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City of Westminster

Committee Agenda

Title:	**Health & Wellbeing Board**
Meeting Date:	**Thursday 20th November, 2014**
Time:	**4.00 pm**
Venue:	**Rooms 3 & 4 - 17th Floor, City Hall**

Members:

Councillor Rachael Robathan	Cabinet Member for Adults & Health
Dr Ruth O'Hare	Central London Clinical Commissioning Group
Councillor Danny Chalkley	Cabinet Member for Children's Services
Councillor Barrie Taylor	Minority Group
Meradin Peachey	Tri-Borough Public Health
Liz Bruce	Tri-borough Adult Social Care
Andrew Christie	Tri-borough Children's Services
Dr Naomi Katz	West London Clinical Commissioning Group
Janice Horsman	Healthwatch Westminster
Jackie Rosenberg	Westminster Community Network
Dr David Finch	NHS England

Members of the public are welcome to attend the meeting and listen to the discussion.

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

An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter. If you require any further information, please contact the Committee Officer, Andrew Palmer:

Telephone: 02076412802
Email: apalmer@westminster.gov.uk
Corporate Website: www.westminster.gov.uk

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

AGENDA

PART 1 (IN PUBLIC)

1.	**MEMBERSHIP** To report any changes to the Membership of the meeting.	-
2.	**DECLARATIONS OF INTEREST** To receive declarations of interest by Board Members and Officers of any personal or prejudicial interests.	-
3.	**MINUTES AND ACTIONS ARISING** I) To agree the Minutes of the meeting held on 19 June 2014. II) To note progress in actions arising.	(Pages 1 - 8)
4.	**CHILDREN & YOUNG PEOPLE MENTAL HEALTH TASK & FINISH GROUP** To discuss and endorse the final recommendations of the Task & Finish Group.	(Pages 9 - 68)
5.	**SCHOOL NURSING REVIEW AND SERVICE RE-DESIGN** To consider the results of the review of school nursing services, together with options relating to service design and future commissioning intentions.	(Pages 69 - 76)
6.	**LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT** To consider the Annual Report from the Local Safeguarding Children Board and reflect on areas for joint-working and partnership to improve outcomes for children at risk.	(Pages 77 - 134)

7.	**PRIMARY CARE COMMISSIONING** To discuss how consideration of the commissioning of primary care can be taken forward.	(Pages 135 - 138)
8.	**BETTER CARE FUND** To receive an update on Westminster's Better Care Fund submission.	(Pages 139 - 140)
9.	**CONTRACTING INTENTIONS** **I) <u>Central London Clinical Commissioning Group</u>** **II) <u>West London Clinical Commissioning Group</u>**	(Pages 141 - 258)
10.	**WORK PROGRAMME** To consider the Work Programme for the second half of the 2014-15 municipal year.	(Pages 259 - 262)
11.	**ITEMS ISSUED FOR INFORMATION** To provide Board Members with the opportunity to comment on items that have been previously circulated for information. **I) Primary Care Commissioning – further information.**	**-**
12.	**ANY OTHER BUSINESS**	**-**

Peter Large
Head of Legal & Democratic Services
12 November 2014

Dates of future meetings for 2014/15:

- Thursday 22 January 2015
- Thursday 19 March 2015
- Thursday 21 May 2015

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DRAFT MINUTES

CITY OF WESTMINSTER

WESTMINSTER HEALTH & WELLBEING BOARD
18 SEPTEMBER 2014
MINUTES OF PROCEEDINGS

Minutes of a meeting of the **Westminster Health & Wellbeing Board** held on Thursday 18 September 2014 at 4.00pm at Westminster City Hall, 64 Victoria Street, London SW1E 6QP

Members Present:
Chairman: Councillor Rachael Robathan, Cabinet Member for Adult Services & Health
Vice-Chairman: Dr Ruth O'Hare, Clinical Representative from the Central London Clinical Commissioning Group
Cabinet Member for Children & Young People: Danny Chalkley
Minority Group Representative: Councillor Barrie Taylor
Director of Public Health: Meradin Peachey
Tri-Borough Executive Director of Children's Services: Rachel Wright-Turner (acting as Deputy)
Tri-Borough Executive Director of Adult Social Care: Liz Bruce
Clinical Representative from the West London Clinical Commissioning Group: Dr Phillip MacKney (acting as Deputy)
Representative of Healthwatch Westminster: Janice Horsman
Chair of the Westminster Community Network: Jackie Rosenberg
Representative for NHS England: Dr Belinda Coker (acting as Deputy)

Also in Attendance:
Councillor David Harvey.

1. MEMBERSHIP

1.1 Apologies for absence were received from Andrew Christie (Tri-Borough Executive Director of Children's Services) and Dr David Finch (NHS England). Rachel Wright-Turner and Dr Belinda Coker attended as their respective Deputies.

2. DECLARATIONS OF INTEREST

2.1 No declarations were received.

3. MINUTES AND ACTION TRACKER

3.1 **Resolved**:

3.1.1 That the minutes of the meeting held on 19 June 2014 were approved for signature by the Chairman.

3.1.2 That progress in implementing actions and recommendations agreed by the Board be noted.

4. BETTER CARE FUND PLAN 2014-16 REVISED SUBMISSION

4.1 The Board received a progress report from Liz Bruce (Tri-borough Director of Adult Social Care) and Cath Attlee (Tri-borough Adult Social Care) on the Better Care Fund Plan, which had been agreed by the Health & Wellbeing Board in March 2014 and submitted to the Department of Health (DoH) in April. The Board noted that following further guidance and a revised template, the DoH had requested that the Plan be revised to include additional material and be resubmitted. Issues to be set out in the revised Plan included more detail on funding and local risk sharing, unplanned admissions to hospital, and an evidence based delivery plan. The revised submission needed to be sent to NHS England by 19 September 2014.

4.2 The Tri-borough Director of Adult Social Care confirmed that the additional information that had been requested would be submitted as a supplement to the Plan which had been approved by the Westminster Health & Wellbeing Board in March. It was agreed that the final version of the revised submission would be circulated to Board members for information, with sign-off then being delegated to the Chairman and Vice-Chairman.

4.3 **Resolved:** That the final version of the revised submission be circulated to members of the Westminster Health & Wellbeing Board, with sign-off being delegated to the Chairman and Vice-Chairman, subject to any comments that may be received.

5. CLINICAL COMMISSIONING GROUP CONTRACTING INTENTIONS 2015-16

5.1 The Board received presentations from Dr Kiran Chauhan (Central London CCG) and Louise Proctor (West London CCG), which provided an overview of the approach being taken in developing the commissioning intentions of Westminster's Clinical Commissioning Groups (CCGs) for 2015-16. The Board noted that the Contracting Intentions of the two CCGs largely followed the same strategic agenda, and would be issued to Providers in October.

5.2 Dr Chauhan reported that the main projects for the Central London CCG for the next year included patient empowerment and strengthening networks to give them long, healthy and independent lives; moving forward on whole systems working

and implementation of the community independence service model; the reconfiguration of primary services; and the delivery of integrated Out of Hospital Care.

5.3 The Central London CCG would continue to develop closer interaction with GPs, and to focus on Westminster's most vulnerable groups, such as rough sleepers; and would progress national priorities for services relating to mental health, dementia, and cancer. The CCG would also continue integrate IT systems, and work with local authorities to implement the programme of change for nursing homes.

5.4 Louise Proctor reported that while the contracting Intentions of the two CCGs largely followed the same strategic agenda, the West London CCG would be taking forward Clinical Systems Improvement; and looking to redesign care for older people and provide better integrated support. The CCG would also work towards providing 7-day GP access in response to the Prime Minister's Challenge Fund.

5.5 The Board discussed the commissioning intentions of the two CCGs, and acknowledged the need for proposals to reflect what local people wanted. Members highlighted the value of services being integrated wherever possible and of increasing capacity at GP Practices; and commented on the need to provide language specific counselling, and to contact displaced communities where psychological therapies may be needed. The Board also commended the work of the Primary Care Plus service, which helped people navigate into the care they needed.

5.6 **Resolved:** That the Commissioning Intentions of the Central London and West London Clinical Commissioning Groups for 2015-16 be noted.

6. PRIMARY CARE COMMISSIONING

6.1 Karen Clinton (Head of Primary Care, NHS England North West London Region) presented a report which provided detail on the commissioning and quality assurance of Primary Care Services by NHS England, and how they performed their responsibilities. Priorities for the forthcoming year included the transformation of Primary Care; patient empowerment; Whole Systems Integrated Care; and service reconfigurations. The Board noted that currently there were approximately 400 GP practices in North West London, with approximately 2,000 patients per GP.

6.2 NHS England had established three Local Area Teams in London which covered the North West; North East & Central; and South. Karen Clinton confirmed that the Primary Care Framework and Strategies fitted in with the Area Teams, and that a conscious decision had been made not to write Strategies which did not align with local Out of Hospital services.

6.3 Karen Clinton commented that it was rare for GP practices in Westminster to close, which reduced the opportunity for practices to be reviewed and re-procured. Members sought clarification as to whether new services could be commissioned in response to population growth, and the Head of Primary Care confirmed that although there was currently no available funding for new practices, funding could be obtained for additional GP's at existing practices in response to a rise in population.

6.4 The Board considered that commissioning was a critical element in the delivery of Out of Hospital Services in Westminster, and discussed how GP capacity could be ensured across all areas. The Board acknowledged that the availability of premises was a key issue in Westminster; and discussed the co-commissioning of Primary Care Services between CCGs and NHS England at one location, with other partners being brought in at a later stage. The Board noted that the NHS currently held the funding for the core contracts, with the remaining services being funded by CCGs, and agreed that integrated co-commissioning would bring the separate together again.

6.5 The Head of Primary Care also informed the Board that a commitment had been made in response to the Prime Minister's Challenge Fund, to offer seven day opening at a network of GP practices in North West London next year; in which patients would be able to see a GP within 24 hours between 8am and 8pm Monday to Friday, and between 8am and 6pm at weekends.

6.6 The Board discussed the ratio of GPs in relation to the population across Westminster, and requested details of the number of patients who were from out of borough. Members also sought clarification of the premises which were known to be under pressure, and where out of hours capacity was situated.

6.7 **Resolved:** That

1) The overview of the Central London Clinical Commissioning Group Contracting Intentions for 2015/16 be noted;

2) The Commissioning proposals be taken forward at the next meeting of the Westminster Health & Wellbeing Board in November; and

3) Details be provided of the number of GPs in relation to the population across Westminster, together with the number of people registered with those GPs; those who are from out of borough; GP premises which are known to be under pressure; and where out of hours capacity is situated.

7. MEASLES, MUMPS AND RUBELLA (MMR) VACCINATION IN WESTMINSTER

7.1 Sobia Chaudhry (Population Health Practitioner Manager, NHS England), Sana Rabbani (Immunisation Commissioning Manager, NHS England) and Meradin Peachey (Director of Public Health), presented a report which outlined the current position of MMR vaccination in Westminster, and which considered how uptake on

immunisation could be improved. The roles and responsibilities relating to vaccination had changed following the Health & Social Care Act 2012, with immunisation now being delivered in GP practices. The Board noted that NHS England were seeking changes to the current contract so that vaccinations could be provided by Health Visitors.

7.2 The new configuration of the health system had created opportunities to improve the quality of commissioning, service provision and the uptake of vaccination programmes. In London, NHS England had established a single commissioning team for immunisations, which had enabled the development of robust processes for contracting, commissioning and monitoring providers.

7.3 A number of projects and actions were currently underway in London to help improve uptake, which would have an impact within Westminster. These included projects in Primary Care; improving data flow and the use of data to improve quality; and system-wide projects to ensure good oversight and the sharing of best practice. The Board acknowledged that NHS England, CCGs and local authorities all had a role to play in communication and collaborative working, to ensure that there were sustainable improvements in uptake rates for immunisation. Members noted that current uptake on MMR vaccination stood at 30% for the overall population, and 50% for the 0-5 age group.

7.4 The Board discussed the difficulty in obtaining reliable data, and suggested that greater focus was given to the strategy and practical steps that were being taken to reach people, rather than what had been achieved. Members also commented on the prevalence of measles and other diseases, and suggested that it would be useful to receive details of the number of cases that were occurring. The Board also highlighted the importance of Westminster's Clinical Commissioning Groups being involved in the review of immunisation.

7.5 The Board commented on the possible impact of migration and of other countries operating different systems, and acknowledged that issues relating to MMR also affected other forms of immunisation such as for diphtheria and whooping cough.

7.6 **Resolved:** That a further report setting out a strategy for how uptake for all immunisations could be improved, and which provides Ward Level data together with details of the number of patients who have had measles, be brought to the forthcoming meeting of the Westminster Health & Wellbeing Board in January 2015.

8. THE PHARMACEUTICAL NEEDS ASSESSMENT

8.1 The Board received an update on preparing the draft Pharmaceutical Needs Assessment, from Colin Brodie (Public Health Services) and Holly Manktelow (Senior Policy Officer). The Assessment was a statutory responsibility of the Health & Wellbeing Board, which sought to map current services against need, and assist NHS England as a market entry and commissioning tool for reviewing

new applications for pharmacies in Westminster. The Board noted that the completed Assessment would need to be published by 1 April 2015

8.2 Although there had been some slippage in the original timescales agreed by the Board in March 2014, the Pharmaceutical Needs Assessment Task & Finish Group would be ready to begin the consultation on the draft Assessment in October.

8.3 The final draft of the report would be circulated to Board members for comment, after which the Task & Finish Group would commence with the 60 day statutory consultation.

8.4 **Resolved:** That progress in the Pharmaceutical Needs Assessment be noted.

9. WORK PROGRAMME

9.1 The Board reviewed its Work Programme for 2014-15.

9.2 Members agreed that an update on Primary Care Commissioning should be included in the Agenda for the forthcoming meeting on 20 November; and that a further report on immunisation be submitted to the meeting in January 2015. The Board also agreed that Health Checks needed to be added to the Work Programme for a future meeting.

10. ITEMS ISSUED FOR INFORMATION

10.1 A number of papers had been circulated to Board members for information separately from the printed Agenda:

- Joint Strategic Needs Assessment Review
- Tri-Borough Learning Disabilities Action Plan
- Health & Wellbeing Engagement Strategy

11. SILVER SUNDAY

11.1 The Board commended the Silver Sunday programme, which had been created through the Sir Simon Milton Foundation as a national celebration of older people, and their contribution to communities. Silver Sunday offered people over 65 a variety of free activities, and provided a chance to keep active in body and spirit, to try new things, and to meet their neighbours and overcome loneliness.

11.2 Board members agreed to proactively support the programme by displaying publicity material at GP practices and other public areas.

12. TERMINATION OF MEETING

12.1 The meeting ended at 6.04pm.

CHAIRMAN _____ DATE _____

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City of Westminster

Westminster Health & Wellbeing Board

Date:	**20th November 2014**
Classification:	**General Release**
Title:	**Children & Young People Mental Health Task & Finish Group**
Report of:	**Tri-Borough Executive Director of Children's Services**
Wards Involved:	**All**
Policy Context:	**Health and Wellbeing**
Financial Summary:	**None**
Report Author and Contact Details:	Steve Buckerfield - Acting Head of Children's Joint Commissioning, steve.buckerfield@nw.london.nhs.uk, 020 3350 4331

1. Executive Summary

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

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

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

1.4 Healthwatch has also undertaken some qualitative research with service users to inform this work, summarised in the Powerpoint presentation attached at Appendix C.

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

2. Key Matters for the Board's Consideration

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

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

3. Background

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

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

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

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

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

4. Legal Implications

4.1 N/A

5. Financial Implications

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

5.2 In 'rethinking' the Westminster approach to children's mental health and emotional wellbeing, a business case may be required to either strengthen or re-align services and sources of support for families. Should this prove to be the case a separate report would be drafted and submitted to the appropriate local authority and/or clinical commissioning group committees.

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

Steve Buckerfield, steve.buckerfield@nw.london.nhs.uk or

Chris Swoffer, cswoffer@westminster.gov.uk

APPENDICES:

A: Full report of the Children, Young People and Mental Health Task and Finish Group
B: Presentation for the Westminster Health and Wellbeing Board
C: Presentation from Healthwatch research with service users.

BACKGROUND PAPERS:

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

November 2014

Contents

Summary of recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Introduction

Background

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

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

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

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

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

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

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

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

National Context

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

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

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

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

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

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

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

Local Context

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

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

1.13 CAMHS is organised across 4 tiers of service:

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

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

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

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

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

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

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

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

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

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

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

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

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

Local figures

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

Table 1: Children's Services customer profile

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

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

Table 2: In Hours CAMHS funding across Tri-borough

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

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

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

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

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

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

Methodology

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

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

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

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

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

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

A New Vision?

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

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

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

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

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

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

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

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

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

1.35 This leads us to return to the key question:

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

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

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

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

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

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

To complement this however early intervention could be strengthened:

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

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

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

[9] Minister for Care and Support

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

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

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

2 Early Intervention and Prevention

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

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

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

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

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

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

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

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

Access, Outcomes and a Single Point of Access

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

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

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

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

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

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

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

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

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

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

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

Effective examples of best practice also exist internationally.

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

Awareness and Confidence for Front-line Staff

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

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

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

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

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

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

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

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

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

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

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

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

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

Cyber Bullying

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

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

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

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

Case Study – Cyber Mentors

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

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

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

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

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

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

Self Harm

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

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

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

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

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

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

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

Mental Health and Gangs

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

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

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

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

Eating Disorders

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

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

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

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

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

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

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

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

Recommendations

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

Recommendation 1

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

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

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

Recommendation 2

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

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

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

Recommendation 3

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

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

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

Recommendation 4

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

3. Parental Mental Health

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

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

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

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

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

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

Background

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

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

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

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

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

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

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

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

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

Local progress – performance indicators

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

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

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

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

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

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

Data collection and information sharing

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

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

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

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

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

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

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

Multi-agency working

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

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

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

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

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

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

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

Early Progress

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

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

Case Study – Kidstime

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

Staff awareness and training

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

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

Early Progress

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

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

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

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

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

Early Progress

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

Recommendations

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

Recommendation 5

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

a) Asked about their parental responsibilities and

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

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

Recommendation 6

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

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

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

Recommendation 7

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

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

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

Recommendation 8

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

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

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

Recommendation 9

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

Recommendation 10

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

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

National Context

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

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

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

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

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

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

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

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

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

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

Local context

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

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

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

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

[43] CQUIN – Commissioning for Quality and Innovation

Local data

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

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

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

Service Model and thresholds to care

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

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

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

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

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

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

Leadership

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

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

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

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

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

Recommendations

Recommendation 11

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

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

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

Recommendation 12

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

5. Acknowledgements

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

Thanks go to:

Central London Clinical Commissioning Group

West London Clinical Commissioning Group

Hammersmith and Fulham Clinical Commissioning Group

Westminster City Council

Royal Borough of Kensington and Chelsea

London Borough of Hammersmith and Fulham

Central and North West London NHS Foundation Trust

West London Mental Health NHS Trust

Healthwatch

Cardinal Hume Centre

Spurgeons

Rethink

Westminster Academy

Local Safeguarding Children Board

Westminster IAPT

Imperial College Healthcare NHS Trust

Central London Community Healthcare NHS Trust

Children, Young People and Mental Health

Report of the Task and Finish Group

November 2014

Reviewing CAMHS.....

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

Task and Finish Group: Recommendations

Early Intervention and Prevention

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

Parental mental health

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

Transition to adult mental health

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

Rethinking children's mental health?

Questions to consider:

- Does the traditional CAMHS service model which is currently delivered in Westminster meet the needs of children and young people today?

- How should we support those who are emotionally vulnerable although do not require clinical treatment?

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

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

Rethinking children's mental health services

Emotional Vulnerability  Diagnosed Mental Illness

A new vision

A new vision?

Key questions for the Health and Wellbeing Board to consider

The Health and Wellbeing Board are invited to discuss:

1. What a “fit for purpose” mental health and emotional wellbeing service for Westminster could look like?

2. What we need to do together to deliver this?

3. How important the role of community and individual resilience is and what role should the Voluntary and Community Sector, Schools and other organisations play in improving emotional wellbeing and resilience?

Next steps…

- Implement Task & finish Group recommendations
  - Improving access
  - Programme for schools
  - Whole family approach in adult mental health
  - 16 to 25 years, mental health needs and transition

- Work with NHS England and the national CAMHS Taskforce to improve pathways between community and inpatient CAMHS

- Rethinking young people's mental health provision in Westminster
  - Voluntary sector
  - 'Headspace' style hubs – what's feasible
  - Young people's mental health in Westminster: building a coalition for change and improvement……

Acknowledgements

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

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

healthwatch Central West London

From the mouths of….

…I just create noise to get away… it upsets my mum

Who? How? What?

Whats working?

What changes would you want to see?

Tell us your story

Why are young people falling through the gaps?

What needs changing?

Events

Face to face

Online

Interviews

Survey

Focus groups

healthwatch Central West London

Young people …

We just need a new house

…some staff are nice, some are evil geniuses…

…I am not as angry as I was before I came…

…My mum drinks alcohol to calm her down…

…hurting yourself can feel so good which sounds stupid but its true…

…I just create noise to get away…

Yes, I know about my care plan…

…school is the worst place, no-one cares…

What would I change? People to stop annoying me

…Night time can be scary, its when the noise comes back…

..when your mum is ill then you can talk to people but my friend, her mum is at work she cant talk to people – people take more care of me at school and there are people outside of school and she wants the same… (15)

I know I am not like my brother

What would make it better? If I could go home and the kids up the road moved to another house

healthwatch Central West London

Family carers …

No one would talk to me about medication, I know him best I know what worked before

…Parents need other parents to support them…

…My son won't go far out of the area because he gets paranoid that something might happen to him…

…CAMHS unit was the first place where I felt the professional did not judge me for being a bad parent…

… services come and go, because there is a lot in the press then there will suddenly be a lot of services, but give it a couple of years and it will be different…

…I would do anything to have stopped my son from smoking, I just didn't know it could get this bad, maybe if they spoke the effects of smoking cannabis in primary school…because that is when it started…

…the CAMHS admission has given me my son back…

…Secondary schools are too big to deal with vulnerable kids…

…There should be people at the GP to talk to because Gp's are not always easy to talk to and appointments are quick…

… Depression in mothers is a problem, both before a child becomes ill and then afterwards – they cannot cope – it (sometimes) makes the mum much worse…

I think it is just a bunch of stuffy nosed old men sitting around talking about what is best for us

…Girls have to be thin and look amazing – even 8 year old little girls get bullied for not having straight hair…

…Pressures are sometimes too much when you are coming to England to live – children have to be different here…

healthwatch Central West London

Frontline workers..

More joined up approaches between charities, health services and schools.

Very often what is needed is a stable, nurturing, consistent figure where parents are unstable or emotionally absent.

Don't close cases after a DNA

I think that adolescent young peoples team s should go up to the age of 25 as younger people find it very hard to access adult services

(Locally) Our CAMHS service has been cut by a third . We have no in patient beds. We have no secondary services. We work alongside a stretched and cut social services.

There is just simply not enough CAMHS, and what is there, is hard to access. Therapy should be on site in schools.

11-18 yrs. Pressures of academia or working to support self/family. I have concerns about mounting pressures from social media and cyber bullying alongside traditional classroom bullying.

15 is an age where mental health problem seem to emerge in both genders, but girls often overdose or self harm, which brings them to CAMHS services. There are enormous pressures on this age group. Social (peers/fashion/body/family/media/social networks), academic/school, future fears (will I get a job, where will I live), gangs, sexual pressures

Outcomes have been varied. Sometimes excellent service, sometimes communication with myself as referrer has been poor, sometimes it has taken an extremely long time for referral to go through, particularly recently

Interim conclusions

- Patchy provision of mental health information in schools
- Unclear referral pathways and responsibilities for agencies
- Limited evidence of the four tier model in practice
- Lack of local inpatient beds
- Impact of child diagnosis on parent/carer and siblings requires further consideration
- Frontline workers citing reduced local provision
- Limited up-to-date resources for accessing & signposting services
- No support groups specifically for carers with children experiencing mental health problems
- Evidence that children and young people talk to their parents as first point of reference
- Significant levels of DNAs

Recommendations

1. Tailored group support specific to CAMHS; harnessing & developing peer support opportunities
2. Mainstream awareness raising and education for parents about common signs and symptoms of mental wellbeing
3. A consistent offer to schools to support mental health awareness
4. Public messages which highlight the links between mental health & healthy lifestyles, building resilience
5. Simplify referral pathways for families & frontline workers, enabling greater integration
6. Further work required to understand the underlying reasons & impact of DNAs and to ensure equality of access – impressionistically some families & young people are in double jeopardy owing to layers of deprivation
7. The Think Family approach should permeate all agencies and sectors, supported by common tools, protocols & information sharing.

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City of Westminster

Westminster Health & Wellbeing Board

Date:	**20 November 2014**
Classification:	**General Release**
Title:	**School Nursing Review and Service Re-design**
Report of:	**Meradin Peachey, Director of Public Health**
Wards Involved:	**All**
Policy Context:	School Nursing services are commissioned by Public Health, but have an impact on both wider health and children's services and align to the WCC HWB strategy
Financial Summary:	**NA**
Report Author and Contact Details:	Julia Mason Families and Children's Public Health Commissioner t. 020 7641 4653 e-mail: jmason@westminster.gov.uk

1. Executive Summary

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

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

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

2. Key Matters for the Board's Consideration

2.1 Findings from the evidence review

2.1.1 An evidence review of the effectiveness of school based health models found that nurses working in schools are well placed to make a positive difference to children's physical and emotional health. Nurses are trusted and popular with parents and schools and provide good value for money by supporting children's attendance, reducing school staff time in managing health problems and reducing children's use of emergency care services.

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

2.1.3 Nationally there is only a small pool of registered post-graduate SPHN (Specialist Public Health Nurse) School Nurses, currently about 1,300 in England. Any service model needs to make best use of their public health and leadership skills to manage a grade and skill mixed workforce of Staff Nurses, Nursery Nurses and SN Assistants forming part of the school health service that works to clear outcomes around e.g. sexual and mental health, obesity and other health preventative initiatives.

2.2 Consultation findings

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

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

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

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

2.2.5 A significant number of schools in Westminster expressed a low level of satisfaction with the provision and consistency of the current SN service, although examples of excellent practice in individual schools were also identified. Schools felt the current service lacked the capacity to identify and meet the wider health needs of pupils, their families and the school community, especially at secondary level. Schools' priorities for a new SN service are:

- Co-ordinating and supporting management of care plans for increasing number of children with long term health conditions and special educational needs in mainstream school, to enable them to manage their condition well and to maximise their health and school attendance.

- Targeted early years SN/health, child development and parenting provision for vulnerable children and their families to better prepare them for transition to nursery and reception so children are ready to thrive at school. Also, to improve liaison with nurseries and schools so plans can be put in place to support vulnerable children's health and development needs before they start school.

- More SN involvement in integrated team around the school, early help services and whole school initiatives e.g. Healthy Schools Partnership, obesity prevention and dental health in order to maximise outcomes and minimise duplicat*i*on of *e*ffort.

- Health screening and co-ordinating access to other health services; especially liaising with GPs, CAMHS and adult mental health services.

- Delivery of specific health education and promotion sessions for children and parents e.g. on puberty, hygiene, FGM.

- Safeguarding and targeted provision for excluded children and those in alternative provision

- Paediatric Nursing provision to provide clinical care for children with very complex health needs attending special schools

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

2.2.7 SNs also reported a significant proportion of their time was spent on safeguarding, especially attending in case conferences when it was not always clear what value they could bring to the meeting. They reported that it was difficult to cover vacancies or sickness and this resulted in gaps in service, low visibility and lack of continuity.

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

2.3 Core components of a new model

2.3.1 It is proposed that a new effective model of school health is developed, that achieves efficiencies within current levels of funding and focuses on improving priority child health outcomes, to include all the components described below:

- Provision of school aged immunisation is de-commissioned by WCC (to be commissioned by NSHE), but health promotion of immunisation is retained to ensure local immunisation rates are maintained and improved;

- Provision of the Healthy Child Programme of screening and health assessments and delivery of the NCMP (a mandatory requirement) is commissioned;

- A school health information website & 'virtual school nurse' and confidential text service is commissioned;

- Evidence-based interventions with clear outcomes linked to child public health programmes and priorities (e.g. obesity prevention, oral health promotion) are commissioned to link effectively all school based health interventions and outcomes and current ineffective interventions e.g. Fit and Fruity healthy eating sessions, are decommissioned;

- Skill and grade mix team of SPHN SNs (post graduate qualified school nurses) registered nurses, nursery nurses and other health workers or assistants is established to work to most efficacy;

- A paediatric nursing service is commissioned by Central London CCG for QE2 and College Park Specials schools;

- A lead SN for excluded children is commissioned;

- Safeguarding: a pilot is commissioned of the Shropshire school nursing health needs assessment model for all children subject to initial or review Child Protection conferences.

2.3.2 In addition to the core components of the new model described above, two initial options have been developed to make best use of school nursing workforce and other health resources. The Health and Well Being Board are asked to consider the initial options below and to give a steer on the direction of travel for the re-commissioning of a school health/school nursing service.

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

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

3. Background

3.1 Schools provide an important learning and nurturing environment for the vast majority of children and adolescents throughout the years of critical physical, social and psychological development. Besides parents and the wider family, school is a primary institution for improving children's health and well being. This is why effective provision of support, and relevant health services, for pupils, their families and the wider school community, is essential for the current and future health of the local population.

