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**City of Westminster**

# Committee Agenda

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| Title: | **Health & Wellbeing Board** |
| Meeting Date: | **Thursday 15th July, 2021** |
| Time: | **4.00 pm** |
| Venue: | **Rooms 18.01 - 18.03 - 18th Floor, 64 Victoria Street, London, SW1E 6QP** |

Members:

Councillor Tim Mitchell (Chair)

Councillor Timothy Barnes

Cllr Cen Kemahli (Chair)

Councillor Josh Rendall

Cllr Nafsika Butler-Thalassis

Sarah Newman Bi-Borough, Children's Services

Olivia Clymer Healthwatch Westminster

Tania Kerno Healthwatch RBKC

Jo Ohlson NHS England North West London

Bernie Flaherty Bi-Borough, Adult Social Care

Toby Hyde Imperial College NHS Trust

Philippa Johnson Central London Community Healthcare NHS Trust

Dr Andrew Steeden Chair of West London CCG

Detective Inspector Nicki Beecher Metropolitan Police

Dr Neville Purssell Central London CCG

Hilary Nightingale

Darren Tully

Heather Clarke

Angela Spence

Russell Styles
Senel Arkut

**Due to social distancing measures we invite members of the public to join us virtually. If you have a disability and require any special assistance please contact the Committee Officer (details listed below) in advance of the meeting.**

**If you require any further information, please contact the Committee Officer, Alexandra Deolinda-Severino, Portfolio Adviser.**

**Email: adseverino@westminster.gov.uk**
**Corporate Website:** www.westminster.gov.uk

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

# AGENDA

## PART 1 (IN PUBLIC)

| | | |
|---|---|---|
| 1. | **WELCOME TO THE MEETING** | |
| 2. | **MEMBERSHIP**<br>To report any changes to the Membership of the meeting. | |
| 3. | **DECLARATIONS OF INTEREST**<br>To receive declarations by Members and Officers of the existence and nature of any pecuniary interests or any other significant interest in matters on this agenda. | |
| 4. | **MINUTES** | **(Pages 5 - 12)** |
| **PART A - COVID-19** | | |
| 5. | **COVID-19 VERBAL EPIDEMIOLOGY UPDATE AND LOCAL VACCINATIONS UPDATE** | |
| 6. | **PRIMARY CARE AND MENTAL HEALTH RECOVERY UPDATE** | **(Pages 13 - 30)** |
| **PART B - ITEMS SPONSORED BY THE BOARD** | | |
| 7. | **ICS UPDATE** | **(Pages 31 - 34)** |
| 8. | **HEALTH AND WELLBEING BOARD AWAY DAY** | **(Pages 35 - 38)** |
| 9. | **WCC RBKC JOINT HWB HD AND AW FUNDING REPORT** | **(Pages 39 - 48)** |
| 10. | **WESTMINSTER'S PARTNERSHIP RESPONSE TO SERIOUS YOUTH VIOLENCE** | **(Pages 49 - 60)** |

**Stuart Love**
**Chief Executive**
**8 July 2021**

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# MINUTES

CITY OF WESTMINSTER

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

**Health & Wellbeing Board**

**MINUTES OF PROCEEDINGS**

Minutes of the virtual joint meeting of Westminster City Council's and the Royal Borough of Kensington & Chelsea's **Health & Wellbeing Board** held on 27 May 2021 at 4pm.

**Present:**

Councillor Cem Kemahli (RBKC - Lead Member for Adult Social Care and Public Health)
Councillor Tim Mitchell (WCC - Cabinet Member for ASC and Public Health)
Councillor Josh Rendall (RBKC - Lead Member for Family and Children's Services)
Councillor Tim Barnes (WCC - Cabinet Member for Children's Services)
Councillor Lorraine Dean (WCC - Deputy Cabinet Member for Children's Services)
Councillor Nafsika Butler-Thalassis (WCC - Minority Group Representative)
Councillor Christabel Flight (WCC - Deputy Cabinet Member for Adult Social Care and Public Health)
Councillor Marwan Elnaghi (RBKC - Chair of Adult Social Care & Health Select Committee)
Senel Arkut (Bi-Borough - Head of Health Partnerships and Development)
Claire Barry (NWL Cancer Alliance)
James Benson (ICP Chair)
Anna Bokobza (Imperial College Healthcare)
Emma Bikupski (Local Safeguarding Children Partnership Business Manager)
Dr Kathie Binysh (Head of Screening NHSEI London)
Iain Cassidy (OpenAge)
Lena Choudhary-Salter (Westminster Community Network)
Heather Clarke (Housing and Regeneration)
Olivia Clymer (Healthwatch Westminster)
Dominic Conlin (Deputy for Leslie Watts, Chelsea, and Westminster)
Anna Cox (Public Health Business Partner)
Robert Craig (Director of Development & Partnerships, Royal Brompton Hospital)
Sarah Crouch (Deputy Director of Public Health)
Bernie Flaherty (Executive Director for ASC and Health)
Angela Flahive (Head of Safeguarding Review and Quality Assurance)
Jenny Greenfield (Kensington and Chelsea Social Council)
Richard Grocott-Mason (Managing Director, Royal Brompton Hospital)

Simon Hope (Deputy for Joe Nguyen, North West London CCG)
Philippa Johnson (Central London Community Healthcare NHS Trust)
DI Mark Kent (Metropolitan Police)
Tania Kerno (Healthwatch RBKC)
Jeffrey Lake (Deputy Director of Public Health)
Anne Pollock (Principal Policy Officer)
Anna Raleigh (Director of Public Health)
Visva Sathasivam (Director of Social Care)
Ela Sen-Pathak (Deputy for Ade Odunlade, CNWL)
Gemma Stanton (Cabinet Secretariat Manager, WCC)
Susan Sinclair (NWL Cancer Alliance)Dr Andrew Steeden (Chair, West London CCG)
Russell Styles (Deputy Director of Public Health)
Jo Thomas (Director of Communications and Public Affairs, Royal Brompton Hospital)
Dr Mona Vaidya (Central London CCG)

**1. WELCOME TO THE MEETING**

1.1 Councillor Cem Kemahli welcomed everyone to the meeting. The Board confirmed that as the meeting had been due to be held within RBKC, Councillor Kemahli would chair the meeting in line with the agreed memorandum of understanding.

**2. MEMBERSHIP**

2.1. Apologies for absence were received from Ade Odunlade (CNWL), Robyn Doran (CNWL), Raj Mistry (Executive Director Environment and City Management), Janet Cree (NWL ICS COO), Jo Ohlson (CNWL CCGs), Aileen Buckton (Chair of Children's Safeguarding Board), and Annabel Saunders (Bi-Borough Children's Services Director of Operations and Programmes).

3. **DECLARATIONS OF INTEREST**

3.1. There were no declarations of interest.

**4. MINUTES**

**RESOLVED:**

4.1. That the minutes of the Kensington & Chelsea and Westminster joint Health & Wellbeing Board meeting held on 23 March 2021 be agreed as a correct record of proceedings.

**5. COVID-19 VERBAL EPIDEMIOLOGY UPDATE AND LOCAL VACCINATIONS UPDATE**

5.1. Anna Raleigh (Director of Public Health) gave a commentary on her presentation, which had been circulated following the meeting.

5.2. Simon Hope (Borough Director) updated the Board on vaccinations. He noted the approach was to align vaccinations without breaking management of testing. There was work underway to bring forward second doses for patients aged 70 and over from 12 weeks to 8 weeks.

5.3. The local authority, public health, NHS and third sector were working collaboratively as a system to roll out the vaccination programme. Residents aged 30 plus were able to receive vaccinations. There was an increase of vaccination capacity in Westminster of over 20,000 a week. The AstraZeneca vaccine was safe for second doses, but national guidance stated people aged 40 and under should receive Pfizer or Moderna.

5.4. The Bi Borough vaccine bus had launched, it would spend three days a week in both Westminster and RBKC for the next two weeks. There was a push in both boroughs to ensure as many pharmacies as possible were signed up to the national system to book vaccinations. There were also some pharmacy pop-ups under the clinical governance framework of a PCN able to vaccinate patients.

5.5. In response to questions, the following points were made

(i) There were hopes to ensure the Pfizer vaccine would become available on vaccination buses. This involved working to ensure it could be safely transported
(ii) While clinics were available to all, advertising too widely could lead to large numbers of people which would be difficult to manage.
(iii) Individuals who were over 30 could choose to receive the AstraZeneca vaccine but most were only available for second doses.
(iv) While mass vaccine centres were listed as walk-in centres, they were just about managing capacity.

## 6. ROYAL BROMPTON UPDATE

6.1. Dr Richard Grocott-Mason (Managing Director) and Rob Craig (Director of Development and Partnerships) presented an update on the Royal Brompton Hospital, a copy of their presentation was circulated.

6.2. The hospital treated patients of all ages that required specialist heart and lung care. Patients were concentrated in London and South-east England but there were patients from all over England.

6.3. During the peak of the pandemic the hospital more than doubled capacity for critical care. The hospital cared for patients with Covid-19 from other intensive care united in NWL to relieve capacity.

6.4. The hospital was also a national provider for ECMO which was a machine to support patients whose lungs were damaged and needed oxygen via an

artificial lung. During the peak of the pandemic, 28 patients were on ECMO and outcomes were good with a survival rate of 70%.

6.5. Both hospitals continued to treat patients with non-Covid-19 heart and lung disease, as well as treating patients with heart surgery, transplantation, and lung cancer surgery.

6.6. As an organisation, the hospital made a significant investment in staff health and wellbeing during the year, this included staff psychological support.

6.7. Children's services were a particular focus over the past year, work was done throughout the pandemic to ensure treatment and surgery for children with congenital heart disease was able to continue unaffected. This led to some longer-term advantages, as there was now a permanent joint multidisciplinary team for specialist cardiac treatment between Evelina Children's Hospital and the Royal Brompton. As a long-term commitment, the Brompton service would also remain a part of the West London Children Alliance.

6.8. There were several developments at Royal Brompton hospital, including a new imaging centre that would open at the beginning of 2022. As well as further collaboration between Royal Brompton and Royal Marsden, including a long-term partnership for a joint thoracic oncology service which focused on cancers of the lung and chest.

6.4 In response to questions, the following points were made:

(i) Any plans that would involve moving would be long-term and services were not moving for at least a decade. The reference to 5-7 years in the report referred to children's inpatient services that would move from the Brompton site depending on new facilities being built.
(ii) There were no changes in relation to other hospitals in NWL, during the pandemic the working arrangements were as positive.
(iii) The hospital was evaluating the right option for services, the pandemic provided an opportunity for learning that would factor into the evaluation of services.
(iv) The Board welcomed ongoing discussions and further details on plans going forward.

