/a	45%	43%	42%	n/a

Figure 11
Uptake of child flu vaccination for Kensington & Chelsea and Westminster CCG compared to NWL, London and England for Winter 2017/18 (September 1st 2017 – January 31st 2018)

CCG	% of 2 year olds	% of 3 year olds	% of Reception	% of Year 1	% of Year 2	% of Year 3	% of Year 4
Brent	29.7	31.2	30.5	30.5	24.2	22.6	22.1
Central London (Westminster)	27.7	25	51.3	46.9	45.7	32.6	37.1
Ealing	35.9	33.8	38.6	35.4	32.3	30.1	27.4
Hammersmith & Fulham	32.3	31.7	49.5	41.2	43.3	43.3	37.8
Harrow	25.2	29.5	56.6	54.8	53.8	50.1	49.8
Hillingdon	31.9	33	49.1	50.3	47.5	47	41.2
Hounslow	30.8	31.1	55.1	53	59.9	47.7	45.8
Kensington & Chelsea	28.1	26	43.4	40.4	45.8	40.1	42.1
London	33.2	33.3	51.6	49.6	48.2	45.6	43.8

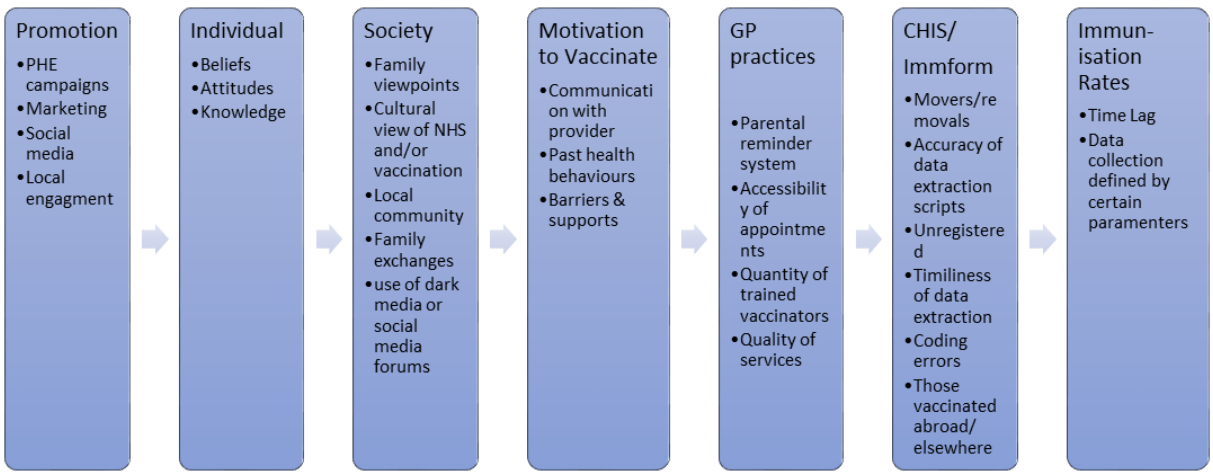
England	42.8	44.7	62.6	61	60.4	57.6	55.8

Source: PHE (2018)

5.7 What are we doing to increase uptake of COVER?

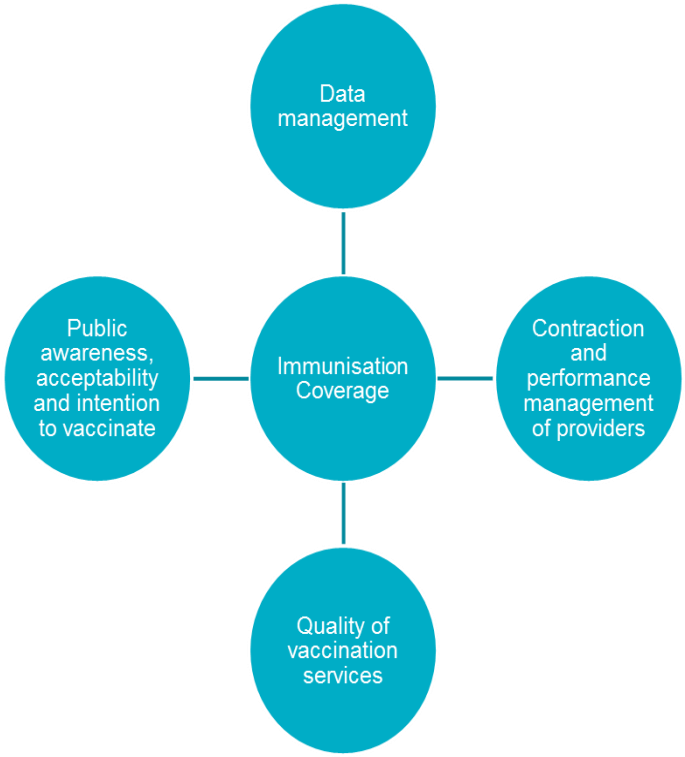
- Kensington & Chelsea and Westminster like other London boroughs performs below England averages for completed routine childhood immunisations as indicated by MMR 2nd dose and preschool booster. This is also below the recommended WHO 95% recommended uptake levels. Improving uptake rates in Kensington & Chelsea and Westminster is being undertaken by pan London endeavours as well as local borough partnership work between CCG, local authority, PHE and NHSE London. This involves examining uptake data, looking at local need and formulating a plan to increase uptake.
- Increasing coverage and uptake of the COVER reported vaccinations to the recommended 95% levels is a complex task. Under the London Immunisation Board, PHE and NHSE (London) have been working together to improve quality of vaccination services, increasing access, managing vaccine incidents and improving information management, such as better data linkages between Child Health Information Systems (CHIS) and GP systems. As well as these pan London approaches, NHSE (London) have been working locally with PHE health protection teams, CCGs and local public health teams in local authorities to identify local barriers and vulnerable or underserved groups and to work together to improve public acceptability and access and thereby increase vaccine uptake. Figure 12 shows the complexity around increasing the uptake of immunisation rates in London.

Figure 12
Logic Model for Improving Immunisation Uptake Rates in London



- The London wide Immunisation Plan for 2017/18 included sub-sets of plans such as improving parental invites/reminders across London, which the evidence repeatedly states as the main contributor to improving uptake of 0-5s vaccinations (see figure 12). A census of London's 1,346 GP practices resulted in the production of 0-5s call/recall best practice pathway and a 0-5s best practice pathway. Under the London Immunisation Partnership PHE and NHSE (London) are evaluating the impact of these pathways over the next few months.
- An evaluation of the 300 practices in London last year in relation to improving uptake of COVER reported vaccinations also concluded that practices need support around information materials to discuss with parents which the NHSE (London) immunisation team are addressing in conjunction with our PHE colleagues.
- Since April 2017, London's child health information systems (CHIS) are being provided by four hubs which feed a single data platform. This has simplified the barriers previously experienced by London have a large number of different data systems 'talking to each other'. Now all CHIS information is on one system fed by three data linkage systems from GP practices, which in turn are now on one of three systems. This change should remove many of the data errors in the past that had led to an overestimation of unvaccinated children. However, London continues to have a large proportion of children vaccinated overseas which often means that children are reported as unvaccinated when they have been vaccinated but on a different schedule. Work is underway to help GPs code the vaccinations of these new patients.

Figure 13
Infographic of action plan to improve immunisation coverage by working in partnership on each of the four areas below



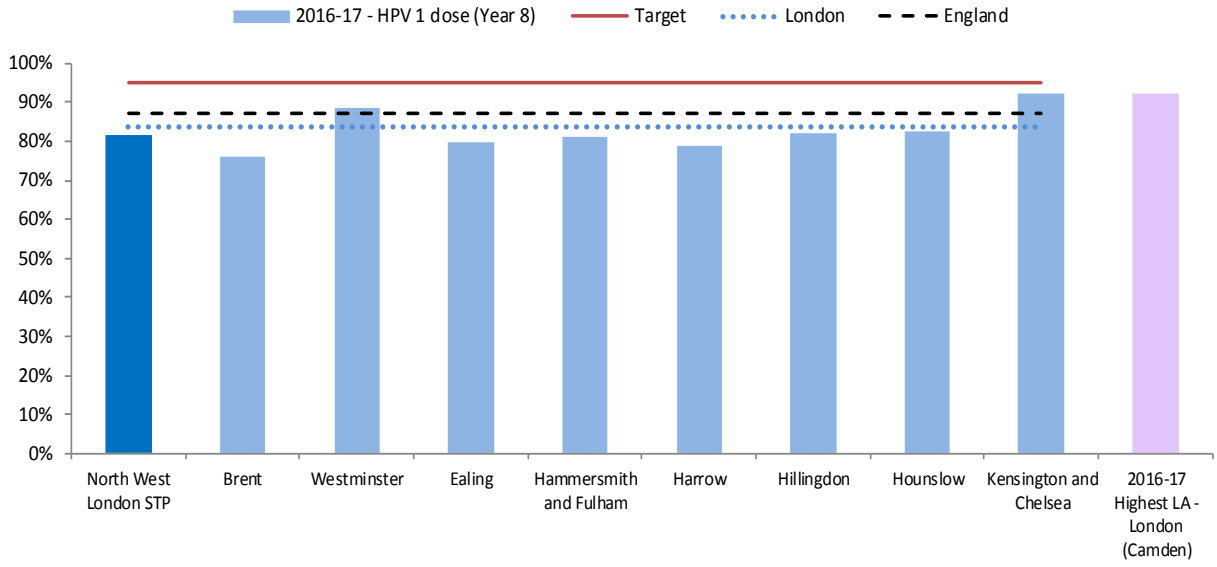
6 School Age Vaccinations

- School Age vaccinations consist of :
    - HPV vaccine for 12-13 year old girls – this programme will be rolled out to boys in September 2019.
    - Tetanus, diphtheria, polio booster (Teenage Booster) at age 14/15 for boys and girls
    - Meningitis ACWY at age 14/15
    - Annual child 'flu vaccination programme which in 2017/18 covered Reception to Year 5 in primary schools

6.1 HPV vaccination

- Human papillomavirus (HPV) vaccination protects against viruses that are linked to the development of cervical cancer
- HPV vaccination has been offered to 12-13 year old girls (Year 8) since the academic year 2008/09. Originally the course was 3 doses but following the recommendation of the Joint Committee of Vaccinations and Immunisations (JCVI) in 2014 is that two doses are adequate.
- Since 2008/09, there has been a steady increase of uptake both nationally and in London. However the introduction of a two course programme instead of a three course programme meant that many providers didn't offer the second dose until the next academic year. For 2015/16, London was the only region to commission both doses to be given within one academic year. This has continued until this year, 2018/19 where providers are now given a choice of whether to deliver both doses in one year or one dose in year 8 and the second in year 9 due to the increasing pressure of the school flu programme which has now expanded. CNWL, who deliver the programme in Kensington & Chelsea and Westminster, have opted to continue to deliver both doses in one year.
- Kensington & Chelsea and Westminster's uptake for 2 completed doses are 66.6% and 69.6% respectively which is below the London average of 75.3% and the NWL STP area average of 72.1%.

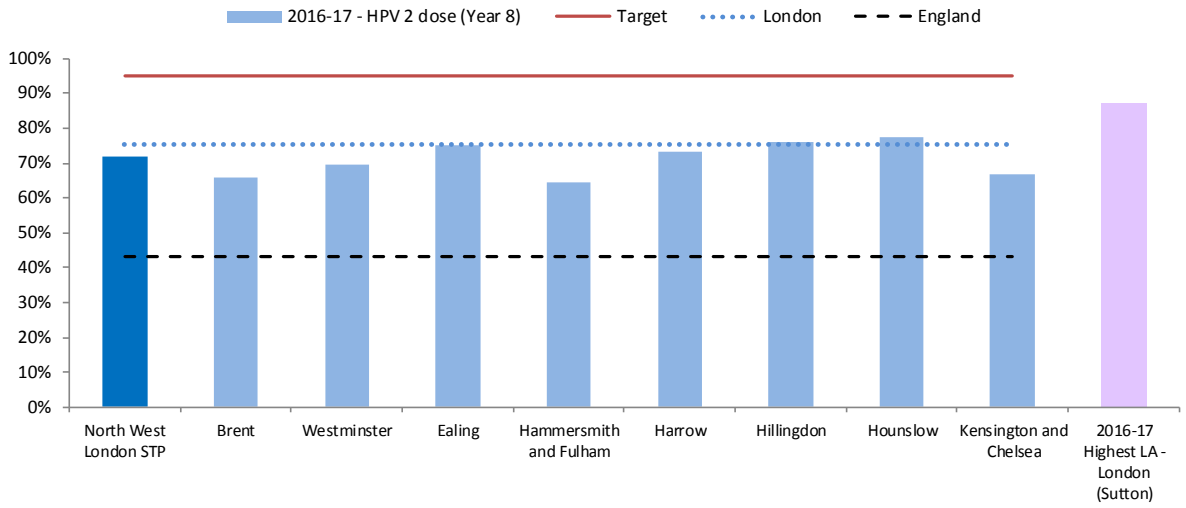
Figure 14
Dose 1 HPV Year 8



	Eligible	Vaccinated	2015-16	Eligible	Vaccinated	2016-17
ENGLAND	**288,536**	**251,010**	**87.0%**	**299,198**	**260,959**	**87.2%**
London	**42,666**	**35,787**	**83.9%**	**44,535**	**37,336**	**83.8%**
North West London STP	**9,644**	**7,872**	**81.6%**	**10,143**	**8,251**	**81.3%**
Brent	1,618	1,107	68.4%	1,601	1,215	75.9%
Westminster	858	835	97.3%	882	781	88.5%
Ealing	1,701	1,250	73.5%	1,735	1,386	79.9%
Hammersmith and Fulham	703	559	79.5%	954	775	81.2%
Harrow	1,219	1,004	82.4%	1,240	976	78.7%
Hillingdon	1,724	1,554	90.1%	1,776	1,461	82.3%
Hounslow	1,420	1,182	83.2%	1,491	1,229	82.4%
Kensington and Chelsea	401	381	95.0%	464	428	92.2%
2016-17 Highest LA - London(Camden)				925	854	92.3%

Source: PHE (2018)

Figure 15
Completed HPV course Year 8 (2 doses)



	Eligible	Vaccinated	2015-16	Eligible	Vaccinated	2016-17
ENGLAND	**288,536**	**116,191**	**40.3%**	**299,198**	**128,868**	**43.1%**
London	**42,666**	**31,922**	**74.8%**	**44,535**	**33,535**	**75.3%**
North West London STP	**9,644**	**6,870**	**71.2%**	**10,143**	**7,309**	**72.1%**
Brent	1,618	1,107	68.4%	1,601	1,055	65.9%
Westminster	858	541	63.1%	882	614	69.6%
Ealing	1,701	1,145	67.3%	1,735	1,304	75.2%
Hammersmith and Fulham	703	343	48.8%	954	615	64.5%
Harrow	1,219	932	76.5%	1,240	908	73.2%
Hillingdon	1,724	1,511	87.6%	1,776	1,348	75.9%
Hounslow	1,420	1,101	77.5%	1,491	1,156	77.5%
Kensington and Chelsea	401	190	47.4%	464	309	66.6%
2016-17 Highest LA - London(Sutton)				925	1,348	87.3%

Source: PHE (2018)

6.2 Men ACWY

- This vaccination protects against four main meningococcal strains (A, C, W and Y) that cause invasive meningococcal disease, meningitis and septicaemia.
- As seen in Figure 15, the uptake rate for Kensington & Chelsea was 88.8% and for Westminster it was 88.0% for Year 10 which is above the North West, London and England average.

Figure 16
MenACWY uptake in Year 10 (14-15 years)

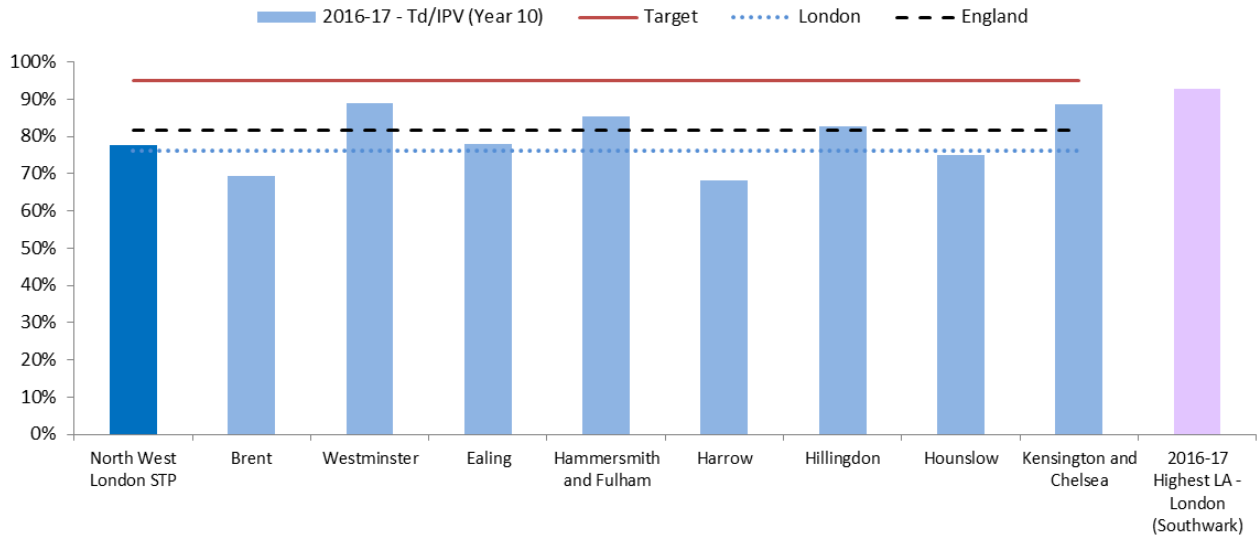
	Eligible	Vaccinated	2015-16	Eligible	Vaccinated	2016-17
ENGLAND	**270,383**	**208,759**	**77.2%**	**538,530**	**444,507**	**82.5%**
London	**57,517**	**36,297**	**63.1%**	**69,472**	**51,995**	**74.8%**
North West London STP	**17,773**	**13,333**	**75.0%**	**19,332**	**15,208**	**78.7%**
Brent	2,892	1,859	64.3%	3,103	2,190	70.6%
Westminster	1,604	1,294	80.7%	1,647	1,450	88.0%
Ealing	2,916	2,042	70.0%	3,330	2,628	78.9%
Hammersmith and Fulham	1,374	1,047	76.2%	1,533	1,305	85.1%
Harrow	1,980	1,496	75.6%	2,446	1,728	70.6%
Hillingdon	3,443	2,846	82.7%	3,568	2,956	82.8%
Hounslow	2,781	2,166	77.9%	2,882	2,220	77.0%
Kensington and Chelsea	783	583	74.5%	823	731	88.8%
2016-17 Highest LA - London (Kingston upon Thames)				1,796	1,671	93.0%

Source: PHE (2018)

6.3 Td/IPV

- The school leaver booster is the fifth dose of tetanus, diphtheria and polio (Td/IPV) vaccine in the routine immunisation schedule and completes the course, providing long-term protection against all three diseases.

