Who are we?
The Health and Wellbeing Board is a joint board of the Council and CCG which provides the strategic leadership for the health and social care in the city. Meetings are open to the public and everyone is welcome.

Where and when is the Board meeting?
This next meeting will be held in the Brighthelm Church and Community Centre on Tuesday, 20 October 2015, starting at 4.00pm. It will last about two and a half hours. There is public seating and observers can take part in an informal question and answer session with the Board prior to the formal meeting, starting at 3.30pm and they can leave when they wish.

What is being discussed?
There are five main items on the agenda
- Residential Rehabilitation Services
- Adult Social Care Services: The Direction of Travel 2016-2020
- Strengthening Primary Care Services in Brighton & Hove
- Safeguarding Adults Board Annual Report 2014-15
- Local Safeguarding Children Board Annual Report 2014-15

In addition there are a range of papers covering the plans for winter and an update on the progress of the Mental Health and Wellbeing Strategy.

What decisions are being made?
- The Board will consider formally endorsing the St Mungo’s Charter
- To agree for the commissioners to negotiate contracts for residential rehabilitation contracts
- To agree the direction of travel for Adult Social Care Services
- To endorse the Children & Young People’s Mental Health and Wellbeing Transformation Plan for Brighton & Hove
Health & Wellbeing Board

Presenting Officer
or
Public Speaker

Cllr Yates
Chair
(Voting member)

Nataasha Watson
Lawyer BHCC

Mark Wall
Secretary · BHCC

Denise D’Souza
Statutory Director Adult Services · BHCC
(Non-voting Statutory member)

Dr. Xavier Nalletamby
CCG
(Voting member)

Cllr Mac Cafferty
(Voting member)

Dr. George Mack
CCG – Lay Member
(Voting member)

Frances McCabe
Healthwatch
(Non-voting Statutory member)

Pennie Ford
NHS England
(Non-voting co-optee)

Cllr Barford
Lead Member for Adult Services
(Voting member)

Cllr Penn
Lead Member for Mental Health
(In attendance – Non-voting)

Public Seating

Press

Officers and Representatives
attending
Health & Wellbeing Board
20th October 2015
4.00pm
Brighthelm Church and Community Centre

Who is invited:

Councillors Yates (Chair), K Norman (Opposition Spokesperson), Mac Cafferty (Group Spokesperson), Barford and G Theobald, Dr Christa Beesley (Brighton and Hove Clinical Commissioning Group), Dr Darren Emilianous (Brighton & Hove Clinical Commissioning Group), Geraldine Hoban (Brighton and Hove Clinical Commissioning Group), Dr George Mack (Brighton and Hove Clinical Commissioning Group) and Dr Xavier Nalletamby (Brighton and Hove Clinical Commissioning Group), Denise D'Souza (Statutory Director of Adult Services), Pinaki Ghoshal (Statutory Director of Children's Services), Dr Tom Scanlon (Director of Public Health), Graham Bartlett (Brighton & Hove Local Safeguarding Children's Board & Adult Safeguarding (Combined Role)), Pennie Ford (NHS England) and Frances McCabe (Healthwatch)

Who is unable to attend:

Contact:

Mark Wall
Head of Democratic Services
01273 29100606
mark.wall@brighton-hove.gov.uk

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Date of Publication - Monday, 12 October 2015
AGENDA

Formal matters of procedure

This short formal part of the meeting is a statutory requirement of the Board

19 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

The Chair of the Board will formally ask if anyone is attending to represent another member, and if anyone has a personal and/or financial interest in anything being discussed at the meeting. The Board will then consider whether any of the discussions to be held need to be in private.

20 MINUTES

The Board will review the minutes of the last meeting held on the 21st July 2015, decide whether these are accurate and if so agree them.

Contact: Mark Wall Tel: 01273 291006
Ward Affected: All Wards

21 CHAIR'S COMMUNICATIONS

The Chair of the Board will start the meeting with a short update on recent developments on health and wellbeing.

22 FORMAL PUBLIC INVOLVEMENT

This is the part of the meeting when members of the public can formally ask questions of the Board or present a petition. These need to be notified to the Board in advance of the meeting. Ring the Secretary to the Board, Mark Wall on 01273 291006 or send an email to mark.wall@brighton-hove.gov.uk

(a) Petition for a New Nursing Home – Lead petitioner, Elle McIntyre (copy attached).

Contact: Mark Wall Tel: 01273 291006
Ward Affected: All Wards
The main agenda

Papers for Decision at the Health & Wellbeing Board

23 ST. MUNGO'S CHARTER 19 - 24
Notice of Motion referred from full Council on the 16th July 2015, together with a briefing paper from the Director of Public Health (copy attached).

Contact: Mark Wall, Alistair Hill Tel: 01273 291006, Tel: 01273 296560
Ward Affected: All Wards

24 RESIDENTIAL REHABILITATION SERVICES 25 - 38
Report of the Director of Public Health (copy attached).

Contact: Kathy Caley Tel: 01273 296557
Ward Affected: All Wards

25 ADULT SOCIAL CARE SERVICES; THE DIRECTION OF TRAVEL 2016 -2020 39 - 50
Report of the Statutory Director for Adult Social Care (copy attached).

Contact: Philip Letchfield Tel: 01273 295078
Ward Affected: All Wards

26 UPDATE ON CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH AND WELLBEING TRANSFORMATION PLAN FOR BRIGHTON AND HOVE 51 - 284
Report of the Chief Operating Officer of the CCG (copy attached).

Contact: Gill Brooks Tel: 01273 574635
Ward Affected: All Wards

Papers for Discussion at the Health & Wellbeing Board

27 THE FUTURE MODEL OF CARE FOR COMMUNITY SHORT TERM SERVICES 285 - 324
Joint report of the Chief Operating Officer of the CCG and Statutory Director for Adult Social Care (copy attached).

Contact: Jane MacDonald, Tel: 01273 295038, Keith Hoare Tel: 01273 574773
Ward Affected:  All Wards

28 BETTER CARE FUND SECTION 75 QUARTERLY PERFORMANCE UPDATE INCLUDING FOCUSED INFORMATION ON HOMELESSNESS

Joint report of the Chief Operating Officer of the CCG and the Director of Public Health (copy attached).

Contact:  Alistair Hill, Ramona Booth
Tel: 01273 296560,
Ward Affected:  All Wards

Papers to Note at the Health & Wellbeing Board

29 MENTAL HEALTH AND WELLBEING STRATEGY – PROGRESS

Report of the Assistant Chief Executive, BHCC (copy attached).

Contact:  Paula Murray
Tel: 01273 292536
Ward Affected:  All Wards

30 BRIGHTON AND HOVE LOCAL HEALTH ECONOMY COLD WEATHER PLAN 2015

Report of the Director of Public Health (copy attached).

Contact:  Kevin Claxton, Sarah Podmore
Tel: 01273574732,
Ward Affected:  All Wards

31 FUEL POVERTY & AFFORDABLE WARMTH STRATEGY FOR BRIGHTON & HOVE

Joint report of the Director of Public Health and the Executive Director for Environment, Development & Housing – BHCC (copy attached).

Contact:  Miles Davidson
Tel: 01273 29- 3150
Ward Affected:  All Wards

32 BRIGHTON & HOVE LOCAL HEALTH AND SOCIAL CARE SURGE AND CAPACITY PLAN 20116

Report of the Chief Operating Officer for the CCG (copy attached).

Contact:  Geraldine Hoban
Tel: 01273 574863
Ward Affected:  All Wards
33 **BRIGHTON & HOVE SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2014/15**

Report of the Statutory Director for Adult Social Care (copy attached).

*Contact:* Michelle Jenkins  
*Tel:* 01273 296271  
*Ward Affected:* All Wards

34 **LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2014-15**

Report of the Statutory Director for Children’s Services (copy attached).

*Contact:* Mia Brown  
*Tel:* 07584217256  
*Ward Affected:* All Wards

35 **PRIMARY CARE SERVICES IN BRIGHTON & HOVE**

Report of the Chief Operating Officer of the CCG (copy attached).

*Contact:* Geraldine Hoban  
*Tel:* 01273 574863  
*Ward Affected:* All Wards

**WEBCASTING NOTICE**

This meeting may be filmed for live or subsequent broadcast via the Council’s website. At the start of the meeting the Chair will confirm if all or part of the meeting is being filmed. You should be aware that the Council is a Data Controller under the Data Protection Act 1988. Data collected during this web cast will be retained in accordance with the Council's published policy (Guidance for Employees’ on the BHCC website).

For further details and general enquiries about this meeting contact Democratic Services, 01273 2910066 or email democratic.services@brighton-hove.gov.uk
Public Involvement
The Health & Wellbeing Board actively welcomes members of the public and the press to attend its meetings and holds as many of its meetings as possible in public.

If you wish to attend and have a mobility impairment or medical condition that may require you to receive assisted escape in the event of a fire or other emergency, please contact the Democratic Services Team (Tel: 01273 291066) in advance of the meeting. Measures may then be put into place to enable your attendance and to ensure your safe evacuation from the building.

Brighthelm has facilities for people with mobility impairments including a lift and wheelchair accessible WCs. However in the event of an emergency use of the lift is restricted for health and safety reasons please refer to the Access Notice in the agenda below.

An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter and infra-red hearing aids are available for use during the meeting. If you require any further information or assistance, please contact the receptionist on arrival.

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If the fire alarm sounds continuously, or if you are instructed to do so, you must leave the building by the nearest available exit. You will be directed to the nearest exit by council staff. It is vital that you follow their instructions:

- You should proceed calmly; do not run and do not use the lifts;
- Do not stop to collect personal belongings;
- Once you are outside, please do not wait immediately next to the building, but move some distance away and await further instructions; and

Do not re-enter the building until told that it is safe to do so.
1. **Procedural Business**

   (a) **Declaration of Substitutes**: Where Members of the Board are unable to attend a meeting, a designated substitute for that Member may attend, speak and vote in their place for that meeting.

   (b) **Declarations of Interest**:

      (a) Disclosable pecuniary interests
      (b) Any other interests required to be registered under the local code;
      (c) Any other general interest as a result of which a decision on the matter might reasonably be regarded as affecting you or a partner more than a majority of other people or businesses in the ward/s affected by the decision.

      In each case, you need to declare
      (i) the item on the agenda the interest relates to;
      (ii) the nature of the interest; and
      (iii) whether it is a disclosable pecuniary interest or some other interest.

      If unsure, Members of the Board should seek advice from the Lawyer or Secretary preferably before the meeting.

   (c) **Exclusion of Press and Public**: The Board will consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, that the press and public should be excluded from the meeting when any of the items are under consideration.

   **NOTE**: Any item appearing in Part Two of the Agenda states in its heading the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the public.

   A list and description of the exempt categories is available from the Secretary to the Board.
4.00pm 21 July 2015
Auditorium - The Brighthelm Centre

Minutes

Present:
Councillors Yates (Chair), K Norman (Opposition Spokesperson), Mac Cafferty (Group Spokesperson), Barford (Lead Member for Adult Social Care), and G Theobald, Dr. Darren Emilianous, Geraldine Hoban, Dr. Christa Beasley, Dr. George Mack; Clinical Commissioning Group.

Other non-voting members present:
Frances McCabe Health Watch, Pinaki Ghoshal, Statutory Director of Children’s Services Denise D’Souza, Statutory Director of Adult Social Care Dr. Tom Scanlon, Statutory Director of Public Health.

Also in attendance:
Councillor Penn (Lead Member for Mental Health): Dr. James Thallon, Medical Director NHS England, Mia Brown and Dr. M. Kammerling, Consultant in Public Health Medicine, Screening and Immunisation Lead for Surrey and Sussex PHE/NHSE.

Apologies: Dr. Xavier Nalletamby, Pennie Ford, NHS England and Graham Bartlett.

Part One

1 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

1.1 Prior to taking the formal items on the agenda, the Chair welcomed everyone to the first meeting of the Board following the recent local council elections. He also stated that he wished to clarify the position of Councillor Penn following a question during the informal question time prior to the start of the meeting. He noted that
Councillor Penn was the council’s Lead Member for Mental Health and as such he had invited her to attend the meetings of the Board and to speak on matters relating to mental health.

1.2 Councillor G. Theobald noted that Councillor Penn was sitting with the other Council Members of the Board and stated that he felt it was inappropriate and confusing as she would not be able to vote on any matters. He felt that she should be invited to come to the table and speak on matters but should not sit with the Members of the Board on a permanent basis as this gave the wrong picture. She should be treated like any other representative who was invited to speak and come forward to address the meeting at the appropriate time.

1.3 The Chair noted the comments and stated that he felt it was appropriate for Councillor Penn to be invited to attend and to sit with the Board.

1.4 Councillor Mac Cafferty asked for guidance on the matter and clarification of the position.

1.5 The Lawyer to the Board stated that the Councillor had been invited to attend the meeting by the Chair in her capacity as Lead Member for Mental Health. There was no suggestion that the membership of the Board was being altered or that there were any changes to the terms of reference proposed. The meeting was open to all Members to attend and they could seek the Chair’s agreement to speak on a matter. However, she noted that concerns had been expressed and suggested that further discussions with Members could be held outside of the meeting to clarify matters.

1.6 Councillor K. Norman stated that the Chair had approached him prior to the start of the meeting and asked if he would move seats on this occasion, which he had agreed to do. He accepted that any Member had the right to attend and speak at the meeting with the Chair’s permission, but this did not extend to sitting with the Board on a permanent basis; and suggested that if this was to be the case that discussions could have been held prior to the meeting.

1.7 The Chair noted the comments and stated that he believed the matter had been discussed at the pre-meeting but he was happy to discuss it further outside of meeting. In the meantime he was happy for Councillor Penn to sit with the Board.

1.8 The Chair noted that Mia Brown was attending for Graham Bartlett and Dr. Thallon was attending on behalf of Pennie Ford.

1.9 In accordance with Section 100A(40) of the Local Government Act 1972 (as amended), it was considered whether the press and public should be excluded from the meeting during the consideration of any items contained in the agenda, having regard to the nature of the business to be transacted and the nature of the proceedings and the likelihood as to whether, if members of the press and public
were present, there would be disclosure to them of confidential or exempt information as defined in Section 100I (1) of the said Act.

1.10 RESOLVED: That the press and public be not excluded from the meeting.

2 CONSTITUTIONAL MATTERS

2.1 The Board considered a report of the Monitoring Officer which set out the Board’s terms of reference, its membership and programme of meetings for 2015/16.

2.2 RESOLVED: That the report be noted.

3 CHAIR’S COMMUNICATIONS

3.1 The Chair welcomed everyone to the meeting and noted that at the Health and Wellbeing Board meeting on the 24th March 2015 approval was given for the City Council and the Clinical Commissioning Group (CCG) to undertake preliminary engagement with potential providers in the city to explore a new model of care for Community Short Term Service (CSTS) beds.

3.2 These beds are provided in a range of units:

- Craven Vale – City Council – 24 beds
- Knoll House – City Council – 20 beds
- Highgrove Nursing Home – Victoria Nursing Home – 21 beds

3.3 He noted that since 2012 a higher proportion of people were being discharged from hospital straight to their own home with support from community short term services, and the comparatively smaller proportion of people that do require care in one of the bedded units are the most dependent and have the most complex needs.

3.4 The current service specification for CSTS beds has been in place since 2012 and a new model of care is required to meet the needs of people with high levels of complexity and dependency. Potential providers were therefore invited in April to put forward their ideas for what the new model of care for CSTS beds could look like. These were submitted in May and meetings were then held with all interested providers to explore their ideas in more detail.