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

3.3 The review process included:

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

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

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

3.5 Other drivers, priorities and consultation findings have informed options for a new school health model:

- Children are starting school and nursery earlier and more vulnerable children need significant support to achieve a good level of school readiness (a key early years' public health outcome).
- A qualified health professional/nurse is needed to support referrals and contribute to delivery of integrated customer journeys/care pathways for public health interventions and services delivered through schools, such as child oral health promotion programmes, the NCMP, obesity prevention and healthy family weight services and young people's sexual health services.

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

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

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

4. Legal Implications

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

4.2 Provision of school aged immunisation is now the commissioning responsibility of NHS England (Health and Social Care Act 2012).

5. Financial Implications

5.1 Adequate budget and resources have already been allocated

If you have any queries about this Report please contact:

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City of Westminster

Westminster Health & Wellbeing Board

Date:	20th November 2014
Classification:	General Release
Title:	**LSCB Annual Report**
Report of:	Tri Borough Children's Services
Wards Involved:	All
Policy Context:	Working Together (2013) places a requirement on the Local Safeguarding Children Board to send its Annual Report to the Chairman of the local Health and Well Being Board
Financial Summary:	None
Report Author and Contact Details:	Tim Deacon,Tri Borough Children's Services Tel: 0208753 5140 E-mail: tim.deacon@lbhf.gov.uk

1. Executive Summary

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

2. Key Matters for the Board's Consideration

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

2.2 It is recommended that the Board considers the report and makes any representations to Jean Daintith, the Independent Chair of the LSCB. The Health and Wellbeing Board should consider how it can collaborate with the LSCB on shared priorities and through short life working groups.

2.3 The LSCB would welcome actions from the Westminster HWB to:

1. Improve local responses to the identification of children in families where parental substance misuse and/or parental mental health, FGM, and children at risk of sexual exploitation is an issue.
2. Establish best practice in identifying early neglect within health agencies, to ensure that neglect of children is appropriately identified and responded to
3. Clarify how the LSCB should support HWB task and finish groups (on issues such as parental substance misuse, parental mental health, and transition between children and adult mental health services)
4. Develop a culture of 'challenge' from health agencies, to promote improved safeguarding practice within partner agencies
5. Promote the learning from SCRs within health agencies. This also includes need for:
    - Improved communication between GPs and HVs
    - Clarification of systems and processes for transfer in / out of child health records (Sofia SCR)

3. Background

3.1 The Annual Report details both the core functions of the LSCB as well as the priorities that were established in April 2012.

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

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

3.4 The commitment to ensure that local as well as national priorities are addressed has shaped the work of the LSCB in the past year. The agenda has been progressed successfully through active short life improvement groups and sub groups of the Board. Borough-based partnerships have included a proper focus

on local activities and there are developing relationships with the Children's Trust and each of the Health and Well-Being Boards. Increasingly there is a linkage to the Health and Wellbeing Boards' priority themes for children, and duplication is avoided, whilst shared priorities are acknowledged. This linkage is key to the LSCB being seen as effective in both governance and partnership.

4. Legal Implications

4.1 No Comment

5. Financial Implications

5.1 No Comment

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:
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APPENDICES: **Tri-borough Local Safeguarding Children Board Annual Report 2013/14**

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Tri-borough Local Safeguarding Children Board

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

Foreword

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

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

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

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

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

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

Jean Daintith
Independent Chair

Contents

Executive summary

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

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

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

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

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

1. Introduction

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

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

1.3 The annual report should:

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

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

2. Background and Context

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Governance & Accountability

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Westminster Prevention of Harm

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

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

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

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

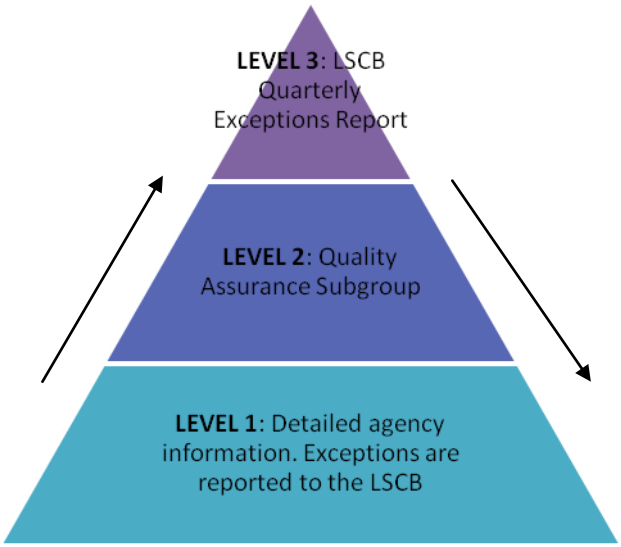
RBKC's partnership is chaired by the Joint Head of Safeguarding, Review and Quality Assurance. A constant core membership, with over ten agencies represented, has been maintained. Representation from the voluntary and community sector has been recently strengthened through the recruitment of a further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

Key achievements of the group include:

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

4. Quality and Effectiveness

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Learning and Development

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Case Review and Child Death Overview Panel

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Engagement and Participation of Children and Young People

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

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

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

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

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

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

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

8. Equality and Diversity

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

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

8.3 Specific developments include:

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

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

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

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

9. Communication and Awareness raising

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

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

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

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

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

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

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

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

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

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

10. Early help and prevention of harm

2013/14 Business Plan priorities:

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

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

Early Help

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

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

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

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

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

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

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

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

Multi-Agency Safeguarding Hub (MASH)

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

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

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

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

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

How MASH has improved information sharing.....

Case example 1:

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

Case example 2:

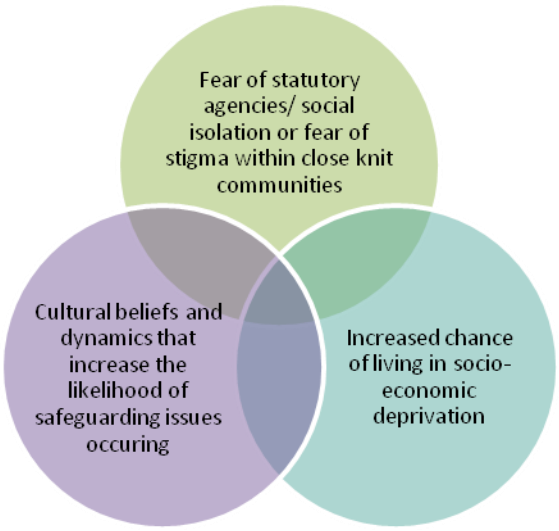
A GP raised concerns to MASH about pregnant mother and 4 yr old child having moved in to the area from Newham fleeing domestic abuse and living in a refuge. MASH was able to ascertain from other professionals details for the unborn baby's father following refusal from mother to give this information.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

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

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

Safeguarding outcomes for black and minority ethnic children

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



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

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

Safeguarding in relation to faith or belief

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

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

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

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

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

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

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

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

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

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

Links with the voluntary sector

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

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

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

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

Strengthening links to the Adult Safeguarding Board

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

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

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

2013/14 Business Plan priorities:

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

Data collection and review

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

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

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

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

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

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

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

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

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

Safeguarding arrangements and improved outcomes for children

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

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

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

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

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

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

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

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

Learning from inspections and case reviews

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

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

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

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

12. Practice areas to compare, contrast and improve together

2013/14 Business Plan priorities:

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

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

Missing children

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

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

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

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

Spotlight on..... domestic violence

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

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

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

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

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

Self-harm and suicide

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

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

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

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

Child Sexual Exploitation and sexual violence

12.8 A short-life working group to review multi-agency practice in relation to young people affected by sexual violence and gangs and sexual exploitation provided its final report to the LSCB in June 2013. The group was initiated as local agencies recognised that the three boroughs each had a range of initiatives underway and that the safeguarding needs of adolescents, especially looked-after young people and care leavers, are complex and challenging, requiring a different approach from child protection work in younger age groups.

12.9 The group identified three key strands of work to promote a reduction in youth violence and sexual exploitation across the three boroughs, noting that these strands of work need to be considered alongside other related LSCB workstreams such as children who go missing and children at risk of self-harm. These strands included: a need for improved preventive work through the engagement of schools and local communities; improve multi-agency partnership working around youth violence and sexual exploitation; and improve the wider framework for agencies working together.

12.10 Alongside this, the LSCB commissioned the development of a Child Sexual Exploitation (CSE) Strategy, which was published in early 2014, and agreed to adopt the new Pan-London Child Protocol. This was to ensure that a shared approach to tackling child sexual exploitation was taken across all agencies.

12.11 The work plan arising from the short-life working group is now being coordinated through the Multi-Agency Safeguarding Hub (MASH) & CSE Sub-Group (of the LSCB). Since being established, the group has developed and published guidance on CSE referral pathways and the role of the newly created Multi-Agency Sexual Exploitation (MASE) Panel meetings. The MASE Panel, which started to meet monthly from January 2014, is jointly chaired by the Police and Tri borough sexual exploitation lead within social services; the panel has a strategic over view of cases and provides quality assurance in respect of investigations, case work and outcomes for children and young people.

12.12 Multi-agency training on CSE has been incorporated into the LSCB training and development schedule to ensure staff have an improved awareness of to identify and respond to cases. Individual briefing sessions on CSE have also been held for staff working in Housing.

12.13 The Metropolitan Police Service has created a dedicated Child Sexual Exploitation team to deal with the most serious allegations of CSE. The team works closely with partner agencies and employs a number of tactics to protect children. These include full intelligence and background profiling, disruption techniques to thwart those trying to exploit children, interviews with victims and provision of support and safeguarding, as well as the prosecution of offenders.

12.14 The first Tri-borough 'Problem Profile' has been produced to provide the LSCB with a clearer analysis of the prevalence and nature of CSE that local services are currently addressing.

Outcomes for children who are vulnerable from adults within the Criminal Justice System

12.15 Children are vulnerable to adults within the criminal justice system (CJS) in generally two ways: first, and most common, children of adults involved in the CJS may be more vulnerable to poverty, abuse and poor life chances. The siblings of those involved in serious youth violence and gang activity may be vulnerable by association. Secondly, children may be vulnerable to adults who target children for the commission of offences, often of a sexual nature, and may either be known to the offender or randomly targeted through circumstance.

12.16 Outcomes for the first group of children are improved when the agencies working with a family unit communicate well and openly and that there is face to face liaison between the agencies. By working with the adults and seeking to improve their life circumstances, the Probation Service can also improve the prospects for the children involved. The key to improved outcomes for children in these circumstances is:

- Effective identification of the children involved with adults in the CJS
- Competent and comprehensive assessment of the risks posed
- Identification and liaison with other agencies involved with the children and their families
- Effective intervention with the adults to improve their circumstances and by association those of the children.

12.17 For the second group of children, the victim may be a random selection and therefore protection of the child relies on good management of the perpetrator concerned. Most of these offenders will be subject to the local Multi-Agency Public Protection Arrangements (MAPPA) facilitated by the Local Authority, Police, Probation Service and Prison Service. A management plan will be in place for each MAPPA case and the risks are assessed on a sliding scale. Those cases with the most serious risks are managed at Level 3 and this involves a regular review at a minimum of every six weeks with all agencies involved meeting together. Where specific children are identified as being at risk, liaison with relevant LA services can take place.

12.18 A continued gap in the effective identification of children involved with adults in the CJS is the Probation Service's case recording systems; at present the case record system does not quantify how many cases are flagged for a contact with children's services nor how many cases have contact with children. The Assistant Chief Officer of London Probation is raising this with the national probation service as a priority area for addressing.

13. Continuous improvement in a changing landscape

2013/14 Business Plan priorities:

- ✓ Good representation of all agencies at LSCB and within its subgroup activities. This should include the strengthening of links between the LSCB and the local partnership boards, Health and Well Being Boards, Public Health and with the Judiciary
- ✓ To strengthen links with Youth Offending Services and develop an understanding of the issues for children in the secure estate
- ✓ Continue to identify and respond to the safeguarding implications of Housing Reform on vulnerable children
- ✓ Establish and respond to changes in the local safeguarding arrangements for Probation and Police
- ✓ promote improved safeguarding practice in schools, ensuring learning from case reviews, and the development of quality assurance, support, challenge and training

13.1 The landscape of services delivered and commissioned locally for children and families has gone through unprecedented change over the past few years. Understanding the implications of and identifying any risks for the safeguarding of children, which are presented by these changes, is complex and ever evolving. The LSCB has prioritised a number of activities within its business plan to ensure that the LSCB plans and continually reviews the quality of services, and that risks presented by the changing landscape are mitigated.

Good representation and strengthening of links

13.2 Over the course of 2013/14 the Board recruited four Lay Members, a representative from Wormwood Scrubs (the local Category B men's prison in Hammersmith and Fulham), and improved the commitment from schools. This wider membership has expanded the basis for engagement of local agencies but also presents a challenge to ensure that each is able to contribute and demonstrate their impact at Board meetings.

13.3 The three Clinical Commissioning Groups' (CCGs) membership of the LSCB has been strengthened through the presence of the Director of Quality and Patient Safety and the Associate Director for Safeguarding. The CCGs' Safeguarding Team development has also increased capacity of health representation at the LSCB subgroups. The CCG Safeguarding Team host a range of health groups focusing on safeguarding children at operational and strategic levels. The key purpose of these meetings is to disseminate LSCB messages, challenge Health response to LSCB priorities, and consider wider national safeguarding priorities.

13.4 The Board has identified the need to be more rigorous in respect of monitoring the attendance of individual agencies and their contributions. Formal arrangements to monitor attendance, at the main Board and subgroups, are being developed, so that there is more formal evidence to present to challenge partners on non-attendance.

13.5 The well established Westminster 'Prevention of Harm' partnership group is led by Westminster's Director of Family Services and has a strong business plan. It has taken a lead role in developing Tri-borough initiatives including early help, parental substance misuse, sexual exploitation, and work in the area of faith and culture The Kensington and Chelsea and Hammersmith & Fulham partnership groups are well represented multi-agency groups that discuss and disseminate key LSCB documents. It is expected that the Partnership groups will share best practice and review their terms of reference to ensure that they are more challenging and focused on the priorities of the main LSCB.

13.6 To ensure the robustness of governance arrangements a protocol of joint working has been drafted between the LSCB and key partners and partnerships. This document, and steps to secure these arrangements, needs to be agreed by the Board at the earliest opportunity in 2014/15. Opportunities for senior officers outside of the three local authorities, to challenge the LSCB and Chair, at other agencies' board meetings have not been fully utilised. However, recent work to engage Health and Wellbeing Boards gives an impetus to mutual challenge and will need to be followed up by HWBBs as well as the LSCB.

Strengthen links to Youth Offending Service and issues for children in the secure estate

13.7 The LSCB Independent Chair, the Youth Offending Service (YOS) Manager, and one of the Directors for Family Services met with the Governor, and several of their team, at Feltham (Young Offenders Institute). The LSCB Chair had requested this meeting to be organised by the Chair of Hounslow LSCB, specifically because of the fact that the Tri-borough LSCB covers an area that has the highest number of young people in Feltham of any other LSCB. The outcome has been not only an improvement in engagement about young offenders from the YOI but better planning for transfer and release. The YOS was concerned about gang-related activity by young offenders in the YOI and has now delivered training programmes for staff at the YOI about 'handling' this with our young offenders.

Responding to Housing Reform

13.8 Safeguarding vulnerable children and families has had a strong focus across the wide range of housing services provided across the tri-borough. This includes all boroughs having robust protocols in place to work with Children's Services for the most vulnerable households in housing need, providing young people leaving care with a wide range of housing and support options, using bed and breakfast accommodation now only as a last resort, providing a co-ordinated service providing housing advice and employment services to those households affected by welfare reform, ensuring all front-line staff are trained in safeguarding practice and prioritising overcrowded households for moves into larger accommodation.

Spotlight on housing.....

There is an acute shortage of accommodation across the three boroughs which is affordable to households on low or modest incomes. House prices and private sector rents have risen dramatically over the last few years and the three authorities are the most expensive places in the country to live. This has intensified the pressure on the limited affordable accommodation available and on the three housing services. To this has been added the impact of the Government's welfare reform programme;

- Local Housing Allowance and caps on Housing Benefit payments which have restricted the benefit available to private sector tenants, with the effect that many of these tenancies have become unsustainable;
- The Introduction of the Overall Benefit Cap of £500pw for families and couples and £350pw for single people, with the difference between these amounts and previous entitlement being made up effectively by reductions in Housing Benefit;
- Removal of the Spare Bedroom Subsidy for social housing tenants, which for those deemed to be under-occupying their home has led to a reduction of 14 % (1 spare room) or 25% (2 spare rooms) in their Housing Benefit;
- The imminent introduction of Universal Credit (a limited rollout has already started in LBHF) which will replace a number of different benefits and credits with one single monthly payment and will eventually affect tens of thousands of households in the three boroughs.

In Housing terms, the combined impact over the last few years of the housing market position and the welfare reform programme has been:

- The loss of private sector tenancies by households on low incomes;
- Increased pressure on the homelessness services of the three authorities;
- Increased difficulty in securing good quality temporary accommodation in-borough and the need to procure it primarily in other parts of London;
- Increased difficulty in avoiding the use of Bed and Breakfast accommodation for homeless families;
- Greater demands from social tenants to downsize and to move overcrowded families into more suitable accommodation.

13.9 Provisions for safeguarding vulnerable children and families across the wide range of housing services provided within the three boroughs have been sustained against a background of challenging changes in the local housing environment. In response to these pressures the three Housing services in 2013/14 have:

- Dramatically reduced or (in two cases) eliminated the use of B&B for families;
- Reached a position in which there are no families in B&B which have been there for over 6 weeks;
- Adopted systems of suitability assessments in which before placements of families are made into either temporary or permanent accommodation there is a full assessment of the suitability of the offer in terms of its quality, type, size, location and cost, taking into account the needs of the family, including children; Adopted

protocols which involve Childrens and Adults services in decisions about individual households affected by welfare reform;

- Implemented moves for under-occupying and overcrowded households;
- Sustained programmes for the provision of supported accommodation for people with particular housing requirements, e.g. children leaving care, people with mental health issues or people with a physical or learning disability.

Establish and respond to changes in the local safeguarding arrangements for Probation and Police

13.10 The Probation Service has provided a number of updates to the Board during 2013/14 concerning the split of the service into two separate organizations. From 1 June 2014 the National Probation Service (NPS) will manage all court work, any high risk offenders and those subject to MAPPA. The Community Rehabilitation Company (CRC) will manage medium and low risk offenders. Currently both organisations are in public ownership but the Government plans to sell the CRC to the private sector and the tendering and bidding process is underway. This sell off is likely to occur at the end of 2014 with an effective start date of April 2015.

13.11 Both new organisations are currently working to the policies of the former Probation Trust but in time both will need to develop their own. This split will present challenges for safeguarding and child protection as the LSCB and three local authorities will have to develop liaison arrangements with both organisations. Both organisations will be managing cases where work with children is necessary. Indeed it is expected that many domestic violence perpetrators will be managed within the CRC.

13.12 Locally, within the Tri-Borough, it is expected that all Probation staff responsible for case management of offenders will partake in the training programmes offered through the LSCB. This expectation is written into the appraisal planning cycle. These arrangements will need to be developed with both new organisations (CRC and NPS).

13.13 The Health Service has also undergone a year of establishing itself, following significant changes in its structure. The key lesson for CCGs has been to develop leadership across the health economy in an increasingly complex commissioning environment. This is a recognised challenge for the CCGs in ensuring that appropriate links and influences are maintained in order to continue to develop the golden thread of safeguarding throughout the whole health system. This should be reviewed by the LSCB in 2014/15.

Promote improved safeguarding practice in schools

13.14 The Tri-borough Safeguarding in Schools and Education Officer has taken a lead role in promoting improved safeguarding practice in schools.

13.15 A number of maintained and independent schools have conducted audits of their safeguarding practice during 2013/14. Maintained Schools are participating in self-audits

(Section 175) regarding the effective delivery of their safeguarding responsibilities. This provides the opportunity to share good practice across schools and to pick on any emerging themes or gaps to inform future training. The audit programme also includes Independent Schools (section 157). The outcomes are being reported back to the LSCB via the Q&A Subgroup. To promote the use of the audit tool, and to improve the number of schools engaging in this agenda, the Safeguarding in Schools and Education Officer will be focusing on a different phase of schools each school term during 2014/15. All schools will be asked to complete the audit tool which will then be followed up with learning events to share best practice, identify gaps or where further support is needed, and to share current guidance and information on priority areas for the LSCB, such as FGM, CSE, e-safety and work around faith and culture.

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

13.17 The Team Around the School approach has also afforded the opportunity to consider more complex issues across a particular school population regarding risk factors associated with eating disorders, social networking, cyberbullying and suicidal ideation through an enhanced Team Around the School approach by extending the agency representation to include CAMHs and streamlining referral pathways.

13.18 Representatives from MASH have contributed to single agency training for Child Protection training for schools. Schools have very much valued this input and have reported a much clearer idea of the role of MASH which has in turn strengthened schools' engagement and communication with the MASH.

14. Conclusion and future priorities

14.1 This information submitted and presented in this annual review demonstrates that the LSCB for Hammersmith & Fulham, Kensington and Chelsea, and Westminster fulfils its statutory responsibilities in accordance with Children Act 2004 and the Local Safeguarding Children Board Regulations 2006. This Review is evidence that the LSCB has coordinated the work of agencies, represented on the Board, for the purposes of safeguarding and promoting the welfare of children in the area. The review also captures the mechanisms the LSCB has in place to ensure and monitor the effectiveness of what is done by agencies to safeguard and promote the welfare of children across the three boroughs.

14.2 The role and scope of the Tri-borough LSCB is considerable. Key achievements from 2013/14 include:

- ✓ The publication of the Threshold Guidance and a Local Assessment Protocol.
- ✓ The roll out of MASH across all three boroughs.
- ✓ Development of CSE strategy and MASE panel.
- ✓ The work to strengthen agencies response to missing children and child sexual exploitation.
- ✓ Strengthening of local safeguarding networks through the three local Partnership groups.
- ✓ Establishment of Section 11 panel which has promoted improved standards of safeguarding within partner agencies.
- ✓ Development of training program that includes E learning and new specialist courses.
- ✓ LSCB Newsletter promoted across all agencies.
- ✓ The strengthening of relationships with the community, faith and voluntary sector.
- ✓ Young people contributing more significantly to the safeguarding work of the Borough.
- ✓ Publication of SCR in January 2013 with associated learning events.

14.3 Areas for development, or where progress is not as good as the LSCB would want it to be, are highlighted throughout the document. Below is a summary of these development points and other observations captured while compiling this report.

Governance arrangements:

- Safeguarding is a priority for statutory members of the LSCB; this is evidenced by the strong commitment and contribution to subgroups and short-life working groups. Actions for improvement have been identified where individual agencies have not fully engaged in the past.
- There is evidence that partners hold each other to account for their contribution to the safety and protection of children and young people but there is no formal way in

which this is collated. The Chair prioritised this for action during 2013/14 and further initiatives during 2014/15 will see challenge better promoted and evidenced.

- The Tri-borough Board and subgroup structure enables partners to assess whether they are fulfilling their statutory duties to help, protect and care for children and young people. The Board wants to capitalise on joint working with the three Health and Wellbeing Boards, and this should be strengthened during 2014/15 following the agreement of a joint working protocol. Relationships with other partnerships also need to be articulated.
- The LSCB Business Plan should be made more 'SMART' in future. In particular the business plan should identify what impact it intends to have on improving outcomes for children and young people. Consideration should also be given to streamlining the number of actions to make the Board more focused. This needs to be balanced with ensuring the LSCB does not overlook key areas of importance for children and young people's well-being.
- The LSCB should consider commissioning a Joint Strategic Needs Analysis (JSNA) of local safeguarding needs - that is owned and shared by partners - to strengthen the LSCB's priority setting process.
- There should be a concerted effort by all standing and short-life subgroups of the board to evidence the impact the LSCB is having on outcomes for children and young people. This could be supported by a review of how groups report to the Board and how the subgroups manage and evidence their work.
- It would be useful for the chairs of the three local partnerships groups to review the strengths and weaknesses of their groups and share learning and best practice

Quality and Effectiveness:

- The Quality Assurance Framework is now established which is starting to evidence 'how much, how good, and what difference'; however the 'what difference' aspect of this needs further development so that the LSCB is able to evidence with some confidence the impact it is having on outcomes for children and young people.
- The case audits undertaken by the Quality and Assurance Subgroup demonstrate that the LSCB is able to understand the quality of practice and areas for improvement.
- The LSCB should develop its performance monitoring to focus more on outcomes and the impact of services on outcomes. Adopting a more 'thematic' approach may help strengthen this focus on outcomes.
- There are continuing challenges to data collection and performance monitoring from some partner agencies, this should be escalated to the Board for discussion and action.
- The 2014/15 audits on sexual exploitation and neglect are likely to inform future LSCB priorities.
- Section 11 reporting could be made more prominent at the Board.

Learning and development:

- The LSCB has a comprehensive framework of learning opportunities for staff working with children in the three boroughs as evidenced through the training programme and learning from case review and audits. The LSCB training offer is regularly reviewed and demonstrates that it is quick to respond to local demands

- The evaluation of training is mainly focused on the take-up and quality of training; the Learning and Development Subgroup should develop mechanisms to evaluate its effectiveness and impact on improving front-line practice and the experiences of children, young people and families as soon as possible.
- The LSCB needs to assure itself that key messages and lessons from case review and audits are reaching frontline staff across all agencies.

Communication and dissemination:

- The development of the standalone LSCB website should help to ensure that the LSCB has a strong identity and that it is able to effectively communicate the local 'safeguarding story'.
- The LSCB needs to assure itself that key messages and lessons from case review and audits are reaching frontline staff across all agencies.

LSCB Priorities:

- Neglect is a cross-cutting theme that needs to be highlighted across all the other priorities.
- Child sexual exploitation, gangs, missing young people, suicide risk are linked further high priorities
- Responding to national issues at a local level, such as female genital mutilation, will also be high on the LSCB's priorities.

Early help

- The LSCB ensures that high quality policy and procedures and in place, as evidenced by the publication of the Threshold Guidance and a Local Assessment Protocol. The LSCB should assure itself that policies and procedures are regularly monitored and evaluated for their effectiveness and impact, possibly through a rolling audit programme.
- There should be further consideration given to how the Board will monitor and challenge the effectiveness of early help services, including MASH, in the future.
- The work around faith and culture is a significant; further work by the LSCB is required to ensure that this is fully embedded and its effectiveness evaluated. Further resources may need to be identified to support this work long-term into the future.
- Female Genital Mutilation is an area that has been consistently raised by partners as a priority for further action. The work of the standing (implementation) group, set up in March 2014, should be included in the business plan for 2014/15, and challenged by the Board.
- Shared priorities for action between the LSCB and Adult Safeguarding Board should be identified – this may be a good forum to take forward priorities around domestic violence, parental mental health and parental substance misuse.

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

- The impact of the LSCB in this area is not as clear as other priority areas of the Business Plan. Further consideration should be given to the added value the LSCB can bring to improving the impact of services on outcomes for children and young people and how it should hold agencies to account in this priority area.

- An audit of cases regarding practice in relation to neglect is planned for 2014/15. Recommendations for the LSCB should be incorporated into the Business Plan in this section.

Compare and contrast

- The close relationship between partners ensures that the LSCB understands the nature and extent of local issues for children and young people. Significant developments have taken place over the past year to progress work on missing children and sexual child exploitation and further work is planned on FGM.
- In order to avoid any drift in any of the working groups (in regards to scope and timescales) stronger project management support needs to be put in place, with more clearly defined timescales, purpose and specified outcomes of work. The LSCB will need to ensure that it has the appropriate resources to support this activity.
- Probation and the CRC should take steps to ensure that children involved with adults in the Criminal Justice System are identified in recording systems.

Changing landscape

- The LSCB and Chair has demonstrated challenge to agencies – such as Health, Police and Probation – in regards to the effectiveness of safeguarding during structural change. The LSCB should ensure that it continues to challenge the Local Authority following structural change.