Figure 17 Td/IPV- Year 10 (14-15 years)



	Eligible	Vaccinated	2015-16	Eligible	Vaccinated	2016-17
ENGLAND	**300,431**	**225,005**	**74.9%**	**530,308**	**433,307**	**81.7%**
London	**62,053**	**39,888**	**64.3%**	**73,169**	**55,646**	**76.1%**
North West London STP	**17,773**	**13,190**	**74.2%**	**19,332**	**15,041**	**77.8%**
Brent	2,892	1,869	64.6%	3,103	2,152	69.4%
Westminster	1,604	1,296	80.8%	1,647	1,462	88.8%
Ealing	2,916	2,034	69.8%	3,330	2,598	78.0%
Hammersmith and Fulham	1,374	1,059	77.1%	1,533	1,310	85.5%
Harrow	1,980	1,428	72.1%	2,446	1,669	68.2%
Hillingdon	3,443	2,843	82.6%	3,568	2,955	82.8%
Hounslow	2,781	2,072	74.5%	2,882	2,165	75.1%
Kensington and Chelsea	783	589	75.2%	823	730	88.7%
2016-17 Highest LA - London (Southwark)				2,511	2,329	92.8%

Source: PHE (2018)

6.4 What are we doing to improve uptake in Kensington & Chelsea and Westminster?

- As well as these pan London approaches, NHSE (London) have been working locally with Central London and West London CCGs, the local Public Health team and local school age provider to focus and identify local barriers and vulnerable or underserved groups and to work together to improve public acceptability and access and thereby increase vaccine uptake. One example of this is our local flu working group which meets monthly throughout the flu season. Key agenda items are local communications, data analysis, current vaccination uptake, national updates and school engagement.
- Since July 2017, we have had two 'deep dive' workshops with our nine school age vaccination providers across London where we focused on the service

factors impacting upon uptake. The main issues were identified as school refusals, lack of return of paper consent forms, self-consent and lack of school support. We have been working with our providers to rectify these and other issues including a pilot of three organisations using e-consent. This involves developing a communication strategy between providers and schools as well as developing an escalation process that they can follow.

- Following on from that, the last quarterly meeting of the London Immunisation Partnership (June 2018) did a deep dive into the factors impacting upon school aged vaccination rates, looking at data management, quality of services, commissioning and provider performance and public acceptability. An action plan has been devised with our partners which was circulated in February 2019 to them. The aim was to make a SMART annual plan that we can deliver together across London to improve uptake.
- As part of the Evaluation, Analytics and Research Group (EAR) of the London Immunisation Partnership, we continue to work with our academic partners in examining the factors impacting upon school aged vaccination uptake. We've completed a study looking at service factors impacting upon Men ACWY and another on HPV (both papers are currently under review for peer review journals). We are collaborating on the evaluation of the e-consent and contributing to a RCT on incentives to improve return of consent forms. We are also working on developing teacher training on school aged vaccinations (an action arising from our deep dive).

7 Outbreaks of Vaccine Preventable Diseases

- PHE NWL Health Protection Team has the remit to survey and respond to cases of vaccine preventable diseases. Where they declare a cluster or an outbreak, NHSE (London) have commissioned Imms01 which is the commissioner response. Under this we can mobilise a provider service response to vaccinate the designated contacts.
- During 2017/18, a total of 20 confirmed measles cases were reported for NWL. 1 confirmed case was reported in Kensington & Chelsea and 2 in Westminster. However, at 1.0/100,000 inhabitants, the rate of confirmed measles in NWL in 2017/18 was much lower than the previous year's peak rate of 3.7/100,000 but higher than the rates from 2013 to 2015. The rate of confirmed mumps in NWL in 2017/18 was 2.8/100,000 inhabitants, over twice the rate in 2016 (1.2/100,000) and the second annual increase in a row. NHSE (London) are working with PHE Health Protection Teams as part of the London Immunisation Business Group to reduce the number of measles and mumps cases in the population by increasing uptake of MMR in the adolescent and adult populations as well as the under 5s.

8 Next Steps

- NHSE (London) continues to work on delivering the WHO European and national strategies to improve coverage and to eliminate vaccine preventable diseases. In London this is done through the London Immunisation Plan which is reviewed annually by the London Immunisation Partnership.

- Quarterly assurance is provided on Kensington & Chelsea and Westminster through the NWL Immunisation Performance and Quality Board where challenges and solutions can be discussed around the performance data and the surveillance data.

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City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Westminster Health & Wellbeing Board

RBKC Health & Wellbeing Board

Date:	**28th March 2019**
Classification:	**General Release**
Title:	**Update from Central London CCG on commissioning arrangements**
Report of:	**Central London Clinical Commissioning Group**
Wards Involved:	**All**
Financial Summary:	**N/A**
Report Author and Contact Details:	**Neville Purssell, Chairman, Central London Clinical Commissioning Group**

1. Executive Summary

1.1 This report provides an update on the commissioning priorities for the NW London Collaboration of CCGs and the recently published five year framework for GP contract reform to implement the NHS Long Term Plan.

2. Key Matters for the Board

2.1 The Board is asked to note the paper.

3. Background

3.1 Central London CCG, as one of the eight NW London CCGs is signed up to and part of the Health and Care Partnership (formerly the STP). The aim of the Health and Care Partnership is to deliver a shared health and local government ambition across NW London.

3.2 The Partnership works to add value across the NW London Health and Care system and support tangible improvements to health and care services for the

two million people who make up the NW London community, helping people to be well and live well.

3.3 The detailed report attached provides an update and assurance that the NW London health and care system, which includes Central London CCG, is taking forward our strategic transformation objectives in effective and demonstrable ways. The impact of this will be improved services and outcomes for our population.

3.4 In January NHS England published Investment and Evolution: A five year framework for GP contract reform to implement the NHS Long Term Plan. Amongst other things this set out some important developments in respect to Primary Care Networks (PCNs). These networks will cover 100% of the population and will need to be in place by 1 July 2019.

3.5 Within Central London we have been working on the network principle for a couple of years and have already established four networks. More information will shortly become available nationally on how these will develop. However, we know that PCNs will be seen as an essential building block of every Integrated Care System (ICS). There will be eligibility criteria that PCNs will need to comply with and which the CCG will need to confirm have been met. PCNs will need to have boundaries that make sense to its constituent practices, other community based providers and its local community. The CCG allocation includes 0.25WTE payment for a clinical director for each PCN. The role includes ensuring that the PCN delivers the seven specifications outlined below.

3.6 The framework introduces additional roles into the primary care team which are recurrently reimbursed:

- social prescribers (100% reimbursement),
- clinical pharmacists (70% reimbursement),
- physician associates (70% reimbursement),
- first contact physiotherapists (70% reimbursement),
- first contact community paramedics (70% reimbursement).

3.7 The reimbursement for the first two roles is introduced in 2019; in 2020 the first contact physiotherapists and physician associates are introduced with paramedics introduced in 2021 as at this point additional paramedics come out of training.

3.8 The PCNs will be expected to deliver against seven specifications. Investment and service delivery grow in tandem across the five year period. The seven specifications are focused on areas where Primary Care Networks can have significant impact against the ‘triple aim’:

• improving health and saving lives (for example from strokes, heart attacks and cancer);
• improving the quality of care for people with multiple morbidities (for example through holistic and personalised care and support planning, structured

medication reviews, and more intensive support for patients who need it most including care home residents);

• and helping to make the NHS more sustainable (for example, by helping to reduce avoidable hospital admissions).

3.9 The seven national service specifications are:

- Structured medications review and optimisation – 20/21
- Enhanced health in care homes – to implement the vanguard model, a multidisciplinary offer to care homes delivered by the primary care network– 20/21
- Anticipatory care requirement for high need patients experiencing several long term conditions, to be jointly delivered with community services, working in 30-50,000 patient footprints. The full requirements will be developed by the ICS and commissioned from the Primary Care Networks from their CCGs – to commence in 20/21 and develop over subsequent years.
- Personalised care – to deliver the six main components of the comprehensive model of personalised care – shared decision making, enabling choice, personalised care and support planning, social prescribing, supported self-management and personal health budgets - to commence in 20/21 and develop over subsequent years
- Supporting early cancer diagnosis, the primary care networks working alongside the Cancer network, with a key role to ensure that GPs are using the latest evidence based guidance to identify people at risk of cancer and make timely referrals – to commence in 20/21 and develop over subsequent years.
- CVD prevention and diagnosis will start in 21/22 following development and testing of the best delivery model.
- Tackling neighbourhood inequalities to be introduced in 21/22, including a review of vaccination and immunisation.

3.10 All of the above are key to the delivery of local services that are integrated and better co-ordinated across Westminster. It will be important for the Health and Wellbeing Board to have further updates on both the Health and Care Partnership and the new GP framework as things develop.

4. Options / Considerations

4.1 No decisions are required as this is an update paper.

5. Legal Implications

5.1 There are no legal implications arising from this report.

6. Financial Implications

6.1 There are no direct financial implications arising from this report. The CCG is awaiting further information from NHS England in respect to any central funding available to develop the work associated with the new GP framework.

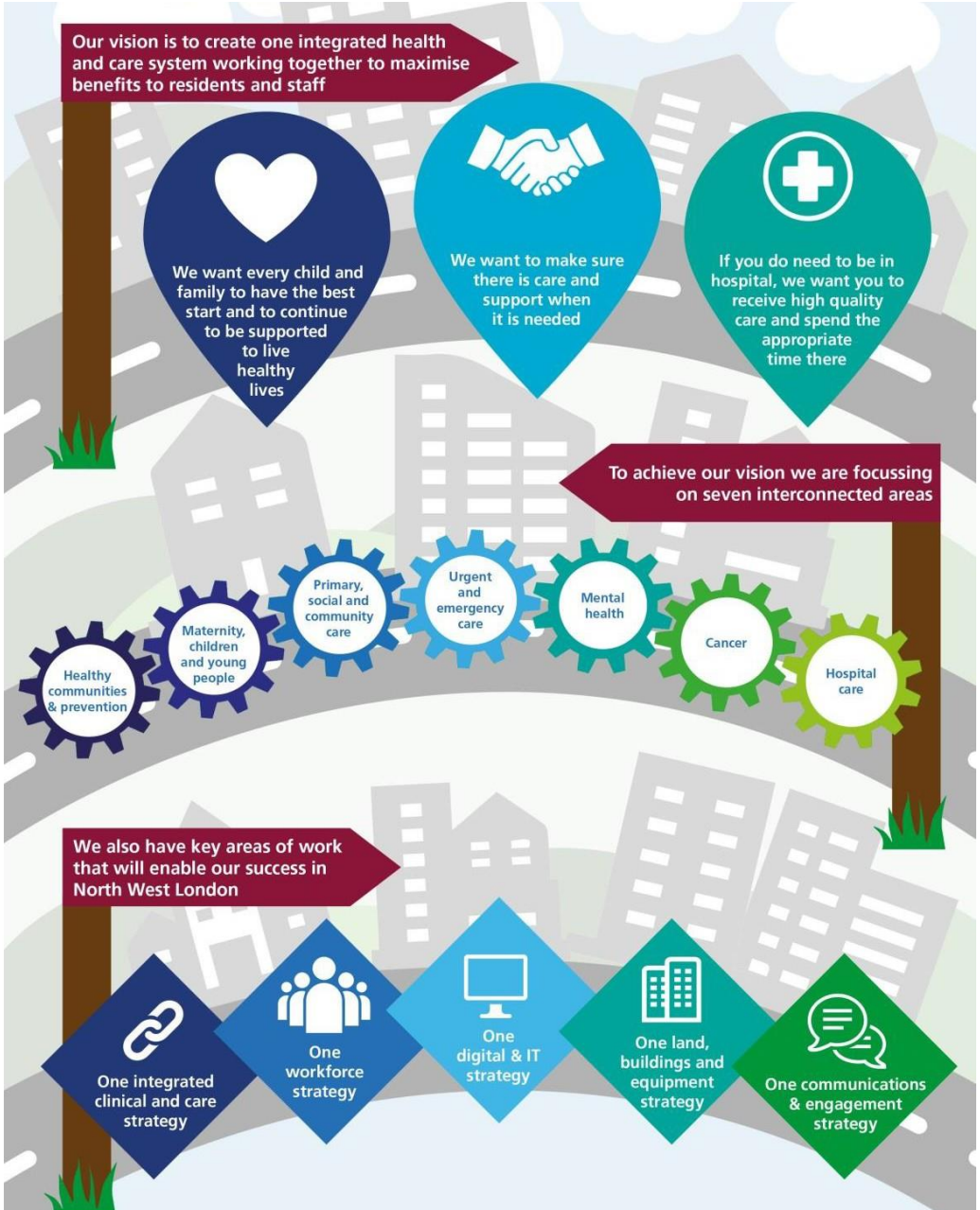
If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

Neville Purssell
Email: clccg.communications@nhs.net

APPENDICES:

Appendix A – Improving Care Across NW London

Improving care across North West London



An update - NW London Health & Care Partnership progress 7 March 2019

Introduction

This report provides a summary of progress up to January 2019, towards achieving the transformation objectives of the Health and Care Partnership and the progress made on the NW London governance.

General Updates

Governance review of our Partnership

The process of transitioning to our new Health & Care partnership arrangements continues to make good progress. The first Partnership Operations Group is scheduled for 14th March and the first Health and Care Partnership Board for 23rd May.

Meanwhile the Clinical and Quality Leadership Group have held a workshop to debate and agree what outcomes we should measure our success as a health and care partnership - which are the outcomes by which we should hold ourselves to account and measure our improvement. We also have held a workshop for all provider CEOs and CCG chairs where we collectively developed principles for how we should be working differently as a system rather than a set of leaders of single organisations. These will be agreed through the Health and Care Partnership Board and brought back to a future Joint Committee. We are in the process of developing the outcomes dashboard that will enable us to have good visibility of these.

We are in the process of identifying SROs, clinical leads and project leads for each of our seven interconnected portfolio areas, as well as working with all CCGs and our other stakeholder organisations to identify who should site on the programme boards and how these will best work with local governance arrangements.

National & local alignment

We have undertaken an initial review of how our refreshed partnership plan aligns with the intentions of the NHS long term plan. This has previously been shared with Joint Committee members through other meetings and members will recall that there is close alignment. Over the coming months we will work through our programme boards and other forums to further develop our thinking and crystallise this into NW London's 5 year strategy in light of the national plan. Public and staff engagement will form a significant part in developing this and we are working with our lay partners to develop our approach to facilitate meaningful public input.

Transformation progress

The following section outlines key progress in our 7 interconnected portfolio & enabler areas

1) Healthy Communities & Prevention

Our aim: *to support people to support themselves and others, to live full and active lives in their community*

The shadow Healthy Communities and Prevention Board met on 31st January. As part of the refresh a new lay member and third sector representative joined the Board. This further reiterates our commitment to ensuring a stronger voice is heard from the third sector & patients/residents of NW London.

1.1) Promoting Self Care

Digital SelfCare solutions to long term condition management

myCOPD (Chronic Obstructive Pulmonary Disease) - The NHS long term plan has indicated that the myCOPD app can be provided to patients via GPs. In NW London we believe this will really help to support patients to be increasingly 'active' in their self-care. Plans are being developed to support the roll-out of the myCOPD app and the NW London '*myCOPD ''sharing the learning' event'* which was held early February, helped to support shared learning.

myHeart - Similarly the roll-out of the myHeart health app has commenced through the Cardiac Health and Rehabilitation services at Imperial College Healthcare NHS Trust. So far, 25 patients have enrolled.

Diabetes - An additional 2500 '*Diabetes Health App*' licenses have been procured for our eight CCGs. These are targeted to general practices where the need is most, 64 practices have signed up. To date, over 450 patients have enrolled and a plan is in place to rapidly expand this, with over 7,000 patients being offered the use of this app via email or text message.

Patient Activation Measure (PAM) Assessment - So far 34,744 patients across NW London have completed a PAM assessment including 4,265 re-assessments which will help support the management of their healthcare. In addition, PAM will be included within the Health Help Now app from February 2019 for West London CCG.