3.5 A total of 6 providers submitted their ideas and met with City Council and CCG commissioners. These included existing and new providers. Given the level of interest evidenced for delivery of a new model of care for CSTS beds, and the variety and complexity of the ideas presented, the Health and Wellbeing Board is asked to note that the CCG and the City Council will continue to develop the new model of care over the coming 3 months, taking on board the options and ideas gathered from the recent engagement exercise, with a view to presenting more formal proposals on a way forward at the October meeting of the Board.
3.6 He stated that these proposals will also be informed by the capacity and demand review that Ernst and Young recently completed for the CCG, which will provide evidence for the number and type of community beds that the city requires to meet the needs of the local population.

3.7 The Chair confirmed that a partnership event would be taking place on the 15th September here at Brighthelm from 2.00 to 5.00pm and that the next Board meeting would therefore be on Tuesday 20th October at 4.00pm.

4 MINUTES

4.1 The minutes of the last Board meeting held on the 24th March 2015 were agreed and signed by the Chair as a correct record.

5 FORMAL PUBLIC INVOLVEMENT

5.1 The Chair welcomed Mr. Kirk to the meeting and invited him to put his question to the Board.

5.2 Mr. Kirk thanked the Chair and asked the following question,

“Board members will have seen an Argus article1 about syringe needles in the toilet at the Level. I have heard recently of a case of a little girl injuring herself on a syringe needle in Queens Park. This coincides with the outsourcing of the Substance Misuse Service to Cranstoun/Surrey Borders NHS Trust, in particular, the fact the needle exchange venue has now moved location and the additional services that were offered to clients has new ceased. Apart from the need for the Council to safeguard children playing in Brighton and Hove parks –

a) How does the Council monitor the performance of the new SMS provider?

b) Are there any clauses in the new contract to take account of a degradation of the service? For example, is there a clause in the contract that can enforce the Council taking the service in-house following clear service failure?

c) The SMS service was exemplary and despite advice the Council went ahead with outsourcing. Will the Council take heed that, despite the promises made by alternative providers, outsourcing is so often followed by service inadequacy?”

5.3 The Chair stated that he had a written response which he would ensure was copied to Mr. Kirk following the meeting and replied, “The Substance Misuse Neighbourhood Liaison Officers have been in touch with the Police, CityClean and City Parks and to date have not been able to confirm that the child did injure herself on a needle i Queen’s Park. The drug litter bins in the public toilet at the
The Level were installed in October 2014 in response to an increase in needle finds over the summer months.

Pavilions were not able to continue to provide a needle exchange from the building used by the previous provider in St. George’s Place. The needle exchange is currently being provided from premises on Ditchling Road. In addition 18 local pharmacies provide a needle exchange.

In regard to your other points, performance is managed through the contract and against predetermined key performance and quality outcome indicators. The performance of the new SMS provider, Pavilions is being monitored at quarterly contract review meetings chaired by the Lead Commissioner for Alcohol and Drugs. Performance data and information is drawn from national statistics, activity based reports and service provider summaries. In addition, monthly mobilisation and post contract commencement meetings have been held with Pavilions in order to address transitional issues.

With regard to drug litter, relevant service information is included in the quarterly Service Provider summaries, which include Needle Exchange and Open Access interventions.

Where the Local Authority is of the opinion that a material breach has occurred then the authority may take any of the following actions:

(i) Require the contractor to submit a performance improvement plan to address the areas of concern;
(ii) Suspend the individual service element, without terminating the contract;
(iii) Without terminating the entire contract, terminate the individual service element and then the Authority may supply or procure a third party to deliver this element of the service.

The previous adult drug and alcohol service providers were not provided by the council, but by a partnership of NHS and non-statutory providers. The Pavilions partnership consists of a range of partners including the NHS and local agencies. The performance of the partnership is being monitored and performance issues will be addressed as described above.

5.4 Mr. Kirk thanked the Chair and stated that he understood there could be a number of variances in service provision and asked whether the monitoring included asking the staff how good the service was?

5.5 The Chair stated that he had met with staff and received positive feedback and he would continue to seek that feedback.

5.6 The Chair noted that there were no other public questions.
6 **ISSUES RAISED BY COUNCILLORS AND MEMBERS OF THE BOARD**

6.1 The Chair noted that no items had been submitted by Members for consideration at the meeting.

7 **ETHICAL CARE CHARTER**

7.1 The Board considered a Notice of Motion, concerning the Ethical Care Charter approved by the Council on the 30th January 2014 and referred to the Board for consideration; along with a briefing paper from the Executive Director for Children’s Services.

7.2 The Board welcomed the briefing paper and noted that there were 12 providers across the city and that aspects of the Charter had already been included in current contractual arrangements. The Board also noted that there had been a move to more flexible provision of support plans and whilst there was a preference to phase out zero our contracts, it was recognised that in some cases they may be preferred by some care workers.

7.3 **RESOLVED:** That the notice of motion and the action being taken to provide future arrangements for the commissioning of care be noted.

8 **TIME TO CHANGE PLEDGE**

8.1 The Board considered a Notice of Motion, concerning the Time to Change Pledge approved by the Council on the 26th March 2015 and referred to the Board for consideration; along with a briefing paper from the Director of Public Health.

8.2 The Board welcomed the motion and supported the intention to sign up to the Charter and adopt the pledge across all areas of provision within the council and partnership organisations / agencies. The Board also noted that there would be a need to look at the level of resources and suggested that this should be addressed in some way.

8.3 Councillor Penn thanked the Board for their support and stated that there was a lot of misunderstanding around mental health and she hoped that by discussing matters it would help to improve that situation and give a positive message.

8.4 The Chair stated that he hoped matters would be taken forward including the question of resources as part of the work on the development of the Mental Health & Wellbeing Strategy. He also offered to provide an update on this as part of his Chair’s communications at the next Board meeting.

8.5 **RESOLVED:** That the notice of motion be noted and the Board agree to adopt the Time to Change Pledge and encourage others to do so.
9 CONSULTATION ON EXTENSION OF SMOKE FREE AREAS

9.1 The Director of Public Health introduced the paper which outlined the advantages and practicalities of extending smoke-free spaces in Brighton and Hove to include city parks and beaches. He noted that the issue had raised a lot of interest in the city and sought the views of the Board on the proposals.

9.2 The Environmental Health Manager stated that it was intended to consult the public on the proposals to extend smoke-free spaces to include parks and beaches across the city. He noted that should there be a significant level of support any decision to introduce smoke-free areas would not have any legal backing and would require people to adhere to the ban on a voluntary basis. Such voluntary bans had already proved successful in children’s playgrounds and it was hoped could be extended to other areas.

9.3 The Director of Public Health stated that signage would be provided and it was then anticipated that it would become self-policing. He noted that such areas had been successfully introduced in Bristol.

9.4 The Board welcomed the paper and the proposals to extend smoke-free areas and queried whether as a result of the consultation it would be possible to select specific areas if it appeared that there was not support for all areas to be included. The Board also expressed some concern over how well it could work in some areas such as the beach when other activities such as barbecues were prohibited but generally appeared not to be enforced.

9.5 The Chair stated that it was a difficult issue and there was a need to find out the level of public appetite for the introduction of smoke-free areas in parks and on the beaches. It was something that would need public support to be successful as it would limit public freedom albeit for public good.

9.6 The Board agreed that there was a need to determine what level of public support existed and noted that it was intended to bring a report back to the December meeting on the outcome of the consultation process.

9.7 RESOLVED:

(1) That the paper be noted and that a public consultation exercise be undertaken to gauge public support for the extension of smoke-free spaces to include parks and beaches within the city; and

(2) That a paper on the outcome of the consultation and options for any extension of smoke-free areas be brought to the December meeting of the Board.
10 PUBLIC HEALTH NURSING COMMISSIONING FOR HEALTHY CHILD PROGRAMME 0-19

10.1 The Public Health Programme Manager introduced the paper which detailed the Public Health Nursing commissioning strategy for the delivery of the Healthy Child Programme 0-19 years. She noted that in October 2015 the responsibility for commissioning Public Health services for children aged 0-5 years would transfer from NHS England to the Council. It was therefore proposed that these services should be combined along with those under the Healthy Child Programme and commissioned under one Public Health Nursing Contract from 2017/18. In order to meet this proposal there was a need to extend current contract with Sussex Community Trust (SCT) to March 2017.

10.2 The Executive Director for Children’s Services drew the Board's attention to paragraph 4.2 of the paper and noted that the integration of services was a central part of the commissioning process and would build on the current model.

10.3 Dr. Beasley stated the proposed integration was welcome and hoped that there would be an opportunity to look at the clusters across the city and primary care provision.

10.4 The Public Health Programme Manager stated that a Transition Board would be established, chaired by NHS England which would bring in colleagues from all areas to look at the future provision of services and improvements that could be made.

10.5 RESOLVED: That the proposed Public Health Nursing commissioning strategy be noted and the extension of the contracts with SCT until the 31st March 2017 as detailed in the paper be agreed.

11 RESPONSE TO CHILD SEXUAL EXPLOITATION (CSE) WITHIN BRIGHTON & HOVE

11.1 The Executive Director for Children’s Services introduced the paper and noted that the matter of child sexual exploitation (CSE) had been discussed at the last meeting and it had been agreed to have a further report. He also noted that since the last meeting, there had been an Ofsted inspection and one area it had looked at was CSE; and the inspectors’ comments had been very positive. There was a lot of work taking place with schools and the police and this was overseen by the Safeguarding Board. It was recognised that there were victims in the city and others yet to be identified.

11.2 Dr. Mack noted that there were budgetary pressures and a projected overspend in some areas and queried how this would have an impact on the work to address CSE.
11.3 The Executive Director for Children’s Services stated that overall projection for Children’s Services had increased, however resources had been put into priority areas and work was in hand to bring the overall projection down.

11.4 **RESOLVED:** That the Board’s assurance for the developing response to CSE within Brighton and Hove be noted and the Board’s thanks to the officers for a detailed paper be recorded.

12 **HOUSING ADAPTATIONS SERVICE UPDATE**

12.1 The Executive Director for Adult Services introduced the paper which provided an update on the Housing Adaptations Service for 2014/15, including Disabled Facilities Grant (DFG) investment in private sector housing. She stated that the Housing & New Homes Committee had considered a report at its meeting on the 17th June and referred it to the Board for information; and noted that an extract from the minutes of the meeting had been included in the agenda papers.

12.2 Councillor G. Theobald noted that there was a significant under-spend for disabled adaptations in private sector homes and asked how this was being addressed.

12.3 The Executive Director for Adult Services stated that there was a need to encourage landlords to undertake works so that greater provision could be made.

12.4 Frances McCabe noted that adaptations were important in terms of enabling people to return to their homes and queried whether there was any information on the impact of this and whether in the future adaptations would be made to meet needs.

12.5 The Executive Director for Adult Services stated that a lot of work was being done to reach the lifetime homes standard but that the DFG was not really the mechanism to enable people to return to their homes.

12.6 The Chair noted that the Housing & New Homes Committee had expressed concerns about the level of delayed discharges because of the need for improvements/adaptations to be made and suggested that he should discuss this further with the Chair of the Committee and report back to the Board.

12.7 **RESOLVED:**

(1) That the paper and extract from the Housing & New Homes Committee meeting be noted; and

(2) That is be noted that the Chair of the Board would discuss the concerns of the Housing & New Homes Committee with its Chair and report back to a future meeting of the Board.
13 CHILDREN’S SERVICES OFSTED INSPECTION AND REVIEW OF LOCAL SAFEGUARDING CHILDREN BOARD 2015

13.1 The Executive Director for Children’s Services introduced the paper which provided an update on the recent Children’s Services Ofsted inspection and detailed the proposed action plan resulting from the inspection report. He noted that overall the report was positive having looked at around 200 cases of looked after children and met with parents, grandparents, adopters, carers and young people. The finding was one of requiring improvement to be good, but a number of actions had already been identified and put in place.

13.2 The LSCB Business Manager stated that the review of safeguarding had come out as good and this reflected the journey that had been undertaken over the past year. There had been changes to the governance arrangements which were more transparent and the Inspector’s recommendations had already been built into the action plan. She noted that the Inspection team had commented on how well developed the CSE approach was in the city.

13.3 The Executive Director for Children’s Services noted that a re-inspection was expected for 2018, although the current framework was under review and may look rather different. The main concern had been around front-line arrangements and a consultation on changes to this had finished and was due to be implemented which would see social workers within smaller teams and working with young people throughout their lives rather than being split between specific age groups.

13.4 Frances McCabe referred to the number of looked after children and queried how this compared with other authorities and how the level of placements outside of the city was being addressed.

13.5 The Executive Director for Children’s Services noted that the council had been found to be good by the Inspectors in terms of looked after children. The council had a higher number of young people in care compared to its statistical neighbours but that had always been the case and in fact numbers were increasing across the country. The vast majority of placements were within a 20 mile radius of the city centre and work was ongoing to reduce the number beyond that down. There were regular review meetings and more robust arrangements to track children through their educational life were being implemented as part of the action plan.

13.6 RESOLVED:

(1) That the Ofsted report listed as appendix 1 to the paper be noted; and

(2) That the Local Authority post Ofsted action plan as detailed in appendix 2 to the paper be noted.
14 INTERIM REPORT: PROGRESS ON THE MERGING SPECIAL EDUCATIONAL NEEDS AND DISABILITIES (SEND) REVIEW IN CHILDREN’S SERVICES AND THE LEARNING DISABILITY (LD) REVIEW IN ADULT SERVICES

14.1 The Assistant Director, Children’s and Adult Services introduced the paper which detailed the progress of the two reviews in Children’s and Adult Services and set out the direction of travel for merging Special Educational Needs and Disabilities (SEND) review and the Learning Disability (LD) review. She noted that SEND review had been reported to the joint meeting of the Health & Wellbeing Board and Children & Young People Committee in February. The LD review had then been taken to the Board following that meeting and since then a decision had been taken to merge the two reviews because of the degree of overlap across both areas.

14.2 She stated that it was intended to come back to a joint meeting of the Board and Children & Young People Committee towards the end of October with recommendations for an integration of the services. There had been an initial consultation exercise with families which had raised a number of concerns and it was proposed that a cross-cutting reference group should be established to review the proposals and to help steer changes in areas. She stated that she had attended the Children, Young People & Skills Committee meeting on the 20th July who had made it clear that they would like to remain involved and had suggested that joint Working Group consisting of representatives from the committee and the Board be established.

14.3 Councillor Mac Cafferty welcomed the report but expressed concerns about the integration of services and possible reduction of provision for children and young people. He sought an assurance that any amalgamation would result in a better outcome with dedicated service provision to meet children’s mental health.

14.4 The Executive Director for Children’s Services stated that by combining the reviews and taking into consideration the overlap in areas, it should result in a range of recommendations to reflect an integrated service. There would likely be some aspects that were particular to children and young people and others to adults, but having a personalised approach should provide a more uniform provision.

14.5 The Executive Director for Adult Services stated that the personalisation approach for provision was very important to parents and a lot of time had been spent on how the transition of service provision would be achieved to reassure all those involved.

14.6 Councillor K. Norman welcomed the paper and stated that he felt it was the right approach, although it was going to be a difficult task.

