Public Document Pack

City of Westminster

Committee Agenda

Title:	**Health & Wellbeing Board**
Meeting Date:	**Thursday 19th November, 2015**
Time:	**4.00 pm**
Venue:	**Rooms 3 & 4 - 17th Floor, City Hall, 64 Victoria Street, London SW1E 6QP**

Members:

Councillor Rachael Robathan (Chairman)	Cabinet Member for Adults & Public Health
Dr Neville Purssell	Central London Clinical Commissioning Group
Councillor Danny Chalkley	Cabinet Member for Children and Young People
Councillor Barrie Taylor	Minority Group
Eva Hrobonova	Tri-borough Public Health
Liz Bruce	Tri-borough Adult Social Care
Andrew Christie	Tri-borough Children's Services
Dr Philip Mackney	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 Part 1 of the Agenda

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

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

Tel: 020 7641 8470; Email: thowes@westminster.gov.uk
Corporate Website: www.westminster.gov.uk

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

AGENDA

PART 1 (IN PUBLIC)

1. MEMBERSHIP

To report any changes to the Membership of the meeting.

2. DECLARATIONS OF INTEREST

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

3. MINUTES AND ACTIONS ARISING **(Pages 1 - 16)**

I) To agree the Minutes of the meeting held on 1 October 2015.

II) To note progress in actions arising.

4. HEALTH AND WELLBEING HUBS **(Pages 17 - 26)**

To consider the Health and Wellbeing Hubs Programme.

5. DEVOLUTION TO LONDON: UPDATE FOR BOARD MEMBERS **(Pages 27 - 34)**

To consider the update on devolution to London.

6. PRIMARY CARE CO-COMMISSIONING **(Pages 35 - 42)**

To consider the report on Primary Care Co-Commissioning.

7. LIKE MINDED - NORTH WEST LONDON MENTAL HEALTH AND WELLBEING STRATEGY - CASE FOR CHANGE **(Pages 43 - 62)**

To consider the briefing paper on Like Minded – North West London Mental Health and Wellbeing Strategy – Case for Change.

8. SYSTEM CHANGE REQUIRED AS A RESULT OF THE LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT **(Pages 63 - 124)**

To note the report on the system change required as a result of the Local Safeguarding Children Board Annual Report.

9. MINUTES OF THE JOINT STRATEGIC NEEDS ASSESSMENT STEERING GROUP MEETING HELD ON 30 SEPTEMBER 2015 **(Pages 125 - 132)**

To note the Minutes of the Joint Strategic Needs Assessment Steering Group meeting held on 30 September 2015.

10. WORK PROGRAMME **(Pages 133 - 134)**

To consider the Work Programme for 2015/16.

11. ANY OTHER BUSINESS

Charlie Parker
Chief Executive
13 November 2015

This page is intentionally left blank

CITY OF WESTMINSTER

MINUTES

Health & Wellbeing Board

MINUTES OF PROCEEDINGS

Minutes of a meeting of the **Health & Wellbeing Board** Committee held on **Thursday 1st October, 2015**, Rooms 3 & 4 - 17th Floor, City Hall.

Members Present:
Chairman: Councillor Rachael Robathan , Cabinet Member for Adults and Public Health
Clinical Representative from the Central London Clinical Commissioning Group: Dr Neville Purssell (acting as Deputy)
Cabinet Member for Children and Young People: Councillor Danny Chalkley
Minority Group Representative: Councillor Barrie Taylor
Acting Director of Public Health: Eva Hrobonova
Tri-borough Director of Children's Services: Liz Bruce
Clinical Representative from West London Clinical Commissioning Group: Dr Philip Mackney
Representative from Healthwatch Westminster: Janice Horsman
Chair of the Westminster Community Network: Jackie Rosenberg

Also Present: Councillor Barbara Arzymanow and Louise Proctor (Managing Director, NHS West London Clinical Commissioning Group)

1 MEMBERSHIP

1.1 Apologies for absence were received from Dr David Finch (NHS England), Dr Belinda Coker (NHS England) and Matthew Bazeley (Managing Director, NHS Central London Clinical Commissioning Group).

1.2 Apologies for absence were also received from Dr Ruth O'Hare (Central London Clinical Commissioning Group) and Andrew Christie (Tri-Borough Executive Director of Children's Services). Dr Neville Purssell (Central London Clinical Commissioning Group) and Ian Heggs (Tri-borough Director of Schools Commissioning) attended as their respective Deputies.

1.3 The Chairman advised the Board that Dr Ruth O'Hare was standing down as the Chair of the Central London Clinical Commissioning Group (CCG). The Chairman wished to place on record her gratitude for the enormous contribution that Dr Ruth O'Hare had made to joint working in Westminster

and to the Board. The Chairman then stated that she looked forward to working with Dr Neville Purssell who would take Dr Ruth O'Hare's place on the Board and as Chair of the Central London CCG.

2 DECLARATIONS OF INTEREST

2.1 No declarations were received.

3 MINUTES AND ACTIONS ARISING

3.1 **RESOLVED:** That

(1) The Minutes of the meeting held on 9 July 2015 be approved for signature by the Chairman; and

(2) Progress in implementing actions and recommendations agreed by the Westminster Health and Wellbeing Board be noted.

4 CENTRAL LONDON CLINICAL COMMISSIONING GROUP - BUSINESS PLAN 2016/17

4.1 Dr Neville Purssell introduced the report and advised that Central London CCG's Business Plan for 2016/17 was based on its vision to deliver care that was personalised, localised, integrated and centralised. The personalised care would ensure each person's care was unique. A key aim was to provide an integrated journey for patients and there would be re-configuration of the Whole Systems Integrated Care (WSIC). Dr Neville Purssell advised that the general themes of the Business Plan were linked to the wider North West London themes. The Board heard that a lot of work was underway in transforming mental health services and the affordability of WSIC presented a number of challenges.

4.2 Daniela Valdes (Head of Planning and Governance, NHS Central London CCG) then set out Central London CCG's transformational objectives for Westminster in 2015/16. The Board heard that the CCG wanted to address Westminster's priority in inequalities by developing a clear plan to address key areas of focus arising from the Joint Strategic Needs Assessment (JSNA) for the tri-boroughs and the CCG would be working closely with the JSNA to achieve this. In addition, the CCG sought to confirm models of care for key areas by establishing clear, shared delivery models and supporting incentive approaches. It also sought to establish priorities for contracting by developing a set of 'must do' key performance indicators (KPIs) to be included in contracts relevant to Westminster's needs. Daniela Valdes emphasised that the KPIs should reflect equalities considerations as well as financial performance. Programmes were to be re-configured to ensure planned care and a shift in care from acute services to community care services was being undertaken. As well as the transformation in mental health services, the Board noted that primary care would be strengthened by increasing out of hospital initiatives.

4.3 In reference to the transformation in mental health services, the Board emphasised the need for a joined-up approach, particularly as some mental health services were provided by local authorities. It was commented that the proposal to have a clear strategy in place by June 2016 regarding primary care estates was ambitious. Another Member stated that it was important to demonstrate how partner organisations would work together, including health trusts, and that the partner organisations understood how they would work collaboratively. It was asked whether a joint commitment would be made by partner organisations and suggested that a common statement from the partner organisations be made to show how they would work together.

4.4 In reply, Dr Neville Purssell advised that the CCG was considering how it could bring some services out to the community, however finding available and appropriate accommodation was an issue. An assessment of what would be needed to provide more community services was required and Dr Neville Purssell acknowledged that this piece of work should be undertaken jointly with partner organisations, including local authorities. He advised that one of the WSIC's aims was to work with the providers network to maximise benefit both in terms of patients and in meeting financial challenges. Increasing the number of those in community care would take some pressure off acute services and allow it to focus on priorities, as well as being financially desirable. Daniela Valdes added that discussion was just beginning on how the partner organisations would work together and that some acute service providers were also willing to offer community services. The WSIC also sought to emphasise that organisations work collaboratively in partnership in meeting future challenges.

4.5 Jackie Rosenberg stated that her experience of attending Provider Network meetings of the Central London CCG demonstrated the scale of the challenges faced. She advised that she was working as the voluntary and community sector representative with colleagues, including with the Council's Social Services to design a Whole Systems new integrated model of care for those over 65 years of age and those with long term health conditions. A business case had been produced and it had been demonstrated how important contributions from the voluntary and community sector were. She spoke of the challenges of moving from the current model of care to a new model of care. She stated that investment would be needed to achieve the new model of care through 'invest to save'. However, no agreement on investment had been agreed as funds were not yet available and she felt that some organisations needed to set aside self-interest to facilitate this. The challenge was to make these funds available and she suggested that it needed to be driven from a larger scale than just the individual CCGs in order to make it affordable.

4.6 The Board recognised the enormous challenges faced in changing the model of care and recognised there was not a large amount of investment available to undertake this. It was requested that the the West London CCG Business Plan for 2016/17 be circulated to the Board. In reply, Louis Proctor (Managing Director, West London CCG) confirmed that the Business Plan would be circulated and the principles included focusing on mental health and a business case was being prepared for January 2016 in respect of WSIC to

take into account the number of people with long term health needs. Louise Proctor advised that the WSIC was similar to Central London CCG with some differences in approach and the Business Plan also outlined the journey of integration. There were also some differences on the technological platform used, with one IT system across all practices which facilitated joining up of records. Dr Neville Purssell advised that three 'test villages' were being set up in Central London as part of phasing in a care coordinating system by April 2016 which would eventually serve all the entire population.

4.7 A Member spoke of the big pressure in Westminster in respect of the GP estates and enquired whether West London CCG faced similar pressure. In reply, Louise Proctor advised that West London CCG was required to have an estates strategy by March 2016 that looked to understand what services and providers were currently in place, how the estate could accommodate this and what properties were available and she added that primary care estates were also a challenging issue for the West London CCG.

4.8 A Member enquired what steps were taken by the Central London and West London CCGs to ensure that providers were in tune with the business plans. In reply, the Chairman advised that providers met with CCGs on a quarterly basis to discuss such issues, whilst providers including Imperial College Healthcare NHS Trust also met monthly in respect of the Better Care Fund. She added that it was encouraging that Imperial College had also put themselves forward to be a community care provider.

5 WESTMINSTER HEALTH AND WELLBEING HUBS PROGRAMME UPDATE

5.1 Liz Bruce (Tri-borough Director of Adult Social Care) presented the report and advised that the main purpose of the programme was to ensure that resources that were already available were being used effectively and to make services more accessible, particularly for young people, who may be reluctant to access services in the way they were currently offered. The programme also looked to address supporting older people who may be socially isolated. Liz Bruce advised that the programme was now achieving better outcomes and in the longer term it was planning to change patient behaviour in order to help reduce costs.

5.2 Eva Hrobonova (Acting Tri-borough Director of Public Health) added that Public Health were involved in a number of initiatives in the programme, including the Newman Street Project temporary accommodation project. Meenara Islam (Principle Policy Officer) then provided further details on the Newman Street Project, which provided accommodation to single, homeless people with complex and multiple needs, including mental health issues. She advised that there were four floating support officers involved in the project who sought to identify the needs and aspirations of those staying at Newman Street and to help improve uptake of services for them. The project also sought to address preventative measures and was working with Great Chapel Street Primary Care Centre who were helping to improve access to services.

5.3 The Chairman stated that the Programme was at an early stage and was looking to intervene to help older and young people's needs at an earlier stage and to make services more accessible. She welcomed ideas from the Board. A Member commented that sport and leisure would play an increasing role in helping people to a healthier lifestyle and suggested that there was an opportunity to integrate activities at the Moberly Sports and Education Centre. Therefore, he suggested that thought be given as to whether Moberly Sports and Education Centre was an appropriate site to accommodate activities. He also felt that it may be more helpful to use the term 'professional support' rather than 'services'. In reply, Liz Bruce stated that there should be consideration as to how empty space could be utilised, whilst it was important to consider where professional services would be located and how would they be accessed. She emphasised the importance of sharing assets to help work in an integrated way. The Chairman added that those in most need may not be able to access sports and leisure centres, whilst the hubs could also provide virtual professional support and services.

5.4 A Member commented that were was a lot of expertise amongst community organisations and more effort should be made to engage with such organisations. For example, she stated that her organisation had played a key role in ensuring that the Newman Street Project happened. The Member stressed the importance of allowing voluntary and community organisations to contribute to the programme and at an early stage to help co-design and co-produce schemes. She suggested that a half day session be run to discuss ideas on how the programme can be taken further. Another Member also expressed an interest in her community organisation being involved and stated that a multi-organisational approach would be beneficial, particularly in early intervention work for areas such as domestic violence and young offenders.

5.5 The Chairman explained that the programme had been reported back to the Board at an early stage to ensure that suggestions and contributions could be made to help shape and develop the programme. She welcomed both community and health organisations to join the programme's Working Group. The Board agreed that Meenara Islam contact Members to nominate volunteers to become involved in the programme and the Working Group. It was also agreed that an update on the programme be provided at the next meeting.

6 DEMENTIA JOINT STRATEGIC NEEDS ASSESSMENT - COMMISSIONING INTENTIONS AND SIGN OFF

6.1 Colin Brodie (Public Health Knowledge Manager) introduced the item and stated that data from a wide range of sources had been taken to help inform future commissioning intentions for dementia. He advised that dementia rates were increasing and it was predicted that those with dementia would increase by around 55% in the next three years across the tri-boroughs. Dementia diagnosis rates were also rising because of improvements in diagnosis rates. The Board heard that most of the cost of supporting those with dementia fell on unpaid carers and adult social care, and so there would be a need to support, advise and empower cares to fulfil this role without a detriment to

their own quality of life. There was also a need to increase training for both paid and unpaid carers. Colin Brodie advised that because dementia services were provided by a range of services, better cohesion and collaboration was needed through well-coordinated information, advice, advocacy and outreach services. It was also recognised that people with dementia needed to receive parity of access across mental and physical health services.

6.2 Colin Brodie advised that the dementia Joint Strategic Needs Assessment (JSNA) was rated against National Strategy Objectives, NICE guidance and views expressed by people with dementia and their carers, qualitative research with clinicians and other supporting evidence. The key themes from the North West London Strategic Review of Dementia had highlighted the importance of achieving timely diagnosis, whilst balancing against support being available for post-diagnosis. Colin Brodie then referred to the 32 recommendations in the report on how dementia services should be provided.

6.3 Lisa Cavanagh (Interim Joint Commissioner – Dementia) commented that local authorities and CCGs needed to consider how the Dementia JSNA had informed them and she emphasised the importance of the need to ensure that dementia services aligned with the North West London Strategy. The Board heard that consultation with stakeholders about the proposals had been undertaken over August and September and data was being collected to assess whether there were any gaps in services. The information obtained would help inform development of service models and examples of good practice at centres would be identified to help improve services. Lisa Cavanagh advised that overall the aim was to provide enhanced dementia services. It was intended to provide a 'hub and spoke' model involving main hubs supported by resource centres. The recommendations had identified that there had been fragmentation of services and the hub model sought to align all services. Lisa Cavanagh sought views as to whether a Joint Health and Social Care Dementia Programme Board across the tri-boroughs was desirable.

6.4 The Board welcomed the recommendations in the report, however in respect of the recommendations concerning residential care, it was noted that this piece of work was already being undertaken by local authorities and CCGs on older people. In respect of a Joint Health and Social Care Dementia Programme Board across the tri-boroughs, it was commented that this would make sense in ensuring a more joined-up approach. It was suggested that a multi-agency forum be created to help support the changes to Dementia Services and that the model of residential care be replaced by extra care and other models of care. Another Member felt that more information was needed on how to address dementia to help voluntary organisations such as the befriending service in Westminster that worked with older people. She stressed that dementia was a public health issue and suggested that key supportive messages would be useful. The Board acknowledged that charities also did a lot of work on dementia.

6.5 Louise Proctor advised that there was a coordinator of care in terms of total needs for older people in WSIC and that work on dementia should be coordinated with this. The Board agreed that progress on the dementia JSNA

be reported back to the 21 January 2016 meeting. The Board also agreed that Lisa Cavanagh look into setting up a body to oversee implementation of the dementia strategy with a view to the body regularly report back to the Board. The Board signed off the Dementia JSNA.

7 WESTMINSTER PRIMARY CARE PROJECT UPDATE

7.1 Stuart Lines (Deputy Director of Public Health) introduced the report and advised that the project looked at future needs of primary care through assessing demographics, disease patterns and policy changes. He then introduced Damien Highwood (Evaluation and Performance Manager,) who gave a presentation on the three stages of the project. The first stage looked at demographics, including a record of projections, including breaking down into selected age groups, and developing a model linking population to future needs. The Board heard that the population had grown by 3% in the last year despite a fall in birth rates as death rates had also fallen. There had been a significant increase in those over 85 years of age, with numbers doubling in the last 13 years. Damien Highwood advised that the issue of accuracy for demographics also needed to be considered as it was complicated by factors such as the large numbers of second home owners in Westminster and the national and international flows of people in and out of the borough. Another issue was the percentage of population that were registered with GPs. Damien Highwood advised that the second stage involved overlaying other impacts on demand, whilst the third stage involved creating model development opportunities for the future.

7.2 Andrew Rixom (Public Health Analyst) added that 50% of the population were classified as fit and healthy with no health issues. Obtaining local data was also largely dependent on GPs sharing data with the local authority's data.

7.3 The Board welcomed the useful information that had been collated to date that would help inform where to focus future primary care services. A Member commented on the pressures on adult social care funding both locally and nationally if demand rose as projected. A number of interdependencies existed within primary care, such as the level of vacancies in NHS and how this related to immigration policy. Another Member remarked that it was important to tackle preventative illnesses through changing lifestyles and diet. She also suggested that consideration of what areas were experiencing a population increase in Westminster on a ward basis would be beneficial. It was commented that the impact of changes to the tax credit system should be factored in. It was also important to consider whether population was based on the Census or the register of GPs, whilst the challenges of delivering primary care whilst fewer new GPs and nurses were coming through also needed to be considered. It was noted that obesity and the effects of it had not been mentioned in the report and presentation.

7.4 In reply to the issues raised, Andrew Rixom acknowledged that tackling preventative illnesses through lifestyle and diet changes could be included as a factor for the model. Immigration was also a factor and the Board was advised that the death rate figures for those over the age of 85 was based on figures from the Office for National Statistics. It had been expected that the

death rate amongst the over 85s would continue to fall, however this had not been the case in the last three years. Andrew Rixom stated that cultural and behavioural elements also needed to be considered. He advised that GP lists in Westminster were variable in terms of whether they accurately reflected population and some patients, such as those in Queens Park and Paddington areas, may not be Westminster residents. Andrew Rixom acknowledged that obesity was also a factor and that it could lead to the prevalence of some diseases.

7.5 Damien Highwood stated that changes of policy, both at Westminster and national level, may also impact upon primary care and these would be factored into the model. It was important that the relevant partners, organisations and agencies reached an agreement into what the likely impact of changes to policy would be.

7.6 The Board agreed that phase two of the project should provide an overlay of the present situation and identify influencing factors, as well as taking stock of the existing GP provision. The Board agreed that the third phase should involve local authorities and CCGs considering how they would provide primary care services to meet future needs. The importance of ensuring that there was representation on all sides was emphasised. The Board also requested that Stuart Lines work with CCGs and NHS England in developing the Westminster Primary Care Project.

8 CHILDREN AND FAMILIES ACT UPDATE

8.1 Ian Heggs presented the report and advised that the Act represented significant changes to the way services are delivered to young people with Special Educational Needs (SEN). He advised that the Government had extended the time that Education Health and Care Assessments should be undertaken from 14 weeks to 20 weeks due to the problems local authorities were having in meeting this timeframe. In the case of Westminster and the other tri-boroughs, the proportion of SEN pupils was above the national average. The Board noted that the extension of some Education Health and Care Plans up to the age of 25 placed more financial pressures on local authorities as no additional funds were provided for this. However, a more joined-up approach was being taken and draft guidance was to be published in respect of post-19 education. There was also now provision of transport for post-19 year olds. Ian Heggs advised that a Parent Reference Group had been set up in April 2014 as part of the key theme of ‘co-production’. Although the Group was new, steps were being taken to strengthen its role.

8.2 A Member commented that the changes from a more personalised transport provision for SEN pupils to the current service involving larger vehicles had broken personal relationships and had been a stressful experience for some SEN pupils. He expressed concern about the additional financial pressures on local authorities to provide extended services and the stresses it placed on staff. In reply, Ian Heggs advised that additional temporary grants for SEN pupils were available and he would provide details to Councillor Barrie Taylor on this, as well as workload information for SEN staff. Ian Heggs added that finding high quality SEN staff was a national issue.

9 BETTER CARE FUND UPDATE

9.1 Liz Bruce presented the report and advised that a reduction in savings and benefits in delivering the plan was expected from the original forecast due to reductions in expected benefits arising from residential and nursing placements and Section 75 Agreements. As a result, a savings gap of £2.489m was forecast and some real financial challenges lay ahead. Liz Bruce drew the Board's attention to the revised expected savings as set out in the report. The Board noted that a Director for WSIC had been recruited.

10 PRIMARY CARE CO-COMMISSIONING UPDATE

10.1 Christopher Cotton (PA Consulting) presented the report and advised that the eight local CCG Co-Commissioning Joint Committees work was framed by the North West London Co-Commissioning Committee. Board Members were invited to represent the Board on the local Joint Committees. Christopher Cotton advised that the CCG chairs considered how primary care would look like in the future and discussed issues concerning implementation, funding and the model of care. The Joint Committees considered governance issues and proposals and regular updates on their work could be provided to the Board. Christopher Cotton added that co-commissioning would increase scope for pharmacies in the future.

10.2 Louise Proctor stressed the importance of ensuring the appropriate representation on the local CCG Co-Commissioning Joint Committees. She stated that striking the right balance with the role of NHS England was also important. Louise Proctor acknowledged that it was better to have a local conversation and to able to influence local decisions in co-commissioning, however it did present a more complex way of decision-making.

10.3 A Member commented on the challenges posed by primary care co-commissioning, such as the current fragmented nature of the provider network and the potential conflict of interest that may arise from an organisation that played both a commissioner and provider role. There were also concerns about the quality of service provided by new providers and their financial stability. The issue of how CCGs were faring in terms of risk management and risk assessment also needed to be considered. The Board concurred that conflict of interest was an issue. A Member requested more information on social services authorities and other local authorities in North West London in future papers. Another Member stated that the financial challenges could not be underestimated, particularly in respect of adult social care, and it was important that partners worked together closely to address this.

10.4 The Board emphasised the importance of local authority representation in terms of governance. The Board acknowledged that although the overall direction of travel was satisfactory, there were a number of elements that were challenging to manage. The Chairman indicated that more time would be given to discussing primary care co-commissioning at future Board meetings.

11 MINUTES OF THE JOINT STRATEGIC NEEDS ASSESSMENT STEERING GROUP MEETING HELD ON 27 JULY 2015

11.1 The Board noted the minutes of the Joint Strategic Needs Assessment Steering Group meeting held on 27 July 2015.

12 WORK PROGRAMME

12.1 The Board noted the current Work Programme.

13 ANY OTHER BUSINESS

13.1 There was no additional business for the Board to consider.

The Meeting ended at 6.16 pm

CHAIRMAN: _____ **DATE** _____

WESTMINSTER HEALTH & WELLBEING BOARD
Actions Arising

Meeting on Thursday 1st October 2015

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

Meeting on Thursday 9th July 2015

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

Update on Preparations for the Transfer of Public Health Responsibilities for 0-5 Years		
Board to receive an update in 2016.	Public Health	To be considered at a meeting in 2016.

Meeting on Thursday 21st May 2015

Action	Lead Member(s) And Officer(s)	Comments
North West London Mental Health and Wellbeing Strategic Plan		
That a briefing paper be prepared outlining how the different parts of the mental health services will work and how various partners can feed into the process.	NHS North West London	To be considered at a forthcoming meeting.
Adult Social Care representative to be appointed onto the Transformation Board.	NHS North West London Adult Social Care	To be confirmed.
Children and Young People's Mental Health		
A vision statement be produced and brought to a future Board meeting setting out the work to be done in considering mental health services for 16 to 25 year olds, the pathways in accessing services and the flexibility in both the setting and the type of mental health care provided, whilst embracing a multidisciplinary approach.	Children's Services	To be considered at a forthcoming meeting.
The role of pharmacies in Communities and Prevention		
Public Health Team and Healthwatch Westminster to liaise and exchange information in their respective studies on pharmacies, including liaising with the Local Pharmaceutical Committee and the Royal Pharmaceutical Society.	Public Health Healthwatch Westminster	Completed
Whole Systems Integrated Care		
That the Board be provided with updates on progress for Whole Systems Integrated Care, with the first update being provided in six months' time.	NHS North West London	First update to be considered at the 19th November 2015 Health and Wellbeing Board meeting.
Joint Strategic Needs Assessment		
Consideration be given to ensure JSNAs are more line with the Board's priorities.	Public Health	Report being considered 9th July 2015
The Board to be informed more frequently on any new JSNA requests put forward for consideration.	Public Health	On-going.
Better Care Fund		
An update including details of performance and		Update to be

spending be provided in six months' time.		considered at the 19th November 2015 Health and Wellbeing Board meeting.
Primary Care Co-Commissioning		
Further consideration of representation, including a local authority liaison, to be undertaken in respect of primary care co-commissioning.	Health and Wellbeing Board	In progress
Work Programme		
Report to be circulated on progress on the Primary Care Project for comments.	Holly Manktelow Health and Wellbeing Board	Circulated.
The Board to nominate a sponsor to oversee progress on the Primary Care Project in between Board meetings.	Health and Wellbeing Board	To be confirmed.
NHS England to prepare a paper describing how they see their role on the Board and to respond to Members' questions at the next Board meeting.	NHS England	To be considered at the 9th July 2015 Health and Wellbeing Board meeting.