## 7. HEALTH AND WELLBEING STRATEGY REFRESH, POSITION STATEMENT AND HWBB ROLE

7.1. Senel Arkut (Bi-Borough Director of Health Partnerships) updated the board on the health and wellbeing strategy. As part of its statutory duties, that Board had a requirement to oversee each borough's health and wellbeing strategy.

7.2. RBKC's strategy would expire this year and WCC's strategy was due to expire in 2022. While there was work underway on the new strategy, there had been an increased demand on services and resources due to the pandemic. There was also a significant restructuring of the NHS, and as a statutory body, the role of the Board was also changing.

7.3. The role of the Board was expected to oversee the local ICP (Integrated Care Partnership) work of health and care delivery while also taking an active role in shaping the future of services and service delivery in a more strategic partnership and integrated approach.

7.4. The aim was to incorporate the changes and learning because of the pandemic into the new joint health and wellbeing strategy. The Board generally agreed to the proposed continuation of the current strategy for RBKC pending the launch the joint Kensington & Chelsea and Westminster strategy, as well as the new role of the HWBB. Papers on both would be presented to the Board in due course.

7.5. The Board was the only statutory Board that remained locally. As a result, the board had a responsibility to ensure a platform was provided for collaboration and that the work was conducted in an integrated way through the delivery of integrated patient-focused services. This fit in with the aims and purposes of the ICP, and it was an aim that the Board had an oversight of the ICP activities and priorities, as well as regular updates from the ICP on the development of work locally.

**8. ICP STRUCTURE, PRIORITIES AND RELATIONSHIP WITH THE JOINT HWBB**

8.1. James Benson (ICP Chair) presented an update on the ICP structure, priorities, and relationship with the HWBB, a copy of the presentation was circulated.

8.2. There was rich data in terms of public health indicators, and it was recognised that some of the big challenges in communities were obesity, diabetes, hypertension etc.

8.3. There were key principles set for NWL as a priority. This included managing public health, developing the primary care networks, reviewing, and improving diabetes care etc.

8.4. On local priorities, there was a focus on strategy and learning from the pandemic, as well as methods of working collaboratively to maximise health and care delivery and reducing duplication of effort. In addition to supporting residents to stay at home and being discharged in a safe and timely manner when in hospital.

8.5. Work has begun on project plans that look at key areas, measures for consideration and key performance indicators. There were plans to take this to the first partnership board meeting. A variety of partners were invited to join the partnership board, which was scheduled once a month for both RBKC and WCC individually.

8.6. In response to questions the following points were made:

(i) The pandemic revealed inequalities across both boroughs. There was a need for further work on population health management, but it was

important to first identify key areas that require further work and then look at how population health management would be embedded in that work.

(ii) With regards to the timeline for the new arrangements, initial meetings would begin over the next two months for each borough.

(iii) It was important to look across both boroughs on health inequalities, obesity was an area that needed particular focus, and it was important to work collaboratively to make a difference.

(iv) Ensuring residents understood systems and felt actively involved was a topic that required further discussion. Work would explore ways of ensuring that patients were practically heard and engaged with.

(v) As the ICP develop, the focus would not be solely on health. The CCG has been asked to write to partners in RBKC and WCC to build an understanding.

(vi) There were several priorities that overlap among partners, and work could be done to bring these together and change ways of working.

(vii) On the possibility of a Bi-Borough ICP, it was important to first work as individual ICPs and delivering improvements for citizens. There was optimism that in time, the 2 ICPs will evolve organically into 1 Bi Borough ICP.

(viii) There were discussions on developing work to understand and work towards addressing the health inequalities in both boroughs.

(ix) Over the next year there were additional roles opening in primary care such as mental health practitioners.

(x) There were conversations on improving the use of data, but there was an existing understanding of the health and care of the population.

8.7. The Chair noted it was important to ensure local priorities matched with wider ones and suggested this was kept as an ongoing agenda item for the Board.

## 9. CANCER SCREENINGS AND RECOVERY UPDATE

9.1. Anna Raleigh (Director of Public Health) introduced the item. NHS England was responsible for commissioning the NHS cancer screening programme and the local authority public health maintained an oversight role.

9.2. This included reviewing trends and highlighting concerns to ensure adequate delivery of the screening services to the local population. The Board was invited to consider the reports, to comment on the recovery plans, and consider a timeframe for discussion to come back to the HWBB.

9.3. Dr Kathie Binysh presented an update on cancer screenings. Services were paused during the first lockdown; work was done to screen those that were particularly high risk. Recovery was currently underway; bowl and cervical screening programmes were either recovered or close to being recovered. The breast screening programme was more challenging, but it was anticipated that the programme would be recovered by March 2022.

9.4. In response to questions the following points were made:

(i) There were concerns about the increasing inequalities as part of the recovery programme. Officers assured the board that reducing inequalities was at the heart of interventions that would be supported over the next number of years.
(ii) Smear testing remained a challenge, there appeared to be a decline in women taking up cervical screenings over time both locally and nationally. This may have been related to confusion as to whether it was required if they had been vaccinated, but it was still required.
(iii) There were conversations ongoing with colleagues in the CCG on understanding and validating data.

9.5. The situation would be monitored given the significant impact on morbidity and mortality of late cancer diagnosis. The Chair welcomed an update and the Board noted to invite screening colleagues to a future meeting once updated data was available.

**10. CHILDREN'S ANNUAL SAFEGUARDING REPORT**

10.1. Angela Flahive (Head of Safeguarding Review and Quality Assurance – Children's Services) and Emma Biskupski (Local Safeguarding Children Partnership Business Manager) presented the Children's Annual Safeguarding Report to the Board.

10.2. The report covered three boroughs, RBKC, WCC and H&F. All partnerships were required by the Department of Education to review their working arrangements in the first year. An independent reviewer had been commissioned and this contributed to the formation of decisions around the Bi-Borough partnership.

10.3. On safeguarding figures, 2593 referrals were made to children's social care in RBKC and 2012 in WCC. RBKC figures reflected all contacts while WCC counted the formal referrals.

10.4. The police were major contributors in terms of referrals, followed by education and health colleagues. The most common age group referred were children aged 10-15 years, as they were they most common cohort supported through child protection plans.

10.5. A new safeguarding partnership had been created that was Bi-Borough, with the introduction of a new independent chair Aillen Buckton.

10.6. Three safeguarding partners were involved in new arrangements: the CCG, police, and the local authority. Partners were consulted but the partnership took lead in identifying key areas and priorities.

10.7. Three subgroups were also developed for partnership which included: case review, better practice and development and engagement and accountability.

10.8. Local children and adolescent mental health services were run by CNWL and systemic clinician services within children services. There were also several mental health services that were promoted.

10.9. There continued to be challenges to meet the needs of the most vulnerable children and young people, there were joint packages of care, but it was a complex and challenging issue.

**11. ANY OTHER BUSINESS**

11.1. Senel Arkut (Bi-Borough Director of Health Partnerships) spoke of the 2020-2021 CCG assessment review request, as part of the Health and Social Care Act 2012, NHS England has a duty to consult with the Board on the contribution to the delivery and any joint HWB strategies. To fulfil this statutory responsibility NHS England circulated a consultation questionnaire designed to assess the effectiveness of the CCG's working relationship with statutory bodies within the local system. The questionnaire would be shared with the Board in due course.

The Meeting ended at 5.53pm.

**CHAIR:** ______________________ **DATE** ____________________

City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Westminster Health & Wellbeing Board

RBKC Health & Wellbeing Board

| | |
|---|---|
| **Date:** | 29 June 2021 |
| **Classification:** | **General Release** |
| **Title:** | Primary Care and Mental Health Recovery Update |
| **Report of:** | NW London Integrated Care System (ICS) and Bi-Borough Teams |
| **Wards Involved:** | All |
| **Financial Summary:** | |
| **Report Author and Contact Details:** | Joe Nguyen, *Central London Borough Director, NWL CCG (joe.nguyen@nhs.net),*<br>Simon Hope, *West London Borough Director, NWL CCG (simonhope@nhs.net),*<br>Ela Pathak-Sen, *Westminster Borough Director, CNWL (ela.pathak-sen@nhs.net), and*<br>Ann Sheridan, *K&C Borough Director, CNWL (ann.sheridan@nhs.net)* |

## 1. Executive Summary

1.1 Primary Care and Mental Health are both strategic priorities of our local NHS recovery programme and ensuring we are able to build on the lessons learned during the pandemic – ensuring we are addressing the need of residents and patients and joining up our resources to provide a more direct and holistic approach to care and support.

## 2. Key Matters for the Board

### 2.1 Primary Care

2.2 Primary care across both boroughs would like to thank and acknowledge the helpful report by Healthwatch titled 'Residents Experiences of Using Primary Care Services' in April 2021 which has identified including patient access, communications, patient engagement and quality of care during Covid19 pandemic. We will be working with GP practice patient participation groups (PPGs) and setting up a joint task & finish group to address the recommendations including updating websites, phone messages, reviewing and improving digital and online information and consultation. We will be developing a joint action plan which will be shared at a subsequent Health and Wellbeing Board.

2.3 Post Covid, the direction of travel for general practice and primary care moving forward is to work together as Primary Care Networks and joining up with system partners including community and mental health, social care and voluntary sector to develop 'team-based' care approach – which will allow patients to have access to more coordinated services, access to wider range of professionals, appointments that work around their lives and personalised responses which recognises what matters to them.

2.4 What we learned during the pandemic is that primary care and system partners need to focus more in inequalities, better utilise remote monitoring, Long Term Conditions (proactive care), addressing mental health needs and supporting people post-Covid which is also prioritised within our Integrated Care Plans (ICPs) across both boroughs.

2.5 General practice will continue to develop and refine the 'triage-led' care model to ensure same day consultation to all, with a mix of virtual and face-to-face appointments where required, rapid access to acute advice and guidance and 8-8, 7 days a week model.

### 2.6 Mental Health

2.7 As part of the Mental Health Recovery action plan – our local focus is to fully embed/accelerate the mobilisation of new integrated primary-community Mental Health Hub – 'Community Living Well+' in RBKC and Community MH Hub in Westmisnter.

2.8 The key features of the community hub model include:

- All resources in one hub – every person to have a named worker
- Separate 48 hour urgent referral route with daily triage
- Joint working with Primary Care Networks (PCNs) – working to address both physical and mental health needs
- DIALOG+ to be used to inform every assessment (personalisation)
- Delivery of intervention based care – i.e. targeted to individual needs

2.9 This will improve patient experience through reduction in referrals, thresholds, and offering a 'team-based' care approach that allows the input and collaboration of primary care, mental health, 3rd sector and social care professionals.

2.10 In Westmisnter – the model has already been implemented in September 2020 with further development work to incorporate social care agenda and recruitment of additional primary care mental health roles across the 4 Primary Care Networks (PCNs).