Appendix A

Members of the Tri-borough Local Safeguarding Children Board (2013/14)

Name	Position	Organisation
Jean Daintith	Independent Chair	n/a
Andrew Christie	Executive Director of Children's Services	Tri-borough Children's Services
Liz Bruce (deputy for Board was Gill Vickers)	Executive Director of Adults' Services (DASS) Director for Operational Adults' Services	Tri-borough Adults Services
Cllr Heather Acton	Deputy Cabinet Member for Children & Young People	Westminster City Council
Cllr Helen Binmore	Cabinet Member for Children and Education	Hammersmith and Fulham Council
Cllr Elizabeth Campbell	Cabinet Member for Family and Children's Services	Royal Borough Kensington and Chelsea
Clare Chamberlain	Director of Family Services	Royal Borough of Kensington and Chelsea
Steve Miley	Director of Family Services	Hammersmith & Fulham
James Thomas	Director of Family Services	Westminster City Council
Debbie Raymond	Head of Safeguarding, Review and Quality Assurance Service	Tri-borough Children's Services
Tim Deacon	LSCB Business Manager	Tri-borough Children's Services
Will Jones	Assistant Chief Officer	London Probation Trust
Paul Monk	Chief Inspector	Metropolitan Police (CAIT)
Lucy D'Orsi	Chief Superintendent	Metropolitan Police (LBHF)
Peter Harwood	Head Teacher of Special school	Woodlane School
Sally Whyte	Secondary Head Teacher	Lady Margaret School
Wayne Leeming	Primary Head Teacher	Melcombe School
Ian Heggs	Director for Schools Commissioning	Tri-Borough Children's Services
Greg Roberts	Housing Services	Westminster City Council
Adam Taylor	Community Safety Partnerships	Westminster City Council
Liz Royle	Head of Safeguarding	Central London Community Health Care, Chair of L&D Group
Dr Louise Ashley	Director of Nursing, Quality and Assurance,	Central London Community Health Care
Eva Hrobonova	Deputy Director for Public Health	Tri-borough Councils
Nicky Brownjohn	Associate Director for Safeguarding	Central London ,West London, Hammersmith and Fulham, Hounslow and Ealing Clinical Commissioning Groups (CWHHE)
Senga Steele	Deputy Director of Nursing	Imperial Healthcare NHS Trust
Zafer Yilkan		CAFCASS

Andrea Goddard/Paul Hargreaves	Designated Doctor for Safeguarding	Central London, West London, Hammersmith and Fulham CCGs Medical Adviser to LSCB
Patricia Grant / Sarah Hamilton/ Sian Thomas	Designated Nurse for Safeguarding	Central London, West London, Hammersmith and Fulham CCGs Health Adviser to LSCB
Libby McManus (deputy for Board is Vanessa Sloane)	Director of Nursing and Quality.	Chelsea and Westminster Hospital
Jonathan Webster	Director of Quality, Patient Safety and Nursing	CWHHE CCG Collaborative representative for Central London/ West London/ Hammersmith and Fulham CCGs
Catherine Knights	Associate Director of Operations	Central North-West London Mental Health Trust
Johan Redelinghuys	Director of Safeguarding	West London Mental Health Trust
Denise Chaffer (previously Janet Shepherd)	Director of Nursing	NW London Area Team NHS England
Steve Lennox	Director of Quality and Health Promotion	London Ambulance Service
Sally Jackson	Voluntary sector representative	Standing Together
Elizabeth Virgo, Tola Dehinde, Poppy Scott-Plummer, Andrea Andriou	Lay Members	n/a
Mark Emmett	Head of Safer Prisons, Equalities and Diversity.	Wormwood Scrubs Prison

Appendix B

Tri-borough LSCB Statement as at 31st March 2014 for 2013/14 Financial Year

	LBHF	RBKC	WCC	Total
Reserves 13/14	(72,000)	(67,370)	(167,635)	(307,005)
Reserves available 13/14	**(29,050)**	**(110,320)**	**(167,635)**	**(307,005)**
Total Partner Contributions	**(88,950)**	**(82,290)**	**(85,250)**	**(256,490)**
LSCB Expenditure in 2013/14				
Salary expenditure	86,156	82,721	83,355	252,232
Training	14,236	4,290	5,652	24,178
Case Reviews	10,151	0	25,125	35,275
Multiagency Auditing	5,781	5,781	5,781	17,343
Other Expenditure	3,955	0	0	3,955
Total expenditure	**120,279**	**92,792**	**119,913**	**332,983**
1314 Outturn Variance	**31,329**	**11,422**	**7,840**	**50,590**
Reserves Closing balance	(29,050)	(111,240)	(140,812)	(281,102)

The considerable reserves (totalling £307k) was carried forward from 2012/13 from the three previous Boards, with a previous agreement for these fund to be used to resource case reviews, and where sufficient funds exist in the respective reserves, on cross-borough LSCB projects. In 2013/14, the Board decided to fund the Community Development Worker post, resource multi-agency LSCB audits and to fund a number of case reviews.

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City of Westminster

Westminster Health & Wellbeing Board

Date:	**20th November 2014**
Classification:	**Public**
Title:	**Primary Care Commissioning**
Report of:	**Health and Wellbeing Board Chairman**
Wards Involved:	**All**
Policy Context:	**Health**
Financial Summary:	**TBC**
Report Author and Contact Details:	**Holly Manktelow, Senior Policy & Strategy Officer** **Tel: 02076412757** **email: hmanktelow@westminster.gov.uk**

1. Executive Summary

1.1 Following a discussion between the Chairman of the Health and Wellbeing Board and the Chair of Central London Clinical Commissioning Group (CCG), it was agreed that the Westminster Health and Wellbeing Board should discuss the possibility of undertaking a piece of work on the commissioning of primary care.

2. Key Matters for the Board's Consideration

2.1 The Health and Wellbeing Board are asked to provide a view on whether they believe a task and finish group on the commissioning of primary care would be useful at this stage and if so:

a) What are the key questions that the task and finish group could consider;

b) What are the key deliverables that the Health and Wellbeing Board would wish to achieve from the task and finish group's work;

c) How we could protect against any conflicts of interest arising from the fact that general practitioners are key members of the Health and Wellbeing Board;

d) Should we look to commission external expertise to lead on this work on behalf of the Health and Wellbeing Board; and if so

e) Should this be co-funded by the local authority and Clinical Commissioning Group members of the Health and Wellbeing Board.

2.2 Alternatively, the Health and Wellbeing Board are asked to consider whether existing work being undertaken by all 8 North West London CCGs, through the Strategy and Transformation team around primary care transformation, could cover this remit and if so, how this work can be shaped by, and report into the Health and Wellbeing Board.

3. Background

3.1 In September 2014, the Westminster Health and Wellbeing Board received a report from NHS England on primary care commissioning. During this discussion, the Health and Wellbeing Board became aware of the following issues and concerns in relation to primary care commissioning in Westminster:

- Several practices within Westminster have given notice to terminate their contracts in the last year and the cohort of individual GPs within Westminster is ageing. NHS England do not have any additional funding for new practices in Westminster;

- The availability of premises is a key issue in Westminster and will increasingly become a problem as GP's chose to retire, maintaining their property (i.e. the surgery) for their retirement;

- The commissioning framework for primary care is fragmented. NHS England currently holds the funding for the core GP contracts, while remaining services are funded by Clinical Commissioning Groups. Local authorities also commission services from GPs on an ad hoc basis.

- Only limited data is collected by NHS England relating to individual GPs and their practices which can make it difficult to understand the current provision within Westminster and prepare for issues which may arise in the future.

3.2 Alongside these issues and concerns identified by the Health and Wellbeing Board, the Board noted several opportunities which are developing locally which may make improvements to primary care in Westminster. These are:

- The introduction of co-commissioning of primary care services between NHS England and Clinical Commissioning Groups

- The introduction of GP networks as part of the whole systems integration programme, which will improve the way that patients can access primary care services;

- The work underway locally to deliver improvements to primary care through the Prime Minister's Challenge Fund such as the introduction of seven day GP networks

3.3 A limited window of opportunity to undertake further work to improve primary care in Westminster may arise through the recent report of the London Health

Commission. This report makes a number of recommendations for the Mayor of London and other agencies on improving health and wellbeing in London, including some specific recommendations relating to GPs. These include:

- The promotion of GPs working in networks (which is already being developed for the Westminster area) and allowing patients to move freely within these networks;

- Putting in place arrangements, through the move to co-commissioning, to allow existing and new providers to set up new GP services in areas of persistent poor provision;

- Urging NHS England to introduce a five year £1 billion investment programme to improve GP premises in London and to reform the rent reimbursement system for GP premises;

- For NHS England to rebalance expenditure across the system, moving money from specialised services and investing in primary and community care;

- For health commissioners to increase the proportion of total London NHS spending dedicated to GPs, primary and community services and facilities; and

- Improvements in digital technologies.

3.4 The Chairman of the Health and Wellbeing Board and the Chair of Central London Clinical Commissioning Group believe that, due to the circumstances above, there could be a good opportunity for partners from across the system to work together on improving and ensuring the sustainability of primary care in Westminster.

3.5 The Health and Wellbeing Board are asked to provide a view on whether they believe a task and finish group on the commissioning of primary care would be useful at this stage and if so:

a) what are the key questions that the task and finish group could consider;

b) what are the key deliverables that the Health and Wellbeing Board would wish to achieve from the task and finish group's work;

c) how we could protect against any conflicts of interest arising from the fact that general practitioners are key members of the Health and Wellbeing Board;

d) should we look to commission external expertise to lead on this work on behalf of the Health and Wellbeing Board; and if so

e) should this be co-funded by the local authority and Clinical Commissioning Group members of the Health and Wellbeing Board.

3.6 If the Health and Wellbeing Board wish to move forward with this proposal, then they may wish to consider doing so in partnership with the Hammersmith and Fulham Health and Wellbeing Board and the Kensington and Chelsea Health and Wellbeing Board, or potentially extending the invitation to other Health and Wellbeing Boards working within the geographical boundaries of the North West London CCG collaborative.

4. Legal Implications

4.1 Not applicable at this stage

5. Financial Implications

5.1 Due to the specialised nature of this work and the complex nature of the issues that need to be responded to, it is recommended that the Health and Wellbeing Board consider bringing in external expertise to lead on this work. This may also help to respond to the potential conflict of interest which could arise due to the membership of local GPs on the Health and Wellbeing Boards.

5.2 However, the Health and Wellbeing Board should note that bringing in external expertise will require some resource to be invested into this work. It is proposed that if the Health and Wellbeing Board wishes to proceed with this, that this resource should be invested from both local authority and Clinical Commissioning Groups

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

Westminster Health & Wellbeing Board

Date:	**20th November 2014**
Classification:	**General Release**
Title:	**UPDATE ON THE BETTER CARE FUND**
Report of:	**Executive Director Adult Social Care**
Wards Involved:	**All**
Policy Context:	The programme of work is consistent with the stated vision and objectives of the partners within the Westminster Health & Wellbeing Board, and is a mechanism for delivering the outcomes and efficiencies required from Better City, Better Lives.
Financial Summary:	The Better Care Fund (BCF) brings together a number of existing funding sources for savings. The BCF in 2015/16 ensures that Tri-borough receives funding for the Care Act (£748k for WCC), all the investment costs of the new Community Independence Service (£856k for WCC) and should generate recurrent savings (£2.2m for WCC in 2015/16). It also protects social care by continuing to pass through the Social Care to Benefit Health funding, currently worth £4.9m in WCC.
Report Author and Contact Details:	James Cuthbert, Whole Systems Lead James.Cuthbert@lbhf.gov.uk 07792 963830

1. Summary

1.1 On 18th September Westminster Health & Wellbeing Board discussed the revised Better Care Fund (BCF) Plan which was due to be submitted the following day. The revised text was not available at the meeting but the paper presented explained the areas of change and a verbal update was provided on the negotiations being undertaken between the Local Authority and the NHS to finalise the financial arrangements of the fund. The plan was submitted late on 19th September, with the approval of the Cabinet Member, and a copy circulated to all members of the Board on 22nd September with a covering note from the Executive Director.

1.2 As indicated at the Board Meeting, the overall plan is the same as that submitted in April but over the summer there was a change of emphasis in relation to the national funding flows. The purpose of this was to mitigate the potential risk to hospitals of slow delivery of the proposals for out of hospital care, but it did create an increased risk to social care. This has been addressed locally through constructive negotiations between the CCGs and the local authorities ensuring that council leaders are satisfied that actual and potential social care costs arising from the BCF are adequately protected.

1.3 Following submission there was a period of three weeks during which NHS England reviewed the submissions and brought queries and clarifications to the partners in order to provide assurance that the BCF Plan proposed was robust and achievable. Following this exhaustive process the Tri-borough Better Care Fund Plans were given assurance without conditions and given the go ahead to proceed with implementation.

1.4 The Better Care Fund Steering Group has been meeting to drive forward the four workstreams and in particular progress has been made with the development of the Community Independence Service which forms a key component of the development of integrated health and social care in the borough. A specification has been agreed and providers have been invited to submit proposals to lead the CIS programme.

1.5 Work has also been progressing on the commissioning of additional neuro-rehabilitation beds, implementation of a 7 day social care service to facilitate discharges and prevent unnecessary admissions and developing an integrated placement team.

1.6 The three Cabinet Members and CCG Chairs have agreed to the establishment of a BCF Board to oversee implementation and this will ensure regular reporting to the Health and Wellbeing Boards on progress.

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

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APPENDICES:

BACKGROUND PAPERS:

City of Westminster

Westminster Health & Wellbeing Board

Date:	**Thursday 20 November 2014**
Classifiation:	**General Release**
Title:	**NHS CENTRAL LONDON CCG CONTRACTING INTENTIONS 2015/16**
Report of:	**Central London CCG**
Wards Involved:	**Westminster**
Policy Context:	**-**
Financial Summary:	**-**
Report Author and Contact Details:	Daniela Valdés, Head of Planning & Governance, Central London CCG. daniela.valdes@nhs.net

1. Executive Summary

1.1 In Central London CCG, we believe high quality care provided in the most clinically appropriate settings is the only way to create a sustainable health system; this will give our patients, residents and visitors the best chance of being empowered to longer, better, healthier lives. We have done a lot of good work in recent years, but are aware that in order to continue providing the best service to patients in Westminster, we need to do much, much more.

1.2 Fundamental to this work is the developing of a health and care system that:

- **Is grounded in excellent out of hospital services** – 80%-90% of health contact occur in general practice and community services so making sure these services are high quality is paramount.
- **Delivers care closer to people's homes** – where appropriate we would like to bring services traditionally provided in hospitals into the primary care system.
- **Is integrated where appropriate** – we will always join up care where there is clear benefit to doing so.

- **Is based on robust clinical evidence** – we will make the best use of evidence where this is available; we will innovate, evaluate and share knowledge where we believe there is potential to go further.

- **Allows our hospitals to see the right people at the right time** – we have high quality hospital services and we need to make sure that the services are reserved for those with genuine need rather than through a lack of alternatives.

- **Is underpinned by integrated IT systems** – by the end of this year, all of our General Practices will be using SystmOne as their IT platform and many of our providers will have access to key information; this will allow more joined up clinical management and minimise duplication.

- **Involves our patients and service users at every stage of development** – we have a strong track record on engagement with all partners and stakeholders, but particularly with our patients and residents which we will put our energy and passion into growing further.

2. Key Matters for the Board's Consideration

2.1 (This paper is for noting). NHS CLCCG will continue to work with the Council in areas such as Childhood Obesity, which were included in the contracting intentions document.

3. Background

3.1 Following the presentation of the Draft contracting intentions in the previous Health and Wellbeing Board, NHS CLCCG finalised and issued the document together with contract notices for healthcare providers.

3.2 The purpose of this document is to set out for providers the priority contracting intentions for Central London Clinical Commissioning Group for 2015/16, which will inform contract negotiations. Note the document should be read in the context of the CCG's wider commissioning plans and with reference to the strategic context.

3.3 A further document aimed at the general public (the commissioning intentions) will be published in December.

4. Legal Implications

4.1 The document was issued in accordance to the contracting requirements with our providers.

5. Financial Implications

5.1 None for the Council.

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

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APPENDICES: **Central London CCG Contracting Intentions 2015/16**

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NHS
Central London
Clinical Commissioning Group

Central London CCG

Contracting intentions 2015/16

V. 12.0

Version	Date	Owner
1.0	3/09/14	MJ
2.0-4.0	22/9/14	DV
5.0	24/09/14	DV
6.0	25/09/14	KC
7.0	25/09/14	DV
8.0	26/09/14	CP
9.0-12.0	23/10/14	DV

Contents

Introduction

The purpose of this document is to set out for providers the priority contracting intentions for Central London Clinical Commissioning Group for 2015/16, which will inform contract negotiations. This document should be read in the context of the CCG's wider commissioning plans and with reference to the strategic context set out in the next section.

A further document aimed at the general public (the commissioning intentions) will be published in December.

This document is structured in 8 sections.

- Section 1, provides the strategic context of these plans;
- Section 2, outlines the CCG's approach to the contracting round;
- Section 3, summarises the strategic priorities for 2015/16, across particular areas of delivery;
- Section 4, identifies key quality and outcome improvements;
- Section 5, sets out high-level procurement plans;
- Section 6, focuses on local pathway priorities;
- Section 7, summarises the above intentions; and,
- Section 8, outlines equality impacts of the above plans.

For added transparency, Appendix 1 includes a glossary of most common acronyms used in this document.

1. Strategic context

The eight CCGs in North West London, with our local authorities and other partners, are in the process of implementing wide scale changes to the way in which patients experience and access health and social care. These plans are ambitious and transformational, and the vision is set out below.

We want to improve the quality of care for individuals, carers, and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their community.

This vision is supported by 3 principles:

1. *People and their families will be empowered to direct their care and support and to receive the care they need in their homes or local community*

2. *General Practitioners ('GPs') will be at the centre of organising and coordinating people's care*

3. *Our systems will enable and not hinder the provision of integrated care.*

We started the implementation of this vision in 2013/14, and have been putting many of the fundamental building blocks in place during 2014/15. Some of the key enablers have been:

- Primary Care Navigators, Community Independence Service and care planning through Wellwatch;
- 7 day working in primary care and social care;
- Development of GP federations, which has commenced in 2014/15;
- Development of Out of Hospital contracts, which will be commissioned at network/locality level later in 2014/15, replacing practice level local enhanced services and ensuring wider population coverage;
- Closure of Hammersmith Hospital Emergency Department and Central Middlesex A&E unit;
- Implementation of a single GP IT system, SystmOne, across the majority practices in Central London, with all practices due to migrate by December 2014;
- Establishment of whole system integrated care early adopters, with business cases for implementation from April 2015 being developed; and,
- Contracts with all key NHS providers that incentivise the transformation of services and the movement of services out of hospital.

We intend to build on this further during 2015/16.

2. Approach to the contracting round

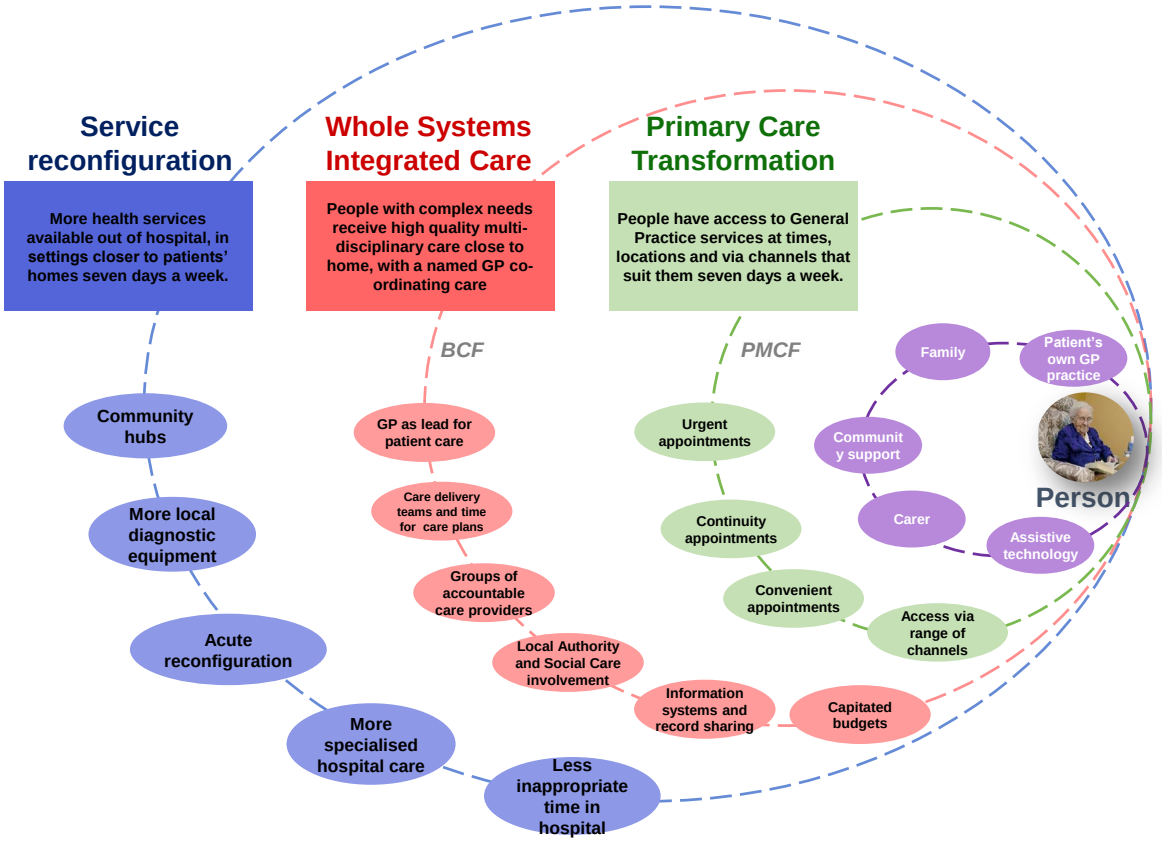
Our approach to the contracting round will build on the approach taken in 2014/15. We will be working closely with the other CCGs in the collaborative (or 'CWHHE', the working partnership between Central London, West London, Hammersmith and Fulham, Hounslow and Ealing Clinical Commissioning Groups), and also with our colleagues in Brent, Harrow and Hillingdon, to maintain strategic alignment. Our primary objective is the delivery of our strategic vision, and we expect to negotiate contracts that will support us in the delivery of that vision, with a focus on transformational change and service integration. We will expect our providers to demonstrate how they are transforming their services to meet that challenge and how they are moving towards the Shaping a Healthier Future ('SaHF') service standards. We will seek to ensure that the incentives and penalties within contracts are aligned to ensure the delivery of the required transformation. All CCGs in NWL have whole systems integrated care early adopters who are developing models of care, and we expect to commission these during 2015/16, either in shadow or live form. We expect to reflect this within our 2015/16 contracts with the relevant providers.

Patient empowerment, and putting the patient at the heart of all we do, is fundamental to our vision. Generally providers are not doing this at present. We will seek to embed a requirement for much greater patient focus within our contracts for 2015/16.

We intend to start our contract negotiations earlier for 2015/16, with the aim of agreeing the baseline activity and many of the schedules before Christmas, subject to any changes that may be required as a result of the publication of planning guidance and 2015/16 tariffs in late December. This will give us the opportunity for better quality discussions and earlier certainty regarding 2015/16, enabling better planning and therefore a greater chance of delivery of the agreed changes. We expect all contracts to be signed by 31 March 2015.

3. Strategic Priorities for 2015/16

Our vision is underpinned by the 4 key work streams of i) Service reconfiguration under *Shaping a Healthier Future*; ii) Whole Systems Integrated Care; iii) Primary Care Transformation and iv) Patient Empowerment. This is shown in the diagram below.



We are currently developing the 5 year roadmap that sets out all the key milestones over the next 3-5 years to ensure that the vision is realised. The following section sets out the delivery priorities and milestones for 2015/16 against each of these key programmes.

3.1. Service Reconfiguration

Shaping a Healthier Future, the acute reconfiguration programme in NW London will centralise the majority of emergency and specialist services (including A&E, Maternity, Paediatrics, Emergency and Non-elective care) to deliver improved clinical outcomes and safer services for our patients. Agreed acute reconfiguration changes will result in a new hospital landscape for NW London. The SaHF Reconfiguration programme will oversee:

- The existing hospital landscape of nine hospitals reconfigured to provide five Major Acute Hospitals;

- Ealing and Charing Cross sites redeveloped, in partnership with patients and stakeholders, into Local hospitals;

- Hammersmith Hospital established as a specialist hospital; and

- Central Middlesex Hospital will be redeveloped as a Local and Elective Hospital.

Clinical standards

The programme supports the achievement of enhanced clinical standards. As part of the original development of NW London's vision, NW London's clinicians developed a set of clinical standards for Maternity, Paediatrics, and Urgent and Emergency Care, in order to drive improvements in clinical quality and reduce variation across NW London's acute trusts.

These clinical standards, along with the London Quality Standards and the national Seven Day Services Standards, will underpin quality within the future configuration of acute services, including along the urgent and emergency care pathway. North West London is committed to delivering seven day services across the non-elective pathway by March 2017, based on the national clinical standards, in order to improve the quality and safety of services and to support emergency care flow.

The acute reconfiguration is dependent on significant take-up of existing and new out of hospital services being delivered locally by all CCGs to ensure that patients only go to hospital when they need to.

As part of a common commitment across NW London, CCGs will commission services from Acute Trusts that meet the agreed clinical standards, including those defined by the Shaping a Healthier Future programme, London Quality Standards, and national Seven Day services standards. In 2014/15 the baseline of delivery against the Seven Day standards has been established, and a NWL prioritisation has been agreed to guide the sequencing of Seven Day standard achievement through until March 2017.

As of April 2015, all Acute Trusts will meet the following seven-day standards:

- Time to first consultant review: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.

- On-going review: All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate.

- Diagnostics: Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be

available seven days a week: within 1 hour for critical patients; within 12 hours for urgent patients; within 24 hours for non-urgent patients

In addition, Acute Trusts will be expected to produce quarterly patient experience reports that compare feedback from weekday and weekend services.

Over the course of 2015/16, Acute Trusts will work towards achieving the following seven-day standards:

- Multi-disciplinary Team review: All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.

- Shift handover: Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.

All providers across primary, community and social care will work towards seven-day discharge pathways – e.g. that support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

2014/15 service changes

Following the 'full' support of the Secretary of State in October 2013 and after the review of the Independent Reconfiguration Panel, priority service changes are being delivered in 2014/15:

- Transition of services from the Emergency Unit at Hammersmith Hospital

- Transition of services from the A&E at Central Middlesex Hospital

- All Urgent Care Centres ('UCCs') moved to a common operating specification, including a 24/7 service

The programme has also been undertaking contingency planning for the potential transition of Maternity and Paediatrics services at Ealing Hospital.

Contracts for 2015/16 will reflect the full year effect of the changes above.

OBC development

Outline Business Cases (OBCs) will be developed and centrally reviewed for all sites in 2014/15 (major and local hospitals). Additionally, the programme is also developing an Implementation Business Case (ImBC) to ensure that the refined solution for NW London remains affordable and aligned with the clinical vision. OBCs for Major and Local Hospitals are expected to be approved by NHSE, NTDA, DH and HMT in 2015/16, and following this Full Business Cases will be developed to allow the redevelopment of sites to continue.

Out of Hospital services

Central London, West London, Hammersmith & Fulham, Hounslow and Ealing CCGs are working together to enable transformation within primary care across the CWHHE collaborative. Each CCG has an Out of Hospital ('OOH') strategy that describes keeping the patient at the centre of their own care, with the GP as a key provider and coordinator of services. In addition, key strategic priorities for the CCGs are to improve quality, reduce variation within primary care and ensure all patients within the CCG have equity of access to commissioned services. The CWHHE collaborative has therefore agreed to realign services to support the delivery of the OOH strategies, including the commissioning of a consistent range of services – an OOH portfolio - from GP networks. The portfolio comprises the following services:

Table 1 Portfolio of Out of Hospital Services

Services	
Ambulatory Blood Pressure Monitoring ('ABPM')	Diabetes (High Risk)
Access	Electrocardiogram ('ECG')
Anti-Coagulation Monitoring	Homeless
Anti-Coagulation Initiation	Near patient monitoring
Care planning	Phlebotomy
Complex common MH	Ring pessary
Complex wound care	Severe and enduring MH
Diabetes Level 1	Simple wound care
Diabetes Level 2	Spirometry Testing
Diabetes (High Risk)	Spirometry Testing

The table below describes the services to be commissioned through the Out of Hospital Services commissioning programme. The unit construction method, indicative current service impacted, and total expected activity volumes for a full year for the CCG are shown. Please note that we do not expect a full year of activity to be transferred in 2015/16 as we will be phasing roll out. We will work with providers over the next three months to define

how each provider will be impacted. Where services are predicted to meet 100% population coverage, decommissioning notices will be issued to current providers, as appropriate.

Table 2 Portfolio of Out of Hospital Services – Expected Provider impacts

Central London OOH Services	Activity Forecast: 100% coverage	Activity Type (contact or package)	Acute Point of Delivery (POD)
ABPM	4,000	Per test	Cardio OPD
Anticoagulation Monitoring	1,935	Package p.pt p.a (FA+12FU)	Clin Haem OPD
Anticoagulation Initiation	829	Package p.pt p.a (FA+8FU)	Clin Haem OPD
Case Finding, Care Planning & Case Management	3,950	Per patient	N/A
Complex Common Mental Health Management	1,792	Package p.pt p.a (FA+7FU)	N/A
Complex Wound Care	208	Per contact	Various
Diabetes (Level 1)	5,923	Package p.pt p.a (FA+2/3FU)	Diabetes OPD
Diabetes (High Risk)	3,700	Package p.pt p.a (+2appts)	Diabetes OPD
Diabetes (Level 2)	178	Package p.pt p.a (FA+2FU*)	Diabetes OPD
ECG	4,463	Per test	Cardio OPD
Homeless	1,916	Package p.pt p.a (FA+11FU)	A&E/ NEL
Near Patient Monitoring	908	p.pt p.a	Rheum OPD
Phlebotomy	64,499	Per venepuncture	
Ring Pessary	407	Per ring p.pt p.a	Gynae OPD
Simple Wound Care	2,080	Per contact	Various
Spirometry Testing	3,259	Per test	Respir OPD
Transfer of Care: Severe and Enduring Mental Illness	296	Package p.pt p.a	N/A

Source: CLCCG

Mental Health Transformation

In 2015/16, CCGs wish to see continued implementation of the Shaping Healthier Lives 2012-15 core initiatives including:

- **Urgent Care**: Roll out of the Single Point of Access ('SPA') and 24 hour, seven-day access to home-based urgent assessment and initial crisis resolution work.