Meeting on Thursday 19th March 2015

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

Meeting on Thursday 22nd January 2015

Action	Lead Member(s) And Officer(s)	Comments
Better Care Fund Plan		
Further updates on implementation of the Care Act to be a standing item on future agendas.	Adult Social Care	Completed.
Child Poverty		
Work to be commissioned to establish whether and how	Children's	In progress.

all Council and partner services contributed to alleviating child poverty and income deprivation locally, through their existing plans and strategies – to identify how children and families living in poverty were targeted for services in key plans and commissioning decisions, and to also enable effective identification of gaps in provision.	Services	
To identify an appropriate service sponsor for allocation to each of the six priority areas, in order to consolidate existing and future actions that would contribute to achieving objectives.	Children's Services	In progress.
Local Safeguarding Children Board Protocol		
Protocol to be revised to avoid duplication and to be clear on the different and separate roles of the Health & Wellbeing Board and the Scrutiny function.	Local Safeguarding Children Board	Completed.
Primary Care Commissioning		
A further update on progress in Primary Care Co-Commissioning to be given at the meeting in March 2015.	Clinical Commissioning Groups. NHS England	Completed.

Meeting on Thursday 20th November 2014

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

Meeting on Thursday 18th September 2014

Action	Lead Member(s) And Officer(s)	Comments
Better Care Fund Plan 2014-16 Revised Submission		
That the final version of the revised submission be circulated to members of the Westminster Health &	Director of Public Health.	Completed.

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

Meeting on Thursday 19th June 2014

Action	Lead Member(s) And Officer(s)	Comments
Whole Systems		
Business cases for the Whole Systems proposals to be submitted to the Health & Wellbeing Board in the autumn.	Clinical Commissioning Groups.	Complete.
Childhood Obesity		
A further report to be submitted to a future meeting of the Westminster Health & Wellbeing Board by the local authority and health partners, providing an update on progress in the processes and engagement for preventing childhood obesity.	Director of Public Health.	To be considered at a forthcoming meeting
The Health & Wellbeing Strategy		
A further update on progress to be submitted to the Westminster Health & Wellbeing Board in six months.	Priority Leads.	Completed
NHS Health Checks Update and Improvement Plan		
Westminster's Clinical Commissioning Groups to work with GPs to identify ways of improving the effectiveness of Health Checks, with a further report on progress being submitted to a future meeting.	Clinical Commissioning Groups	Completed

Joint Strategic Needs Assessment Work Programme		
The implications of language creating a barrier to successful health outcomes to be considered as a further JSNA application. *Note: Recommendations to be put forward in next year's programme.*	Public Health Services Senior Policy & Strategy Officer.	Completed

Meeting on Thursday 26th April 2014

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

City of Westminster

Westminster Health & Wellbeing Board

Date:	19 November 2015
Classification:	**General Release**
Title:	Health and Wellbeing Hubs
Report of:	Liz Bruce, Executive Director of Adult Social Care and Health
Wards Involved:	All
Policy Context:	The programme of work is consistent with the stated vision and objectives of the partners within the Westminster Health and Wellbeing Board, and is a mechanism for delivering the strategic ambitions, outcomes and efficiencies required from City for All.
Financial Summary:	NA
Report Author and Contact Details:	Meenara Islam, Principal Policy Officer, Westminster City Council mislam@westminster.gov.uk / 020 7641 8532

1. Executive Summary

1.1. The Health and Wellbeing Hubs programme was initiated to test how best to improve the lives and outcomes of disadvantaged and groups individuals through changing the way we work within the Council and with our partners. The focus is on improving the use of our estates so as to increase access to preventative services for those at risk of experiencing multiple needs, thereby preventing the development of complex issues that are costly to individuals, families and public services to resolve. . This paper builds on the previous Health and Wellbeing Board paper on this topic for the meeting of 1 October 2015.

2. Key Matters for the Board

2.1. The Health and Wellbeing Board is asked to note the plans the Council and partners have started to scope as potential areas of work. The Board is also asked to consider how:

- This programme of work relates to projects currently underway or being planned by partners;
- Partners can contribute to the future development of this programme of work.

3. Background

3.1. At the Health and Wellbeing Board's meeting on 1 October, we introduced the concept and thinking behind Health and Wellbeing Hubs and the three broad cohorts we would like to target – youth, older people and single homeless adults. Since then we have worked with partners to develop the work streams in these areas, which this paper sets out.

3.2. The approach of Health and Wellbeing Hubs is based on Public Service Reform principles around co-location; joint working between multiple sectors and professions to build services around individuals. The overarching mission of the programme is to intervene with high risk cohorts at early stages to prevent them from requiring complex and often costly public services, such as admissions to Accident and Emergency departments or emergency service call outs. We will do this by using existing services but changing the way we work to deliver them, to improve the health and wellbeing outcomes of Westminster citizens.

4. Evidence base

4.1. A robust evidence base underpins our approach. Nationally, Troubled Families was deemed a success as a result of its holistic approach to tackling the issues of individuals and their families and by building services around them and providing access to services through a single point. Locally, the Tri-borough Family Recovery Programme, worked with families with a combination of problems and needs which meant they were at risk of losing their homes, their liberty or their children by intervening as early as possible and providing intensive, tailored support. An independent evaluation[1] found improved outcomes for children, improved family resilience, and reduced the resource burden on the public purse.

[1] Brandon, M., Sorenson, P., et al (2014) *Evaluation of the Tri-borough Family Coaching Service. Accessed via: https://www.uea.ac.uk/documents/3437903/4264977/FCS+report+%2B+exec+sum+20+Oct+2014_FINAL.pdf/5459c6d5-d8d7-4457-ada1-2f1846958fcd*

4.2. The Westminster Integrated Gangs Unit (IGU) is a model of integrated co-located services aimed at working with people aged between 11-24 years to prevent entry into, and facilitate exits from, gangs. The targeted interventions are delivered by a multi-professional team, who provide a single access point to a range of existing services, improving outcomes for the individual by tackling multiple needs at once.

4.3. A recent study[2] found that better co-ordinated interventions from statutory and voluntary agencies can not only reduce the collective cost of public services provision, but also improve overall outcomes for people by tackling their multiple issues rather than handling separate concerns individually. The Health and Wellbeing Hubs concept takes the learning from approaches tested at both national and local level to build a refreshed model which can be distinguished by its emphasis on health and wellbeing as a starting point.

4.4. To further reinforce the evidence base for Health and Wellbeing Hubs we will also be looking at the cost/benefit of the project work in our initial focus areas (outlined below). The complexity of the service provision picture and the myriad factors that impact on people's health and wellbeing outcomes make it difficult to establish the impact of these types of these types of changes exactly. However, all available data will be used to analyse impact and generate learning, which can be fed back in to support further development and refinement of the model over time.

5. Governance

5.1 The development of the programme is guided by a Cabinet Member Steering Group, which is chaired by Cllr Rachael Robathan. The Steering Group consists of senior officials from across Westminster City Council representing a range of service areas include estates, area management and libraries. The operational design and delivery is being led by a Programme Board, chaired by Liz Bruce, which seeks to operationalise the principles of the programme.

5.2 Both these groups have been operating for three months in order to collate evidence and garner consensus and support internally across all council service areas. We will now be seeking to gain representation on these groups from the voluntary sector, Healthwatch Westminster and other relevant partners. Health partners have agreed to join the Programme Board and support the development, delivery and piloting work.

[2] McNeil, C. & Hunter, J. (2015) *Breaking Boundaries.* London: IPPR
Accessed via: http://www.ippr.org/publications/breaking-boundaries-towards-a-troubled-lives-programme

6. Single homeless adults – Newman Street

6.1. Single adults who have presented to the council as homeless have been identified as a priority cohort that we would want to help with this more holistic approach to their health and wellbeing. One of four general needs Temporary Accommodation facilities for single adults located within the borough , Newman Street has some of the most disadvantaged and complex residents. It is a mixed-sex facility comprising of 77 self-contained studio flats. It is not supported housing but has on-site Floating Support workers. The Floating Support service pairs a key worker with the vulnerable adult, who assesses their needs and develops a support plan to address these needs. Support packages include:

- benefits advice, including making applications and attending benefit interviews and assessments;
- sustaining tenancy, including support to develop budgeting skills and other skills essential to managing tenancy;
- accessing local services, for example mental health teams, drug and alcohol services and BME services;
- developing life skills, including support to access occupational therapy;
- social inclusion, supporting customers to access education, voluntary work, employment and leisure services;
- tackling complex debt problems, referring to specialist debt advice services where needed;
- building and strengthening relationships with family and friends; and
- resettlement, helping customers to move on to more appropriate accommodation.

6.2. The majority of Newman Street residents are vulnerable adults with complex multiple needs, which include substance and alcohol addiction, significant mental and physical health issues and history of crime and/or anti-social behaviour. With this range of needs their level of dependency on a number of different public services is high, and is highly likely to increase further over time. A recent study[3] published by the Institute for Public Policy (IPPR) presented findings to substantiate claims that those with substance misuse issues also have issues with mental health, offending and homelessness. They also found evidence that those suffering multiple 'disadvantages' or issues have worse outcomes than those who have single disadvantages. The study concluded that addressing the

[3] McNeil, C. and Hunter, J. (2015) *Breaking Boundaries – Towards a Troubled Families Programme for People Facing Multiple and Complex Needs.* London: IPPR

multiple of needs of people in the round in parallel rather than addressing single issues at a time was more cost effective and could result in better outcomes. The Troubled Families programme has been a hailed a success in tackling multiple vulnerabilities.

6.3. We are jointly developing with our providers, public health department, CLCCG and the Great Chapel Street Primary Care Centre, a model which is not dissimilar to Troubled Families or the Westminster Integrated Gangs Unit (IGU) approaches to vulnerable people with multiple needs to test the following hypothesis: **by targeting existing services at people with multiple complex needs through addressing their multiple needs in parallel and proactively taking services to them, we can improve their life chances.**

6.4. The most common outcomes residents want for themselves include:

- improved (or better managed) physical health;
- improved (better managed) mental health;
- effective withdrawal and treatment from substances for those who want it;
- take up of employment and education opportunities; and
- a feeling of greater safety and security in their home environment

6.5. We want to help people realise these outcomes. We will do this by changing the way we work together – sharing information and intelligence, jointly planning and problem solving on individual cases, and building service packages around an individual rather than making individuals fit the offer. Simultaneously, we will reduce duplication across the public services involved in the care of this cohort, share resources and expertise and ultimately save money by managing future need and diverting people away from costly services. Floating Support workers, with their critical role in assessment and action planning for individuals, are the front-line representatives of the partnership approach and have a role in supporting residents to engage with the revised offer.

6.6. Whilst we have begun this work with local partners, as our residents would expect us to, we welcome involvement from Health and Wellbeing Board members and their organisations. We want to make this programme a place based approach not confined to any one institution and sector.

7. Widening preventative access – Older People Hubs

7.1. With their tendency to experience increased dependency on high cost health and wellbeing services over time, older people are also seen as a priority cohort who

could benefit from the Health and Wellbeing Hubs approach. The aim of this project is to explore opportunities to cluster advice/information and community/voluntary sector together in new ways and new combinations, offering local people more 'under one roof', to find out:

- Whether offering a broader range of advice/information and community-led/voluntary sector services in a range of settings (e.g. libraries) can increase take-up of those offers

- If being able to go to a location people find familiar and convenient, and by finding services there that may be new to them alongside ones they already use, target cohorts will be encouraged to access more of our preventative offer

7.2. A strategic review of health and social care low level services for Older People living in Westminster was undertaken in 2010 and enabled the Council for the first time to show the wards with older people most at risk of a deterioration in independence, health and wellbeing and where our resources should be targeted to help prevent this deterioration. These were Church Street, Regents Park, Queens Park, Westbourne, Harrow Road, and Churchill.

7.3. Initial contracts were let in July 2011, up to 2015. A decision was taken by the Contracts Approval Board in June 2015 to directly award contracts to the existing providers for the four older peoples' hubs (which cover the five priority wards), for a period of 24 months to end July 2017.

7.4. A review of the four existing Older Peoples' Hubs in Westminster commenced early in September and will conclude in November 2015. The purpose of the review is to:

- identify all current activities and the locations where they are delivered, be these hubs or other community locations including libraries;

- obtain attendance figures at each of the activities available;

- identify the cohorts currently accessing the services e.g. those aged 50 – 65, those preparing for retirement, those with chronic conditions and those 80 plus; and,

- identify those who are accessing the hubs, and also identify those who are not and possible reasons why.

7.5. To date, the review has found that:

- Activities tailored for men/to attract more men are required as they are under-represented in services.

- There is a need to increase referrals from people with more complex needs. Additional support (e.g. someone to accompany them to activities, push wheel chairs and provide them with regular assistance) is needed to support older people with mobility issues to attend community based activities.

- There is a need to increase the number of some BME communities accessing services.

- Reliable and timely transportation is required. It is worth noting that the Westbourne Hub is currently working on a small pilot project with Westway Community Transport, which aims to book and bring people to the same activity each week.

- There are limited opportunities at weekends. Older people can feel more isolated as many community facilities are closed at this time.

- There is an on-going issue/process to get information to those who are particularity isolated and not accessing local services and activities.

8. Engagement

7.1 Health and Wellbeing Board members were contacted in October 2015 inviting their thoughts on the design, delivery and review of our pilot work streams and wider programme development. To achieve the greatest impact from adopting a more holistic approach to meeting people's health and wellbeing needs, we need to work collaboratively with all the providers of those services, service users and Westminster residents. Through the development of the workstreams, partners - including the voluntary sector – will be involved, helping us to make wider sector and service links, co-designing models for service delivery and identifying future opportunities for co-location and effective use of collective assets. Partners and people will also be actively involved in co-producing future work streams to build on the current initial projects and develop the hubs approach further.

9. Wider opportunities

9.1. The projects outlined above identify opportunities to better use assets owned by the Council and our partners to improve access to preventative services, thereby helping residents to live as independent lives as possible and avoiding the need

for more costly and less effective interventions later on. If successful, these projects will provide a platform for further improvements and the Board is invited to consider the following opportunities:

9.2. Property: what opportunities are there to use our properties more efficiently to deliver services to shared cohorts?

9.3. Area working: what opportunities are there to use our estates to develop a more targeted and joined-up approach to delivering multiple services locally?

9.4. Community spaces and libraries: what opportunities are there to optimise the value we get out of community spaces across the City– providing a greater mix and maximising their occupancy to meet the needs of the local community?

10. Legal Implications

10.1. Not applicable

11. Financial Implications

11.1. Staff time excluded, there are no direct costs associated with this programme at present.

11.2. Over the medium term, this programme of work will aim to produce a robust business case that will assess the cashable savings that could be delivered to the Council and to partners by adopting more efficient and effective ways of working. The business case will be underpinned by a cost benefit analysis of the projects that will consider in detail: the current service costs - upstream and down-stream; future anticipated funding changes; projections of potential savings; analysis of where costs/savings fall (WCC and partners); savings profile over time and any costs to implement.

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

Meenara Islam, Principal Policy Officer

Email: mislam@westminster.gov.uk

Telephone: 020 7641 8532

This page is intentionally left blank

City of Westminster

Westminster Health & Wellbeing Board

Date:	19 November 2015
Classification:	**General Release**
Title:	Devolution to London: update for Board members
Report of:	Cllr Rachael Robathan, Chairman
Wards Involved:	All
Policy Context:	City for All /Devolution to London
Financial Summary:	No financial implications
Report Author and Contact Details:	Majeed Neky, Principal Policy Officer, Westminster City Council mneky@westminster.gov.uk / 020 7641 2127

1. Executive Summary

1.1 This report provides an update on work being pursued by the City Council with partners in London, including, London Councils, CCGs, NHS England, Public Health England, London Enterprise Panel, borough groupings such as Central London Forward, and the Greater London Authority, to secure new devolved powers and freedoms for the capital across a number of policy themes.

2. Key Matters for the Board

2.1 The Board is asked to consider:

- The implications of the likely devolution of powers to London, and the changes in governance including the strengthening of sub-regional groupings of boroughs that this will entail, for the delivery of the Health and Wellbeing Board's priorities in partnership with others;
- The capacity of the Health and Wellbeing Board in its current structure to respond to the likely challenges and opportunities arising from devolution to London; and
- The ability of the Health and Wellbeing Board to maximise opportunities in policy areas with strong links to health, notably employment and complex dependency and the more effective use of public sector estates.

3. Devolution in London and Westminster City Council's involvement to date

3.1 As a clear 'outlier' amongst local authorities, with some unique challenges and opportunities arising from Westminster's geography, the City Council has been seeking greater local autonomy to set and implement policy for a number of years and in a number of different policy areas. The Coalition Government's agenda around devolution to cities and regions, which has been continued and escalated under the current Conservative Government, has over the last two years become the primary vehicle for the City Council in pursuing these ambitions.

3.2 The City Council was instrumental in the negotiation of a Growth Deal for London in 2014, which included a number of pilots and initiatives across areas such as employment, skills and business support. One of the most prominent was the sign-off in principle of a pilot in central London to pioneer an improved approach to supporting long-term unemployed Londoners with health conditions back into work. The project, 'Working Capital', has now commenced delivery and will work with several hundred eligible Westminster residents over the next few years.

3.3 The pre-General Election period saw an escalation of the Government's devolution agenda, most notably through two ground-breaking 'deals' with the Greater Manchester Combined Authority: the first offering a range of powers and funding across employment, skills, business support, planning and housing in exchange for the city-region agreeing to bring in an elected Mayor;' the second giving the city-region control over £6bn of health and social care spending to speed up integration of different services. In London, the Chancellor of the Exchequer and the Mayor of London announced a 'long-term economic plan for London' in February 2015 which included a number of new initiatives relevant to this agenda, including an indication that adult skills commissioning responsibilities would be devolved in some form to London and the establishment of a London Land Commission to identify and make better use of surplus public sector brownfield land in the capital.

3.4 Following the General Election, the Government extended its offer to localities to put forward 'deal' proposals to Government that would boost growth and support public service reform, and included a Cities and Local Government Devolution Bill in its Queen's Speech to underpin further deals. With Cornwall already having struck a deal with Government, 38 further deal proposals were received by Government by its initial deadline in early September, including a set of propositions from London.

4. London's 'asks'

4.1 The London Proposition sets out asks and offers from London in six key areas:

- **Employment and complex dependency:** commitment from the Department for Work and Pensions and other departments to pool resources to support long-term unemployed people into work, through 'hub' based service delivery and a co-designed, intensive programme for the hardest to help. This would be backed by an 'invest to save' financing model that allowed London to retain some of the savings from reducing benefit expenditure to reinvest in local programmes

- **Skills:** commitment to devolve the adult skills budget (19+) and allow London to improve the match between skills provision and current and future industry needs through setting incentives, agreeing outcome frameworks with colleges and improving labour market intelligence

- **Enterprise support:** commitment to devolve various national budgets and programmes, such as UK Trade and Industry budgets and the national Growth Accelerator programme, to the London level to give businesses and entrepreneurs a 'one stop shop' for advice and support

- **Health and care:** commitment to back one or more health and social care integration pilots in areas within London, building on existing local work such as the Better Care Fund

- **Crime and justice:** commitment to devolve budgets in specific areas (e.g. preventing extremism) and provide for better integration between different emergency services to save money and improve performance

- **Housing:** commitment to allow London to trial a number of measures to boost house building, including greater local flexibility on raising and spending funding and in setting planning fees

5. Health devolution

5.1 London Councils and the Mayor of London submitted a Devolution and Public Service Reform proposition to central government on 4 September, which included a broad model of reform for health and care. The model included a range of 'asks' (set out in appendix A) aimed at enabling rapid improvements in the health of Londoners through integration across health and care to increase prevention and early intervention and faster redesign of health and care services and facilities driving better care quality and access, reduced pressure on A&E and fewer hospital admissions.

5.2 The London Proposition proposed at three levels – local; sub regional and pan-London, underpinned by asks of national government and bodies. This multi-

spatial approach allows for maximum flexibility and subsidiarity at the most effective levels recognising the local complexities of existing arrangements. Westminster currently works across at least 6 separate, but layered, geographies within health and social care. Some of these geographies have developed organically, while some have been developed specifically because of a shared need or a joint-priority. It is important that the arrangements which are developed are flexible enough to allow commissioning and joint-working across a variety of footprints.

5.3 In order to secure agreement for the proposals around health and care the London government, in partnership with NHS organisations, will be pursuing a supportive Comprehensive Spending Review outcome; establish pilots and develop an Agreement for further joint work.

Pilots

5.4 To build a case to secure agreement on specific devolution asks (e.g. new powers and flexibilities, funding, etc.) devolution pilots in health were proposed. The pilots are expected to develop models which will test and prove the case for the 'asks' and use the opportunity to identify further asks or areas of blockages. Pilots were invited for the following areas:

- whole system sub-regional transformation – sub-regional partnership working will be integral to progressing the devolution agenda but there are no robust examples yet operating in London. A pilot in this area should aim to build a sustainable and cohesive health and care system over the lifetime of the current pilot;
- local integration – a pilot in this category will design and deliver a fully integrated health and care system at borough level building on the Better Care Fund approach to pooling funding and developing integrated commissioning;
- estates - securing sufficient and appropriate estate to deliver health and care and releasing the potential in current NHS estate in London should be a focus of a pilot in this category. There will be some 'asks' that are better suited at a pan-London level;
- prevention - this category is not defined reflecting the fact that there were no specific public health asks. A prevention pilot could seek to test how devolved powers and functions could help accelerate progress on making the shift to prevention and early intervention, which is central to the London proposition.

5.5 London Councils have confirmed there have been expressions of interest for piloting each of the four areas. A formal announcement of the pilots is expected in late November.

5.6 *An Agreement for London* – the Agreement is integral for a positive CSR outcome is intended as a vehicle driving the case for London devolution. The Agreement will be the first public statement of London's devolution approach and establish clear objectives and principles for joint work between London and national government and bodies. The Agreement will also be a tool for securing NHS partner support and resources from national bodies to support developmental work, which need to be matched by partnerships. A strand of work around the development of the London business case summarising the learning from the pilots and other work to prove the case for full devolution for London will also be set out in the Agreement.

6. Governance

6.1 A key question for London to answer has been how any devolved settlement would be governed. A consensus has been developed through dialogue between partners, principally London Councils and the GLA that structures based on the London Councils Congress, which brings together the Mayor of London and a representative grouping of London borough Leaders, should be the principal vehicle for pan-London decision-making. Beneath this, it is felt likely that sub-regional groupings such as Central London Forward will need to play a larger and more formal role.

6.2 These questions are currently being further explored in parallel with the passage of the Cities and Local Government Devolution Bill, which has passed through the House of Lords and entered the House of Commons in autumn 2015. This provides a legislative underpinning for the devolution 'deals' that Government is negotiating with cities, most obviously in allowing places such as Greater Manchester and the Sheffield City Region to implement city-region-wide elected Mayors.

7. Likely next steps

7.1 Announcements in a number of these areas are expected in the coming weeks and months, with key milestones centring on the 2015 Spending Review and the 2016 London Mayoral election.

7.2 Sub-regional working across the footprint of borough groupings such as Central London Forward and the West London Alliance is likely to become a more prominent feature of 'business as usual' service delivery for London boroughs, particularly in areas such as employment and skills. Given the links between these policy areas and health, and the lack of co-terminus administrative geographies operating across CCG clusters and local authority clusters, the Board may wish to give consideration to how it should best approach these likely shifts in London governance.

7.3 Significant thought is being given at both local and national levels to how a more intensive, integrated and locally-determined model of employment support for groups with health conditions can be deployed, particularly with the contracts for the current Work Programme coming to an end in 2017 and the Spending Review likely to place further pressure on DWP budgets. In this context the Board may wish to give consideration to how the various initiatives on employment and health being pursued by member organisations can be better aligned in order to maximise impact and ensure an agile response to national policy changes.