2.11 In RBKC, final Standard Operating Model (SOP) agreed with staffing, systems and IT, training, communications workstreams preparing for go-live. Recruitment to new roles and expanded 3rd sector underway.

## 3. Options / Considerations

3.1 The board is asked to provide a steer and feedback on the 'direction of travel' and help inform our local primary care and mental health recovery agendas.

## 4. Legal Implications

4.1 None

## 5. Financial Implications

5.1 None

**If you have any queries about this Report please contact:**

**Joe Nguyen,** Central London Borough Director, NWL CCG (joe.nguyen@nhs.net),

**Simon Hope**, West London Borough Director, NWL CCG (simonhope@nhs.net),

**Ela Pathak-Sen**, Westminster Borough Director, CNWL (ela.pathak-sen@nhs.net),
and

**Ann Sheridan,** K&C Borough Director, CNWL (ann.sheridan@nhs.net)

**APPENDICES:**
Primary Care Recovery Update
Mental Health Recovery Update

**BACKGROUND PAPERS:**
None

NHS
Central and
North West London
NHS Foundation Trust

# Mental Health Recovery: Primary Care & MH

# June HWBB



Wellbeing for life

# DHSC Mental Health Recovery action plan

NHS
Central and North West London
NHS Foundation Trust

HM Government

## COVID-19 mental health and wellbeing recovery action plan

**Our plan to prevent, mitigate and respond to the mental health impacts of the pandemic during 2021 to 2022**

Published **27 March 2021**

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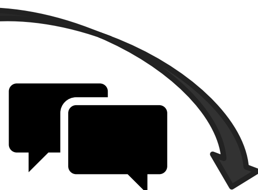

## Serious mental illnesses

Individuals living with serious mental illnesses often face the greatest challenges with their mental health, and have reported more acute difficulties during the pandemic. The roadmap out of lockdown is for many a very welcome step back toward normality, but may well present challenges for those living with a severe mental illness and navigating further changes to life and routine. We also know that this group are at greater risk of poor physical health and have a higher premature mortality rate than the general population. In the context of COVID-19, we have worked across the NHS, public health and the voluntary and community sector to support the psychological and social needs of this group during this time, and most recently to support equitable uptake of the COVID-19 vaccine.

Holistic and joined up support for this group will continue to be a priority area for action during the coming year and beyond.

In particular, the implementation of the modernised Community Mental Health Framework presents a real opportunity for local systems to come together and consider the psycho-social needs of this group in the round. These new and integrated models of care move away from siloed, hard-to-reach services towards joined up care across primary and secondary health care, social care, the voluntary and community sector, and housing to support individuals with long term and severe mental illnesses to stay well and recover in the community. On top of planned investment, these transformation plans will benefit from additional funding in 2021 to 2022 to go further, faster.

Need to fully embed/accelerate delivery of new integrated primary-community MH hub model: '*Community Living Well+*' *(RBKC) or Community MH Hub (Westminster)*

# 10 Principles of new Community Hub Model

NHS
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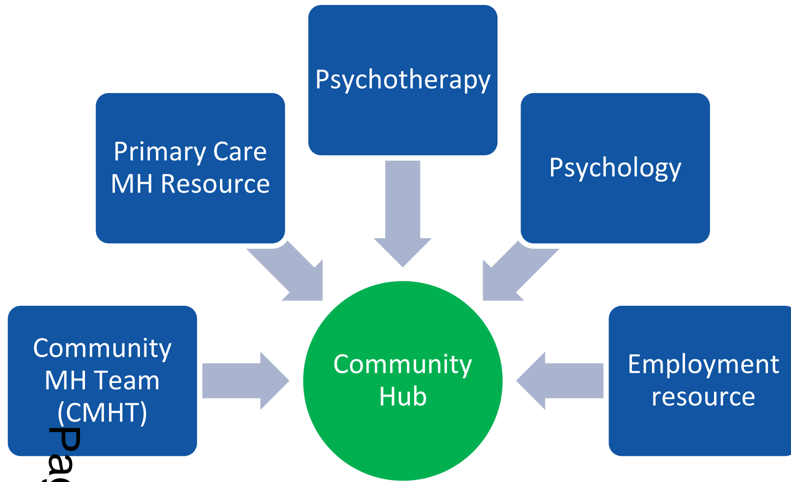
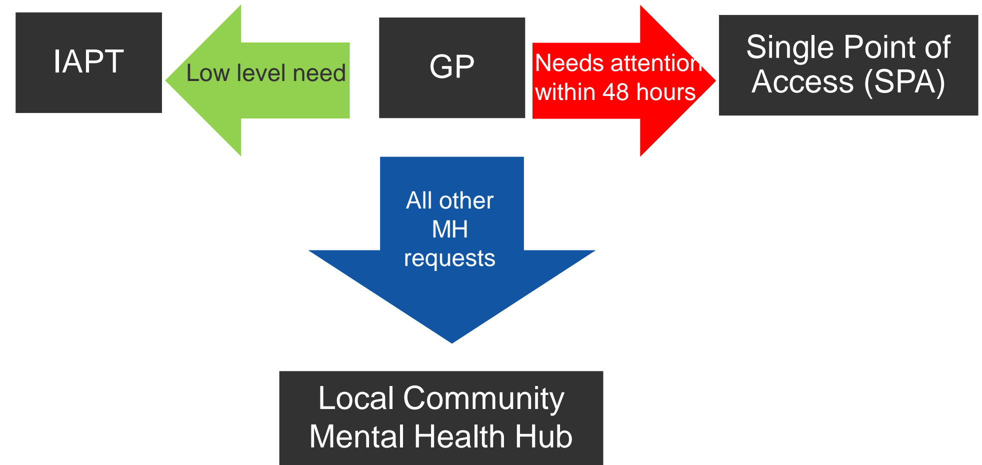
NHS Foundation Trust

## 1) All resource, where possible, in the hub

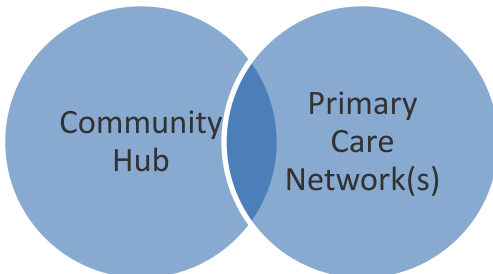




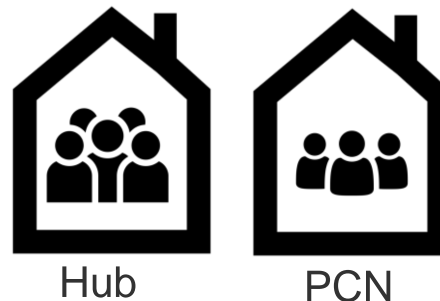

## 2) Separate 48 hour urgent referral route



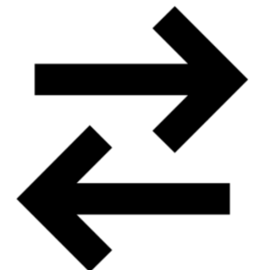

## 3) Community hubs aligned to PCNs




## 4) Regular Hub and PCN catch ups




## 5) Less focus on caseloads more on flow



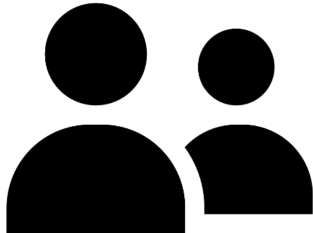
# 10 Principles of new Community Hub Model

NHS
Central and
North West London
NHS Foundation Trust

6) Daily Senior Triage meeting

7) DIALOG+ to be used to inform every assessment





8) Every person to have a named worker

9) Delivery of intervention based care not generic care coordination

10) Every member of staff dedicated to supporting the physical health needs of their service users

# Overall Delivery model

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NHS Foundation Trust

Inputs to daily triage meeting

- GP referral
- Internal CNWL teams

## The Hub

**Daily triage meeting**

- All tasks actioned
- Senior team meeting
- Oversight of all resource availability

Send back to triage

- Gather further information
- Give advice to referrer → Case closed
- Signposting → Case closed
- Refer to specialist services → Outside the Hub
- Direct allocation for intervention → Goes into Hub general activity

## Hub interventions

DAILY MDT MEETING

| Expert assessment/ consultation | Medicines management | Social care intervention | Community engagement | Psychological therapy | Supported self-management | Carer support |
|---|---|---|---|---|---|---|

## Underpinning principles

- Physical health with mental health
- Minimise bureaucracy
- Working as One Team
- Shared responsibility for patients and resource
- Optimises use of community based resources
- Active intervention with clear outcome
- Preparing for end of intervention rather than discharge

# How will this improve services?

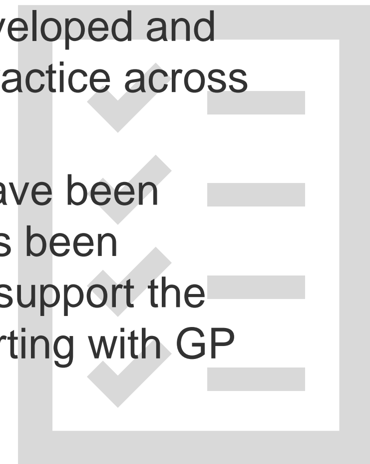
Central and North West London NHS Foundation Trust

- No primary, secondary care divide - conversations and tasks, not referrals
- No thresholds
- Rapid communication to patient and referrer following triage
- Shared ownership of resource utilisation
- More intervention than assessment – defined, shorter, outcome informed episodes of care
- Redefining discharge - no cliff edges
- Increased confidence of primary care clinicians through regular contact with mental health colleagues and MDT support
- Enhanced offer incorporating 3rd sector, social care and new innovative roles
- **Enhanced patient experience, referrer experience, staff experience**

# Where are we on implementation in Westminster?

NHS
Central and North West London
NHS Foundation Trust

- New integrated, population based community mental health hubs went live in September 2020
- Regular review and tweaking of the model of delivery with significant positive improvements in the triage model and integrated working within the teams across professions
- Continual effort to ensure that the social care agenda is being delivered in the hubs at all areas of the new pathway e.g. identifying and addressing social care needs at the earliest stage (triage) and ensuring service users receive the required assessments and care that is care act compliant throughout their recovery journey
- Currently undertaking a review against the SOP. Action plans will be developed and led locally to address areas of improvement using learning from good practice across teams
- Mental Health Additional Role Reimbursement Scheme (ARRS) roles have been agreed for each of the four PCNs in Central London. Job description has been agreed with PCN directors and will be out to advert ASAP. This role will support the triage function of the new hubs in addition to working closely and supporting with GP practices in the aligned PCNs