14.7 The Board noted that a joint meeting of the Children, Young People & Skills Committee and the Health & Wellbeing Board would need to be scheduled for the
end of October/early November. It was also noted that there was a need to review the terms of reference of the Children, Young People & Skills Committee although this would not be completed before the Joint meeting. The Board also noted that as part of the consultation on the joint review input would be sought from all those involved including parents, third sector providers etc.

14.8 The Lawyer to the Board noted that a clear decision making process would be required for the joint meeting and that both bodies would be informed by the joint discussion. However, the recommendations for each would need to be set out so that everyone was aware of who was taking each decision and how that impacted on any others.

14.9 The Board also noted that significant changes were likely to be put forward and that consolidation of services would be a part of that change, although the aim was to enhance the quality of service provision without detraction from the quality. There was an expectation that improvements could be delivered across the city and that savings could be achieved.

14.10 **RESOLVED:**

(1) That the paper be noted and the direction of travel be approved;

(2) That it be noted that concrete proposals to amalgamate specialist provision for children with SEN and disabilities, including behavioural, emotional and mental health difficulties, will be presented to the Board in October/November;

(3) That the setting up of a cross-party Members’ Reference Group to oversee both reviews during the implementation phase be approved.

15 **UPDATE ON CANCER SCREENING IN BRIGHTON AND HOVE**

15.1 Dr. Kammerling introduced the paper which detailed the actions taken following the recommendations of a Task & Finish Group that had reviewed the issues raised by a presentation on cancer screening to the Board in October 2014.

15.2 Councillor Mac Cafferty welcomed the paper and noted that GP practices were working in clusters and queried whether that might lead to ‘super practices’ being established.

15.3 The Chief Operating Officer for the CCG informed the Board that there were 6 clusters across the city covering a population of 55,000 each, which would share resources and had scope to work across the areas.
15.4 Dr. Beasley stated that all practices had been asked about the idea of having ‘super practices’ and there had been no interest expressed for this but rather a preference for the federated model.

15.5 Dr. Mack stated that he was pleased to see the progress made but queried whether there could be any improvement in the release of data e.g. cervical smear information from NHS England.

15.6 Dr. Kammerling stated that it was accepted that there was a need to improve the time-lag for the release of data; however there was a due process that had to be followed. He hoped that by the autumn there would be a visible improvement.

15.7 The Chair thanked Dr. Kammerling for attending the meeting and providing the update.

15.8 **RESOLVED:** That the paper be noted.

16 **BETTER CARE FUND UPDATE**

16.1 The Chief Operating Officer for the CCG introduced the paper which detailed the Better Care Fund for Brighton and Hove and provided a breakdown of the Section 75 pooled fund. It also provided an update on the performance and delivery of the Better Care Programme. She stated that it was intended to bring a quarterly report to the Board for information and that it was hoped to formalise the arrangement under the Section 75 Agreement by the end of the month.

16.2 **RESOLVED:** That the paper be noted.

17 **GP PRACTICE CLOSURES**

17.1 Dr. Thallon introduced the paper which detailed the background in relation to the recent closure of GP practices within the city and the role of NHS England in relation to the closure of a GP practice. In regard to the two closures within the city, he noted that in one case the Partners had returned the contract and in the other case the CQC had sought the closure of the practice resulting from a review of operating procedures. He noted that the closure had caused a level of stress and anxiety that this would be looked as part of the review into the matter. However, he also noted that there had been a high degree of silence over the closure from users/patients etc.

17.2 The Chair stated that he had only taken over in May and had been struck by the speed of how things developed and welcomed the support that had been provided. He also wished to extend the Board’s thanks to the practice that took on the contract and the group of patients.
17.3 Councillor G. Theobald stated that concerns remained over how the position had been reached and what level of support existed to help practices before they reached a critical stage. He hoped that this would also be considered as part of the review into the matter.

17.4 Dr. Thallon stated that he was sure the review would look at the issue and noted that support was available from the CCG, Local Medical Centre and NHS England, who was committed to working with practices across the country.

17.5 Dr. Beasley noted that the LMC gave advice and the CCG had a Quality Team to help practices and to give practical support. It was also hoped that with the introduction of the clusters peer support would also become available and beneficial.

17.6 The Chief Operating Officer for the CCG stated that one aspect that would need to be considered was the financial viability of practices in the City. There were a number of relatively small ones and some in poor premises and therefore the business models would need to be looked at. There was a need to be more proactive and it may be that the clustering of practices would result in a more collaborative approach; otherwise it was likely that more practices would go under.

17.7 Frances McCabe noted that NHS England had previously agreed to provide information following a formal review of Eaton Place and asked if that could be actioned.

17.8 Dr. Thallon stated that he would have to check on the situation regarding Eaton Place but was happy to report back in due course. In terms of why one practice falls into financial difficulty and another does not, it was not easy to answer and suggested that the CCG might be better placed to recognise when a practice was falling into difficulty. He agreed that there was room for improvement in regard to working with the CCG and that there was a need to support vulnerable patients better in such circumstances and to provide information at an earlier stage.

17.9 The Chair thanked Dr. Thallon for attending the meeting and stated that he was reassured to an extent that NHS England would review the process. He would await their findings and would also welcome an action plan from both NHS England and the CCG to give the Board assurance about future processes.

17.10 **RESOLVED:** That the paper be noted.

18 **CHILDREN AND YOUNG PEOPLE’S MENTAL HEALTH AND WELLBEING TRANSFORMATION PLAN FOR BRIGHTON AND HOVE**

18.1 The Children and Young People’s Mental Health and Wellbeing Commissioner introduced the paper which detailed the Children and Young People’s Mental Health and Wellbeing Transformation Plan for Brighton and Hove. She stated
that council officers and the CCG were working with Public Health to develop a Joint Needs Assessment which would be aligned to the Children’s Strategy and a report brought to the autumn meeting of the Board.

18.2 She also informed the Board that the council had been asked to submit a transformation plan to the National Task Force in September. She was still awaiting guidance on the actual submission required and its due date but sought the Board’s agreement to the submission of a plan as requested and drew attention to the draft on pages 189 and 190 of the agenda. She welcomed any comments by email and any suggestions for what could be included or looked at prior to the final document being prepared.

18.3 The Executive Director for Children’s Services suggested that the draft submission could be considered by the Children & Young People Wellbeing Strategy Group prior to it being sent.

18.4 **RESOLVED:** That the paper be noted and the submission of the transformation plan in accordance with the required deadlines be approved.

The meeting concluded at 7.15pm

Signed

Chair

Dated this day of 2015
Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. **Petition – Nursing Home**

1.1. Petitions

1.2 This paper is to be made available to the general public.

1.3 This paper is for the Health & Wellbeing Board meeting on the 20\textsuperscript{th} October 2015.

1.4 Mark Wall
Secretary to the Board
Tel: 01273 291006
mark.wall@brighton-hove.gov.uk

2. **Decisions, recommendations and any options**

2.2 That the Board respond to the petition from Ms. Mcintyre.

3. **Relevant information**

3.1 The petition is being submitted to the Health & Wellbeing Board for consideration.

3.2 To receive the following petition.

“We the undersigned petition Brighton & Hove Council to build a nursing home that covers Huntington disease needs.”

Lead petitioner: Ms. Mcintyre.

Supporting Information:
“There is no nursing home that covers this illness in Sussex. My great auntie passed away due to this illness, she was in a home in Colchester and family had to travel to see her and relatives had to move counties and leave the rest of family members behind. There are plenty of sufferers out there and they should be closer to home.”
Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. **St. Mungo’s Charter – Notice of Motion**

1.1 The paper is available to all members of the public.

1.2 The paper is for the Health & Wellbeing Board meeting on the 20th October 2015.

1.3 Author of the Paper and contact details:
Mark Wall, Secretary to the Board
Tel. 01273 291006
mark.wall@brighton-hove.gov.uk
Alistair Hill, Consultant in Public Health
Tel. 01273 296560
alistair.hill@brighton-hove.gcsx.gov.uk

2. **Summary**

2.1 To consider the notice of motion referred from the full Council meeting held on the 16th July 2015 detailed in paragraph 4; and the information relating to the Charter detailed in the briefing update in paragraph 5.

3. **Decisions, recommendations and any options**

3.1 To determine whether any action should be taken in light of the notice of motion.
4. **Relevant information**

**NOTICE OF MOTION - ST. MUNGO'S CHARTER**

“This Council resolves to:

- Support the Health & Wellbeing Board’s work to tackle health inequality and inclusion in relation to homelessness as exemplified in the recent report on health inequalities by the Director of Public Health.

- Request that the Health & Wellbeing Board fully appraise itself of The St Mungo’s Charter for homeless health, and considers signing up to the charter as confirmation of the council’s commitment.”

5. **Supporting documents and information**

Briefing update from Director of Public Health

5.1. The Charter for Homeless Health¹ (see appendix 1) states that “people who are homeless face some of the worst health inequalities in society. They are at much greater risk of mental and physical health problems than the general population and their experiences of homelessness often make it more difficult to access the healthcare they need”.

5.2. The charter commits the Health and Wellbeing Board to changing this by:

<table>
<thead>
<tr>
<th>Identifying need:</th>
<th>We will include the health needs of people who are homeless in our Joint Strategic Needs Assessment. This will include people who are sleeping rough, people living in supported accommodation and people who are hidden homeless. We will work with homelessness services and homeless people to achieve this.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing leadership:</td>
<td>We will provide leadership on addressing homeless health. Our Director of Public Health has a key leadership role to play in tackling health inequalities and will lead in promoting integrated responses and identifying opportunities for cross boundary working.</td>
</tr>
<tr>
<td>Commissioning for inclusion:</td>
<td>We will work with the local authority and clinical commissioning groups to ensure that local health</td>
</tr>
</tbody>
</table>

services meet the needs of people who are homeless, and that they are welcoming and easily accessible.

5.3 In Brighton & Hove our work on homelessness and health is addressing the principles of the charter by the following means:

Identifying need
Our Joint Strategic Needs Assessment\(^2\) includes a section on rough sleeping and single homelessness\(^3\) (updated in 2014) which describes the health and wellbeing needs of rough sleepers, and people receiving housing support and living in emergency accommodation. As part of the JSNA programme approved by the Health and Wellbeing Board, a Homeless Health Audit was conducted in 2013-14\(^4\). This was conducted in partnership with homelessness services, and has informed action to improve the health of homeless people in the City.

Providing leadership
The importance of this issue for the city has been highlighted in recent Public Health Annual Reports, including the 2014 report on health inequalities.

In 2014 a Homeless Integrated Health and Care Board was established, chaired by a Consultant in Public Health, as part of the Better Care programme. The vision of the board is to:

“*Improve the health and wellbeing of homeless people by providing integrated and responsive services that place people at the centre of their own care, promote independence and support them to fulfil their potential*”.

Membership of the Board includes representatives of BHCC, the CCG and NHS Trusts, GPs, community and voluntary sector, Substance Misuse services, Sussex Police and service users.

Commissioning for Inclusion
Homelessness has been included as a key priority within the Better Care programme. In addition to the Board described above, a Homeless Leads meeting, including commissioners from the CCG, Adult Social Care, Housing and Public Health, has been established to oversee the commissioning of services that will deliver the Boards

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\(^2\) [http://www.bhconnected.org.uk/content/needs-assessments](http://www.bhconnected.org.uk/content/needs-assessments)
\(^3\) [http://www.bhconnected.org.uk/sites/bhconnected/files/jsna-6.4.3-Rough-sleepers2.pdf](http://www.bhconnected.org.uk/sites/bhconnected/files/jsna-6.4.3-Rough-sleepers2.pdf)
vision, and ensure that plans to improve health and wellbeing are aligned with related NHS and Council commissioning strategies and the development of a strategy to prevent rough sleeping.

5.4 A full update on this Better Care work stream will provided to the Health and Wellbeing Board in October 2015.
Charter for homeless health

People who are homeless face some of the worst health inequalities in society. They are at much greater risk of mental and physical health problems than the general population and their experiences of homelessness often make it more difficult to access the healthcare they need.

The Health and Wellbeing Board is committed to changing this. We therefore commit to:

Identify need: We will include the health needs of people who are homeless in our Joint Strategic Needs Assessment. This will include people who are sleeping rough, people living in supported accommodation and people who are hidden homeless. We will work with homelessness services and homeless people to achieve this.

Provide leadership: We will provide leadership on addressing homeless health. Our Director of Public Health has a key leadership role to play in tackling health inequalities and will lead in promoting integrated responses and identifying opportunities for cross boundary working.

Commission for inclusion: We will work with the local authority and clinical commissioning groups to ensure that local health services meet the needs of people who are homeless, and that they are welcoming and easily accessible.

Signed: ............................................................................................................................

Chair: ............................................................................................................................ Health and Wellbeing Board

Date: ............................................................................................................................
Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. **Residential Rehabilitation Services in Brighton and Hove**

1.1. The contents of this paper can be shared with the general public.

1.2. This paper is for the Health & Wellbeing Board meeting on the 20\textsuperscript{th} October 2015

1.3. Author of the Paper and contact details
    Kathy Caley, Lead Commissioner for Substance Misuse, Brighton and Hove City Council.
    01273 296557.
    kathy.caley@brighton-hove.gov.uk

2. **Summary**

2.1 Until April 2015, residential rehabilitation services were jointly commissioned by Public Health and the Housing Related Support team. In April 2015 the budget and commissioning responsibility transferred to Public Health.

2.2 Existing contracts for residential rehabilitation will expire on 31\textsuperscript{st} March 2016. This paper makes recommendations for the process of awarding future contracts.

3. **Decisions, recommendations and any options**

3.1 That the Board agrees for the commissioners to seek to negotiate contracts with the current providers, with the option of moving to a competitive process if negotiations fail:
3.2 That the Director of Public Health be granted delegated authority to conduct the negotiations on the Council’s behalf, and to run a competitive procurement in the event that negotiations fail:

3.3 That the Director of Public Health be granted delegated authority to award the contract after negotiations with the current providers or competitive tender process has taken place.

4. **Relevant information**

**Substance Misuse Services in Brighton and Hove**

4.1 Adult community based substance misuse services (drug and alcohol treatment services for people aged 18 and over) are provided by ‘Pavilions’, a partnership of organisations led by Cranstoun, which began providing services in Brighton and Hove on the 1\textsuperscript{st} April 2015. A range of treatment interventions are offered to support service users to work towards recovery in a community setting. Each person entering treatment services is allocated a ‘care co-ordinator’ to work specifically with them around their needs. Some service users will benefit from the more intensive, structured support that can be provided in a residential programme.

‘Residential rehabilitation’ can be defined as *a programme to establish a state in which clients remain alcohol/drug free and physically, psychologically and socially capable of coping with the situations encountered. Residential rehabilitation generally involves communal living with other alcohol/drug misusers in recovery, and can include group and individual relapse prevention, counselling, individual key working, improving skills for daily living, training and vocational experience, housing and resettlement services and aftercare support.*\(^{1}\)

4.2 Residential rehabilitation aims to reduce substance misuse and associated homelessness by providing treatment and support to enable individuals to achieve abstinence and recovery, independent living and to take part in work and learning opportunities. Individuals are required to give up their current accommodation to move into full time residential rehabilitation. It is vital that service users understand the commitment this requires.

Evidence of Effective Practice

4.3  NICE guidance supports the provision of residential treatment for people who are seeking abstinence and who have significant co-morbid physical, mental health or social problems\(^2\). In 2012 the National Treatment Agency (now part of Public Health England) stated that service users who need residential rehabilitation should have access to it, and partnerships should not inappropriately restrict availability. The NTA also commented that because of the high cost of residential rehabilitation, the focus should be on high complexity cases\(^3\).