- **Liaison Psychiatry**: Further benchmarking of services to drive increased standardisation of investment, activity, impact and return on investment.

- **Whole Systems/Shifting Settings**: Building upon work to date to implement Primary Care Plus, test, refine and roll out a new model of 'community staying well' services for people with long-term mental health needs. This entails providing the GP (as accountable clinician) with a range of care navigation, expert primary mental health and social integration/recovery support services to deliver care closest to home and prevent avoidable referral to secondary care.

In 2014/15, the Transformation Programme Board has sponsored development work streams in dementia, learning disability, perinatal mental health and Improving Access to Psychological Therapies ('IAPT'). CCGs will expect providers of these services to implement the key pathway, models of care and quality standards that emerge from these work programmes. The Board has also sponsored a review of Child and Adolescent Mental Health Services (CAMHS) Out of Hours Services; based on the outcomes of this review we will commission services to address current disjoints, this may involve re-commissioning collaboratively with the other NWL CCGs a new provider of service. This review is due to be complete early autumn 2014.

In June 2014, the Collaboration Board supported the need for co-ordinated, system-wide change in NWL as the best way to achieve our vision for mental health and wellbeing services, ensuring mental health has an equal priority with physical health, and that those with mental health needs get the right support at the right time. . It agreed that a programme of work should be delivered to address the strategic challenges and opportunities facing mental health and wellbeing services in NWL. Since then, engagement has been undertaken with a wide group of stakeholders to gauge their interest in the programme and their views regarding its scope and the timescales within which each stage of the programme could be achieved. Stakeholders include all NWL CCGs and Local Authorities, WLMH, CNWL, Directors of Public Health, members of the Mental Health Programme Board, Lay Partners and Imperial College Health Partners.

Overall enthusiasm and commitment has been high whilst recognising the need to ensure alignment with existing local programmes and priorities and national initiatives. In September the Collaboration Board noted progress on development of the NWL Whole System Mental Health and Wellbeing Strategic Plan and endorsed a Programme Initiation Document setting out the governance arrangements, overall timetable and the resourcing requirements to deliver this exciting and important piece of work. The programme will likely commence in November 2014, with a case for continuity and change produced six months afterwards, and

options for change six months after that. There may be a need for public consultation depending on which options are developed.

3.2. Whole Systems Integrated Care

In the summer of 2013, along with partner organisations across North West London ('NWL'), we committed to a vision to create "better coordinated care and support, empowering people to maintain independence and lead full lives as active participants in their community." The Whole Systems Integrated Care ('WSIC') programme was established to achieve this shared vision. As indicated in our commissioning intentions last year, an extensive programme of co-design ran through 2013/14, which included partners from health and social care organisations across NWL, service users and carers.

NWL is one of fourteen national integrated care 'Pioneers'. We are currently developing detailed local plans in order to begin implementation in 2015/16 and will continue our commitment to collaboration and co-production with our partners. We anticipate that our transition to full Whole Systems Integrated Care will take three to five years, at which point we will be:

- Commissioning fully integrated models of care based on the holistic needs of different population groups, encompassing both health and social care

- Jointly commissioning for each population group a set of outcomes across health and social care, with a single, combined, capitated budget to achieve them. Through capitation, we will support service users to access a personal budget for health and social care needs as agreed through the development of a personalised care plan

- Commissioning a group of providers to offer an integrated care service to the population groups. We anticipate that these providers will work together as an Accountable Care Partnership ('ACP') and be held collectively accountable for achieving the commissioned outcomes and managing the associated financial risk for the population groups.

In 2015/16, we will begin to move towards Whole Systems by implementing elements of a new model of care, employing a joint commissioning approach and continuing to work collaboratively with providers to support the development of ACPs. We expect to reflect the agreed model of care and payment arrangements in the 2015/16 contracts for the relevant providers.

All providers will continue to have the opportunity to participate in the development of WSIC through a collaborative, iterative process. Through on going co-production with both our partners and service users, we will continue to build towards a model of integrated care that best meets the needs of our residents. We expect providers currently working with population groups in our local area to respond to these intentions.

In Central London CCG, we have agreed through our Early Adopter partnership to start by focusing on over 75s and healthy, over 75s with a long term condition and under 75s with a

long term condition. Therefore, in 2015/16 the following will be within the scope of the new model of care for these groups:

- Primary care
- Social care
- Secondary care
- Community
- Mental health
- Voluntary/third sector

We will continue to work with all partners through co-production to ensure alignment between the development of WSIC and the implementation of the Better Care Fund.

Better Care Fund

The Better Care Fund (BCF) is a key enabler for Whole Systems Integrated Care, and is being taken forward across the Tri-borough through four major workstreams:

- Integrated Operational Services, including Community Independence Service Plus, 7-day working, and Homecare
- Service User Experience
- Integrated Community Contracting and Commissioning
- Programme Delivery, including IT and implementation of the Care Act 2014.

Two major schemes within the BCF that are particularly significant for Hammersmith & Fulham are described below. These schemes represent a continuation of the direction we set out in our commissioning intentions for 2014/15; they are aimed at addressing increased demand and complexity of need amongst older people as well as improving efficiency and reducing duplication, the schemes are:

a. Transforming nursing and residential care home contracting
b. The integrated crisis response/community independence service (ICR/CIS).

These services are outlined below.

a. Transforming Nursing and Residential Care home contracting. The Tri-borough CCGs and Local Authorities will develop their proposals to integrate the functions of commissioning, contracting and assuring the quality of care home placements across the three boroughs. Within Tri-borough, there is currently no consistent approach to contracting, brokerage and monitoring of placements whether funded by Adult Social Care or Health and this results in a lack of alignment with regard to contracting, safeguarding and quality assurance resources, intelligence and expertise.

   Our proposal for a single integrated commission team will eliminate gaps, duplication and disconnects across Nursing and Residential Care placements by creating a consistent, joint approach to contracting, safeguarding and escalation, and oversight of the sector, tailoring and focusing care around the individual.

In 2015/16 we will:

- Integrate the contracting and brokerage functions for Nursing and Residential Care placements across adult social care and health, creating a single team. Under this arrangement CCGs will continue to have governance for health-funded placements and the local authority will continue to have governance for adult social care placements.
- Align the teams that undertake reviews of placements and that also gathers and monitors provider data and intelligence. This will include intelligence about the quality of placements and safeguarding concerns
- Work jointly to shape the provider market, to optimise the quality and value of placements and to support its development to align with our strategic direction

Within the scope of this project is:

- Integration of the contracting and brokerage functions across Local Authority and Health placement teams, including:
  - Funded Nursing Care (FNC)
  - Non-residential Continuing Health care placements
  - Residential Continuing Health care placements
  - Adult Physical Disabilities placements
- Feasibility evaluation of increasing delegated authority thresholds for Continuing Health care placements
- Improved monitoring and pooled intelligence around service provision
- Qualification and quantification of potential financial savings associated with a joint contracting/brokerage team (supported by improved provider intelligence)

b. *The Integrated Crisis Response / Community Independence Service.* As part of the Better Care Fund, the implementation of a Tri-borough Integrated Crisis Response and CIS will commence in 2015/16 with a transition year during which a phased approach will be taken with existing providers to work to a new single model service specification.

Following consultation with providers and co-design with patients on the proposed model and investment for 2015/16, commissioners will further specify how they will implement the recommendation set out in the detailed business case (September 2014), '*that the new investment of £7.4m would be packaged up and offered out to the existing set of providers, in order to appoint two lead providers (1 in social and 1 in health) to manage the delivery of the new service*'. For health, a process will be run between existing providers in order to appoint the lead provider who would then work together with the local authority lead provider in partnership to ensure delivery of a single integrated service.

In Quarter 3 of 2014/15, commissioners will inform existing providers of the process to select a lead organisation(s) and of their requirement to work together under a

formal agreement during 2015/16. This process will be completed by 1st April 2015 and will be informed by our work with patients in preparation for the transition year. The process will be designed to secure the collaborative agreement across all providers to implement the necessary changes that deliver the outcomes specified under the new service model.

The lead provider (s) will need to demonstrate how they will ensure:

- A rapid response multidisciplinary team ('MDT') providing community care within two hours and for up to five days.
- Non-bedded community rehabilitation, treating non-complex conditions in a community setting.
- Integrated reablement with access to short term community beds between six and twelve weeks.
- Seven-day support to help people leave hospital.

3.3. Primary Care Transformation

A number of drivers have combined to create a pressing need to transform access to General Practice in NW London:

- **Patient expectations**: In a recent survey of NWL patient priorities for primary care, seven of the top ten issues related to improved access.
- **Implementation of the Shaping a Healthier Future reconfiguration programme**: The Independent Reconfiguration Panel ('IRP') report on NWL's Shaping a Healthier Future programme requires GP practices in NW London to move towards a 'seven day' model of care to support the agreed changes to acute services.
- **Contractual drivers**: With effect from April 2014, GMS contractual arrangements have been amended to reflect an increased emphasis on improved access to General Practice.
- **Financial drivers:** A consistent, system-wide access model has the potential to reduce costs for both commissioners (reduced service duplication) and providers (more efficient use of resources).
- **Legislative changes:** The approval of the Legislative Reform (Clinical Commissioning Groups) order 2014, allows CCGs to form joint committee when exercising their commissioning functions jointly; as well as enabling CCGs to exercise their commissioning functions jointly with NHS England via a joint committee.

- **Primary care strategic framework:** NHS England has released a set of descriptors covering 3 areas – Accessible Care, Co-ordinated Care and Proactive Care. On going, they will be used to support local transformation strategies

Though it may be part of the solution, expanding capacity alone will not improve access to General Practice. Any strategy for transforming access to General Practice must therefore comply with four overarching principles:

1. **System-wide reconfiguration of access to all 'General Practice'-type services:** the provision of additional urgent appointments outside of core hours is unlikely to lead to sustainable improvements to access. In order to ensure that we are able to deliver services that genuinely reflect patient needs and preferences, we need to be thinking about seven-day working across General Practice in its totality.

2. **Financially and operationally sustainable**: A new model must be affordable and deliverable. In the long-term this probably means no net increase in cost or workforce.

3. **Meets patient expectations**: A new model must deliver the type of appointments patients want, when they want them.

4. **Reconfigures both supply and demand such that both are mapped more closely to clinical need**: Though patient choice should be respected, every effort should be made to ensure that patients receive care appropriate to their clinical condition. This means mapping capacity more closely to clinical need.

NWL have resourced a Primary Care Transformation programme to take this work forward. The programme comprises 5 distinct workstreams, some of which are described below.

Prime Minister's Challenge Fund

CCGs in NW London were awarded funding through a successful application to the Prime Minister's Challenge Fund ('PCMF'). This is now a significant enabler for the delivery of NW London's vision for a transformed primary care landscape in allowing, through a combination of NWL and NHSE funding, an extension to GP access and continuity in the short term (by the end of 2014/15) as well as putting the right support in place to nurture and grow GP networks (in 2014/15 and beyond).

The Challenge Fund will focus on outcomes around Urgent and Community Care to ensure that patients have access to General Practice services at times, locations and via channels that suit them, seven days a week.

It is planned that the PMCF project will produce outcomes covering around the below principles.

Chart 1 Prime Minister's Challenge Fund principles and implementation guide

		Network responsibility	Implementation guide for 2014/15
URGENT CARE	• Patients with urgent care needs provided with a timed appointment within 4 hrs.	✓	Long term
	• Patients with non-urgent needs will be able to contact a clinician within 48hrs by phone, online or in person.	✓	Long term
	• Telephone advice and triage available 24/7 via 111.		
CONTINUITY CARE	• All individuals who would benefit from a care plan will have one.	✓	Medium term
	• Everyone who has a care plan will have a named 'care co-ordinator'.	✓	Medium term
	• GPs will work in multi-disciplinary networks.	✓	Medium term
	• Longer GP appointments for those that need them.	✓	Medium term
CONVENIENT CARE	• Access to General Practice 8am-8pm (Mon-Fri) and 6hrs/day during the weekend.	✓	Long term
	• Access to GP consultation in a time and manner convenient to the patient (via a range of channels including telephone, email and videoconference).	✓	Short term
	• Online appointment booking and e-prescriptions available at all practices.	✓	Short term
	• Patients given online access to their own records.	✓	Short term
	• Online access to self management advice, support and service signposting.		

We are doing this by supporting practices to develop strong networks and plans; so that by the end of 2014 / 2015 business cases will be available for a new model of care, and quick wins (e.g. around new applications for technology) will have been implemented. All PMCF activity is expected to align with changes in the GP contract agreement.

Primary Care Strategic Framework

NHS England has released a set of descriptors covering 3 areas – Accessible Care, Co-ordinated Care and Proactive Care. Further work is on going to refine and develop these as part of a pre-engagement phase.

The three areas are in effect a specification within a strategic commissioning framework to support local primary care transformation. This specification describes the service offer that patients could expect in the future across London, but it acknowledges implementation plans will need to be locally developed to meet the needs of different populations. In addition, it is expected that working in this way, will relieve pressure and therefore enable general practice to deliver the improvements in care, that they want.

It is now anticipated that these descriptors will be ready for wider engagement at the end of 2014. Our work is now focussed on engaging with stakeholders and understanding how the descriptors could support a new model of care.

3.4. Patient Empowerment

As part of the wider integration agenda with Adult Social Care, we have been working in partnership with patients, carers and voluntary organisations to co-design and commission a range of patient empowerment programmes. The programmes will be targeted at supporting people with long terms conditions to take more control of their health and wellbeing. The outcome of engagement has enabled us to identify and embed an approach to working with patients, service users, carers and stakeholders. Our approach is therefore:

- Collaborative: bringing together clinicians, staff, patients, service users and the community together as equal partners to develop and implement the BCF programme
- Evidence-based: engaging to co-design evidence based and locally appropriate solutions to promote integrated health and social care
- Asset-based : developing the capacity of patients, service users and the community to engage effectively in identifying needs, project planning and development, procurement, implementation and evaluation.
- Continuous and iterative: engaging to build and refine sustainable models for local delivery that reflect the needs and aspirations of local people and frontline staff

In terms of the programmes, these include the below.

Improving Experience of Integrated Care

The aim of this project is to monitor improvements in patient, customer and carer experience of integrated care by establishing an integrated system for capturing, using and integrating real-time patient, service user and carer experience and intelligence. The developed approach will be used to capture initial baseline intelligence of patient experience and continued monitoring of patient experience of integrated care, specifically regarding the Community Independence Service (CIS), and then eventually across wider transformation projects. This project will also support wider engagement and communications across the Better Care Fund and Whole Systems agenda by providing tools and support to facilitate effective engagement and co-design.

Embedding Self-Management

To support patients and communities to have greater control over their health and wellbeing by co-designing a package of self-management programmes and interventions with customers, more specifically we will:

- Commission new and expand existing evidence-based self-management programmes and co-design of condition specific self-management programmes to address gaps in service provision. We will do this by working in partnership with local 3rd Sector organisations.
- Deliver a workforce development programme on self-care and self-management to ensure that frontline

- Establish a central point of contact: To provide tailored support and sign-posting in the health and social care systems, for those with long-term health conditions and their carers

4. Quality and outcome improvements

4.1. Required performance and quality improvements

The table below sets out how Central London CCG will aim to improve quality through our contracting intentions.

Table 3 Key Quality indicators and targets

Provider Organisation	Quality improvements Identified	Possible Stretch targets
Central London Community Healthcare Trust	Referrals responded to during the day, twilight or night periods within 24 hours	Acknowledgement of complaints within 2 days of receipt
	Reduction in Grade 3 and 4 Hospital Acquired pressure ulcers	
	Root Cause Analysis outcomes and Serious Incident notifications	
CNWL	IAPT recovery rates	
	Performance of early intervention of new psychosis cases	
Other providers	Improvement in maternity-related indicators (e.g. % of first booking maternity appointments by 12 weeks, breast feeding initiation)	Falls for 100 bed days
	Root Cause Analysis outcomes and Serious Incident notifications	
Cancer-related indicators for all providers	Access and report turnaround time available in accordance with RCGP/RCR 2013 guidance. Waiting times: Urgent (1 week Maximum), Routine (1 week desirable, 2 week maximum). Reporting Turnaround time Next working day with 90% Tolerance.	
	Same day access and report for X-Ray diagnostics in case of high-risk lung cancer cases.	
	National Cancer Peer Review Programme (NCPR) with a compliance threshold of 75%. All cancer MDTs to be quorate with core membership present at 95% of meetings and that individual core members attend 66% of meetings.	
	For Lung cancer • A thoracic surgeon is present at all MDTs • Any abnormal CxRs with a suspicion of lung cancer are flagged to the MDT. • CT prior to first OPA - • CT scan prior to bronchoscopy 95% • Clinical nurse specialist present at diagnosis 80%	

Provider Organisation	Quality improvements Identified	Possible Stretch targets
	For breast cancer services • That an individual surgeon has a caseload of 50 per annum • That each service provides a one stop diagnostic service • That the service is delivered through the 23-hour stay model • That patients have access to immediate reconstruction That 70% of new patients are followed up through a stratified pathway of supported self-management For colorectal cancer services • All surgeons are completing the required minimum numbers of 20 cases with curative intent per annum. • Each MDT completes a minimum of 60 cases with curative intent per annum.	

Source: June performance reports, relevant guidance.

We will also be including safeguarding elements as one of the focus quality areas in our contracts for 2015/16, through the following:

- Safeguarding quarterly reports to be completed in a framework agreed with the designated nurses and adult leads.
- Reflection on learning from safeguarding team.
- Training, supervision and partnership working to be included in quarterly reports.
- Learning from case reviews and national reports.
- Detail of any specific developments.
- Annual safeguarding report.
- Quality schedule is cross referenced to these points.
- Referrals to the Local Area Designated Officer ('LADO') related to an allegation against members of the provider trust staff communicated to the commissioner within one working day of the referral.

4.2. Gaps in service delivery and improving outcomes

After reviewing the local Public Health needs assessment framework and taking account of the work that has been done to identified need through the Joint Strategic Needs Assessment ('JSNA'), we recognise that there are a number of gaps in our current provision. This will require the CCG to work closely with public health and LA colleagues as the only way of ensuring improvements is to work in collaboration with other key agencies.

We have identified the following gaps in service where we want to do further work over the coming year:

- Child health (including obesity, dental health jointly with partners) ;
- Maternity, given current provider performance on key indicators;
- Substance misuse services (joint with partner agencies);
- Preventative strategies:
    - Child and adolescent MH services;
    - Falls; and,
    - Sexual health (jointly with partner agencies).

We intend to work with WCC to develop support services for families with multiple needs to ensure consistency in provision and improved outcomes.

In addition we will strengthen the way in which the third sector is able to actively engage with and participate in health services. Therefore we will to look at ways in which it is possible to work with the third sector holistically to support whole systems integrated care and village working.

4.3. Information technology

The CCG will continue to establish information technology across its commissioned services to ensure integrated and fit for purpose solutions that link primary care with other settings of care. For the coming year the intention is to build on the established programmes. Business Intelligence is a key enabler in all aspects of the CCGs commissioning programmes and providers will be asked to align their IT offering to achieve the overarching principle of achieving one actual or virtual electronic patient record across all settings of care.

The objective is to implement three layers of clinical information exchange where at least one of the following is in place in any setting of care:

- ***Level 1 -*** There is access to and two way information exchange as well as associated workflow within a common clinical IT system and a shared record between the GP and the care provider.
- ***Level 2 -*** Where the above is not possible due to technical, operational or financial constraints that as a minimum, the respective IT systems in primary care and elsewhere are interoperable and in full conformance with the current Interoperability Toolkit (ITK) standards (or other common messaging standards) as defined by the Health and Social Care Information Centre (HSCIC).
- ***Level 3 -*** Where neither of the above is relevant or feasible then the Summary Care Record is enabled, available and accessible particularly where patients are receiving care out of area.

The CCG will work towards the sharing of clinical records in different settings of care within robust information governance frameworks and processes across the health and social care

community. Providers will be expected to actively consent patients when sharing their records.

The CCG has made considerable investment in ensuring a unified primary care IT platform. Current and future providers will be required to work within the frameworks and opportunities that a single IT system across primary care can offer. This will be translated into more granular service specifications, service improvement plans and/or CQUINs where relevant. Explicitly, the CCG will expect all staff working in community settings to use SystmOne as default clinical system and will expect providers delivering ambulatory urgent care to use SystmOne.

The overriding objective is to improve standards of care facilitated by the accurate, timely and appropriate information exchange. However, at the core will be the principle of the primacy of the primary care record and the objective to directly or indirectly achieve the outcome of one patient one integrated record.

The technology currently in place and due to be implemented during 2015-16 will bring about a turning point in how different organisations work together to provide patient centric care. The CCGs will encourage all existing and future providers to:

- Fully exploit the opportunities by the standardised and common technology platforms, engaging staff to collaboratively design and implement solutions that bring about improvements in diagnosis, treatment and longer term care.
- Implement work and information flows that will reduce the administrative and processing burden on clinical and administrative staff across different organisations.
- Ensure that information exchange is in real time, processed within native IT systems of the organisation, accurate in content, structure and coding at the point of data entry.
- Inform and enable patients to improve their understanding and access to their medical records and take a proactive role in their own care through the use of technology solutions that will improve access to their own records and interaction with care providers. In effect, enabling self-care planning tools and solutions where appropriate and particularly targeted at patients with long term conditions.

It is a key objective to enable patient access to a suite of online services as well as their own records within a robust and secure environment. Under the Prime Ministers Challenge fund programme GP practices have been and will continue to provide patients access to their online services. Providers outside of primary care will also be asked to develop or link with existing systems so that patients have greater access to wider online services and records.

The CCG will in addition focus on these areas:

- Continue working to improve the timeliness and quality of information sent to or accessible by providers from GP practices via clinical IT systems and to ensure the most up to date, relevant and accurate information is always sent.

- Continue working with providers to enable safer and more efficient electronic methods of communication between them and primary care, building on the previous work and solutions around CQUINs with a greater emphasis on structured coding and integrated workflow.
- Extending the diagnostic cloud across the NW London health economy, ensuring the principle of one patient, one diagnostic record across NW London. Embedding the access to pathology and radiology results across all settings of care. Ensuring that ordering tests and receiving results across NW London are exclusively done electronically with minimal manual or paper based processes.
- Within the better care fund programme work with social services to develop an interface between IT systems and more robust information exchange within common information governance frameworks. Principally that all non-healthcare providers use the NHS number as the unique identifier of the patient for all services in order to integrate records.
- Developing tools for GP clinical IT systems to provide integrated services and processes such as in common clinical templates, status alerts and searches that will highlight key patients requiring further attention. Providing a patient risk stratification tool within (rather than outside) GP clinical systems, integrating more closely with other IT systems where the patient may have a record.

In addition the CCG will seek to implement (or make better use of) during 2014/15 and the following years, national and regional strategic IT systems such as:

- Choose and Book and its replacement system e-Referrals
- Ensuring high utilisation of the Electronic Prescribing System
- Close integration and information flows with Coordinate my Care system
- Maintain the high availability of accurate and timely Summary Care Record.

5. Procurement plans

The table below sets out services impacted by procurement plans initiated in 2014/15 or 2015/16.

Table 4 services impacted by procurement plans

Services where procurement is initiated in 2014/15 but there will be impact in 2015/16	*Status*	Joint commissioning	Expected Service Start date
Basic Foot Care	Contract mobilisation	With WL	Jan 2015
Diagnostics	ITT stage	NWL-wide	Oct 2015
Ophthalmology	Business case approved	With WL and HFCCG	April 2015
Expert patient programme	Business case approved	With WL and HFCCG	TBC
Respiratory and cardiology	Business case	With WL	April 2015
Dermatology	Business case	With WL	April 2015
Wheelchairs	Business case	NWL-wide	Unknown
MSK	Business case	Unilateral	Sept 2015
Community gynaecology/ urology	Business case	With WL	Sept 2015
Diabetes	Business case	Unilateral	Sept 2015
Urgent care centre at St Mary's	Scoping		TBC

Services to be procured in 2015/16	*Status*	Joint commissioning	Expected Service Start Date
NHS 111	Planning	NWL wide	Oct 2015
Gastroenterology	Planning	TBC	TBC
Podiatry	Planning	TBC	TBC
ENT	Planning	TBC	TBC
Rhematology	Planning	TBC	TBC
Out of Hours CAMHS Service	Scoping	TBC	TBC

Services to be procured in 2015/16	*Status*	Joint commissioning	Expected Service Start Date
Community Independence Service	Scoping	*With WL and HFCCG*	April 2015
Community transport	Scoping	TBC	TBC
Other interpreting services	Scoping	TBC	TBC
Other services as part of WSIC	Scoping	TBC	TBC

6. Local pathway priorities

6.1. People with a learning disability

The CCG recognises that people with a learning disability can often find it difficult to access services in a way that meets their individual needs. Work will be undertaken during the year with people with learning disabilities, their carers and other partners across the statutory and third sector to improve access to equitable healthcare. This will include primary and secondary health care, as well as keeping people safe and reducing the inequalities that people with learning disabilities face that impact on their access to effective health care.

6.2. Carers

We will continue to invest in services for carers, building on the work done in 2014/15, which has included the development of primary care based support for carers and for young carers.

As part of its Equality Objectives for 2013-2017, the CCG has committed to improving the rates of identification and support provided to carers and young carers, including within a primary care setting, and seek to offer appropriate support.

We will develop our plans in line with the intentions in the Care and Support Act, which outlines the need to provide support services to carers, rather than simply identifying their needs.

6.3. Young Carers

We will continue to maintain investment in supporting carers, with support to young carers a key priority, working closely with partners and with organisations beyond health and social care (including education) in order to continue identifying and supporting carers. This will include a family based approach to support carers and their families to improve access to health care and reduce health inequalities. We will also establish a mechanism to improve the rates of identification of young carers through primary and secondary care.

6.4. Working with the CCG membership and wider stakeholders

We will seek to strengthen the relationship between the CCG Governing Body and the member practices. This will be through further implementation of the 360 action plan, in particular:

- improving communication with member practices;
- supporting GPs to become involved in Governing Body business; and,
- improving the way that clinical quality groups undertaken their roles.

We will also aim to strengthen working arrangements with local patients and communities by continuing to build on current working arrangements with the User Panel and the wider voluntary sector organisations.

7. Summary intentions

The tables below includes a summary of Central London CCG's contracting intentions in the areas of:

a. Acute Service Reconfiguration
b. MH Transformation
c. Whole Systems Integrated Care (including Better Care Fund work streams)
d. Primary Care Transformation
e. Patient Empowerment
f. Children's Services
g. Cancer

Table 5a Summary of contracting intentions by key deliverable area (Acute Service Reconfiguration)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
Acute Service Reconfiguration			
Urgent and emergency care services	**Impact of changes to Hammersmith Hospital and Central Middlesex Emergency Departments** The full year effect of the new 24/7 Urgent Care Centre ('UCC') at Hammersmith implemented in September 2014 will occur in 2015/16, including the activity transfers to other hospitals.		**Acute Trusts** (A&E and admissions flows)
	St Mary's UCC service The St Mary's UCC and Emergency Department ('ED') will be required to deliver the Shaping a Healthy Future ('SaHF') specification by 31 March 2015 as part of the wider primary care urgent care system changes and we will commission against that specification for 2015/16. This will include implementing: • 24 hour primary care leadership • Positive redirection to primary care • Discharge summaries within 24 hours • SystmOne Interoperable IT systems We intend to achieve better value for money for this service, including market testing if appropriate.		**Imperial College Healthcare NHS Trust**
	NHS 111 services The NHS 111 service is due to be re-commissioned in 2015/16 and work will commence on this in 2014/15. This service needs to integrate with the urgent care system.	Jointly with other North West London CCGs	**Current and potential service providers**

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
	Primary care out of hours services The GP Out of Hours service for opted-out practices is due to be re-commissioned in 2015/16. This service needs to integrate with the urgent care system.		**Current and potential service providers**
Planned care service redesign	In 2015/16, we will be mobilising services that have been procured in 2014/15: • Ophthalmology • Dermatology • Musculoskeletal ('MSK') • Cardiology/respiratory combined service • Wheelchairs • Community diagnostics Robust Communications Strategy to all stakeholders to launch new CL Planned Care Services. Service Specification development will be undertaken with local provider organisations, and aligned to Chelsea and Westminster Hospital and Imperial College Health Care Trust Out Patient O/P Clinical Transformation Plans 15/16. We will ensure that clinical reviews for supporting service redesign are aligned to the Annual Audit Plan. We will integrate a decision making tool for primary care (which may involve a procurement)	**Joint with WL CCG and HFCCG** • Ophthalmology **Joint with WL CCG** • Dermatology • Cardiology / Respiratory **Joint with North West London ('NWL') CCGs**[1] • Wheelchairs • Diagnostics	**Current and potential providers** (service delivery) New Community Incentivised Care Episode Contracts (prevention of acute admissions) to be issued. **Acute Trusts** Transfer of outpatients' appointments and outpatient procedures leading to 20-80% reduction in activity levels from acute to community setting established via commissioning round 2015/16. ***(£3.4m of cardiology and respiratory outpatient services to be decommissioned from existing acute and community providers; £450k of ophthalmology outpatient services to be decommissioned from existing acute providers.***) **Community providers** Current providers of community MSK, Diabetes, Dermatology, Cardio and Respiratory Rehabilitation will also be affected in 2015/16 by change of provider. .