Social Prescribing - The scoping of Social Prescribing provision across NW London has now been completed. It includes a Digital Social Prescribing pilot within West London which is progressing with 10 practices identified to participate.

We contributed to the London Mayor's vision which is currently out for consultation, and the NHS Long Term Plan has announced that there will be funding for Social Prescribing link workers through the Primary Care Network funds for 2019/20. NW London will of course be ensuring we align and maximise any opportunities.

1.2) Promoting Healthy Lifestyles

The shadow programme group agreed that the workstream priorities for 2019/20 would continue to be alcohol misuse and childhood obesity. Outcome indicators which will help monitor progress were agreed by the board and will be formally signed off at the next meeting in March.

2) Maternity & Children & Young People

Our aims: *to develop our Health and Care System offer for Children and Young People which looks beyond illness and to improve safety, continuity and personalisation of maternity care*

2.1) Children & Young people (CYP)

Children and Young People is being proposed as a new programme within the Health & Care Partnership's plan, although it already has existing structures. We are currently working with system colleagues to appoint to the senior clinical and managerial roles which will oversee the programme or work. Additionally we are exploring the option for the existing NW London Children and Young People Network to also fulfil the function of the programme board.

The initial projects have been agreed as:

1) Asthma - adopting best care across NW London
2) Complex Care needs – improving what matters to children & young people
3) Dental - improving dental care
4) Starting well & staying well – jointly with the Maternity Programme

2.2) Ma terni ty 'Bette r Bir ths ' (our Local Maternity System)

December 2018 marked the closure of the maternity early adopters programme. These pathways are being trialled with women using the birth centre at Imperial, and women booked for elective Cesarian sections at Northwick Park.. The next phase of the Maternity Transformation Programme includes aims to decrease stillbirths, neonatal deaths and intrapartum brain injuries between now and March 2021. However we are awaiting confirmation of funding by NHSe for this important programme; we have received positive reassurance that this will be forthcoming and the programme will commence once this is confirmed.

Continuity of Carer

Women experiencing care from the same midwife throughout their journey increased last month following the launch of new models to increase the continuity of carer rate. This includes a birth centre model at Imperial and an elective C-section caseload at Northwick

Park. Further models are being launched in February and March to ensure we reach a 20% target of women booked onto a continuity of carer pathway.

Safer Carer

A new 'Safer care project' is in development focusing on sharing learning from clinical incidents, standardising pathways and collaborating on safety initiatives. This aims to launch in April 2019.

3) Primary, Social & Community *NB: there are many interdependencies between this portfolio area and the Urgent & Emergency Care portfolio area. Please ensure the 2 areas are taken as a 'whole'.*

Our aim: *to improve community based care so as to support people closer to home and prevent deterioration in their health and wellbeing*

3.1) Supporting Primary Care at scale

The national investment & evolution five year financial framework has been released which includes a Primary Care Network directed enhanced service (DES) for commencement from the 01 July. This national steer was anticipated and we are actively working to understand the impact to us here in NW London.

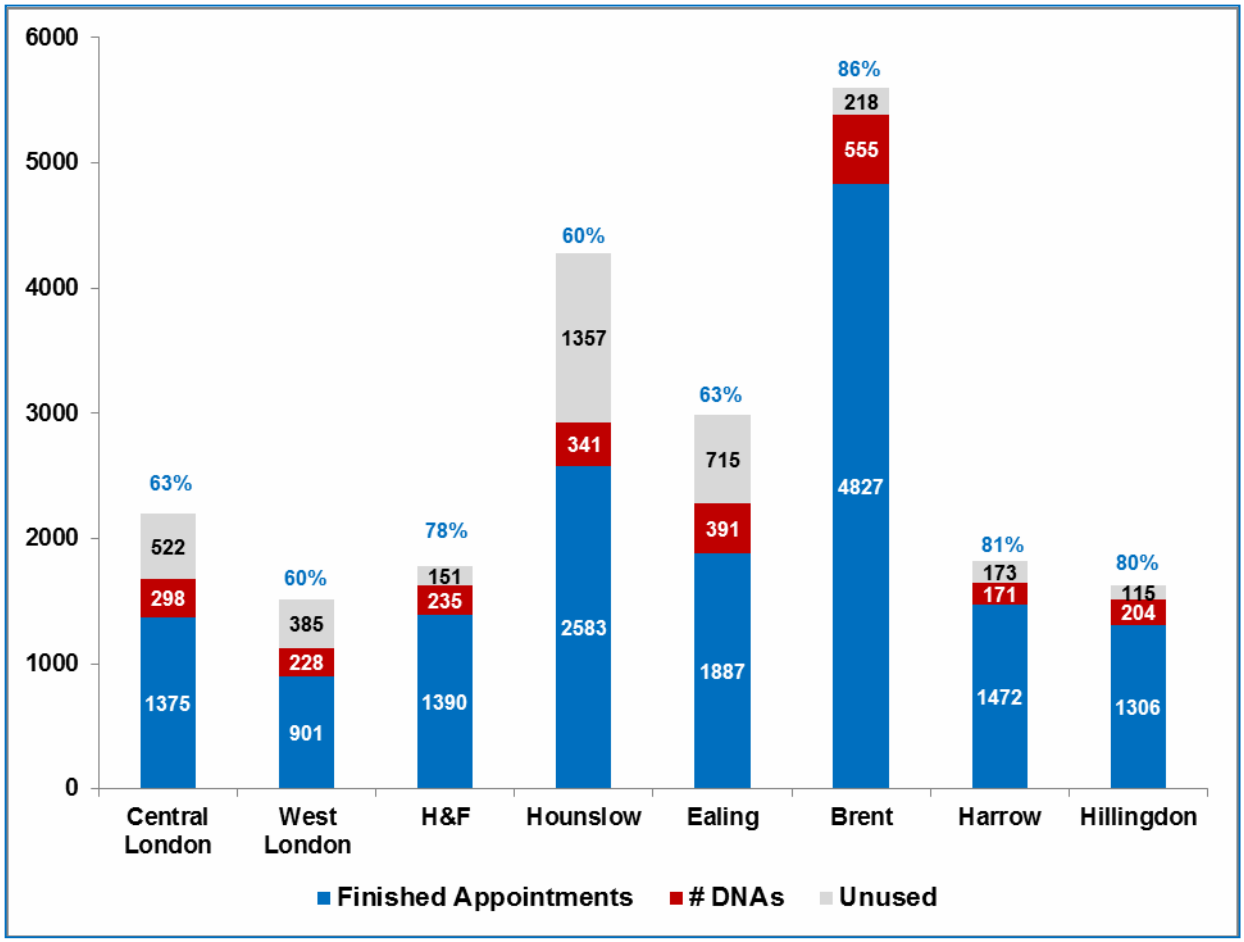
Another national steer which we are actively participating in is the NHS Digital App. Work has commenced with Brent to support its development as a Digital Accelerator site.

Further funding which will offer resilience support to practices in NW London has also been confirmed. Team working with commissioning partners has resulted in the identification of a number of practices which would benefit from this type of support and we are working to tailor the support required. However one such initiative which has been designed to develop and support clinical and managerial leaders of our Federations (ie the '*Confident Leader Programme*') is imminent with the contract being signed by the provider. The programme will run throughout the year.

GP extended access

GP extended access – work continues to ensure that there are appointments available & being utilised from 08:00 to 20:00 across NW London. In January, there were over 21,000 appointments available for patients within the extended access hubs where 72% (up by 5% from December) appointments were used. Figure 1.1 offers a graphical representation of this by CCG.

Figure 1.1: Appointment Utilisation by CCG



In addition, '*In-hours booking'* is now live within Hammersmith & Fulham and Central London. Ealing, Brent, Harrow and Hillingdon are expected to go live in February. This means patients can book an appointment with their GP practices through 111 at all hours of the day.

Recently a patient survey was completed in Ealing where 100% of the patients that used the Extended Access service were highly impressed with their appointment times with 90% of patients able to meet face-to-face with a GP. Also, when asked to rate their quality of care, 100% of patients said they experienced an excellent or good quality of care and all said they would recommend the service.

Patient Feedback:

'The NHS was really listening to patients and were being responsive to working people and parents with children'.

'Great idea, this may put less stress on NHS A&E in hospitals'

Online consultations

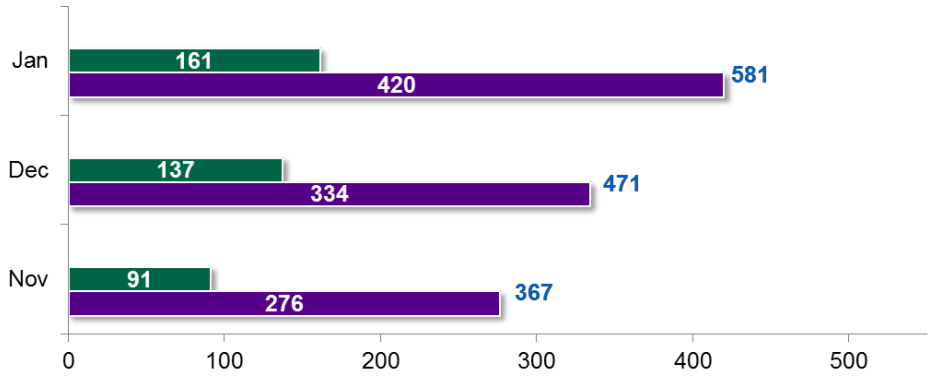
Online consultations is now live across 16 practices in Brent with another 6 expected to go live in February which will include another network (Kilburn) joining the pilot. There are also another 7 practices live in Central London.

Since the service commenced in November last year, across two networks in Brent and one Primary Care Home in Central London, patients have been steadily submitting e-consultations to GPs.

To date there have been over 2200 patients (1419 in Brent & 832 in Central London) who have submitted e-consults. Further fact and figures include;

- approx. 150 have booked an appointment with a GP in the Extended Access hub or their home practice
- 43 patients were issued with a prescription
- 101 patients have had telephone consultations
- 168 patients have been sent an e-consult message
- 100% of the e-consults that have been submitted have been responded to within 48 hours.

Figure 1.2 : Online consultations by Clinical and Administration consults for Brent Nov 2018 to Jan 2019



Key green = Admin purple = Clinical

The above chart shows the number of online consultations submitted in Brent from November to January. These are split into administrative and clinical queries. All 'eConsult' queries submitted by patients are received at their registered practice and filtered by the lead administrator. All administrative queries (i.e. repeat prescriptions, request for medical notes, reports or letters) are dealt with by the practice administrators. Clinical queries (i.e.

general medical advice, pains and illnesses covering a range of conditions), are submitted to the clinicians in the eHub and are dealt with accordingly, resulting in remote closure via telephone call, direct message to patient, prescriptions or a booked face-to-face appointment at patient's practice or extended access hub as appropriate.

Patient feedback:

- *'The service was a much quicker and more efficient way to request assistance from the GP practice than calling or going in person, and the whole process worked smoothly from start to finish'.*
- *'I was contacted within the time frame and offered good advice and an appointment was made quickly for the next day to see a GP. All went very smoothly as it should be if I were able to get through to the surgery and not have to wait forever to get an appointment. I am very pleased with this new service and recommend it to others'.*
- *'I was pleasantly surprised at the speed of receiving a reply. The service is amazing and if it eases the workload of the GPs and nurses it's a winner in my opinion'.*

Primary Care Workforce

A key element of the national investment & evolution five year financial framework is the funding of five alternative primary care roles (e.g. Clinical Pharmacist and Social Prescribing link workers) for primary care networks.

Two Primary Care Homes in NW London have now commenced the use of the workforce workload modelling tool. This will support practices in mapping out their workload.

In addition, further funding to aid innovative recruitment and retention support has been confirmed for NW London in the following 2 areas:

- a pilot a programme that will retain GPs in areas of deprivation and support GPs through Quality Improvement methodology and workshops
- work to support the recruitment and retention of Nurses in general practice.

3.2) Supporting people with Frailty

NW London frailty teams in Northwick Park Hospital and The Hillingdon Hospitals' continue to work in A&Es throughout December and January and we await activity and impact data. Their support is helping to ensure people are supported to receive ongoing care at home rather than being admitted into hospital.

Health Education England has allocated funding for the development of an advanced frailty practitioner role working between Chiswick Nursing Centre, their local GP Practice and Charing Cross Hospital. The role will provide expert support, advice and liaison to staff in these organisations as well as wider system partners to try and reduce the number of

ambulance conveyances and admissions to hospital. The role will deliver training and education to teams in all of the organisations to improve care. In order to help quantify impact we are working to devise metrics to help evidence whether the change is successful including impact on the well-being of residents.

***3.3/4) <u>Supporting people with Dementia & in the Last phase of life</u>** (telemedicine)*

Enhanced care in care homes - '*Is my resident well*?' training empowers care home staff to identify deterioration earlier resulting in residents receiving more timely care within their home. The locally commissioned care home training provides both cross cutting and bespoke training with targeted training linked to local priority clinical competencies, including dementia and end of life care. As of 31 January, 853 participants have been trained in 84 care homes across NW London, with an increase of 215 participants in January. The increased numbers of care home staff receiving training will encourage better care, improved communication and raised understanding around key pathways between hospitals and other NHS care teams with the care home workforce.

Our Health and Care Partnership is implementing the NHSe's '*medicines optimisation in care homes programme*'. Pharmacists working in care homes improve care and quality, reduce risk of harm from medicines and release staff resources. NW London has secured some funding which has been used to recruit and train four new pharmacists and a pharmacy technician who have now started work. To support the pharmacy teams in their roles, NHS England is delivering a development programme which began on 30 January 2019.

The '*hospital transfer protocol',* which is designed to improve communication and relationships between hospitals and care homes when care home residents are admitted to hospital, has been rolled out across NW London and work continues with hospitals to ensure care home residents are recognised during admission, treatment and discharge. A patient-level case review of the hospital experience of care home residents is underway at Chelsea & Westminster Hospital. The review will analyse the journey of care home residents through hospital up until discharge back to their care homes. The review will examine how the current protocol is working and help providing insight on how we can support and expedite discharge from hospital for care home residents.

The specialist telephone advice line for care homes continues to run Monday to Sunday, 08:00 to 02:00, staffed by nurses with specialist skills in supporting people at the end of their life. There were 307 calls from 73 care homes in January 2019, with over 3000 calls to the service from April 2018 to January 2019. Call numbers have increased from last year. The top five reasons of calls included lower respiratory tract infection, urinary tract infection, falls, cough and vomiting.

The first wave of the roll out of video consultation technology to care homes is now live in eight care homes. The care homes have a portable tablet and are able to access face-to-face advice and support by dialling the 111*6 service. As well as connecting care homes to the 111*6 telemedicine service, we have connected a GP practice to one of their local care

homes to help provide more primary care support to those care home residents and to understand how technology can help deliver better care to care home residents.

3.5) Supporting People with Diabetes

NW London has been working both locally (in borough/CCG footprints) and collectively across the entirety of NW London, together we have delivered the outcomes below.

a) Drop in annual growth of acute diabetes admissions (8.3% (2017/18) to 4.9%(2018/19)
b) Cost growth has slowed to 7.9% in 2018/19 for diabetes in-patients from 11% annually for the past four years.
c) In five of our CCGs (Central, West London, Hammersmith & Fulham, Hounslow and Ealing) for the first time since 2005, the number of people with diabetes newly diagnosed each year has reduced. (This coincides with the Out of Hospital contract which includes screening, annual review and offer of referral into the National Diabetes Prevention Programme).
d) Some CCGs, e.g. Hounslow, have improved the three treatment targets of HbA1c, blood pressure and cholesterol so effectively that they are seeing a reduction in acute activity and QIPP savings

The following infographics offer additional insight into challenges for our population here in NW London, the positive impact we are having and key messages from the NHS Long Term plan – all of which is being taken into account as colleagues work to identify key priority areas for 2019/20

North West London Diabetes Transformation Programme

The challenge:

£22m predicted rise in cost of diabetes in-patient activity in 2019/20 if we do nothing

Over **148,000** people in NWL with diabetes

Over **90,000** people in NWL with diagnosed non-diabetic hyperglycaemia

Over **1 in 10** people in NWL have diabetes or NDH (likely to be nearer 1 in 7)

of all hospital admissions have diabetes

of all bed occupancy is for people with diabetes

Over **£140m** annual cost of complications

£84m cardiovascular
£32m foot
£11m renal (excluding transplant and dialysis)

Over **£37m** annual cost of diabetes medication alone (excluding other medicines)

The programme:

4 project areas and **2** key enablers spanning **8** CCGs

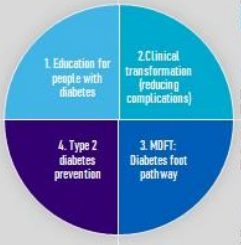
Structured education
More patients receiving self-management support

10,146
received structured education since April 2017 (4666 since April this year)

664
patients received digital structured education

Prevention

6958
Patients referred to National Diabetes Prevention Programme since April 2018



Clinical transformation
Integrated outcomes based contract developed

639
healthcare professionals have received PITstop, PrePITstop or Cambridge Diabetes Education Programme training to date

876
hospital, care home and mental health team care professionals trained using diabetes 10 point training

Diabetes foot pathway
additional podietrists supporting improved footcare pathway including weekend cover

8%
reduction in in-patient footcare activity compared with last 4 years

Digital
EMISweb diabetes template rolled out to primary care
WSIC diabetes benchmarking, population health and care radar complete and rolled out
Information governance complete, supporting more robust data extraction and integration
KnowDiabetes website refresh nearly complete
Know Diabetes contact centre to pilot Q4 18/19
At scale **digital behaviour change content and campaigns** near completion