8. Legal Implications

There are no specific legal implications for the Board to be aware of.

9. Financial Implications

There are no specific financial implications for the Board to be aware of.

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

Majeed Neky, Principal Policy Officer

Email: mneky@westminster.gov.uk

Telephone: 020 7641 2127

Appendix A – London Proposition: health and care

The proposals for health and care devolution were set out at three levels[1]:

Local

- Joint prevention and integration plans to secure increased prevention, early intervention, personalisation and integrated out of hospital services, overseen by Health & Wellbeing Boards and aligned with sub-regional strategic plans
- Full pooling and joint commissioning of NHS, social care and public health budgets through s75 agreements
- local public asset plans and scheme development to secure facilities to deliver accessible, multi-purpose, integrated out-of-hospital services in line with prevention and integration plans

Sub-regional

- Strategic partnerships established to develop plans for transformation to sustainable future models of care across local health economies, with which local out of hospital plans are aligned
- Joint commissioning to secure delivery of sub-regional plans transformation funding devolved through London level for use by sub-regional partnerships subject to robustness of governance, transformation plans and delivery mechanisms
- approval of sub-regional partnership required for NHS providers to access 'cash support'
- sub-regional estate plans and scheme development to unlock redevelopment of under-used NHS estate, aligned with local public asset planning

Pan-London

- London strategic partnership board with oversight of devolved working at all levels
- a London 'cash support' regime for NHS providers facing deficits, operated to support delivery of sub-regional transformation plans
- London level partnership accountable for strategic city-wide estate planning, approval of local and sub-regional development cases and funding allocations, supporting London Land Commission actions to improve utilisation of public sector assets
- Develop regulatory and fiscal city-level public health interventions

[1] London Councils

To enable London partners to operate together in this way, key devolution asks of government and the national NHS will include:

- multi-year allocations of NHS and local authority funding on a borough footprint
- London's share of all national NHS transformation funding devolved to London, for allocation to sub-regional or local levels subject to robust governance and transformation plans
- NHS capital budget, nationally held assets and decision-making powers for capital and asset management devolved to London
- NHS budget for and decision-making over 'cash support' for NHS providers facing deficits and power to amend tariff devolved to London
- public health powers e.g. power for the Mayor to raise the minimum age for buying tobacco
- agreement to streamlining national programmes and devolving NHS England decision-making and powers to the regional level as much as possible

City of Westminster

Westminster Health & Wellbeing Board

Date:	19 November 2015
Classification:	**General Release**
Title:	Primary care co-commissioning
Report of:	Central London CCG and West London CCG
Wards Involved:	All
Policy Context:	Primary care co-commissioning has brought CCGs into the commissioning of local GPs services and, through this, enables them to align the development of primary care with the wider transformation of local health and care services.
Financial Summary:	Not applicable
Report Author and Contact Details:	Christopher Cotton Lead for primary care co-commissioning, North West London Collaboration of CCGs chris.cotton@nw.london.nhs.uk

1. Executive Summary

1.1 This paper updates the board on developments in primary care co-commissioning since its last discussion about this area. It covers the governance structure for co-commissioning (including representation from this board), the review of all general practice PMS contracts now underway and being led by NHS England, and the design and roll-out of new local models of primary care.

1.2 An invitation has been extended by the CCGs to the board to nominate a representative to attend their co-commissioning meetings as a non-voting advisor.

2. Key Matters for the Board

2.1 The board is asked to note and discuss the content of this report.

3. Background

3.1 Primary care co-commissioning launched in Westminster (and across North West London (NWL)) on 1 April 2015. This followed a period of intense engagement by both CCGs with their local GPs and then CCG-based membership votes emphatically in favour of taking this step. Since then the CCGs' co-commissioning joint committees (see below) have concentrated on the development of new models of primary care, the PMS review, and the finalisation of CCG-level and NWL-wide governance structure.

4. Considerations

The structure for co-commissioning in Westminster and across North West London

4.1 Central London CCG and West London CCG have been co-commissioning primary care medical services (GP services) with NHS England since April 2015. This includes both the setting of strategic direction and individual contracting decisions. The move to joint co-commissioning followed a long period of engagement with GPs in Westminster and votes by the two CCGs' member practices and governing bodies.

4.2 Co-commissioning is designed to support the realisation of the CCGs' vision for primary care in Westminster, which places GPs at the centre of organising and coordinating care for people, seven days a week, through both individual practices and practice networks. By aligning this work with transformation work across NWL, co-commissioning is designed to achieve the following outcomes for patients:

- services that are joined up, coordinated, and easily navigated, with more services available closer to people's homes;
- high quality out-of-hospital care;
- improved health outcomes, equality of access, reduced inequalities, and better patient experiences; and
- enhanced local patient and public involvement in developing services, with a greater focus on prevention, staying healthy, and patient empowerment.

4.3 The CCGs have each established a co-commissioning joint committee, comprising lay, clinical, and executive members from both the CCG and NHS England. This joint committees will have two types of meeting: –each CCG joint committee will operate individually for decisions that impact only on their own populations and the eight joint committees from across North West London will be for common strategic issues where decisions have an impact across the eight CCGs.

4.4 The Central London CCG and West London CCG joint committees have met three times (in common with the other NWL joint committees) according to terms of reference agreed by the governing bodies. This month, the two governing bodies considered refreshed terms of reference that also make provision for the local joint committee meetings. These contained the following main provisions (subject to approval) for each joint committee:

- The membership and quorum of the joint committee will contain for all meetings a combination of lay, clinical, and executive members from Central London CCG and NHS England.

- Local meetings of the joint committee will be chaired by a CCG lay member.

- The committee will aim to make decisions by consensus wherever possible. Where this is not achieved, a voting method will be used in which the voting power of each individual present is weighted so that each party (CCG and NHS England) possesses 50% of the total voting power.

- The Health and Wellbeing Board and Healthwatch are both entitled to send representatives to joint committee meetings as non-voting advisors.

- For local meetings of the joint committee, the CCG is able to appoint any number of additional local stakeholders as non-voting advisors to inform discussions.

- The CCG and NHS England are committed to ensuring that the public voice is reflected in the decisions taken through primary care co-commissioning. This is enabled through membership of the joint committee and attendance at meeting, as well as through the intrinsic approach taken to the areas of business to be dealt with (as per the NHS operating framework). Additionally, the joint committee meets in public and the terms of reference contain a series of other provisions designed to maximise public transparency.

- When the eight joint committees from North West London meet together in common, they meet at the same time and place, to the same agenda, and are presided over by a single meeting chair – but each joint committee retains its individual decision-making authority.

- Decisions will be taken by the joint committee in the areas shown in the table below (which also notes in which areas decisions can be taken outside the joint committee according to standing operating procedures (‘approved policies’) and where urgent decisions, as defined in NHS England’s London-wide operating model, might be required).

Name	Function	Joint committee decisions needed	Decision possible with approved policy	Potential need for urgent decisions
Determination of key decisions or requests	List closure		■	
	Practice mergers / moves	■		
	Boundary changes		■	
	Securing services through APMS contracts	■		
	PMS (reviews, etc.)	■		
	Discretionary payments		■	
	Remedial and breach notices	■		■
	Contract termination - e.g. death / bankruptcy / CQC	■		■
	Contractual changes (contentious / important)	■		■
	Contractual changes (transactional)		■	
Financial Processes	Ensuring budget sustainability	■		
	Management accounting	■		
Strategy and Policy	Securing quality improvement	■		
	Developing and agreeing outcome framework – e.g. LIS	■		
	Securing consistent population based provision of advanced and enhanced services	■		
	Premises plans, including discretionary funding requests	■		

4.5 National guidance entitles a representative from this board to attend joint committee meetings as a non-voting advisor.

4.6 At their September meeting, the eight NWL joint committees discussed a range of issues relevant across the eight CCGs, including the PMS review and approaches to developing new local models of primary care. These are described in more detail later in this report.

4.7 There will be no move to delegated co-commissioning (under which primary care medical services budgets come under full CCG control) without broad engagement of all stakeholders, including this board. As with joint co-commissioning, moving to delegated co-commissioning would require approval through votes of GP practices and the governing body in both Central London and West London.

The review of PMS contracts

4.8 NHS England is leading a national review of all GP PMS contracts. Given the advent of co-commissioning, making decisions about the future shape of these contracts is now a joint responsibility of the CCG.

4.9 PMS (Personal Medical Services) are a type of GP contract introduced in 2004 to support Primary Care Trusts to commission additional services from GPs, linked to the specific needs of local populations. They exist mainly in contrast to GMS

contracts, which provide for 'core' GP services. Nationally, PMS practices attract approximately £14 of additional funding per patient.

4.10 Both West London CCG and Central London CCG have a relatively high concentration of PMS contracts – 16 out of 35 and 22 out of 51 respectively.

4.11 The purpose of the review is to ensure that this additional investment, or 'premium' funding, represents value for money. It should also:

- reflect joint NHS England /CCG strategic plans for primary care;
- secure services or outcomes that go beyond what is expected of core general practice or improve primary care premises;
- help reduce health inequalities;
- give equality of opportunity to all GP practices (i.e, PMS, General Medical Services (GMS), and Alternative Providers Medical Services (AMPS)), provided they are able to satisfy the locally determined requirements; and
- support fairer distribution of funding at a locality level.

4.12 Any savings released from current PMS contracts as a result of this review must be reinvested into general practice and support increased equality in the primary care offer to all patients in Westminster.

4.13 The PMS review offers a good opportunity to deliver and embed aspects of the London-wide *Strategic Commissioning Framework* (SCF) across London PMS practices and GMS as services are equalised. The SCF is a view of how primary care in London should function to be accessible, co-ordinated, and proactive and developed using public, clinician and stakeholder feedback through an extensive engagement process. NHS England is now drawing from the SCF a draft menu of specification options that could be commissioned as services over and above the basic requirements of practices, with money released from PMS contracts (and other sources if available). The options are believed to be appropriate for commissioning at a practice level, measurable, and able to make a real impact on services to patients.

4.14 The co-commissioning joint committees discussed the PMS review at their June and September meetings. NHS England set out the background to and rationale for the review, with committee members emphasising the need to prioritise the improvement of patient services and alignment with other initiatives. London wide LMCs were involved in these discussions and will be further engaged in advance of practice-level discussions.

4.15 The NWL CCGs have mobilised a PMS review steering group, which will undertake the work required for the eight joint committees to make decisions about a NWL-wide strategic approach to the review. The group is convened and chaired by NHS England and comprises lay, clinical, and executive members from the CCGs. It will make recommendations to the CCGs' joint committees.

4.16 A key issue for the PMS review is that its outputs support ongoing work to design and develop a new model of primary care for Westminster, in turn based on the *Strategic Commissioning Framework* (SCF). This is challenging, given the schedule for the PMS review, which requires completion by the end of March 2016 (with the possibility of a short extension). The CCGs and NWL-wide primary care transformation team are currently working on the detailed planning required to align the different pieces of work.

Designing and implementing a new model of primary care for Westminster

4.17 The coincidence of the PMS review process and the influence of the SCF on general practice over the coming months and years mean that this is the best possible opportunity to consider what primary care should look like and deliver for Westminster residents.

4.18 In parallel with other CCGs in North West London, Central London and West London CCGs are developing new models of primary care with the aim of enabling people to receive high quality, responsive care that is appropriate for their individual needs in a location closer to home and at time when it is more convenient for them.

4.19 The new models of primary care aim to ensure that people who are generally healthy have easier access to services outside of work hours at locations that are convenient to them, with online access to appointment booking and their own care records.

4.20 People with complex conditions will also experience continuity and planned coordination of care as facilitated by their GP or lead clinician, who they know and trust, supported by a wider multi-disciplinary team. All patients will experience better access to preventative services, health promotion and advice.

4.21 A guiding principle for this work is to ensure that general practice is sustainable, both in terms of funding and the workforce required to deliver and support care. One of the ways that general practice in Westminster has sought to address these challenges is through practices coming together to operate at scale as GP federations. This enables practices to scale up benefits for patients, improve access (including in the evenings and at weekends), and to deliver value for money by sharing some functions (e.g. HR, IT and patient booking) – whilst retaining the fundamental attributes of general practice delivering continuity and integrated care for people.

4.22 Across Westminster, there are now two GP federations that cover the whole population. The West London GP Federation comprises 53 practices, and Central London Healthcare comprises 37 practices. These new types of provider present the opportunity to deliver existing primary care services differently, or to extend the services available.

4.23 The two CCGs are currently beginning essential engagement on:

- the local vision for primary care;
- what outcomes are needed to meet the needs of residents;
- what services should be included; and
- how these models can be implemented.

4.24 These conversations are also taking into account important enablers, such as:

- the primary care workforce;
- the estate that services are being provided in and from;
- availability of extended access;
- IM&T infrastructure – including data sharing and patient online service.

4.24 Common themes are emerging from the conversations that have taken place in Central and West London CCGs to date. These include the following:

- It is widely agreed that GPs and other practice staff should be responsible for designing these plans (with support from the CCGs and other colleagues), and that lay partners should also be involved in this process. These are the partners with the clearest view of what needs to happen, and to understand the practicalities in getting there.

- The SCF provides a helpful framework that should be used to make sure new models of care comply with patient expectations and good practice as understood at a pan-London level. This includes meeting the specifications for proactive, accessible and coordinated care as articulated in the SCF.

- The GP federations are the proposed route for delivering primary care services at scale, but require support to develop the skills and capacity to fulfil this role.

- More detailed conversations are needed to understand what is the most appropriate scale to operate services at – including considerations around whether it could be beneficial or economical to offer any services at the level of the triborough.

4.25 These conversations will continue to progress through a series of seminars and workshops. Initially these are with CCG colleagues (including GP board members) to scope the local vision from the commissioning perspective. Over time attendance will be opened up to representatives of the GP federations, and potentially to other stakeholders.

4.26 Throughout this work the CCGs are continuously cross-checking primary care plans with the progress made through the Whole Systems Integrated Care programme. Work is required to ensure that the programmes are complementary and mutually supportive. This approach will maximise the collective impact of local conversations and initiatives to design and set up better, more integrated out of hospital services with primary care as the foundation.

5. Legal Implications

5.1 The co-commissioning structures and processes have been established with NHS England in line with national guidance.

6. Financial Implications

6.1 The two CCGs' joint committees will decide upon an approach to transitional funding for PMS practices impacted by the review. (There will be detailed analysis of the financial impact of the PMS review on individual practices as part of the contract negotiation phase.) This will be linked to a broader piece of financial modelling that determines the investment required to support a new primary care model in Westminster and sets out options for how it can be realised.

If you have any queries about this report or wish to inspect any of the background papers please contact:
Dr Christopher Cotton
chris.cotton@nw.london.nhs.uk
07770 853 394

APPENDICES:

None.

BACKGROUND PAPERS:

- The papers discussed at the September meeting of the North West London joint committees in common, including about new models of primary care and the PMS review, can be accessed here - http://www.centrallondonccg.nhs.uk/news-publications/publications.aspx?n=2422
- The Strategic Commissioning Framework can be accessed here - https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2015/03/lndn-prim-care-doc.pdf.

City of Westminster

Westminster Health & Wellbeing Board

Date:	19 November 2015
Classification:	**General Release**
Title:	Briefing Paper for Like Minded – NWL Mental Health and Wellbeing Strategy – Case for Change
Report of:	**Matthew Hannant**, Interim Senior Responsible Officer, Director of Strategy & Transformation (Acting), NWL Collaboration of CCGs **Fiona Butler**, Clinical Responsible Officer, Chair of NWL Mental Health and Wellbeing Transformation Board, West London CCG Chair.
Wards Involved:	All
Policy Context:	Mental health and wellbeing
Financial Summary:	As the strategy is still being developed, there are not yet any financial implications identified.
Report Author and Contact Details:	Jane Wheeler, Acting Deputy Director, Mental Health, Strategy and Transformation Team, North West London Collaboration of CCGs jane.wheeler2@nhs.net

1. Executive Summary

1.1 This report sets out the background to the development of the North West London Mental Health and Wellbeing Strategy Case for Change, as part of the Like Minded Programme. The Case for Change describes a shared understanding of the issues the health and social care sectors face in relation to Mental Health and Wellbeing and the shared ambitions for change. It is designed as a call to action – outlining the areas of work that should be developed in the next phase of the programme.

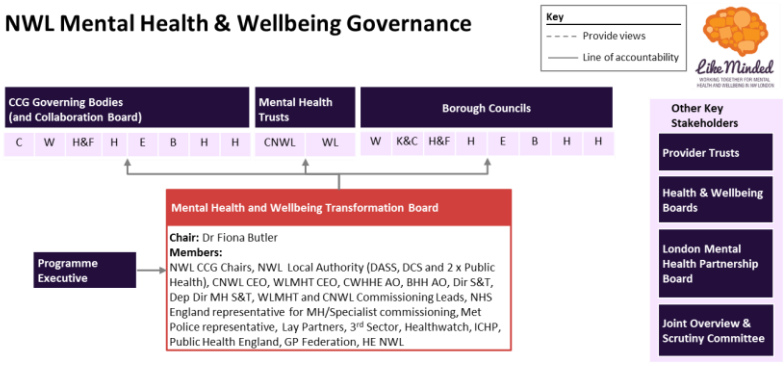
2. Key Matters for the Board

2.1 The Westminster Health and Wellbeing Board is requested to endorse the Like Minded Case for Change and provide any feedback that can inform development of models of care and support.

3. Background

3.1 In June 2014 the NWL Collaboration Board (across the 8 Clinical Commissioning Groups (CCGs)) agreed to build on the previous mental health strategy (called 'Shaping Healthier Lives', 2012-15) and initiate the North West London-wide mental health and wellbeing programme, called 'Like Minded' (2015-2020).

3.2 The governance of the programme is through the NWL Mental Health and Wellbeing Transformation Board. The Board was formed in May 2015 and has representation from CCGs, Local Authorities, both Mental Health Trusts, other stakeholders and service users (see governance chart below). The Board oversees and supports the development and implementation of Like Minded. Their role is to identify the most appropriate priorities and solutions for the programme and ensure delivery. It will manage the interdependencies with other related programmes and transformation work (for example, Whole Systems Integrated Care) across the eight boroughs as well as from our service user groups (such as the Making A Difference Alliance who represent mental health services users and their support networks.)



3.3 The first phase of the Like Minded programme focused on the development of a 'Case for Change', which describes the eight major issues identified across North West London relating to mental health and wellbeing, and the ambitions to improve outcomes and experiences (see section 4 below). The 8 issues are summarised in the table below. The Case for Change is built on a wide range of data, people's experiences, best practice and a structured approach to prioritisation, to agree a number of shared priority workstreams.

	Major Issues	Case for Change Ambitions
1.	Too many people face mental health needs alone.	We will ensure that mental health needs are better understood and more openly talked about and we will improve the range of services for people with mental illness in North West London.
2.	Not enough people know how to keep mentally well.	We will improve wellbeing and resilience, and prevent mental health needs where possible, by: • supporting people in the workplace; • giving children and young people the skills to cope with different situations; • reducing loneliness for older people.
3.	We need to improve the quality of care for those with serious and long term mental health needs.	For people with serious and long-term mental health needs we will: • make their care journey simpler and easy to understand; • develop new, high-quality, services in the community; • focus care on community based support rather than just in-patient care so people can stay closer to home.
4.	Too many people experience common mental illness, such as depression and anxiety, in silence.	For those people experiencing depression and anxiety we will: • Improve how quickly we identify, especially when people are not currently receiving other healthcare; • Improve the quality and quantity of therapy that doesn't require medicines.
5.	3 in 4 of lifetime mental health disorders start before you are 18.	We will ensure that implementation of the national strategy for children and young people responds to our local needs.
6.	New mothers, those with learning disabilities, the homeless and people with dementia do not get the right mental health care when they need it.	We will improve the care for specific groups in our community and support available to those who don't always get the mental health care they need within existing services.
7.	Too many people with long term physical health conditions do not have their mental health taken into account… and vice versa.	We will make sure that physical health and mental health are supported for people with existing physical or mental long-term conditions, learning from other work in NW London around the importance of joining up care.
8.	Our systems often get in the way of being able to provide high quality care.	Make sure that our systems help, rather than hinder, joined up care.

3.4 The Case for Change development was led by the North West London Mental Health and Wellbeing Transformation Board. It has also received input from practitioners, commissioners, voluntary sector service users and carers, some of whom are represented on the Transformation Board through the National Survivor User Network and West London Collaborative.

3.5 The Like Minded team have developed a longer narrative Case for Change document, with a supporting short summary. The short summary is presented today for your endorsement, and the longer document is available for download here: http://www.healthiernorthwestlondon.nhs.uk/mental-health.

3.6 The key issues for North West London have been identified within the Case for Change, and a number of ambitions for improvement are described. The programme has defined the issues into a number of clear workstreams to ensure we deliver on our ambitions.

3.7 These workstreams have been convened with partner involvement and with distributed leadership from across sectors. The next steps for each of these workstreams are set out below:

Workstream	Key update/next steps
1) Wellbeing and prevention	Workstreams and workplans developed for workplace wellbeing interventions and prevention of conduct disorder, led by Public Health and with input from Frontier Economics. Draft 'Call for Action' papers to be presented to 18 November NWL Mental Health & Wellbeing Transformation Board.
2) Serious and Long Term mental health needs	Workshops were run throughout September. Current focus is on mapping data and describing current 'as is' state, including current transformation work. A draft Model of Care and Support was endorsed at the 23 October NWL Mental Health and Wellbeing Transformation Board.
3) Common mental health needs	Initial workshop to be held to scope breadth of work. A detailed review of the data will follow to understand the current 'as is' state for people with common mental health needs.
4) Children and Young people	Transformation Plan for NHS England Future in Mind developed which presents a united approach to improving the mental health and wellbeing of children and young people across the 8 North West London CCG and LA areas. Plan submitted to NHS England on 16 October 2015. Next steps are to secure NHSE sign-off and develop implementation plans.

5) Existing projects	Existing mental health projects, such as perinatal and learning disabilities, will be continued and report to the programme's Strategic Implementation & Evaluation Board.
6) Enablers	Agreement to develop and address enablers with other Strategy & Transformation programmes, in particular Whole Systems Integrated Care and Primary Care.

4. What this means for Westminster Health and Wellbeing Board

4.1 <u>What this means for Westminster</u>

The workstreams within the strategy each have a different focus, but are likely to impact on a number of services delivered within Westminster:

- Primary care services;
- Community mental health services;
- Inpatient mental health services;
- Public Health services;
- Children & Young People's services (see the NWL Transformation Plan in response to Future in Mind for more information).

Over the coming months the impact will be more clearly defined, through the development of models of care and support with North West London stakeholders, including members of Westminster HWBB. We will provide an update on the draft models of care and support to the Health and Wellbeing Board as they are developed.

We also need to link to the local community services redesign to ensure new models of care being developed by our providers link to our North West London strategy. This includes, for example, working with the new Single Point of Access for mental health services developed by CNWL, launching on 3 November, to ensure this single number and referral process for all mental health referrals improves access to services and makes services user's care journeys easier to understand.

4.2 <u>How we can work with Westminster to deliver a joint approach</u>

Each workstream within the Like Minded strategy has the potential to impact on services delivered by Local Authorities, therefore input from Westminster Council to each workstream is important now and as the programme progresses. We are keen to build on the Whole Systems Integrated Care approach, working closely with all key stakeholders across North West London to develop models of care and scope options for delivery.

4.3 Role of the Health and Wellbeing Board in delivering this strategy

We ask for endorsement of the Case for Change at this stage. When we next present at the Health & Wellbeing Board we will have more detail on the role of stakeholders within Westminster, including members of the HWBB, in delivering the strategy.

4.4 To date, we have presented the Like Minded programme at the following Boards in Westminster:

Forum	Date	Discussion
Central London CCG	11 February 2015	Programme Initiation Document discussed at Central London CCG Governing Body Seminar
	9 September 2015	Case for Change presented at Central London CCG TRG meeting
	9 September 2015	Governing body endorsement of Case for Change
	23 September 2015	Programme update presented at Central London CCG User Group
Westminster HWBB	21 May 2015	Programme update presented at Westminster HWBB

4.5 In addition, we have:

- Held a meeting for Children and Young people work stream – understanding experiences with the Westminster Youth Team (23 March 2015)
- Run a workshop on socially excluded groups in Westminster Central Hall (6 May 2015)
- Held a Community of Interest meeting at One Great George Street, Westminster (1 July 2015)
- Held an 'Innovation Lab' for Serious and Long Term Mental Health Needs at Pimlico Academy, Westminster (22 September 2015).
- Andrew Christie, Tri-borough Director of Children's Services, represents other DCSs within the West London Alliance on the Mental Health and Wellbeing Transformation Board.
- Had attendance from Tri-borough public health teams at workshops and significant input into each workstream – particularly the Wellbeing & Prevention workstream.