[1] NHS North West London Collaborative of Clinical Commissioning Groups are a collaboration of NHS Brent CCG, NHS Central London CCG, NHS Ealing CCG, NHS Hammersmith & Fulham CCG, NHS Harrow CCG, NHS Hillingdon CCG, NHS Hounslow CCG, and NHS West London CCG.

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
			Proposed Key Performance Indicators/CQUINS • Community providers: Accountability for GP Education • Acute providers: Follow-up appointments transfer into community Primary care: Undertaking GP Education.
	In 2015/16, we will be reviewing and redesigning following services, with associated procurements: • Gastroenterology, • Podiatry • Ear, Nose & Throat ('ENT') • Rheumatology • Diabetes • High Cost Drugs (Ophthalmology) • Gynaecology/urology combined service.	**Joint with WL CCG** • Gynaecology/ Urology	Currently there is no ENT, Gastroenterology or Rheumatology Services in the community. The ambition is to move a minimum of 30% of acute activity in this setting. Rheumatology and Gastroenterology (Upper Gastro-Intestinal) are in the upper quartile of acute overspends, regarding prescribing costs. The ambition is to reduce prescribing spend by a minimum of 15% for these service areas. Diabetes,
End of life care services	A strategic review of end of life care provision is to be completed in 2014/15; this is expected to have key recommendations for increasing the number of people able to die in the place of their choosing and making greater use of care planning by reducing the number of A&E visits and emergency admissions in the last year of life.	Jointly with LA	**Community palliative, hospice care services, and bereavement, ambulance and primary care services** (service delivery) **Acute Trusts** (admissions and A&E avoidance, LoS reductions)
Improve care home provision	As part of our review of care home provision in 2014/15, we will be reviewing demand and capacity and making recommendations for implementation commencing in 2015/16. This will include using intelligence about the quality of placements and safeguarding arrangements. We will also agree the refurbishment and refit phase	Jointly with LA	**Care home providers** (service delivery)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
	of SHOSP programme in 2014/15 for implementation in 2015/16. In 2015/16 through the BCF we will integrate the contracting and brokerage functions for Nursing and Residential Care placements across adult social care and health, creating a single team. Under this arrangement CCGs will continue to have governance for health-funded placements and the local authority will continue to have governance for adult social care placements. We will work jointly to shape the provider market, to optimise the quality and value of placements and to support its development to align with our strategic direction.		

Table 5b Summary of contracting intentions by key deliverable area (Mental Health Transformation)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
Mental Health Transformation			
Dementia services	Additional Dementia diagnosis services have been commissioned in 2014/15 from non-recurrent funds. This second half of this contract will be delivered in 2015/16. In addition, the North West London Mental Health Programme Board is undertaking a review of dementia services; this review will be reporting later in 2014/15 and in 2015/16 we will be implementing the recommendations. These are likely to include creating a pathway which: • Increases capability to diagnose dementia in primary care. • Increases specialisation of secondary care services to cover complex diagnosis. • Increases the scope of practitioners working at the primary/secondary interface. • Strengthened post-diagnosis support services including advocacy and advice service. We will commission services in line with the outcomes of this review.		**Primary care, MH Trusts & Third sector** (service delivery)
Increasing Access to Psychological therapies	NHS England's Operating Plan in 2014/15 mandates psychological therapies capacity at 15% of the Common Mental Illness prevalence to be provided by all CCGs in 2015/16. Central London CCG has commissioned additional capacity to meet this requirement as an interim measure, potentially until the end of 2015/16, while work is underway to review and benchmark provision across NWL. The recommendations of this review are expected later in 2014/15 and will be implemented in 2015/16. This is likely to include procurement to increase the diversity of provision and extend services to include young people, long-term conditions, Medically Unexplained Symptoms ('MUS') and severe and enduring MH problems.		**CNWL, Third sector providers and Primary Care** (service delivery) **CNWL Trust** (admissions avoidance through early intervention)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
Shifting Settings of Care	Building on the Primary Care Plus Mental Health Service ('PCP') which is established in Central London, we will review the specification for the current service in order to increase the transfer of services out of secondary community MH to primary care to support people in their homes. This will include: • Strengthening the capability of referral management and signposting services for routine services through the non-urgent single point of access. • Reviewing the model of care for stepping down patients from secondary community care services and achieving the ambitions of Shaping Healthier Lives. This may also include a competitive tendering process depending on the progress made with the current service. We will also seek to repatriate out of area activity to local providers reducing spot-purchase costs.		**CNWL and third sector providers** (service delivery) **CNWL** (admissions avoidance and LOS reduction for MH) Based on work being completed in 2014/15, we will set the number of step downs to be achieved using the RAG-rated recovery caseload with the expectation that all appropriate green-rated patients are stepped down, and all amber-rated patients have a plan. **Out of area placement providers** through MH trust efficiency
Urgent care services	Building on the parity of esteem agenda, and in response to the Crisis Concordat 2014, we will work with providers to implement a value-for-money, 24/7 single point of access to urgent and emergency MH services. This will provide rapid access to appropriate service, including crisis response, Assessment and Brief Treatment, home treatment and signposting to relevant services. We will contract with providers to ensure treatment of MH emergencies has the same importance as a physical health emergency. We will review services to reduce the likelihood of future crisis through multi-agency recovery focused		**CNWL, primary care and Third sector** (service delivery) **CNWL Trust** (admissions avoidance)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
	post crisis support. During 2015-2016, commissioners will contract with providers to: • Implement expediently any remaining performance improvement to deliver the NWL MH access standards for achievement by end of Quarter 1 (where necessary). • Contract for a quality improvement trajectory in terms of key Shared Care communication paperwork (MH2 – MH5.3, including those specifically tested under the Urgent Care and Access CQUIN: MH3, MH5.1 and MH5.3), for achievement by end of Quarter1 (where necessary). • Ensure that the needs of a range of currently under-served groups are met, such as the needs of those in transition from CAMHS, those with Personality Disorder and those with severe behavioural disorders. • Address workforce development by delivering relevant training to support clinical pathways and develop core skills and competencies to enable the CCG to deliver high quality services. Utilise developments in electronic e-referral systems and 'intelligence sharing' to enable trusted assessment across teams, improved access to treatment, faster response times and 'improved local health record self -ownership'.		
Parental mental health services	We will implement the recommendations of the Health and Wellbeing Board Children and Young People's Mental Health Working Group regarding Parental Mental Health by improving the resources available in the community for parental mental health.		**Various providers**
Perinatal mental health service	We will commission services based on the recommendations of the review that is being undertaken in 2014/15. This is likely to include: • Services for all women who may experience a common mental illness (anxiety and depression) during pregnancy as well as those with a known MH problem or those who develop severe mental illness, which can be accessed to perinatal MH services for GPs and community		**CNWL and third sector providers**

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
	health professionals. • Specialist perinatal services for all women with MH needs, incorporating MH midwives, and specialist MH nurses working with community midwifery teams and health visitors. • GPs to have access to a service to get specialist advice from and refer when required. • Commission third sector involvement to support families.		
Continued implementation of psychiatric liaison standards	Specifically, in 2015/16, commissioners will be seeking to: • Secure full roll out of, and reporting against, the developmental measures being piloted by CNWL under the 2014-15 quality dashboard relating to patient experience, clinical outcomes and referrer experience. • Achieve greater core standardisation of services across all sites in terms of workforce skills mix, costs, activity, impact and productivity in line with contractual requirements. • Obtain further commissioning and delivery clarity on the nature of services across sites and, where there is a significant on-going psychological therapy provided for those with Long Term Conditions, ensure synergy with IAPT commissioning and delivery. We will require providers to work with us to understand the impact of changes in urgent care and IAPT current provision on Psychiatric Liaison Services		**CNWL** (service delivery)
Suicide prevention	We will continue to lead on implementing the Tri-Borough CCGs' Suicide Prevention Strategy 2013-18. In 2015/16 we will commission a suicide awareness and intervention training programme for multi-sector providers.	HFCCG, WL CCG, Public Health	**Potential providers**

Table 5c Summary of contracting intentions by key deliverable area (Whole Systems Integrated Care)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
Whole Systems Integrated Care (including Better Care Fund work streams)			
New models of care in place for early adopters	**Capitated budgets and system management** Shadow capitation budgets will be in place and monitored for identified patient cohort, to enable the management of the new care model through the Whole Systems Integrated Care ('WSIC') provider network.	Westminster City Council ('WCC')	**Acute, community, mental health and primary care providers**
	Improving provision for people with long term conditions Through the WSIC model, we will support patients who are diagnosed with a long term condition through education and information to manage their condition and stay well.		**WSIC provider network** (service delivery) **Acute Trusts** (admissions and Accident and Emergency – A&E – avoidance, Length of Stay – 'LoS'- reductions)
	Improve care plan delivery and coordination Using a shared, single system, we will deliver care plans for those that need them in conjunction with care professionals, patients and care co-ordinators. The current care planning service Wellwatch, and Patient Referral Service, both delivered by Central London will be decommissioned and replaced by care planning and coordination within the Whole Systems Integrated Care model of care.		
	Improve care for vulnerable elderly We will commission greater geriatrician input into villages[2], including developing our falls prevention service.		
	Strengthening primary care services We will support the development of primary care through integration and alignment with other key services to strengthen provision and resilience.		**GP practices and GP provider network** (service delivery)
	Improve patient wellbeing We will implement a methodology for measuring and monitoring self-reported wellbeing using patients' life priorities in their care plans.		**WSIC provider network** (service delivery)

[2] Sub-localities.

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
Implement new Community Independence Service model	A set out in section 3.5. above, a process will be run between existing providers in order to appoint a lead health provider to work in partnership with a lead local authority partner to ensure delivery of a single integrated service. Starting in quarter 3 of 2014/15 commissioners, the process will be completed by 1st April 2015 in preparation for the transition year. The process will be designed to secure the collaborative agreement across all providers to implement the necessary changes that deliver the outcomes specified under the new service model. The lead provider (s) will need to demonstrate how they will ensure: • A rapid response multidisciplinary team (MDT) providing community care within 2 hours and for up to 5 days • Non-bedded community rehabilitation, treating non-complex conditions in a community setting. • Integrated reablement with access to short term community beds between 6 and 12 weeks. • 7 day support to help people leave hospital.	Hammersmith & Fulham CCG ('HFCCG') West London CCG ('WLCCG') WCC Royal Borough of Chelsea & Kensington ('RBKC') London Borough of Hammersmith & Fulham ('LBHF')	**Central London Community Healthcare ('CLCH') and WCC** (service delivery) **Acute Trusts** (admissions and A&E avoidance, LoS reductions ***c.£1.3m NEL and £16 k A&E decommissioned across all providers***) **Residential and care homes** (placement avoidance and LoS reduction)
Improve services for the homeless	**Service integration** We will continue to work with providers to ensure that physical and MH services for the homeless are fully integrated.		**Acute. MH and Community Trusts**
	Intermediate Care services Building on the work done to pilot intermediate care services for the homeless in 2014/15, we will commission a targeted intermediate care facility linked to local hostel provision to support patients discharged from hospital and reduce admission to hospital.		**Current and potential providers** (service delivery) **Acute and MH services** (admissions and A&E avoidance)
	Other services We will continue to commission the Hepatitis C clinic started in 2014/15 for the second year of the pilot. We will continue to commission support services for the homeless through		**Primary care** (service delivery)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
	Groundswell. We will consider commissioning addition services for Tuberculosis in primary care.		
Extend the provision of neuro-rehabilitation and intermediate care beds	Benchmarking and a Tri-borough needs analysis has been undertaken for intermediate care in 2014. This indicates that an increase in step up intermediate care beds including neuro-rehabilitation bedded capacity is likely to be needed across the Tri-borough in order to meet the national average and deliver sustainable provision. We will complete the necessary detailed work to progress this and understand fully the implications in terms of dedicated medical support, enhanced nursing care provision and quick access to diagnostics, as well as financial and activity modelling to underpin future requirements.	Joint with HFCCG and the Tri-borough LA	**Acute, community and social care providers**
Explore extending the provision of intermediate care beds	The benchmarking and needs analysis work undertaken for intermediate care services in 2014/15 indicates that additional intermediate care beds could be required across the Tri-borough in order to meet the national average and deliver sustainable provision. With this in mind, we will explore extending the provision of step up intermediate care beds across the Tri-borough to avoid preventable hospital admissions. If the CCG decides to commission this service it will require dedicated medical support, enhanced nursing care provision and quick access to diagnostics to support people with exacerbated long-term conditions.	Joint with HFCCG and the Tri-borough LA	**Acute, community and social care providers** (extended service delivery)
Making Every Contact Count	We will work with providers to support them to proactively identify and take opportunities to have brief, purposeful conversations with patients and their families/carers about health and wellbeing issues outside the primary purpose of the contact. This includes helping them resolve their ambivalence to change and providing information and signposting to services on lifestyle issues (e.g. physical activity, smoking, diet) as well as wider determinants (e.g. housing conditions, social isolation, childhood poverty)	WCC	Current and potential providers

Table 5d Summary of contracting intentions by key deliverable area (Primary Care Transformation)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
Primary Care Transformation			
Deliver population-wide access to Out of Hospital services in general practice	The CCGs in the CWHHE collaborative are working together to enable transformation within primary care. The CCGs have agreed to realign services to support the delivery of the Out of Hospital strategies, including the commissioning of a consistent range of services – an Out of Hospital services portfolio - from GP federation(s). In 2015/16, the roll-out of the service portfolio will be completed with the aim to have full population coverage by 2016/17. Further details are provided in Section 6. This will result in shifts of activity out of hospital for: • A&E and Urgent Care Centre attendances • Wound care service (simple and complex) • Diabetes and endocrinology outpatients • Gynaecology outpatient procedures • ECG diagnostic testing • Ambulatory Blood Pressure Monitoring • Respiratory diagnostic services • Mental health services for complex common and severe and enduring conditions		**GP provider network** (service delivery) **Acute, Mental Health and Community Services** (activity moved to primary care settings) ***(expected decommissioning of services across all acute providers amounting to £3.5m based on latest business case)***
Deliver Prime Minister's Challenge Fund objectives	As described in section 3.3, we will work with our GP provider network to implement: • 7 day primary care services operating within federation(s) • A range of consultation methods to be available to practices (telephone/email/Skype); this includes the evaluation of the Skype pilot we have undertaken in 2014/15.		**Primary care** (service delivery) **Acute Trusts** (reduced demand)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
	• Alternative appointment booking methods to be available in primary care (e.g. online booking). • Patients being able to access their records online. • Increased capacity and evenings and weekends.		
Improving medication compliance	We will continue to work closely with our prescribers to: • Ensure that patients on multiple medications have regular reviews. • Ensure that those patients whose clinical outcomes do not match their medications are reviewed. • Use hybrid workers to ensure patients are taking medications effectively. • Ensure that patients' medications are reviewed following an inpatient stay.		**Primary care** (Service delivery)
Improve services for people with suspected Deep Vein Thrombosis ('DVT')	We will evaluate the pilot for testing patients in primary care with suspected DVT as part of a revised DVT pathway involving acute ambulatory care. We will consider wider roll out and implementation within primary care as an additional Out of Hospital Services Contract		**Primary care and ChelWest Hospital and Imperial College Healthcare Trust** (Service delivery) **Acute Trusts** (admissions and A&E avoidance)
Better understanding of services available within villages	Implement the findings of the village needs assessment programme to strengthen use of local services.		**Various, especially Third sector**

Table 5e Summary of contracting intentions by key deliverable area (Patient Empowerment)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
Patient Empowerment			
Increase use of personal health budgets	Working with the local authorities we will expand the patient/customer groups who are offered personal health budgets ('PHB'). Personal health budgets offer an opportunity to engage people in their support planning, their health outcomes and the choice of health services to meet those outcomes. We aim to increase the ways in which people with significant health needs can shape their own care, take more control, have more choice and increase person-centred care. These actions within our principles of market development and integrated personal commissioning. Areas of focus are. • **Personal health budgets for people with Continuing Healthcare** ('CHC'). We will continue to offer these to everyone who is eligible of CHC in all care groups. Everyone who is CHC eligible is currently offered the opportunity for a personal health budget (notional, managed or through direct payments). • **Mental Health Personal Health Budgets**: We will complete the mental health pilot with WLCCG and Kensington and Chelsea MIND and in line with (awaiting) 2015 guidance on personal health budgets and mental health, we will make these available for certain groups, by working with the independent sector as key designing partner. • **Long Term Conditions Personal Health Budgets**: Personal health budgets will be offered to people with a range of Long Term Conditions. We will undertake a pilot for LTC and publish our offer from April 2015, as well as challenge our existing service provision by reviewing all relevant contracts to determine areas which are 'cashable' and can be used to provide services in a different way. This may be through 'top slicing' a small percentage of contract value in order to use the money differently. • **Children's Personal Health Budgets:** We will continue to work with our Local Authority partners to implement the Children and Family Act 2014 and in particular, new undertakings in relation to personal health budgets. This will include signposting eligible children, young people and families and ensuring personal health budgets are considered as part of the Continuing Healthcare plans. We will also ensure the transition from children's services to adult services works seamlessly for those who have personal health budgets, as part of their support plans.	Joint with LA	**Various**

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
Self-management through the Better Care Fund ('BCF')	Strengthen the choices available to patients.	Joint with LA	**Various**
A strong expert patient service	We will be mobilising a new Expert Patient Service for patients, including an on-line version, which is being procured in 2014/15.	HFCCG and WL CCG	**DESTA (Current provider) and potential providers**
Improve patient transport	Based on finding of the community transport survey and service review being undertaken in 2014/15, we will make adjustments as necessary to the delivery model, which may involve procuring a new patient transport service or using existing framework agreements.		**Current and potential providers**
Improving understanding and knowledge of patient experience	We will contract to improve the quarterly submission by providers of patient experience reports to ensure that they include complaint themes, survey results and friends and family results and the actions being taken to deliver improvements We will also continue to support GP practices to establish and maintain Patient Participation Groups.		**All Trusts** **GP practices**
Improving patient and carer experience across health and social care for people	We will establish and embed processes to enable people with a learning disability to engage with existing engagement routes by making them fully accessible, or provide a forum for people with learning disabilities to be fully engaged in developing and improving access to mainstream health services and reducing health inequalities. Establish an accessible process/mechanism to enable people with a learning disability to provide feedback on their experience of services.	Joint with LA	**Various**

Table 5f Summary of contracting intentions by key deliverable area (Children's services)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
Children's Services			
CAMHS services	Based on the findings of the National Review of CAMHS, the local review of CAMHS being undertaken in 2014/15 through the Health and Wellbeing Board Children and Young People's Mental Health Working Group, and the review of CAMHS out of hours services, we will redesign and/or commission a number of services. • A Tri-Borough behavioural support team for CAMHS Learning Disabilities ('LD'). • Improved front door – consultation and advice service and more efficient and effective access to CAMHS. • A streamlined Tri-borough looked after Children CAMHS. • An improved 24/7 crisis response services by integrating out of hours services with mainstream provision. • Training and public education programme with Public health and potentially safeguarding boards Tri-borough. We will work with NHS England ('NHSE') to ensure good pathways into and out of CAMHS tier 4. We will ensure CAMHS Improving Access to Psychological Therapies ('IAPT') is at the centre of commissioning and outcome measurements.	Joint with the LA	**MH Trusts**
Improving children and young peoples' services in villages	We will evaluate the 2014/15 pilot and consider a wider service in line with Connecting Care for Children; this will involve increasing the number of children's clinics and multidisciplinary team meetings in primary care settings. We will work jointly with our LA partners when considering re-staging of these services in the community to achieve maximum efficiencies and co-location of services for children and families.	Joint with LA	**Primary Care and Acute Trusts** (multi-disciplinary service delivery)
Tackling childhood	Working with Public Health we will review current obesity services	Joint with LA	**All**

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
obesity	provision design and commence implementation of new obesity pathways to direct those at most risk to interventions aimed at reducing childhood obesity.		
Improve outcomes for mothers and babies	We will review current provision jointly with LA and NHS England and implement changes that will improve the services provided and implement the recommendations from SaHF in relation to maternity care including: • Consolidation of maternity and neonatal services from seven to six sites to provide comprehensive obstetric and midwife-led delivery care and neonatal care. • Consolidation of paediatric inpatient services from six sites to five sites to incorporate paediatric emergency care, inpatients and short stay /ambulatory facilities. To support the delivery of this transition a central booking system will be implemented to co-ordinate the booking process across the receiving sites	Joint with LA and NHS England	**Acute Trusts (Chelsea and Westminster, Hillingdon, Northwest London Hospital Trust, Imperial and West Middlesex)**
Speech and Language	Westminster Speech and Language Provision was reviewed in 2013-14. Upward pressure on demand was recognised and in line with recommended best practice, a Tri-Borough Joint Commissioning Group was established with local authority partners. The joint Commissioning Group is now developing a re-procurement plan for 2015-16 and detailed project proposals will be drawn up once NWL CCG procurement input has been secured.		**Current providers**
Children's and Families Act 2014 (including personal health budgets)	We will implement changes required as a consequence of the Act. These include: • Signposting families to the LA 'local offer' website which summarises Education, Health and Care service available for young people with Special Educational Needs ('SEN') and disabilities		**Various**

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
	• Continue to commissioning local child development services to provide timely health assessments for Education, Health & Care Plans. • Collaborating with our LA partners to deliver 'personal health budgets' and 'joint commissioned' services for young people with SEN and disability needs.		
Improve transition services for 15-17 year olds	Jointly with LA, we will review current provision for this group of patients. Based on the findings of this review we will seek to lessen the impact of moving from paediatric to adult services; this is likely to be by commissioning specific services for adolescents or by changing the traditional age boundaries associated with particular services.	Jointly with LA	Acute, Mental Health and Community Trusts
School nursing services	We are considering commissioning additional special school nursing services to meet the complex health needs of children attending.	Jointly with LA/ public health	
Health visiting	We will work closely with Public Health and LA colleagues to secure effective transition of the service from NHSE.	Jointly with LA/ public health	

Table 5g. Summary of contracting intentions by key deliverable area (Cancer Services)

Key deliverable area	Contracting intention	Joint Commissioners	Expected provider impacts (financial and activity, when known)
Access to Diagnostic services	All GPs to have direct access to: • **colonoscopy** for low risk, not no risk of cancer via a diagnostic service; • **flexible sigmoidoscopy** for low risk, not no risk of cancer; • **non-obstetric ultrasound** for low risk, not no risk of cancer; and, • same day **chest x-ray for high risk of cancer** and access for low risk, not no risk of cancer.		**Current and potential providers**
	In order to promote the earlier diagnosis of ovarian cancer, services will be commissioned to support US and CA125 concurrently.		**Current and potential providers**
	In order to support the reduction of the risk of delayed diagnosis, all commissioned services will be required to formally report A&E, Urgent care Centres and inpatient chest X-rays ('CxR').		**Current and potential providers**
Robust treatment decision-making	All commissioned cancer services will participate in the National Cancer Peer Review Programme ('NCPR') or other quality assurance programme as defined by commissioners.		**Current and potential providers**
	All cancer services commissioned will be required to demonstrate robust treatment decision making through MDT.		**Current and potential providers**
Robust service specification	Robust service specification for cancer services: • All lung cancer services will be commissioned in line with best practice through a timed pathway. • Endobronchial US ('EBUS') services are commissioned to an agreed service specification and tariff. • All breast cancer services will be commissioned in line with best practice through a timed pathway and follow up in line with the National cancer survivorship initiative ('NCSI'). • All services for prostate cancer will be commissioned in line with NICE guidance through a timed pathway with follow up in line with the NCSI. • All services for colorectal cancer ('CRC') will be commissioned in line with NICE guidance through a timed pathway with follow up in line with the NCSI.		**Current and potential providers**

Key deliverable area	Contracting intention	Joint Commissioners	Expected provider impacts (financial and activity, when known)
Cancer as a long term condition	Agree and implement service consolidation plans – providers will work with their Integrated Cancer System ('ICS') and commissioners to implement the cancer Model of Care		**Current and potential providers**
	All cancer services will be commissioned to deliver the recovery package as described in the NCSI. • For Breast Cancer- 70% of new patients are followed up through a stratified pathway of supported self-management. • For Colorectal cancer – 40%of new patients are followed up through a stratified pathway of supported self-management. • For Prostate Cancer-40%of new patients are followed up through a stratified pathway of supported self-management.		**Current and potential providers**
Appropriate management of the late effects of anti-cancer treatment	Services will be commissioned to manage some of the consequences of anti-cancer treatment as below. • Services for the management of gastro-intestinal ('GI') late effects: All Multi-disciplinary teams ('MDT') that use pelvic Radiotherapy ('RT') will have agreed pathways in place for the management of GI late effects. • Services for lymphedema: All MDTs where treatments may result in lymphoedema have agreed pathways in place to access services including exercise as per NICE guidance. • Services for psychological and physical sexual related problems: All MDTs where treatments may result in sexual function problems both male and female have clear referral pathways in place for management.		**Current and potential providers**
Contracting of additional cancer services	Services will be commissioned to provide pathways for the management of treatment related fertility issues.		**Current and potential providers**
	Services will be commissioned for the management of those with a family history of moderate risk breast cancer to a Pan London specification.		**Current and potential providers**
	Services for the provision of Metastatic Spinal Cord Compression ('MSCC') will be commissioned in line with NICE QS56.		**Current and potential providers**

8. Equality impacts

8.1 Duty to Involve

Our CCG is mindful of its individual participation duty to ensure that we commission services which promote the involvement of patients across the full spectrum of prevention or diagnosis, care planning, treatment and care management when discharging its duty. We have been working in partnership with patients, carers, the wider public and local partners to ensure that commissioned services are responsive to the needs of our population.

Our Patient and Carer Experience Strategy was co-designed with patients, carers and stakeholders to identify the key priority areas. It requires commissioned providers to ensure that patients, service users and carers are provided with opportunities to get involved in shaping and influencing services and the organisations as a whole.

We therefore expect providers to evidence their engagement with service users and carers in the planning, development and delivery of their services. More specifically, we expect providers to:

- Train and support service users and carers to be effectively engaged in the design and delivery of services as well as in shaping and influencing the organisation as a whole.
- Work with local voluntary organisations and patient groups to deliver a programme of staff training and capacity development in order to understand the experience of specific groups and communities.
- Ensure that any feedback about their services reflects the diversity of the patient and service user population.
- Work in partnership with local health and social care organisations to capture experiences relating to integrated care.

8.2 Promoting Equalities and Improving Patient Experience and Access

We expect providers to measure patients, service user and carers experience of access to services and demonstrate that commissioned services are accessible by all. This will be evidenced by:

- Patient experience. Information to include data relating to key equality groups. More specifically, data should be recorded in line with the categories and sub-categories as defined by the Office of National Statistics ('ONS') in order to reflect the diversity of the local population. In addition, the data should be assessed to establish if:
    - There are differences in the outcomes experienced by patients, service users and carers;

  - There are differences in the perception of treatment and care between patients, service users and carers from different equality groups; and,
  - Action has taken place to address gaps in relation to points 1 and 2.

- Uptake and Use of services. To assess whether:
  - There are differences in the frequency of usage by different equalities groups e.g. A&E and UCCs;
  - The services are being delivered to meet the needs of the diverse population;
  - There is anything further the service can do to increase usage by those groups of patients that currently under-use the service; and,
  - Action has taken place to address gaps in relation to points 1, 2 and 3.

- Complaints and other feedback. To assess whether:
  - There are any differences in the rate of complaints from different groups with different needs or circumstances;
  - There are particular aspects of the service that cause problems for particular groups of patients, service users and carers;
  - There are an underlying causes or barriers that mean that certain groups are receiving a better service than others;
  - Different groups have varying expectations of the service; and,
  - Equalities monitoring is carried out for investigated complaints on a sample basis by the Complaints Team and reported on quarterly basis.

- Children with disabilities. To ensure that providers have in place a range of facilities and support available to children with disabilities and their carers, specifically:
  - Waiting areas that are sensitive to the needs of disabled children;
  - Changing Places / Toilets for children with complex needs, equipped with the right equipment and enough space;
  - Facilities for complex needs children admitted to hospital wards provide adequate hoists and changing facilities, as well as suitable food and nutrition e.g. pureed food;
  - Signposting to support groups;
  - Offering coping strategies at the point of diagnosis; and,
  - That parents and GPs are copied in on all doctors and therapist reports.

8.3. Engaging with stakeholders

Our contracting intentions are based on on going engagement around our strategic plans. A high-level impact assessment of our contracting intentions, measured against our Equality Objectives for 2013-16, is set out below.

- *Goal 1: Better health outcomes for all.* Our contracting intentions set out a broad programme of work which we believe fully encompasses the general themes of our action plan.

- *Goal 2: Improved patient access and experience.* Areas of delivery around increased access to psychological therapies, population-wide access to out of hospital services in general practice and seven-day primary care services. During 2015/16 we will continue work to improve our understanding and knowledge of patient experience through better provider patient experience reports.
- *Goal 3: Empowered, engaged and well supported staff*. As the CSU is reincorporated into the CCG, we will be undertake a review of our new workforce to effectively assess the development needs of our staff, particularly those with caring responsibilities, those with disabilities and those from Black, Asian and Minority Communities.
- *Goal 4: Inclusive leadership at all levels.* The Equalities Reference Group across the CWHHE Collaborative will continue to report to our relevant Governing Body Committee, ensuring we deliver on our equality objectives. We will also undertake further work during 2015/16 to strengthen our current governance structures.