# Where are we on implementation in K&C?

- SOP drafted being finalised
- Final detail around staffing and process being added to the triage functions of each hub
- Comms and engagement group formed with reps from CNWL, CLW and LA – Comms strategy developed and outputs and timeframes defined
- Systems and IT group formed to deliver data migration of cases into the integrated hub teams as well as IT support, phonelines, emails that will need to be set up to ensure a fluid pathway
- Both Primary and secondary care staff combined and aligned to PCNs
- Training package for all staff being developed and will be delivered – July – September
- Social Care T&F group restarted to ensure Social Care agenda being delivered in the new teams
- PCN introductory engagement sessions with lead consultant and manager from each PCN
- Recruitment to new roles both in CNWL and newly expanded 3rd sector contracts underway

# Further detail RBKC: Old Structures

K&C South CMHT | K&C North CMHT | QPP CMHT | PCLN | Step 4

# New Structures



## Covering borough of K&C

### K&C South Hub

- Brompton PCN
- K&C South PCN

### K&C North Hub

- Neohealth PCN
- WestHill & Inclusive K&C PCN

## Covering borough of Westminster

### QPP Hub

- WestHill & Inclusive QPP PCN

Mind Kensington & Chelsea | The Royal Borough of Kensington and Chelsea | City of Westminster | Community LivingWell – Working together for your wellbeing | SMART | North West London Integrated Care System – Working together for better health and care | NHS Central and North West London NHS Foundation Trust

# GP referral pathway

**Patient presents at GP with MH need**

Needs attention within 48 hours → **Single Point of Access** (star)

(star) Takes self referrals

# COMMUNITY LIVING WELL+

**IAPT** (star)

**Local Community Mental Health Hubs**

**Wellbeing Services** (star)

- Peer Support
- Navigators
- Employment Support

Please note there will be strong links between IAPT, SPA, Community Hubs and Wellbeing Services all of which will take and receive referrals from each other and work in an integrated way to deliver care for the local population of K&C and QPP

# Bi-Borough
## Integrated Care Partnerships (ICP)

## Primary Care Recovery Update



29 June 2021

# **Recovery:** General practice at the heart of integrated care

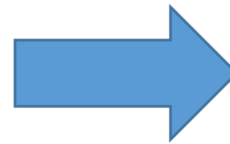
Our draft aspirations set out then for General Practice within North West London map to our core strategic goals of ensuring General Practice is at the heart of how we delivery our Primary Care Networks which supports the deliver of an Integrated Care System that works for everyone

## Patients

- **More coordinated services** where they do not have to repeat their story multiple times.
- **Access to a wider range of professionals** in the community, so they can get access to the people and services they need in a single appointment.
- **Appointments that work around their lives,** with shorter waiting times and different ways to get treatment and advice including digital, telephone-based **and face-to-face.**
- **More influence** when they want it, giving more power over how their health and care are planned and managed.
- **Personalisation** and a focus on prevention and living healthily, recognising what matters to them and their individual strengths, needs and preferences.

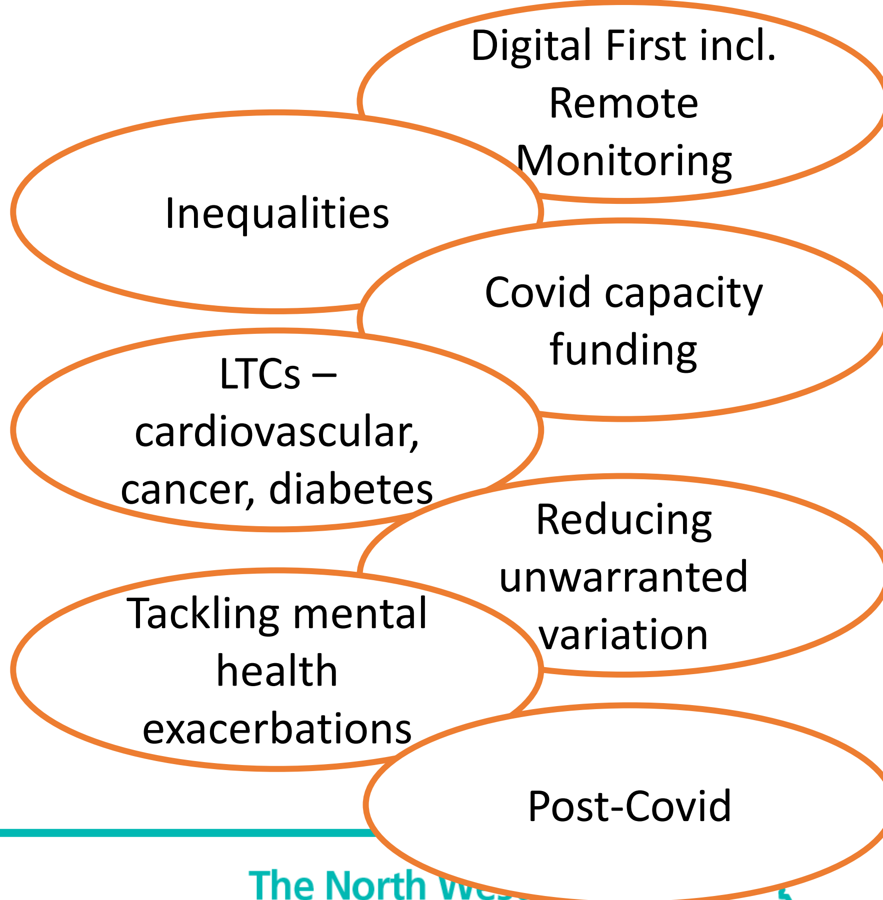
## Practices, providers and the wider system

- **Greater resilience:** by making the best use of shared staff, buildings and other resources, they can help to balance demand and capacity over time.
- **Better work/ life balance:** with more tasks routed directly to appropriate professionals, such as clinical pharmacists, social prescribers, physiotherapists.
- **More satisfying work** with each professional able to focus on what they do best.
- **Improved care and treatment for patients,** by expanding access to specialist and support services such as social care.
- **Greater influence** on the wider health system, leading to more informed decisions about where resources are spent.
- **Cooperation across organisational boundaries** and teams to allow better coordination of services.
- **Wider range of services in a community setting,** so patients don't have to default to the acute sector.
- Developing a **more population-focused approach** to system wide decision-making and resource allocation, drawing on primary care expertise as central partners.
- **More resilient primary care,** acting as the foundation of integrated systems.



## Learning from the last year

A greater emphasis is now needed on the following priority areas:




Workforce capacity/skills as an enabler

# …what does that mean for patient access in North West London?

*Overview informed by a population health management approach*

**Triage-led reactive care**

- Triage-led model delivered via digital as far as clinically possible
- Access to same day consultation for all
- Face to face settings determined by blue/amber/green/shielded status to ensure safe care
- Health need resolved within minimum time and with minimum settings
- Rapid access to acute specialist advice to reduce
- 8 – 8 7 days a week

**Team-based proactive care**

- Focus on prevention and proactive care
- Timely identification of conditions
- Use of population health data to prioritise care and improve outcomes
- Care plan-led holistic physical and mental health care
- Care delivered on a team basis
- Specialist input and management of disease accessible in the community

**Team-based care in the home**

- Responsive, co-ordinated delivery of proactive care
- Maximise use of the multi-agency team and care planning to deliver person-centred care
- Care plan at the centre of care delivery
- Minimise individual and episodic contacts with services
- Use of tele-monitoring and equipment to support prioritisation of clinical review and decision-making

**Shielded care/ extremely vulnerable**

- Proactive monitoring, holistic physical and mental health care, specialist input and management of disease
- Proactive co-developed care plan in place that supports self-care and wellbeing
- Minimise face to face contact with health and care professionals, working as a team to support the patient
- Identification of shielded group via SCR to maximise safe delivery of urgent/unplanned care

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# Westminster Health & Wellbeing Board — RBKC Health & Wellbeing Board

| | |
|---|---|
| **Date:** | Thursday 15th July |
| **Classification:** | **General Release** |
| **Title:** | NHS Commissioning changes update - ICS development |
| **Report of:** | Health & Wellbeing Board |
| **Wards Involved:** | All Wards |
| **Financial Summary:** | N/A |
| **Report Author and Contact Details:** | Simon Hope – Borough Director, West London CCG<br>Joe Nguyen – Borough Director, Central London CCG |

## 1. Executive Summary

1.1 Health and Local Authority partners across North West London (NWL) are taking relevant steps towards development of the new NWL Integrated Care system (ICS), which will operate in shadow form from October 2021, and is expected to become a statutory body in April 2022.

1.2 The ICS will agree core strategic priorities for NWL, and bespoke priorities for Boroughs, based on locally identified need. The ICS financial strategy will directly tackle inequalities and direct resource where the need is greatest and reduces the current variation in outcomes within and between boroughs.

## 2. Key Matters for the Board

2.1 Local Authorities and the NHS in NWL will, together with residents, deliver a real and felt difference in care and outcomes in NWL through the ICS. We are determined to maintain our commitment to collaborative action, along with the

agility and pace in decision-making that has characterised our response to the pandemic and vaccine.

2.2 North West London was formally designated as an ICS from April 2021, and ICSs are expected to become statutory bodies from April 2022, pending national legislation. In reality, we have been working as an ICS across all parts of the local NHS and our eight local authorities for some time, and this partnership working was strengthened as we worked together in response to the Covid-19 pandemic.

2.3 Our collective leadership is committed to continued progress in improving outcomes and supporting recovery while responding to the proposed new legislation to embed new arrangements for collective strategic planning and collective accountability across partners.

2.4 Together we will do the following.

- Agree core strategic priorities for ICS and bespoke priorities for Boroughs. And agree an ICS financial strategy that directly tackles inequalities and directs resource where the need is greatest and reduces the current variation in outcomes within and between boroughs.

- Ensure integrated delivery, as local as possible, through the eight ICPs.

- Hold ourselves and each other to account through trusting relationships and good governance.

2.5 The NHS in NW London has a significant underlying deficit. We are working to understand the drivers of this deficit and we will reduce costs through increased productivity which will not impact on the quality of patient care.

2.6 The ICS has an independent Chair, Dr Penny Dash and an interim Chief Executive, Lesley Watts (also chief executive of Chelsea and Westminster NHS Foundation Trust). Statutory accountability remains with statutory bodies – Trust boards, local authorities and the CCG governing body – until ICSs become statutory bodies and take on the CCG statutory functions.

2.7 The ICS will operate formally in shadow from October and subject to proposed legislation, is expected to become a statutory body in April 2022.

2.8 We expect senior appointments to the NW London ICS to be confirmed in the autumn. Our current ICS plan will be further developed following the publication of the ICS Design Framework by NHS England on 16 June 2021. All partners will work together to design a governance structure that will assure the success of the ICS and maximise opportunities for residents and stakeholders to work with us to deliver on our vision.

## 3. Options / Considerations

3.1 The Health and Wellbeing Board is asked to review the approach to ICS development described, and comment as appropriate.