5. Legal Implications

5.1 The programme will support the co-production of models of care and support, agree outcomes, assess impact of any proposed changes and oversee the production of business cases. While this may lead to proposals which constitute significant service change and therefore potentially formal consultation, it is envisaged that there will also be large parts which can be taken forward without

formal consultation. A key role for the NWL Mental Health and Wellbeing Transformation Board is in quality assuring the development and implementation process. We have a good understanding of the process based on previous consultations such as for Shaping a Healthier Future, and we will build on this knowledge. We have secured legal advice from Capsticks, and will continue to do so.

5.2 All NHS bodies proposing a service change must involve the public, patients and staff from initiation through to implementation. National guidance is set out in 'Planning and delivering service changes for patients' (NHSE Dec 2013). This offers a good practice guide intended to help shape local arrangements and to be used in a way that is both proportionate and flexible. Public consultation is required if there is a significant change to the way services are provided.

5.3 Any service change large or small needs to comply with the NHS England four tests and demonstrate evidence of:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- A clear clinical evidence base
- Support for proposals from clinical commissioners

6. Financial Implications

6.1 One of the stated objectives of the programme is to develop improved outcomes – and ensure a financially sustainable system for at least the next 5 years. In working up detailed models with partners, the financial impact will be a key consideration. It is too early to quantify the impact at this stage of the programme therefore there are no financial implications identified yet for the Council. The cost of developing the models, and any financial implications within them, will be met by existing resources.

Please remember that if you wish the information you are providing in this report to remain confidential, we may be able to accommodate you. Please contact apalmer@westminster.gov.uk for guidance.

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

Jane Wheeler, Acting Deputy Director, Mental Health, Strategy and Transformation Team, North West London Collaboration of CCGs

Email: jane.wheeler2@nhs.net

Telephone: 07875 429 320

APPENDICES:

Improving mental health and wellbeing in North West London Case for Change – a summary

BACKGROUND PAPERS:

Supporting documents can be found in the following web page: http://www.healthiernorthwestlondon.nhs.uk/mental-health

Like Minded
WORKING TOGETHER FOR MENTAL HEALTH AND WELLBEING IN NW LONDON

August 2015

Improving mental health and wellbeing in North West London

Case for Change - a summary

What this paper is about

We are setting out the vision for improving mental health and wellbeing across North West (NW) London. We don't say how we are going to do this – that's next – but it is an important step in bringing people together and agreeing a common goal for what the improvements need to be.

Why mental health and wellbeing is important to us all

We all have mental health – for some of us it's great and for some of us it is a real struggle. For many of us, it will be an issue at some stage either personally or for a friend or family member. Mental health needs can affect any of us, although we know there are certain things which makes us more at risk such as family history, abuse, debt, drugs, unemployment and loneliness.

Too many of us think it won't affect us, but it could. Mental illness affects more of us than cancer. It affects more of us than heart disease or stroke. It affects more of us than diabetes.

Over the course of a year, almost one in four people will have a diagnosable mental illness… Perhaps the person in the queue with us at the checkout. Three of the children in the class with our child. Thirteen people on the bus with us in the morning; maybe a hundred on the same tube train.

We want to help people improve their personal mental wellbeing, to know how to look after themselves and keep well. But we also want to make sure that if you do need help, that it is there for you.

There is some excellent care and support but we need to do more

In many places across NW London, the NHS, councils and charities are already working together to provide critical support for those in need. However, many of us still don't get the help we deserve and we want to change that.

25% of people with mental health problems receive treatment, compared to **75%** of those with heart disease and **92%** of people with diabetes.

For example, only a quarter of people with anxiety and depression receive treatment compared to more than 90% of people with diabetes.

The issues and our ambitions

The goal is to promote wellbeing and to improve the mental health care and support we receive if we need it.

We have identified eight major issues that we currently face in NW London and the ambitions that we must all sign up to if we are to improve things.

1 Too many people face mental health needs alone

The issue:

- Mental health needs are experienced by many of us but only a minority receive treatment.
- Depression and anxiety are by far the most common issues, affecting around 1 in 6 of the adult population in London.
- In NW London we estimate that 2 out of 3 people living with mental health needs are not known to health services.
- Too many people face their issues alone, afraid of the stigma or don't know where to get help.

Our ambition:

We will ensure that mental health needs are better understood and more openly talked about and we will improve the range of services for people with mental illness in NW London

The issues and our ambitions

2 Not enough people know how to keep mentally well

The issue:

- Mental wellbeing is about how happy we are and how satisfied we feel with our life.
- What makes us feel good is different for everyone but will often include things like relationships, work, housing, exercise, money and friendships.
- Whilst we don't always know exactly what causes mental illness, we know that certain things can put us at risk and looking after our personal wellbeing can help that.

Our ambition:

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

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

3 We need to improve the quality of care for those with serious and long term mental health needs

The issue:

- Serious long term mental health needs can have a devastating impact on our lives from our relationships, jobs and friends.
- Around 23,000 people in NW London have been diagnosed with schizophrenia, bipolar and/or psychosis, which is double the national average. Around 60% of these people are supported in the community.
- The demand on existing services means sometimes people wait too long to receive routine care.
- Between 13% and 52% of people accessing mental health care are also accessing substance misuse services.

Our ambition:

For people with serious and long-term mental health needs we will:

- **make their care journey simpler and easy to understand.**
- **develop new, high-quality, services in the community.**
- **focus care on community based support rather than just in-patient care so people can stay closer to home.**

The issues and our ambitions

4 Too many people experience common mental illnesses, such as depression and anxiety, in silence

The issue:

- Common mental health needs – such as depression, anxiety, Obsessive Compulsive Disorder and Post Traumatic Stress Disorder – are experienced by nearly a quarter of million people in NW London.
- The impact on lives is significant with women typically unwell for 7 years and men for 10 years.
- The suicide rate amongst this group is 20 times higher than average.
- Too many people do not seek help and when people do, often the mental illness is missed.
- This means that two-thirds of people not receiving any care.
- For those who do receive care, the quality of community based services are not always good enough.

Our ambition:

For those people experiencing depression and anxiety we will:

- **Improve how quickly we identify, especially when people are not currently receiving other healthcare.**
- **Improve the quality and quantity of therapy that doesn't require medicines.**

The issues and our ambitions

5 3 in 4 of lifetime mental health disorders start before you are 18

The issue:

- The mental health needs of children and young people have been neglected for too long.
- Around half of all mental health needs in adults emerges by the age of 14, and three-quarters of lifetime mental health disorders have their first onset before the age of 18.
- However less than 10% of CCG mental health spend is invested in care for young people.
- The national Children and Young People's Mental Health and Wellbeing Taskforce identified the problems which stop us from providing excellent mental health care.
- The publication of the *Future in Mind* report is enabling people working with children to look at how they can improve experiences for young people.

Our ambition:

We will ensure that implementation of the national strategy for children and young people responds to our local needs.

Around **50%** of mental health needs start before the age of **14**

The issues and our ambitions

6 New mothers, those with learning disabilities, the homeless and people with dementia do not get the right mental health care when they need it

The issue:

- Depression affects many thousands of new mothers across NW London and tragically, suicide remains a leading cause of death for expecting and new mothers.
- 25-40% of people with learning disabilities have mental health needs and the prevalence of schizophrenia in this groups is three times that of the general population.
- People who are homeless often have both physical and mental health needs as well as substance misuse needs. Their situation means they often cannot manage their own condition.
- Dementia is a rising challenge for NW London and many people remain undiagnosed.

Our ambition:

We will improve the care for specific groups in our community and support available to those who don't always get the mental health care they need within existing services.

7 Too many people with long term physical health conditions do not have their mental health taken into account... and vice versa

The issue:

- People with mental health needs are at higher risk of developing significant, preventable physical health conditions such as respiratory disease.
- People with Schizophrenia are twice as likely to die from cardiovascular disease.
- Similarly, too many people with long-term conditions do not have their mental health needs properly taken into account despite being two to three times more likely to have a mental health need than the general population.

Our ambition:

We will make sure that physical health and mental health are supported for people with existing physical or mental long term conditions, learning from other work in NW London around the importance of joining up care.

The issues and our ambitions

8 Our systems often get in the way of being able to provide high quality care

The issue:

- We must make sure we have the right number of staff and that their skills are developed.
- We must ensure more people - including nurses, social workers, police, housing officers, and teachers - have awareness of mental health issues.
- We need better data and information sharing to know where we are successful and where we are not.
- We need better buildings in which to provide the care for those needing mental health support.

Our ambition:

Make sure that our systems help, rather than hinder, joined up care.

Next steps

In developing our understanding of the challenges we have listened to our residents, professionals and other interested parties. We have been heartened to hear great examples of sensitive care where our teams go the extra mile. But our plans described here are based on the examples we heard where we can do better.

We will continue to listen to feedback to make sure that we have identified that right issues and ambitions to be able to improve mental health care and support in NW London.

Once we have agreement, we will continue to work with patients and organisations across NW London to develop the plan on how to achieve our ambitions.

MENTAL HEALTH AND WELLBEING IN NORTH WEST LONDON

2 million

The total population of North West London.

£460 million

Mental health accounted for almost 12.5% of **£460 million** of the total NHS spend across NW London in 2012/13. West London has the 4th highest rate of SMI (serious mental illness) in the country (1.46%) Rates of SMI are estimated to be 1.08% across NWL (compared with 0.84% in England).

250,000

people with MH conditions including.

30,000

people with SMI.

16,000

people with Dementia.

What is Like Minded?

Like Minded is a project which brings together service users, carers, the workforce, third sector and other experts to co-design the strategy to improve mental health and wellbeing across North West London.

Contact: LikeMinded@nw.london.nhs.uk

City of Westminster

Westminster Health & Wellbeing Board

Date:	19 November 2015
Classification:	**General Release**
Title:	System change required as a result of the Local Safeguarding Children Board Annual Report
Report of:	Jean Daintith, Independent Chair of the LSCB
Wards Involved:	All
Policy Context:	Section 14A of the Children Act 2004 requires the Chair of the LSCB to publish an annual report on the effectiveness of safeguarding and the promotion of the welfare of children. The report should be submitted Chair of the health and wellbeing board.
Financial Summary:	There are no financial implications for the purposes of this report.
Report Author and Contact Details:	Steve Bywater, Policy Manager steve.bywater@lbhf.gov.uk / 020 8753 5809

1. Executive Summary

1.1 This report summarises the context within which the LSCB's annual report is produced and highlights existing links between the LSCB and the Health and Wellbeing Board (HWB). There is also a summary of the key areas covered in the annual report and priorities which have been identified for safeguarding activity in 2015/16. A number of recommendations are identified which are intended to prompt further discussion as to how existing relationships between the two Boards might be developed still further to increase the impact made on respective priorities. Suggestions are also made of some areas where the two Boards may share a common agenda.

2. Key Matters for the Board

2.1 The Board is invited to consider and comment upon the contents of the LSCB's Annual Report as well as responding to the recommendations outlined at the end of this paper.

3. Background

3.1 Local Safeguarding Children Boards (LSCBs) have a statutory obligation to compile and publish an Annual Report and to provide this to the Chair of the local HWB. The report is expected to provide an assessment of the effectiveness of local arrangements to safeguard and promote the welfare of children. The report for 2014/15, which accompanies this report, reviews and evaluates the achievements and progress of the LSCB which covers Westminster, Kensington and Chelsea and Hammersmith & Fulham. It also identifies future priorities and an assessment of challenges faced going forward.

3.2 In its broadest sense safeguarding refers to promoting the well-being of children, a shared responsibility of both Boards. The HWB considers how the health needs of children are met and has an influence on this broader safeguarding agenda. The HWB can also use this influence with health partners to ensure that the LSCB is getting the right support to ensure that agencies working with children are meeting the highest standards.

4. The Annual Report

4.1 The 2014/15 Report has a particular focus on the main priorities identified in the LSCB's 2014/15 Business Plan and reviews activities carried out, any impact and what further steps are required to ensure that progress continues to be made. These include activities to improve Early Help and better outcomes for children subject to child protection plans and those who are looked after. There is also a review of progress on issues where shared approaches have been developed across the three boroughs, for example in relation to child sexual exploitation, female genital mutilation, domestic violence and abuse and e-safety.

4.2 There have been a number of activities to improve the effectiveness of the LSCB. These include a range of approaches to engaging children and young people in awareness of safeguarding and the work of the Board. There have also been initiatives to improve communication with a new website now online and various initiatives to improve the multi-agency workforce's learning from reviews and audits carried out by the Board.

4.3 The Annual Report provides an overview of other key functions of the LSCB including quality assurance, the role of the Local Authority Designated Officer in managing allegations made against adults working with children, complaints and training. The report also describes the context in which the various partner

agencies are operating with details of the demographics and profile of vulnerable children in each of the authorities.

4.4 Based upon a review of progress to date as reflected in the report, the LSCB has identified its priorities for the current year which are listed at the end of the report and reflected in the 2015/16 Safeguarding Plan. The intention is to continue to address longer term issues whilst responding to emerging issues, as the LSCB continues make progress with these priorities.

4.5 There are three broad priorities for 2015/16:

- **To continue to deliver the core business of the Board at high quality** (with a particular focus on the role of Early Help, engaging diverse communities; the effectiveness of child protection plans, multi-agency responses to neglect and meeting the safeguarding needs of children with mental health concerns, disabled children and those affected by domestic abuse).

- **To improve the Board's effectiveness in reducing harm to children** (including learning from each other in a context of organisational change, learning from case reviews; meeting the needs of children from marginalised groups, effective communication with the multi-agency workforce, holding each other to account and challenges that improves outcomes and maximising wider partnerships to better influence impact on the ground).

- **To ensure effective, proportionate, multi-agency responses to safeguarding issues which affect children & young people with high levels of vulnerability** (with a particular focus on those at risk of or have experienced Female Genital Mutilation, substance misuse, going missing, sexual exploitation or radicalisation, being a perpetrator of abuse and exploitation, being involved with gangs).

4.6 There is a summary of the work of the Child Death Overview Panel which considers circumstances relating to the deaths of children and a section which describes Serious Care Reviews (SCRs). These are initiated where abuse or neglect of a child is suspected and the child has died or has been seriously harmed. Two SCRs commenced in the three boroughs in 2014/15 and actions were taken in response to one which was completed. Key learning included the need to avoid "compartmentalising" cases which can stifle thinking about the wider needs of children and there were specific learning points about working with mobile families, children in need, adoptive families, emotional attachment disorders, concealed pregnancy and how schools might best respond to drug use amongst pupils.

5. Conclusions of the Annual Report

5.1 The report concludes that the LSCB has a good overview of practice which protects and safeguards children and young people, has worked well to anticipate and respond to significant issues affecting their lives and has challenged LSCB members to promote the best outcomes for children and young people.

5.2 The report also highlights areas where progress is not as good and where further development is required. These are reflected in the 2015/16 Safeguarding Plan which informs the current activities of the LSCB. Some specific actions for partner agencies are also identified. There are areas where the Board wishes to further develop its existing links with agencies also represented on the Health and Wellbeing Board. This includes working with Adults Services in supporting young people who are involved with sexual exploitation through the transition to adulthood and developing links between the Local Authority Designated Officer (who ensures coordinated, consistent management of responses to allegations made about staff) with designated allegations management leads. The Child Death Overview Panel is seeking to develop the role of Public Health to its activities. There is also a general aim to engage a wider range of agencies in leading the LSCB's sub-groups and short-life working groups.

5.3 There are recommendations to continue to improve the engagement of some agencies in the active work of the Board as well as continuing to improve communications with all staff and the wider community.

6. Recommendations

It is recommended that:

6.1 The Health and Wellbeing Board notes the contents of the LSCB's Annual Report.

6.2 The Health and Wellbeing Board considers the effectiveness of contributions from local partners to the LSCB. Agencies represented on the Health and Wellbeing Board (Children's Services, Adult Social Care, West London CCG, Central London CCG, Public Health and NHS England) are also represented on the LSCB.

6.3 That members of the Board identify priorities of the LSCB's 2015/16 Safeguarding Plan which may benefit from further consideration by the Health

and Wellbeing Board or more collaboration between the two Boards. The following developments may be of particular interest:

- Recommendations from a short-life working group which is considering the impact of parental mental health on children.

- Briefings about learning from serious case reviews, particularly regarding issues relating to the Health and Wellbeing Board's priorities or wider agenda.

- Meeting safeguarding issues for young people as they go through transition to adulthood and services designed for adults.

- Oversight of information sharing and referral patterns in relation to female genital mutilation between agencies represented on the Health and Wellbeing Board.

7. Legal Implications

7.1 Section 13 of the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals (other than the local authority) that should be represented on LSCBs. The LSCB has a range of roles and statutory functions including developing local safeguarding policy and procedures and scrutinising local arrangements. The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area (this is a statutory requirement under section 14A of the Children Act 2004). The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the health and wellbeing board.

8. Financial Implications

8.1 There are no financial implications for the purposes of this report.

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

Steve Bywater, Policy Manager

Email: steve.bywater@lbhf.gov.uk

Telephone: 020 8753 5809

LIST OF APPENDICES:

LSCB Annual Report 2014/15

Local Safeguarding Children Board

Hammersmith & Fulham | Kensington and Chelsea | Westminster

Annual Report 2014/15

Local Safeguarding Children Board

For Hammersmith and Fulham, Kensington and Chelsea, and Westminster

Contents

FOREWORD
By the Independent Chair

This is my third annual report as Independent Chair. My role tasks me with ensuring that the Board fulfils its statutory objectives and functions: the coordination of safeguarding work of agencies and ensuring that this is effective.

I am impressed by the dedication and skills of frontline staff and the outcomes for children and young people. Whilst the LSCB (Local Safeguarding Children Board) does not commission services directly, we seek to influence services and practice through the contribution of Board members and our partnerships. We also take challenge very seriously. This often happens in the context within which services are delivered, and through the attitudes, values, and behaviours of staff and frontline managers. It also happens through the Board's discussions and influence. This year an increased focus on Child Sexual Exploitation (CSE) and Female Genital Mutilation (FGM) relates directly to the challenge that we have made to one another to protect children from harm. Early help and engagement with community organisations have been at the forefront of this.

The LSCB members have carefully reviewed progress over the past year and have identified and agreed shared priorities for 2015/16. These priorities are a combination of work that we believe requires ongoing attention to ensure a clearer impact as well as a focus on emerging issues which need to be on our agenda. In agreeing these priorities we have sought to ensure that the work of the LSCB continues to have an impact on the effective safeguarding of the diverse children and young people living in the three boroughs.

Please read this Annual Report. It may help you to understand the work that we do and how it joins up across the agencies. I hope that you will hold the LSCB to account on our plans for next year. We are keen to learn when things don't go as well as they should and when mistakes are made so that we can make the improvements that are needed for children and young people.

Most of the time, work with children and their families goes well and is unnoticed. I want to thank staff for the difference that you continue to make in the lives of those with whom you work.

Jean Daintith
Independent Chair

BACKGROUND TO THE REPORT

Under section 14A of the Children Act 2004 the Independent Chair of the LSCB must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the Health and Well-being Board.

This report is structured in two parts. Firstly it reviews the activity in the past year to deliver the priorities identified in the LSCB's 2014/15 Business Plan. The second part describes the wider context of the LSCB, who it works with, how it is governed and its membership, with an overview of a number of its key functions. The report concludes with a summary of the LSCB's priorities for 2015/16, as informed by the review of its effectiveness to date and partners' agreement of what needs to happen next.

CHAPTER 1 – PROGRESS ON PRIORITY AREAS 2014/15

The 2014/15 LSCB Business Plan identified four key priority areas for development over the year. These included Early Help and the Prevention of Harm; Child Protection and Looked After Children; Practice Areas to Compare and Contrast; and Continuous Improvement in a Changing Landscape. This section reviews what was done for each of these areas, the impact of the work and what needs to happen next to ensure continuing improvement. There is a particular focus on a number of particular areas for development which were addressed over the year including some high-profile issues which are covered in more detail as "spotlights". Progress on other sub-priorities that were highlighted is reflected elsewhere in this report.

1.1 Early Help and Prevention of Harm

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 2014/15 business plan priorities therefore reflected a need amongst all agencies to improve early help services and the early identification of and help for children at risk.

The range of early help services is good in all three boroughs. The voluntary sector is funded to make a significant contribution to this. Expectations are high from professionals about getting a response if a referral is made; and there is challenge if the response is not what was expected.

2014/15 Business Plan priorities:

- ✓ Local Early Help arrangements are effective in preventing harm and keeping children safe
- ✓ Early Help services are strengthened in relation to identification and response to parental mental health and substance misuse
- ✓ Work around safeguarding in relation to faith and belief is embedded and evaluated
- ✓ Schools and voluntary sector identify safeguarding needs leading to timely response

Local Early Help arrangements are effective in preventing harm and keeping children safe

What have we done?

An Early Help outcomes framework has been agreed and a single Early Help Offer is now available across the three boroughs. The Threshold of Needs Guidance also incorporates thresholds for early help, including identification and assessment. A recent development is the 'Best Start in Life' project group across Health and the three Local Authorities who are

aiming to integrate a pathway for 0-5 year olds and implement a 'whole system' for early years. Each borough has an Early Help Service which provide a range of services including universal and targeted provision through Children's Centres; teams which carry out casework with families who have levels of need just below the threshold for children's social care; parenting programmes and joint work with schools, health and the police.

The Multi Agency Safeguarding Hub has assisted in establishing where cases should be referred to at the initial stages when they first come into Children's Social Care promoting informed referrals to Early Help Services.

In addition, there have been significant Early Help developments led by a range of agencies including:

- The '**Focus on Practice'** programme started during the year including training from January 2015. The wider aim of the programme is to improve the effectiveness of direct work with families and key anticipated outcomes are reductions in the number of looked after children and reducing referrals to children's social care. Early help workers in local authority services are receiving training in modules in systemic practice, motivational interviewing, and parenting theory and skills. The programme is expected to have a major effect on the way Early Help is provided, its impact in reducing the need to escalate services to statutory services and the need for cases to be re-referred after case closure.
- **Imperial Health Care Trust** (at Queen Charlotte's Hospital and St Mary's Hospital) as well as partners in Westminster Family Services through the Queens Park Project have piloted the National Society for the Prevention of Cruelty to Children (NSPCC's) evidence-based "Coping with Crying" programme to raise awareness of parents about how to cope when their baby cries. A similar programme in the United States was shown to have reduced the number of shaken babies or non-accidental head injuries by 47%.
- **The London Community Rehabilitation Company** (CRC) is now ensuring that all new cases are referred to social services to check whether the person or family are known. This process helps to keep the safeguarding of children at the forefront of staff actions when working with individual offenders.
- The LSCB has continued to hear about the impact of welfare reforms on families who seek help from the **Homeless Person's Service** and considers that, at a local level, the implications are as well-managed as they could be, whilst the national system is one that impacts disproportionately on London thresholds.
- **The Safeguarding in Schools lead** has ensured that guidelines have been circulated on when and how to refer a child missing from Education to Early Help services and the ACE Team (Attendance, Child employment and entertainment and Elective home education). The lead has also promoted awareness in schools of private fostering, and making sure schools understand the interface with the Multi-Agency Safeguarding Hub (MASH). An audit tool has been developed and distributed to schools (including independent schools) to support the evaluation of the degree to which they meet their safeguarding responsibilities. Schools have been prioritised for a comprehensive safeguarding audit including an action plan to address any identified gaps or areas requiring strengthening.
- An LSCB event was held with **the Voluntary Sector** in May 2014 which strengthened their links with the Partnership Groups and LSCB representation within the Voluntary

Sector fora. The voluntary and faith sectors' contacts with a wide range of families means they are well placed to offer 'universal' help, advice or referral on of children and their families to more specialist services. The involvement of the Community Development Worker for Faith and Communities has had a significant role in developing this work over the past year.

- Work initiated by the **Westminster Partnership Group** regarding parental mental health was taken forward by the three Health and Wellbeing Boards who conducted a Task and Finish group on Mental Health leading to a local action to improve services.
- The **Integrated Gangs Unit** (IGU) in WCC have links with other services across the three boroughs and work with young people considered in a short life working group on gangs and CSE two years ago. The IGU focuses on diverting young people from gang involvement, with particular links with Multi-agency Public Protection Arrangements (MAPPA), Police and Children's Services are strong. The IGU has had considerable successes in engaging and safeguarding this difficult to reach group of young people.

What difference has it made?