Residential Rehabilitation Provision in Brighton and Hove

4.3  In the last ten years Brighton and Hove has consistently been ranked in the highest three DAAT (drug and alcohol action team) areas (out of 159) for the proportion of all clients in treatment accessing residential rehabilitation. Data for 2013/14 shows Brighton and Hove as the area with the highest proportion of clients, with 9% of all clients in treatment attending residential rehabilitation.

4.4  Brighton and Hove is unusual in the approach to residential rehabilitation provision. The majority of Local Authorities rely on ‘out of area’ providers of residential rehabilitation to meet their clients’ needs and clients could be placed a considerable distance from their home\(^4\). Whilst for a small number of individuals this can be helpful (if a client is fleeing domestic or sexual violence, or if a client has considerably high needs that cannot be met locally), high numbers of individuals will want to continue to live in Brighton and Hove after completing treatment. It is therefore considered beneficial to support these individuals to build ‘recovery capital’ in their own home city, so that when they do complete treatment they are able to re-integrate with the local community. They will also continue to have access to the support network they will have established during treatment and recovery.


\(^3\) National Treatment Agency. *The Role of Residential Rehabilitation in an Integrated Treatment System.* 2012

\(^4\) There are 159 DAAT areas. 65 responded to a survey asking about the model used in their area. 37 use only out of area providers. The remaining areas use mainly out of area, with a small amount of in-city provision. Only two other areas that responded said they use only in-city provision.
4.5 In Brighton and Hove residential rehabilitation is provided by two ‘in-city’ providers: Brighton Housing Trust’s Addiction Service, and CRI’s St Thomas Fund. For 2015/16, the total spend on residential rehabilitation services is £690,739. This funds a total of 79 ‘units’ of accommodation.

4.6 The Community Care Budget is accessible for local residents who would benefit from an out of area placement. The substance misuse budget is approximately £94,000 and this funds roughly ten placements per year. Referrals to out of area placements are overseen by the specialist substance misuse social workers, working within treatment services.

4.7 Brighton and Hove has a long history of working with BHT and CRI to ensure that residential rehabilitation services are available for Brighton and Hove residents with addiction problems. Services have been provided by both organisations, initially via contracts with Housing Related Support (since approximately 2003), until Public Health took over commissioning responsibility in 2015/16.

4.8 Both services work to support clients to achieve a detoxification followed by abstinence, however, the overarching philosophy of the two providers differs slightly. BHT Addiction Services are based on a 12 step treatment model integrated with CBT treatment interventions. The use of illicit drugs or alcohol is a breach of license, leading to eviction. This is made very clear to clients at both assessment and start of treatment induction. If a client is evicted, providing they show motivation to change the behaviour that put their recovery or the recovery of others at risk, staff work with their care coordinator for a fast track re-referral back into treatment with the service. Treatment outcomes in the service have demonstrated the value of the consistent use of this approach.

4.9 CRI use interventions based on Cognitive Behavioural Therapy (CBT). Abstinence is still the end goal for service users, but there is a greater degree of flexibility as to how this is achieved. If a service user does have a lapse, they will initially be supported to address this, rather than evicted immediately. The distinction between the two services is an important one for service users to understand, and certain individuals may be better suited to one approach than the other. However, the overall aim of both services is the same, in that they support a wide range of individuals to recover from addiction.

Improvement work
4.10 A programme of service improvement work is underway with the current providers, based on a review of residential rehabilitation provision undertaken in 2014. A number of areas were identified for development that will support the greatest number of service users to successfully complete treatment. These are:

- **Development of eligibility criteria** - Since assuming commissioning responsibility for residential rehabilitation services, eligibility criteria have been developed by the Public Health team, to allow transparency for service users and ensure that the most appropriate individuals are referred to the most appropriate service. A guidance document on eligibility has been jointly developed by BHT and CRI, in partnership with commissioners. Clients who are motivated to change, who are high risk and have complex needs will be prioritised.

- **Ensuring that appropriate preparation work is undertaken by client** – Potential clients are expected to show their commitment to residential rehabilitation by attending preparation ‘drop-in’ groups. The programme of work offered by providers in this stage of treatment has been developed to ensure that clients are fully informed about what to expect once they are in residential rehabilitation, and are aware of the requirements that will be put upon them to change.

- **Development of a consistent and fair lapse/relapse policy** – BHT and CRI have slightly different approaches to this element of service delivery, and a guidance document to support this, and to ensure that clients understand what is required of them, has been developed.

- **An approach to ‘frequent returners’** – research literature acknowledges that clients are likely to need to undergo more than one treatment episode before abstinence is achieved. This is the case locally for 34% of those who have undertaken residential rehabilitation since 2003, who have had more than one episode. Providers have developed personalised approaches to support these

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5 Figure taken from Nebula, data recording system used to capture all activity. Data from 21/09/2003 to 31/03/2015
frequent returners, to ensure that the reason they left treatment unsuccessful previously is addressed in their next treatment episode. The aim is to reduce the number of people who ‘frequently return’ to treatment.

Benefits accrued from In-City Provision

4.11 The benefits of in-city provision include:

- Enabling the essential pre-treatment contact or preparation work, including visits to the residential rehabilitation unit to be undertaken, and with it, a better understanding of what residential rehabilitation will bring.
- The intensive support needed to link service users with local physical health treatment providers to obtain the care they need.
- Being taught skills to manage the risks to their recovery that are specific to Brighton and Hove, where they will still be living post treatment. This will include learning to live a ‘crime free’ life in Brighton and Hove.
- Integrating with the recovery support network already available in Brighton and Hove, which will be vital to their ongoing recovery on leaving treatment.
- Being supported by volunteers/recovery mentors who have already been through local services and ‘recovered’, which empowers individuals in their own recovery.
- If they are a parent, being able to have ongoing contact with their children, and therefore being able to commit to residential rehabilitation.
- Established links in the supported housing pathway, a crucial stage post treatment.

Current Provider Outcomes

4.12 Providers are monitored against the percentage of ‘successful completions’ from treatment services. The Public Health Outcome Framework defines this as the number of individuals that leave treatment successfully (free of drug/s of dependence) who do not then re-present to treatment again within six months.

4.13 The majority of people accessing substance misuse treatment services require support for their opiate addiction. The most recent
data set indicates that there were 1241 opiate users in treatment compared to 262 non-opiate users, 757 alcohol users, and 251 alcohol and non-opiate users (categories set by Public Health England).

4.14 Residential rehabilitation services contribute significantly to successful completion rates for opiate users, with 37% of all opiate successful completions coming from individuals who have been in residential rehabilitation at some point. Individuals with opiate dependence issues are often the most complex users of treatment services, and residential rehabilitation can offer them the intensive support they need to overcome their addiction. These individuals will also be linked into community treatment services, where referrals for residential rehabilitation will originate from, and they may have initially received interventions in the community. However, the causal role of residential rehabilitation in their successful recovery should be acknowledged. Since assuming commissioning responsibility, the Public Health team has put in place a quarterly performance monitoring system that will allow variance in performance between the two residential rehabilitation providers to be identified, and focused on in improvement plans. The aim is to ensure that the opportunity for successful completion from treatment is the same for individuals regardless of which residential rehabilitation service they access.

4.15 As documented above, clients accessing substance misuse services are likely to undergo more than one treatment episode before abstinence and ‘recovery’ is achieved. The majority of individuals accessing residential rehabilitation only have one episode (66% of all individuals accessing services since 2003). A further 21% have had two episodes of residential rehabilitation treatment. A small number, 9%, had three episodes of residential rehabilitation treatment. See appendix 1 for the full breakdown of episode numbers. The programme of service improvement work outlined earlier provides detail on how service users are given enhanced support to reduce the number of attempts needed to achieve full recovery.

Recommendation for Service re-design with existing providers

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6 Data is taken from the National Drug Treatment Monitoring System (NDTMS) and is for the period of 01/10/2013 to 30/09/2014, with re-presentations up to 31/03/2015
4.16 There are a number of practical reasons for the recommendation to undertake a service re-design with existing providers in the first instance. These are as follows:

- **Desire to continue with in-city provision model** – given the benefits of this service model, documented above, the Public Health team wish to continue with in-city provision. Service users have voiced their support for this model, and as demonstrated, residential rehabilitation contributes significantly to overall outcomes. Should there be the need, there is also provision for individuals to attend an out-of-area placement if required.

- **Premises requirements** – any organisation providing residential rehabilitation services in the city would be required to have access to appropriate buildings to provide the required treatment. Recent experience of the community substance misuse services seeking appropriate accommodation has highlighted the difficulties in acquiring buildings. BHT and CRI already have appropriate buildings in place, some of which have been recently upgraded using Public Health England Capital Grants funding.

- **Extensive improvement work already underway** – as detailed above, extensive improvement work is underway with existing providers. This work will help to ensure that the right individuals are accessing residential rehabilitation, and that they are receiving appropriate support and interventions.

**Future contractual position**

4.17 The proposal is to negotiate three year contracts with existing providers, with the potential to extend for one further year. This will tie in with Brighton and Hove City Council’s current four year budgetary planning cycle. As part of the service re-design, commissioners will work with providers to develop the most clinically and cost effective service delivery model. In line with required Public Health budget reductions, it is anticipated that a twenty percent saving will be made across residential rehabilitation services from 2016/17 onwards. This will reduce the spend on residential rehabilitation services from £690,739 to £552,591 per year.

**Community Engagement and Consultation**
4.18 An independent Substance Misuse Service User Involvement Worker is commissioned by Public Health and employed by MIND in Brighton and Hove, to undertake all relevant community engagement and consultation. As part of the review of residential rehabilitation services in 2014, extensive service user consultation was undertaken. In total 63 service users took part in the consultation. The views obtained were used in the improvement work programme. The feedback from people using the services was extremely positive. Areas where improvements could be made centred on ensuring that all clients were aware of the choice of services available to them more generally, and in making informed decisions regarding their care. These are addressed in the residential rehabilitation review actions discussed earlier.

4.19 The Involvement Worker undertakes an annual service user consultation, and from the responses generates ‘treatment priorities’ for the year ahead. Residential rehabilitation, as well as ‘recovery and reintegration support, with housing and wraparound services for sustained abstinence’ are consistently high on the list of service user priorities.7

Conclusion

4.20 The continuation of the in-city service model for the provision of residential rehabilitation is the preferred option. Negotiating new contracts with current providers is the most suitable way of ensuring this. The extensive improvement work underway will ensure that the quality of services continue to improve.

4.21 A competitive tender process will be commenced should it not be possible to negotiate new contracts.

5. Important considerations and implications

Legal:

5.1 Residential rehabilitation services fall within Schedule 3 of the Public Contracts Regulations 2015 and are required to be awarded in accordance with Section 7 of the Regulations (except where the value of the proposed contract is less than £625k, in which case only the general obligations of transparency and fairness apply).

7 Residential rehabilitation extract summary paper from Rick Cook, SU Involvement Worker, August 2015
5.2 For Schedule 3 contracts with a value in excess of £625k the Council is required to publish a contract notice in OJEU setting out the process by which it is intended to award the contract.

5.3 There is currently some uncertainty about the extent to which it is necessary to run a full competition prior to the award of such contracts, however the Council has previously taken the view that this is not strictly necessary for this type of service; and that the requirements set out in the 2015 Regulations and the EU Procurement Directive can be satisfied by advertising an intention to negotiate with existing providers, moving to a full competition only where such negotiations are not successful. The EU Directive recognises that there will not always be an established market for Schedule 3 services, and the intention of the Directive and the UK Regulations is to stimulate the development of such markets, not to force unnecessary competition where no genuine cross border market exists.

5.4 If and when terms are agreed with the current providers, the contracts entered into will need to be in a form approved by the Head of Law, and executed as Deeds.

Legal Office consulted: Natasha Watson Date: 5th October 2015

Finance:

5.5 The 2015/16 budget for residential rehabilitation services is £0.691m and the proposals set out in this paper seek to reduce the level of funding by at least 20% (£0.138m) from 2016/17 onwards. It is considered that the preferred option to deliver this level of saving is by negotiating with existing providers and the outcome of these will help inform current service and financial planning across Public Health.

Finance Officer consulted: Mike Bentley Date: 15th September 2015

Equalities:

5.6 Equalities, and the reduction of health inequalities, are considered in the service specification development of any Public Health service. Services will be developed to ensure that all individuals have equal access.

Sustainability:
5.7 The continued provision of ‘in-city’ residential rehabilitation is the preferred approach of commissioners. Reducing the overall budget in line with budget pressures should allow the service to be provided in a sustainable way.

Health, social care, children’s services and public health:

5.8 This is covered in the body of the report.

6 **Supporting documents and information**

6.1 Appendix 1 – Number of episodes of residential rehabilitation
Appendix 1 – Number of episodes of residential rehabilitation

The data below illustrates the episodes of residential rehabilitation treatment undertaken by individuals before they achieved full ‘recovery’. The majority of individuals, 66.3%, only required one episode of residential rehabilitation. As the data shows, two individuals accessed residential rehabilitation nine times before they were able to achieve recovery. N.B. the data covers all episodes of residential rehabilitation since 2003.

<table>
<thead>
<tr>
<th>Episodes in residential rehabilitation since 2003</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>556</td>
<td>66.3%</td>
</tr>
<tr>
<td>Two</td>
<td>178</td>
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<td>Three</td>
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</tr>
<tr>
<td>Six</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>Nine</td>
<td>2</td>
<td>0.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>838</td>
<td></td>
</tr>
</tbody>
</table>
Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. **Adult Social Care Services; The Direction of Travel 2016 - 2020**

   - The contents of this paper can be shared with the general public.
   - This paper is for the Health & Wellbeing Board meeting on the 20th October 2015.
   - Author of the Paper and contact details
     Philip Letchfield, Head of Modernisation philip.letchfield@brighton-hove.gov.uk

2. **Summary**

   2.1 This report sets out proposals for the future delivery of adult care services in Brighton & Hove over the period 2016-20. It covers commissioning, service provision and assessment services. The paper sets out the broad direction of travel for services over this period within which more detailed implementation plans will be developed. This direction of travel will underpin the 4 year integrated service and financial planning process.

   2.2 The paper sets out the wider context within which the proposals have been developed.

   2.3 The proposals will affect citizens and their carers who have adult care and support needs, all staff in adult care, other Directorates within the Council and our partners across the city. The proposals will inform the appropriate communication and consultation processes with stakeholders as more detailed implementation plans.
are developed, linked to the 4 year integrated service and financial planning process.

3. Decisions, recommendations and any options

3.1 The Board is recommended to approve the direction of travel for adult care services set out in this report and note this will inform the 4 year integrated service and financial planning strategy for adult care services.

4. Relevant information

4.1 The whole City has a part to play in enabling people with care and support needs to live independent and safe lives and to enjoy the same opportunities as other people in the City. Adult Social Care is one partner in delivering this objective but can only achieve this vision in partnership with the rest of the Council, and wider partnerships including our neighbourhoods and communities, the Health service, the Police and our independent and voluntary sector providers.

4.2 Within this context of partnership the report sets out proposals for the future delivery of adult social care services in Brighton & Hove over the period 2016 – 2020. These proposals have been developed within the context of some key drivers for change which are considered in the following paragraphs (4.3 to 4.7).