We have gathered feedback from our user panel and received a number of comments and requests for clarification. The comments we received related to:

- Our mandate from NHSE to procure local 111 services in 2015/16;

- Activities we undertake to keep dementia at bay, such as our memory café, and art and signing classes. We have also recently approved the utilisation of dormant funding for a dementia out-reach service to be provided by CNWL.

- The support available to patients with communication difficulties, which covers all communication barriers (including limited knowledge of the English language, learning disabilities, visual and/or hearing impairment);

- Our work with our IAPT providers on how we can increase access to psychological therapies to our minority populations (e.g. Black, Asian and Minority Ethnic groups, Lesbian, Gay, Bisexual and Transgender groups; Deaf or hard of hearing, young people, foreign language speakers, and people with long term conditions);

- Our plans to define and deliver mental health education training to key partners, e.g. GPs and practice staff;

- What we are doing to reduce gaps in transition from CAMHs to Adult services, reflecting different thresholds by evaluating discharge work into primary care and protocols of transition for those going to Adult services; and,

- How we are working with our mental health secondary care provider to improve the efficiency of bed availability in order to reduce the cost of purchasing beds elsewhere (‘spot purchase costs’).

Appendix 1 Glossary

Acronym	Term
A&E	Accident & Emergency
ABPM	Ambulatory Blood Pressure Monitoring
ACP	Accountable Care Partnership
AMU	Acute Medical Unit
BAME	Black, Asian and Minority Ethnic
BCF	Better Care Fund
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CHC	Continuing Healthcare
ChelWest	Chelsea and Westminster Hospital NHS Foundation Trust
CI	Commissioning Intention
CLCCG	Central London Clinical Commissioning Group
CLCH	Central London Community Healthcare
CRC	Colorectal Cancer
CT	Computerised Tomography
CxR	Chest X-Rays
DVT	Deep Vein Thrombosis
EBUS	Endobronchial Ultrasound
ECG	Electrocardiogram
ED	Emergency Department
ENT	Ear, Nose and Throat
FYE	Full Year Effect
GI	Gastrointestinal
GMS	General Medical Services
GP	General Practitioner
GSTT	Guy's and St Thomas' Hospital NHS Foundation Trust
HENWL	Health Education North West London
HFCCG	Hammersmith and Fulham Clinical Commissioning Group
HIV	Human Immunodeficiency Virus
IAPT	Improving Access to Psychological Therapies
ImBC	Implementation Business Case
ICHT	Imperial College Healthcare Trust
ICS	Integrated Cancer System
ICU	Intensive Care Unit
IRP	Independent Reconfiguration Panel
IT	Information Technology

Acronym	Term
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LA	Local Authority
LADO	Local Area Designated Officer
LBHF	London Borough of Hammersmith and Fulham
LD	Learning Disabilities
LGBT	Lesbian, Gay, Bisexual and Transgender
LoS	Length of Stay
LTC	Long Term Condition
MDT	Multidisciplinary Team
MH	Mental Health
MRI	Magnetic Resonance Imaging
MSCC	Metastatic Spinal Cord Compression
MSK	Musculoskeletal
MUS	Medically Unexplained Symptoms
NAS	National Autistic Society
NCPR	National Cancer Peer Review Programme
NCSI	National Cancer Survivorship Initiative
NEL	Non-Elective Admissions
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NWL	North West London
OBC	Outline Business Case
ONS	Office for National Statistics
OOHS	Out of Hospital Services
OPA	Outpatient Appointment
p.a.	Per annum
PCCJC	Primary Care Co-Commissioning Joint Committee
PCP	Primary Care Plus Mental Health Service
PHB	Personal Health Budget
PMCF	Prime Minister's Challenge Fund
PPG	Patient Participation Group
PRS	Patient Referral Service
QIPP	Quality Innovation Productivity Prevention
RBKC	Royal Borough of Kensington and Chelsea
RCGP	Royal College of General Practitioners
RCR	Royal College of Radiologists
RT	Radiotherapy
SAU	Surgical Assessment Unit

Acronym	Term
SEN	Special Educational Needs
SaHF	Shaping a Healthy Future
SHSOP	Specialist Housing Strategy for Older People
SPA	Single Point of Access
TB	Tuberculosis
UCC	Urgent Care Centre
UCLH	University College London Hospitals NHS Foundation Trust
US	Ultrasound
VANA	Village Asset Needs Assessment
WCC	Westminster City Council
WLCCG	West London Clinical Commissioning Group
WSIC	Whole Systems Integrated Care

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City of Westminster

Westminster Health & Wellbeing Board

Date:	**20 November 2014**
Classification:	**General Release**
Title:	**NHS WEST LONDON CCG CONTRACTING INTENTIONS 2015/16**
Report of:	**West London CCG**
Wards Involved:	**Queen's Park and Paddington**
Policy Context:	**-**
Financial Summary:	**-**
Report Author and Contact Details:	Katie Beach, Head of Strategic Planning, West London CCG Email: katie.beach@inwl.nhs.uk

1. Executive Summary

1.1 The Health and Wellbeing Board is invited to review the CCG's Contracting Intentions for 2015/16, which were circulated to providers on 30 September 2014. At this stage, the intended audience for the document is providers, as it focuses largely on impact of the CCG's schemes on contracts in 2015/16.

2. Key Matters for the Board's Consideration

2.1 The Health and Wellbeing Board is requested to note the CCG's Contracting Intentions for 2015/16.

3. Background

3.1 The CCG has developed its Contracting Intentions for 2015/16, which reflect the next stage in the delivery of Shaping a Healthier Future and the local Out of Hospital Strategy.

3.2 The 2015/16 Contracting Intentions have two main angles:

- The delivery of the key NWL strategic priorities, including patient empowerment, primary care transformation, Whole Systems Integration and service reconfiguration.

- Responding to local issues, gaps and priorities.

3.3 The contents of the document build on the 2014/15 Commissioning Intentions and include an overview of next steps in the main strategic programmes in North West London. The contents of the document are therefore not new; they reflect the on-going development of schemes which will be familiar to the Health and Wellbeing Board.

4. Legal Implications

4.1 N/A

5. Financial Implications

5.1 N/A

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

Katie Beach at katie.beach@inwl.nhs.uk

BACKGROUND PAPERS:

The CCG's Contracting Intentions for 2015/16 are attached.

NHS
West London
Clinical Commissioning Group

West London CCG Contracting Intentions 2015/16

Contents

1. Introduction

The purpose of this document is to set out for providers the priority contracting intentions for NHS West London Clinical Commissioning Group (CCG) for 2015/16, which will inform contract negotiations. This document should be read in the context of the CCG's wider commissioning plans and with reference to the strategic context set out in the next section.

2. Strategic context

The 8 CCGs in North West London, with our local authorities and other partners, are in the process of implementing widescale changes to the way in which patients experience and access health and social care. These plans are ambitious and transformational, and the vision is set out below.

We want to improve the quality of care for individuals, carers, and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their community.

This vision is supported by 3 principles:

1. *People and their families will be empowered to direct their care and support and to receive the care they need in their homes or local community*
2. *GPs will be at the centre of organising and coordinating people's care*
3. *Our systems will enable and not hinder the provision of integrated care.*

We started the implementation of this vision in 2013/14, and have been putting many of the fundamental building blocks in place during 2014/15. Some of the key enablers have been:

- Putting Patients First, Primary Care Navigators and the Community Independence Service
- 7 day working in primary care and social care
- Development of GP federations, which has commenced in 2014/15
- Development of Out of Hospital contracts, which will be commissioned at network/locality level later in 2014/15, replacing practice level local enhanced services and ensuring wider population coverage
- Closure of Hammersmith Hospital Emergency Department and Central Middlesex A&E unit
- Implementation of a single GP IT system, SystmOne, across the majority of practices in West London, with all practices due to migrate by December 2014
- Establishment of Whole System Integrated Care early adopters, with business cases for implementation from April 2015 being developed
- Contracts with all key NHS providers that incentivise the transformation of services and the movement of services out of hospital

We intend to build on this further during 2015/16.

3. Approach to the contracting round

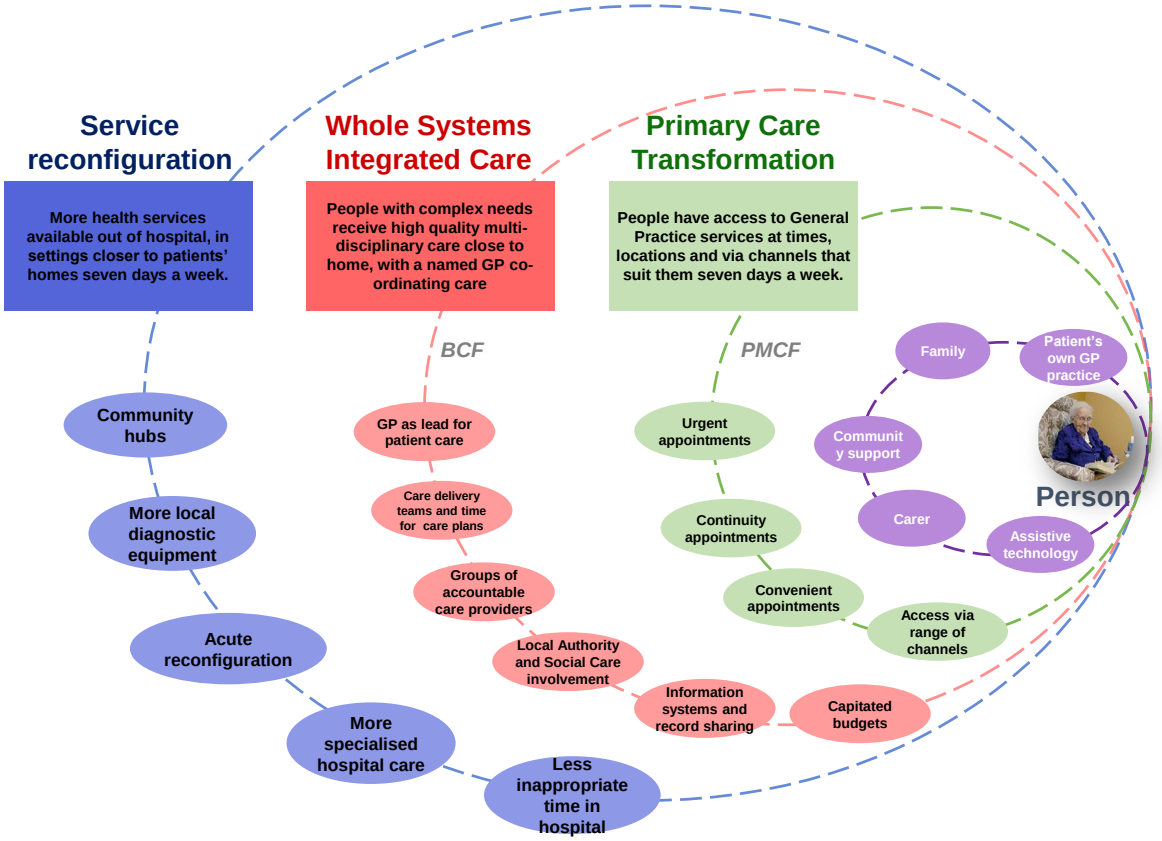
Our approach to the contracting round will build on the approach taken in 2014/15. We will be working closely with the other CCGs in CWHHE, and also with our colleagues in Brent, Harrow and Hillingdon, to maintain strategic alignment. Our primary objective is the delivery of our strategic vision, and we expect to negotiate contracts that will support us in the delivery of that vision, with a focus on transformational change and service integration. We will expect our providers to demonstrate how they are transforming their services to meet that challenge and how they are moving towards the SAHF service standards. We will seek to ensure that the incentives and penalties within contracts are aligned to ensure the delivery of the required transformation. All CCGs in NWL have whole systems integrated care early adopters who are developing models of care, and we expect to commission these during 2015/16, either in shadow or live form. We expect to reflect this within our 2015/16 contracts with the relevant providers.

Patient empowerment, and putting the patient at the heart of all we do, is fundamental to our vision. Generally providers are not doing this at present. We will seek to embed a requirement for much greater patient focus within our contracts for 2015/16.

We intend to start our contract negotiations earlier for 2015/16, with the aim of agreeing the baseline activity and many of the schedules before Christmas, subject to any changes that may be required as a result of the publication of planning guidance and 2015/16 tariffs in late December. This will give us the opportunity for better quality discussions and earlier certainty regarding 2015/16, enabling better planning and therefore a greater chance of delivery of the agreed changes. We expect all contracts to be signed by 31 March 2015.

4. Strategic priorities for 2015/16

Our vision is underpinned by the 4 key workstreams of i) Service reconfiguration under *Shaping a Healthier Future*; ii) Whole Systems Integrated Care; iii) Primary Care Transformation and iv) Patient Empowerment. This is shown in the diagram below.



We are currently developing the 5 year roadmap that sets out all the key milestones over the next 3-5 years to ensure that the vision is realised. The following section sets out the delivery priorities and milestones for 2015/16 against each of these key programmes.

4.1 Service Reconfiguration

Shaping a Healthier Future (SaHF), the acute reconfiguration programme in NW London, will centralise the majority of emergency and specialist services (including A&E, Maternity, Paediatrics, Emergency and Non-elective care) to deliver improved clinical outcomes and safer services for our patients. Agreed acute reconfiguration changes will result in a new hospital landscape for NW London. The SaHF Reconfiguration programme will oversee:

- The existing hospital landscape of nine hospitals reconfigured to provide five Major Acute Hospitals;
- Ealing and Charing Cross sites redeveloped, in partnership with patients and stakeholders, into Local Hospitals;
- Hammersmith Hospital established as a specialist hospital; and
- Central Middlesex Hospital will be redeveloped as a Local and Elective Hospital.

<u>Clinical Standards</u>

The programme supports the achievement of enhanced clinical standards. As part of the original development of NW London's vision, NW London's clinicians developed a set of clinical standards for Maternity, Paediatrics, and Urgent and Emergency Care, in order to drive improvements in clinical quality and reduce variation across NW London's acute trusts.

These clinical standards, along with the London Quality Standards and the national Seven Day Services Standards, will underpin quality within the future configuration of acute services, including along the urgent and emergency care pathway. North West London is committed to delivering seven day services across the non-elective pathway by March 2017, based on the national clinical standards, in order to improve the quality and safety of services and to support emergency care flow.

As of April 2015, all acute trusts will meet the following 7 day standards:

- Time to first consultant review: all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.
- On-going review: all patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate.
- Diagnostics: hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: within 1 hour for critical patients; within 12 hours for urgent patients; within 24 hours for non-urgent patients.

In addition, in 15/16 acute trusts will be expected to produce quarterly patient experience reports that compare feedback from weekday and weekend services.

Over the course of 2015/16, acute trusts will work towards achieving the following 7 day standards:

- Multi-disciplinary Team review: all emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.
- Shift handover: handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.

All providers across primary, community and social care will work towards 7 day discharge pathways - i.e. that support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

The acute reconfiguration is dependent on significant take-up of existing and new out of hospital services being delivered locally by all CCGs to ensure that patients only go to hospital when they need to.

2014/15 service changes

Following the 'full' support of the Secretary of State in October 2013 following the review of the Independent Reconfiguration Panel, priority service changes are being delivered in 2014/15:

- Transition of services from the Emergency Unit at Hammersmith Hospital
- Transition of services from the A&E at Central Middlesex Hospital
- All Urgent Care Centres (UCCs) moved to a common operating specification, including a 24/7 service

The programme has also been undertaking contingency planning for the potential transition of Maternity and Paediatrics services at Ealing Hospital.

Contracts for 2015/16 will reflect the full year effect of the changes above.

OBC development

Outline Business Cases (OBCs) will be developed and centrally reviewed for all sites in 2014/15 (major and local hospitals). Additionally, the programme is also developing an Implementation Business Case (ImBC) to ensure that the refined solution for NW London remains affordable and aligned with the clinical vision. OBCs for Major and Local Hospitals are expected to be approved by NHSE, NTDA, DH and HMT in 2015/16, and following this Full Business Cases will be developed to allow the redevelopment of sites to continue.

Out of Hospital Services

Central London, West London, Hammersmith & Fulham, Hounslow and Ealing CCGs are working together to enable transformation within primary care across the CWHHE collaborative. Each CCG has an Out of Hospital ('OOH') strategy that describes keeping the patient at the centre of their own care, with the GP as a key provider and coordinator of services. In addition, key strategic priorities for the CCGs are to improve quality, reduce variation within primary care and ensure all patients within the CCG have equity of access to commissioned services. The CWHHE collaborative has therefore agreed to realign services to support the delivery of the OOH strategies, including the commissioning of a consistent range of services – an OOH portfolio - from GP networks. The portfolio comprises the following services:

Services	
Ambulatory Blood Pressure Monitoring	Diabetes (High Risk)
Access	Electrocardiogram
Anti-Coagulation Monitoring	Homeless
Anti-Coagulation Initiation	Near patient monitoring
Care planning	Phlebotomy
Complex common MH	Ring pessary
Complex wound care	Severe and enduring MH
Diabetes Level 1	Simple wound care
Diabetes Level 2	Spirometry Testing
Diabetes (High Risk)	Spirometry Testing

The table below describes the services to be commissioned through the Out of Hospital Services commissioning programme. The unit construction method, indicative current service impacted, and total expected activity volumes for a full year for the CCG are shown below. Please note that we do not expect a full year of activity to be transferred in 2015/16 as we will be phasing roll out. We will work with providers over the next three months to define how each provider will be impacted. Where services are predicted to meet 100% population coverage, decommissioning notices will be issued to current providers, as appropriate.

Out of Hospital Service	WL Activity Forecast (100% coverage)	Activity Type (contact or package)	Indicative Acute Point of Delivery (POD)
ABPM	4,737	Per test	Cardio OPD
Anticoagulation Monitoring	2,303	Package p.pt p.a (FA+12FU)	Clin Haem OPD
Anticoagulation Initiation	987	Package p.pt p.a (FA+8FU)	Clin Haem OPD
Case Finding, Care Planning & Case Management	4,699	Per patient	N/A
Complex Common Mental Health Management	2,238	Package p.pt p.a (FA+7FU)	N/A
Complex Wound Care	247	Per contact	Various
Diabetes (Level 1)	8,024	Package p.pt p.a (FA+2/3FU)	Diabetes OPD
Diabetes (High Risk)	4,370	Package p.pt p.a (+2appts)	Diabetes OPD

Diabetes (Level 2)	241	Package p.pt p.a (FA+2FU*)	Diabetes OPD
ECG	5,310	Per test	Cardio OPD
Homeless	5,028	Package p.pt p.a	A&E/ NEL
Near Patient Monitoring	1,081	p.pt p.a	Rheum OPD
Phlebotomy	76,735	Per venepuncture	
Ring Pessary	484	Per ring p.pt p.a	Gynae OPD
Simple Wound Care	2,475	Per contact	Various
Spirometry Testing	3,877	Per test	Respir OPD
Transfer of Care: Severe and Enduring Mental Illness	481	Package p.pt p.a	N/A

*11 appts for patients who need GLP-1 and insulin.

Mental Health Transformation

In 2015/16, CCGs wish to see continued implementation of the Shaping Healthier Lives 2012-15 core initiatives including:

- Urgent Care: roll out of the SPA and 24/7/365 access to home-based urgent assessment and initial crisis resolution work.
- Liaison Psychiatry: further benchmarking of services to drive increased standardisation of investment, activity, impact and return on investment.
- Whole Systems/Shifting Settings: building on work to date to implement primary care plus, to test, refine and roll out a new model of 'community staying well' services for people with long-term mental health needs, providing the GP (as accountable clinician) with a range of care navigation, expert primary mental health and social integration/recovery support services to deliver care closest to home and prevent avoidable referral to secondary.

In 2014/15, the Transformation Programme Board has sponsored development work streams in dementia, learning disability, perinatal mental health and IAPT. CCGs will expect providers of service to implement the key pathway, models of care and quality standards that emerge from these work programmes. Regarding CAMHS OOH, CCGs will be commissioning a new provider of service, following that service review, due to be complete early Autumn 2014.

In June 2014, the Collaboration Board supported the need for co-ordinated, system-wide change in NWL as the best way to achieve our vision for mental health and wellbeing services, ensuring mental health has an equal priority with physical health, and that those with mental health needs get the right support at the right time. It agreed that a programme of work should be delivered to address the strategic challenges and opportunities facing mental health and wellbeing services in NWL. Since then, engagement has been undertaken

with a wide group of stakeholders to gauge their interest in the programme and their views regarding its scope and the timescales within which each stage of the programme could be achieved. Stakeholders include all NWL CCGs and Local Authorities, WLMH, CNWL, Directors of Public Health, members of the Mental Health Programme Board, Lay Partners and Imperial College Health Partners.

Overall enthusiasm and commitment has been high whilst recognising the need to ensure alignment with existing local programmes and priorities and national initiatives. In September the Collaboration Board noted progress on development of the NWL Whole System Mental Health and Wellbeing Strategic Plan and endorsed a Programme Initiation Document setting out the governance arrangements, overall timetable and the resourcing requirements to deliver this exciting and important piece of work. The programme will likely commence in November 2014, with a case for continuity and change produced six months afterwards, and options for change six months after that. There may be a need for public consultation depending on which options are developed.

4.2 Whole Systems Integrated Care

In the summer of 2013, along with partner organisations across North West London (NWL), we committed to a vision to create "better coordinated care and support, empowering people to maintain independence and lead full lives as active participants in their community." The Whole Systems Integrated Care (WSIC) programme was established to achieve this shared vision. As indicated in our commissioning intentions last year, an extensive programme of co-design ran through 13/14, which included partners from health and social care organisations across NWL, service users and carers.

NWL is one of fourteen national integrated care 'Pioneers'. We are currently developing detailed local plans in order to begin implementation in 15/16 and will continue our commitment to collaboration and co-production with our partners. We anticipate that our transition to full Whole Systems Integrated Care will take three to five years, at which point we will be:

- Commissioning fully integrated models of care based on the holistic needs of different population groups, encompassing both health and social care
- Jointly commissioning for each population group a set of outcomes across health and social care, with a single, combined, capitated budget to achieve them. Through capitation, we will support service users to access a personal budget for health and social care needs as agreed through the development of a personalised care plan
- Commissioning a group of providers to offer an integrated care service to the population groups. We anticipate that these providers will work together as an accountable care partnership (ACP) and be held collectively accountable for achieving the commissioned outcomes and managing the associated financial risk for the population groups.

In 15/16, we will begin to move towards Whole Systems by implementing elements of a new model of care, employing a joint commissioning approach and continuing to work collaboratively with providers to support the development of accountable care partnerships.

All providers will continue to have the opportunity to participate in the development of WSIC through a collaborative, iterative process. Through ongoing co-production with both our partners and service users, we will continue to build towards a model of integrated care that best meets the needs of our residents. We expect providers currently working with population groups in our local area to respond to these intentions.

Whole Systems for patients aged over 75

West London CCG's key integration programme is its Putting Patients First (PPF) programme, which supports the principles of care planning, case management and multi-disciplinary working. The programme has been rolled out to all GP practices in West London and other providers are involved through regular multi-disciplinary team meetings at practice level. The principles embedded within PPF will be built upon as part of our Whole Systems programme in 15/16 to include the following key schemes:

1. Development of accountable care partnerships as colleagues from across health and social care are brought together from their parent organisations to deliver person-centred, integrated care
2. A co-ordinated health and social care team working together to provide access to reablement and rapid response services (Integrated Crisis Response/Community Independence Service programme enabled through the Better Care Fund)
3. An Older Adult Support Team, including geriatric and mental health geriatrician input, supporting case managers and carrying out domiciliary visits
4. A transformed primary care service with the skills and capacity to be central to the model of care for this cohort of patients
5. Further enhancement to the current MDT structure through development of Primary Care Navigator and Case Manager roles currently operating as part of PPF. These case managers offer continuity and pro-active case management for our complex patients and their role will be the bed rock for Whole Systems. In addition we will expand our mental health practitioner and prescribing roles to ensure complete coverage of all of our practices
6. A single point of access through a Central Coordination Team to ensure high quality provision of health and social care in the community, avoidance of unnecessary admissions and early safe discharge of patients from hospital
7. North and South Integrated Hubs would deliver the care based on what the Central Coordination Team delegates to them. They work with the individual's GP and home carers, who sit in the GP practices, and the wider multi-disciplinary team to deliver the right interventions at the right time and in the right setting
8. Self-care, community capital and the voluntary sector are core parts of the model.

Scheme 2 above has been rapidly enabled through the focus provided by the BCF. Therefore this scheme is currently the most advanced, with the business case for new investment having been signed off by our Governing Body and the Health and Wellbeing Boards. The scheme supports the development of an integrated health and social care team providing services where possible in people's own homes to keep them out of hospital and residential care. Crisis response is a key function within an older person's care pathway, so will form a key component of a Whole Systems model of care. The components which need further focus as we move forward include proactively managing patients when they are stable and supporting self-care.

In addition, scheme 3 has been worked up and a business case has been agreed which will see an Older Adult Support Team in place for winter 2014. This team will form a key function as part of a whole system in West London CCG.

Work will continue during the autumn to develop a full business case for Whole Systems, which incorporates Integrated Crisis Response/Community Independence Service and the Older Adult Support Team as key functions, but set within the context of an accountable care partnership. There will be further work to understand how these functions operate as part of a whole system which places primary care in the centre.

Whole Systems for patients with long-term mental health needs (LTMHN) - the 'Community Living Well Service'

During 2014-2015, the Mental Health Programme Board has overseen a NWL-wide programme to support development of innovative service models for people with mental health needs to 'live well' in the community, increasing their resilience and social integration, and decreasing their reliance on secondary care services. Two 'early adopter' sites exist, one of which is West London CCG (the other is Hounslow), which have been developed in partnership with the Tri-Borough Public Service Reform programme to ensure join up with key services required to support recovery.

Following significant local co-production with service users, carers, advocates, GPs, third sector and mental health professionals, a new 'Community Living Well' service model has emerged. This would be the 'first port of call' for GPs when they need support for their patients, or advice on management of their mental and physical health in an integrated primary/community-based service. Critically, it would also provide GPs and those with mental health needs who do not need secondary care with access to expertise that supports recovery and social integration, from social networks, activities and time-banking, to support with housing, employment, training, life skills, meaningful activity, housing and benefits: all the wider determinants of good mental health.

During the latter part of 2014-15, detailed process co-design will take place to determine how the model will operate. The principle of co-production, with service users at its heart, will drive this, and will be embedded as an on-going part of how the service operates. The model envisaged will be located in a community setting, with flexible access and support that 'wraps round' the needs of service users.

It is envisaged that a detailed specification of this service will be complete by March 2015 with a forward procurement and mobilisation plan in place in Quarter 1 of 2015-16.

Better Care Fund

The Better Care Fund (BCF) is a key enabler for Whole Systems Integrated Care, and is being taken forward across the Tri-borough through four major workstreams.

Two major schemes within the BCF that are particularly significant for West London are described below. These schemes represent a continuation of the direction we set out in our commissioning intentions for 2014/15; they are aimed at addressing increased demand and

complexity of need amongst older people as well as improving efficiency and reducing duplication. The schemes are:

- Transforming nursing and residential care home contracting
- The Integrated Crisis Response/Community Independence Service (ICR/CIS).

Transforming Nursing and Residential Care home contracting:

The Tri-borough CCGs and Local Authorities will develop their proposals to integrate the functions of commissioning, contracting and assuring the quality of care home placements across the three boroughs. Within Tri-borough, there is currently no consistent approach to contracting, brokerage and monitoring of placements, whether funded by Adult Social Care or health, and this results in a lack of alignment with regard to contracting, safeguarding and quality assurance resources, intelligence and expertise.

Our proposal for a single integrated commissioning team will eliminate gaps, duplication and disconnects across nursing and residential care placements by creating a consistent, joint approach to contracting, safeguarding and escalation, and oversight of the sector, as well as tailoring and focusing care around the individual.

In 2015/16 we will:

- Integrate the contracting and brokerage functions for nursing and residential care placements across adult social care and health, creating a single team. Under this arrangement, CCGs will continue to have governance for health-funded placements and the local authority will continue to have governance for adult social care placements
- Align the teams that undertake reviews of placements and that also gather and monitor provider data and intelligence. This will include intelligence about the quality of placements and safeguarding concerns
- Work jointly to shape the provider market, to optimise the quality and value of placements and to support its development to align with our strategic direction.