- ✓ LBHF Early Help services have contributed to reductions in numbers of children with child protection plans and those entering care; improved identification and support of young people subject to child sexual exploitation; reductions in homelessness amongst 16 and 17 year olds; improved identification and support of young carers; ensuring that only small numbers of families referred need to be "stepped up" to statutory social care teams; success in addressing substance misuse amongst young people.
- ✓ RBKC Early Help services have shown an average increase of 11% in school attendance for children they have worked with at the point of case closure and an impact on reducing the need for cases to be "stepped up". Monitoring of outcomes has shown that on average, outcomes have improved across all dimensions for families worked. There has been a particular impact upon meeting emotional needs, education and learning and family routine.
- ✓ WCC Early Help services have identified a significant number of children who have been supported to remain with their families after previously having been identified as being on the "edge of care". A reduction in the percentage of young people not in education, employment or training (NEET) has also been noted following interventions. They have worked with young people who have been arrested by the police and can demonstrate that most of the young people concerned have not gone on to reoffend.
- ✓ WCC Early Help service has also worked in partnership with Save the Children on FAST (Families and Schools Together) which is an evidence based programme to build stronger bonds between parents, schools and communities. This has been delivered in 23 Westminster schools and evaluations have shown improvements of family and parent-child relationships, as well as reductions in difficulties experienced by children in school.
- ✓ Following learning from case reviews, a Children in Need chair has been introduced with the aim that cases held in early help services, where there are emerging concerns, are reviewed independently to ensure that they are managed in the right service.
- ✓ Children missing education referrals have been received from a wide range of agencies including different council departments, health professionals and members of the public. The majority of these referrals are satisfactorily resolved by the ACE team with

cases only concluded as 'untraceable' following extensive reasonable enquiries undertaken.

- ✓ Over the course of 2014/15, 765 evaluation forms were received from parents who had received preventative input and advice through the local pilot of the NSPCC's Coping with Crying programme.
- ✓ The management of cases of young adult offenders and their potential association with children under 18 has been improved by increased co-working by CRC with the youth offending services in the three boroughs and frequent information sharing between the agencies.
- ✓ While the numbers of families in placed in Bed and Breakfast accommodation fluctuated over the year, there were no families living in such accommodation for longer than six weeks. There are examples of good practice from Housing in all three boroughs in helping families early. For instance in Hammersmith and Fulham, households which have medical or social vulnerabilities, as well as those where there are children in critical stages of their education, have been receiving tailored support.
- ✓ Coordinated multi-agency support through the "Team Around the School" approach has been enhanced to better address any increased safeguarding issues such as emotional wellbeing of children. This approach was undertaken with a particular secondary school in Westminster which has resulted in an improved approach including the relationship with CAMHs.
- ✓ A Mental Health Task and Finish Group was initiated by the three Health and Wellbeing Boards but informed by work of Westminster's LSCB Partnership Group. Its action plan includes an expectation that services providing mental health care to adults should be contractually required to ask patients about parental responsibilities and to assess the potential impact of their mental health problems on their children. The numbers of parents and carers identified are submitted in quarterly safeguarding reports. In addition, Chelsea and Westminster Hospital has a Lead Midwife for mental health and she works with mothers to ensure they are supported and referred to appropriate services.
- ✓ All three boroughs have methods and interventions for addressing radicalisation in schools that are innovative and built into the curriculum. There is a significant emphasis on safeguarding (see "Spotlight on safeguarding children from radicalisation" below).
- ✓ The IGU has maintained a significant reduction in violent offences in Westminster.
- ✓ The Section 11[1] reporting format has been revised in response to feedback from the voluntary sector.

Next steps

- Support and challenge all agencies to be able to describe more clearly and evaluate the important contribution that Early Help is making to ensure positive outcomes for children's safeguarding.

[1] Section 11 of the Children Act 2004 place duties on a range of agencies which come into contact with children to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. The LSCB has responsibility to ascertain compliance with this.

- There is regular reporting from the Children's Services performance team on Early Help but the way this is monitored and challenged has been identified as an area for development by the QA subgroup in the 2015/16 Business Plan.
- LSCB to have oversight of and opportunity to challenge initial impact of Focus on Practice on indicators that are expected to lead to better outcomes. These include anticipated reductions in numbers of children entering care, subject to child protection plans or rereferrals. The programme is being independently evaluated by the Institute of Education and the findings will be reported to the LSCB.
- Build upon improved joint working between Community Rehabilitation Company (CRC) and youth offending and other children's services as work takes place with a new cohort of young people becoming 18.
- Recommendations made about parental mental health by the Mental Health Task and Finish Group need to be effectively implemented along with any further actions recommended by a short life working group on parental health being led by both the Mental Health Trusts for the Board in 2015/16.
- Continue to evaluate and report on projects in relation to faith and belief which aim to engage and improve outcomes for children, incorporating this into ongoing activity.

Spotlight on safeguarding children from radicalisation

The LSCB recognises that young people are best safeguarded from 'radicalisation' through the creation of networks that engage young people with life-enhancing, respectful ideologies; challenging casual prejudice in families; creating communities where there is a shared language of non-militancy; and diverting young people from peer groups who share extremist world-views. These are all activities that need to be joined-up with other partnerships - especially with schools, youth, community and faith organisations, young offender and prison institutions, as well as through direct work with families.

What we have done?

- There have been significant developments regarding engagement of key agencies in the Prevent agenda. The Safeguarding Lead for education has been a longstanding member of the local Channel Panels (there are two panels, one for Hammersmith & Fulham and Kensington and Chelsea and another panel for Westminster). In the past year, membership of the LBHF/RBKC panel was expanded to include a Team Manager from Family Services to provide children's social care perspective as well as representation from the Tri Borough Youth Offending Service.
- The Prevent agenda has been included in the rolling training for designated teachers and governors. In addition, Prevent training has been provided for over 1700 staff in 140 schools across the three boroughs with an ongoing programme planned for 2015/16.
- Information about the Prevent agenda has been shared with the significant number of schools in the independent sector.
- There has been effective multi-agency support for schools and colleges in managing the repercussions in local communities when cases involving individuals (usually young adults) have attracted significant publicity.

- Building upon existing knowledge of and links with Supplementary Schools, the LSCB Community Development Worker and Prevent leads have been mapping Madrassas in all three boroughs with a view to improve communication and provide active support to raise the profile of the Prevent agenda along with wider safeguarding issues.
- CLCH is fully compliant with prevent duties as outlined 2015 guidance. It has a Prevent policy in place and has continued to cover the issues involved as part of their mandatory training offer. It is covered through Safeguarding Adults Level 1 training (90% compliance) and 50% of all staff have so far received Prevent training.

What difference has it made?

- ✓ The overall impact of local developments has been that emerging concerns are being consulted on earlier, with referrals made to the Channel panel where required. This means interventions can take place prior to any crime being committed.
- ✓ Although data in relation to this cannot be published, there are anecdotal indications that a greater proportion of Channel Panel referrals now come from schools or are regarding a child or young person.
- ✓ The agenda of Channel panels has widened to include more intelligence from schools rather than a sole focus on information from the police about individuals who are a cause for concern. This has led to a broader understanding of links between individual young people and has enabled a more preventative approach on some cases. Schools now actively take part in Channel discussions about individuals who are linked to children who are on their roll.
- ✓ Younger siblings and other extended family have been safeguarded and supported to continue to go to school and access other services following high profile cases involving other family members.
- ✓ There have been specific examples of successful interventions to address concerns about behaviour and developing attitudes of individual children which suggested that they were becoming radicalised. This has included work with children who have special educational needs.
- ✓ Independent schools have started to request specific advice and input about the Prevent agenda.
- ✓ Prevent leads have become an established and significant point of consultation for schools.

Next steps

- Embed developments by engaging members of the Tri-borough Prevent Steering Group in relevant LSCB sub-groups.
- Replicate practice in LBHF and RBKC to engage a Family Services Team Manager in WCC's Channel Panel.

- Continue to raise the profile of the Prevent agenda in schools and colleges through training, tailored input and awareness raising, with a particular focus on the independent sector.
- Provide information and workshops for representatives from Madrassas and Supplementary Schools to improve communications signpost access to the existing multi agency LSCB Training programme.
- Ongoing analysis of referrals to and outcomes from Channel to ensure it is effective, particularly in response to children at risk of radicalisation
- Develop support for children where there is evidence that their parents have become radicalised
- Continue to develop our awareness of links with the e-safety agenda to safeguard children from the risks of internet and social media as a means of radicalisation.

1.2 Better Outcomes for Children Subject to Child Protection Plans and those Looked After

2014/15 Business Plan priorities:

- ✓ All child protection plans are relevant to the risks and needs of the child and lead to effective support that improves their outcomes and life chances.
- ✓ Learning from case reviews improves the quality of practice and service that children, young people and families receive.
- ✓ Staff working across all agencies are better able to identify and support children who are at risk of neglect.

Child protection plans are relevant to the risks and needs of the child and lead to effective support that improves their outcomes and life chances.

What have we done?

- The Quality Assurance function within local authority Children's Services maintains an oversight of children with child protection plans. Numbers of children becoming subjects of a plan and numbers where their plan has ended are monitored through reports to the QA sub-group. Where the LSCB has noted changes in local trends, this has been highlighted and challenged at the LSCB. This happened in April 2014 in relation to LBHF when it was noted at the LSCB meeting that there had been an increase in children subject to plans. This prompted more analysis of data and cases to review whether different thresholds were being applied. There have also been frequent care and contrast exercises across the three boroughs to understand trends and take action to ensure thresholds are consistently applied.

- When actions have been taken to address increases in numbers of child protection plans, these have been discussed at partnership group meetings to develop a consensus on thresholds and the degree to which different agencies are aware of and agree with these.

- The Signs of Safety model has been introduced into child protection case conferences in in all three boroughs with all social workers receiving two days of training to use the techniques in practice. The model aims to work collaboratively and in partnership with families and children to conduct risk assessments and produce action plans for increasing safety, and reducing risk by focusing on strengths, resources and networks that the family have.

What difference has it made?

- ✓ The increased number of child protection plans in LBHF during 2014/15 prompted an external audit in the form of a 'Safeguarding Stocktake' which examined cases and child protection practice, leading to a set of recommendations. The numbers of children in LBHF with child protection plans have since declined.
- ✓ The introduction of Signs of Safety/Strengthening Families approaches has led to an increasing focus on reducing risks to children rather than plans which are lists of tasks that must be completed.
- ✓ The majority of children who have been subject of child protection plans do not require such plans in the future.

Next steps

- ✓ Continue to review and challenge how the Board can be most effectively informed about trends and outcomes in relation to children with child protection plans including through reports provided by Child Protection Conference chairs and data reviewed by the QA subgroup.

Learning from case reviews improves the quality of practice and service that children, young people and families receive.

One Serious Case Review was published in 2014/15 and a second completed SCR has not yet been published owing to ongoing legal proceedings but initial learning has been shared across agencies. Multi-agency themed audits in 2014/15 covered cases where there were issues of domestic abuse, neglect and child sexual exploitation. It is important that recommendations and outcomes of such audits are communicated and lead to better practice or outcomes for children. Individual agencies continue to be responsible for ensuring that recommendations from the audits are followed through.

What have we done?

- Learning Events have been held to disseminate key learning from the reviews, including when it has not been possible to publish final reports from SCRs.
- A new 'Quality Assurance Manager' role has been developed, partly to improve engagement of other agencies with audits such as schools as well as maintaining an overview of audit outcomes.
- A quarterly *Learning Review* has been published which summarises learning from case reviews at both the local level and further afield as well as providing details of additional information or resources to support practice. This has been cascaded to staff via Board members and is used at training events.
- A practice note has been published regarding processes that should be followed when Children in Need move between authorities.

What difference has it made?

- ✓ Local protocols have been developed to improve multi-agency engagement in strategy discussions
- ✓ Improvements have been made to Health case transfer protocols and linking of patient records
- ✓ Action has been taken place to ensure frontline staff have a good understanding of welfare rights and that local thresholds do not operate in relation to families in particular situations;
- ✓ Findings from Serious Case Reviews led to a number of new tools to better understand neglect as described in "Raising the Profile of Neglect" below.

Next steps

- Review the impact of improved communications about learning from reviews, including sampling the awareness of relevant multi-agency practitioners.
- Continue to ensure that clear action plans result from ongoing case reviews and that actions agreed are completed with the impact tracked over time.

Raising the Profile of Neglect

What have we done?

- There has been a particular focus this year on learning from reports about neglect of younger children and teenagers. Awareness of the consequences of neglect of children in the first two years of life had a higher profile following a multi-agency audit in December 2014. This led to the initiation of a Neglect short life working group which will report in 2015/16. Other developments included new tools to help front line staff to identify cases of neglect and evidence the referrals they make to statutory child

protection services. The tool includes a check list and template for evidence recording based on templates used in schools but to be rolled out more widely across agencies such as early years providers. Another tool is being trialed which assists in recording evidence of the child's experience relating to neglect with the aim of avoiding drift where neglect is identified.

- The MASH has revised its case rating system to ensure that signs of neglect are more readily recognised including where multiple referrals have been made on the same child. Such cases are then escalated to an early help social worker.
- The Neglect Short Life Working Group (SLWG) also focused on situations where families miss important appointments for their children, drawing upon individual agency work, particularly that undertaken by Health. Following learning from a SCR carried out in Greenwich, there has been a focus on Health, schools, Housing and social care considering their respective responses to families moving in and out of the local area.
- A Neglect strategy and action plan has been agreed by the LSCB Board. LSCB Neglect training has been reviewed and individual agencies asked to reconsider the content of internal training in light of local and national case reviews and the Ofsted Thematic report in 2014.
- The Independent Chair has worked with the DCI for the Child Abuse Investigation Team (CAIT) to follow up concerns that resource constraints on the CAIT were having implications for joint investigations and police attendance at strategy meetings. The Board has also reviewed the Metropolitan Police Service policy on changes to the practice of police not carrying out "welfare checks", introduced in 2014 to ensure that police do not attend premises when they have no legal power to enter.

What difference has it made?

The impact of the significant number of developments outlined above will be evaluated during 2015/16 and beyond.

- ✓ The Independent Chair was given an assurance by the DCI of the CAIT that despite resource constraints, the Metropolitan Police Service audited the performance of the CAIT and that it was well case-managed at a local level. The Board has also been assured that children would not be left unprotected, and there is no evidence that this has happened locally. Locally the police have stated that whenever there are sufficient grounds to suspect a child is at risk, an officer will attend and take appropriate action.

Next steps

- Ongoing evaluation of recent developments to improve responses to neglect.
- Continue to develop and publish learning materials.

- Each agency to identify and agree a specific action to improve the identification of neglect with the LSCB to facilitating the coordination of action to ensure that it is directed to where it is most effective.
- Further testing of the Threshold of Needs Guide to ensure it continues to provide appropriate indications of neglect (as well as other issues such as CSE, missing children and risk of radicalisation). It will also be updated in light of the publication of Working Together 2015.
- Continue to review the degree to which social workers are accompanied by Police colleagues when carrying out 'joint' investigations and reporting in to the police.

1.3 Practice areas to compare, contrast and improve together

Since 2012, organisations working across the three boroughs have sought to take advantage of the opportunities afforded through a single LSCB covering three boroughs by using a compare and contrast process to identify and learn from the best practice. This approach has been applied to priority areas of the LSCB's Business Plan in 2014/15.

2014/15 Business Plan priorities:

- ✓ Improve practice in respect of children and young people at risk of child sexual exploitation (CSE)
- ✓ Improve practice in respect of children who are subject to or at risk of female genital mutilation
- ✓ Improve response to domestic violence and abuse
- ✓ Develop a co-ordinated approach to e-safety.

Spotlight on child sexual exploitation

What have we done?

- There has been a significant level of activity overseen by the LSCB to address CSE which has gathered momentum over the course of the year. The shared CSE Strategy and action plan is overseen by the MASH, Missing and CSE sub-group and reported to the Board. An agreed risk assessment tool is in place which has been developed over time to make it more user-friendly to assess all children and young people who may be at risk. The MASH has developed systems to identify all resident children receiving services or subject to referrals who meet the criteria for being at risk of sexual exploitation as determined through Metropolitan Police CSE Operating Protocol. Each local authority has a nominated CSE coordinator who provides a point of contact, advice or consultation for any professional who is concerned that a child may be at risk of or experiencing CSE.
- The Multi-Agency Sexual Exploitation (MASE) panel was set up in early 2014 and provides a strategic overview of the identification, support and protection of children and young people at risk of CSE. It meets monthly with good representation from

relevant agencies and all three boroughs. The MASE has also developed its overview of interconnections between victims, perpetrators, and potential locations of concern which may require a planned and coordinated response.

- There have been ongoing developments in terms of use of information which is matched with other data to map perpetrators and locations of exploitation. Problem profiles have been developed and shared with the sub-group.
- Regular reviews of trends in relation to CSE identified some concerns about the quality of data regarding children and young people at risk, particularly in relation to differences between the reported number of cases by the local authorities compared to the Police in WCC and perceived low numbers of Category 1 cases overall. This was audited by the MASH Detective Inspector. He found that Police data included children who were not residents of WCC but were victims of CSE within the borough boundaries and included young adults who were making historical allegations. Otherwise, Police and the local authority were recording information about the same children. It was also concluded that the local authority CSE Co-ordinators were appropriately screening and applying thresholds so cases were only classified as Category 1 when there was clear evidence that the case should be deemed a CSE concern.
- The publication of the report of the Independent Inquiry into CSE in Rotherham (1997-2013) has led to additional local scrutiny by Chief Executives and elected members in all three boroughs. This also contributed to a more multi-departmental approach across the councils. A particular initiative resulting from was the Metropolitan Police's Operation Makesafe programme which will be implemented in 2015/16 with the involvement of departments responsible for Licensing, Environmental Health and Community Safety as well as local business communities.
- The LSCB offers specialist CSE training. Signs and indicators of CSE as well as signposting to CSE leads, the MASE and details of learning from case reviews are now included in the core multi-agency safeguarding training programme. Train the trainer programmes have been provided for all Designated Teachers for Child Protection in maintained schools across the three boroughs, including CSE as a key area. In CLCH the named Nurses for Child Protection attend the MASE and share any concerns and information relating to children at risk of CSE. CLCH staff have received training on the signs and indicators of CSE and so are aware of this form of abuse. Where they have concerns they seek advice from the CLCH Safeguarding team to make the appropriate referral into children's services.
- Multi-agency meetings take place in all three boroughs to plan interventions and responses for both victims and perpetrators. Probation, the Police, Community Safety and Anti-Social Behaviour Teams use innovative approaches to disrupt perpetrator activity and improve safety in emerging locations of concern. Over the past year, a number of children have been moved out of the area for their own protection, either through an identified care placement or through work with the Housing Department.

What difference has it made?

- ✓ There has been significant review of how CSE is recorded to ensure that as well as cases which meet Metropolitan Police thresholds, children who are at risk of CSE are also monitored and tracked by the three local authorities with oversight from the MASE. This approach will be rolled out, monitored and developed in 2015/16, in particular ensuring that a consistent threshold is being applied where children are thought to be vulnerable. Cases where risks have been effectively addressed are also being tracked to gain a better overview of the "journey" of individual children and interventions which have made a difference.
- ✓ A multi-agency LSCB audit of CSE cases showed a general improvement in the way that multidisciplinary work was carried out with young people at risk of CSE, compared with a previous audit in 2013. Effective communication between agencies in relation to plans and interventions was noted as well as good multidisciplinary working between police and local authority services to achieve short term safety for children.
- ✓ A police audit of perceived differences between police and local authorities data identified good levels of multi-agency working on all cases reviewed.
- ✓ There have been examples of schools receiving coordinated support with concerns about potential CSE from more than one borough, addressing the complexities of providing services for children attending school outside of their home borough. Schools have engaged in mapping of CSE and Serious Youth Violence and their interrelationships. This mapping has informed "Team Around" approaches coordinating multi-agency support for schools, in particular those providing alternative educational provision. There is now wider multi-agency information sharing about vulnerabilities and risks for individual young people before they are placed in such provision, including liaison with MASH and the Youth Offending Service.
- ✓ A contract for Barnardos to provide specialist services in LBHF has been reviewed and now includes a greater focus on outcomes and a role in the training of foster carers. Barnardos worked directly with 10 young people throughout the year. There has also been a good impact from work undertaken by specialist sexual health workers who work intensively with young people and build key relationships in the borough.
- ✓ Frameworks to support multi-agency information sharing and mapping have led to the identification of "locations of concern" or hotspots. One example was where mapping of victims and alleged perpetrators led to a park being identified as a location where CSE activity was taking place. This led to cross-departmental work to improve lighting, CCTV, cutting back hedges, and additional police patrols. Since then there have been no further referrals to MASE about CSE cases involving the park and as a result it is not currently considered a location of concern.
- ✓ Partnership working between police, local authority and parents led to child abduction notices being served regarding two victims of CSE in one of the boroughs.

Next steps

- The shared risk assessment tools will continue to be revised to ensure they can be used to screen children at the earliest stage, linking them to the Integrated Children's System to ensure relevant cases are flagged consistently.
- Develop plans to better identify, monitor and support children and young people for who there are concerns about potential CSE but who don't meet the threshold for Category 1 interventions.
- Ensure plans by MASE to develop strategic responses continue to be effective, including oversight of the success of disruption and intervention strategies; ongoing integration with serious youth violence panels; communicating the themes of strategic intelligence with practitioners e.g. mapping of local "locations of concern", information about emerging patterns of activity and links with work with gangs.
- Ensure that Operation Makesafe is implemented and that the impact of the programme is evaluated.
- Ensure protocols are further developed and refined to ensure detailed assessments of risk take place in relation to vulnerable young people placed in alternative educational provision. Also ensure that staff working directly with these young people receive training on current safeguarding issues including CSE.
- Further develop links with Adults' Services to ensure young people who are victims and/or perpetrators of CSE are supported through the transition into adulthood.

Spotlight on Female Genital Mutilation (FGM)

What have we done?

- An LSCB standing group was established to improve practice regarding FGM and with an initial aim to improve information sharing between Maternity services and children's social care.
- There is now a designated Child Protection Adviser for FGM in each borough providing consultation to partner agencies and overseeing cases, tracking referral activity and outcomes. A dedicated post has also been introduced who has shared good practice identified locally at both the London LSCB Chairs' meeting and the National Association of Chairs Group.
- FGM has been incorporated within the MASH threshold framework, rated as AMBER status when a woman has been identified as affected by FGM and she has a female child. This rating means that inter-agency checks will be undertaken without the requirement for family consent. There has also been work in partnership with the Metropolitan Police London wide strategy and assisting the London LSCB in updating risk assessment guidance for front line staff.
- A pilot project at St. Mary's Hospital took place in 2014 through a partnership between Children Services, Maternity Services and Midaye, a community organisation. Through

this, women referred to the clinic are jointly assessed by Health and Social Services with parallel support from a community based Health Advocate. Once a family has been identified, MASH checks are undertaken and then the cases are reviewed at a multi-disciplinary meeting where plans are made to offer support and assess the family circumstances in a holistic way. Where a woman has or is expecting a female child this will include a social work assessment. The emphasis of this project is on early identification and prevention so that time can be taken to work with families, to help them to understand the health and legal consequences of FGM, and to empower parents to keep their child safe in the face of social and familial pressure to conform to tradition. Following the pilot, the DfE awarded an innovation grant to enable the roll out across the three boroughs by extending the pilot at the hospital.

- A second pilot has started but focusing instead on children and young people who have suffered FGM. This builds upon on a partnership between Imperial College NHS Trust and Children's Services, planned in conjunction with the Police. Children who have been victims of FGM will receive a joint examination by a Consultant Paediatrician and Consultant Gynaecologist, as well as immediate access to a child psychologist and specialist social worker. This will be available to all children and families across the three boroughs and will be piloted for six months.
- The Safeguarding in Education Lead has carried out targeted work to increase awareness among school staff about the indicators of and responses to FGM and highlighting specialist support and advice. In Westminster, FGM is now routinely considered as part of the Team Around the School model.

What difference has it made?

- ✓ Over the last year, referral numbers have increased which is seen as an early indicator of improved practice. However, referrals in relation to FGM remain low, suggesting that under-reporting remains a concern for all three Boroughs as is the case elsewhere in London.
- ✓ As raised awareness is a key element of better identification and response to families and children who may be at risk of FGM, the significant amount of training for relevant staff will increase impact.

Next steps

- Finalise the LSCB FGM strategy and embed it across agencies.
- Confirm the draft information sharing protocol to clarify when information about an adult survivor of FGM should trigger information sharing between agencies in order to consider the safety of the child. This is informed by pilot work which is already demonstrating the ability of agencies to work together.

- Refine best practice models in cases where a child protection investigation is initiated, such as how medical examinations, interviews and legal proceedings are most effectively conducted.
- Monitor and review the extension of the FGM Clinic project into Queen Charlotte's hospital and support a further extension to Chelsea and Westminster Hospital as well as additional resources such as a male worker and psychological support for survivors.
- Continue to engage schools serving communities which are likely to have high levels of FGM prevalence in a trial approach which will involve a targeted multi-agency meeting to share information about cases where there is a worry or concern.
- Review and develop the pilot working with children and young people who have suffered FGM

Spotlight on Missing children

What have we done?