4.3 The Care Act provides the statutory framework through which the Council must operate in meeting the care and support needs of adults and carers in the city. The Care Act is centred on the personalisation of social care, giving people as much choice and control as possible and establishes clear duties regarding wellbeing, prevention, co-operation between agencies, information and advice, safeguarding, carers rights, assessment and the provision of a diverse high quality social care market place. The legislation provides a positive statutory framework which supports our local aspirations but also sets out the statutory boundaries within which we must operate.

4.4 The financial context over the next 4 years is extremely challenging. Adult social care has already delivered £16 m savings over the previous 5 years. Further savings of £7.14 million were agreed for 2015/16 as part of the Councils budget setting. Over the next 4 years we are currently anticipating delivering a further saving of £21.9m as
part of the 4 year integrated service and financial planning process to support the Council to reduce the budget gap.

4.5 The Better Care programme provides an opportunity to help local people stay healthy and well, one element of this will involve improved co-ordination and integration of services across the health and social care sector. The Board will be aware of this programme and its progress through previous reports it has received.

4.6 Alongside increasing financial challenges and statutory duties care services will also need to respond to the potential for increased demand alongside the increasing complexity in people’s care needs.

4.7 A skilled workforce will be essential to the delivery of good quality care services in the coming years. Our current analysis indicates that we have an aging workforce in the sector with a disproportionate number of staff aged 55 years and over, there is high turnover of staff, many staff are low paid and there are also recruitment and retention issues in relation to professional staff. We are currently developing a workforce strategy that will cover the period 2016-20 in order that a skilled and stable work force is in place. This will take full account of the Ethical Care Charter in line with the outcome of the Health and Well Being boards discussions at its previous meeting.

4.8 Given the context outlined above the key challenges for adult care over the coming years are to deliver good outcomes for local people, achieve financial balance and meet our new extensive statutory duties. Our vision for meeting these challenges is visually represented at appendix 1 as a journey and is constructed around 4 key elements outlined below.

a. **Signposting**: The provision of accessible information and advice to enable people to look after themselves and each other, and get the right help at the right time as their needs change. Good quality information and advice will be available to all to help people plan for the future, reduce the need for care services and where possible maintain independence.

b. **Stronger communities**: Help build support networks where people live by working in partnership with local health and wellbeing services. This is rooted in the recognition that we are all inter-dependent and we need to build supportive relationships and resilient communities. We will expect to share
responsibility with individuals, families and communities to maintain their health and independence.

c. **Getting people on the right track:** Preventative services that help people stay independent for longer, and support them to recover back to good health after illness. These services will be joined up with and delivered with our partners.

d. **Citizens will be in control of their own care:** When people do need some extra care and support, services will be personalised, and more joined-up around individual needs. Personal budgets and direct payments are central to this approach.

4.9 All of these 4 key elements are already in place to some degree, over the coming years there is an opportunity to develop these services further, improve co-ordination and ensure maximum impact. This can achieve better outcomes for people, promoting their independence and well being, ensure adult social care meets its statutory duties and reduce or delay the demand for care and support funded by adult social care services through its community care budget or in house provision. This is a critical factor in adult social care achieving financial balance as the community care budget is by far the biggest element of adult social care expenditure. Achieving a £21.9 million reduction in expenditure will inevitably require reductions in community care budget expenditure. It is acknowledged that delivering this vision is complex and challenging, it will require some difficult decisions and the implementation will require excellent partnership working and timely delivery plans. However there are also real opportunities for progress through programmes such as Better Care, Community Collaboration, City Neighbourhoods and Customer First in a Digital Age.

4.10 Personalisation is at the heart of the vision outlined above. This includes engaging with local people in service design and development, working with people to assess their individual needs and design support plans, ensuring all eligible service users have a personal budget and people are supported to receive this as a direct payment, developing a care market that can respond creatively to people’s needs and aspirations and supporting people to use direct payments creatively and collectively within their communities. Delivering this vision is wholly aligned to our duties under the Care Act.
4.11 In responding to the changes ahead of us, we will always consider the needs and preferences of the individual, but we will also have to balance this against the effective and efficient use of resources. We must ensure that we have sufficient resources to meet the needs of all people who are assessed as eligible for social care support and we must focus resources on support that prevents delays and reduces the need for care and support.

4.12 Given the context and broad vision described above this report seeks to outline the anticipated direction of travel in relation to the existing provision of adult social care within the Council, covering Commissioning, Assessment and Provider services over the coming 4 years.

4.13 With regard to the commissioning of services it is anticipated that over this period:
   a. Services will be commissioned on a more co-ordinated and integrated basis across the Council and with other statutory partners, building on the solid foundation we currently have in place. Currently similar services can be commissioned separately by different directorates within the Council and colleagues in the Clinical Commissioning Group.
   b. Citizens and service users will be fully engaged throughout the commissioning process.
   c. A wider range of services that promote independence, are outcome focused and support a personalised approach will be in place.
   d. Safe mechanism will be in place so that individual support plans can be placed on line enabling accredited providers to respond creatively as to how they could best meet the personas requirements. People will also have the option to have flexible, personalised support, tailored to individual preferences without having to manage the responsibility of cash direct payments through new contractual specifications (known as Individual Service Funds).
   e. We will reduce and delay the demand for long term care in the community by commissioning services that support independence and personal control.
   f. We will further develop our understanding of a fair price for care services in partnership with the care sector.
   g. We will look to commission services in the city that keep people close to their family and communities when they require care and support.
4.14 With regard to assessment services it is anticipated that over this period:

a. The Councils in house assessment services will be increasingly focused on intervention and support for people with the most complex needs and those where the level of risk to the individual or others is assessed as high.

b. The in house workforce will be increasingly composed of staff with a professional qualification or social. The actual number of staff employed within the Council will have reduced.

c. By deploying mobile technology, for example tablet computers, our staff will be able to complete their assessments directly with people in the community, delivering a more personalised and efficient service.

d. Citizens will be supported to complete assessments of need, including an enhanced on line assessment offer. The support will be proportionate and appropriate and may come from a range of sources including family, community support and the voluntary sector.

e. Our approach will be an asset or strengths based one, focusing on what people can do and what they have to offer their community.

f. All people who are eligible for services will be offered a personal budget and the numbers of people choosing to purchase their own services through Direct Payments will increase significantly.

g. Integrated assessment across primary care and social care will be fully implemented through the Better Care Programme.

h. We will enable people to live with the risks that can be inherent in living independently whilst ensuring they are safeguarded from significant harm.

4.15 With regard to our in house service provision, which has relatively high unit costs, it is anticipated that over this period:

a. We will cease to provide services in house where good quality services can be provided more cost effectively by others, subject to appropriate consultation and approval.

b. In house services will support adult social care in meeting its statutory duties and provide services where other providers are not available.

c. We will review with people using services and their families whether their support plans could be provided in a more personalised and cost effective manner. As a consequence some existing in house provision could be re-provided.
We will disinvest in our buildings based care to promote more personalised care based in the community and individuals’ homes.

Our remaining in house provision is likely to be specialist and short term in nature and can evidence it is value for money.

Changes in the provision of in house services will require careful planning and implementation so that it keeps pace with the more personalised provision of care.

These proposals envisage a significant period of change across adult social care; people using services, their families, our partners, our staff and unions will all need to be fully engaged. It will be essential that effective partnerships are sustained and developed if these changes are to be achieved and positive outcomes secured for local people. Risk and contingency plans will need to be robust to ensure statutory duties are met.

Throughout the process of change set out in this document we will continue to reference best practice, benchmark and work with other Councils who will be subject to similar drivers for change.

### 5. Important considerations and implications

**5.1 Legal**

Specific reference is made in the body of this report to the Council’s (and statutory partners) duties under the Care Act 2014 and the proposed approach in this report is underpinned by those duties. Implementation of the proposed direction of travel must ensure ongoing adherence to statutory requirements in addition to the duty to the public purse, appropriate consultation involving affected and interested parties and compliance with the Human Rights Act 1998.

*Sandra O’Brien Senior Lawyer 24 September 2015.*

**5.2 Finance**

The direction of travel and proposed approaches set out in this report will be reflected in the 4 year integrated service and financial plans. It is anticipated that savings of £21.9m can be achieved over the 4 year period but there are significant risks attached. There are significant challenges in 2015/16 as a result of unachieved savings from previous years although mitigating actions have been put in place. Detailed savings plans for 2016/17 are being developed alongside the longer term service plans. Initial 4 year service and
financial plans will be considered by Policy & Resources Committee on 3 December 2015

*Finance Officer consulted: Anne Silley*  28/09/15

5.3 **Equalities**
The proposals in this paper will have implications for people using social care services and their families, our staff and our wider partners. The broad intention is to ensure that adult social care is able to support good outcomes for all local people, meet all its statutory duties and achieve financial balance over a 4 year period. More detailed proposals will feature in the integrated service and financial planning process and through service redesign plans and will be subject to equalities impact assessments in line with Council policy. The proposals at this stage remain a broad direction of travel.

4.4 **Sustainability**
The paper is intended to support the delivery of a sustainable adult social care service that can meet its statutory duties, deliver positive outcomes for local people and maintain financial balance. More detailed proposals will consider and address any specific sustainability implications as they are developed. Consider and address any sustainability implications.

- **Health, social care, children’s services and public health**
The delivery of this programme will require partnership working with colleagues in the Council, e.g. housing, children’s services and public health and external partners in the NHS and the private and voluntary sector. Effective programmes that promote well-being and independence, provide timely preventive interventions and engage with local communities are essential if positive outcomes are to be delivered for local people and the pressure on adult care budgets alleviated. The report notes opportunities that are available through programmes such as Better Care, Community Collaboration, City Neighbourhoods and Customer First in a Digital Age.

6. **Supporting documents and information**
Our journey ahead...
Where will care and support services be in the next five years?

1. **Signposting**
   Information and advice to enable people to look after themselves and each other, and get the right help at the right time.

2. **Stronger communities**
   Help people to build support networks by working in partnership with local health & community services.

3. **Getting people on the right track**
   Preventative services that help people stay independent for longer, and support them to recover after illness.

4. **Citizens will be in control of their own care**
   When people do need extra care and support, services will be personalised, and more joined-up around individual needs.
Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. **Children and young people’s mental health and wellbeing**

   **Transformation Plan for Brighton and Hove**

1.1. This paper can be seen by the general public.

1.2 20\textsuperscript{th} October 2015

1.3 Author: Gill Brooks, Children and young people’s mental health and wellbeing commissioner, Brighton and Hove CCG  
gill.brooks1@nhs.net

2. **Summary**

2.1 Improving the mental health and wellbeing of children and young people in Brighton and Hove is a Clinical Commissioning Group (CCG) and Brighton and Hove City Council (BHCC) Children’s services priority. This has been identified following stakeholder feedback, new mental health access targets and national recommendations. Whilst there are fantastic services in pockets across the City, they are working in isolation and in a fragmented way, not necessarily together as a whole system. The services are often reactive rather than proactive and not always able to respond to need. Over the next 5 years, the CCG will continue to work with partners including children and young people, their parents and carers, to develop an integrated and whole system approach to change and improve the mental health and wellbeing services in the City.
2.2 The CCG, with Public Health is carrying out a Joint Strategic Needs Assessment on mental health and wellbeing including autism for 0-25 year olds. The JSNA will be available in December 2015 and will inform future commissioning decisions.

2.3 The CCG, Children’s Services and Public Health are also developing a Children’s Strategy which will be presented at The Health and Wellbeing Board in December 2015; mental health will be a key component of the strategy.

2.4 Nationally, there is a great deal of focus on children’s mental health services, recognising this is an area where improvements need to be made. Norman Lamb, Care Minister, led a taskforce of experts on Children’s Mental Health services, calling for a whole child and family approach, improving interventions and recovery, working with the voluntary sector and digital systems to break down barriers to develop a whole system service. The recommendations in Future in Mind: promoting, protecting and improving our children and young people’s mental health and wellbeing also include:

   a) A local Transformational Plan, and following completion will facilitate NHS England prioritising further investment in CCG areas that demonstrate robust action planning;

   b) A Joint Strategic Needs Assessment; and

   c) An annual ‘local offer’ outlining what the needs of the population are and what the CCG and BHCC are commissioning to address those needs.

2.5 Each CCG area was asked to produce a Transformation Plan and submit to NHS England by 16th October 2015. Early drafts produced in September 2015, of this Transformation Plan have been shared and supported by the Health and Wellbeing Board senior officer’s group. Following feedback from the draft submission from NHS England in late September a further draft was presented at the Health and Wellbeing Board pre meeting on 6th October 2015. At that time the CCG was still waiting for final feedback from NHS England prior to final submission to them on 16th October 2015 and therefore the Plan in these papers is still in draft at the time of submission of papers to the Health and Wellbeing Board.

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2.6 Given the conflicting timelines for submission of the final Plan, approval was given at the pre meeting on 6th October 2015. This enabled submission on 16th October 2015 to NHS England.

This paper is the draft submission of the Transformation Plan. Any amendments following final NHS England will be highlighted at the Health and Wellbeing Board meeting.

2.7 The principles of the Brighton and Hove Transformation Plan are:
   a) Involve children and young people;
   b) Foster resilience across the system;
   c) Prevent deterioration;
   d) Engage children and young people in their care;
   e) Reach out to where children and young people are;
   f) Care for the most vulnerable groups;
   g) Improve access;
   h) Intervene early;
   i) Provide the best start in life;
   j) Prepare for adulthood;
   k) Build capacity across the system;
   l) Collaborative and joint commissioning;
   m) Physical and mental health issues are addressed equally; and
   n) Ensure access to services in a crisis especially out of hours.

3. Decisions, recommendations and any options
   This paper is presented to the Health and Wellbeing Board for:
   a) Endorsing the final submission of the Children and young people's mental health and wellbeing Transformation Plan; and
   b) Endorse that this plan will be published on CCG and Local Authority websites in response to the national requirement to be more transparent.

4. Relevant information
   Background and context

4.1. Mental health issues generally begin before adulthood with half long-term mental health issues occurring by the age of 14 years. Improving mental health in early life will have physical health benefits as well as increase life expectancy and quality of life.

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ability to socialise and sustain employment and/ or education. Those young people who are not in education, employment or training (NEET) are more likely to suffer with mental health issues. Significant focus on improving the mental health of young people will reap long-term benefits associated with personal as well as health and social costs.

4.2. Mental health problems, in particular depression, are the largest contributor to the global burden of disease among young people. In Europe, the estimate is almost one in ten 18-years-olds suffers from depression and some risky behaviour that many young people engage in can contribute to health problems later in life.

4.3. UK data suggests that at any one time about 10% of all 5-16 year olds will be suffering from a clinically diagnosable mental health problem.

4.4. Locally we have specific needs around mental ill-health in Brighton and Hove. The population (0-19 year olds) of Brighton and Hove is 58,600 with an estimated 3,095 children (5-16 years) with a mental health disorder such as conduct disorders and 1,195 children (5-16 years) with emotional disorders. With regards to self-harm we have seen an increase of 40% from 2010 until 2013, with increased levels of risk and severity in presentation. There are significantly higher rates of hospital admissions for self-harm for young people in Brighton & Hove. In 2012/13 there were 281, 0-24 year olds admitted to hospital for self-harm.