Within the scope of this project is:

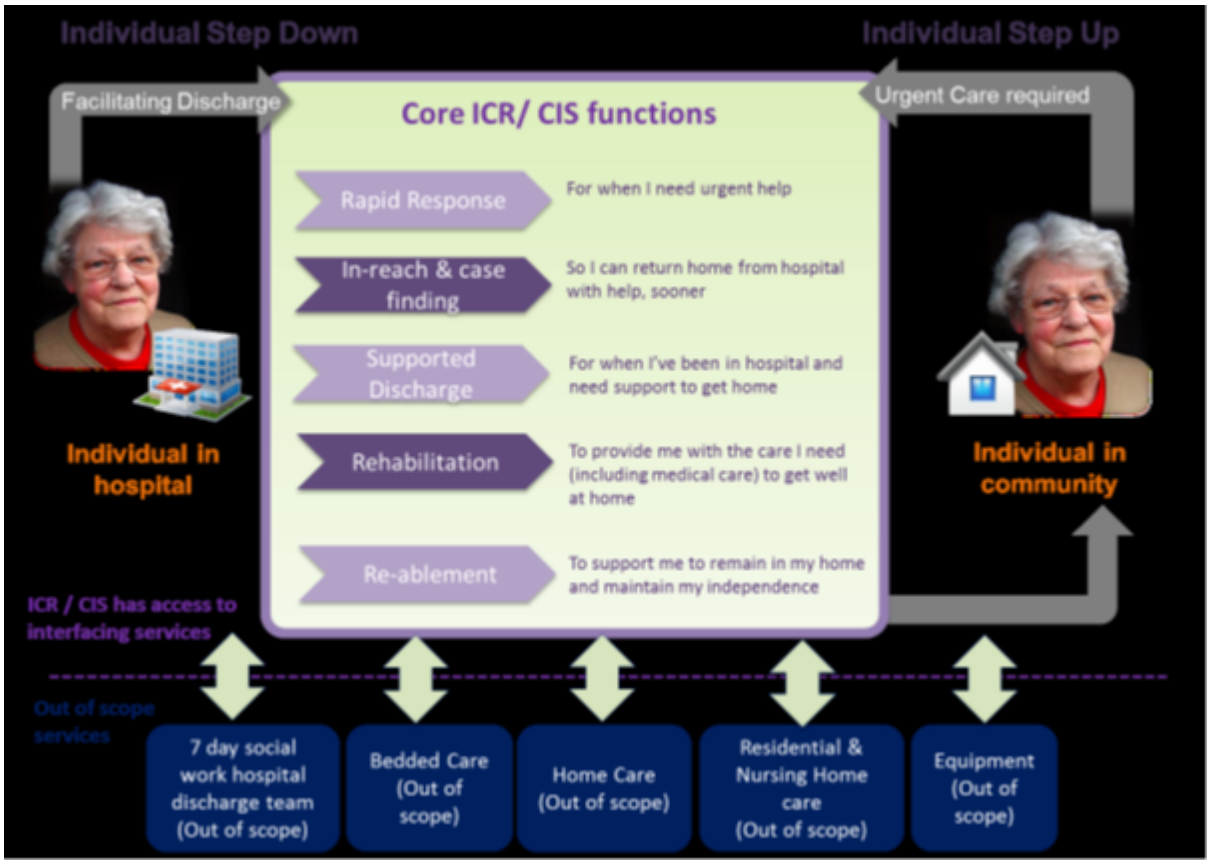
- Integration of the contracting and brokerage functions across Local Authority and Health placement teams, including:
  - Funded Nursing Care (FNC)
  - Non-residential Continuing Health care placements
  - Residential Continuing Health care placements
  - Adult Physical Disabilities placements
- Feasibility evaluation of increasing delegated authority thresholds for Continuing Health care placements
- Improved monitoring and pooled intelligence around service provision
- Qualification and quantification of potential financial savings associated with a joint contracting/brokerage team (supported by improved provider intelligence).

The Integrated Crisis Response/Integrated Community Independence Service (ICR/CIS):

The Tri-borough CCGs and Local Authorities are developing their intentions to commission a single Integrated Crisis Response/Community Independence Service. 'Integrated Crisis Response' indicates that this service responds to people with acute needs who are otherwise at risk of being admitted to hospital or a care/nursing home placement. It is also named 'Community Independence Service' to reflect the rehabilitation and reablement offer which enables people to regain their independence and remain in their own homes. The service is delivered by a multi-disciplinary team of community nurses, social workers, occupational therapists, GPs, geriatricians, mental health workers and others.

<u>What's in scope?</u>

Figure A provides a simple visual of the proposed ICR / CIS model from the patient's perspective.



A single integrated service specification for ICR/CIS starting in 2015/16 has been agreed by the CCGs and Local Authorities. This specification is for health and social care providers to work to one standard. The specification proposes an integrated, multi-disciplinary model of care that includes:

- A Single Point of Access (SPA) and referral (triage)
- 7 day a week hospital discharge services intrinsic to ICR/CIS 'case finding' and 'in reach' functions

- A rapid response multi-disciplinary team (MDT) providing community care within 2 hours and for up to 5 days
- A short term intensive intermediate community team which includes access to short term community beds reablement services for between 6 and 12 weeks
- Non-bedded community rehabilitation, treating non-complex conditions in a community setting.

The service we commission will be required to liaise with the registered GP as part of any decisions made about the patient. The Putting Patients First (PPF) case managers are the key care coordinators supporting patients whilst they are stable and also whilst they are requiring a crisis intervention.

The outcomes this will achieve are:

a) To enable individuals to be as healthy and independent as possible, maintaining/ regaining/or improving their quality of life and well being
b) To support individuals' choice to live in the most appropriate place of their choice, according to their needs and to have control over their lives
c) To ensure that the individuals' experience is a positive one by ensuring the service is personalised and seamless within the system.
d) To ensure that the treatment, care and support that is provided is right for the individual's needs, in the right setting and respects their individuality and dignity
e) To increase integration and efficiencies across health and social care to ensure strategic investment of funds and resources to maximise value for money.

Significantly, this will mean the following differences from April 15 onwards

- Single entry point into the service
- Single assessment process
- 2 hour rapid response
- Standardised hours for all functions
- 7 day working
- Medical input across all three services
- Single set of KPIs and outcomes monitoring framework
- S113 agreements established across each of the boroughs.

Following consultation with providers and co-design with patients on the proposed model and investment for 2015/16, commissioners will further specify how they will implement the recommendation set out in the detailed business case (September 2014), that:

- The new investment of £7.4m would be packaged up and offered out to the existing set of providers, in order to appoint two lead providers (1 in social care and 1 in health) to manage the delivery of the new service. A process will be run between existing providers in order to appoint 2 lead providers who would then work together in partnership to ensure delivery of a single integrated service.

In Quarter 3 of 2014/15 commissioners will inform existing providers of the process to select the lead providers and the requirements for these providers work together under a formal

agreement during 2015/16. This process will be completed by 1st April 2015 and will be informed by our work with patients in preparation for the transition year. The process will be designed to secure the collaborative agreement across all providers to implement the necessary changes that deliver the outcomes specified under the new service model.

4.3 Primary Care Transformation

A number of drivers have combined to create a pressing need to transform General Practice in NW London:

- **Patient expectations and requirements:** In a recent survey of NWL patient priorities for primary care, seven of the top ten issues related to improved access.
- **Patient needs:** The capacity of primary care is being placed under pressure. GPs are now managing more – and more complex – patient needs, including increasing numbers of patients living with long term conditions. London has many examples of great primary care and general practice. However, the service is nevertheless too variable and in places, unable to cope with the pressures placed on it today and into the future.
- **Implementation of the Shaping a Healthier Future reconfiguration programme:** The Independent Reconfiguration Panel (IRP) report on NWL's Shaping a Healthier Future (SaHF) programme requires GP practices in NW London to move towards a 'seven day' model of care to support the agreed changes to acute services.
- **Contractual drivers:** With effect from April 2014, GMS contractual arrangements have been amended to reflect an increased emphasis on improved access to General Practice.
- **Financial drivers:** A consistent, system-wide access model has the potential to reduce costs for both commissioners (reduced service duplication) and providers (more efficient use of resources).
- **Legislative changes:** The approval of the Legislative Reform (Clinical Commissioning Groups) order 2014, allows Clinical Commissioning Groups to form a joint committee when exercising their commissioning functions jointly; as well as enabling CCGs to exercise their commissioning functions jointly with NHS England via a joint committee.
- **Primary care strategic framework:** NHS England has released a set of descriptors covering 3 areas – Accessible Care, Co-ordinated Care and Proactive Care. In the future, they will be used to support local transformation strategies.

Though it may be part of the solution, expanding capacity alone will not sustainably improve General Practice. To deliver a new model of care that will drive a new model of General Practice, any strategy must deliver against 4 criteria:

1. **System-wide reconfiguration of access to all 'General Practice'-type services:** the provision of additional urgent appointments outside of core hours is unlikely to lead to sustainable improvements to access. In order to deliver services that genuinely reflect patient needs and preferences, we need to think about 7 day working across General Practice in its totality.
2. **Financial and operational sustainability:** a new model must be affordable and deliverable. In the long-term this probably means no net increase in cost or workforce.

3. **Meeting patient expectations:** a new model must deliver the type of appointments patients want, when they want them.
4. **Reconfigures supply and demand such that both are mapped more closely to clinical need:** Though patient choice should be respected, every effort should be made to ensure that patients receive care appropriate to their clinical condition. This means mapping capacity more closely to clinical need.

NWL have resourced a Primary Care Transformation programme to take this work forward. The programme comprises 5 distinct workstreams, which are described below:

Prime Minister's Challenge Fund (PMCF)

On 1st April 2014 this initiative was launched to improve access to general practice and test innovative ways of delivering GP services. NWL was chosen to deliver the largest pilot scheme - covering nearly 400 practices, and 1.8 million residents. This funding (matched by contributions from NWL CCGs) will be a significant enabler to delivery of NW London's vision for a transformed primary care landscape.

It is planned that the PMCF project will produce outcomes covering Urgent, Continuous and Convenient Care:

		Network responsibility	Implementation guide for 2014/15
URGENT CARE	• Patients with urgent care needs provided with a timed appointment within 4 hrs.	✓	Long term
	• Patients with non-urgent needs will be able to contact a clinician within 48hrs by phone, online or in person.	✓	Long term
	• Telephone advice and triage available 24/7 via 111.		
CONTINUITY CARE	• All individuals who would benefit from a care plan will have one.	✓	Medium term
	• Everyone who has a care plan will have a named 'care co-ordinator'.	✓	Medium term
	• GPs will work in multi-disciplinary networks.	✓	Medium term
	• Longer GP appointments for those that need them.	✓	Medium term
CONVENIENT CARE	• Access to General Practice 8am-8pm (Mon-Fri) and 6hrs/day during the weekend.	✓	Long term
	• Access to GP consultation in a time and manner convenient to the patient (via a range of channels including telephone, email and videoconference).	✓	Short term
	• Online appointment booking and e-prescriptions available at all practices.	✓	Short term
	• Patients given online access to their own records.	✓	Short term
	• Online access to self management advice, support and service signposting.		

We are doing this by supporting practices to develop strong networks and plans, so that by the end of 2014 / 2015 business cases will be available for a new model of care, and quick wins (e.g. around new applications for technology) will have been implemented. All PMCF activity is expected to align with changes in the GP contract agreement.

Primary Care Strategic Framework

NHS England has released a set of descriptors covering 3 areas – Accessible Care, Co-ordinated Care and Proactive Care. Further work is ongoing to refine and develop these as part of a pre-engagement phase.

The three areas are in effect a specification within a strategic commissioning framework to support local primary care transformation. This specification describes the service offer that patients could expect in the future across London, but it acknowledges implementation plans will need to be locally developed to meet the needs of different populations. In addition, it is expected that working in this way will relieve pressure and therefore enable general practice to deliver the improvements in care that they want.

It is now anticipated that these descriptors will be ready for wider engagement at the end of 2014. Our work is now focused on engaging with stakeholders and understanding how the descriptors could support a new model of care.

4.4 Patient Empowerment

As part of the wider integration agenda with Adult Social Care, we have been working in partnership with patients, carers and voluntary organisations to co-design and commission a range of patient empowerment programmes. The programmes will be targeted at supporting people with long-term conditions to take more control of their health and wellbeing. The outcome of engagement has enabled us to identify and embed an approach to working with patients, service users, carers and stakeholders. Our approach is therefore:

- **Collaborative**: bringing together clinicians, staff, patients, service users and the community together as equal partners to develop and implement the BCF programme
- **Evidence-based**: engaging to co-design evidence-based and locally appropriate solutions to promote integrated health and social care
- **Asset-based**: developing the capacity of patients, service users and the community to engage effectively in identifying needs, project planning and development, procurement, implementation and evaluation
- **Continuous and iterative**: engaging to build and refine sustainable models for local delivery that reflect the needs and aspirations of local people and frontline staff**/**

In terms of the programmes, these include:

Improving Experience of Integrated Care

The aim of this project is to monitor improvements in patient, customer and carer experience of integrated care by establishing an integrated system for capturing, using and integrating real-time patient, service user and carer experience and intelligence. The developed approach will be used to capture initial baseline intelligence of patient experience and continued monitoring of patient experience of integrated care, specifically regarding the Community Independence Service (CIS), and then eventually across wider transformation projects. This project will also support wider engagement and communications across the Better Care Fund and Whole Systems agenda by providing tools and support to facilitate effective engagement and co-design.

Embedding Self-Management

We will support patients and communities to have greater control over their health and wellbeing by co-designing a package of self-management programmes and interventions with customers. Specifically we will:

- **Commission new – and expand existing – evidence-based self-management programmes** and co-design condition specific self-management programmes to address gaps in service provision. We will do this by working in partnership with local 3rd sector organisations
- **Deliver a workforce development programme** on self-care and self-management
- **Establish a central point of contact** to provide tailored support and sign-posting in the health and social care systems, for those with long-term health conditions and their carers.

5. Required quality and outcome improvements

Quality

The CCG has identified priority areas for quality improvement in its main providers. These are detailed below.

Provider	Required quality improvements
CLCH	• Referrals responded to during the day, twilight or night periods within 24 hours • Reduction in grade 3 and 4 hospital acquired pressure ulcers.
CNWL	• Percentage of complaints agreed to within agreed targets • IAPT access: 15% of people with depression receiving psychological therapy • Recovery rate IAPT: 50% of people who complete treatment and are moving to recovery • Decreased number of violent and aggressive incidents.
Imperial	• Choose & Book: ensure sufficient appointment slots are available • Percentage of complaints agreed to within agreed targets • Decrease the percentage of cancellations by hospital for non-clinical reasons • Breastfeeding initiation rate • First booking maternity appointments completed by 12 weeks + 6 days as a percentage of total booking appointments in month, excluding late referrals (women referred after 10 weeks + 6 days).
Chelsea and Westminster	• Improvements in elective c/section rates • Palliative care patients who died in their preferred place of death.

Safeguarding

All services commissioned by the CWHHE CCGs must comply with the current legislation and NHS assurance systems covering safeguarding children and adults.

In respect of safeguarding children, services must comply with Section 11 (Children Act 2014), Working together to Safeguard Children (2013) and the current London Child Protection Procedures.

In respect of safeguarding adults, services must comply with the current London Safeguarding Policy and Procedures and be compliant ready for the Care Act 2014 which comes into force in April 2015.

Services must provide quarterly reports completed in a framework agreed with the designated nurses and adult leads and be prepared to report on their compliance with any additional statutory frameworks published during the period of the contract.

Quarterly reports must include training data, supervision provision, activity utilising partnership working, as well as a summary of learning from local and national case reviews or reports. The quality schedule is cross referenced to these points.

An annual report must be submitted to the CCG by August 1st.

Referrals to the Local Authority Designated Officer in relation to allegations against staff working with children or vulnerable adults must be reported to the Designated Nurse and Commissioner within one working day.

6. Information Technology

The CCG will continue to establish information technology across its commissioned services to ensure integrated and fit for purpose solutions that link primary care with other settings of care. For the coming year the intention is to build on the established programmes. Business Intelligence is a key enabler in all aspects of the CCGs commissioning programmes and providers will be asked to align their IT offering to achieve the overarching principle of achieving one actual or virtual electronic patient record across all settings of care.

The objective is to implement three layers of clinical information exchange where at least one of the following is in place in any setting of care:

- *Level 1* - There is access to and two way information exchange as well as associated workflow within a common clinical IT system and a shared record between the GP and the care provider.
- *Level 2* - Where the above is not possible due to technical, operational or financial constraints that as a minimum, the respective IT systems in primary care and elsewhere are interoperable and in full conformance with the current Interoperability Toolkit (ITK) standards (or other common messaging standards) as defined by the Health and Social Care Information Centre (HSCIC).
- *Level 3* - Where neither of the above is relevant or feasible then the Summary Care Record is enabled, available and accessible particularly where patients are receiving care out of area.

The CCG will work towards the sharing of clinical records in different settings of care within robust information governance frameworks and processes across the health and social care community. Providers will be expected to actively consent patients when sharing their records.

The CCG has made considerable investment in ensuring a unified primary care IT platform. Current and future providers will be required to work within the frameworks and opportunities that a single IT system across primary care can offer. This will be translated into more granular service specifications, service improvement plans and/or CQUINs where relevant. Explicitly, the CCG will expect all staff working in community settings to use SystmOne as default clinical system and will expect providers delivering ambulatory urgent care to use SystmOne.

The overriding objective is to improve standards of care facilitated by the accurate, timely and appropriate information exchange. However, at the core will be the principle of the primacy of the primary care record and the objective to directly or indirectly achieve the outcome of one patient one integrated record.

The technology currently in place and due to be implemented during 2015-16 will bring about a turning point in how different organisations work together to provide patient centric care. The CCGs will encourage all existing and future providers to:

- Fully exploit the opportunities by the standardised and common technology platforms, engaging staff to collaboratively design and implement solutions that bring about improvements in diagnosis, treatment and longer term care.
- Implement work and information flows that will reduce the administrative and processing burden on clinical and administrative staff across different organisations.
- Ensure that information exchange is in real time, processed within native IT systems of the organisation, accurate in content, structure and coding at the point of data entry.
- Inform and enable patients to improve their understanding and access to their medical records and take a proactive role in their own care through the use of technology solutions that will improve access to their own records and interaction with care providers. In effect, enabling self-care planning tools and solutions where appropriate and particularly targeted at patients with long term conditions.

It is a key objective to enable patient access to a suite of online services as well as their own records within a robust and secure environment. Under the Prime Minister's Challenge fund programme GP practices have been and will continue to provide patients access to their online services. Providers outside of primary care will also be asked to develop or link with existing systems so that patients have greater access to wider online services and records.

The CCG will, in addition, focus on these areas:

- Continue working to improve the timeliness and quality of information sent to or accessible by providers from GP practices via clinical IT systems and to ensure the most up to date, relevant and accurate information is always sent.
- Continue working with providers to enable safer and more efficient electronic methods of communication between them and primary care, building on the previous work and solutions around CQUINs with a greater emphasis on structured coding and integrated workflow.

- Extending the diagnostic cloud across the NW London health economy, ensuring the principle of one patient, one diagnostic record across NW London. Embedding the access to pathology and radiology results across all settings of care. Ensuring that ordering tests and receiving results across NW London are exclusively done electronically with minimal manual or paper based processes.
- Within the Better Care Fund programme, work with social services to develop an interface between IT systems and more robust information exchange within common information governance frameworks. Principally that all non-healthcare providers use the NHS number as the unique identifier of the patient for all services in order to integrate records.
- Developing tools for GP clinical IT systems to provide integrated services and processes such as in common clinical templates, status alerts and searches that will highlight key patients requiring further attention. Providing a patient risk stratification tool within (rather than outside) GP clinical systems, integrating more closely with other IT systems where the patient may have a record.

In addition the CCG will seek to implement (or make better use of) during 2014/15 and the following years, national and regional strategic IT systems such as:

- Choose and Book and its replacement system e-Referrals
- Ensuring high utilisation of the Electronic Prescribing System
- Close integration and information flows with Coordinate my Care system
- Maintain the high availability of accurate and timely Summary Care Record.

7. Local pathway priorities, gaps in service delivery and improving outcomes

Minor Surgery

The CCG is currently reviewing current minor surgery services commissioned from primary care and assessing scope for further development.

Learning Disabilities

For those with learning disabilities and their families, following on from the Winterbourne View Concordat, commissioning will be taking account of the national guidance (to be published later in the financial year) from the recently established Joint Improvement Programme and NHS England National Expert and Advisory Group.

To best support people with learning disabilities at home and in their communities, and reduce the reliance on hospital care, the design of services will be done in co-production with NHS providers, Local Authorities, charities and social enterprises.

Ensuring integrated local healthcare and housing provision takes account of the impact on primary and social care capacity following the reduction in the number of adult mental health beds across localities, commissioners will be particularly focused on commissioning pathways that take account of people with a learning disability and significant mental health need (dual diagnosis).

The 2015/16 commissioning priorities will focus on all mental health pathways at crisis, assessment, treatment and staying well stages, ensuring each pathway clearly determines, articulates and accommodates where and what reasonable adjustments in care are being made and delivered for those people with learning disabilities.

Working closely with Local Authorities on market development and service specifications, providers will be required to demonstrate that:

- Service users and their carers are able to receive an appropriate level of support in relation to day service provision, employment, housing, respite care, etc within their local communities.
- Services will significantly reduce the impact on secondary care provision.
- Services enable people with learning disabilities to be cared for and/or live independently within their local communities.
- The physical and financial resources in place are appropriate in terms of capacity and skills and competencies. And, that those resources are flexible enough to meet the needs of the individual i.e. by offering a high quality, value for money range of services e.g. in-reach services, supported living schemes, etc.

In addition, commissioners will be working to improve the ways in which people with learning disabilities are able to engage in providing feedback about services. Specifically, this will mean:

- Embedding learning disability into existing engagement processes by making them fully accessible, or providing a forum for people with learning disabilities to be fully engaged in developing and improving access to mainstream health and reducing health inequalities.
- Ensuring that we are able to collect feedback on the experience of patients with learning disabilities in an accessible format.
- Rolling out accessible devices to capture the experience of people with learning disabilities in primary, acute and community health care settings
- Working with people with learning disabilities, their carers and other partners across the statutory and third sector to improve access to equitable healthcare.

Carers

The CCG will continue to invest in services for carers, building on the work done in 2014/15, which has included the development of primary care based support for carers and for young carers.

As part of its Equality Objectives for 2013-2017, the CCG has committed to improving the rates of identification and support provided to carers and young carers, including within a primary care setting, and seek to offer appropriate support.

The CCG will develop its plans in line with the intentions in the Care and Support Act, which outlines the need to provide support services to carers, rather than simply identifying their needs.

Young Carers

We will continue to maintain our investment in supporting carers, with support to young carers as a key priority. We recognise the importance of working closely with partners and with organisations beyond health and social care, including education, in order to continue identifying and supporting carers.This will include a family based approach to support carers and their families to improve access to health care and reduce health inequalities.

The CCG will improve the rates of identification of young carers through primary and acute care.

8. Procurement plans

A summary of our specific procurement plans are set out in the table below and anticipated 'go live' dates are included in brackets.

Services where procurement is initiated in 2014/15 but there will be impact in 2015/16	**Services being procured in 2015/16**
111 (October 2015)	
Chel West UCC (October 2015)	
Expert Patient Programme (April 2015)	
Diagnostics (April 2015)	
Dermatology (April 2015)	
Cardiology (April 2015)	
Respiratory (April 2015)	
Ophthalmology (July 2015)	
Mental health service user group (Q1 2015/16)	
Wheelchairs (October 2015)	
Face to face interpreting services (Q2 2015/16)	

Providers should note that the St Charles Urgent Care Centre and GP Out of Hours contracts are under review and may be subject to procurement exercises later in 2014/15 or in 2015/16. The Out of Hours CAMHS service is under review in 2014/15 and may be subject to a tender exercise in 2015/16.

9. Contracting Intentions

Whole Systems Integrated Care (including Better Care Fund work-streams)			
Key deliverable	**Contracting intention**	**Joint commissioners**	**Sectors impacted**
New models of care in place for early adopters for over 75s and people with long-term mental health needs	<u>Whole Systems for patients aged over 75</u> In 2015/16, health and social care commissioners will hold multi-provider accountable care partnerships to account for delivery of population health outcomes for this population group. We will be co-commissioning an accountable care provider to commence during 2015/16 to deliver the range of services below: • 7 day services and a 24/7 over 75 primary care crisis response service. • Enhanced primary care service for over 75s • Outreach acute services working as part of a local community hub. There will be an underpinning principle of moving from unplanned to planned care for our over 75 population. A commitment will be expected from all providers to work differently within the umbrella contract for Whole Systems. Shadow capitated budgets will be in place and will be monitored for this patient cohort. The intended impact is to reduce hospital unplanned demand and the sizing of the above services will be quantified during analytical modelling by December 2014	Westminster City Council and the Royal Borough of Kensington and Chelsea	Acute, community, primary care, mental health, social care, GP out of hours, London Ambulance, third sector

	and will influence the final requirements of new services. <u>Whole Systems for patients with long-term mental health needs</u> In 2015/16, health and social care commissioners will hold multi-provider accountable care partnerships to account for delivery of population health outcomes for this population group. We will be co-commissioning an accountable care provider to commence during 2015/16 to deliver the range of services below: • Support for GPs in the management patients with long-term mental health needs • Access to expertise that supports recovery and social integration, from social networks, activities and time-banking, to support with housing, employment, training, life skills, meaningful activity, housing and benefits There will be an underpinning principle of supporting people with mental health needs to 'live well' in the community, increasing their resilience and social integration, and decreasing their reliance on secondary care services. A commitment will be expected from all providers to work differently within the umbrella contract for Whole Systems. Shadow capitated budgets will be in place and will be monitored for this patient cohort. It is envisaged that a detailed specification for this service will be complete by March 2015 with a forward procurement and mobilisation plan in place in Quarter 1		

	of 2015-16.		
Implement new Community Independence Service model	As part of the Better Care Fund, the implementation of a Tri-borough Integrated Community Independence Service will commence in 2015/16 with a transition year during which a phased approach can be taken with existing providers to work to a new single model service specification. Following consultation with providers and co-design with patients on the proposed model and investment for 2015/16, commissioners will further specify how they will implement the recommendation set out in the detailed business case (September 2014), that: • The new investment of £7.4m would be packaged up and offered out to the existing set of providers, in order to appoint two lead providers (1 in social care and 1 in health) to manage the delivery of the new service. A process will be run between existing providers in order to appoint 2 lead providers who would then work together in partnership to ensure delivery of a single integrated service. In Quarter 3 of 2014/15, commissioners will inform existing providers of the process to select the lead providers and the requirements for these providers work together under a formal agreement during 2015/16. This process will be completed by 1st April 2015 and will be informed by our work with patients in preparation for the transition year. The process will be designed to secure the collaborative agreement across all providers to implement the necessary changes that deliver the outcomes specified under the new service model. The lead provider(s) will need to demonstrate how they will ensure:	Hammersmith and Fulham CCG, Central London CCG and the Tri-borough local authorities	Community trusts, mental health trusts, acute trusts and social care providers

	• A rapid response multidisciplinary team (MDT) providing community care within 2 hours and for up to 5 days • Non-bedded community rehabilitation, treating non-complex conditions in a community setting. • Integrated reablement with access to short term community beds between 6 and 12 weeks • 7 day support to help people leave hospital.		
Develop and embed the Older Adult Support Team as part of the Community Independence Service model	As part of the CCG's in-year development work with the Community Independence Service, a pilot Older Adult Support Team will be developed in the north and the south of West London for implementation in December 2014 with a view to formally contracting this for the full year effect 2015/16. The pilot service will be provided by Chelsea and Westminster in the south and Imperial in the north, with input to both pilots from CNWL. The teams, led by consultant physicians, will provide: • Proactive care: case management support to practice MDTs and care homes • Reactive care: support for patients requiring step up care • Training and education: CIS/Rapid Response/discharge teams, care homes, primary care, LAS Outcomes in the specification for this service will be: • To maximise care and support in a person's own home so they can live independently for as long as possible • To maintain people in an appropriate setting when in an acute crisis and when on a stable platform • To assist with ensuring A&E and UCC visits and non-elective admissions are appropriate, and to reduce hospital length of stay	West London CCG only	Acute, mental health and community providers

	• To improve complex case management, case review and consultation within a MDT setting • To provide case specific education and training • To provide specialist input to the development of community provider networks.		
Putting Patients First: patients at risk of hospital admission to have a care plan in place and case management where appropriate	The CCG will continue to commission GP practices to deliver care planning for patients at-risk of hospital admission (via the CWHHE care planning Out of Hospital contract) and this will continue to be central to our Whole Systems model. Multi-disciplinary team working will continue to be embedded in all GP practices, and all practices will have practice-facing community nursing teams and case managers, offering continuity and case management for those who need it. A cohort of case managers are currently provided by CLCH. This service is currently being reviewed as part of a SDIP and the findings of this may inform a revised role description for these case managers going forward. We will develop multi-disciplinary case management roles to ensure that patients are case managed by the professional most appropriate to their needs. Implications of this are as follows: • Additional mental health case managers will need to be identified, to ensure complete coverage • Social workers will continue to attend MDTs in practices • We will also commission pharmacists to attend multi-disciplinary team meetings and undertake home visits via Brent CCG (hosting prescribing team). We will continue to commission Primary Care Navigators to support older patients with complex needs and to	West London CCG only	Primary care, community, mental health, third sector and social care providers

	ensure the content of care plans is meaningful to patients.		
Transforming nursing and care home contracting	Enhanced primary care provision in care homes will be ensured through the delivery of Out of Hospital specifications. Most significantly, the care planning and case management specification which will ensure appropriate care planning is taking place. We will continue to roll out the ICP Care Home Innovation Project to ensure complete coverage of all our care homes. This will require pharmacists, physiotherapists, GPs and district nurses to regularly attend MDTs in care homes. This work will support a reduction in non-elective admissions and A&E/UCC attendances from care homes, which will impact acute providers. In 2015/16, as part of the Better Care Fund, we will: • Integrate the contracting and brokerage functions for nursing and residential care placements across adult social care and health, creating a single team. Under this arrangement CCGs will continue to have governance for health-funded placements and the local authority will continue to have governance for adult social care placements • Align the teams that undertake reviews of placements and that also gather and monitor provider data and intelligence. This will include intelligence about the quality of placements and safeguarding concerns • Work jointly to shape the provider market, to optimise the quality and value of placements and to support its development to align with our strategic direction.	Hammersmith and Fulham CCG, Central London CCG and the Tri-borough local authorities	Nursing and care home providers, primary care, social care providers and community and acute trusts
Support the implementation of the new Tri-	Contracts with the new home care providers will be held	Hammersmith and	To be confirmed

borough Homecare service which includes the provision of low level health tasks (procurement is being led by the Tri-borough Local Authorities)	by the Tri-borough Local Authorities. The requirements to provide clinical training and governance under the new model of care will be advised. Further information on the impact of re-provision of low level health tasks will follow.	Fulham CCG, Central London CCG and the Tri-borough local authorities	
Extend the provision of neuro-rehab and intermediate care beds	For intermediate care, benchmarking and Tri-borough needs analysis work has been undertaken in 2014/15. This indicates that an increase in step up intermediate care beds, including neuro rehabilitation bedded capacity, is likely to be needed across the Tri-borough in order to meet the national average and deliver sustainable provision. We will complete the necessary detailed work to progress this and understand fully the implications in terms of dedicated medical support, enhanced nursing care provision and quick access to diagnostics, as well as financial and activity modelling to underpin future requirements.	Hammersmith and Fulham CCG, Central London CCG and the Tri-borough local authorities	Acute, community and social care providers