## 4. Legal Implications

4.1 There are no legal implications of the paper.

## 5. Financial Implications

5.1 There are no financial implications of the paper.


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

Simon Hope – Borough Director, West London CCG

Joe Nguyen – Borough Director, Central London CCG

**Email:** simonhope@nhs.net / joe.nguyen@nhs.net

**Telephone:** 020 3350 4496


**APPENDICES:** N/A

**BACKGROUND PAPERS:** N/A

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Westminster Health & Wellbeing Board | RBKC Health & Wellbeing Board

| | |
|---|---|
| **Date:** | **15 July 2021** |
| **Classification:** | **General Release** |
| **Title:** | **Health and Wellbeing Board Away Day** |
| **Report of:** | **Senel Arkut, Director of Health Partnerships** |
| **Wards Involved:** | **All** |
| **Report Author and Contact Details:** | **Anne Pollock, Principal Policy Officer (apollock@westminster.gov.uk)** |

## 1. Executive Summary

*1.1* There have been significant changes to NHS structures, as well as health and care service delivery during the pandemic. The development of a single Integrated Care System (ICS) and the emergence of Integrated Care Partnership (ICP) and the abolishment of CCGs as statutory health bodies, provides an opportunity to review how the HWBB interacts to ensure local health and care services are delivered and priorities are met.

*1.2* To ensure the Health and Wellbeing Board (HWBB) fulfils its statutory duties, providing robust governance to support local integration and overseeing health and care delivery, the board members need to review the HWBB Terms of Reference (ToR), as well as the priorities in a changing landscape so they are well aligned with the whole system. The board will also have oversight on the health and care inequalities work to tackle disparities together with partners with an interest in the health and wellbeing of Kensington & Chelsea and Westminster residents

## 2. Key Matters for the Board

*2.1* The Board is asked to note the proposals to organise a Board Development Day to consider the new role of the HWBB in a changing health and care context, including a new ToR, and board priorities that will also address health and care inequalities in RBKC & WCC.

## 3. Background

*3.1* Health & Wellbeing Boards were established by the Health and Social Care Act 2012, and originally were seen to be the engine room for integration, a platform to bring together key partners across the local health and care system could come together to develop shared understanding of local needs, work together to improve the health and wellbeing of their local population, and hold the system to account to deliver HWBB priorities. Across the country, there has been discussion about the role and purpose of these boards within the new Integrated Care Systems. NHS England suggests some guidance will be developed. The Covid pandemic has changed the health landscape and emphasised the Health Inequalities, and the importance of the wider determinants of health (Marmot, 10 years on); whilst the ICS has changed our operating context, with different structures and relationships established

*3.2* As part of the Board Development work, it is recommended that the Board refreshes its' Terms of Reference (ToR)

*3.3* The Board also sets the framework for the new Joint Health & Wellbeing Strategy and ensure that the Board is well-placed to deliver on the strategy and realise impact

*3.4* The new regionalised health commissioning model for north west (NW) London was launched in April 2021. Bringing together NHS and local authorities across the sub region, it aims to collectively improve life expectancy and quality of life, reduce health inequalities and achieve good health outcomes.

*3.5* The NWL ICS covers a population of 2.2 million people across eight London boroughs.

*3.6* The ICS aims, in line with the NHS 5 Year Plan and recent NHS White Paper, to ensure this budget represents value-for-money, is distributed evenly, and is targeted to improve health outcomes and reduce inequalities. This means closer working between the NHS, local councils and the wider community, including the VCS, academic institutions and Healthwatch.

*3.7* Listening to residents will be key to ensuring they receive the best care and health outcomes. Local authorities and local partners will therefore need to play a key part in reflecting the needs and interests of our local communities.

*3.8* This change represents an opportunity to review the role of the Kensington & Chelsea and Westminster HWBB direction of travel – to ensure Cllrs, patient representatives, as well as leaders have an oversight of the local integration and delivery of the priorities, to ensure it continues to provide a platform for local partners with a stake the Health and Wellbeing of our residents, as well as ensuring

our local voice is heard at the ICS level. Besides its new roles and responsibilities, the HWBB will continue to play a key role in ensuring all system partners develop a shared understanding of system priorities and actions to address health and care inequalities.

*3.9* In the interest of collaborative place-based leadership, HWBBs could be a key building block of the ICS if they are given a strong oversight role and are involved in the development of their plans. As the only statutory local body, the HWBB will play a key role in addressing the wider determinants of health. This will be achieved by ensuring local government and other partners can shape the ICS, so that, together with the NHS, we will ensure accountable, sustainable and effective health and care systems that address health inequalities and improve population health. This is in line with the new collaborative approach, and would mean it is accompanied by both greater local democratic accountability and enhanced external scrutiny.'

*3.10* As previously reported to the Board, the HWBB has not established its priorities since 2019/20 owing to the pandemic, instead largely focusing on the covid-19 response. As we move towards recovery, we will ensure that the board's work is focused on the emerging needs of our communities, and that local priorities are clearly communicated to inform and influence ICS and ICP priorities.

**4. Options / Considerations**

*4.1* Given the significant change in context facing health and care service structure and delivery, it is recommended that a review and workshop is carried out of the board's role within the new regionalised NW London care model, as well as considering our boroughs' priorities going forward.

*4.2* As this discussion will require dedicated time and focus to ensure robust proposal development, it is not suitable as a board item. As such, the board is asked to note officers' recommendations for a Board Development Day with an external facilitator to be held in September. Areas to cover include

- Role - What is the best, most purposeful role for the Board
- Purpose - What should our focus be in this new context?
- Who should the Board membership include going forward?
- Review and refresh the ToR to reflect the changes in the HWBB role and responsibilities
- What works?
- What doesn't work?
- What are the opportunities and challenges facing the Board?
- Where should we focus?
- What are the alternatives?

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

**Anne Pollock, Principal Policy Officer**

**Email: apollock@westminster.gov.uk**

Westminster Health & Wellbeing Board

RBKC Health & Wellbeing Board

| | |
|---|---|
| **Date:** | 15 July 2021 |
| **Classification:** | **General Release** |
| **Title:** | Hospital Discharge and Ageing Well funding |
| **Report of:** | NHS North West London (NWL) CCG |
| **Wards Involved:** | Enter details if relevant |
| **Financial Summary:** | Details in report |
| **Report Author and Contact Details:** | Ian Robinson, Associate Director for Continuing Health Care and Louise Proctor, Director for Local Care – NHS North West London Clinical Commissioning Group |

## 1. Executive Summary

*1.1* This paper provides the Board with an update on the hospital discharge funding arrangements put in place, funded by NHS England (NHSE), in response to the Covid-19 pandemic.

*1.2* The paper also updates the Board on funding decisions by NWL Integrated Care System (ICS) in relation to the Ageing Well programme.

## 2. Key Matters for the Board

*2.1* The Board is asked to note and provide comment on the funding arrangements for hospital discharge, as well as the pressures placed on all partners in delivering requirements as a result of changes implemented due to the Covid-19 pandemic.

## 4. Background

3.1 Since the 19th March 2020, as a response to pressures on acute services from Covid-19, the Government has allocated specific funding to support discharge from hospital to enable quick and safe discharge and more generally reduce pressure on acute services.

3.2 From 1 April 2021, all ICSs been allocated a capped system budget. The budget will continue to be held centrally by NHS England and NHS Improvement, with clinical commissioning groups (CCGs) being reimbursed based on their actual spend. The amount each system can spend is capped. For NWL the ICS the capped budget is £10.6m. Where a system uses its allocated discharge budget in full, it will need to fund and maintain hospital discharge services from its core system budgets up to 30 September 2021.

3.3 All eight local authorities in NWL have raised concerns with the CCG about the workload and financial impact on local authorities of the hospital discharge programme in 2021/22 and their ability to assess the number of people and to input into CHC assessment. The CCG has requested additional information from the councils to demonstrate the increase against pre-Covid levels on local authority workloads based on hospital discharge numbers requiring a Care Act Assessment.

## 3 Options / Considerations

3.3 The Board is asked to make comment on the following proposed actions, and whether other actions should be considered.

I. Local authorities to demonstrate and evidence increase in workload compared to pre Covid levels
II. Local authorities to propose what additional staffing is required based on increase in workload
III. Understand the financial benefit on local authority budgets of not paying for the first 4/6 weeks of care, compared to pre Covid levels
IV. CCG/Local Authorities to understand the cost impact of being reimbursed for less than six weeks (beyond Quarter 1 when 6 week funding reduces to 4 weeks and then ceases), and how many cases this would apply to.
V. Ensure commitment of local authorities to support CHC assessments in a timely fashion to meet the 28-day target set for CHC by NHSE.
VI. ICS/CCG to make request to NHSE for additional funding to offset local authority cost pressures based on analysis above.

It should be noted that any expenditure above the cap, is at the CCG's risk and the CCG is not in a position to underwrite local authority costs if the request for additional funding is unsuccessful. It may be possible to repurpose other sources of funding such as schemes within the Better Care Fund.

## 4 Legal Implications

4.3 None

**5 Financial Implications**

5.3 Details of the financial envelope available on the schemes described are in the report.

**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 tfieldsend@westminster.gov.uk or Gareth.Ebenezer@rbkc.gov.uk for guidance.**

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

Ian Robinson, Assistant Director / Head of Continuing Healthcare & Complex Care (Hospital Discharge funding), NWL CCG

Louise Proctor, Director for Local Care, (Ageing Well funding), NWL CCG

Email: Ian.robinson6@nhs.net

Louise.proctor1@nhs.net

Appendix 1

**Hospital Discharge – Capacity and Financial Support**

**Context**

Since the 19th March 2020, as a response to pressures on acute services from Covid-19, the Government has allocated specific funding to support discharge from hospital to enable quick and safe discharge and more generally reduce pressure on acute services. The funding has been time limited and split into three separate schemes:

**Scheme 1 - those discharged from hospital from 19th March to 31st August 2020**

The Government agreed to fully fund the cost of new or extended out-of-hospital health and social care support packages, from 19th March 2020, for people being discharged from hospital or who would otherwise be admitted into it. The funding also covered the costs of additional short term residential, domiciliary, re-ablement and intermediate care capacity to reduce hospital admissions.

During this time all new NHS Continuing Healthcare (CHC) activity was paused.

Local authorities were asked to pool existing funding for discharge support with this additional money. Once pooled, funding was treated as a single pooled fund under the eight section 75 agreements across NWL and used to deliver the appropriate care for individuals to be discharged under these new arrangements.

**Scheme 2 - those discharged from hospital from 1st September to 31st March 2021**

The Government agreed to continue to provide funding to support timely and appropriate. Under the new arrangements, new or extended health and care support was funded for a period of up to six weeks, following discharge from hospital and during this period a comprehensive care and health assessment for any ongoing care needs, including determining funding eligibility, needed to take place.