*Future in Mind promoting, protecting and improving our children and young people’s mental health and wellbeing*

4.5. There needs to be a shift of balance in children and young people’s mental health and wellbeing services from reactive, towards prevention, promoting mental health and wellbeing, and early intervention, where children and young people can thrive. The

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3 http://www.rcpsych.ac.uk/pdf/Position%20Statement%20website.pdf
5 Quality Criteria for Young People friendly health services, DH, 2011
6 http://www.youngminds.org.uk/training_services/policy/mental_health_statistics
7 CAMHS Prevalence snapshot Brighton and Hove Public Health data 2012
8 http://fingertips.phe.org.uk/search/self%20harm#gid//pat/6/ati/102/page/0/par/E12000008/are/E060000
services should be based around family systems. To achieve this, there needs to be less fragmentation and more integration in a holistic way that takes account of the whole family experience and needs. These aims are reflected in the national strategy around healthcare and in some new, proposed models of care.

4.6. These desired outcomes echo those described in *Future in Mind* (full document can be found in 5.1), written as an open letter to children and young people as follows:

“...we want to help you acquire the resilience and skills you need when life throws up challenges. We want you to know what to do for yourself if you are troubled by emotions or problems with your mental health. That includes knowing when and how to ask for help and, when you do, to receive high quality care. We want services to be able to respond quickly, to offer support and, where necessary, treatment that we know works, to help you stay or get back on track.”

4.7. The recommendations in *Future in Mind* also include:

a) A local Transformational Plan, and following completion will facilitate NHS England prioritising further investment in CCG areas that demonstrate robust action planning;

b) A Joint Strategic Needs Assessment; and

c) An annual `local offer` outlining what the needs of the population are and what the CCG and BHCC are commissioning to address those needs.

**The Transformation Plan**

4.8. NHS England is now developing a major transformation programme to significantly re-shape the way services for children and young people are commissioned and delivered across all agencies over the next 5 years. This includes the development of robust local Transformation Plans that will be publically available.

4.9. The development of the local Transformation Plan for Brighton and Hove was led by the CCG and involved the whole system, including

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10 [http://origin.library.constantcontact.com/download/get/file/1102665899193-1598/five+year+forward+view.pdf](http://origin.library.constantcontact.com/download/get/file/1102665899193-1598/five+year+forward+view.pdf)

11 [http://www.ucl.ac.uk/ebpu/docs/publication_files/New_THRIVE](http://www.ucl.ac.uk/ebpu/docs/publication_files/New_THRIVE)

children, young people and their families. It is essential that The
Plan also has the support of the Health and Wellbeing Board.

4.10. Each area has been asked to produce a Transformation Plan and
submit to NHS England by 16th October 2015. Early drafts
produced in September 2015, of this Transformation Plan have been
shared and supported by the Chair of the Health and Wellbeing
Board and the senior officer’s group. This paper provides an
opportunity for the Health and Wellbeing Board members to
endorse the Transformation Plan submission.

4.11. Over the next 5 years, the CCG will continue to work with partners
including children and young people, their parents and carers, to
develop an integrated and whole system approach to change and
improve the mental health and wellbeing services in the City. The
vision and outcomes we aim to achieve our outlined below:

   a) Build your resilience, promoting good mental health and
      intervening as early as possible to support you, including in
      Primary Care, schools and colleges and Youth settings;

   b) Develop a service that responds to your needs, including in a
      crisis and out of hours environment or situation;

   c) Provide integrated and clear pathways for you, across the
      whole system as well as all ages where possible such as the
      development of an all ages Wellbeing Service and Community
      Eating Disorder Service. Address the issue around transition
      from children to adult services through an all age pathway or
      the development of a youth service (how can CAMHS `hold on` to
      young people longer and how can adult services accept
      young people sooner);

   d) There will be particular emphasis on the most vulnerable
      children and young people such as Children in Care, Youth
      Offending Learning Disability, Neuro-development and
      Autism, as well as homeless;

   e) Ensure our workforce has the right experience, skills and
      competencies to support you, a workforce that feels part of the
      change and commits to the long term change required, and
      uses evidence-based interventions, pathways and outcomes
      tools to treat you;
f) Be more transparent about our commissioning arrangements ensuring strategic commissioning decisions are based on your feedback and involvement and the needs of Brighton and Hove and work with our providers; and

g) To ensure they can deliver improved outcomes.

4.12. In 2015/16, the Transformation Plan funds will be allocated as follows (see table one below). Full details can be found in Section 10 of The Plan.

<table>
<thead>
<tr>
<th>Service development preparation</th>
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<tbody>
<tr>
<td>Innovative digital communications</td>
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<tr>
<td>Sustaining E-Motion</td>
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<tr>
<td>Further development of E-Motion</td>
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<tr>
<td>Preparation for CYP IAPT readiness (Assistant Psychologist and project manager)</td>
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<tr>
<td>Extending the PMHW/ offer to schools</td>
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<tr>
<td>CAMHS/ Schools Link training</td>
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<tr>
<td>Evaluation &amp; Research</td>
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<tr>
<td>Extending outreach counselling in Youth Service settings</td>
</tr>
<tr>
<td>Development of Primary Care &amp; Schools/ Colleges</td>
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<tr>
<td>Health promotion post</td>
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<tr>
<td>Address capacity in the system and system readiness</td>
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<tr>
<td>Project management and clinical expertise resource</td>
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Table one: Transformation Fund cost allocation in 2015/16

4.13. From 2016/17 onwards the Transformation Plan funds will be allocated as follows (see table two below). Full details can be found in section 11 of The Plan.
Innovative digital communications
Sustaining E-Motion
Developing E-Motion further
Investing in crisis and out of hours care
Investing in vulnerable groups (Children in Care)
Continuing with preparation for CYP IAPT readiness (Assistant Psychologist)
Extending TAPA
Continuing to extend the PMHW/ offer to schools
Continuing to extend outreach counselling in Youth Service settings

Table Two: Transformation Plan Funding summary 2016/17 onwards

4.14. The development of the Transformation Plan has involved the whole system and has a clear governance structure in place (see figure one below).

4.15. The Transformation Plan will become embedded in the CCG commissioning and strategic intentions and mainstream planning and assurance processes.

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**Figure One**
5. **Important considerations and implications**

**Legal**

5.1 No legal implications at this time.

**Finance**

5.2 The Chancellor’s autumn statement (December 2014) and Budget (March 2015) announcements of additional money to transform mental health services enable local areas to make good progress on these areas. It is unknown at this time how much money may be available to Brighton and Hove. Nationally money is available as follows:

a) Total £1.25 billion every year for the next 5 years (£15m for perinatal mental health and the rest for children and young people’s mental health services); and

b) £30m each year for the next 5 years for eating disorder and self-harm services.

5.3 To support the transformational change, Brighton and Hove CCG have been allocated the following funds (Table Three below based on population size):

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2016/17</th>
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<tr>
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*Funds being made available to the CCG once the Transformation Plan has been approved by NHS England

**Equalities**

5.4 An Equality Impact Assessment will be carried out as part of the component parts of the Transformation Plan.

**Sustainability**

5.5 A Sustainability Assessment will be completed as part of the component parts of the Transformation Plan.

**Health, social care, children’s services and public health**

5.6 The CCG will work with Children’s Services, Public Health and Children’s Social Care as well as other stakeholders to develop the Transformation Plan.
6  Supporting documents and information

6.1 *Future in Mind: promoting, protecting and improving our children and young people’s mental health and wellbeing* (March 2015) is a report following the national taskforce consultation on children and young people’s mental health led by MP Norman Lamb. (See appendix).

6.2 Brighton and Hove schools have stated that their pupils show an increase in mental health and wellbeing issues and they feel they need more specialist help to support them. In response Public Health and Children’s Services, working in partnership, are proposing a new way of working; a whole school approach to mental health and wellbeing, by establishing a 12 month pilot in 3 secondary schools.

6.3 If the model is successful the aim would be to roll out successful elements to all schools across the City. The aim is to promote, protect and improve children and young people’s emotional health and wellbeing, with immediate access to specialist mental health support as well as building resilience. The detailed proposal can be found in the appendix.

6.4 The CCG, Children’s Services and Public Health have also been successful in a national bid to pilot CAMHS and school links and training that will complement the local pilot. The full details of the bid can be found in the appendix.

Annex A - Brighton and Hove Children and Young People’s Mental Health and Wellbeing Transformation Plan

Appendix Two – Project Plan

Annex 1 - Summary

Annex 2 - Checklist

Annex 3 - Tracker
Brighton and Hove CCG
Children and Young People’s Mental Health and Wellbeing
Transformation Plan
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1. **Introduction**

1.1 The publication of *Future in Mind - promoting, protecting and improving our children and young people’s mental health and wellbeing* \(^1\) heralded a call to transform the services offered to children and young people with mental health and wellbeing issues through the development of a local transformation Plan. To support this change Brighton and Hove Clinical Commissioning Group (CCG) has been allocated the following funds (see table one below):

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Table One: B&H CCG Allocation of funds  
*Funds being made available to the CCG once The Transformation Plan has been approved

1.2 Improving the mental health and wellbeing of children and young people in Brighton and Hove is the CCG and Brighton and Hove City Council (BHCC) Children’s services and Public Health priority. Whilst there are fantastic services in pockets across the City, they are working in isolation and in a fragmented way, not necessarily together as a whole system. The services are often reactive rather than proactive and not always able to respond to your need.

1.3 There needs to be a shift of balance in children and young people’s mental health and wellbeing services from reactive, towards prevention, promoting mental health and wellbeing, and early intervention, where you can thrive. The focus should not just be on the absence of mental health issues but positive functioning\(^2\). The services should be based around your family systems shaped and evaluated by our children/ young people and parents/ carers. To achieve this, there needs to be less fragmentation and more integration in a holistic way that takes account of the whole family experience and needs. These aims are reflected in the national strategy around healthcare\(^3\) and in some new, proposed models of care.\(^4\)

1.4 We will continue to commission for value\(^5\) and reduce variation using National Child and Mental Health Intelligence Network to improve quality outcomes.

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\(^3\) http://origin.library.constantcontact.com/download/get/file/1102665899193-1598/five+year+forward+view.pdf  
\(^4\) http://www.ucl.ac.uk/ebpu/docs/publication_files/New_THRIVE  
\(^5\) http://www.chimat.org.uk/camhs
1.5 These desired outcomes echo those described in *Future in Mind*, written as an open letter to children and young people as follows:

“…we want to help you acquire the resilience and skills you need when life throws up challenges. We want you to know what to do for yourself if you are troubled by emotions or problems with your mental health. That includes knowing when and how to ask for help and, when you do, to receive high quality care. We want services to be able to respond quickly, to offer support and, where necessary, treatment that we know works, to help you stay or get back on track.”

1.6 This vision is reflected in *The Five Year forward View* with its focus on prevention, reducing inequalities, empowering patients, engaging and involving and ensuring new models of care are co-created with children and young people as well as strong clinical leadership.

1.7 Brighton and Hove CCG will ensure there is a balance between a narrow, targeted approach and a too broad a focus in our transformation, by establishing our priorities based on need that generates energy and commitment for the change required. The principles of the Plan are:

a) **Involve** children and young people and parents and carers in the future co-design of services and ensure personalisation is a key element of any future models;

b) **Foster resilience** across the system so that when you need help and support, it is easy to find and access and you know what to do when things escalate;

c) **Prevent deterioration and respond to need**, and ensure people who work with you know how to spot signs and have clear pathways;

d) **Engage** children and young people in their care by allowing you to set your own goals, review plans and progress including Children and Young People’s Improving Access Psychology Therapies (CYP IAPT), Personal Health Budgets and Person Centred Outcomes Measures;

e) **Reach out** to where you are within the community not just receiving support in clinical areas. Adopt the principle that *no door is the wrong door*;

f) **Care for the most vulnerable groups** to access the support they need so that they can feel safe, such as Children in Care, Care Leavers, those at risk of or in contact with the Youth Justice System, neuro-behavioural issues, learning disability and those who are homeless or have suffered abuse. To achieve this we will need to work in partnership with other agencies both locally (Public Health and Children’s Services) as well as nationally with NHS England Health and Justice Commissioners;

g) **Improve access** with clear pathways, referral criteria, information on services and expected outcomes. Re-design so that services are more

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visible with no artificial barriers in the system such as the Children and Adolescent Mental Health Services (CAMHS) tier approach\(^8\);

h) **Intervene early** by continuing to make links with Early Help Hub\(^9\), Stronger Families programme\(^10\) so that children get to the right place, at the right time and receive the right support;

i) Provide the **best start in life** supporting families from pre-birth and a young age, further developing perinatal mental health and making links with Early Years services;

j) **Prepare for adulthood** by ensuring young people transition well at different stages of their life, especially at 18 years old by commissioning all ages/family approach services wherever appropriate;

k) **Build capacity across the system** to deliver evidence-based outcomes and focussed pathways by developing CYP IAPT and a specialist eating disorder service;

l) **Collaborative and joint commissioning** with Children’s Services and Public Health as well as our Schools and Colleges;

m) **Physical and mental health** issues are addressed equally; and

n) Ensure access to responsive services in a **crisis especially out of hours**, linking to Brighton and Hove’s Crisis Care Concordat and ensuring that no-one under 18 years old will be detained in custody under Section 136 of the Mental Health Act\(^11\).

2. **National context**

2.1 Mental health issues generally begin before adulthood with half long-term mental health issues occurring by the age of 14 years\(^12\). In 2004, the prevalence of children’s mental health\(^13\) showed a stark picture where 9.6%/ 850,000 children and young people aged 5-16 years and 7.7%/ 340,000 and 11.5%/ 510,000 aged 11-16 years, have a mental health disorder, effectively meaning that 3 out of a class of 30 schoolchildren will suffer from a diagnosable mental health disorder\(^14\).

2.2 Improving mental health in early life will have physical health benefits as well as increase life expectancy and quality of life, ability to socialise and sustain employment and/or education\(^15\). Those young people who are `not in education, employment or training` (NEET) are more likely to suffer with mental health issues.\(^16\) Significant focus on improving the mental health of young people will reap long-term benefits associated with personal as well as health and social costs.

\(^8\) DH NSFC. Child and Adolescent Mental Health, 2010

\(^9\) http://www.brighton-hove.gov.uk/content/children-and-education/childrens-services/early-help


\(^13\) Green H et al 2005 Mental health of children and young people in Great Britain


\(^15\) http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf

\(^16\) http://www.cypnow.co.uk/cyp/news/1152077/social-isolation-and-neet-status-raise-mental-health-risk-for-young-people
2.3 Mental health problems, in particular depression, are the largest contributor to the global burden of disease among young people. In Europe, the estimate is almost one in ten 18-years-olds suffers from depression\(^\text{17}\) and some risky behaviour that many young people engage in can contribute to health problems later in life.

2.4 UK data suggests that at any one time about 10% of all 5-16 year olds will be suffering from a clinically diagnosable mental health problem\(^\text{18}\).

2.5 It is recognised that mental and physical health are interlinked and both are integral to wellbeing\(^\text{19}\) with those with mental health problems at greater risk of physical health problems. Parity of esteem must be at the heart of decision making and improvements in children and young people’s mental health and wellbeing.

2.6 The Chief Medical Officers (CMO) Annual Report focused entirely on the health of children and young people (2013)\(^\text{20}\) “Our children deserve better: prevention pays”. It promotes a life course approach: *What happens early in life affects health and wellbeing in later life*. This is particularly the case at times of rapid brain growth in the early years (i.e. from birth to 2 years) and adolescence. This is also highlighted as crucial in the recent Public Health England Report on Improving School Readiness, creating a better start for London\(^\text{21}\). This is an indicator of how prepared a child is to succeed in school cognitively, socially and emotionally. School readiness at age 5 has a strong impact on future educational attainment and life chances.