Mental Health
Mental health indicators included in NWL integrated service spec

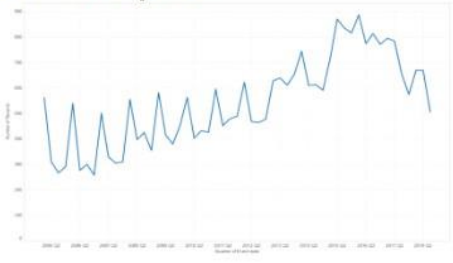
Mental health nurses supporting primary care training

The impact:

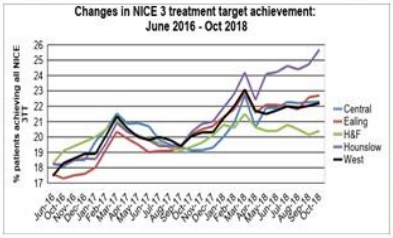
Achieving improvements in key areas

Reducing new diabetes diagnoses

Graph showing reduction in new diabetes diagnoses since introduction of the Non-Diabetes Hyperglycaemia primary care contract and National Diabetes Prevention Programme in 2016



Improving treatment targets, achieving QIPP savings

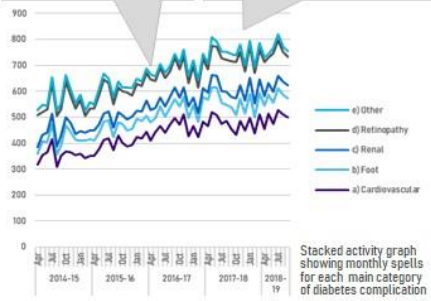


Hounslow CCG
5.3%
improvement in 3 treatment target achievement this year, now achieving QIPP savings from reductions in acute activity

Reducing hospital activity and cost

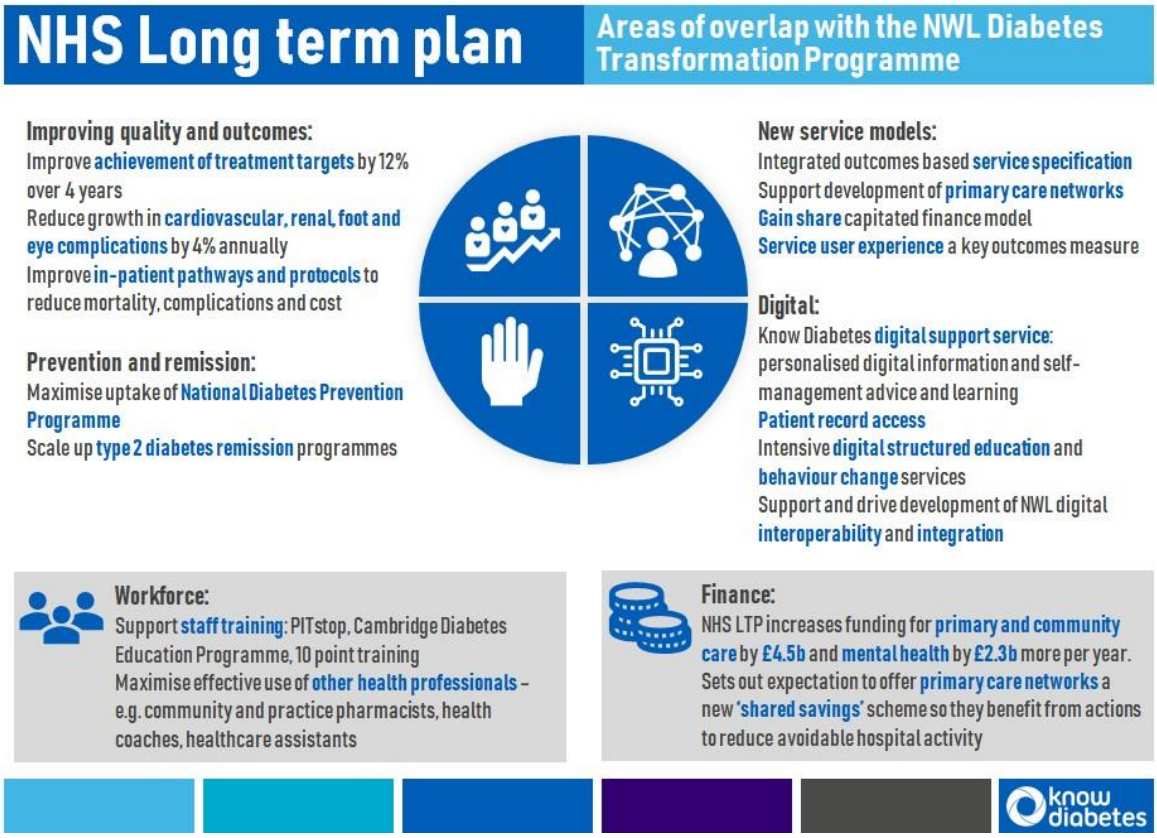
8.3%
Average annual growth in inpatient spells with diabetes complications from 2014-2018

4.9%
FOT growth in inpatient spells (M1-7 2018/19) for diabetes complications



Stacked activity graph showing monthly spells for each main category of diabetes complication

Cost growth for diabetes inpatients has averaged over **11%** annually for the past 4 years and has slowed to **7.3%** in 18/19



4) Urgent & Emergency Care

Our aim: *to ensure Urgent and Emergency care is delivering the right care in the right place (ie home, community or hospital) first time.*

Whilst Urgent and Emergency care has been proposed as a new portfolio area within the Health & Care Partnership's plan, there are already existing structures to align with. We are currently working with system colleagues to appoint to the senior clinical and managerial roles for this interconnected portfolio area as well as ensure 'fit' to the four existing A&E Boards.

There is however significant focus on helping patients to go home as soon as they are fit to leave - through our Home First programme.

Home First

As of December 2018, over 4100 patients were supported using Home First pathway principles. This project has contributed to a reduction in the time older people have spent in hospital by over 5,900 days since April 2018.

The significant impact for people aged 75+ with regard to time spent in hospital after an emergency admission is demonstrated in data on hospital length of stay across NW London and this is illustrated in the graphs below at Figure 1.3

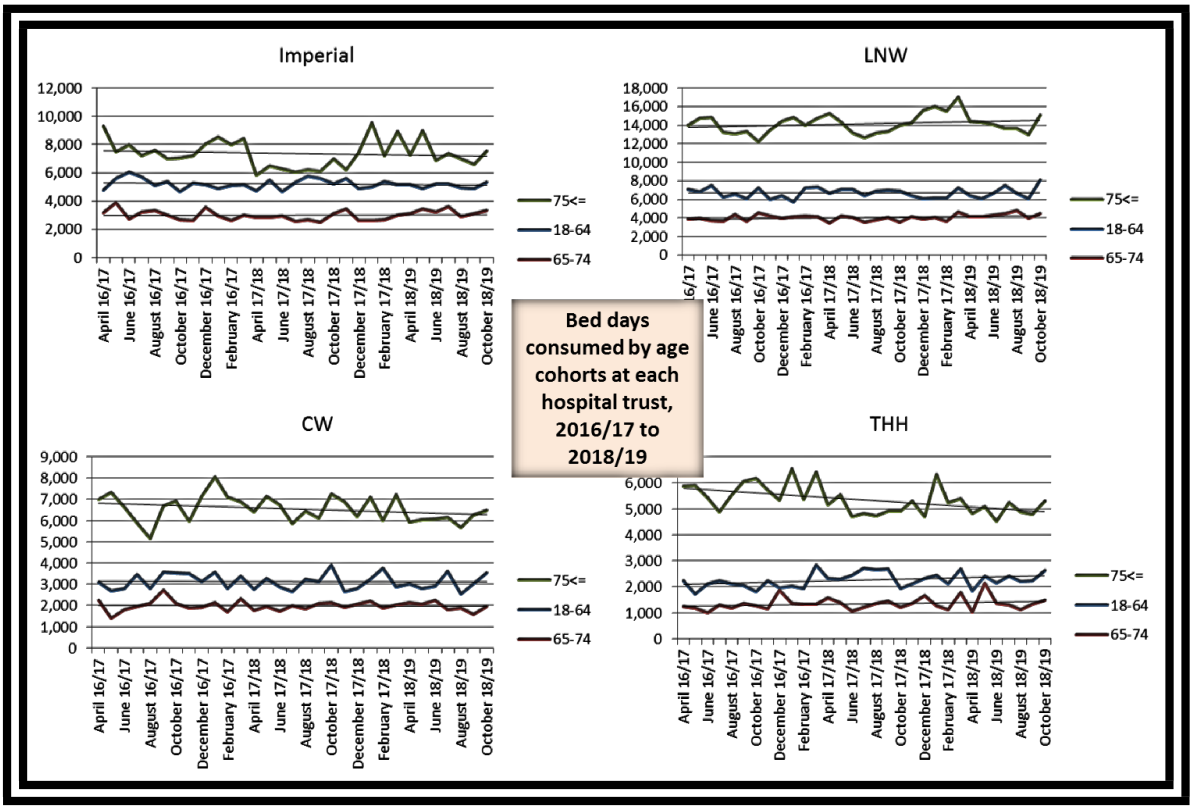


Figure 1.3: Bed days used by 75+ year cohort in NW London

The new streamlined process from six pilot wards in January 2019 saw 19 patients discharged from hospital to community rehabilitation beds. Further intelligence suggests;

- 9 patients were accepted on the same day, the majority within 1 hr of receipt
- 3 patients were discharged to the community based rehabilitation unit within 24 hrs
- 6 were discharged outside of 24 hrs.

Another patient was discharged home for a continuing healthcare assessment. As numbers are low, a review of the continuing healthcare assessment pathway has been held at Chelsea and Westminster Hospital. There will be a renewed focus and drive behind identifying and discharging patients on this pathway for the remainder of the trial period.

5) Mental Health

Our aim: *to improve outcomes for children and adults with mental health, learning disability and autism needs, and enable them to live well through timely access to community based and high quality of care no matter where they live.*

However we recognise that resources within mental health transformation are currently limited and we are therefore continuing to focus on our key areas. In particular for this update 'Transforming Care Partnership' has been highlighted

5.2) ***Focused interventions for targeted populations***

Transforming Care Partnership

The Transforming Care Partnership programme aims to reduce reliance on inpatient care and improve the quality of community-based support for people with learning disabilities and / or autism who have a mental health need and/or challenging or offending behaviour.

NW London has high number of adult patients (40) who are in non-secure inpatient beds and there is a national, but challenging ask, to discharge these patients back into communities. The 'challenge' is due to complex needs and legal circumstances of the individual patients. An integrated model of care and support emphasising the need for early intervention, proactive and reactive support to avoid admissions, including the use of dynamic risk registers and Care and Treatment Reviews have been developed. CCGs and Local Authorities are working in collaboration to implement these tools to manage complex needs in communities to minimise inpatient admissions. Funding has been secured to increase investment in the local community teams to support discharge planning, develop peer-led training programmes for families and interventions to minimise future admissions.

6) Improving Cancer Care

Our Aim *to improve cancer care by early identification, rapid treatment and living well with or beyond cancer. (Earlier diagnosis through strengthened interventions and informed choice, supported by timely and effective multi-disciplinary care which enables people to live as independently as possible with, and beyond a cancer diagnosis)*

Whilst '*Improving Cancer Care*' is being proposed as a new portfolio area within the Health & Care Partnership's plan, there are already existing structures and programmes of work to align with. We are currently working with system colleagues to appoint to the senior clinical and managerial roles for this interconnected portfolio area as well as ensure 'fit' to existing forums.

7) Hospital Care

Our aims: *to implement good quality, sustainable acute care in the most appropriate places as close to people's home as possible and for NHS Providers to work together to improve value and patient experience whilst increasing quality and reducing costs*

7.1)***Implementing in and out of hospital reconfiguration***

Capital business cases to support clinical improvements

A number of provider capital schemes have been approved. These include; improving theatres at Northwick Park and Imperial, and for improvement of patient dormitories and facilities at Central North West London Trust. These schemes will progress to Outline and Full business case development. The acute care transformation team is preparing to support the development and commissioner assurance of these business cases and we are also working to develop a proposal for a NW London acute activity modelling tool. A Technical Group has been meeting regularly to agree assumptions underpinning the model.

Also to note we are continuing with the development & role out of plans for the GP community hubs. This will provide our population here in NW London with the means of obtaining appropriate care in a community setting rather than needing to go to hospital. Task and finish meetings are being held with each CCG to aid their review of hub implementation plans and value for money.

7.2) NHS Providers working together

Outpatients Transformation

The NW London Outpatients Transformation programme is progressing well. During January / February the programme launched 'soft triage' against the first wave of clinical specialties. Initial feedback from the batches of referrals which have been reviewed, has confirmed that there is significant opportunity to improve the quality of referrals. Updates to Gynaecology and Gatroenterology referrals have also been published, reflecting feedback from GPs and the Local Medical Council.

The second wave of specialities (ophthalmology, neurology, respiratory and urology) have commenced with collaborative workshops held during January and February for Respiratory and Urology, and planning for the second Neurology workshop is progressing.

Additionally a suite of outcomes and indicators are in the process of development across all CCGs and Providers. These will track the impact upon outpatient activity and will include evaluation of the impact on non-routine pathways (e.g. suspected cancer pathways) and broader quality related metrics. The details of the indicators are being developed at the moment, but will include:

- Total referrals made into a service from across NW London
- Number of referrals returned to GPs without an appointment being made
- Total number of first and follow up appointments
- Waiting time from referral to first appointment

Enabler - Workforce

Highlights of work underway includes the following;

- **Change Management Facilitators** modules for primary care networks have concluded. Action learning sets are now underway. Two project sites in Westminster are preparing to use the Workforce Modelling Toolkit. An evaluation will be finalised at end of Q4 18/19.
- **Primary Care Retention and Recruitment funding** totalling £330,000 has been distributed to CCG's for local initiatives. A further £50,000 was awarded by NHSe to support a pilot project in NW London to retaining GPs working in areas of high deprivation and further work in recruiting GPs with long-absence back into General Practice.
- **General Practice Nursing (GPN) 10 point plan** – Health Education England have match-funded an additional £34k to support the Legacy mentorship scheme.
- **Community services leadership programme** – A provider has been selected to deliver a leadership development programme to support nurses and therapists working in community provision in leading transformational change.
- **Care Home and Home Care Leadership programme**; Care Home and Home Care managers across CCG and Local Authority commissioned care have been invited to participate in the My Home Life leadership programme targeted at direct care provision. The programme funded by Health Education England will commence delivery in March.
- **Mental Health Workforce**. Health Education England has rated NW London as amber on progress against mental health projects. NW London's mental health workforce plan is being developed with key stakeholders to focus on one service area at a time, commencing with a Children and Young Peoples Mental Health Workforce workshop in February.
- **Apprenticeship Programme**; two approaches are being taken forward by the Staffing Programme Board;

  1) accelerating implementation of standard pay across apprenticeships and a collaborative and consistent approach procuring and managing the providers of apprenticeship programme and

  2) Partnering with local colleges to attract college leavers into non clinical roles in the NHS, with a view to joining apprenticeship programmes in the future. There is the opportunity for a partnership bid against the Mayor of London's European Social Fund allocation to support Londoners into health and care employment.
- **Systems Leadership** - £40k secured from London Leadership Academy. Project Group established with Imperial College Healthcare Partners (ICHP) to lead on procurement of systems leadership, clinical leaders and wider OD programme offers.

Enabler - Digital

Funding bids across NW London were submitted and are being reviewed by NHSe/NHSi, for:

- Health-System Led Investment (HSLI - provider capital for Digital Maturity)
- Electronic Prescribing and Meds Admin (EPMA - two Acute/one Mental Health Trust)
- One London Local Health and Care Records Exemplar (LHCRE)

NW London Health and Care Information Exchange (HCIE) is a key project, to enable better integrated care through shared records, and support NW London's Health Care Partnership transformation such as the Outpatient Programme which will require increased digital interaction with patients.

A NW London Digital Strategy needs to be developed, to support our Health and Care Partnership's Clinical Strategy when it has been fully agreed and ensure we align and deliver to the digital principles set out in the Long Term NHS Plan.

Development of the Whole Systems Integrated Care (WSIC) Data Warehouse has progressed well during the period; Primary Care digital projects have also progressed well, although there is no funding for 2019/20 from the Estates and Technology Transformation Fund (ETTF) which will result in cutting back the digital programme from April 2019.

Conclusion

This paper has provided a summary of progress for the latest reporting period as well introduced the full suite of 7 Portfolio Areas in our Health and Care Partnership Plan.

City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Westminster Health & Wellbeing Board

RBKC Health & Wellbeing Board

Date:	*28th March 2019*
Classification:	**General Release**
Title:	*Local Safeguarding Children Board annual report 17-18*
Report of:	*Jenny Pearce, LSCB Independent Chair*
Wards Involved:	*All*
Financial Summary:	*N/A*
Report Author and Contact Details:	*Jenny Pearce, LSCB Independent Chair (contact via Emma Biskupski, LSCB Business Manager emma.biskupski@rbkc.gov.uk)*

1. Executive Summary

The Local Safeguarding Children Board gives an overview of the work of the Board during 17-18, including our key priorities learning from case reviews and multi-agency audits.

2. Key Matters for the Board

2.1 The LSCB Chair invites the Health and Wellbeing Board to note the annual report for information.

3. Background

Local Safeguarding Children Boards are required to publish an annual report of their work. The LSCB covering Hammersmith & Fulham, Kensington and Chelsea, and Westminster has completed the annual report detailing our work against our key priorities of reducing the harm of domestic abuse and coercive control, tackling

peer on peer abuse (including child sexual exploitation) and hearing the voice of children and young people.