The Government also decided that CCGs must resume NHS Continuing Healthcare assessments from 1 September 2020 and work with local authorities using a trusted assessor model.

Any patients discharged from hospital between 19 March 2020 and 31 August 2020 (scheme 1 clients), whose discharge support package had been paid for by the NHS, needed to be assessed and moved to core NHS, social care or self-funding arrangements by the 31st March 2021. Additional short-term funding was made available by NHSE to pay for additional staff (Social Workers, CHC Nurses, administrative staff) to help clear the backlog of assessments from Scheme 1.

**Scheme 3 - those discharged from hospital from 1st April to 30 September 2021**

Guidance issued in May 2021, advised that the Government has provided a national discharge fund via the NHS, for quarters (Q) 1 and 2 of 2021/22 (1 April 2021 to 30 September 2021), to help cover some of the cost of post-discharge recovery and support services/ rehabilitation and

re-ablement care following discharge from hospital. These financial arrangements apply for patients discharged or using discharge services during that time period.

People discharged between 1 April 2021 and 30 June 2021 (inclusive) will have **up to six weeks** of funded care.

People discharged between 1 July and 30 September 2021 (inclusive) will have **up to four weeks** of funded care.

There is also a requirement for the ICS to maintain a designated site for the discharge of patients who are Covid infectious and need to be discharged to a nursing home.

From 1 April 2021, all ICSs have been allocated a capped system budget. The budget will continue to be held centrally by NHS England and NHS Improvement, with CCGs being reimbursed based on their actual spend up to the cap.

For NWL ICS, this is capped at £10.6m. Where a system uses its allocated discharge budget in full, it will need to fund and maintain hospital discharge services from its core system budgets up to 30 September 2021

| ICS | Scheme 3 Allocation |
|---|---|
| North West London | 10,607,000 |
| North Central London | 10,144,000 |
| South East London | 15,210,000 |
| North East London | 20,491,000 |
| South West London | 14,777,000 |
| **Total** | **71,229,000** |

The forecast based on current spending on hospital discharges requiring domiciliary care at home or a placement in a residential care home will exceed the capped allocation, £10,742,000. This may not include all costs that will be reclaimed by local authorities. The spend does not include additional costs to the ICS on rehabilitation. The CCG has not allocated any funding towards internal staffing or other activities and will continue to be transparent with all partners on spend.

NHSE have not yet issued specific guidance on how the scheme 3 capped allocation can be spent, and whether this includes funding for additional staffing. Further guidance is expected in July 2021.

Should the ICS exceed its capped expenditure, there may be an opportunity to request further support, though agreement is not guaranteed and will be done at the system’s own risk.

There has been no announcement yet on whether there will be any additional funding post September 2021.

**Capacity Issues.**

All eight local authorities have raised concerns with the CCG about the workload and financial impact on local authorities of the hospital discharge programme in 2021/22 and their ability to assess the number of people and to input into CHC assessment. A request has been made to demonstrate the increased workload against pre Covid levels on local authority workloads based on hospital discharge numbers requiring a Care Act Assessment.

There are also concerns on the change of NHSE funding reducing from 6 weeks to 4 weeks as of the 1st July 2021. A request has been made for the CCG to consider funding for 2 weeks to maintain the 6 weeks. This would not be refundable from the NHSE capped allocation and would be a cost pressure to the CCG.

There have been separate historical arrangements under the Better Care Fund (BCF) to support health and social care systems working together across the different boroughs. Additional social workers have been funded within 2020/21 BCF section 75 schemes within Hounslow, Harrow, Hillingdon and Ealing. Under current BCF arrangements with local authorities, the CCG is contributing a total of £1,118,900 towards the costs of social workers. There are also contributions to the cost of care packages included in some BCF arrangements.

It should be noted that in the first quarter of 2021/22, the local authorities have not paid for the first 6 weeks of care for they would previously have been responsible for (both domiciliary care packages and residential placements). In months 1 to 2, local authorities have claimed reimbursements of £1,570,000 just for packages of care they have commissioned.

| **P1 – Months 1 to 2** | **£000** | **No of cases** |
|---|---|---|
| Brent | 300 | 300 |
| Harrow | 266 | 306 |
| Hillingdon | 139 | 180 |
| Hounslow | 0 | 0 |
| Ealing | 249 | 279 |
| Westminster | 165 | 148 |
| K&C | 98 | 41 |
| H&F | 353 | 475 |
| **Total** | **1,570** | |

**Efforts to reduce costs**

During 2020/21, in all boroughs (other than Hounslow) the local authorities commissioned packages of care and non-nursing residential care home placements, with the CHC team commissioning all nursing home placements. Following representation that local authorities are better placed to place people in lower cost (and more appropriate) nursing homes, including their block beds, it has been agreed that all placements (other than complex) will be brokered by local authorities (other than Hammersmith & Fulham and Hounslow). It is expected that this will reduce costs moving forwards.

**Proposed actions:**

1. Local authorities to demonstrate and evidence increase in workload compared to pre Covid levels
2. Local authorities to propose what additional staffing is required based on increase in workload
3. Understand the impact on local authority budgets of not paying for the first 4/6 weeks of care, compared to pre covid levels
4. CCG/Local Authorities to understand the difference between being reimbursed for less than six weeks and how many cases this would apply to.
5. Ensure commitment of local authorities to support CHC assessments in a timely fashion to meet the 28-day target.

Appendix 2

**Ageing Well Funding**

**Context**

The NHS Long-term Plan indicated Service Development Funding (SDF) provided for Community Healthcare services. There are a number of national Ageing Well priorities. In some of these areas NWL has already developed good models of care, and in other areas more work is needed. In addition, local NWL priorities were also considered. NWL developed a set of principles to inform allocation decisions. Crucially alongside this first year of funding system, partners agreed to participate in the detailed comparative analytical work to understand underlying gaps in service and funding to inform future funding decisions/levelling up

**1.1 NWL principles**

NWL agreed a number of principles to support disbursement of this funding. The system agreed a 2 year approach where we work to identify in more granular detail the gaps/inequities in historic funding and seek to support consistent offers across NWL. The principles also include:

- All new funds will resource delivery staff and on costs; not contribute to corporate overheads (NB this principle should be applied to all ICS developments across all programmes)

- Providers agree to focus the national growth allocation on the borough or place, with greatest health deprivation; not to allocate it evenly, eg CLCH focus growth on Brent, not West London, Central London or Hammersmith and Fulham.

- Priority new services, established during Covid or to meet new national standards, should be top sliced and resourced in full from the SDF. In particular, this would include the provision of comparatively sized Discharge Hubs for all acute sites, and the national expectation of Rapid Response provision 8 am to 10 pm 7 days a week. In effect, this is a 'top slice' of the SDF funding.

    - ❑ The Local Care workstream acknowledge the importance placed on the Discharge Hub service by the ICS in order to improve system flow. Baseline acute investment in discharge varies significantly, and this enables a consistent service across NWL. The funding for this service will be supported by the Community SDF for 2021/22 in order to provide certainty to the service and to give time for the ICS to determine the most appropriate and sustainable funding solution from 2022/23 onwards'.

    - ❑ NWL ICS has a signed off the rapid response common specification. With an established gap in operating hours, the investment secures 14 hours of operation 7 days a week across NWL.

- Designate funding to boroughs which do not have core services against the Ageing Well/current NWL priorities.

- ❑ Recognise that these are not yet fully developed specifications but 'gap analysis' shows where key gaps are in anticipatory care, care home support and community diabetes

- Use the historical 'weighted primary care lists' as a means to allocate remaining funding by borough/ICP, via a lead community provider for each borough, in return for explicit commitments from all providers to meet the requirement of the national Aging Well priorities:-

  - ❑ By accepting their share of the SDF, each borough community healthcare provider commits to delivering on the Local Care priorities for 2021/22 and meeting all national requirements of the Aging Well allocations. This includes two hour rapid response, NWL enhanced health in care homes, anticipatory care. Definition of delivery to be agreed via ICS (see draft below).

  - ❑ Where more than one provider in a Borough, the lead Provider will agree appropriate allocations, to deliver the Aging Well requirements (see annex 1 for lead providers).

- In return for this pragmatic approach to Year One of the SDF, all providers commit that Year Two allocations, which are significantly greater, will be prioritised on the boroughs with greater deprivation and lower investment in community services/worse outcomes. This supports progress on the ICS commitment to fair shares and levelling up community services.

  - ❑ During 2021/22, the providers and ICS/CCG will undertake comparisons of financial allocations for key services, which, alongside the PHM strategic work, will inform where greater investment is required. These outcomes by the end of Q3 will inform 2022/23 plans. This work will include consistent productivity as well as absolute cost of activity

  - ❑ The approach ensures investment is released and funds staff, increased activity and improved outcomes in 2021/22 whilst recognising the need for a wider review of value in each borough

- Agreed outcomes are defined against each funded priority – where these are not yet finalised they will be jointly developed in the remainder of Q1 (see slide 11 below).

**1.2 Distribution of recurrent funding**

| | NWL total | CL | WL | H&F | Brent | Harrow | Hillingdon | Ealing | Hounslow |
|---|---|---|---|---|---|---|---|---|---|
| Discharge Hubs | £2,124,000 | | | | | | | | |
| Rapid Response | £1,007,901 | £306,403 | £395,096 | £306,403 | | | | | £385,400 |
| Care Homes | £700,000 | £100,000 | | | £200,000 | £200,000 | | | £200,000 |
| Anticipatory Care | £1,900,000 | £300,000 | | £300,000 | £500,000 | £500,000 | | | £300,000 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Diabetes | £2,000,000 | | | | £500,000 | £1,000,000 | £500,000 | | |
| Fair shares of remainder | £1,811,099 | £173,932 | £186,622 | £211,928 | £292,381 | £183,519 | £225,360 | £304,966 | £232,391 |
| TOTAL (recurrent funding) | **£10,243,000** | **£880,335** | **£581,718** | **£818,331** | **£1,492,381** | **£1,883,519** | **£725,360** | **£304,966** | **£1,117,791** |

- Central London and West London facing discharge hubs (Imperial and Chelsea) receive a share of the Discharge Hub funding designated as system wide
- There is an established gap in commissioned hours for the Rapid response service – allocated funding enable hours of operation from 8 am to 10 pm seven days a week
- West London and some Central London care homes benefit currently from the Imperial Frailty Nursing service, and in West London the My Care My Way team have a responsibility to support care homes. Hence funding solely for Central London where there are gaps in service. Central London does not have equivalent proactive case management support service for frail over 65s and therefore receives funding for anticipatory care
- Both Central London and West London have historically well resourced community diabetes services and therefore receive no funding.

It should be noted that some of this funding will not be utilised until part way through 2021/22. We have agreed that the 'underspend' in year generated should be targeted against locally agreed in year priorities. These may include, but are not limited to, waiting lists, post Covid support and discharge to assess.