2.7 There is good evidence\(^\text{22,23}\) available that provides us with a platform to build sustained improved mental health and wellbeing outcomes for our children and young people.

3. **Local context**

3.1 The total population of Brighton & Hove from the 2011 Census is 273,369. The population 0-17 years old is 49,947 which are 18.3%.

Approximately 19.6% of the local authority’s children are living in poverty\(^\text{24}\). The proportion of children entitled to free school meals in primary schools is 15.5% (national actual percentage is 18.1%)\(^\text{25}\). The proportion of children entitled to free school meals in secondary schools is 14.6% (national actual percentage is 15.1)\(^\text{26}\).

\(^{17}\) Quality Criteria for Young People friendly health services, DH, 2011  
^{18}\) http://www.youngminds.org.uk/training_services/policy/mental_health_statistics  
^{19}\) HM Government (2011) *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages*. London, DoH  
^{22}\) DoH 2004, NSF Children and Young People and Maternity Services  
^{23}\) National Advisory Council (2011) *Making children’s mental health everyone’s responsibility*  
^{24}\) Q3 2013-14 B&H Children’s Services DMT Key Performance Indicator Report  
^{25}\) School Census Data B&H Jan 2014 (includes Academies)  
^{26}\) School Census Data B&H Jan 2014 (includes Academies)
Children and young people from minority ethnic groups account for 21% of all children living in the area, compared with 21.5% in the country as a whole.

3.2 Locally we have specific needs around mental ill-health in Brighton and Hove. The population (0-19 year olds) of Brighton and Hove is 58,600 with an estimated 3,095 children (5-16 years) with a mental health disorder such as conduct disorders and 1,195 children (5-16 years) with emotional disorders. With regards to self-harm we have seen an increase of 40% from 2010 until 2013, with increased levels of risk and severity in presentation. There are significantly higher rates of hospital admissions for self-harm for young people in Brighton & Hove. In 2012/13 there were 281, 0-24 year olds admitted to hospital for self-harm.

3.3 Sussex wide figures - Sussex Partnership NHS Foundation Trust (SPFT) received 2,912 referrals for anxiety and depression among children aged between five and 17 between April 2014 and the end of March compared to 2,439 the year before. Most referrals, 1,264, were for depression, and included 68 children between five and 10 years old.

3.4 The local picture in Brighton and Hove reflects what is happening nationally and across Sussex, such as increased demand for specialist services including tier 4 inpatient beds (NHS England commissioned services). In Chalkhill (local tier 4 facility), there were 68 separate admissions between April 2010 and March 2015 and 50 unique patients. One in five (20%) admissions to Chalkhill over this five year period were for children and young people with eating disorders. The second largest group were those diagnosed with depressive episodes (14%), followed by bipolar affective disorder (11%) and other anxiety disorders (8%). There is one patient aged between 18 and 25 years in an inpatient bed, within the adult inpatient services commissioned by the CCG.

3.5 In Brighton and Hove we have significantly more Children in Care (previously known as Looked After Children) as the 13th highest Local Authority, as well as under 18 year olds with alcohol-related and substance misuse-related, eating disorder and self-harm-related admissions greater than the national average. The majority of secondary school pupils are often or sometimes happy, 92% of 15-16 year olds, but being anxious rises from 45% in 11-12 to 57% in 15-16 year olds. Groups less likely to say they are often happy include: girls, carers, Lesbian, gay, bisexual and Unsure (LGBU) pupils, those who receive extra help, have truanted, been bullied, or tried alcohol or drugs.

3.6 The CCG, with Public Health is carrying out a Joint Strategic Needs Assessment (JSNA) on mental health and wellbeing including autism for 0-25 year olds,

27 2011 Census
28 CAMHS Prevalence snapshot Brighton and Hove Public Health data 2012
29 http://fingertips.phe.org.uk/search/self%20harm#gid//pat/6/ati/102/page/0/par/E12000008/are/E06000036
30 Activity data provided by Sussex Partnership Foundation Trust
31 South East Coast Child Health profile, 2013
alongside a whole system review. The JSNA will be available in autumn 2015 and will inform future commissioning decisions.

3.7 Scope and methodology of JSNA
3.7.1 To identify the mental health and wellbeing needs of children and young people in Brighton and Hove. It is also to review this in light of existing provision within the City and evidence on the most effective ways of addressing the identified needs, and then to recommend priorities and actions for commissioners to consider. Key questions were:
   a) What are the characteristics of children and young people aged 0-25 years in Brighton and Hove?
   b) What are the risk factors, whom are affected, and what are the inequalities and protective factors affecting the mental health and emotional wellbeing of children and young people (0-25 years)?
   c) What are the mental health, emotional and behavioural issues and needs requiring commissioned services?
   d) What services are currently provided to meet those needs? What are the criteria/ what is the eligibility of those services?
   e) What are the outcomes of those services?
   f) How easy is it to access those services? How would children/families and young people prefer to access those services?
   g) How well are services currently provided to meet those needs? What gaps/barriers, if any, need to be addressed?

3.8 Emerging themes from the JSNA are:
3.8.1 The JSNA will be completed and published in November 2015 with a set of findings and recommendations that will inform The Transformation Plan. A Summary JSNA of Brighton and Hove can be found at this link32. Following submission to The Health and Wellbeing Board for approval we will then publish the JSNA online and ensure this is available. The `voice` section of the JSNA gathered the views of children, young people, parents/carer and statutory and non-statutory sector staff in relation to unmet needs in local children’s mental health and wellbeing services. Emerging themes from completed interviews and surveys with 72 local stakeholders are summarised below:
   a) The Tier 3 clinic based structure is not young person friendly;
   b) GPs find there is a lack of clarity around eligibility criteria and referral systems for Tiers 2 and 3, leading to referrals bouncing back;
   c) Tier 3 does not have the capacity to meet current demand, leading to waits for assessments. The service model seems unable to meet the needs of complex cases;
   d) There’s a lack of joint working across services, particularly between GPs and CAMHS and GPs and schools;
   e) Tier 2 lacks capacity - there’s not enough early intervention/primary mental health work, family therapy, outreach work in schools;

f) Tier 3 lacks out of hours/crisis service provision, community eating disorders service, mental health liaison service and dedicated CAMHS team for children in care; and
g) Transition services need improving with an extension up to 25 years.

3.8.2 Some of the commissioning priorities identified by you and acted upon so far include:
a) More early intervention and prevention work, with more investment in Tier 2 Community CAMHS;
b) Development of a mental health liaison service with the Royal Alex Hospital;
c) Improvement in CAMHS communications, pathways and partnership working between tiers, with more accessible community based services.

3.8.3 Commissioning priorities have also been identified through focus groups with Children and young people (approximately 60) and parents (approximately 20).

3.8.4 You felt your ideal service would be:
a) Welcoming, with friendly staff that listen;
b) Located locally, feeling safe and comfortable;
c) Offer a range of treatment options, including activities and groups as well as 1-2-1 work; and
d) Accessible and flexible in terms of availability and choice of appointments, offering outreach and out of hours support by phone, email and other means.

3.8.5 Parents wanted CAMHS to have:
a) More resources in terms of staff and available appointments;
b) Clearer signposting and assessment/referral process;
c) More flexible and accessible services including ability to change pathways and professionals, out of hours support, outreach work, non-clinic based appointments and follow up of people missing appointments; and
d) More early help.

4. Current commissioning intentions of CCG in 2015/16

4.1 The local context has informed our current commissioning intentions and future strategy through needs-based commissioning. In 2015/16 the CCG has invested in and is developing the following areas:
a) Therapeutic Service for children who have suffered sexual assault (commenced January 2015);
b) Improved complex trauma pathway (aged 14 years upwards) to be developed in 2015/16 (implementation expected in April 2016);
c) Mental Health Liaison Team at the Royal Alex Children’s Hospital (expected implementation November 2015);
d) Extension of the Perinatal Mental Health Service at the local Acute Trust (expected implementation September 2015);
e) Development and monitoring of the all ages Crisis Care Concordat Action Plan;
f) Development and monitoring of the local all ages Happiness (Mental Health) Strategy including Innovation Funds available for grassroots wellbeing projects;
g) Development of a Service Development Improvement Plan to enable Sussex Partnership Foundation Trust to achieve the access target for Early Intervention Psychosis by April 2016;
h) Development of a pathway for Medically Unexplained Physical Symptoms for children and adults in 2015/16;
i) Currently undertaking a Joint Strategic Needs Assessment for children and young people’s mental health and wellbeing for 0-25 years (expected published date November 2015); and
j) A whole system review of children and young people’s mental health and wellbeing services, of which findings have informed the Transformation Plan.

5. **Local and regional relevant commissioning strategies and services**

5.1 **Specialist Commissioning**

5.1.1 We are committed to working with Specialist commissioners and regularly attend forums as active members and partners, such as South East Strategic Clinical Network and NHS England and Sussex CCGs Commissioning meetings to agree a planned way forward in response for upcoming guidance on specialist commissioning. We are fortunate in Sussex to have access to a tier four inpatient bed facility, Chalkhill in Haywards Heath. This provides us with an opportunity to work with specialist commissioners on our collaborative commissioning strategy and our emerging eating disorder pathway.

5.2 **Sussex CCGs**

5.2.1 Commissioners of children and young people’s mental health and wellbeing across Sussex have a strong, collaborative working relationship. We have organised a Sussex-wide transformational workshop (April 2015) with commissioners from across Sussex, including Children’s Services and Public Health and our common and largest provider, SPFT to explore common aspirations and goals for improving your mental health and wellbeing services over the next 5 years. Two of the key outcomes were the establishment of a clinically-led working group to develop a Sussex-wide community eating disorder service, and the willingness to develop a response to crisis and out of hours.

5.3 **Five year strategic commissioning priorities for Brighton and Hove CCG**

5.3.1 Brighton and Hove CCG five year strategic commissioning priorities include:

a) Reduce Inequalities – focus on prevention and early detection and include areas identified in the Joint Strategic Needs Assessment and the Annual Public Health Report;
b) Involving Patients and the Public – the CCG should have a greater emphasis on self-management and empowering patients. We should include patients and the public in all of the decisions we make including the difficult decisions about resource and local services;
c) Integration – integration should be at the heart of our commissioning agenda – services should be integrated to ensure efficiency and improve wellbeing; and
d) Quality and efficiency – the CCG should always commission the most cost effective intervention delivered in the most appropriate setting. Our focus should
remain on achieving financial balance but equally on improving the quality of local services.

5.4 **Health and Wellbeing Joint Strategy and Commissioning Strategy: Health and Wellbeing of Children, Young People and Families**

5.4.1 The CCG, BHCC and Public Health are currently writing a Joint Strategy for Health and Wellbeing. One of the areas of focus is children, and local commissioners from the CCG and BHCC are developing a Commissioning Strategy: Health and Wellbeing of Children, Young People and Families, which will be submitted to the Health and Wellbeing Board in December 2015.

5.4.2 In essence the Strategy states that we want all of our children and young people to have the best possible start in life, so that they grow up happy, healthy and safe with the opportunity to fulfil their own potential. Collectively we aspire to deliver child centred services. UNICEF has developed an international framework called the Child Friendly Cities Initiative which notes that “the well-being of children is the ultimate indicator of a healthy habitat, a democratic society and of good governance.” Our intention is that Brighton and Hove can demonstrate that we are a child friendly city.

5.4.3 This strategy supports the wider health and wellbeing strategy for the City and is endorsed by the City’s Health & Wellbeing Board. Through the development of joint commissioning plans, joint commissioning, and pooled budgets where appropriate, it seeks to ensure that there is a balance of support across universal, early help and specialist services.

5.4.4 The strategy brings together multiple policies, reviews and strategies that all focus on improving children and young people’s outcomes including those associated with mental health and wellbeing. These include the Special Educational Needs and Disabilities (SEND) Review where families still felt services across education, health and care were too fragmented and signposted a need for better shared planning and more integrated working around the needs of their children.

5.5 **Better Care programme**

5.5.1 The Better Care Fund was announced by the Government in 2013 to ensure closer integration of health and social care services. The fund provides an opportunity to transform care for the most vulnerable people of Brighton and Hove through increased integration. For Brighton and Hove that focus has been on adult needs, however children’s services can learn from this programme of change.

5.5.2 Our vision for our frail and vulnerable population, including homeless, is to help them stay healthy and well by providing more pro-active preventative services that promote independence and enable people to fulfil their potential with a focus on personalisation. We want services to be responsive when needed (whatever day of the week) and to be provided in a seamless and co-ordinated way to keep people...
supported at home with coordinated community services, thereby minimising admissions to hospital. We see organisations working together in ways to offer this more flexible, person centred approach thereby achieving better outcomes for people and making the best use of available resources.

5.6 Primary Care Transformation

5.6.1 In line with the Better Care vision, the CCG has identified the need to support and strengthen GP practices across the City and reinforce the holistic family care approach. A programme of work (Locally Commissioned Service called LCS) is underway to support collaborative approaches amongst Practices in order to improve health outcomes for children and young people. This will involve closer working relationships across health, Children’s Services, Schools and Public Health and will be a key part of more integrated working in the future. This will address needs holistically and at an individual level (including Right Here’s young people-friendly audit), as well as actively referring children and young people to health improvement services improving social connections and resilience. This will include those with long term conditions who need emotional or mental health support as 12% of young people live with a long-term condition\(^{33}\). The key long term conditions in terms of prevalence are: asthma, diabetes, epilepsy, neurological and congenital conditions – creating complex health needs and disabilities.

5.6.2 Information sharing will be key to this joint working such as GPs having access to Education and Health Care Plans.

5.6.3 The CMO Annual Report\(^{34}\) identified the importance of health professionals, particularly in general practice, taking a whole family approach. Children and young people, who are not supported by appropriate networks and joined up thinking, especially where the GP is not closely involved in care, perform poorly against many of the domains of care. If GPs are bypassed there can be a problem when the child transitions to adult services and they are suddenly left without a clear support network or advocate.

5.6.4 Personal contact with a named care coordinator and/or case manager is an effective way of delivering integrated care. It must be recognised, however, that fully integrated care/ multidisciplinary working takes time to overcome silo working.\(^{35}\)

5.6.5 Children and young people with complex health and care needs, including those with life limited/ life threatened and palliative care needs and disabled children, are often dealing with a number of health issues and have frequent contact with multiple parts of the health system, and therefore rely on there being an integrated, multi-agency approach to support them.

\(^{33}\) Sawyer et al. 2007
\(^{35}\) Clinical and service integration: The route to improved outcomes. N Curry, C Ham (2010)
National evaluation of the DH’s Integrated Care Pilots 2012
5.6.6 Building on the good practice of the multi-disciplinary team working approaches for adults, within the Better Care programme, we would like to extend this to children and young people through identification of high risk children and young people using a risk stratification tool or similar and initiate multidisciplinary case conferences. The aim of risk profiling is to determine those patients who are at higher risk of their conditions deteriorating and at significant risk of emergency hospital admission. The target group would be children and young people with a range of additional needs, including complex needs, requiring integrated support from more than one practitioner.

5.6.7 A risk stratification tool enables primary care to identify individuals, the level of need and risk and complexity and place them in a risk group that can tailor need to appropriate care. This tool offers primary care the chance to improve the quality and experience of patient care of those children and young people who are relatively small in number but require a greater amount of resource.\(^\text{36}\) It should be used as an indicator of complex need as no risk stratification tool is completely accurate.