The report also gives an overview of the multi-agency training that we provide to the children's workforce across Hammersmith & Fulham, Kensington and Chelsea and Westminster, as well as the multi-agency audits that we have worked on. The report also notes the work of our Child Death Overview Panel that reviews the child deaths, both expected and unexpected across the three local authorities, and the future changes expected this year in the development of a larger CDOP footprint. The Independent Chair also comments briefly on the future developments of the LSCB in light of the Children and Social Work Act 2017.

4. Options / Considerations

4.1 Report provided for information.

5. Legal Implications

5.1 Not applicable

6. Financial Implications

Not applicable

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

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Email: emma.biskupski@rbkc.gov.uk

Telephone: 07779 348 094

APPENDICES:
none
BACKGROUND PAPERS:
none

Local Safeguarding Children Board

Hammersmith & Fulham | Kensington and Chelsea | Westminster

ANNUAL REPORT 2017-2018

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Introduction from the LSCB Independent Chair

Independent Chair

Jenny Pearce

Welcome to this year's Local Safeguarding Children Board annual report. This report covers my first full year as chair of the LSCB. I have been impressed by the dedicated commitment to safeguarding children demonstrated by the full range of LSCB partners. The essential element of the success of an LSCB is its partnership arrangements: where emerging issues of concern can be identified, appropriate information can be shared and colleagues can work together towards common aims. Our LSCB achieves this through its quarterly board meetings, its range of sub-groups and by its capacity to respond to emerging issues of concern if and when they arise.

We have three shared priorities that we are all working towards together and we have had regular updates from partners on particular areas of work in progress and under development. This collaboration means that the safeguarding of children remains up to date, becomes a genuinely multi agency endeavour and that support and appropriate challenge between partners on ongoing practice is facilitated.

It is not possible for this annual report to reflect on the year without noting the impact of the tragic fire at Grenfell Tower which happened shortly after I first came into post. Following an internal assessment to ensure that all children directly impacted by the fire were receiving appropriate support, we have continued to have updates at each LSCB meeting to inform partners about ongoing activities with families, communities, schools, health and all other partners impacted by the tragedy. We have received updates on the re-housing of families and children, on the support input for local schools and community groups and have facilitated time for partners to ask questions about any safeguarding concerns they may have about children affected. This work is, and will continue to be, ongoing and of essential priority to the work of the LSCB.

Over and above this essential priority, we have worked together to implement our three safeguarding children priorities that were identified in early 2017 to ensure that:

(1) the LSCB are responsive to the needs of children witnessing/experiencing domestic abuse and coercive control and minimizing the impact of this on children and young people;

(2) that children and young people are kept safe from peer on peer abuse (including during transition into and out of adolescence);

(3) the work of the LSCB is informed by the voice of children and young people resident in the three boroughs. In response we have held a 'No Knife, One Life' event at a local college and, drawing on the learning, are planning a second further event.

While we are moving forward to work on these and other emerging priorities, we have also looked forward to ensure that we are assessing our strengths and identifying areas for improvement. It has been timely that the Children and Social Work Act 2017, supported by 'Working together to safeguard children 2018' (DfE 2018) has created a new platform for arrangements for safeguarding children. Leads from three partners: The Local Authority, Police and Health commissioners will become the three identified

safeguarding partners responsible for funding and overseeing safeguarding arrangements.

The change gives us an opportunity to assess our strengths and identify any existing challenges. To this end we have had focused discussions with the LSCB and targeted meetings on management arrangements and the number, role and focus of LSCB subgroups. I have met with the representative leads of the three partnerships, all of whom are keen to build on the existing strengths of the partnerships in place. There has been agreement that we assess the necessary number of subgroups and the potential strategic role that subgroup chairs could play in directing safeguarding arrangements of the future. These suggestions are under final consideration and will be submitted to central government during 2019.

Central to our developing ideas is the knowledge that any abuse, neglect and/or harm caused to children are intolerable. Numerous reviews, inspections and evaluations have identified that working together, sharing ideas, resources and skills is at the heart of safeguarding children. I hope that this report gives you an overview of the work that we are doing to achieve this.

The local picture

Hammersmith and Fulham

Approximately **33,777** children and young people aged 0 to 17 years live in Hammersmith and Fulham. This is **19%** of the total population in the area.

Approximately **29.7%** of the local authority's children are living in poverty (London average – 24%, national average 20%)

The three most deprived wards with large child populations are Wormholt & White City, College Park & Old Oak, Shepherds Bush Green.

There are **2,900** (15%) workless households in the area with dependent children aged 0 to 19 years compared to London average of 5%.

The proportion of children entitled to free school meals:

- In primary schools is **22.4%** (the national average is **14%**)
- In secondary schools is **19.6%** (the national average is **12.9%**)

Children and young people from minority ethnic groups account for **46%** of all children living in the area, compared with **21. 5%** in the country as a whole.

The largest minority ethnic groups of children and young people in the area are Black and Black British and Mixed.

The proportion of children and young people with English as an additional language:

- In primary schools is **53.8%** (the national average is **20%**)
- In secondary schools is **46.7%** (the national average is **16%**)

At 31 March 2018, **230** children are being looked after by the local authority. There were **125** children subject of a child protection plan, and **1496** children in need.

Kensington and Chelsea

Information about Children and Young People in Kensington and Chelsea March 2018

Approximately **28,890** children and young people aged 0 to 17 years live in Kensington and Chelsea. This is **18%** of the total population in the area.

Approximately **24.8%** of the local authority's children are living in poverty.

There are **1,890** workless households in the area with dependent children aged 0 to 19 years.

The proportion of children entitled to free school meals:

- In primary schools is **23%** (the national average is **14%**)
- In secondary schools is **16%** (the national average is **12.9%**)

Children and young people from minority ethnic groups account for **38.5%** of all children living in the area, compared with **21. 5%** in the country as a whole.

The largest minority ethnic groups of children and young people in the area are Mixed and Black and Black British.

The proportion of children and young people with English as an additional language:

- In primary schools is **53.8%** (the national average is **20%**)
- In secondary schools is **46.7%** (the national average is **16%**)

At 31 March 2018, **87** children are being looked after by the local authority There were **78** children subject of a child protection plan, and **765** children in need.

Westminster

Approximately **44,465** children and young people aged 0 to 17 years live in Westminster. This is **18%** of the total population in the area.

Approximately **34%** of the local authority's children are living in poverty, compared to the London rate of 24% and the national rate of 20%.

The three most deprived wards with large child populations are Queens Park, Westbourne and Church Street.

There are **3,830** workless households in the area with dependent children aged 0 to 19 years.

The proportion of children entitled to free school meals:

- In primary schools is **22%** (the national average is **14%**)
- In secondary schools is **26%** (the national average is **12.9%**)

Children and young people from minority ethnic groups account for **57%** of all children living in the area, compared with **21. 5%** in the country as a whole.

The largest minority ethnic groups of children and young people in the area are Mixed and Black and Black British.

The proportion of children and young people with English as an additional language:

- In primary schools is **69%** (the national average is **20%**)
- In secondary schools is **62%** (the national average is **16%**)

At 31 March 2018, **204** children are being looked after by the local authority. There were **80** children subject of a child protection plan, and **606** children in need.

Local Safeguarding Data 2017/2018

5785 Referrals to Children's Social Care (**1651** LBHF / **2460** RBKC / **1674** WCC)

283 Children were subject to a Child Protection Plan (**125** LBHF / **78** RBKC / **80** WCC)

The percentage of Child Protection Plans that ended but had lasted two years or more is **7.3%** LBHF / **3.3%** RBKC / **7%** WCC

Children on a Child Protection Plan for a second or subsequent time, **22.4%** LBHF / **13.1%** RBKC / **4%** WCC

Neglect was the most frequent reason for children being placed on a Child Protection Plan in 2017-2018

Domestic Abuse continued to be the main parental risk factor leading to children becoming subject of a Child Protection Plan

Neglect, Mental Health, Alcohol and Substance Misuse are also significant factors.

521 children were Looked After (**230** LBHF / **87** RBKC / **204** WCC)

20 Children were in Private Fostering Arrangements (**5** LBHF / **5** RBKC / **10** WCC)

Peer on peer is most common model of CSE but **online grooming and exploitation is a growing concern.**

3 actions identified from Section 11 audits

0 active Serious Case Reviews but 1 LSCB Conference to share the learning from the recent **Clare and Ann Serious Case Review**

100 face to face multi-agency safeguarding training workshops attended by **1753** delegates

6 Designated Safeguarding Lead for Schools Training Sessions

3 Designated Safeguarding Lead for Schools Networking Forums

3 Safeguarding Training workshops for School Governors, accessed by **66** Governors from **50** schools **61** schools in Hammersmith and Fulham, **93%** were rated Good or better

39 schools in Kensington and Chelsea, **100%** rated Good or better

59 schools in Westminster, **97%** rated Good or better

Governance and Structure

All local authority areas were required by law to have a Local Safeguarding Children Board and ours spans the three local authorities of Hammersmith & Fulham, Kensington and Chelsea and Westminster. This is a statutory partnership established following the Children Act 2004, and follows the 'Working Together to Safeguard Children 2015' statutory guidance.

Our LSCB is chaired by an Independent Chair, Jenny Pearce, who joined us in April 2017. The Board meetings take place quarterly, as do the subgroup meetings.

The main functions of the LSCB (as per Working Together to Safeguard Children 2015) are to:

- Develop policies and procedures for safeguarding and promoting the welfare of children in the local area
- Communicate the need to safeguard and promote the welfare of children, raising awareness of how this can be best done and encouraging all to do so
- Monitoring and evaluating the effectiveness of what is done by the local authorities and their Board partners individually and collectively to safeguard and promote the welfare of children
- Participating in the planning of services for children in the local area
- Undertaking reviews of serious cases and sharing the lessons learnt.

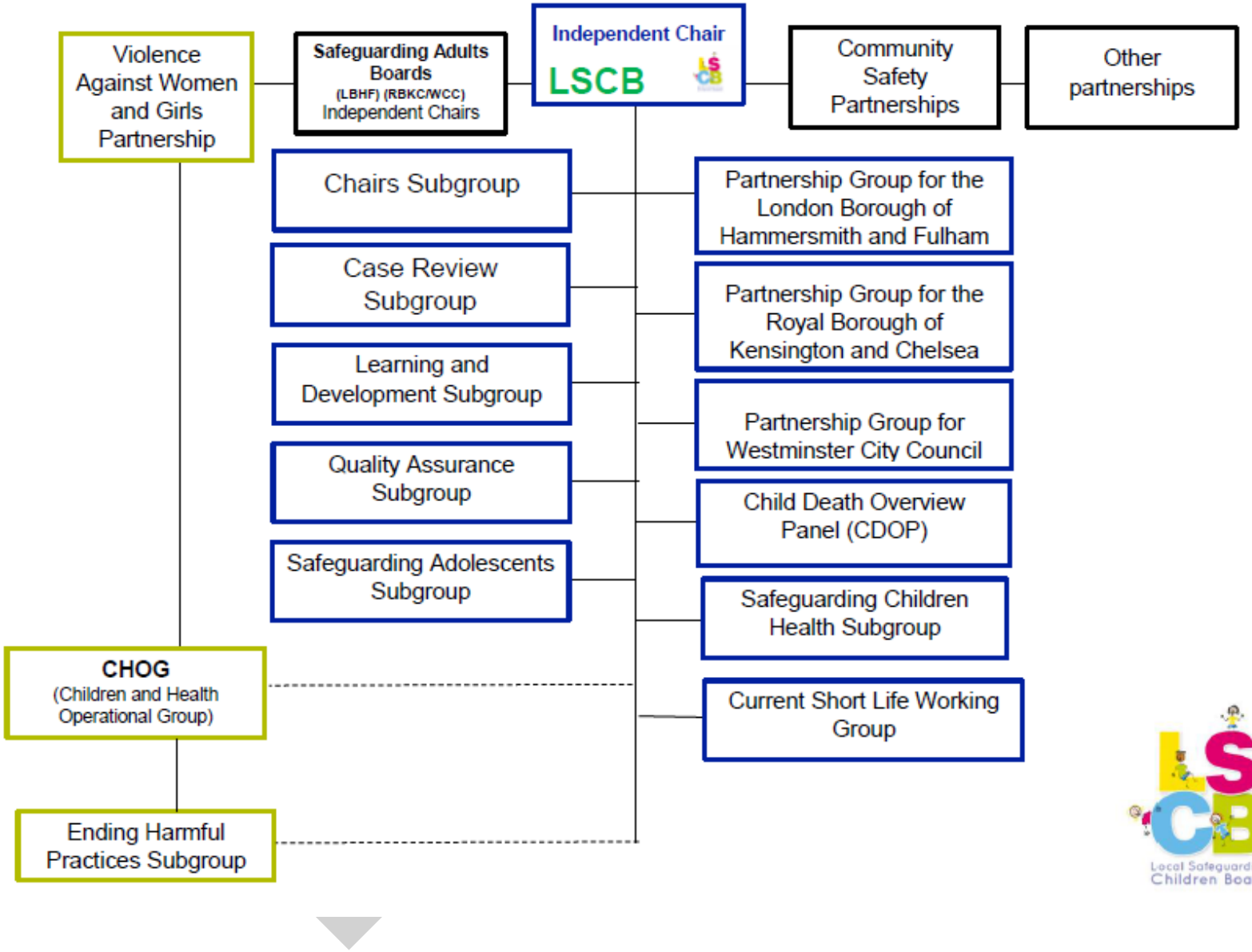
Future of the LSCB

It is important to note that the future of the multi-agency safeguarding partnership is currently being reviewed by the Board, in light of the revised statutory guidance 'Working Together to Safeguard Children 2018', published in July 2018 following the new Children and Social Work Act that received Royal Assent in 2017. This sets out the new framework for the delivery of multi-agency safeguarding arrangements which will come into effect no later than July 2019. These arrangements must be agreed by the Safeguarding Partners (as named in Working Together to Safeguard Children 2018).

Safeguarding partners
A *safeguarding partner* in relation to a local authority area in England is defined under the Children Act 2004 (as amended by the Children and Social Work Act, 2017) as:
(a) the local authority
(b) a clinical commissioning group for an area any part of which falls within the local authority area
(c) the chief officer of police for an area any part of which falls within the local authority area

The Independent Chair has held meetings with the local authority Chief Executives, Directors of Children's Services, Police and Clinical Commissioning Group to begin to develop the new model and this work continues in 2018-2019.

LSCB structure



LSCB Priorities 2017-2018

The new LSCB Chair challenged Board members to agree three key priorities for our work across the partnership.

These include:

Priority 1 – Reducing the Harm of Domestic Abuse and Coercive Control

What is Domestic Abuse?

Any incident of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial, emotional.

Controlling behaviour is a range of acts performed by the abuser and designed to make their victim subordinate and/or dependent.

Coercive behaviour is an act or pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used by the abuser to harm, punish or frighten their victim.

A lot of our work on tackling domestic abuse and coercive control is co-ordinated by the Children and Health Operational Group (CHOG), a shared subgroup of the LSCB and the Violence Against Women and Girls Partnership. Its role is to encourage the implementation of the Co-ordinated Community Response (CCR) model in children and health agencies, both statutory and non-statutory, to improve organisational responses to domestic abuse through both formal and ad-hoc training, advocacy of best practice through various safeguarding and health meetings and forums, representation of survivor's and their children's voices and domestic abuse policy development and implementation.

The Children and Health Operational Group meets on a quarterly basis. Four meetings took place the last year, during which the following themes were explored: Trauma & Adverse Childhood Experiences (ACEs), Coercive Control & Perpetrator Accountability, Engaging / Working with

Perpetrators, Family Support Services & Domestic Homicide Reviews.

The Standing Together Against Domestic Violence (STADV or Standing Together) Children and Health Co-ordinator (who co-ordinates the CHOG) has engaged with a variety of stakeholders such as GP practices, sexual health services, substance misuse services, health visitors, Children's Services, early years' providers, and front-line domestic abuse service providers in the boroughs of Hammersmith & Fulham, Kensington and Chelsea and Westminster. In the last year, one of the main priorities was to enhance the knowledge and skills of professionals working in GP practices, to respond to and prevent further domestic abuse by identifying it, screening patients safely and understanding the risk factors in relation to domestic abuse and referring to MARAC and domestic abuse services.

Key successes include:

- 217 professionals working in GP practices were trained in 2017-2018
- 20 GPs received half-day Domestic Abuse Leads / Champions training
- 160 Domestic Abuse Leads trained up at Chelsea & Westminster Hospital and 90 trained at Imperial Healthcare Trust.
- Health professionals working in GP surgeries reported an increase in their knowledge of domestic abuse and confidence in handling the disclosures because of the training they received
- Domestic abuse briefings were delivered to 57 additional health professionals such as SASH (Support & Advice for Sexual Health) Workers.
- Our Safeguarding Children Health Subgroup received a briefing on the domestic abuse risk assessment tools available.
- The LSCB training programme has signposted to the regular MARAC workshops available once a term and delivered six training sessions on Domestic Abuse and Safeguarding Children
- Challenge raised by the RBKC MARAC co-ordinator about the number of outstanding actions for partners to complete was amplified in the LSCB RBKC Partnership Group.
- Learning from Luton Child J Serious Case Review disseminated through all three Local Partnership Groups and
- Development of co-located IDVAs and DVIP practitioners with Children's Social Care in Hammersmith & Fulham leading to effective partnership working and positive impact on engaging families.
- In Kensington and Chelsea, social workers are consulting with embedded domestic abuse workers and systemic clinicians to think about how best to engage with perpetrators.