**1.3 Next steps**

During July, each borough community healthcare provider has been asked, working with local partners, to develop a delivery plan on how the funding allocated against specific areas will be deployed and where the 'fair shares' funding will be targeted. There is a requirement to demonstrate that the funding is delivering 'additionality' and so plans will require measurable outcomes/impact.

Funding is currently provided for Q 1 and 2 and we will need to demonstrate robust plans to continue funding into Q 3 and 4.

There is work underway on the data collection to inform the work for year two and a more worked up disbursement of the funding, aligned to agreed principles of targeting growth to where there is the greatest need.

# Westminster Health & Wellbeing Board

# RBKC Health & Wellbeing Board

| | |
|---|---|
| **Date:** | 23rd June 2021 |
| **Classification:** | **General Release** |
| **Title:** | Westminster's Partnership Response to Serious Youth Violence |
| **Report of:** | Sarah Newman, Executive Director, Children's Services |
| **Wards Involved:** | All |
| **Financial Summary:** | |
| **Report Author and Contact Details:** | Alice Kavanagh akavanagh@westminster.gov.uk |

## 1. Executive Summary

## 2. Key Matters for the Board

2.1 **Public Health approach to serious youth violence**

2.2 The Health and Well-being Board's role in overseeing health and social care for Westminster, means that it plays an important role in the Public Health approach to tackling the underlying causes of serious youth violence. It is recommended that the Health and Wellbeing Board monitor the underlying health issues and that regular updates are provided to the board from the Serious Youth Violence Reduction Board.

2.3 **Serious Violence statutory duty**

2.4 The Serious Violence statutory duty, which is likely to become legislation in 2021, will place a duty on local organisations to collaborate and plan to prevent and reduce serious violence. Westminster is already doing this work through the Serious Youth Violence Reduction Board and the Safer Westminster Partnership Strategy and Strategic Assessment, and it is recommended that we utilise our strong existing partnership arrangements. The duty places a greater role for education providers and the local authority will need to consult with education providers, as well as strengthen links with health colleagues in this area, particularly the Clinical Commissioning Groups.

2.5 **Involvement of Clinical Commissioning Groups**

2.6 There is a gap in attendance at the Serious Youth Violence Reduction Board from health colleagues. The new statutory duty will place a duty on Health (Clinical Commissioning Groups) to work together with other specified authorities to prevent and reduce serious violence. Health professionals play an important role as they can offer support and are often seen as a universal supportive mechanism for young people and families (e.g. most people go to the GP), as opposed to other "authorities" (e.g. police or Children's Services) and are uniquely placed to have discussion and provide signposting for support. Further collaborating and sharing information amongst services is key for early intervention. It is asked that the CCGs provide a representative to attend the bi-monthly Serious Youth Violence Reduction Board.

## 3. Background

3.1 Serious youth violence is a key priority for Westminster City Council and the Safer Westminster Partnership. The SWP's 2020-23 strategy outlines 'Protecting the most vulnerable in Westminster from becoming victims or offenders of violence or exploitation' as one of its five priorities.

3.2 Levels of serious youth violence have fluctuated over the past year, due to Covid-19 lockdowns. Youth violence and knife crime with injury have increased following each lockdown easing. The night-time economy has an impact on these figures, as most youth violence taking place in Westminster is not committed by Westminster residents, only 40% is1. Non-resident youth violence is most likely to be concentrated in the West End and St James's area. However, there were 50 knife crime with injury victims in Westminster in the last year, aged 1-24. Of the 50

[1] Police CRIS data between October 2019 to September 2020.

offences, 9 were in Westbourne, 6 Little Venice, 5 Church Street and 5 Knightsbridge and Belgravia. The Integrated Gangs and Exploitation Unit has noted an increase in serious youth violence incidents in 2020, with incidents increasing from 55 key incidents in 2019 (1st April to 31st of March) to 134 in 2020 (1st of April 31st March).

3.3 This paper in the appendix provides the current position and multi-agency response to tackling serious youth violence in Westminster (June 2021), as lockdown restrictions lift, and the City reopens. There are concerns that the loosening of restrictions may result in a rise in serious youth violence in the borough, and this paper outlines the strong partnership work that is being carried out to mitigate against this risk.

## 4. Options / Considerations

4.1 The board is asked to provide a steer on how it wishes to provide oversight to the partnership's Public Health approach to Serious Youth Violence.

4.2 The board is also asked to provide guidance and support in how the partnership should engage with the CCGs.

## 5. Legal Implications

5.1 None

## 6. Financial Implications

6.1 None

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

**Alice Kavanagh, Community Safety Commissioning Manager, Westminster City Council**

**Email: akavanagh@westminster.gov.uk**

**Telephone: 07890380239**

**APPENDICES:**
Briefing Note on Westminster's Partnership response to Serious Youth Violence for Health and Wellbeing Board

**BACKGROUND PAPERS:**
None

City of Westminster

# Briefing Note

| Date | 06/07/21 |
| --- | --- |
| Title of Paper | Westminster's Partnership Response to Serious Youth Violence |
| Cabinet Members | Councillor Heather Acton<br>Councillor Timothy Barnes |
| ELT Members | Raj Mistry, Executive Director of Environment & City<br>Sarah Newman, Executive Director of Bi-Borough Children's Services |
| Purpose of Paper | For information |

## 1. Background and context

Serious youth violence is a key priority for Westminster City Council and the Safer Westminster Partnership. The SWP's 2020-23 strategy outlines 'Protecting the most vulnerable in Westminster from becoming victims or offenders of violence or exploitation' as one of its five priorities.

Levels of serious youth violence have fluctuated over the past year, due to Covid-19 lockdowns. Youth violence and knife crime with injury have increased following each lockdown easing. The night-time economy has an impact on these figures, as most youth violence taking place in Westminster is not committed by Westminster residents. However, there were 50 knife crime with injury victims in Westminster in the last year, aged 1-24 and the Integrated Gangs and Exploitation Unit has noted an increase in serious youth violence incidents in 2020, with incidents increasing from 55 key incidents in 2019-20, to 134 in 2020-21. There is concern that as Covid-19 restrictions lift further, that we will see a rise in serious youth violence in the borough.

## 2. Purpose of this paper

This paper provides the current position and multi-agency response to tackling serious youth violence in Westminster (June 2021), as lockdown restrictions lift and the City reopens.

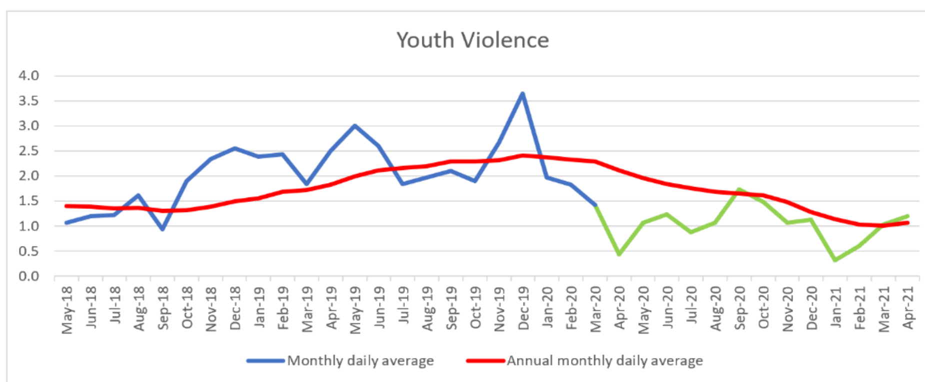
City of Westminster

# Briefing Note

## 3. Levels of serious youth violence in Westminster

Prior to Covid-19, overall crime rates had been increasing in the borough. However, since Covid-19, crime rates in the borough have increased and decreased in line with the three lockdowns.

There were 449 knife crime offences in the last 12 months compared to 1041 the previous year (57% decrease.) Approximately 1.2 victims a day.




There has been a 50% decrease in youth violence victims in the last year. There were 50 knife crime with injury victims under 24. Since January 2021 youth violence has been increasing but as of April 2021 rates are just below pre-pandemic levels.

Most youth violence taking place in Westminster is not committed by Westminster residents, only 40% is[1]. Non-resident youth violence is most likely to be concentrated in the West End and St James's area.

On the ground, feedback from the Integrated Gangs and Exploitation Unit suggests a decrease in serious youth violence activity of 20% during the first lockdown as a result of the stringent restrictions and wide adherence to them in the community, which severely limited movements. However, since this period, those involved returned and became more active and there was no drop in the second lockdown or third lockdown. Serious youth violence incidents increased from 55 key incidents in 2019-20 to 134 in 2020-212.

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[1] Police CRIS data between October 2019 to September 2020.

[2] This must be seen in the context of the IGXU noting that Police information was not always being shared. The issue was raised and in September 2020 information sharing was increased.

City of Westminster

Briefing Note

The rise in violence within Westminster is believed to be linked to a number of connected factors:

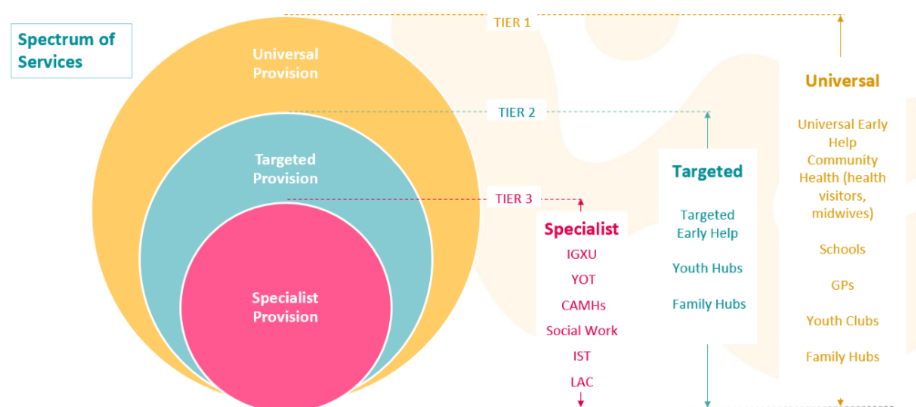
- a drop in numbers involved in County Lines[3];
- 'Olders' returning to the borough who have not been seen for a long time;
- a shift in drug dealing business practices

Additionally, there is a small but significant increase in young women as victims of serious youth violence (from 0 to 3) and a sense that there is more hidden harm than we are aware of. Young people are incredibly active on social media and exchanges on social media will be exacerbating tensions. There are fears about a further increase in the summer as tensions continue to rise and people stay in Westminster who would normally be going away on holiday.