- The appointment of a Missing Children Officer located within the MASH in September 2014 has supported ongoing improvements in practice in line with a Tri-borough Missing Protocol and new government guidance. The post was introduced following a review of the numbers of missing children within the QA subgroup which identified differences across the three boroughs which were found to have resulted from different recording expectations. The Officer had a role in identifying vulnerable 'missing' and 'absent' young people and coordinating responses which would reduce long-term risk. Local authority case management systems have been developed to enable online recording of missing of absent "episodes". The Officer receives daily Missing notifications from the Police (Merlins) and notifications from practitioners and checks compliance with the protocol ensuring relevant follow up actions take place. Quarterly reports have heightened our understanding of each borough's compliance with the protocol and provided more of an understanding of the profile of each borough's children who go missing.
- A Missing Review is held every three months for all stakeholders with developments and required being discussed at the MASH/CSE/Missing Board. Two practice audits have been conducted in the past year which highlighted strengths and gaps within practice which are then followed up by the Missing Children's Officer.
- Meetings with Police have occurred on a regular basis to raise the Police awareness of the importance of Children's Services receiving all Missing Merlins.
- Information provided to RBKC's Care Planning group enables a regular review of the highest risk missing cases leading to management oversight and clear actions being identified.

- Because of the known links between children going missing and risks of CSE, the Missing Officer attends the MASE Panel to ensure intelligence regarding missing children is also considered.

What difference has it made?

- ✓ There is now an increased the awareness of the number of children and young people who go missing within the three boroughs. There are higher levels of understanding amongst frontline staff of the significance of being 'missing'/'absent' as a risk factor and links with other risks such as CSE and gang involvements.
- ✓ Meetings with the Police have increased the number of Merlins being received by Children's Services and their timeliness.
- ✓ There is improved recording of missing episodes on case management systems and Strategy Discussions are held according to statutory requirements.
- ✓ Outcomes from Return Home Interviews are informing on-going reflection and analysis of casework.

Next steps

- Develop practice targeting children who go missing most frequently.
- Continue to provide training in relation to the protocol and any updates as well as the risks associated with going missing including support and advice for professionals from all agencies who may conduct "return home interviews".
- Carry out further audits, including one on the experience of young people who previously went missing, to identify what they found helpful to inform future practice.
- MASH/CSE/Missing Board to receive performance reports including the identification of patterns and themes for individual children as well as for individual boroughs, to inform future multi-agency responses and challenge.

Domestic Violence and Abuse

What have we done?

- A short life working group for domestic violence was established in 2014 to gain a mutual agreement and understanding of the direction of travel for reducing the risks of harm to children from domestic abuse. The group endorsed work carried out by the Early Help Board to provide guidance to frontline social workers in recognising and responding to signs of domestic abuse and proposed that the LSCB should agree to the Tri-borough Violence Against Women and Girls (VAWG) Partnership taking forward and coordinating future work to reduce the impact of domestic abuse. This was agreed in April 2015 with the LSCB to receive regular updates on progress from the VAWG Partnership.

- The VAWG strategy and action plan has been agreed for 2015/16 informed by the views of focus groups of children and young people, facilitated by the LSCB's Community Development Worker. It incorporates a more coherent approach to commissioning and decommissioning voluntary sector services across the three boroughs to ensure a more consistent approach with victims and perpetrators.
- Learning from a SCR in LBHF last year has contributed to new ways of working with families where domestic violence is a feature. In RBKC for example, the significance of domestic violence and abuse has been further emphasised in Practice Week findings and ensuring more meaningful work with men and fathers.

What difference has it made?

- ✓ There has been improved working with the three boroughs' Community Safety Partnerships and a strengthening of the quality assurance and training links with VAWG group.
- ✓ Findings from recent case reviews regarding "disguised compliance" and working with men have influenced the content of systemic training for the Focus on Practice programme, therefore informing future practice of all local authority children's social care and early help staff.
- ✓ In all three boroughs, clinicians are being used to help understand family dynamics and how to change patterns of behaviour. In LBHF, three specialist posts have been created and split case conferences now take place where the father and mother both want to attend and sharing information in the presence of the other would be a problem.

Next steps

- Review progress with the VAWG strategy ensuring improvements are made to services that work with perpetrators and with children impacted by domestic violence.
- Ensure an improved system and directory of services is available by the end of 2015 which is easier for professionals and survivors to access and navigate.
- Use and develop VAWG data to enhance the work of the LSCB and vice versa.
- Work with the VAWG to understand whether we have the right services in place in the three boroughs in the face of reducing resources.

E-Safety

What we have done?

- A Short Life Working Group was established to identify best practice and co-ordinate multi-agency practice regarding e-safety, reporting to the LSCB in January 2015. The group reviewed existing policies, practice and training to identify any gaps to promote a better understanding of the issue for all agencies including safe practice by

professionals. This was informed by the views and suggestions of children and young people and aimed to increase clarity across the multi-agency network in responding to e-safety concerns at a strategic and individual child level. A multi-agency preventive strategy was developed involving training and other practice initiatives.

- Strong links have been developed with 3BM (an employee mutual which provides information technology support to many schools across the three boroughs) who have been an important partner in helping to share information with schools about e-safety. E-safety information will also be included on the LSCB website which will be a helpful resource for schools.
- "Team around the school" approaches have enabled coordinated support and advice (including mental health services) being made available to schools in response to emerging issues which are affecting young people on roll where the medium of social media can be a contributory factor, e.g. self-harm, eating disorders and gender identity.

What difference has it made?

- ✓ E-safety guidance and information has been circulated to all schools including independent schools) via schools' circulars. Information has also been distributed to schools to circulate to children and families.
- ✓ E-Safety has been incorporated into training for Designated Leads for safeguarding in schools, including designated governors, and further specialist training has been commissioned for Designated Leads and specialist staff to commence in September 2015.
- ✓ An e-safety audit tool has been developed and reviewed by the LSCB and circulated to all schools as well as policy templates to be incorporated in school safeguarding and child protection policies.

Next steps

- ✓ Monitor take up of e-safety training as well as identification of e-safety "champions" in schools.
- ✓ Share learning from safeguarding audits carried out from schools where good practice in relation to e-safety is identified.

1.4 Continuous improvement in a changing landscape

2014/15 Business Plan priorities:

- ✓ Work with Health and Wellbeing Boards, and other partnerships, to promote safeguarding as everyone's business
- ✓ Improve the engagement and representation of children, young people and families in the work of the Board
- ✓ Improve the feedback to families in relation to child death overview panel findings
- ✓ Strengthen the role of the borough Partnership Groups in championing local safeguarding practice and improvement
- ✓ Ensure that the LSCB's governance arrangements are fit for purpose and deliver improved local safeguarding practice
- ✓ The LSCB has adequate Business Support to facilitate effective working of the Board
- ✓ The LSCB's training and development programme evaluates its effectiveness and impact on improving front-line practice and the experiences of children, young people and families

Work with Health and Wellbeing Boards, and other partnerships, to promote safeguarding as everyone's business

What have we done?

- We have sought to develop stronger links with the Adult Safeguarding Board and held a joint event in November 2014 to establish areas of common interest. Forty four members attended and took part in two exercises concerning shared themes such as domestic violence and young people going through transition. It was agreed that the respective Independent Chairs would attend each other's Board annually with plans for further joint events. The Chairs continue to meet regularly and to strengthen the linkages with other bodies together, such as the Violence Against Women and Girls Strategic Partnership.
- The LSCB has provided safeguarding input and expertise into a Health and Wellbeing Board (HWB) Task and Finish Group on child and adolescent mental health and has now established terms of reference for a short life working group focusing on parental mental health. Links with the Health and Wellbeing Boards (HWBs) have been strengthened through the LSCB Chair meeting the HWB Chairs and the annual report being presented to HWB meetings. Each borough-based HWB has priorities for children with links to safeguarding and several LSCB members are also members of the HWBs.

What difference has it made?

- ✓ LSCB members have attended training on the implementation of the Care Act and the Adult Safeguarding Board was invited to have representation on the LSCB's short life working group on parental mental health.
- ✓ The agenda at individual Health and Wellbeing Boards has been informed by input from an LSCB perspective. The RBKC HWB requested follow up reports on FGM, CSE and Neglect following presentation of the LSCB Annual Report and actions were agreed, for example to review information sharing and communication in relation to FGM by health agencies.

Next steps

- Where appropriate, the LSCB will now work more closely with the Adult Safeguarding Board on Serious Case Reviews, sharing learning and training events.

Engagement and representation of children, young people and families in the work of the Board

What have we done?

- A safeguarding survey of 134 children and young people across the three boroughs sought views on what they thought safeguarding was and the ways in which professionals, agencies and services should communicate with them. 51% of young people said they had not been asked their views on safeguarding before while 24% could not remember or did not know if their views had been sought. Three key areas were then identified to focus on more widely:

    1. Are young people being asked about safeguarding?
    2. Is there a feedback loop?
    3. Which professionals are young people talking to?

- There have been five meetings with young people between October 2014 and February 2015 one of which was attended by the Independent Chair and other Board members. At least six young people have attended each session. So far the young people have learnt what the LSCB is, what its priorities are and the types of professionals who sit on the board.
- The LSCB Communication Map has been developed which charts the way information can be shared to and from the Board, regarding participation and engagement. Professionals have nominated themselves to be the named person for their respective sector. This means any safeguarding issues, comments or suggestions that young people may want to communicate with the Board on can be collated by those individuals, fed

back to the community development worker and then shared with the Board and vice versa.

- In December 2014, a group of six young people identified 16 safeguarding priorities that they would like to focus on for 2015/2016. Over the last few months other young people across the three boroughs have been invited to select their top two from this list, with a description of what needed to change and how the LSCB can seek to bring about those changes. The recommendation following this piece of work is that the children and young people's chosen top three priorities be incorporated either into the work of the Board or the work of the Community Development Officer for the financial year 2015/2016. The three areas are:

    1. Bullying (including online and in school)
    2. Self harm
    3. Employment, training and education

- The community development worker created a model for a young person's version of the VAWG strategy and is now working with the VAWG partnership to collect feedback from children and young people.
- The community development worker has also developed a working-group with Somalian men from the White City area of Hammersmith & Fulham, who are viewed as "community leaders" in an isolated community. The group was set up in response to a perception from the community that Somalian children were over-represented in the cohort of children with child protection plans and a feeling that they were being responded to unfairly. There have been three safeguarding workshops since December 2014 with six members of the group attending a "Safeguarding Awareness Raising Session" provided for supplementary school teachers including those working from Mosques and Madrassas. While the group is predominantly male, a Safeguarding Awareness Raising Session has also been provided for Somalian mothers in the White City Estate.
- Workshops on Safeguarding have also taken place with members of the Arabic speaking community in RBKC. In addition 18 community groups took part in a workshop on the key Safeguarding requirements for community and youth groups with "Safe Network".

What difference has it made?

- ✓ A cohort of young people is becoming both more informed about the work of the LSCB and more involved in it.
- ✓ Young people contributed to the safeguarding messages communicated locally during Safer Internet Day (February 2015).
- ✓ Members of local communities have engaged with the LSCB including groups who have concerns about safeguarding practice

Next steps

- Build on opportunities to communicate with wider groups of children and young people, e.g. through facilitating workshops at young people's conferences and other events.
- Review the effectiveness of individual schools' plans to raise awareness of safeguarding topics amongst their pupils and share good practice with other schools across the three boroughs.
- Continue to develop more effective ways of ensuring that the views of children and young people influence and inform the priority work of the LSCB.

LSCB website development

What have we done?

- Progress has been made in developing a standalone LSCB website to replace the three single borough LSCB sites. This will support a stronger identity for the shared LSCB which effectively communicates the local 'safeguarding story'. The new LSCB website has been launched in summer 2015 with sections for professionals, children and young people and parents and carers. It includes signposting to relevant resources, information on training, policies and procedures and where to get help and advice relating to safeguarding.
- In other areas of communication, the LSCB has improved. The previously mentioned 'Learning Review' is complemented in Children's Services Departments by bulletins summarising recent LSCB work and by regular communications from Directors of Family Services and the Director of Children's Services. There is also a monthly Policy Digest which includes a section on safeguarding.

What difference has it made?

✓ More staff are aware of the LSCB and there are plans to improve the number of channels through which the Board communicates with them and the wider community in the forthcoming year.

Next steps

✓ Launch and continue to develop the LSCB.
✓ Review and improve the LSCB's communications to reach a wider audience more effectively.

Strengthening the role of borough Partnership Groups in championing safeguarding

What have we done?

- There continue to be positive relationships in all three boroughs across a wide range of partnerships and openness to hearing from others both in meetings and outside. The LSCB has ensured that partners can continue to focus on specific local issues through the borough-based partnership groups whilst retaining oversight.
- All three Partnership Groups now have lay members and good representation from across the agencies. Any weaknesses in representation are being followed up.
- Each Group has developed a local agenda, however it has been acknowledged that they have not consistently taken forward the wider LCSB Safeguarding Plan.

What difference has it made?

✓ The 2015/16 LSCB Safeguarding Plan will inform the annual plans of the Partnership Groups which will include local issues but with stronger linkage to wider, shared priorities. The Chair has strengthened the groups' work by being more rigorous in specifying the outcomes that are to be achieved.

Next steps

- Ensure that ongoing review of the LSCB Safeguarding Plan includes oversight of the degree to which the activity of the three Partnership Groups is supporting and informing the overall aims of the LSCB.

Review of governance arrangements

What have we done?

- Governance arrangements have been reviewed to ensure the LSCB is fit for purpose to deliver improved local safeguarding. We aim to ensure that agendas reflect issues raised by all agencies. There has been particularly strong engagement of Health with the LSCB agenda. The lay members continue to bring active independent thinking to the Board as well as input to subgroups.
- Business planning processes have been reviewed in order to streamline Board priorities and specify outcome measures while ensuring that ongoing work is completed.
- A more robust culture of challenge has been developed with one element of this being the establishment of a 'Challenge Log'. Challenges are raised in a number of ways with major ones submitted to the Chair who may then table them at the following LSCB meeting for discussion. The log records details of the challenge, the date, the agencies involved and the outcome for a child or group of children or wider practice. Challenges are submitted by all agencies and concern a wide range of topics such as FGM, teenage

mental health, information sharing between agencies and the impact of housing benefit caps. Other opportunities for agencies to challenge partners include through the multi-agency case audits, conducted by the Quality and Assurance Subgroup. These are brought to the Board for scrutiny, and development sessions about the learning from case and serious case reviews.

- In May 2014 a peer review was commissioned to assist with assessing the effectiveness of the LSCB. It was led by the Independent Chair of another local authority area with experience in improving LSCBs' functions and led to a number of recommendations where improvements could be made.

What difference has it made?

- ✓ Partners have raised issues for detailed consideration of the LSCB such as the Violence Against Women and Girls Strategy, new Police policies on welfare checks, neglect during the first two years of life and how effectively the health needs of Looked After Children are met, especially those placed out of borough.
- ✓ A more streamlined annual Safeguarding Plan was agreed at the start of 2015/16 which specified outcome measures.
- ✓ Challenge identified the need for a more strategic response regarding FGM to ensure that agencies were joined up. As a result, of this, a short life working group was established and this has led to outcomes specified earlier in this report.
- ✓ The peer review exercise led to recommendations which have been acted upon including the improvement of communications, development of smarter LSCB targets and a review of the support allocated to the LSCB.

Next steps

- Take steps to widen the range of LSCB partners who lead sub-groups or short life work groups.
- Develop the profile of the Board and its activities through key messages communicated to all staff via newsletters and the website.
- Improve the logging of escalations to tie in with the "challenge log", to ensure that LSCB has oversight and can make links to future learning and improvement.

Ensuring adequate Business Support to facilitate effective working of the Board

The business support provided for the Board was reviewed in 2014/15 and a revised support structure has been agreed to be implemented. This includes a full time Business Development Manager who will take a project management approach to the day to day running of the Board as well as developing its activities and evaluating progress in the longer term. The Board will also be supported by a Development Worker who will support the

management of the LSCB and its sub-groups, as well as developing and coordinating strategic plans and initiatives, service improvement and overall administration of the Board.

Ensuring the LSCB's training and development programme evaluates its effectiveness and impact on improving front-line practice and the experiences of children, young people and families

The LSCB benefits from a well-trained workforce in the three boroughs with a focus on practice and resources for early help as well as child protection. Safeguarding is regarded as 'everyone's business'. LSCB training is well regarded across the workforce and is attended by a wide range of agencies. Police attendance is low but they do attend their own safeguarding training. The LSCB trainer has excellent links with Commissioning, Education and Early Years colleagues and therefore has frequent access to conferences or briefing events in order to promote training courses where take up is low.

The Learning and Improvement Framework (LIF) aims to ensure that that the LSCB fulfils its statutory obligations; that the multi-agency workforce is suitably skilled and provided with suitable support to learn and improve; that services improve through developing the workforce; that expectations of member organisations and the LSCB are clear; that single and inter-agency training and learning is of adequate quantity and quality; that a standard is set for professional knowledge, skills and values (via the LSCB Training Strategy).

A summary of the training commissioned by the LSCB in 2014/15 is in Appendix C.

What we have done?

- The Learning and Development (L&D) Group has overseen the LSCB multi-agency training programme which has been publicised through a newsletter to staff across the children's workforce. This year's offer has included Core Training as well as a wide range of specialist courses addressing specific safeguarding issues and training for managers and supervisors. Partner agencies share the delivery of the LSCB training offer although the main contributors continue to be Health and Children Services who delivered 19.8 % and 54.2% of the training respectively. Training courses are also delivered in schools by the Safeguarding in Schools lead which are tailored to schools' specific needs.
- The training offer is informed by learning from case reviews, audits and short life working groups as well as focus groups to review the training offer. Training content has also been revised to reflect national developments, for example Neglect training incorporated lessons from the 2014 Ofsted thematic report. Meanwhile changes were made to training provided by health providers to incorporate FGM and CSE. Corporate 'Prevent' training has been promoted across LSCB members and this will continue into 2015/16.
- LSCB-commissioned training has been subject to quality assurance including observations of trainer delivery and course content and mystery shopping exercises.

- Another action this year was for the LSCB's training and development function to better evaluate its effectiveness and impact on improving front-line practice and the experiences of children, young people and families. A revised process commenced in September 2014, focusing on pre and post course evaluation. It included self-assessment of knowledge and competency with a longer term plan to undertake a longitudinal evaluation from delegates three months and six months afterwards to assess the impact of training on practice.

What difference has it made?

✓ Training provided has reached significant numbers of staff. There have been 13 'Introduction to Safeguarding' workshops training 242 delegates; 34 'Multi-agency Safeguarding and Child Protection' workshops training 673 delegates. Specialist and managerial workshops have delivered training to a further 670 delegates:

- Voluntary sector organisation delegates made up 31% of attendance at 'Introduction to Safeguarding' workshops.
- Attendance rates for core training remain high at 96.2%
- Delegate feedback was positive regarding course content and impact on the delegates' knowledge, skills and practice.

✓ Feedback from staff in 2014/15 has led to changes to the 2015/16 training programme including the offer of half-day refresher safeguarding training (Level 3) for delegates who have already attended a whole day workshop in the past. Courses are also being offered at different times to increase accessibility as well as more access to e-learning and external links to Virtual College for FGM and CSE training.

Next steps

- Review and develop the Learning and Improvement Framework.
- The L&D subgroup will collate and analyse information emerging from Section 11 audits to inform assessment of training effectiveness.
- Revise the LSCB training programme to make it leaner and enable us to respond to new and emerging priorities. For example through working alongside the VAWG group to promote CSE training and Harmful Cultural Practices training from the innovation bid to the DfE. There will also be efforts to make links to Adult Services training and sign post where necessary.
- Identify and respond to lessons from the new process of pre and post course evaluation in terms of what forms of training have the best impact upon professional practice and outcomes for children.

CHAPTER 2 – THE LOCAL AREAS' SAFEGUARDING CONTEXT

Local Demographics

- Between the 2001 and the 2011 Census the population of Hammersmith and 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 and Chelsea is the country's second most densely populated area.
- 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.
- There are an estimated 86,600 children under 16 living in the three boroughs with recent increases in this population in LBHF (+9%) and WCC (+33%) and a decrease in RBKC (-2%).
- 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.

2.1 Vulnerable Children and Young People

This section reviews trends and progress with safeguarding children with high levels of vulnerability. This includes children who need to be supported by a child protection plan and those who need to be in the care of the local authority to keep them safe. It also looks at other cohorts of children and young who have been identified as a priority by the LSCB.

2.2 Children with a child protection plan

Following a child protection case conference which concludes that a child or young person is at risk of abuse, he or she becomes a 'child subject of a child protection plan'. The plan identifies tasks for different agencies to ensure that such children are safe.

At the end of 2014/15, there were **343 children who were subject to child protection plans across the three boroughs**. This included 169 children in Hammersmith and Fulham, 61 in Kensington and Chelsea and 113 in Westminster. Compared with previous years, this is an increase in numbers, except for Kensington and Chelsea which saw a reduction. Compared with most recently available national and London rates (children with child protection plans per 10,000 population, 2012/13), rates were higher in LBHF and lower in RBKC and WCC. Significant work has taken place in LBHF to understand these trends and review practice where required.

2.3 Children in Care

Children in care are "looked after" by one of the three local authorities. Children usually only enter care after significant work which seeks to protect children so they can remain at home with their families. Children can only become looked after either with a parent's consent or following a court decision.

At the end of 2014/15, 469 children were in care across the three boroughs, 185 were looked after by LBHF, 105 by RBKC and 179 by WCC. Numbers of children in care have reduced since 2012 across the three boroughs, although RBKC and WCC saw a slight increase between 2014 and 2015. Rates of children in care are lower in all three authorities compared to national measures (children looked after per 10,000 population 2012/13) and slightly higher than London rates in LBHF.

The three local authorities have agreed a Strategic Plan for Looked After Children and Care Leavers which sets out the vision and intended outcomes for Looked After Children and Care Leavers in the three boroughs from 2014-17. Individual children in care have regular reviews which are chaired by Independent Reviewing Officers (IROs) to ensure their needs are met over time.

Work with Looked after Children is scrutinised at a borough level by the relevant local authority committee but the LSCB also receives an annual report which gives assurances about different stages of the looked after arrangements. The LSCB has a particular interest in the interfaces with CSE, children missing from care, the stability of care leavers' lives, the risks that may arise from children being placed away from the local authority area and the risk and impact of neglect.

2.4 Children who are privately fostered

Privately fostered children are those who live away from home following an arrangement with extended family or friends made by their parent or parents. The ongoing challenge is to raise awareness about these children and their needs so that the local authority is notified

and able to assess situations where private fostering appears to be taking place. A Senior Practitioner was employed during 2014/15 to lead on this work with responsibility to coordinate awareness raising across agencies, and to assess and monitor the children concerned. Most children we are aware of are aged 10 or older. Most referrals tend to originate from the UK Border Agency, school admissions or self-referrals. There is a local trend involving young people, usually aged 14 or older living in the local area with host families to attend international schools and colleges. Additional activity to highlight the needs of these children has led to increased levels of referral in 2015/16. LSCB will review t during the forthcoming year.

2.5 Disabled Children

During 2014/15, of the Children in Need who received a service from children's social care, 6% in LBHF, 5% in RBKC and 11% in WCC were children with disabilities. The proportions of children with these needs have remained broadly constant over the past three years although in WCC the percentage has increased from 5% in 2012/13 to 11% in 2014/5. At the end of the year it was noted that of the children receiving services from Children with Disability social care teams, 3% had child protection plans, 5% were looked after children and the rest were Children in Need. During the review of the LSCB's work in 2014/15 it was agreed that a greater focus on the safeguarding of disabled children and young people was needed and has been identified as a key priority in the 2015/16 Safeguarding Plan.

2.6 Young people at risk of offending

The number of young people across all three boroughs starting to receive interventions from the Youth Offending Service reduced to 444 in 2014/15 from 469 in the previous year. However, numbers starting to receive a service in WCC increased by 10. Those who were subject to remands also reduced from 46 young people to 39 although numbers remained the same in LBHF (18 young people). The number and rates of young people receiving custodial sentences increased in LBHF and WCC although numbers decreased from 13 to 4 young people in RBKC. National rates of young people receiving custodial sentences decreased between 2013/14 and 2014/15.