Planned work for 2018-2019

The LSCB is keen to explore how we could roll out Operation Encompass, a scheme whereby the Police in the Multi-Agency Safeguarding Hub (MASH) contact schools to notify them of specific domestic abuse concerns that may have arisen overnight. This would allow the schools to provide the appropriate pastoral care for children following an incident that they may have witnessed or heard at home.
The LSCB Learning and Development Subgroup will continue to explore how we can deliver training around working with perpetrators of domestic abuse.

Priority 2 – Tackling Peer on Peer Abuse (including Child Sexual Exploitation)

What is Peer on Peer Abuse?
Peer on peer abuse occurs when a young person is exploited, bullied and / or harmed by their peers who are the same or similar age; everyone directly involved in peer on peer abuse is under the age of 18. 'Peer-on-peer' abuse can relate to various forms of abuse (not just sexual abuse and exploitation), and it is important to note the fact that the behaviour in question is harmful to the child perpetrator as well as the victim. There is no clear definition of what peer on peer abuse entails. However it can be captured in a range of different definitions:
Domestic Abuse: relates to young people aged 16 and 17 who experience physical, emotional, sexual and / or financial abuse, and coercive control in their intimate relationships;
Child Sexual Exploitation: captures young people aged under-18 who are sexually abused in the context of exploitative relationships, contexts and situations by a person of any age - including another young person;
Harmful Sexual Behaviour: refers to any young person, under the age of 18, who demonstrates behaviour outside of their normative parameters of development (this includes, but is not exclusive to abusive behaviours);
Serious Youth Crime / Violence: reference to offences (as opposed to relationships / contexts) and captures all those of the most serious in nature including murder, rape and GBH between young people under-18.

What is Child Sexual Exploitation?
Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate, or deceive a child or young person under the age of 18 into sexual activity a) in exchange for something the victim needs or wants and/or b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact. It can also occur through the use of technology.

The MASE (Multi-Agency Sexual Exploitation) Panel covering the three boroughs meets monthly, chaired jointly by the Police and Local Authorities. This is attended by the Local Authority CSE Leads and multi-agency partners. MASE meetings focus on victims, perpetrators and locations of concern and themes as per the London CSE Protocol published in June 2017.

Mapping has been used to try and identify trends, associates and look at the broader picture across various groups of young people to identify and disrupt harmful behaviour. Mapping exercises were also undertaken to help develop our understanding of the both the victim and

offender profile. This has included looking at associates and networks as well as those known to be at risk and cross border mapping across the three boroughs.

There continued to be strong collaboration between the three CSE leads in each borough, who in turn liaise with key services such as sexual health, safer schools officers and community safety.

The CSE leads, along with specialist practitioners and partners collaborated to deliver CSE training and awareness raising sessions to Family Services staff and key partners, as well as taking part in Operation Songtroop, a Police-led initiative to test CSE awareness in hotels.

A short life working group met to consider the needs of young people displaying harmful sexual behaviours. Linked to this, the three local authorities have been successful in obtaining funding via MOPAC to deliver a trauma informed service (Barnardos TAITH model) with perpetrators of harmful sexual behaviour.

An engagement event was held in February 2018 with parents and carers in RBKC to discuss knife crime.

Case Study

In February 2018, the Local Safeguarding Children Board co-hosted an event alongside the Community Safety Partnership and the Police to help support parents and carers to keep young people safe from knife crime. Broadly, the aims of the event were to:

- To help parents/carers understand the risks young people face
- To help parents/carers understand the signs and indicators that their children/young people may be carrying knives
- To help parents/carers understand the impact of social media and the language that young people use to talk about knives
- To help parents/carers understand the breadth of local services available to engage young people in positive activities
- To help parents/carers understand who they can come to for advice and guidance on this issue
- To help local services hear directly from parents/carers about their concerns and what they need from us

We invited parents/carers from across the Royal Borough of Kensington and Chelsea to attend an evening at a local college, where a number of guest speakers gave brief talks, followed by a question and answer panel. The speakers included the LSCB Independent Chair, the Police Borough Commander, a parent who runs a parents' support group in Hackney, a parent whose child was previously involved in knife crime and a young person who was a former gang member.

Local Councillors and faith leaders were also invited to attend. In addition, there were information staffs available from the Early Help Service and EPIC (youth service provider).

Feedback from the audience included concerns about school exclusions, the availability of alternative educational provision, and positive aspirations for young people.

Feedback also suggested that future events may need to be run on a small scale in order to allow for deeper discussions and for all voices to be heard.

One Life, No Knife

This is an initiative that began in Kensington and Chelsea but it is hoped that elements can be replicated in both Hammersmith & Fulham and Westminster.

The Local Safeguarding Children Board, together with the Safer K&C Partnership and Police collaborated to host an evening event for parents and carers in the borough to come and hear from colleagues in Police and voluntary sector services about the challenging subject of knife crime and how to help keep children and young people safe.

The event was also an opportunity for local services to begin a conversation with residents about how we can work in partnership to reduce the risk of harm to our young people.

London Needs You Alive Campaign - MOPAC

Supporting parents and carers to keep young people safe

Hosted by the Safer K&C Partnership, the Local Safeguarding Children Board and the Met Police.

Tuesday 20 February 2018
6pm to 8:30pm

St Charles Sixth Form College, St Charles Square, London W10 6EY

To find out more and to register, visit www.rbkc.gov.uk/knifesafetyevent

This is a free event for parents and carers to hear from those whose lives have been directly affected by knife crime.

You will also hear from the police, community support services and experts suggesting practical steps parents and carers can take to help keep children and young people safe.

We are keen to hear from you about how we can work in partnership together to minimise the risk to our young people.

METROPOLITAN POLICE
TOTAL POLICING

LSCB Local Safeguarding Children Board

K&C PARTNERSHIP

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Case Study

Operation Songtroop

Operation Songtroop (Part of Operation Makesafe) was a Police-led operation to target child sexual exploitation (CSE) within the boroughs of Hammersmith & Fulham, Kensington and Chelsea and Westminster.

It was specifically implemented as a proactive method to address criminal offences associated with CSE that were occurring in certain hotels across the LSCB footprint.

The operation took place in early March 2018, ahead of Operation Makesafe talks that took place across the boroughs before National CSE Awareness Day, also in March 2018. Police worked closely with partner agencies who play an active role in safeguarding children from CSE.

Background:
Hotels have long been recognised as 'hotspots' for child sexual exploitation nationally. It is known that the use of local (national chain) hotels for sex parties remains a feature of the CSE profile across London.

A total of 60 local hotels were selected as part of Operation Songtroop (part of Operation Makesafe), following a review of data gathered from the Multi-Agency Sexual Exploitation Panel (MASE) and other local intelligence.

Our aims:
The key objectives of the operation were:
- to test local hotels' understanding, recognition and response to possible CSE situations from the Operation Makesafe training that they had previously received.
- to share the findings with the hotels themselves as well as partner agencies to identify opportunities for learning, identify patterns and behaviours and to develop intelligence about CSE in order to inform further work in this area.

How we did it:
Each hotel was visited twice, after school, with different pairings of adult and child. The adults took in a clear plastic bag which contained multiple bottles of alcohol that was clearly displayed for the hotel staff to view. The primary objective of the adult was to try and book a hotel room for them and the child and to pay for this using cash.

The adults were encouraged to give other indicators of CSE during the booking process if the opportunity arose, such as being reluctant to provide ID, asking if the room would be available for only a few hours, and to talk for the child if they were spoken to by staff. All of the above indicators are highlighted within the Operation Makesafe training previously delivered to hotels and should have been recognised by hotel staff.

Once each pairing had visited the hotels, they were met by a 'feedback team' who took notes about each scenario. Following this, the hotel staff and general manager were debriefed by Police CSE officers.

Considerations:
Special consideration was given to the appropriate selection of young people who had been trained and prepared for this

operation. The young people were police cadets and were selected because of their previous involvement in 'test purchase' operations with other Police teams. The cadets were of an appropriate age to fully understand the reasons for the operation and all were fully briefed and appropriate consent was sought from parents and carers. After each day, the cadets were de-briefed by the officers from the Police CSE teams to ensure that they felt comfortable during the operation, to see if any follow up support was needed, and to see if they had any suggestions for how it could be improved.

Another key element of Operation Songtroop was that it was a joint piece of work with the partner agencies who work with Police to tackle CSE. This was essential in order to benefit from the expertise of colleagues who make up the MASE Panel. A co-ordinated approach also meant that any safeguarding matters relation to the children participating could be acted on immediately, as well as for any children found to be at risk during the operation.

Results:
A total of 60 local hotels were visited as part of Operation Songtroop. Whilst bookings were not successful in all the hotels (if for example a hotel was fully booked), the adults were not challenged in all but two of the hotels visited, in terms of any of the following indicators:

- Relationship between the adult and child presenting
- The purpose of their visit
- That alcohol was clearly visible
- Why the child was not in school

Only two hotels took proactive steps to challenge the situation or to ensure the child was safe, with one making a call to Police.

The results highlighted the evident lack of awareness of CSE, despite the previous work done by the Police and partners specifically tailored towards these businesses. The fact that bookings were accepted at hotels highlights that children are still at risk of CSE within the three boroughs when entering hotels.

The results of the operation show that the Operation Makesafe training previously delivered to the hotels is not always disseminated by the hotels to their staff as part of routine induction training or regularly enough for it to be familiar to long term staff.

Next steps:
It is anticipated that this operation will be repeated in 18-19 across all three local authorities and that a wider learning event for hotels and licensed premises will be convened so that local businesses can learn more about child sexual exploitation and how to raise concerns locally with Police and Children's Services.

Operation Makesafe

Operation Makesafe has been developed by the Metropolitan Police in partnership with London's boroughs to raise awareness of child sexual exploitation in the business community, such as hotel groups, taxi companies and licensed premises.

The aims
The purpose of the campaign is to help business owners and their employees identify potential victims of child sexual exploitation and, where necessary, alert police officers to intervene prior to any young person coming to harm.

What's involved
Businesses such as hotels, licensed premises and taxi companies are being provided with awareness training to help them recognise the signs of child sexual exploitation. They are directed to call 101, quoting 'Operation Makesafe', should they suspect suspicious behaviour or activity on their premises or in their vehicles.

Met Police call handlers have received specialist training to identify calls relating to child sexual exploitation and provide the appropriate advice and police response.

Online Safety

We know that children and young people are increasingly spending time online. The Internet can be a fantastic resource for young people, but can also expose children to harm.

The LSCB is keen to raise awareness of online safety matters with parents / carers and young people as well as the professionals and volunteers that work with them.

Online Safety Working Group Case Study

A small working group was developed following an emerging concern about keeping children safe online in the Westminster LSCB Partnership Group.

The group wanted to produce some helpful information for parents and carers about keeping their children safe online and ensure this was widely distributed, to coincide with the annual Safer Internet Day which was due to be celebrated on the 06th February 2018. Safer Internet Day is celebrated globally in February each year to promote the safe and positive use of digital technology for children and young people and inspire a national conversation.

Coordinated in the UK by the **UK Safer Internet Centre** the celebration sees hundreds of organisations get involved to help promote the safe, responsible and positive use of digital technology for children and young people.

The day offers the opportunity to highlight positive uses of technology and to explore the role we all play in helping to create a better and safer online community. It calls upon young people, parents, carers, teachers, social workers, law enforcement, companies, policymakers, and wider, to join together in helping to create a better internet.

The working group decided to produce a flyer for parents and carers to help signpost them to already existing resources. The completed flyer was distributed to schools, colleges and early years providers (electronically and in hard copy where requested), as well as to local libraries and children centres. The flyer was also circulated to GP practices across the three local authorities and shared with colleagues in the Police who in turn were able to share it with parents/carers. Copies were also circulated to partner agencies to share with practitioners.

The flyer was then adapted to remove reference to the Safer Internet Day so that it could be used all year round and featured on the LSCB website alongside other helpful resources for parents/carers.

The flyer was also translated into Arabic following a request from the LSCB Lay Member in Westminster who had

recognised that some parents/carers may not be able to engage with the flyers in English.
In 2018-2019, this working group has been expanded to include practitioners from across all three boroughs and we are working on developing further awareness raising sessions and training.

Planned work for 2018-2019

LSCB Partners are keen to develop a greater understanding about Contextual Safeguarding, and will launch a new subgroup for Safeguarding Adolescents that will work to create proactive, preventative multi agency engagement with the social, economic and environmental 'context' within which adolescent risk, harm and vulnerability occur. It will safeguard adolescents through multi agency partnerships to address the diverse, changing and multiple forms of risk and harm impacting on their lives. It will bring assessment of the various safeguarding concerns together, preventing siloed responses to needs artificially separated from each other.

A learning event regarding Contextual Safeguarding for Board members is planned for July 2018 with a speaker from the Contextual Safeguarding Network. Further training will be added via the LSCB training programme and across Children's Services in Hammersmith & Fulham a series of Contextual Safeguarding training workshops have been planned.

It is anticipated that we will develop the role of the MASE panel to also include other forms of harm, including criminal exploitation.

In Hammersmith & Fulham, an integrated and multi-disciplinary Adolescent Service will be developed.

The LSCB will make more enquiries about school exclusions.

The LSCB will seek to collate data on the number of and effectiveness of Adolescent at Risk Meetings.

Priority 3 – Hearing the voice of children and young people

The LSCB Chair held two meetings with both a small group of care leavers and a small group of young people known to the Youth Offending Service to ascertain their views about how safe they feel.

All three local authorities have embedded systemic practice within Children's Services and continue to use the Signs of Safety approach in Child Protection Conferences to ensure that children's experiences are the focus of support and interventions.

Local Authority partners have also collaborated with Future Gov to develop a new digital recording system that better captures the child's journey with Children's Services. This will allow practitioners to make decisions that are informed both by data but also the child's experiences.

Planned work for 2018-2019

The LSCB has created the role of Children and Community Engagement Officer and we are in the

process of recruiting to this post following an appointment that fell through earlier in the year. We also want to build on the One Life No Knife events for parents and carers and host events for young people in order to hear their feedback.

Hearing the voice of children and young people is an area of development for the LSCB and a key priority for our work next year.

Quality Assurance

During 17-18, the LSCB conducted two multi-agency audits: one on Neglect and the other on Child Sexual Abuse.

Neglect Multi-Agency Audit for children aged 7-16 years old:

Agencies involved in the audit included School Nursing, Education, GPs, Police, Community Rehabilitation Company & Probation, Youth Offending and CAMHS. A new neglect screening tool was applied to all cases in the audit sample where children and young people were aged between 7-15 years old. Auditors found that where neglect had been identified, as a safeguarding issue, effective interventions lead to improved outcomes for children. In four of the cases, however, auditors found that neglect had not been identified as a key issue but should have been. Emotional neglect was highlighted as a factor in these cases but practitioners found it more difficult to identify that parents were not responding to their children's needs.

The key findings included:

- Legacy of a long history of neglect, which had been managed or improved for period of time, been partially addressed or had not been successfully addressed in the past.
    - When parenting reaches 'good enough' standard less need for professional intervention but often impact of early experiences felt later.
    - General awareness and understanding of the history (positive finding). Potential to lead to frustration and feelings of hopelessness for professionals working with the case/becoming 'stuck'. Whilst some did feel like that, examples of the opposite and workers committed to making a difference now.
    - Is it possible to change the trajectory at this point? What should our expectations be? Identifying an opportunity to make a difference.
    - Dealing with feelings of frustration and hopelessness- what helps? Supervision, strong professional network, use of clinical workers

- A common feature in many of the cases was potential undiagnosed or untreated emotional/mental health or cognitive needs for the parents (including personality disorder). This made it extremely difficult to work with parents and poses a challenge about how we work with them and how we maintain a professional relationship with them, and address some of their underlying needs when there are no formal services in place.

- Education: It can be a challenge for schools and alternative provisions to meet the needs of young people who have experienced persistent neglect.
    - How do we work with young people excluded from education or not attending? What capacity is there to be creative? Where does the responsibility lie?
    - How effectively do social workers and other professionals escalate concerns about the quality of the education being provided?

- A small proportion of the cases involved specific health needs for the children and there was a need to challenge the parents who were not meeting their child's needs.
    - Whose responsibility is it to challenge the parents?
    - Is there a shared understanding of how the needs will affect the child if untreated / what is the significance?

Outcomes and Recommendations

1. Identifying the opportunity to make a difference

- Establishing and maintaining strong professional networks. Making sure it is clear who needs to be involved and why.
- Continue to ensure regular supervision for practitioners (already in place) which offers space to express feelings of frustrations and hopelessness

2. More successful engagement with parents who have complex emotional, learning or personality needs

- Clinical consultations with systemic practitioners with Children's Services to take place in these cases to explore and review approaches. Learning from these consultations to be broadened to include the multi-agency network involved with child or young person. Professional network to share knowledge of 'what works' for that parent.

3. Ensuring education needs are met appropriately

- Attendance and Inclusion workshops have been held to start to explore how we work with children not consistently in education for a range of reasons.

4. The impact of health needs are fully understood

- Where there are concerns that a child's health needs may not be met, multi-agency meeting is convened to include all the relevant health professionals. Creative approaches to be considered including use of skype and telephone conferencing. These meetings will agree who should take the lead and who should undertake any direct work with the parent.

5. Tailored approaches to working with adolescents informed by research and practice

- Adolescent at Risk model - this is currently being reviewed and developed
- Each borough is developing an approach to working specifically with adolescents. These approaches will be informed by practice experience and should take into consideration the issue and impact of neglect

6. Establish a resource bank for working with Adolescents. Collating tools and best practice evidence from across the three boroughs – this will be led by the Safeguarding Adolescents Subgroup established in 18-19.