## 4. Multi-agency response

**Serious Youth Violence Reduction Board:** The Serious Youth Violence Reduction Board is a multi-agency partnership board which looks at how we can work together to adapt to the changing nature of violence in Westminster. The board looks at the drivers behind serious youth violence in the borough, in order to provide appropriate and co-ordinated strategic and tactical responses, as well as how we can empower our communities to help reduce serious violence. It oversees the partnership's Violence Reduction Action and the Public Health approach to reducing serious youth violence,[4] including piloting initiatives in Church Street with a view to taking these lessons and seeing what can be adapted on a wider scale across Westminster.

**Overview of services working with young people to prevent Serious Youth Violence**
There is a wide spectrum of universal to specialist work across the Council and partner agencies to tackle serious youth violence.




[3] A term used to describe gangs or organised criminal groups involved in exporting illegal drugs into one or more areas using dedicated mobile phone lines. They are likely to exploit children and vulnerable adults to move and store the drugs and will often use coercion, intimidation, violence and weapons.
[4] Public Health approach to serious youth violence is a life course whole system approach, looking at the root causes, wider and contextual influences of health and crime, which is informed by data and intelligence. Prevention and early intervention are key, as well as working with a wide range of partners as part of a long-term, integrated multi-agency approach.

**Integrated Gangs and Exploitation Unit (IGXU):** The IGXU is a non-statutory, multi-agency unit, established in 2011, which identifies and works with young people aged 10-25, who are vulnerable or at-risk of exploitation or are involved in group violence/ gang-related activity. Joint working across Council departments, health and voluntary sector, with integrated police officers which allows for streamlined information sharing and a swift response to evolving tensions in the borough. It aims to improve young people's life choices and reducing SYV by offering 1:1 support, sexual health advocacy, pathways to education, training and employment, family therapy, substance misuse and enforcement. The IGXU is currently working with 87 cases (70 males and 17 females; 55 under 18 years old and 32 over 18 years old).

**Street Work, Workshops and Community Engagement:** The IGXU deliver a range of ad-hoc street work, workshops and community engagement alongside local youth workers including 'drive-out' visits to hotspot areas during Covid-19 offering support and safeguarding and reassurance to the wider community. A dedicated Serious Youth Violence Community Engagement Officer has delivered community events on keeping young people safe and healthy, outreach workshops and group sessions for parents, and discussions on the role of community leaders in reducing serious youth violence. Training has also been developed and delivered to 400 plus frontline professionals from the Council, schools, voluntary sector and partner agencies - RAGE (Raising Awareness of Gangs & Exploitation.)

**Enforcement:** A Serious Violence Enforcement Officer is based within the IGXU and works with key partners to effectively co-ordinate civil and housing enforcement against problematic people and premises where there is evidence of ASB or criminality.

**County Lines and Substance Misuse:** The MPS Gangs Officers lead on investigating County Lines with the primary aim of safeguarding the most vulnerable young people and to identify and pursue offenders. Partners can make referrals via the Multi-Agency Safeguarding hub (MASH) and Child Abuse Investigation Team (CAIT) referrals desk.

**Substance Misuse Strategy:** A bi-borough substance misuse strategy is being developed which will look at how to best support young people, contribute to harm minimisation, and reduce substance misuse. Alongside this, will be the development of an awareness raising campaign about the impact of the drug market on local children, young people, and communities.

**Youth Offending Team:** The Youth Crime Prevention Partnership (YCPP) is an active partnership of local agencies, which acts as the management board that oversees the local delivery of Youth Justice Services. It is chaired by the Executive Director of Children's Services and provides strategic direction to prevent offending and reoffending by children and young people. The YOT currently works with 28 young people and the highest offences in 20/21 were for robbery (23%), drugs (21%) and violence against the person (17%.)

**Early Help:** Early Help works across the universal to targeted spectrum and where most of the early intervention work happens. It is driven by an active Partnership Board, co-chaired with the Young Westminster Foundation. Over 300 staff and patterns have attended trauma informed training. Strong links have been made between primary schools and the 3 family hubs. Where some young

people have a higher level of need and risk, they may be in receipt of a statutory social work intervention.

**Parenting Support:** Parenting courses continued to be delivered throughout the pandemic. Two resource booklets have been produced: 'Advice & Guidance to Parents & Carers about SYV, Knife Crime & Gangs' and 'Talking to your children about a violent incident'. These have been translated into 5 languages and have been circulated widely in the community. Family Services have delivered a 4-month funded project, the Parenting/Carer Champion Network: testing the effectiveness of parents supporting other parents around issues of serious youth violence. 14 Peer Navigators were trained who speak a range of languages.

**Early intervention work with schools:**

- **MPS Safer Schools Partnership:** Westminster has 10 Safer School Officers that cover the Secondary Schools signed up to the Safer School Partnership and a dedicated PRU officer. The Safer Schools Partnership encompasses 14 schools who need regular support. An additional 10 schools link in on ad hoc basis, also supported by local ward teams.
- **School Inclusion and Trauma-Informed Work:** The School Inclusion project prevents school exclusions through a collaborative trauma-informed systemic approach, and as a result our exclusion rates are starting to fall. Working in 16 schools, with 83 teachers trained and 59 young people on the programme. No young person on the programme has been permanently excluded. An award scheme is being finalised for schools who develop the whole school approach and share the learning with other schools.
- **An Early Help Family Practitioner linked to each School** for consultation and advice. This enables reviewing of concerns about pupils, sharing information on services available to support the needs of children and families.
- **Family Hub Partnership Panel:** Schools have an opportunity every month to share concerns with locality partner services, as part of case discussion about families at pre-referral level.
- **West London Zone:** Working in 4 schools, they help children and young people build the relationships and skills they need to get on track socially, emotionally and academically to thrive in adulthood.
- **Mental health support teams in schools:** Teams deliver evidence-based interventions for mild to moderate mental health issues, supporting senior mental health lead in schools to introduce or develop their whole school approach, giving timely advice to school staff and liaising with external specialist services to help children and young people to get the right support and stay in education.
- **'Safe Camp'** which is run by London Sports Association and supported by the MPS in Pimlico. Police provide input on safety, stop and search etc.
- **IGXU Schools and Youth Engagement Officer:** This role will support the delivery and development of projects, training and workshops within schools and youth clubs.

**Partnership working with the Police:** The Local Authority has a close working relationship with the police and below are some examples of this work:

- **Problem solving partnerships:** These meetings for key ASB hot-spot areas involving police, council, registered housing providers, contracted street-based services and Westminster Housing, in response to community concerns and ASB triggers.
- **Police Youth Engagement & Diversion Team**: The 11 YE&D Team officers work with partners to identify young people at early stages of being involved in criminality or at risk of becoming involved to divert them. They identify early engagement opportunities, attend youth clubs and other diversionary opportunities and collectively work with young people and their families.
- **Concern Hub**: This is a meeting to map all youths of concern and ensure there is co-ordinated partnership activity to engage and divert.
- **Home Visits**: The MPS are mapping the entire cohort of youths of concern, RAG-ing them and then ensuring that they all get regular home visits to engage and divert. Reds will be visited once a week, ambers once a month, and greens once every three to six months.
- **Community calls**: BCU Commander has attended 3 community calls hosted by WCC between BAME community representatives, youth representatives and cross-party councillors, to hear and address concerns.
- **Monthly meetings held between MPS BCU and WCC** regarding gangs tensions. Attended by IGXU leads and Children's Services Director.

**Voluntary sector:** The Council has strong links with many of the voluntary sector providers who deliver services in Westminster. Key to this relationship are the Young Westminster Foundation, who we work closely with in developing projects providing early intervention and diversion from serious youth violence. The Young Westminster Foundation have recently conducted *'Our City, Our Future'* 2020/21 needs analysis, covering the issues and experiences of young people growing up in Westminster over the past year.. A key finding was that over 70% of young people expressed concern about people carrying knives, being followed or ambushed, or sexual harassment or assault. The Young Westminster Foundation has also produced a website https://ourcity.org.uk/ for young people to access information on activities, programmes and support for young people under 25. There is a range of activity taking place over the summer for young people, including summer camps, sports, arts, cooking, mentoring and leadership.

## 5. Post-incident response:

When serious incidents of violence occur, there is a need for joined up working across the partnership to supress escalation in violence, co-ordinate diversion and engagement activity, and ensure all safeguarding concerns are appropriately managed. In immediate response to a serious incident of violence; a Partnership Violence Suppression (PVS) Meeting is chaired by a Police Senior Officer, with key representatives across the Police & Local Authority present. This is a short action

focused meeting to ensure that there is a co-ordinated response to tackling violence on the BCU. Individuals involved are identified and engaged with immediately to prevent further violence.

The council, police and other partners have developed a Violent Incident Response Procedure following a murder or other incident of serious violence. The purpose is to ensure a co-ordinated response to the victim/s and suspect/s families as well as 'connected-communities' such as schools, colleges, friends etc. The aim of the Partnership Community Conference is to discuss a clear and consistent community message and methods of delivery, including standard holding message; the need for any community meetings with local community groups; potential deployment of partnership representatives into the community; the role that local elected Members, community groups and faith groups can play in delivering messages and providing feedback; and whether there are other events to build on e.g., Police Anniversary events, memorial events, funerals, judicial proceedings.

## 6. Serious Violence Statutory Duty

The serious violence duty is a duty placed on local organisations to collaborate and plan to prevent and reduce serious violence, as set out in the Police, Crime, Sentencing and Courts (PCSC) Act 2021. Draft guidance has been published in May 2021 and it is likely that it will become law later in the year. The duty requires the following specified authorities within a local government area to work together to prevent and reduce serious violence: Police; Justice (Probation Services and YOTs); Fire and Rescue; Health (Clinical Commissioning Groups); local authorities. The key requirements for Westminster are:

- **To be part of a multi-agency partnership to reduce serious violence.** This does not need to be a new structure, and existing structures, such as the Serious Youth Violence Reduction Board, can be used. Membership of the board has been reviewed and the one gap is the Clinical Commissioning Group who we would need to engage with and ensure representation at the Serious Youth Violence Reduction Board. It is also recommended that educational

establishments are represented at the partnership meeting. There is also an opportunity to engage wider partners, such as registered housing providers.

- **To produce a serious violence strategic needs assessment and strategy**. There is no need for a dedicated serious violence strategy, the strategic needs assessment and strategy produced by the CSP can be used for both the Serious Violence Duty and Crime and Disorder Act requirements. The Serious Youth Violence Reduction Board agrees that the Safer Westminster Partnership's strategy and strategic assessment give a detailed account of our needs and strategic intentions around serious youth violence.
- **To consult with education providers** located in the partnership area, including: local authority maintained schools, academies, independent schools, free schools, alternative education providers and further education. It seems that education providers are not required to co-operate but rather where an education provider chooses to or is requested to actively collaborate with the partnership, they should be asked to input into the development of the strategic needs assessment and consent to any actions in the strategy which apply to them.

Recommendations will be made to the Safer Westminster Partnership as to how we will adequately meet the new requirements within the statutory duty.