Patient Empowerment			
Key deliverable	**Contracting intention**	**Joint commissioners**	**Sectors impacted**
Strengthen self-management and patient education	<u>The Better Care Fund</u> The Better Care Fund Self-Management Work-stream will commission various projects under a framework for self-management transformation, including: • Workforce training and development • Capacity-building for existing self-management programmes • Process development to support transformation. The project will coordinate existing self-management transformation but also commission services that are not currently being delivered under the above framework. The details of these commissioning intentions are still being developed, in collaboration with other relevant project leads. In 2015/16 all providers will be expected to: • Train staff in motivational interviewing and patient activation models • Support design and enable access to self-care websites • Refer patient to self-care programmes. <u>Other CCG work-streams</u> The CCG is commissioning PPE grants to support self-management in 2014/15 and the successful projects will continue to run into 2015/16. The CCG is commissioning a health mentoring scheme in 2014/15, which is anticipated to extend into 2015/16. We will commission the Expert Patient Programme for	Central London CCG, Hammersmith and Fulham CCG and Tri-borough local authorities	All providers

	the Tri-borough in 2014/15 and this will be mobilised in 2015/16. We will continue to commission Primary Care Navigators in 2015/16 and will explore opportunities to maximise their role in supporting older patients with complex needs.		
Enhance methods of capturing and acting on patient feedback	<u>The Better Care Fund</u> As part of the Better Care Fund Patient Experience Work-stream, we plan to commission an organisation or agency within the next financial year to: • Co-design an approach for capturing experience of integrated care • Collect baseline data on patient experience before the implementation of the Community Independence Service • Collect comparative data during and after the implementation of the Community Independence Service • Embed a sustainable approach to capturing experience of integrated care to be used across BCF schemes. The principle commissioned organisation will be responsible for sub-commissioning support from local and voluntary authorities. In 2015/16 all providers will be expected to: • Ensure access to real time patient feedback on their experience of integrated care • Evidence action planning in response to patient experience data capture • Ensure provision of information and presentation of data which reflects the diversity of our population.	Central London CCG, Hammersmith and Fulham CCG and Tri-borough local authorities	All providers

	Other CCG work-streams The CCG will continue to support GP practices to establish and maintain Patient Participation Groups in 2015/16. We will re-commission the mental health service user group for the Tri-borough in 2014/15 and this will be mobilised in 2015/16.		
Expand coverage of Personal Health Budgets	During 2015/16 we will to increase the take up of Personal Health Budgets by providing greater support to people who wish to have a Personal Health Budget and making them available to a wider range of people. Continuing Healthcare Personal Health Budgets Personal Health Budgets will continue to be offered to everyone who is eligible for Continuing Healthcare in all care groups. Mental Health Personal Health Budgets We will complete the mental health pilot with WLCCG and Kensington and Chelsea MIND and, in line with 2015 guidance on Personal Health Budgets and mental health, aim to make these available for certain groups of people. Long Term Conditions Personal Health Budgets Personal health budgets will be offered to people who have long-term conditions across a range of health conditions. We will undertake a pilot for LTC and publish our offer from April 2015. We will develop this offer initially around therapies. We will review all relevant contracts to determine areas which are 'cashable' and can be used to provide services in a different way. This may be through 'top slicing' a small percentage of contract value in order to use the money differently.	Central London CCG, Hammersmith and Fulham CCG and Tri-borough local authorities	Community services, social care providers and third sector

	Children's Personal Health Budgets We will continue to work with our Local Authority partners to implement the Children and Family Act 2014 and in particular, new undertakings in relation to Personal Health Budgets. This will include sign posting eligible children, young people and families and ensuring Personal Health Budgets are considered as part of the Continuing Healthcare plans.		

Primary Care Transformation			
Key deliverable	**Contracting intention**	**Joint commissioners**	**Sectors impacted**
Deliver population-wide access to Out of Hospital services in general practices	The CCGs in the CWHHE collaborative are working together to enable transformation within primary care. The CCGs have agreed to realign services to support the delivery of the Out of Hospital strategies, including the commissioning of a consistent range of services – an Out of Hospital services portfolio - from GP federation(s). The portfolio comprises the following services: <u>Group 1: primary care services which will not result in reduced activity in other providers</u> Primary care access Care planning Complex common mental health Diabetes level 1 and diabetes high risk Homeless <u>Group 2: services which, when fully established in primary care, will reduce the amount of activity in other settings</u> Anti-coagulation monitoring Anti-coagulation initiation Simple wound care Complex wound care Diabetes level 2 Near patient monitoring Phlebotomy Severe and enduring mental health Ring pessary Ambulatory Blood Pressure Monitoring*	CWHHE CCGs	Primary care, acute providers, mental health providers and community providers

	ECG* Spirometry Testing* At this stage, the impact on individual acute, community and mental health providers is yet to be fully confirmed, as the new GP federation(s) are in the process of confirming contracted services and activity levels. It is also recognised that the implementation of these services will have varying impact as some are new, whilst others represent an extension of existing services, both in terms of specification and population coverage. In 2015/16, the roll-out of the service portfolio will be completed with the aim to have full population coverage by 2016/17. *Community providers have already been given notice that community cardiology and respiratory services are being tendered by the CCG in 2014/15. Some direct access diagnostics activity will be delivered under the new community contracts during 2015/16, but the CCG expects that as GP federations become established, the majority of this work will be done in primary care.		
Deliver Prime Minister's Challenge Fund objectives	We will commission primary care to deliver the objectives in the Prime Minister's Challenge Fund. These will include: • 7 day primary care services to be in operation within federation(s) • A range of consultation methods to be available to practices (telephone/email/Skype) • Alternative appointment booking methods to be available in primary care (ie online booking) • Patients to be able to access their records online.	NWL CCGs	Primary care

Mental Health Transformation			
Key deliverable	**Contracting intention**	**Joint commissioners**	**Sectors impacted**
Improve dementia services and achieve nationally mandated targets	The NWL Mental Health Programme Board is undertaking a review of dementia services; this review will be reporting later in 2014/15 and in 2015/16 we will be implementing the recommendations. These are likely to include creating a pathway which: • Increases capability to diagnose dementia in primary care • Increases specialisation of secondary care services to cover complex diagnosis • Increases the scope of practitioners working at the primary/secondary interface • Strengthens post-diagnosis support services including advocacy and advice services The CCG will be continuing to work to achieve the nationally mandated dementia diagnosis target.	Westminster City Council and the Royal Borough of Kensington and Chelsea	Primary care, mental health trusts and third sector
Increase Access to Psychological Therapies and achieve nationally mandated targets	The NHS England operating plan in 2014/15 mandates the following standards: • 15% of patients with common mental illness to enter treatment in IAPT services • 50% of patients reach recovery Providers will be expected to sustain performance at or above these levels in 2015/16. West London CCG has commissioned additional capacity to meet this requirement in 2014/15. Work is currently underway to review and benchmark provision across NWL. The recommendations of this review are expected later in 2014/15 and will be implemented in 2015/16. This is likely to include procurement to increase the diversity of provision and extend services to include young people, long-term conditions, medically unexplained symptoms (MUS) and severe and enduring mental health problems.	Westminster City Council and the Royal Borough of Kensington and Chelsea	Mental health trusts

Shifting Settings of Care: support people with mental health problems to be seen closer to home	We will continue to support people with mental health problems to be seen closer to home and in a less stigmatised setting. Primary care service provision will be enhanced. Provision will be designed and delivered by appropriately skilled local multidisciplinary teams and resources, working collaboratively across and between secondary, primary and third sector organisational and geographical boundaries with service users and their families and carers at the heart of decision making. To stimulate new ways of working that allows a remodelling of the workforce, and to enable the shifting of care closer to home to be achieved on a larger scale and in a consistent way, a range of resources, incentives and information will be proactively deployed and monitored to establish how providers impact directly or indirectly on quality outcomes and system flows e.g. [including but not exclusive to]: • A reduction in the burden on secondary care – delivering segments of mental health care pathways in community settings and close to patient's homes (e.g. recovery housing provision). • Prevention of patient's illness and injury, and improvements in independent living. We will also seek to repatriate out of area activity where appropriate to local providers reducing spot-purchase costs.	Westminster City Council and the Royal Borough of Kensington and Chelsea	Mental health trusts, primary care and third sector
Urgent care service development to ensure that everyone who need it has timely access to evidence-based care	Building on the parity of esteem agenda, and in response to the Crisis Concordat 2014, we will work with providers to implement a value-for-money, 24/7 single point of access to urgent and emergency mental health services. This will provide rapid access to appropriate service, including crisis response, Assessment and Brief Treatment, home treatment and signposting to relevant services.	Westminster City Council and the Royal Borough of Kensington and Chelsea	Mental health trusts, primary care and third sector

	We will contract with providers to ensure treatment of mental health emergencies has the same importance as a physical health emergency. We will review services to reduce the likelihood of future crisis through multi-agency recovery focused post crisis support. During 2015-2016, commissioners will contract with providers to: • Implement expediently any remaining performance improvement to deliver the NWL MH access standards for achievement by end of Quarter 1 (where necessary). • Contract for a quality improvement trajectory in terms of key Shared Care communication paperwork (MH2 – MH5.3, including those specifically tested under the Urgent Care and Access CQUIN: MH3, MH5.1 and MH5.3), for achievement by end of Quarter 1 (where necessary). • Ensure that the needs of a range of currently under-served groups are met, such as the needs of those in transition from CAMHS, those with Personality Disorder and those with severe behavioural disorders. • Address workforce development by delivering relevant training to support clinical pathways and develop core skills and competencies to enable the CCG to deliver high quality services. • Utilise developments in electronic e-referral systems and 'intelligence sharing' to enable trusted assessment across teams, improved access to treatment, faster response times and 'improved local health record self -ownership'.		
Continued implementation of psychiatric liaison standards	Specifically, in 2015/16, commissioners will be seeking to: • Secure full roll out of, and reporting against, the developmental measures being piloted by	NWL CCGs	Mental health trusts and acute trusts

	CNWL under the 2014-15 quality dashboard relating to patient experience, clinical outcomes and referrer experience. • Achieve greater core standardisation of services across all sites in terms of workforce skills mix, costs, activity, impact and productivity in line with contractual requirements. • Obtain further commissioning and delivery clarity on the nature of services across sites and, where there is a significant on-going psychological therapy provided for those with Long Term Conditions, ensure synergy with IAPT commissioning and delivery. We will require providers to work with us to understand the impact of changes in urgent care and IAPT current provision on Psychiatric Liaison Services. A review of Liaison Psychiatry Services has taken place across NWL during 2014/15 and as part of that it is the intention in 2015/16 that the Liaison Psychiatry Service in mainstream acute ward settings (not A&E) will be fully funded through the PbR Tariff. The CCGs expect the acute trusts to continue to provide a comprehensive in-patient Liaison Psychiatry Service to ensure the safety and appropriate referral of these patients to the relevant service. The provision of any additional physical care required due to a patient's mental health is included in the Admitted Patient Care PbR Tariff, although the treatment of their mental health condition is not and the patients would need to be referred to a mental health provider in the normal way through the Liaison Psychiatry Service. In addition, if an acute trust is caring for a patient with a mental health comorbidity /complication (e.g. dementia)		

	then whilst the Trust may sub-contract the care from a specialist mental health provider the Trust will be funded for this through the complications /comorbidities tariff. The CCGs will expect this to be fully operational from 1 April 2015 and will be seeking assurance through the contracting round that both the operational and business arrangements between the Trust and any sub-contractor have been agreed to the mutual satisfaction of both parties.		
Improve perinatal mental health services	We will commission services based on the recommendations of the review that is being undertaken in 2014/15. This is likely to include: • Services for all women who may experience a common mental illness (anxiety and depression) during pregnancy as well as those with a known MH problem or those who develop severe mental illness, which can be accessed to perinatal MH services for GPs and community health professionals. • Specialist perinatal services for all women with MH needs, incorporating MH midwives, and specialist MH nurses working with community midwifery teams and health visitors. • GPs to have access to a service to get specialist advice from and refer when required. • Commissioning third sector involvement to support families.	Westminster City Council and the Royal Borough of Kensington and Chelsea	Mental health trusts and third sector
Improve suicide prevention services	In 2015/16 we will consider commissioning a suicide awareness and intervention training programme for multi-sector providers.	Westminster City Council and the Royal Borough of Kensington and Chelsea	Mental health trusts and third sector

Children's Services			
Key deliverable	**Contracting intention**	**Joint commissioners**	**Sectors impacted**
Deliver integrated hubs for children	We will evaluate the success of the existing Connecting Care for Children hubs and consider wider roll out in 2015/16. Subject to evaluation, the CCG may look to extend the hubs to 50% of all practices in 2015/16.	West London CCG only	Acute, community and primary care providers
Commission child-centred Child and Adolescent Mental Health Services (CAMHS)	Intentions will be informed by guidance and specifications published by a number of NHS England CAMHS Clinical Reference Groups specifically focused on complex pathways i.e. Tier 4, Deaf Services, Secure Services and psychological therapies. In addition, services will be commissioned in the context of the outputs and recommendations associated with the Healthcare Select Committee Enquiry, with opportunities for commissioning alliances with NHS England explored in earnest. Following local community CAMHS reviews and working closely with stakeholders, commissioners will look to: • Jointly commission Behavioural Support Teams for children and adolescents with learning disabilities • Improve out-of-hours crisis response times and service provision • Jointly commission training and public education programmes with public health partners and safeguarding boards • Deliver equitable access to sustainable, high quality, productive and efficient CAMHS services, wherever a service user resides in North West London • Through multiagency collaboration, streamline the pathway for looked-after children in mental health.	Westminster City Council and the Royal Borough of Kensington and Chelsea	Mental health trusts

	The Out of Hours CAMHS contract is being reviewed in 2014/15 and may be subject to a tender exercise in 2015/16.		
Deliver improvements to maternity services	We will implement the recommendations from Shaping a Healthier Future for maternity services, including: 1. Consolidation of maternity and neonatal services from seven to six sites to provide comprehensive obstetric and midwife-led delivery care and neonatal care. 2. Consolidation of paediatric inpatient services from six sites to five sites to incorporate paediatric emergency care, inpatients and short stay /ambulatory facilities. The key trusts for these services will be Chelsea and Westminster, Hillingdon, Northwest London Hospital Trust, Imperial and West Middlesex. To support the delivery of this transition a central booking system will be implemented to co-ordinate the booking process across the receiving sites.	NWL CCGs	Acute trusts
Deliver improvements in Speech and Language services	We will implement the outcomes of the service specification review for Speech and Language Therapy.	Westminster City Council and the Royal Borough of Kensington and Chelsea	Community trusts
Implementation of Children and Families Act 2014	We will implement changes required as a result of the Children and Families Act (including personal health budgets). These will include: • Signposting families to the local authority 'local offer' website which summarises Education, Health and Care service available for young people with Special Educational Needs (SEN) and disabilities • Continuing to commission local child development services to provide timely health assessments for Education, Health & Care Plans	Westminster City Council and the Royal Borough of Kensington and Chelsea	Community and social care providers

	• Collaborating with our local authority partners to deliver Personal Health Budgets' and joint commissioned services for young people with SEN and disability needs.		

Urgent Care			
Key deliverable	**Contracting intention**	**Joint commissioners**	**Sectors impacted**
Full year impact of changes to Hammersmith Hospital and Central Middlesex EDs	Full year effect of new 24/7 UCC at Hammersmith. Reflect full year effect of activity transfers to other hospitals.	NWL CCGs	Acute providers
Deliver agreed standards for 7 day working	Over the course of 2015/16, acute trusts will work towards achieving the following 7 day standards: • Multi-disciplinary Team review: all emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours • Shift handover: handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week. All providers across primary, community and social care will work towards 7 day discharge pathways. This means that support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.	CWHHE Collaborative	Acute, community and mental health providers

Design and commission an integrated urgent care system to support patients to access the right care at the right time	We will commence a procurement exercise for the Chelsea and Westminster and Imperial Urgent Care Centres during 2014/15, with a view to contract award and mobilisation taking place in October 2015/16. Existing Urgent Care Centre contracts are expected to be operating in line with the Shaping a Healthier Future specification by March 2015.	Central London CCG and Hammersmith and Fulham CCG	Acute, community and GP Out of Hours providers
	We will re-commission the NHS 111 service. The procurement exercise will commence in 2014/15 and contract award and mobilisation will happen in 2015/16, in time for service launch of October 2015.	North West London CCGs	NHS 111 providers
	We will review the Urgent Care Centre contract at St Charles during 2014/15, with a view to designing an integrated and streamlined model of urgent care at the St Charles site. This may involve a procurement process.	West London CCG only	Community and GP Out of Hours providers
	We will review the GP Out of Hours service during 2014/15, with a view to designing a service that is integrated with the rest of the local urgent care system. This may involve a procurement process.	Hammersmith and Fulham and Central London CCGs	GP Out of Hours providers
	Along with other CCGs in NWL, we will consider use of MCAP across the West London health economy to ensure effective use of healthcare resources to best support and respond to patients' needs.	NWL CCGs	Acute and community providers

Planned Care			
Key deliverable	**Contracting intention**	**Joint commissioners**	**Sectors impacted**
Design and commission planned care services closer to home	We will procure a community ophthalmology service for the Tri-borough during 2014/15, with mobilisation and activity impact in 2015/16. 30% of first appointments and 50% of follow up appointments are expected to transfer from Imperial and Chelsea and Westminster into the community in 2015/16, with effect from July 2015. Acute trusts will be expected to discharge patients back into the community service for follow up where clinically appropriate. The new community service is due to be launched in July 2015. We will identify new NICE approved ophthalmology treatments and the options that can be used for secondary care ophthalmology treatments i.e. Wet AMD that will create significant cost efficiencies and improve patient experience. Current analysis indicates upper quartile levels of spend on high cost ophthalmology drugs within secondary care with additional management on-cost charges.	Central London CCG and Hammersmith and Fulham CCG	Acute and community providers
	We will procure respiratory and cardiology community services during 2014/15, with mobilisation and activity impact in 2015/16. The new community services are due to be launched in April 2015. Notice has already been served to Imperial (community cardiology) and CLCH (community COPD/respiratory and heart failure nursing). The CCG will reduce cardiology and respiratory outpatient first and follow up activity by 70% at Imperial, Chelsea and Westminster and The Royal Brompton to	Central London CCG	Acute and community providers

	reflect the shift into community. NB this is a joint procurement with Central London CCG, and Central London expect the activity shift to be up to 80%.		
	We will continue to progress the procurement of a community dermatology service in 2014/15 and the new service is due to commence in April 2015. Our current estimate is that a further 30% of first appointments and follow up appointments would be expected to transfer from Imperial and Chelsea and Westminster into the community in 2015/16. Notice has already been served to the incumbent community service provider.	Central London CCG	Acute and community providers
	We will scope opportunities to design and procure community services for gynaecology and urology in 2015/16.	To be confirmed	Acute and community providers
	We will explore enhancing the existing MSK community service by extending it to include an integrated rheumatology pathway in 2014/15. Our current estimate is that 40% of acute activity from Chelsea and Westminster and Imperial may be expected to transfer into the community in 2014/15 with a further 10% shift in 2015/16. We will fully implement the recommendations of the CWHHE MSK Review in 2015/16	West London CCG only	Acute and community providers
	We will conclude our review of our diabetes community service pathway with a view to standardising services across CWHHE.	CWHHE CCGs	Community providers
	We are jointly re-procuring a diagnostics service in 2014/15 to commence in April 2015. As is currently the case, the activity to be delivered through the contract is on the basis of no volume guarantees. Notice has	NWL CCGs	Diagnostics providers

	already been served to the incumbent provider.		
	We are continuing to jointly re-procure a wheelchairs service in 2014/15 and expect the new service to be live by October 2015. Notice has been served to the existing provider.	NWL CCGs and Barnet CCG	Wheelchair providers

10. Equalities and engagement

Duty to Involve

West London CCG is mindful of its individual participation duty to ensure that we commission services which promote the involvement of patients across the full spectrum of prevention or diagnosis, care planning, treatment and care management. In discharging its duty, the CCG has been working in partnership with patients, carers, the wider public and local partners to ensure that the services that are commissioned are responsive to the needs of the population.

Our Patient and Carer Experience Strategy was co-designed with patients, carers and stakeholders. It requires commissioned providers to ensure that patients, service users and carers are provided with opportunities to be involved in shaping and influencing the service and the organisation as a whole.

We therefore expect that providers will provide evidence of engagement of their service users and carers in the planning, development and delivery of services. More specifically, we expect that providers:

- Train and support service users and carers to be effectively engaged in the design and delivery of services as well as in shaping and influencing the organisation as a whole
- Work with local voluntary organisations and patient groups to deliver a programme of staff training and capacity development relating to understanding the experience of specific groups and communities
- Ensure that feedback on services reflects the diversity of the patient and service user population
- Work in partnership with local health and social care organisations to capture experience of integrated care.

Promoting equalities and improving patient experience and access

We expect providers to measure patient, service user and carer experience of accessing services and demonstrate that commissioned services are accessible by all. Evidence of this will be demonstrated by the provision of evidence in the following areas:

- Patient experience data. This should incorporate data relating to key equality groups. More specifically, data should include ONS categories plus sub-categories in order to reflect the diversity of the local population. The data should be analysed to assess whether:
    - There is a difference in outcomes of experience by patients, service users and carers
    - There is a difference in the perception of treatment and care between patients, service users and carers from different equality groups
    - Action has taken place to address gaps in relation to the points above.

- Uptake and Use of services. Providers should assess whether:
    - There are differences in the frequency of usage by different equalities groups e.g. A&E and UCCs
    - The services are delivered to meet the needs of the diverse population
    - There is anything the service can do to increase usage by those groups that under-use the service
    - Action has taken place to address gaps in relation to the points above.

- Complaints and other feedback. Providers should assess whether:
    - There are differences in the complaint rates for different groups with different needs or circumstances
    - There are particular areas of the service that causes a problem for particular groups of patients, service users and carers
    - There is an underlying cause or barrier that means that certain groups are receiving a better service than others and
    - Whether or not different groups have different expectations of the service
    - For investigated complaints equalities monitoring is carried out on a sampling basis by the Complaints Team and reported quarterly.

- Children with disabilities. Providers should ensure that they have in place a range of facilities and support available to children with disabilities and their carers. More specifically:
    - Waiting areas should sensitive to the needs of disabled children
    - Changing places and toilets for complex needs children which incorporate the right equipment with enough space
    - Signposting to support groups and coping strategies offered at point of diagnosis
    - Facilities for complex needs children admitted to hospital wards should include adequate hoists and changing facilities as well as adequate food and nutrition e.g. pureed food.
    - Parents and GPs should be copied in on all doctors and therapist reports.

Responding to local needs

The Contracting Intentions table details our specific intentions for 2015/16. The CCG's plans directly respond to patient and public feedback and equalities issues within the CCG. For example, we know that patients in specific communities (such as BME communities) are not accessing psychological therapies services in proportion to their needs. Our continued investment in psychological therapies services through the Primary Care Mental Health Service, alongside targeted engagement with these communities, will help to ensure that these needs are addressed.

In addition, we are continuing to commission the Primary Care Navigator programme to support older and vulnerable patients to navigate health services and to ensure their care is integrated and person-centred.

Our PPG grants programme has allowed us to commission projects from third sector organisations to support seldom-heard groups. Examples include: dementia volunteering; health representatives project for people with learning disabilities; health access for BME people with long term conditions; Reach Programme for young people and access to health care; and our Healthy Lifestyles Programme for BME communities in the Queens Park and Paddington area. We will be commissioning further projects through this mechanism in the autumn of 2014, for projects to run into 2015/16.

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City of Westminster

Westminster Health & Wellbeing Board

Date:	**20th November 2014**
Classification:	**Public**
Title:	**WORK PROGRAMME**
Report of:	**Head of Legal & Democratic Services**
Wards Involved:	**All**
Policy Context:	**Health & Wellbeing**
Financial Summary:	**None**
Report Author and Contact Details:	**Andrew Palmer, Committee & Governance Services: telephone 020 7641 2802 email apalmer@westminster.gov.uk**

1. Executive Summary

1.1 The Westminster Health & Wellbeing Board is invited to review its Work Programme for 2014-15.

2. Key Matters for the Board's Consideration

2.1 That the Westminster Health & Wellbeing Board considers whether any changes need to be made to the Work Programme for 2014-15.

3. Background

3.1 At its first meeting of the 2014-15 cycle on19 June, the Westminster Health & Wellbeing Board considered and agreed issues for future consideration for including in its Work Programme (attached as Appendix A). The Board has the opportunity to review its work programme at each meeting

3.2 The Board also considered dates for future meetings, which would take place 6 times per year. Dates for future meetings are:

- Thursday 22 January 2015
- Thursday 19 March 2015
- Thursday 21 May 2015

3.4 The 2014/15 work programme will be co-ordinated as much as is appropriate alongside the Health & Wellbeing Boards in the London Borough of Hammersmith & Fulham and the Royal Borough of Kensington & Chelsea. The work programme for the first half of 2014/15 is attached as Annex A.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact: Andrew Palmer, telephone 020 7641 2802, email apalmer@westminster.gov.uk

APPENDICES

A: Work Programme

Appendix A

Westminster Health & Wellbeing Board
Work Programme 2014/15

Agenda Item	Issue and/or decision	Reason	Lead
Meeting Date 20th November 2014			
Children and Young People Mental Health Task and Finish Group	Discussion and endorsement of Final Report and recommendations from the Task and Finish Group	Health and Wellbeing Strategy – Priority 2	Dr Ruth O'Hare (Board Lead) Steve Buckerfield (Task and Finish Group Lead)
School Nursing	To consider the results of the review of school nursing services and consider options relating to service design and future commissioning intentions	Links to P1 and P2	Meradin Peachey
Local Safeguarding Children's Board Annual Report	To consider the annual report from the Local Safeguarding Children's Board and reflect on areas for joint-working and partnership to improve outcomes for Children at risk	Request from LSCB Chair	Jean Daintith (LSCB Chair) Andrew Christie Tim Deacon (LSCB Manager)
Primary Care Commissioning Task and Finish Group	Discussion and consideration of the establishment of a Task and Finish Group focused on the commissioning of primary care.	Opportunity identified at September board meeting	Holly Manktelow/Liz Bruce
Better Care Fund	To update the Board on Westminster's Better Care Fund submission.	Standing item	Liz Bruce
CCG Contracting intentions	Discussion of DRAFT contracting intentions and business plans	Legislative requirement	Daniela Valdés (CL CCG) Katie Beach (WL CCG)

Meeting Date 22nd January 2015			
Contracting intentions and Business Planning	*Endorsement of final commissioning intentions and business plans*	*Legislative requirement*	Daniela Valdés (CL CCG) Katie Beach (WL CCG)
Housing Strategy	*Update on development of Westminster Housing Strategy and opportunity to provide further steer*	*Item of Interest*	*TBC*
Report on access to services	*Report on commissioned research into access to services*	*Item of Interest*	*TBC*
Care Act Implementation	*Report on the implementation of the Care Act – focus on new responsibilities around advice and prevention*	*Item of Interest*	*TBC*
Tackling Child Poverty	*Development of the Child Poverty Strategy*	*Item of interest*	*Executive Director of Children's Services* *Strategic Director of Housing and Regeneration*
Health Visiting Transition	*To understand the children's public health (0 -5) due to transfer to LAs in October 2015 and consider links to HWB Strategy priorities around early years such as School Nursing, MMR etc*	*Links to P1*	*Meradin Peachey*
Measles, Mumps and Rubella (MMR) update	*Report on the strategy for how uptake for all immunisations could be improved including ward level data.*	*Links to Priority 1 and key public health issue*	*Meradin Peachey (PH)* *Gemma Harris (NHSE)*