7. Dip sample neglect screening to be undertaken in Early Help and YOS to evaluate how we are identifying neglect in this age group (7-16 years) – we aim to complete this in 18-19.

Child Sexual Abuse Audit:

The particular focus for this audit was to consider the multi-agency response to cases where there had been questions, indicators and concerns about sexual abuse, as well as cases where sexual abuse has been alleged or investigated. Cases were audited between November 2017 and January 2018.

Many of the areas of learning and reflection identified during this audit reflect those recognised as part of recent national research. As local multi-agency partners we grapple with similar dilemmas and challenges in our response to sexual abuse. We know that most victims of sexual abuse are abused by someone in their trusted circle and that it can be years before a child is in a position to disclose the abuse to anyone. Yet, often we rely on children to tell us about abuse before we feel able to take action. The majority of cases reviewed as part of this audit involved a disclosure by a child or young person which appropriately triggered an investigatory and safeguarding response. However, these children had contact with various agencies prior to disclosure (at both a voluntary and statutory level). This audit did not find evidence that obvious or overt signs and indicators

were missed, in nearly every case. Instead it prompted reflection about how we are able to be more professionally curious and how we open up opportunities for children (and parents/carers) to talk and feel safe to explore things they feel worried or uncomfortable about.

Some of the ways we can do this include building and promoting relationships (with children, families and within professional networks), seeking to understand the way family networks function (including the significant people in their lives) and by holding the possibility of sexual abuse in mind. When approaching our assessments and investigations we need to remember that criminal investigation is just a small part of the work and should not be the primary focus; the welfare and safety of the child or children involved is much broader than this.

Strengthening communication between social workers and health professionals in the planning and execution of investigations should help us shift the focus. Non-abusing parents/carers have a key role in recognising abuse, increasing safety, helping children talk and supporting children to recover. We need to think about how we promote and support this. Often this means addressing their individual difficulties or support needs. Domestic abuse was a feature in a number of the cases audited and reinforced the importance of recognising the impact of domestic abuse when assessing and supporting the capacity of the non-abusing parent to act protectively.

It is hoped that this audit has raised awareness and prompted reflection in the safeguarding partnership and individual agencies about our responses to sexual abuse.

The Quality Assurance Subgroup has developed an action plan to address the recommendations in the audit. This includes ensuring that Strategy Discussions include meaningful contributions from appropriate health partners and ensuring that all partners are confident in their role and responsibilities to contribute to these meetings. We want to continue to build relationships between health practitioners and social workers and plan to host local networking events to facilitate this. We also plan to review how social workers work alongside Police colleagues for ABE interviews and what training may be required to facilitate this. The LSCB will monitor the progress of the TAITH project that is working to support children who are displaying harmful sexual behaviours, and we will review pathways and access to therapeutic interventions for child victims of sexual abuse.

Section 11 Audit findings:

The section 11 audits are a useful way to check the safeguarding arrangements within agencies and provide the Board with assurance that agencies are doing what they can to ensure the safety and welfare of children.

In 2017-2018, the audits were circulated to maintained schools in all three local authorities, private health providers and one local NHS trust.

An analysis of the audits completed by schools found that schools had a safeguarding children policy in place, and a Designated Safeguarding Lead who had a clear job description that highlighted the breadth of their role. Not all schools reported they had a back-up designated safeguarding lead who could cover the role when required. Most schools were able to report on a clear culture of listening to the voice of children and young people within their setting. Most schools had also been able to access key safeguarding documents and contacts from the LSCB website. One area that the schools were less confident about was on the LSCB priorities, so the Board needs to explore further ways of ensuring this information is cascaded to schools.
A concern that was noted through the audits (and the Designated Safeguarding Leads Forum)

was around communication with key partners, with some schools reporting frustrations at the lack of feedback from Children's Social Care and in some cases schools not being aware that children they work with have an allocated social worker. Schools reported they were able to access appropriate safeguarding training but there were some further requests on training on FGM and Child Sexual Exploitation.

Future audits in 2018-2019 will include the local authorities, and voluntary sector partners.

Learning from Case Reviews

The Case Review Subgroup is made up of multi-agency partners including Police, Health and Local Authorities and was chaired previously by the Director of Family Services in Hammersmith & Fulham. However, following a change in role, the subgroup was subsequently chaired by the LSCB Independent Chair. In 2017-18 the subgroup met and reviewed:

- 5 Serious Case Reviews published by other LSCBs
  Themes explored included suitability of special guardianship orders, effective services to meet the needs of vulnerable adolescents due to neglect, appropriate multi-agency responses to vulnerable adolescents at risk of exploitation through radicalisation, effective supervision to challenge fixed thinking around a case, transitions between children and adults services.
- A challenge to another LSCB on a finding included in a newly published serious case review.
- An unpublished learning review from another LSCB
- 3 local cases not meeting the threshold for serious case review but where learning is applicable
- Changes to the Serious Case Review process due to be implemented following the Government's consultation on Working Together to Safeguard Children 2018.
- 3 action plans from local Serious Case Reviews

The LSCB worked in partnership with two other LSCBs on the Luton Child J Serious Case Review, which was published in June 2017. Child J was a thirteen-month-old boy who had moved with his mother and her new partner to Luton after spending his early life in Hammersmith and Fulham and Ealing. Whilst there was very limited work with the family in Hammersmith and Fulham, we have cascaded the learning from the serious case review to practitioners via our LSCB multi-agency training programme and a local lunch and learn session. In addition, the Cabinet Member for Children's Services in Hammersmith & Fulham wrote to the then Minister with responsibility for child safeguarding, asking that government review and set out guidance so that there is no room for variation between authorities and clarity about what should happen when a 'Child in Need' moves into a new area. This is partially reflected in the revised 'Working Together to Safeguard Children 2018' which now states that 'Where a child in need has moved *permanently* to another local authority area, the original authority should ensure that all relevant information (including the child in need plan) is shared with the receiving local authority as soon as possible. The receiving local authority should consider whether support services are still required and discuss with the child and family what might be needed, based on a timely re-assessment of the child's needs, as set out in this chapter.'

A challenge to one of the findings in the review was raised by a local partner agency (Standing Together) and escalated by the Chair of the LSCB to the Luton LSCB.

Members of the Case Review Subgroup also contributed to the delivery of the LSCB Learning Event for the Clare and Ann Serious Case Review that took place in January 2018 where over 100 practitioners from local services attended.

The LSCB is awaiting the publication of a local Safeguarding Adults Review (SAR) to learn from the case of an adult where practitioners could not gain access, leading to a near miss. This SAR was commissioned by the Safeguarding Adults Board in December 2017 and the LSCB will work in partnership with the Adults Board to disseminate the learning once published.

LSCB Multi-Agency Training

The LSCB training programme is coordinated by our LSCB Multi-Agency Trainer with support from the Learning and Development Subgroup. Between April 2017 and March 2018, the LSCB delivered 100 face to face training workshops through the LSCB training programme. A total of **1753** delegates attended the workshops from a range of agencies across the partnership, including many in the voluntary sector. Across all of our workshops offered, there was an average booking rate of **97.6%**, illustrating the high demand for safeguarding children training, whilst overall attendance at training (across all workshops) was **71.6%**.

The Learning and Development Subgroup approved revised terms and conditions for the LSCB training programme to start in 2018-2019, and it is hoped that this will further reduce the number of delegates not attending training and raise revenue for the development of the LSCB training programme where cancellation fees are applied.

The LSCB training programme is split into three main sections:

Mandatory training: this features our two core training workshops which are the Introduction to Safeguarding Children (1/2 day) and the one day Multi-Agency Safeguarding and Child Protection Workshop.

Specialist training: this features a variety of more specialist topics, including Safeguarding Children and Domestic Abuse, Child Sexual Exploitation, Safeguarding Children and Gang Awareness, Private Fostering Workshops, and a new workshop on Online Safety we have developed.

Managerial training: this features training such as our Meet the LADO workshop and Safer Recruitment and Safer Recruitment Refresher workshops.

Further details about our training offer can be found on the LSCB website: www.rbkc.gov.uk/lscbtraining

The LSCB conducts a training needs analysis every year in order to help inform the design and commissioning of the training. This involves consulting with partners about their training needs, and helps us to understand what the emerging needs may be and if we need to expand on or deliver new training topics.

The LSCB is proud of the collaborative working demonstrated in the delivery of the LSCB training programme. Wherever possible, the LSCB asks key partners to deliver or co-deliver the training workshops so that local knowledge and expertise can be shared and the table on the page 21 demonstrates this.

The LSCB hosted a learning event in January 2018 to highlight the learning from a local Serious Case Review: Clare and Ann. This case involved a mother, who, whilst acutely unwell, killed her partner and eldest daughter, and seriously injured the couple's youngest child. The aims of the event were to explore the key learning points within both the Serious Case Review and the Domestic Homicide Review, and share updates from key partners about the changes that have been implemented since the reviews were first published. 121 local practitioners attended the event and 86.25% of attendees who completed an evaluation rated the event as 'good' or 'excellent'.

The LSCB monitors the feedback from LSCB training workshops, but acknowledges that it is still challenging to monitor the impact of the training we deliver. At every workshop we deliver, we ask delegates to rate the workshop experience, as well as whether the learning outcomes have been

met. Some example feedback from a couple of our mandatory workshops are displayed below:

Delegates are asked to rate their knowledge and understanding of the learning outcomes before the workshop and after. They are also asked to rate the training experience overall.

This is the scale they are asked to use.

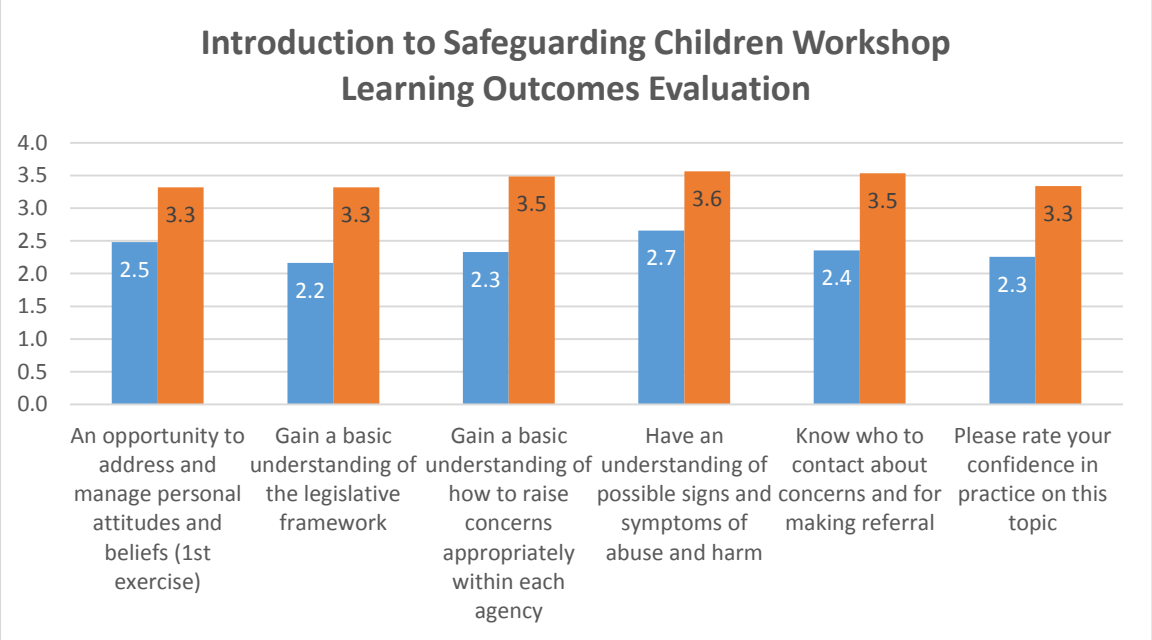
Poor = 1 Satisfactory = 2 Good = 3 Excellent = 4

Legend

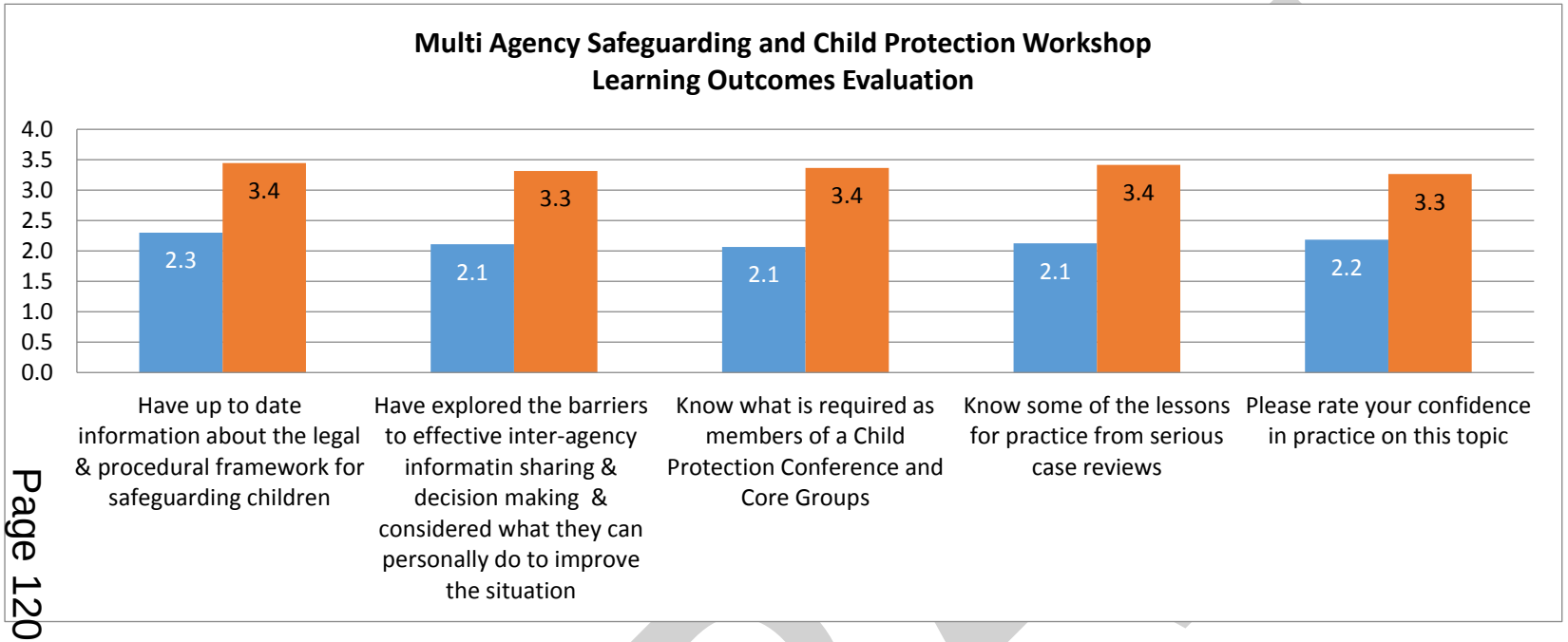
- Before the workshop - After the workshop

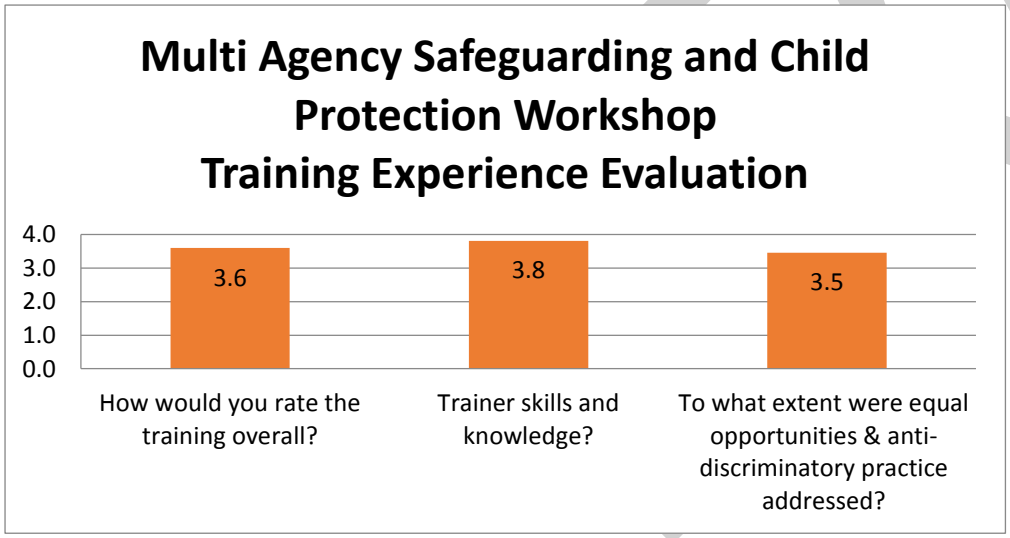
The following charts show the average scores given for learning outcomes and training experience for the Core workshops:

Sessions Delivered: 12 Delegates: 206



Sessions Delivered: 34 **Delegates: 705**





The Learning and Development Subgroup has also tried to monitor the impact of the training course that we deliver via the LSCB training programme. Delegates are asked to share feedback at the end of each workshop about how what they've learnt will impact on their practice. We also send a smaller number of delegates a follow up email survey to check the impact three to six months following their attendance at training. We have noted that only a small percentage of delegates complete this. The LSCB Learning and Development Subgroup will continue to monitor and challenge this in 18-19.

Future plans:

In 2018-2019, the Learning and Development Subgroup are keen to support the workforce to gain a better understanding of contextual safeguarding, in order to build on our work to safeguard adolescents in particular. We are also keen to re-launch our 'Learning from Serious Case Reviews' workshops.