2.7 Young people with mental health issues

Use of mental health services by children and young people is recorded for each of the three CCGs covering the three boroughs. 2,451 referrals were made to Child and Adolescent Mental Health Services (CAMHS). Although the highest number of referrals was recorded for West London CCG, the highest rate of referrals was seen in Hammersmith & Fulham CCG. For all three CCGs, 104 children were admitted to hospital with a primary diagnosis of mental or behavioural disorder in 2014/15 with the admission rate per 10,000 children being the highest in Hammersmith & Fulham CCG (13.4 admissions per 10,000 children). While there has not been a specific focus on the safeguarding needs of children with these needs in 2014/15, there has been significant activity carried out through the Health and Wellbeing Boards and the Children's Trust Board. The Safeguarding Plan for 2015/16 prioritises ensuring that safeguarding practice meets the needs of children with mental health concerns.

CHAPTER 3 – GOVERNANCE AND ACCOUNTABILITY

3.1 What is the LSCB?

The Local Safeguarding Children Board (LSCB) is a statutory body which agrees how relevant agencies work together to help make children and young people safer through promoting the welfare of children and making sure that work taking place is effective. The work of the LSCB during 2014/15 was governed by statutory guidance in *Working Together 2014 (Section 13)* and from March 2015 *Working Together 2015* (Chapters 3-5).

Since April 2012 a single LSCB has been in place to represent the three local authorities of Hammersmith and Fulham (LBHF), Royal Borough of Kensington and Chelsea (RBKC) and the City of Westminster (WCC). A LSCB across three boroughs works well for many partners, particularly as it reduces the duplication of senior managers having to attend three different LSCBs and enables greater engagement. This is particularly the case for some Health leads and the CAIT representative who have regional responsibilities which cover multiple boroughs. There has also been a positive impact on attendance and strength of input. There are complications for some locally-run services such as Police, Housing and Schools at Board level, as representative Board members do not work in arrangements that cross the three boroughs. The communication burden for such partners is challenging but this is partly addressed through the work of the borough-based Partnership Groups.

There is a significant advantage in having best practice, learning and resources from the three boroughs shared, compared and contrasted 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. An LSCB for three boroughs has also enabled shared structures and processes to develop, for example in relation to missing children and child sexual exploitation. This is of benefit for agencies operating in a part of London where children often go to school or receive services in neighbouring boroughs which can otherwise lead to confusion over pathways to services and their thresholds.

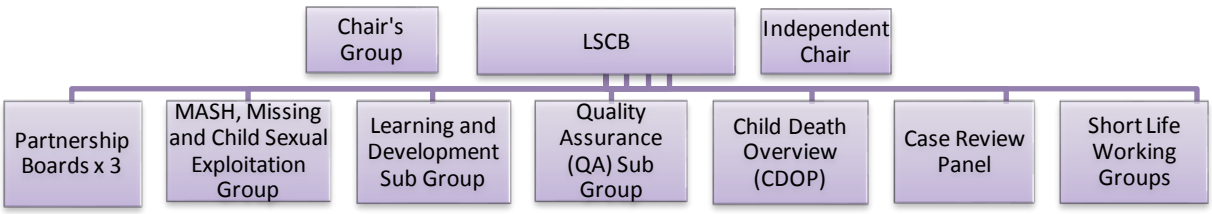
The shared Board is numerically large and the Independent Chair therefore needs to be active and visible across a number of key service areas. Governance arrangements need to ensure that the Chief Executives of each local authority are accountable for the arrangements being made. These arrangements are in place with a protocol agreed with the Chief Executives in 2013. The Scrutiny Committees in each borough receive and consider this Annual Report (as do the three Health and Well-being Boards). The time required to meet these demands is significant but through this the Board benefits from significant review of and feedback about its work.

VISION OF THE LSCB

The LSCB for the three boroughs aims to be 'excellent' in its role in ensuring agencies work effectively together to help make children and young people safer and promoting their welfare. We will make a proportionate response to national issues. A focus on what works best for children means we will support early help and promote family-based care wherever possible. We will work with partners to encourage and challenge a range of organisations to raise their profile to ensure that safeguarding is everyone's business. We will continue to have short-life focus groups to learn and improve and to disseminate learning and knowledge. All of our work will be informed by the voice of the child and the experience of our looked after children. We will manage within our resources but continue to raise any additional requirements where resource limitations impact on our ambition to fulfill our function well.

3.2 LSCB Structure

The structure of the Board and it's subgroups in 2014/15 was as follows:



3.3 Key roles

Independent Chair

The LSCB has been led by Jean Daintith, Independent Chair for three years since its inception in 2012. The Independent Chair is directly accountable to and meets regularly with the Chief Executives of Hammersmith & Fulham, the Royal Borough of Kensington and Chelsea and Westminster City Council. She also works closely with the Executive Director of Children's Services.

Local Authorities

All three local authorities are required to establish a Local Safeguarding Children Board under Section 13 of the Children Act 2004. The leaders of the three councils are responsible for the effectiveness of their respective LSCB arrangements with the Chief Executives accountable to their Leaders.

There is a Lead Member for Children's Services in the Cabinet of all three councils. The Lead Members are responsible for ensuring that their respective councils meet their legal

responsibilities in relation to safeguarding children. All three Lead Members are members of the LSCB with the status of "observers" as defined through Working Together 2015. They also receive regular briefings in relation to safeguarding developments and concerns from the Executive Director of Children's Services and the relevant borough based Family Services Director.

Partner Agencies

Section 13 of the Children Act 2004 sets out which partners must be represented on the LSCB. The representatives of these partners are at a level in their organisation at which they are able to commit to agreed developments in local policy or practice as determined by the LSCB as well as being able to hold their agency to account. There are examples of where the Independent Chair has challenged the level of representation provided by particular agencies which have led to improvements.

Designated Professionals

There are two Designated Doctors, one for Central London Clinical Commissioning Group (CCG) (Westminster) and a second for Hammersmith & Fulham CCG and West London CCG (Kensington and Chelsea). There are also two Designated Nurses covering the same three CCGs. The Designated Professionals' role is to work across the local health system to support other professionals in their agencies on all aspects of safeguarding and child protection. They provide advice and support to health commissioners in CCGs, the local authority and NHS England, other health professionals in provider organisations, quality surveillance groups, regulators, the LSCB/SAB and the Health and Wellbeing Board. They also quality assure the Governance and Accountability arrangements of Provider agencies through their Section 11 audits.

3.4 Organisation of the LSCB

The Board is chaired by an Independent Chair and meets four times a year. In addition to the quarterly meetings, the Board has two half-day development sessions or extra-ordinary meetings and holds special events to provide opportunities for active learning from the findings of 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. Partnership groups also ensure an ongoing focus on specific local issues with oversight from the Board.

A list of LSCB members as at May 2015 can be found in Appendix A. There has been a focus on increasing the participation of key partners and their attendance at the main Board is recorded in Appendix B. An increased representation at the LSCB from schools has been noted although it has been a challenge to have all three school representatives at the Board at the same time. The link with education has been strengthened by the School Improvement Service regularly participating in the QA sub-group. The three Borough Police services are represented at the Board by one Chief Superintendent who is then responsible

for communicating key messages to colleagues in the other two boroughs which can be a challenge.

Communication with local schools about safeguarding outside of LSCB meetings has improved significantly. The LSCB's Safeguarding in Education officer has established active links with schools' safeguarding leads. The officer along with the Local Authority Designated Officer (LADO) have also made progress with engaging the significant number of private and international schools in the three boroughs. An Independent Schools forum has been established with a focus on Safeguarding and Child Protection. This is well attended and feedback from schools is positive with an increase in requests for advice or support being noted. The Director of Education and the Safeguarding in Education Officer have regular mechanisms for communication with schools about relevant matters, including private and independent schools and the Independent Chair of the LSCB has attended the Head Teachers Executive meeting to discuss safeguarding.

The Independent Chair has intervened where there have been concerns about communication between related agencies, levels of representation at the Board or the impact of changes in resourcing. This has included challenge of the Child Abuse Investigation Team (CAIT) regarding regional levels of resourcing for investigations and strategy meetings and raising this issue with London Councils. There are examples of where other partners have responded to challenge about their level of representation which have led to new arrangements which have improved the contributions made to discussions and debates as well as the quality of joint working between meetings.

3.5 Key relationships

Health and Wellbeing Boards

There is a Health and Wellbeing Board in each of the three boroughs. The Boards are chaired by the Lead Member for Adults Services and members include representatives from local authority services (including the Executive Director of Children's Services), the Lead Members for Children's Services, the NHS and the voluntary sector. A protocol for working arrangements has been agreed between the LSCB and each of the three Health and Wellbeing Boards which has enabled the Independent Chair to present the LSCB Annual Report to each Board as well as the identification of shared priorities in relation to safeguarding children.

Children's Trust Board

A single Children's Trust Board was established for all three boroughs in 2014/15. It is chaired by the Executive Director of Children's Services who is also a member of the LSCB. In its first year, the Children's Trust Board has focused on developing multi-agency approaches to key commissioning developments including child and adolescent mental health and sexual health. The Independent Chair has presented the LSCB's priorities to the Children's Trust Board which informed the CTB's initial workplan.

Clinical Commissioning Groups (CCGs)

There are three CCGs covering the LSCB's area but the CCG collaborative group represents these at the LSCB with the Director and Assistant Director of the collaborative being members of the Board.

In addition, all relevant health organisations attend a Health Sub-group which is chaired one of the Designated Nurses. This was set up at the end of the 2014/15 and will be absorbed into the overall governance structure in 2015/16.

In 2014/15, Child Death Overview Panel (CDOP) work was led by the Clinical Commissioning Groups on behalf of the LSCB. The CDOP has continued to report to the LSCB and strengthen the links with the other subgroups to ensure that safeguarding issues are fully addressed and learning achieved to prevent future deaths.

3.6 Quality Assurance

The Quality Assurance (QA) subgroup takes a lead role in fulfilling the LSCB's scrutiny functions. The Quality Assurance Framework, launched in 2013, 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 through relevant reporting mechanisms for discussion and decision, with the results fed back down and action followed up by the QA subgroup or individual agencies.

The data set examined by the subgroup has identified patterns, changes and early warning signs within interagency safeguarding work (see sections on Child Protection Plans and Missing Children for examples). Some agencies which collect information regionally or with alternative boundaries have had difficulties providing data specific to one or three boroughs and there are some logistical issues with collating a data set from such a wide range of sources to enable all emerging issues to be responded to in a timely way. However, management information has improved this year: better information from the Police has allowed the group to examine conviction rates while information from Housing has fed into the Domestic Violence Strategy. An area for development will be to find ways to use the large amount of data more meaningfully and selecting particular themes for analysis.

The QA subgroup has carried out a number of multi-agency themed audits of front-line practice concerning specific Board priorities. In 2014/15 this has included domestic abuse, neglect and child sexual exploitation. These were led by officers independent and external to the LSCB usually reviewing up to 15 cases from the three boroughs. In the last year, additional resource has been created for audit arrangements by putting in place a new 'QA Manager' role, in order to ensure improved agency engagement, such as with schools and to enable more robust reporting on the impact of audits on front line practice and outcomes for children. Audit findings are presented at LSCB meetings and agencies are tasked to take action as required. The new QA Manager role will follow up recommendations to ensure

learning is widely disseminated and impact is measured. Recommendations from past multi agency audits will be reviewed at Board meetings.

In 2014/15, the pan-London template for Section 11 reporting was reviewed and revised, based on Working Together guidance and to make the audits more evidence based. The new template will also encourage an improved partnership approach for the identification of strengths and weaknesses and offering mutual support, rather than an approach which previously may have been viewed as criticism or scrutiny by the Local Authority. Audits will be conducted electronically so that results can be collated and analysed and presented to the QA subgroup for scrutiny. The final draft will be trialed during the summer of 2015. Further to a Voluntary Sector Safeguarding event in May 2014 there has been a strengthening of links with partnership groups and LSCB representation at Voluntary Sector fora. The key focus is Section 11 responsibilities and liaison with the Commissioning Directorate concerning services commissioned by the local authority to work with children and young people.

In addition, the LSCB has considered findings from new Local Authority Ofsted reports and paid regard to issues relating to safeguarding and child protection which have emerged from Ofsted School inspections. Consideration has been given to carrying out a JSNA on children's safeguarding although Public Health advice has been that a JSNA may not be the right tool for this purpose. The three HWBs have commissioned a number of JSNAs, including one on child poverty and this will inform the Board's work.

A peer review of the LSCB recommended that the Board should monitor the impact of restructured front line services. In the last year, the relevant Assistant Director presented a report to the LSCB following the development of a number of services for looked after children and care leavers which were shared by all three boroughs. A report with a similar focus is anticipated on the progress of the restructured Adoption and Fostering service. The Board has been updated on Focus on Practice, a significant transformation programmes across Children's Services, and Partnership Groups have also discussed any emerging pressures on front-line services. In addition the Chair of the LSCB introduced a standing item at the Board meetings for agencies to update on organisational changes that impact on service delivery. The opportunity to challenge agencies about practice is explicit both in meetings and by professional contacts between Board members outside meetings.

Again this year, each of the boroughs has conducted a 'Practice Week' through which managers undertook practice observations and case file audits, as well as providing coaching and feedback sessions with staff and supervisors. Common themes are subsequently written up to inform learning, development and follow up discussion. This also gives staff an opportunity to talk about work they are proud of and any barriers that may exist to getting the best outcomes for children. In particular, managers look at the journey of the child and evidence which clearly communicates purpose of interventions. Results of the practice weeks include a focus on the quality of return home interviews for missing children which also informed the development of the new Missing Children Co-ordinator role.

3.7 Local Authority Designated Officer (LADO)

A well established LADO service continues to develop strong working relationships across children's services within the three boroughs and with external statutory partners. This builds a coordinated and consistent approach to allegations management, facilitates the dissemination of guidelines in respect of safe working practice and aids the development of organisational cultures which facilitate safeguarding. Strong links have also been established with the regulators and inspectorate and with LADOs both across London and nationally; the LADO lead co-coordinates the pan-London LADO group and this year organised the second National LADO Conference which was hosted by shared Children's Services of the three boroughs.

During 2014/15 there were 148 allegations referred to the LADO across the three boroughs (LBHF:68, RBKC:21, WCC:59) from a wide range of agencies and relating to both professionals and volunteers who work with children.

The LADO lead sits on the Learning and Development subgroup and delivers nationally accredited safe recruitment training which is open to all agencies. A separate refresher course is also available taking learning from Serious Case Reviews and a 'meet the LADO' session has also been added to the LSCB. Explicit reference to the arrangements for managing allegations in the three boroughs is also made in all multi – agency training and there is emerging evidence that this has led to an increase in reporting and consultation.

Nationally the successful prosecution of high profile perpetrators of abuse has enabled further victims to come forward with confidence. This has been reflected locally by an increase in referrals and of referrals of a historic nature in particular. In addition the number of referrals relating to conduct outside the workplace has increased particularly with regard to adults who work with children who have accessed and/or are in possession of child abuse images. The LADO works closely with HR departments in the three boroughs and with those providing Human Resources services for partner agencies. Organisations also regularly ask for LADO advice relating to the suspension of employment , matters relating to disciplinary procedures and referrals to the Disclosure and Barring Service and professional bodies.

The introduction of new arrangements relating to disqualification by association has also led to an increase in contact with LADOs for advice in terms of assessment of risk and the application to Ofsted for waivers relating to those involved.

There has also been an increase in referrals and consultations relating to adults, working in various sectors, who have not been appropriately trained and supported to work with children and young people, some of whom have complex needs. Often these cases do not reach the threshold for criminal investigation or intervention by children's services but evidence a need for adults working in this sector to be clearly briefed about conduct and expectations relating to their work with children and young people. It is also becoming evident, when cases are investigated, that early signs of offender behaviour are not always recognised as a cause for concern; staff may not be equipped to recognise these concerns or are not confident to report them.

The following areas have been identified for development by the LADO service:

- Continue to raise the profile of the service with all partner agencies to ensure that referrals and consultations continue to be timely and appropriate.
- Review key contacts with partner agencies in order to provide a directory for all those who hold the LADO function.
- Increased liaison with Adults' Services on the development of the role of designated allegations' management leads.
- Continue to roll out lessons learned from Serious Case Reviews to reinforce best practice.
- Brief teams and organisations on safe working practice including revised national guidance is expected later this year.
- Increase understanding and awareness for those in the children's workforce regarding the modus operandi of offenders.

3.8 Complaints

Complaints regarding the conduct of Child Protection Conferences are dealt with under the LSCB Complaints Procedure. The complaints procedure has two stages with a strong emphasis on resolving complaints at the first stage. From 1 April 2014 to 31 March 2015, 9 complaints were recorded at Stage One of the complaints Procedure. The LSCB successfully resolved 7 complaints at Stage One and 2 were escalated to Stage Two.

Learning from complaints is an important part of the LSCB's philosophy and managers responding to complaints are encouraged to identify any shortcomings within the service and to inform the service user of any actions which will be taken to prevent a recurrence of the event which led to the complaint. Examples of learning during the last year are:

- Following the consideration of a complaint at Stage Two, the LSCB agreed to undertake a review of the way information is recorded for Review Child Protection Conferences. This had a particular emphasis on accuracy so that information provided from previous conferences has a review date, and where the information is no longer accurate, it should be updated in the conference minutes.

- A review of the management of split conferences was also undertaken, including the information provided to families in order to improve practice and enhance parent participation.

3.9 Financial arrangements

The total budget for 2014/15 from partner contributions was £250,241. £167,591 was contributed by the three local authorities with additional contributions totalling £82,650 from the Metropolitan Police, Probation, CAFCASS and the CCGs. Additional expenditure during the year was covered from LSCB reserve funding.

Budget Summary Table

	LBHF	RBKC	WCC	FORECAST
Contributions received in 2014/15				
Sovereign Borough general fund (BUDGET)	-65,951	-49,340	-52,300	**-167,591**
Partner Contributions in 2014/15				
Metropolitan Police	-5,000	**-5,000**	-5,000	**-15,000**
Probation	-2,000	**-2,000**	-2,000	**-6,000**
CAFCASS	-550	**-550**	-550	**-1,650**
CCG (Health)	-20,000	**-20,000**	-20,000	**-60,000**
Total Funding excluding reserves 2014/15	**-93,501**	**-76,890**	**-79,850**	**-250,241**
Forecast Expenditure in 2014/15	**LBHF**	**RBKC**	**WCC**	**FORECAST**
Salary expenditure	89,195	84,582	82,099	**255,876**
Independent Chair	9,319	9,319	9,319	**27,957**
Training	11,221	13,321	13,321	**37,863**
Peer review	1,891	1,891	1,891	**5,673**
Multiagency Auditing	9,303	9,303	9,303	**27,909**
SCR expenditure 1415	18,714		14,581	**33,295**
Other LSCB costs	3,794	6,879	4,569	**15,242**
Total expenditure	**143,437**	**125,295**	**135,083**	**403,815**
Outturn variance in 2014/15 including SCR	**49,936**	**48,405**	**55,233**	**153,574**
LSCB RESERVES as at P9				
	LBHF	**RBKC**	**WCC**	**FORECAST**
Reserves at start of year	-29,050	-116,240	-145,812	**-291,102**
Adjustments in year	5,000	-5,000		

DD in 201415	18,550	48,405	55,233	**122,188.00**
Reserves to take forward into 2015/16	**-5,500**	**-72,835**	**-90,579**	**-168,914**
	CONFIRMED	*CONFIRMED*	*CONFIRMED*	
LSCB final outturn	**31,386**	**0**	**0**	**31,386**

CHAPTER 4 – WHAT HAPPENS WHEN A CHILD DIES OR IS SERIOUSLY HARMED?

4.1 Child Death Reviews

A Child Death Overview Panel (CDOP) is in place covering the three boroughs. It considers circumstances relating to the deaths of children including any implications for future practice and strategic planning.

Twenty three deaths were reviewed by CDOP during 2014-15. These related to children who died between 2011 and 2015. Of the 23 cases, 9 were unexpected. The key themes for the unexpected deaths related to life limiting disease and sudden unexplained death of infants. Unexpected deaths led to a rapid response investigation led by the Designated Paediatrician for Unexpected Child Deaths to ensure there were effective multi agency investigations carried out and that the families were supported through their bereavement.

The main category of death continues to be perinatal events. This is consistent with the national trend and has led to intensive scrutiny of neonatal deaths by the Designated Paediatrician for Unexpected Deaths in conjunction with a Consultant Neonatologist. The Panel consists of a lay member who advises and ensures that the support that parents receive is adequate and of a high standard. A thorough review of cases has revealed that the standard of care is good. Due to the small number of deaths in the three boroughs there is limited learning arising from the reviews. This is not inconsistent with what is reported by other CDOPs.

What difference has it made?

- Developing LSCB training to include awareness of responsibilities regarding child deaths has led to increased consultation of the Designated Paediatrician for Child Deaths by other Trusts across the three boroughs, neonatal units and Paediatric Intensive Care Units as well as improved links with the Designated Paediatrician for Child Death in neighbouring Brent.
- CDOP reviewed and confirmed the effectiveness of feedback and support for those where the child has died within local NHS hospitals.
- Databases and information gathering processes have been developed to ensure that better information is now available about the ethnicity of children who have died is included.
- A registrar's review of sudden unexpected deaths in infants concluded that many babies who die have factors which put them at risk such as adverse social, environmental and medical factors. As the death of a baby should be described in terms of all the factors present in his or her life and not just the post-mortem findings, the study has demanded that data about child deaths is collected in a more rigorous way going forward.

Next Steps

- As part of a CDOP case in April 2015, the CDOP subgroup reviewed the feedback provided to families regarding Panel findings. The review indicated that information cannot always easily be automatically fed back to families due to third party information and inappropriate information such as criminal investigations. This area requires further development. However, the review highlighted work that needs to take place with childminders ongoing registration requirements. Also, that where a case is subject to coroner's inquest, the inquest findings will be available to the family.
- During 2015-16, links will be made with some of the other CDOPs across North West London to identify how learning from a wider number of cases can be shared.
- More work is required to ensure that those dying in Private Hospitals or outside of the boroughs are receiving effective feedback and support.
- Strengthen the contribution of Public Health to the Panel to support better identification of the extent to which socio-economic factors impact on the deaths of local children and to ensure that the learning from the reviews is incorporated into the Joint Strategic Needs Assessment.
- Strengthen links to local Coroners to support a more effective response to deaths abroad
- Review the Rapid Response Protocol and ensure appropriate linkages between Rapid Response, CDOP and the Case Review Sub Group.

4.2 Case Reviews

A "serious case" is where abuse or neglect of a child is suspected and either the child has died or has been seriously harmed and there is cause for concern about how organisations or professionals worked together to safeguard the child. Locally the LSCB case review sub group considers new child care incidents and makes recommendations to the LSCB Chair on whether a serious case review (SCR) or other type of review should be held.

What have we done?

- In 2014/15, the sub-group oversaw the commencement of two new serious case reviews and received one completed serious case review report. In addition, one new "case review" started, four completed review reports were received along with three Individual Management Reports that contributed to a serious case review in another Local Authority.
- The first SCR initiated was referred to as 'Sofia'. A report was completed and the learning from the review was presented at an LSCB meeting with the Board agreeing a response. A learning event was then held to share findings with the three boroughs and

other Boards who had involvement with the case. This SCR report will be published once criminal proceedings are concluded, so that learning can be disseminated more widely.

- The second SCR initiated was in response to abuse at an international school, based in Westminster. This case attracted national publicity because of the extent of the abuse and the suicide of the alleged perpetrator. The review is ongoing and is likely to report in the autumn 2015, following which it will be published. It is likely to be of national interest and the learning will be disseminated widely.
- The sub group considers national or other Local Authority review reports where there are lessons for local services. This is consistent with the Learning and Improvement Framework.

  Key learning points from reviews identified by the sub group include:

  - The need to avoid a "mindset" approach to cases, where they become compartmentalised as types of cases which require a particular response, e.g. "an adoption case" or "an education case". Compartmentalising cases in this way was seen to have hindered thinking about other relevant issues e.g. links to gangs or parenting issues in the two cases reviewed.
  - The importance of effective reflective supervision and its role in encouraging a more holistic approach to meeting children's needs has been stressed.
  - There has also been learning around working with mobile families, handover of cases, the chairing of Child in Need reviews, working with adoptive families, emotional attachment disorders, best practice in permanency planning, concealed pregnancy and the role of schools in deciding appropriate responses to drug use.

- The Case Review subgroup produces a quarterly 'Learning Review' newsletter to ensure that learning improves the quality of practice. This is circulated to Children's Services and key contacts from partner agencies. In 2015/16 the new website for the LSCB will be a place where all practitioners can access the newsletter and between now and then the LSCB is disseminating the newsletter to front-line staff at safeguarding courses. It is also sent as a link to GPs via CCGs. The Chair of the L&D Subgroup has held two learning workshops as part of the LSCB training offer this year, based on lessons from recent case reviews.

What difference has it made?

Please see sections on Learning of Case Reviews, Domestic Violence and Abuse and Neglect for information about impact of specific SCRs.