In 2018-2019, the LSCB will also need to launch a new learning management system (LMS) for LSCB training bookings. This is because it is anticipated that the current system used by the Local Authorities is due to be upgraded.

The table below demonstrates the wide range of LSCB partner agencies supporting the delivery of LSCB training workshops.

Programme	Workshop	Trainer Agency											Total no. of sessions
		Health	LBHF	RBKC	WCC	Tri-Borough	LSCB Trainer	External Trainer	Standing Together	IKWRO	Turning Point	WAGN	
Core	Introduction to Safeguarding Children						11						11
Core	Multi-Agency Safeguarding and Child Protection (level 3)	9		7			33		2				51
Core	Multi-Agency Safeguarding and Child Protection (Refresher level 3)						5						5
Managerial	Safer Recruitment					4	4						8
Managerial	Safer Recruitment Refresher (level 6)					3	1						4
Managerial	Meet the LADO					5							5
Specialist	CSE: A Trauma Focused Approach											7	7
Specialist	Safeguarding and Domestic Abuse								6				6
Specialist	MARAC Workshop								8				8
Specialist	Safeguarding and Neglect							1	1				2
Specialist	Safeguarding and Gang Awareness		1		1	1							3
Specialist	Ending Harmful Practices (RBKC only)									2			2
Specialist	Ending Harmful Practices					2							2
Specialist	Private Fostering workshop					3							3
Specialist	Young Carers information session					3							3
Specialist	Parental Substance Misuse										1		1
Specialist	CP conference workshop			4		1							5
Specialist	Safeguarding and Supervision								1				1
Specialist	Missing Children protocol		3			3							6
Specialist	Online Safety						2	2					4
Total number of sessions delivered		9	4	11	1	25	56	3	18	2	1	7	137
% of total sessions delivered		6.6	2.9	8	0.7	18.2	40.8	2.3	13	1.5	0.7	5.1	100

Child Death Overview Panel (CDOP)

The Local Safeguarding Children Board functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Board Regulations 2006, under section 14 of the Children Act 2004. The LSCB is responsible for:

- Collecting and analysing information about each death with a view to identifying:
    - Any case giving rise to the need for a review
    - Any matters of concern affecting the safety and welfare of children in the area of the LSCB
    - Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area.
- Putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

Note: The responsibility for determining the cause of death rests with the Coroner or the doctor who signs the medical certificate of the cause of death and not with the Child Death Overview Panel.

The process for reviewing child deaths includes:

- an overview of all child deaths up to the age of 18 years (excluding those babies that are stillborn and planned terminations of pregnancy carried out within the law)
- A multi-agency rapid response meeting is convened following an unexpected child death in order to make initial enquiries and co-ordinate support to the bereaved family.

This has been a challenging year for CDOP colleagues and partner agencies. We have received an increase in child death notifications related to registration of extremely premature infants born alive, as well as the notifications following the tragedy of the Grenfell Tower Fire.

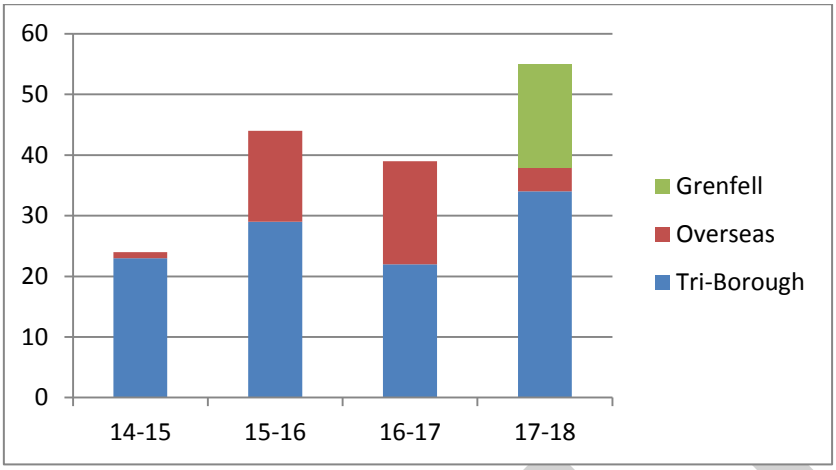
Following an unexpected death, a rapid response meeting is normally held within 5-7 days of the death occurring. This is chaired by the Designated Paediatrician for Child Death.

Modifiable factors are defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced.

The panel has reviewed child deaths that have occurred across the three local authorities, identifying factors that may have contributed to the deaths along with any modifiable factors. The timing of the reviews is subject to the number of cases relating to a particular theme and other processes such as serious case review, police investigation or an inquest occurring.

In 2017-18, the CDOP Panel received 55 child death notifications in total, including

17 children who were victims of the Grenfell Tower fire and four children who normally resided overseas but who died whilst in the LSCB area.

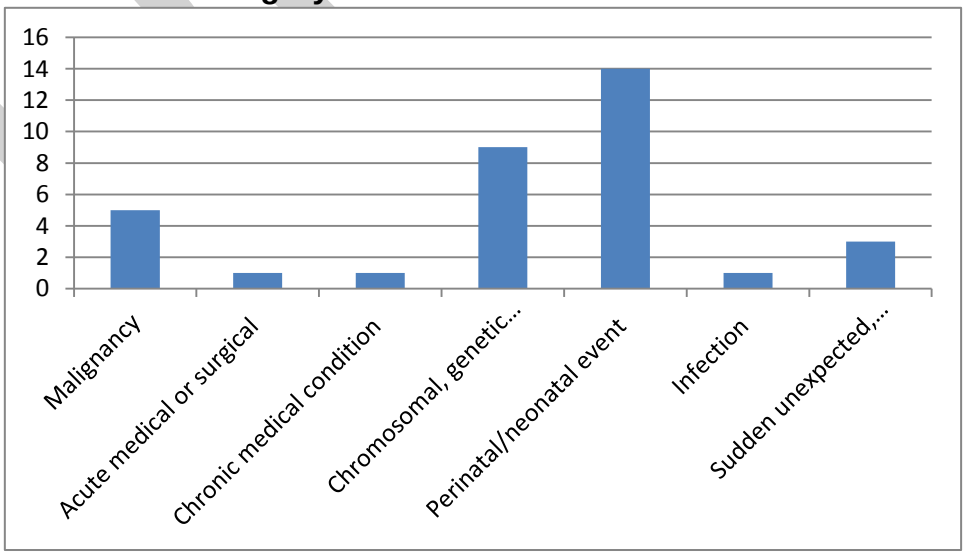


We noted a significant increase in notifications compared with previous years, and whilst the cases associated with the Grenfell Tower fire account for some the increase, there remains an increase of approximately a quarter on the average number of cases notified in the previous three years. This is likely due to an increase in neonatal notifications following the publication of the 'Registration of Stillbirth' briefing paper (House of Commons, 2018) which states 'the birth of a baby who is born alive must be registered, whatever the length of the completed pregnancy. The death of a baby born alive must be registered in the same way as any other death', thus requiring notification to CDOP as well.

Separate to the deaths relating to the Grenfell Fire tragedy, in 2017-18, a total of 12 deaths were unexpected, and required a rapid response meeting to be held. This is similar to 2016-2017 where 32% of the deaths in the LSCB area were unexpected.

The main categories of death for deaths occurring in 2017-18 include perinatal/neonatal events (this is the largest group, and links with the largest age group being neonates under 28 days old), or chromosomal, genetic and congenital and again this relates to this group of six infants under 28 days old.

Provisional category of death for deaths notified in 2017-2018



22 boys and 12 girls died across the LSCB area. The number of boys who have died

is almost double from last year, when 12 boys died and this increase is due to the number of boys under 28 days of age dying in 2017-2018 more than doubling (5 neonatal male deaths in 2016-2017). The majority of the children (74%) were under the age of one and this is similar to last year's figure of 76%.

The CDOP panel was notified of the deaths of four children who normally resided overseas but who died locally. We have seen a significant drop in the number of such children dying as compared to last year. It is unclear why this is, but may be linked to work the CDOP panel has undertaken with private healthcare providers. We convened a themed panel with representatives from the private healthcare sector in order to gain insight into the referral processes, practices and bereavement care, to enable the panel to be assured about the practices undertaken by the specialist nurse for Child Death to review the cases being notified by private providers. No concerns were identified.

Learning from child death reviews:

A number of socioeconomic and economic factors were identified in the deaths reviewed in 17-18, including vulnerable pregnant women with no recourse to public funds, poor housing, chaotic home environment, unsafe sleep environment, temporary housing and knife crime.

A number of parenting and family factors were also identified in the cases reviewed, including parents unable to accept prognosis and wanting to continue active treatment which may not be in the child's best interests, parental mental health issues impacting on their ability to access antenatal care, high maternal BMI and maternal infections associated with increased risk of premature delivery and parental smoking.

The panel also identified an access to healthcare factor in parental access to mental health services during an acute crisis.

The panel identified some service provision and care factors which have been raised with individual providers where appropriate including:

- Increased vulnerability of children following complex surgical and medical interventions
- Appropriateness of transfer to the UK for treatment when the prognosis is very poor
- Appropriateness of extensive invasive treatment in neonates with extremely poor prognosis
- Implantation of multiple embryos during IVF
- Inadequate communication between Health, Social Care and Police, particularly in relation to welfare checks
- Recognition of breech presentation in early labour

Safeguarding factors that the Panel identified included:

- Vulnerability of parents at high risk of suicide following the death of their child
- History of parental alcohol and substance misuse
- History of poor parenting with children's social care involvement, including

known neglect/abuse in the family home
- History of domestic violence in the home
- Young children acting as carers for their younger siblings

Other factors that the Panel identified included:

- Extreme prematurity
- Chorioamnionitis (infection within the womb) and other maternal factors linked with premature delivery
- Congenital complex medical disease

It is important to note that due to relatively low number of deaths, this makes it impossible to provide an accurate statistical interpretation or trend analysis. All unexpected deaths were managed appropriately using the rapid response process.

Relevant learning is cascaded via the health networks in our LSCB area, with the intention that learning from local and national child reviews is incorporated into practice, training and supervision.

Trends and learning identified that may have implications nationally are shared through the national CDOP network.

The future of CDOP and transition to new arrangements

The new 'Working Together to Safeguard Children 2018' was published in July 2018, and alongside this, new guidance for Child death review: statutory and operational guidance (England) was published in October 2018.

The new statutory guidance requires CDOPs to cover a geographical footprint that would enable a minimum of 60 cases to be reviewed per year. In order for our CDOP to meet this requirement, it is anticipated that we will need to merge with at least two neighbouring CDOPs. With that in mind, CDOPs across North West London have been exploring ways in which we could develop a service across this wider footprint.

This guidance sets out the full process that follows the death of a child who is normally resident in England. It builds on the statutory requirements set out in Working Together to Safeguard Children 2018 and clarifies how individual professionals and organisations across all sectors involved in the child death review process should contribute to reviews. The guidance sets out the process in order to:

- improve the experience of bereaved families, and professionals involved in caring for children
  and
- ensure that information from the child death review process is systematically captured in every case to enable learning to prevent future deaths

The new guidance places an emphasis on the Joint Agency Response, which includes home visits by a Child Death Review clinician and senior police officer, as well as bereavement support with the introduction of a new key worker role.

Grenfell Tower Fire

Members of the Local Safeguarding Children Board were deeply saddened by the recent tragedy of the Grenfell Tower Fire and our thoughts rest with the families and friends who lost loved ones in this disaster and the many families who lost their homes.

The Board met shortly after the tragedy in July 2017 and approved the development of the Grenfell Operational Management Group, in conjunction with the Safeguarding Adults Board, to help facilitate information sharing and prioritise actions for partner agencies in their response to the fire.

The Board also received updates on the package of support available to all local schools impacted by the fire, for both the staff and the children and families. An enhanced summer programme 'Summer in the City' was commissioned by the Local Authority and delivered in order to provide local children and families with positive activities to take part in.

Members of the LSCB team supported the staff and volunteers at the Al Manaar Mosque in north Kensington in the immediate few weeks after the fire as well as assisting with outreach work in the community to help promote the local services on offer to support residents in the aftermath of the fire.

Our Child Death Overview Panel (CDOP) team collated the information that was possible to from the Coroner's Court in relation to the very sad deaths of the children as a result of the fire and liaised with the Grenfell Key Workers and Police Family Liaison Officers to ensure that all the bereaved families were signposted to support. As a result of the ongoing Police investigation, Coronial Proceedings and Public Inquiry, the CDOP reviews for the children who died were not able to be completed in full and it is expected that these will be delayed until all other proceedings have concluded.

In the months that followed the fire, the Board received regular updates from colleagues about the work undertaken to re-house families, as well as updates on the delivery of the Grenfell Support Service which allocated dedicated keyworkers to residents affected by the fire, and the development of The Curve facility for residents.
The LSCB facilitated dedicated safeguarding children training sessions for staff and volunteers working at the Curve and we shared advice with the team at the Curve to help them develop their safeguarding children policy.

The Local Authority Safeguarding and Quality Assurance team also assisted the Grenfell Support Team to conduct audits of their casework.

Following the tragedy, the RBKC Early Help service has seen an increase of 13% in early help referrals and as a result a specific team of Early Help practitioners has been set up to respond to Grenfell families. The Local Authority has also set up the Grenfell Education Fund. This provides financial support to schools and is also planning longitudinal studies to understand the longer-term impact on children.

LSCB Website and Social Media

The LSCB website statistics show that the most viewed webpages tend to be the LSCB Training Pages and Safeguarding Contacts Pages. Further development work is needed on the front page of the website, to include a scrolling carousel of news items on the front page, rather than the static image we have currently – we hope that this will enable us to highlight new and refreshed content to visitors.

The LSCB has a social media presence on Twitter (@LSCBx3). We have grown our following to over 500 followers and have used this platform to amplify messages about national safeguarding campaigns led by the DfE and local initiatives such as our One Life, No Knife event for parents and carers. This is something we would like to develop further in 2018-19.

Future priorities

As the LSCB is in transition to our new multi-agency safeguarding arrangements, the priorities will be reviewed with partners again to determine if any updates are required.

Appendix 1 – LSCB Membership and Attendance

LSCB Main Board Attendance 2017-18				
Role	**11th May 2017**	**18th July 2017**	**17th October**	**23rd January 2018**
LSCB Chair	y	y	y	y
Executive Director of Children's Services (Tri-Borough)	y	y	y	n
Director of Family Services (H&F)	y	y	y	y
Director of Family Services (RBKC)	y	y	y	y
Director of Children's Services (WCC)	y	y	x	y
Director of Schools (Asst Director) – Tri-Borough	y	y	y	y
Head of Combined Safeguarding & Quality Assurance (Children's Services)	y	y	y	y
LSCB Business Manager	y	y	y	y
Director of Adults Safeguarding (or rep)	y	y	y	y
Housing	y	y	y	n
Police Borough Commander	y	y	y	n
Police CAIT	y	y	n	n
Probation	y	y	y	y
Community Rehabilitation Company	y	n	n	n
CAFCASS	y	y	y	y
Prisons (Wormwood Scrubs)	y	n	y	n
London Ambulance Service	n	n	n	n
Voluntary Sector (Standing Together)	y	y	y	y
Lay members	y	y	y	y
NHS England	n	y	n	n
Clinical Commissioning Groups	y	y	y	n

Designated Doctor	y	n	y	y
Designated Nurse	y	y	y	y
Head of Safeguarding, CLCH	y	y	y	y
CLCH Director of Nursing	n	y	n	n
Imperial Healthcare Trust, Director of Nursing	y	n	n	y
ChelWest, Director of Nursing	n	n	n	n
WLMHT/West London NHS Trust	n	y	y	y
CNWL	y	y	y	y
Public Health (Tri-borough)	y	n	n	n
Community Safety	y	y	y	n
Policy Team (Commissioning)	y	o	o	o
Head Teachers	y	y	y	y
Cabinet Member for Children's services, H&F	y	n	n	n
Cabinet Member for Family and Children's Services, RBKC	n	n	y	y
Cabinet Member for Children's Services, WCC	y	n	y	n

Appendix 2 – LSCB Budget LSCB Budget

2017/18 Outturn

	2017/18 Outturn				
	LBHF	**RBKC**	**WCC**	**TOTAL**	
CONTRIBUTIONS					
Sovereign Borough General Fund	**-79,169**	**-59,470**	**-77,699**	**-216,338**	*excluding corporate overhead costs*
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**	
London Fire Brigade	-500	-500	-500	**-1,500**	
CCG (Health)	-20,000	-20,000	-20,000	**-60,000**	
Total Partner Income	**-28,050**	**-28,050**	**-28,050**	**-84,150**	
Total Funding (excluding reserves)	**-107,219**	**-87,520**	**-105,749**	**-300,488**	
EXPENDITURE					
Salary expenditure	58,957	58,957	58,957	**176,871**	
Training	2,750	2,750	2,750	**8,250**	
Other LSCB costs	7,700	7,700	7,700	**23,100**	
2016-17 S113 shared cost adjustment	30,779	-40,848	10,069	**0**	
Total expenditure	**100,186**	**28,559**	**79,476**	**208,221**	
Forecast variance	**-7,033**	**-58,961**	**-26,273**	**-92,267**	
Moved to B/S for partner income					
Final outturn variance	**-7,033**	**-58,961**	**-26,273**	**-92,267**	
BALANCE SHEET					
Reserves Brought Forward	-38,183	-70,689	-55,226	**-164,098**	
Adjustment in year				**0**	
Contribution to LSCB balance sheet accounts	-7,033	-58,961	-26,273	**-92,267**	
Reserves to take forward	**-45,216**	**-129,650**	**-81,499**	**-256,365**	

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