Next Steps

- Provide more 'bite-size' courses on learning from current case reviews so that practitioners can attend sessions more easily within busy work schedules.
- A current SCR regarding abuse in an international school in Westminster has highlighted a major learning point at a national level: that the abuser had a previous conviction in the United States but when he was recruited, there were not comprehensive overseas checks. Reviewing how agencies undertake checks for people who have worked or lived abroad may be a national issue for agencies well beyond the LSCB. The LSCB will consider requesting partner agencies to review their own agency and report to the LSCB. The LSCB could also lobby central government for assistance in this area.

CHAPTER 5 – STATEMENT OF SUFFICIENCY AND FUTURE PRIORITIES

5.1 Statement of Sufficiency (LSCB Chair)

Information submitted and presented in this annual review demonstrates that the LSCB for Hammersmith & Fulham, Kensington and Chelsea, and Westminster fulfills 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. It 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 and to challenge agencies to improve coordination and learn from review and audit.

5.2 Priorities for 2015/16

It has been noted that our previous plans have consisted of a long list of actions and we may be criticised for trying to do everything rather than focusing on a few matters. However, we are committed to doing well across all our areas of responsibility. While we aim to be aware of and responsive to the emerging themes of the national and local safeguarding agenda, we are also keen to continue to develop our approach to longer term priorities until we are satisfied that sufficient progress and impact has been made. This is reflected in a number of actions identified in this report where we want to improve still further. We are also conscious of the need to balance priorities to ensure that responses to significant risks to comparatively small numbers of children and young people are progressed while not losing sight of wider safeguarding issues which affect a larger cohort.

For 2015/16 we have sought to design smarter objectives. **The LSCB's Safeguarding Plan for 2015/16** has been signed off by the LSCB. Following a review of the previous year's Business Plan, consultation with partner agencies and discussion with the Board, the headline priorities are as follows:

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

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

Improve the Board's effectiveness in reducing harm to children

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

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

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

Our developments and action in relation to these priorities will be informed by the voice of the child & the experience of our looked after children. We have also indicated how we would expect to measure the impact of our work and will report on our progress with this in our next Annual Report.

Essential Information

Authorship Jean Daintith (Independent Chair of the LSCB) and Children's Policy Team, Westminster, Kensington and Chelsea and Hammersmith and Fulham

Date of Publication October 2015

Approval Process This report has been approved by the LSCB

Copyright and reproduction information This report is a public document

Sources and verification This report contains contributions from the safeguarding community in Hammersmith and Fulham, Kensington and Chelsea and Westminster

Availability and accessibility This report can be downloaded as follows: https://www.rbkc.gov.uk/subsites/lscb/aboutus/publications.aspx

Contact details Steve.Bywater@lbhf.gov.uk (Children's Policy Manager)

APPENDIX A BOARD MEMBERSHIP
(Membership as at May 2015)

Surname	Forename and title	Role	Borough or area (if relevant)	Agency
Armotrading	Lavinia	Designated Nurse for Safeguarding Children Central London and West London CCGs		Health - CCG
Ashley	Dr Louise	Chief Nurse and Director of Quality Assurance, CLCH		Health - CLCH
Brownjohn	Nicky	Associate Director for Safeguarding (CWHH) CCGs		Health - CWHHE CCG
Bywater	Steve	Policy and Performance Manager	Hammersmith & Fulham	Children's Services
Campbell	Cllr Elizabeth	Cabinet Member for Family and Children's Services, RBKC	Kensington and Chelsea	Councillor
Caslake	Melissa	Operational Director of Children's Services (WCC)	Westminster	Children's Services
Chaffer	Denise	Director of Nursing NW London Area Team NHS England		Health - NHS England
Chalkley	Cllr Danny	Cabinet Member for Children's Services, WCC	Westminster	Councillor
Chamberlain	Clare	Director of Family Services (RBKC)	Kensington and Chelsea	Children's Services
Christie	Andrew	Executive Director of Children's Services		Children's Services
Daintith	Jean	Independent LSCB Chair		Independent Chair
Dehinde	Tola	LSCB Lay member	Kensington and Chelsea	Lay person
Dodhia	Hitesh	Head of Operations (Gate / Visits) Wormwood Scrubs		Prisons
Flahive	Angela	Joint Tri Borough Head of Safeguarding Review and Quality Assurance (WCC, RBKC, H&F) Children's Services		Children's Services
Goddard	Andrea	Designated Doctor for Central London CCG		Health - Imperial
Grant	Patricia	Designated Nurse for Safeguarding Children Hammersmith and Fulham CCG Health Adviser to LSCB	Hammersmith & Fulham	Health - CCGs
Hargreaves	Paul	Designated Doctor for Hammersmith & Fulham and West London CCGs	Hammersmith & Fulham	Health - Chelwest
Heggs	Ian	Tri-borough Director for School Commissioning		Education
Hillas	Andrew	Assistant Chief Officer, London Community Rehabilitation Company		Probation

Hine	Coretta	MPS CAIT		Police - Met
Hrobonova	Eva	Consultant in Public Health Medicine		Health - Public Health
Jackson	Sally	Partnership Manager, Standing Together		Voluntary Sector
Jones	Will	Assistant Chief Officer National Probation Service		Probation
Knights	Catherine	Associate Director of Operations, Central North West London Mental Health Trust		Adult Mental Health
Leeming	Wayne	Head Teacher Melcombe Primary School	Hammersmith & Fulham	Education - School
Maclean	Caroline	Director of ASC Ops		Adult Safeguarding
Macmillan	Cllr Sue	Cabinet Member for Family and Children's Services	Hammersmith & Fulham	Councillor
Meyrick	Olivia	Executive Head of QEII and College Park School	Westminster	Education - School
Miley	Steve	Director of Family Services (H&F)	Hammersmith & Fulham	Children's Services
Raymond	Debbie	Head of Combined Safeguarding & Quality Assurance		Children's Services
Redelinghuys	Johan	Director of Safeguarding and Named Doctor WLMHT		Adult Mental Health
Riley	Belinda	Interim LSCB Business Manager		LSCB
Roberts	Greg	Supporting People and Homelessness Strategy Manager (WCC)	Westminster	Housing
Royle	Liz	Head of Safeguarding, CLCH		Health - CLCH
Scott Plummer	Poppy	LSCB Lay member	Hammersmith & Fulham	Lay person
Sloane	Vanessa	Director of Nursing and Quality. Chelsea and Westminster Hospital		Health - Chelwest
Springer	Gideon	Chief Superintendent Borough Commander Hammersmith and Fulham	Hammersmith & Fulham	Police - Met
Steel	Senga	Deputy Director of Nursing		Health - Imperial
Taylor	Adam	Head of Commissioning		Community Safety Team
Taylor	Alan	Head of Safeguarding, London Ambulance Service		Health - London Ambulance
Virgo	Elizabeth	LSCB Lay member	Westminster	Lay person
Webster	Dr Jonathan	Director of Quality, Patient Safety and Nursing CWHH CCG Collaborative		Health - CWHHE CCG
Whyte	Sally	Head Teacher of Lady Margaret Secondary School	Hammersmith & Fulham	Education - School
Yilkan	Zafer	CAFCASS		Cafcass

APPENDIX B LSCB MAIN BOARD ATTENDANCE

Role	16th April 13	16th July 13	15th Oct 13	14th Jan 14	15th Apr 14	15th Jul 14	14th Oct 14	13th Jan 15	21st Apr 15	14th July 15
LSCB Chair	y	y	y	y	y	y	y	y	y	y
Executive Director of Children's Services	y	y	y	y	y	y	y	y	y	y
Director of Family Services (H&F)	y	y	y	y	y	y	y	y	y	y
Director of Family Services (RBKC)	o	y	y	y	x	y	y	y	y	x
Director of Children's Services (WCC)	y	y	y	y	y	y	y	y	y	y
Director of Schools	y	y	y	y	y	y	x	x	y	y
Head of Combined Safeguarding & Quality Assurance	y	y(2)	y	y	y	y	y(2)	y	y	y
LSCB Business Manager	y	x	y	y	y	y	y	y	y	y
Director of Adults Safeguarding	x	y	y	x	y	x	y(2)	y	y(2)	y
Housing	y	y	y	y	y	y	y	y(2)	y	y
Borough Command	x	y	y	y	y	y	y	x	y	y
CAIT	y	y	x	x	y	y	y	y	y	y
Probation	y	y	x	y	y	y	y	x	y	x
Community Rehabilitation Company	o	o	o	o	y	x	x	y	y	y
CAFCASS	y	y	x	y	x	x	x	y	x	x
Prisons	o	o	o	y	x	x	y	y	y	x
Ambulance Service	o	y	y	y	x	y	x	y	y	y
Voluntary Sector	y	y	y	y	x	y	y	x	y	y
Lay member	o	y(2)	y(3)	y(2)	y	y(2)	y(2)	y	y	y(2)
NHS England	x	x	x	x	x	x	y	x	x	x
Health CCGs	y	y	y(2)	y	y	y	y	y(2)	y	y
Designated Doctor INWL/Designated Doctor Chelwest	y(2)	y(2)	y	y(2)	x	y	y(2)	y	x	y
Designated Nurse	y	y	y	y	y	y	y	y	y	y
Head of Safeguarding,	y	x	y	y	y	y	y	y	y	y

CLCH										
CLCH Director of Nursing	x	y	x	y	x	x	y	x	x	y
Imperial Director of Nursing	y	y	y	y	y	y	y	y	y	x
Chelwest Director of Nursing	y	x	x	y	y	x	y	x	x	y
WLMHT	y	y	y	y	y	x	x	y	y	y
CNWL	y	y	y	y	y	y	y	y	y	y
Public Health	y	y	x	y	y	y	y	y	x	y
Community Safety Team (Commissioning)	o	o	o	o	y	y	x	y	y	y
Policy Team (Commissioning)	o	o	o	o	o	o	o	o	y	y
Head Teachers	o	o	o	y(3)	x	x	y	y(2)	x	x
Cabinet Member for Children's services, H&F	o	y	y	y	x	y	x	y	x	x
Cabinet Member for Family and Children's Services, RBKC	y	x	x	y	y	x	y	x	y	y
Cabinet Member for Children's Services, WCC	y	y	y	y	x	x	x	x	x	x

APPENDIX C LSCB TRAINING OFFER 2014/15

The training offer has been as follows:

Core training:

- Introduction to Safeguarding
- Multi-agency Safeguarding and Child Protection

Specialist Training:

- Domestic Abuse and Safeguarding Children
- Parental Mental Health and Safeguarding Children
- Parental Substance Misuse and Safeguarding Children
- Working Effectively with Interpreters
- Abuse and Young People's Relationships
- Girls, gangs and sexual violence
- Awareness of cultural practices (FGM and honour based violence)
- Be wise to Sexual Exploitation
- Safeguarding Children with Special Needs
- Safeguarding Children who may be involved with gangs
- Safeguarding Children: The Impact of Neglect
- Safeguarding Neglect: Identifying and intervening
- E-safety
- Fabricated and Induced Illness
- Working with Difficult and Evasive Families
- Working Effectively with Interpreters
- Forced Marriage and Honour Based Violence (Karma Nirvana Roadshow)
- A whole programme on Joint Investigation – well attended by Children's Services staff but not attended by health or police so it has been removed from 15/16 programme

Managerial Training:

- Safer Recruitment
- Supervision in relation to Safeguarding Children
- Serious Case Review: What do we have to Learn?
- Advanced Skills Workshops for Supervisors: Assessment and Analysis
- Advanced Skills Workshops for Supervisors: Safeguarding young people and gangs.

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. The LSCB training team hosted some of the national Karma Nirvana roadshows to update the workshop on changes to legislation on forced marriage. Other developments and progress against 2014/15 priorities included:

- Neglect Training. This was as a result of individual agencies asking to review internal training in light of local and national case reviews and the Ofsted Thematic Report of 2014.
- Level 3 Safeguarding. The programme includes learning from recent national and local case reviews. It has been updated, with new programmes in place and plans to ensure all LSCB trainers are competent to deliver.
- E-Safety. Following the report and recommendations from the e-safety short life working group, e-safety has been incorporated into training for Designated Leads and further specialist training has been commissioned for Designated Leads and specialist staff to commence in September 2015. There is also signposting to support available from CEOP, NSPCC and Internet Watch Foundation, among others.
- Safeguarding in Schools. From January 2015, the Lead for Safeguarding in Schools has been using a new audit tool to support schools evaluate their effectiveness in meeting safeguarding responsibilities. Evaluation and feedback has been used to inform training on Safer Recruitment including management of allegations in 2015/16.
- Signposting to Prevent workshops.
- Ensuring all agencies have the highest standards in safer recruitment of staff. A revised scenario in multi-agency safeguarding Level 3 course was also included about the role of the LADO to raise awareness and signpost to safer recruitment training.
- The promotion of training amongst community and voluntary sector organisations to increase take-up. The LSCB's Community Development Worker co-ordinated an event for the faith and voluntary sector where the LSCB training programme was promoted.
- A focus on diversity issues (FGM and forced marriage).

Joint Strategic Needs Assessment (JSNA) Steering Group

30th September 2015

Notes

In attendance	
Daniela Valdés (DV) (chair)	Head of Planning and Governance, CLCCG
Angela McCall (AM) (minutes)	Business Support Officer, Public Health
Angeleca Silversides (AS)	Health Watch, CWL
Ann-Marie Smith (AMS)	Tri-borough Children's Services
Jessica Nyman (JN)	JSNA Manager, Public Health
Colin Brodie (CB)	Public Health Knowledge Manager
Mark Jarvis (MJ)	Company Secretary, Hammersmith & Fulham CCG
Shelley Gittens (SG)	Public Health Performance Manager
Angela Spence (ASp)	Kensington and Chelsea Social Council
Samar Pankati (SP)	Public Health Project Manager, CLCCG
Shad Haibatan (SH)	SOBUS
Rachel Krausz	Strategic Delivery Manager, WLCCG
Gayan Perera (GP)	Senior Public Health Analyst
Dr Mona Vaidya (MV)	GP Partner, King's College London
Apologies: Stuart Lines, Meenara Islam	

Item	Action
1. Minutes of last meeting and matters arising	❖ Minutes agreed.
2. Overview of the JSNA Project Plan - **Updates from current deep dive JSNAs**	**End of Life Care JSNA** ❖ Progressing well – a technical document and JSNA report have been produced, containing evidence of best practice, strategy & guidance. The End of Life Care Steering Group last week was used to develop recommendations and it is hoped to be finished late October/early November then it will be finalised and taken to January/February H&WBBs. ❖ **CB** – in the timetable include governing bodies to show this, especially as there is a specific piece of work with NWL CCG collaborative. Governing Body meeting are in January but there are monthly seminars prior to this – JN is looking at taking it in November. Should go prior to H&WBB for CCG endorsement . November or January will be for Governing Body meetings in public to view these and submission is 2 weeks prior to the meeting. ❖ **JN** to present this to Governing Body seminar in November and circulate these minutes. An update is requested by the end of October. **JN** to create a paper for noting for future JSNAs and times & dates. **Health and Disability related Housing JSNA** ❖ Task & Finish group has been very productive and there is a stakeholder workshop on Nov 30th .including people frm Public Health, all Housing Departments, Adult Social Care and Registered Social Landlords. **All** to let JN know of wider stakeholders to publicise this. **Online JSNA Highlight Report** ❖ Recruiting backfill for TJ approval has been received now. ❖ Platform is taking shape. TJs presented a demonstration to each of the H&WBBs which have been well received and endorsed by members and councillors **Dementia**

	❖ To be signed off on Thursday at the WCC H&WBB. **All** to send JN any comms links for this to be included. This will hopefully be published end of this week which is in good timing with National Mental Health Week coming up so could go on the back of this. ❖ It could also go to the 26th October Equality & Diversities Conference - **JN**. **DV** to put JN in touch with comms lead. **Westminster Needs Modelling project** ❖ Meenara was to update but unable to join today. **CB** to ask for a summary update. **JN** forward scope to DV. **Risks & Issues** ❖ Publishing of Childhood Obesity and End of Life Care has been pushed back to January to make sure there is more engagement with CCGs and other departments.
3. Childhood Obesity JSNA	❖ JN wanted to make sure it is on the group's radar. Steering group members reported that it feels like a user friendly document coving a wide range of information and communicating it clearly. **MJ** to discuss with JN governance arrangements. ❖ Consultation with families and preventative work around obesity – there could be more on this and there is question over how to evidence the effectiveness.
4. Application for Students and Young Persons JSNA	❖ An application for a JSNA on Students and Young Adults (age 18-25) was presented to the Steering Group. ❖ Some of the issues discussed included: o There is a big hole from when patients have been discharged from CAHMS and a huge population without a specific resource. o Eating disorders are one of the main issues that are particular to this age group, and such patients often suffer from other problems, i.e., mental health, A&E admissions. It is very difficult to understand how bad the service is in providing systematic care for these patients as there is no way to collate the data. o International students are vulnerable partly due to a lack of understanding of how the NHS

	works. There is no regulation in the UK for universities to report crime so there is a lot more than is often reported. This highlights the need to be looked at because these students don't know where to go to for support. ○ This is a potential piece of work that AS and MV could link with through Healthwatch. ○ Evidence through this JSNA needs to be collated to support the group, looking at the future working generation to reduce the burden on society. ○ The group asked what more would a specific JSNA give than the evidence which MV has already collated. MV fed back that this has to be the formal process to put everything together in a systematic way. ○ How could the JSNA make a change? Eating disorders need to be addressed as there is a 9 month waiting list for patients to be seen at the current service. ○ Systematic recording of movement of this transient population to understand the origin of disease and infection, and some power to enforce containment. Providing some community and voluntary services within these population areas. Infectious diseases is health protection, PHE would need to be involved. ○ This is a central London issue but could become a London issue and LBHF H&WBB specifically endorsed it on 9th September. ○ Evidence may not be in numbers and figures but there is clearly a concern for this age group. ○ It has to be clear which group we are looking at if the JSNA is to go through – if it is specifically students then other people within that age group are at a disadvantage. ○ There is debate about the scope and agreement that West London CCG should be included. If it goes to prioritisation, different chunks of the scope would have to be tackled individually as different pieces of work that all fit into the bigger picture. The assessment will be agreed on these terms and scoping on more detail is needed. ○ **AMS** can help access information on data; A&E etc., service mapping and scoping will need to be carried out. ❖ The Steering Group scored the application using the prioritisation tool and agreed that this issue was a high priority and the JSNA will proceed, pending further scoping. See Appendix 1.

5. CCG presentation: CCG commissioning process	❖ **DV & MJ** put together a presentation on commissioning timelines and what needs to go into the Commissioning Intentions document. A more public facing document will be published in the next quarter. ❖ The process means that people will be engaged much earlier and the dialogue will be an on-going process to think about what objectives look like in commissioning terms. ❖ There is an on-going process of contract monitoring and thinking about changes to contracts over the next session. Contracts will be signed by 31st March. ❖ All work is underpinned by objectives, and level of engagement undertaken to work with stakeholders to shape the future direction of commissioning as it needs to be based on needs of the population and JSNAs are vitally important to shaping this. Co-design is at the core. ❖ Contract monitoring needs more thought on how to get real and valuable patient feedback to help influence and shape how to go about the on-going contract cycle. ❖ Looking to have more system wide and joint understanding with providers. ❖ Monitoring reported around financial implications of projects and internally circulated project monitoring reports. Would JSNA team, JN & CB like to be involved in this? **JN & CB** to discuss with Samar the project book tool for PH. Each CCG has a project management office and their own internal processes & measures. ❖ There is concern about NHS quality of service ❖ CCGs re reengaging much more with PH now, post separation from PCT. MJ is pushing this much more within the CCGs ❖ Business plan for CLCCG is being discussed at the H&WBB tomorrow and will be made public. ❖ **DV** to suggest to CB how PH can become more involved. JSNA could be another enabler. Distributing JSNA agenda in locality conversations with GPs – **CB/JN** could come to these and MJ's user panel meetings for feedback. MJ has been in talks at LBHF on a joint engagement event.
6. Terms of Reference	❖ There was insufficient time for this agenda item, but members agreed that the quorum requirement to have a representative from each council could be met by officers working in Shared Services across the three boroughs, such as Public Health, Children's Services or Adult Social Care.
7. AOB	
Date and time of next meeting: 23rd November 2015, 2-4pm, 15 Marylebone Road	

Appendix 1

JSNA Prioritisation Scoring Tool

Filter question

Question	Yes/No
1. There has not been a deep dive JSNA or another type of review conducted on this subject in the last 3years	None specific to student population, but there are other relevant JSNAs e.g. sexual health JSNA, substance misuse needs assessment
2. Is the research question clearly stated?	Needs some further clarity and scoping. Prioritisation tool has been completed on the basis that the population group are young adults aged 18-25, including students
3. Can the research question be met by a JSNA?	Yes, although some of the specific research questions may not require a JSNA e.g. incidence and prevalence rates

If the answer to all three questions is yes then proceed to the scoring below

Timescales

- How long will this take to undertake? (Short piece of work or longer time frame?) Needs to be scoped and could be individual discrete pieces of work
- How urgent is this? Will be used to inform CCG commissioning intentions

Score each statement with the following:-

Score	Assessment
0	No evidence that this criterion will be met/is not relevant

0.5	Evidence that this criterion is/will partially be met
1	Evidence that this criterion is/will be significantly met
2	Evidence that this criterion is/will be fully met

Criteria	**Score**
Local priority • The topic or question supports the priorities as outlined in the Joint Health and Wellbeing Strategies in the relevant Boroughs • The topic area or question will assist our understanding on how to tackle health inequalities in the relevant Boroughs • The topic affects a significant number of people in the Boroughs • The topic has been identified as a particular need or gap by the people affected	 **2** **2** **1 (as long as extends to all young adults)** **2**
Risk to the future • The topic area is a potential risk to the health and wellbeing of the local population	**2**
Gaps in information • The JSNA will identify unmet need **OR** there is a gap in local intelligence **OR** there have been significant changes to the subject area, locally or nationally	**1**
Cost effectiveness and value for money • Undertaking the JSNA will identify potential net savings and efficiencies in services	 **2**

Potential to affect change • A JSNA on this issue will influence strategic commissioning	**2**
• A JSNA on this issue will empower services to be more effective	**2**
• A JSNA on this issue will empower Health and Wellbeing board members to identify priorities	**1**
Asset mapping • The JSNA will identify local assets	**2**
Total	**19**
More than 16 points = high priority **Between 11-16 points = medium priority** **Less than 11 points = low priority**	

Westminster Health & Wellbeing Board
Work Programme
2016

KEY
FOR DECISION
FOR DISCUSSION
FOR INFORMATION
PLANNING

Agenda Item	Summary	Lead	Item
		TBC	For information
Meeting Date: 21st January 2016: MISCELLANEOUS			
HEALTH AND WELLBEING STRATEGY	Discussion on the refreshed Westminster Joint Health and Wellbeing Strategy	Chairman of the HWB	For decision
JSNA – END OF LIFE and CHILDHOOD OBESITY	JSNA – END OF LIFE and CHILDHOOD OBESITY	Director of Public Health	For decision
HEALTH AND WELLBEING HUBS	Discussion on the Outline Business Case for the development of Health and Wellbeing Hubs in Westminster	Chairman of the Health and Wellbeing Board	For discussion
CHILD POVERTY	Discussion on progress being made to reduce child poverty in Westminster	Exec Director of FCS Housing	For discussion
PRIMARY CARE PROJECT	Update on the Westminster HWB Primary Care Modelling Project	Deputy Director of Public Health	For discussion
WHOLE SYSTEM CARE	Update on Whole Systems Care pioneer work	Director of Whole Systems Care, CLCCG	For discussion
FUTURE IN MIND	Update on mental health strategy work	CLCCG	For discussion
BETTER CARE FUND	Update on implementation Better Care Fund	Exec Director of ASC	For information
PRIMARY CARE CO-COMMISSIONING	Update on development of Primary Care Co-Commissioning	Chairs of CCGs	For information
Meeting Date: 17th March 2016: END OF YEAR STRATEGIC PLANNING MEETING			

STRATEGIC PLANNING	Review delivery and plan for the year ahead	Exec Director of ASC	Planning
PRIMARY CARE PROJECT	Presentation on the findings of the Westminster Health and Wellbeing Board Primary Care Project	TBC	For discussion
BETTER CARE FUND	Update on delivery of the Better Care Fund outcomes in 2015/16 and sign-off of Better Care Fund plan for 2016/17	Exec Director of ASC	For decision
AVAILABLE SLOT			
AVAILABLE SLOT			
AVAILABLE SLOT			
BETTER CARE FUND	Update on implementation Better Care Fund	Exec Director of ASC	For information
PRIMARY CARE CO-COMMISSIONING	Update on development of Primary Care Co-Commissioning	Chairs of CCGs	For information