5.6.8 The impact of implementing the LCS is to improve children and young people’s care and outcomes. From a mental health perspective, the outcomes are based on national mental health guidance\(^\text{37}\) and recommendations as well as user and stakeholder feedback. Essential elements will include:
   a) An improved whole system of care;
   b) Shared decision-making;
   c) Greater provision of services focusing on prevention and promoting improved physical and mental health and wellbeing within community settings;
   d) Achievement of mental health and physical health access targets;
   e) Clear information about how to access all services and what to expect clear referral criteria and consistent standards, including a named accountable clinician;
   f) On-going workforce planning and appropriate skill mix;
   g) A whole system approach to provision, ensuring care is close to home where possible;
   h) Continue to develop clear care pathways, in particular Self-Harm, Eating Disorder, Perinatal, and Student Health with clarity on the role of Primary Care; and
   i) Improved transition between services, especially between children’s and adult services.

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\(^{36}\) Lewis G, 2005 Next steps for risk stratification in the NHS, NHS England
5.6.9 This will be achieved by ensuring:
   a) Actively supporting clusters to develop relationships with other professionals to provide care in a more coordinated and integrated way;
   b) Children and young people with complex needs to be easily identified on Practice lists using a risk stratification tool and then complex need registers will be developed within Practices/Clusters of Practices;
   c) Once identified, children and young people with complex needs will each have a care plan, developed and monitored by an appropriate multi-disciplinary team, that will include a GP;
   d) There should be frequent monitoring according to need, but at least an annual review; and
   e) Children and young people and their families will be empowered to self-manage through the development of structured care according to their needs.

5.7 Winterbourne action plan – Transforming Care
5.7.1 Since May 2011 there have been a number of requirements on the NHS and Local Authorities to review and improve the care for people with complex learning disabilities, and or autism, mental health issues and or challenging behaviours who were being treated in hospitals. Transforming Care published in December 2012 alongside a partnership-wide Concordat sets out a range of actions which would be needed to support the ambitions of:
   a) A dramatic reduction in hospital placements for this group of people and the closure of large hospitals; and
   b) That a new generation of inpatients does not take the place of people presently in hospital.

5.7.2 Sir Stephen Bubb made further recommendations on how this could be achieved.

5.7.3 Locally in Brighton and Hove there is a Winterbourne View Improvement Programme Steering Group and a local action plan that is all ages.


5.7.4 The CCG intends to work with all partners to review the current service provision for children and young people with learning disabilities and or autism, mental health issues and or challenging behaviours, how it links with the adult services and scope future improvements.

5.8 *Special Educational Needs and Disabilities (SEND)*

5.8.1 Following the Children and Families Act (2014)\textsuperscript{41} Local Authorities were obliged to support young people up to aged 25 years who have special educational needs and disabilities. This Act also strengthened the connection with health needs, especially with the development of Education and Health Care Plans. In Brighton and Hove a SEND review\textsuperscript{42} recommendations included the plan to develop an integrated and inclusive service delivery across education, health (including mental health) and care/ disability services with families at the centre bring all the learning support services together to be able to provide a more cohesive offer to schools and meet your needs.

5.9 *Adolescent Review*

5.9.1 The Local Authority are currently reviewing their adolescent services with the aim of creating a more joined up specialist offer targeted at those teenagers who are most vulnerable and most at risk of going into care. This group includes those who are; frequently missing, at risk of/victims of child sexual exploitation (CSE), committing anti-social behaviour or criminal offences or not engaging at school. This group will have some mental health and wellbeing needs.

5.10 *Youth Review*

5.10.1 BHCC are currently reviewing all youth service provision across the City ensuring there is a consistent and clear approach. Any strategic decisions regarding mental health and wellbeing services within youth settings will need to align with this review.

5.11 *Public Health Schools programme*

5.11.1 The Public Health Schools Programme takes a whole school community approach to health and wellbeing for the benefit of pupils, school staff and parents/carers. It is a universal preventative approach proportionate to the level of needs experienced by vulnerable or protected groups. It is offered to all state schools, academies and free schools. It will be rolled out to colleges in due course. There are 75 state schools in the city and to date 45 primary and secondary schools (including special needs schools) and the two academies have engaged in the programme. The Public Health School Team is engaging with the remaining 30 schools.


\textsuperscript{42} http://present.brighton-hove.gov.uk/Published/C00000874/M00005597/AI00044015/$20150126165031_007091_0028782_finaldraftSENDreviewfullreport.docxA.ps.pdf
5.11.2 Each school has a tailored Action Plan developed with the Public Health School Team. The Plans outline a series of initiatives and interventions to address key health and wellbeing issues identified by the schools. The promotion of emotional health and wellbeing is emerging as a key priority. Many schools are taking up the offer of Workplace Health to support the health and wellbeing of school staff as well as parents/carers.

5.11.3 For secondary schools actions are largely centred on improving young people’s emotional health and wellbeing with specific actions to implement a whole school approach to self-harm (in partnership with key agencies). For primary schools a number of actions are on improving emotional health and wellbeing, promoting a healthy weight, physical activity and promoting oral health. There are actions to help schools develop smoke-free environment policies and to promote stop smoking services with staff and parents.

5.12 Early Help Hub and Stronger Families Programme
5.12.1 In Brighton and Hove all agencies believe that early help supports the widespread recognition that it is better to identify and deal with problems early rather than respond when difficulties have become acute and demand action by services which often are less effective and more expensive. The Early Help Partnership Strategy (2013 – 2017) aims to intervene early on various needs including mental health and wellbeing of families in a coordinated response. sets out clearly what we plan to do, and how we intend to work, with an increasing emphasis on the value of Early Help.

5.13 Multi-agency Safeguarding Hub (MASH)
5.13.1 Brighton & Hove MASH launched on 1 September 2014. The team consists of a multi-agency co-located screening service with a team of Social Work Assessment staff. Input into this service is provided from Sussex Police, Education, Youth Offending, Early Help Hub and Health professionals. Staff in the MASH work as partners together to jointly assess and decide upon appropriate an appropriate course of action dependent upon a shared risk grading, regarding the level of need identified for a child and their family.

5.14 Local Safeguarding Children’s Board (LSCB)
5.14.1 The main role of the LSCB is to coordinate what is done locally to protect and promote the welfare of children and young people in Brighton & Hove and to monitor the effectiveness of those arrangements to ensure better outcomes for children and young people. The efficacy of Brighton & Hove LSCB relies upon its ability to champion the safeguarding agenda through exercising an independent voice. The purpose is to make sure that all children and young people in our City are protected from abuse and neglect. Children can only be safeguarded from harm if agencies work well together, follow procedures and guidance based on best practice and are well informed and trained. The LSCB is key to improving mental health and wellbeing of children and young people. This Transformation Plan has considered learning from serious Case reviews and Serious Incidents.
5.15 Health visitors and School Nurses
5.15.1 Health visitors lead an integrated, citywide Children’s Centre service and work in partnership with Social Workers and lead on actions for children using a directory of evidenced based interventions, including support for mental health and wellbeing. Information about all Children in Need is shared with Children’s Centres to ensure services are focussed on these families.

5.15.2 Health Visitors are the lead professional for children under 5. Children’s Centres also provide a wide range of universal and early help services including parenting programmes (Triple P and Protective Behaviours). There is a citywide Family Nurse Partnership for teenage parents.

5.16 The Virtual School
5.16.1 The virtual school monitors and supports children who are in care and their families/carers. Alongside educational attainment and attendance the virtual school also ensures there is recognition and support of pupils’ mental health and wellbeing needs.

5.17 The Health of Children in Care
5.17.1 The Children in Care (previously Looked After Children (LAC)) health team is a multidisciplinary team of experienced nurses and community paediatricians. The team coordinates and delivers health care across services and organisations wherever the child is placed in care. The roles of the nurse consultant and the consultant paediatrician are primarily clinical. The nurse consultant acts as the Designated Nurse for LAC and whilst the medical adviser/consultant paediatrician nominally has the role of Designated Doctor for LAC.

5.18 The Youth Offending Service (YOS)
5.18.1 The YOS has excellent links with social workers and health, with both professions being part of the integrated team. The City Council are scoping the possibility of implementing the SWIFT specialist family service model - a multi-professional specialist service offering a whole family approach.

5.18.2 We recognise that many of the young people in this service have mental health issues. In 2013/14 there were 84 First Time Entrants (FTEs) to the youth justice system, the target for 2014/15 is to reduce this to 70. We work with partners (YOS, Children’s Services, Police, Liaison and Diversion, NHS England Health and Justice Commissioning) to continue to strive to address those needs, engage young people with the support offered and ensure they are integrated into local, mainstream services once they return from custody suites and secure centres.

5.19 Substance misuse
5.19.1 Locally the City has a good alcohol and substance misuse service called ru-ok? The service provides advice and support for under-18s whose lives are affected by substance misuse. A snapshot in September 2014 showed that 22% open to the team were known to tier 2 or 3 CAMHS and a further 19% were known to a Specialist CAMHS nurse within the service.

5.19.2 Oasis Project is a substance misuse service for women and their families providing treatment, support, and/ or therapeutic interventions. The Project also runs a
Young Oasis crèche. In 2013/14, 66 children attended and 79% were on child protection plans.

6. **Current services (mental health and wellbeing)**

6.1 Brighton and Hove has a wide range of services currently available for children and young people needing mental health and wellbeing support. Please see Appendix one for an outline of:
   a) The service descriptions;
   b) The baseline data; and
   c) Declaration of current investment for all commissioners.

6.2 The CCG intends to publish this local offer on our website following NHS England and Health and Wellbeing Board for Brighton and Hove approval of The Transformation Plan.

7. **5 year plan – the transformation of children and young people’s mental health and wellbeing services**

7.1 The Transformation Plan and allocated funding will provide the building blocks for the long term, 5 year plan for transforming services. This section outlines this long term 5 year plan and vision for change.

7.2 Brighton and Hove CCG will continue to work with all partners including children, young people, their parents/ carers to develop an integrated and whole system approach to change to improve your mental health outcomes. The key areas of long term transformational change and proposed outcomes over the next five years (2015 – 2020) are outlined in the table two overleaf.
**Table Two: 5 year strategy areas and outcomes for Brighton and Hove CCG**

| 7.3 | We will work with you to develop a new model for children and young people’s mental health and wellbeing services in the City. This will eliminate the four tier framework\(^\text{43}\) that the system currently has and adopt a more holistic, person-centred approach. Figure one illustrates this vision. |

| a) | Build your resilience, promoting good mental health and intervening as early as possible to support you, including in Primary Care, schools and colleges and Youth settings; |
| b) | Develop a service that responds to your needs, including in a crisis and out of hours environment or situation; |
| c) | Provide integrated and clear pathways for you, across the whole system as well as all ages where possible such as the development of an all ages Wellbeing Service and Community Eating Disorder Service. Address the issue around transition from children to adult services through an all age pathway or the development of a youth service (how can CAMHS `hold on` to young people longer and how can adult services accept young people sooner); |
| d) | There will be particular emphasis on the most vulnerable children and young people such as Children in Care, Youth Offending Learning Disability, Neuro-development and Autism, as well as homeless; |
| e) | Ensure our workforce has the right experience, skills and competencies to support you, a workforce that feels part of the change and commits to the long term change required, and uses evidence-based interventions, pathways and outcomes tools to treat you; and |
| f) | Be more transparent about our commissioning arrangements ensuring strategic commissioning decisions are based on your feedback and involvement and the needs of Brighton and Hove and work with our providers |
| g) | To ensure they can deliver improved outcomes. |

\(^{43}\) DH NSFC. Child and Adolescent Mental Health, 2010
7.4 The proposed developments in the short term (2015/16) and longer term (2017 onwards) will affect all parts of the system including our specialist mental health provider – SPFT. We will continue to work with SPFT to develop a local, specialist service that meets your needs. A service that is responsive, flexible and welcoming, with clear pathways and criteria, that continues to develop and improve with your involvement. We will provide clarity for SPFT on what we want them to provide, and their role within the system-wide response to your needs. Investment in other parts of that system will provide them with the capacity to adapt change accordingly.

7.5 The CCG is also considering emerging themes from the JSNA and what you and your families/ carers have told us, in the development of the Plan and long term strategy, such as:

a) **Clinic-based models are not young-people friendly environments** by working with SPFT to review where appointments are offered to you and how the environment can be improved to be more welcoming;

b) **Lack of clarity on referral criteria and pathways** by ensuring that information is easily accessible for you and services work with referrers and you and your family to develop services that respond to your needs;

c) **Tier two and three capacity to respond to demand** by building additional capacity in the system that meets your need;

d) **Poor experience of CAMHS and accessibility** by developing services that are flexible enough in terms of choice of appointments, time, place and communications;

e) **Lack of joint working across Primary Care, CAMHS and Schools** by implementing the Primary Mental Health Workers in our schools and developing the Children and Young People’s Locally Commissioned Service in GP surgeries;
f) Lack of service response in crisis and out of hours by addressing the specific support required at these times, building on existing structures and working with you to design services that meet needs; and

g) Transition from children’s to adult services needs to be smoother by commissioning all ages pathways wherever appropriate or considering whether a Youth Service would support your needs at this critical time in your life.

7.6 The Brighton and Hove Transformation Plan covers the breadth of need and early identification, from prevention, early help, self-help and promoting good mental health to ensuring when you are in crisis or in need of specialist intervention (including in-patient care) we can fully support you.

7.7 The CCG recognises that some of the transformational change required will take longer to develop and implement and intends to carry out some of the change in the longer term (by 2020). In year one (2015/16) the CCG intends to put in place ‘building blocks’ towards the longer term transformational change required. In years two onwards (2016/17) children and young people’s mental health services will be more accessible, responsive and integrated across the whole system. The longer term plans are outlined below.

7.8 The development of an all ages/ family approach wellbeing service

This development addresses:
- Building resilience, promoting good mental health and intervening as early as possible in universal and targeted services
- Develop a service that responds to needs of individuals
- Integrated pathways across the whole system as well as all ages

7.8.1 The CCG will re-tender the adult wellbeing service in 2017 and intends to ensure the new service is all ages that will start to remove the tiered CAMHS four tier strategic framework44 with a one stop/ single access point service for your universal and targeted needs. The model will:
  a) Place the you and your family at the centre of care;
  b) You will be encouraged and supported to self-manage where appropriate;
  c) Develop a model that promotes early intervention, health promotion and link with Public Health programmes;
  d) Develop a Primary Mental Health response within GP surgeries, schools, colleges, youth services that incorporates children and young people’s Improving access to psychological therapies (CYP IAPT) principles;
  e) Develop complementary support available from the Voluntary sector through our psycho-social contracts;
  f) Reduce the demand on the specialist services (specialist community mental health services as well as inpatient services); and

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44 DH NSFC. Child and Adolescent Mental Health, 2010
g) Ensure you have sustainable outcomes with support through rehabilitation and recovery, exploring the Discovery College / Recovery College model, including the development of a peer support model and learning from the pilot that has started in Hastings, East Sussex.

7.9 A complex post-traumatic stress disorder pathway (14 years upwards)

7.9.1 Complex post-traumatic stress disorder (PTSD) is not a rare condition; however it often gets misdiagnosed due to lack of awareness and education. This can be costly both financially and in terms of basic human suffering. Young people may present with a poly-symptomatic mixture of dissociative symptoms and PTSD symptoms that may be embedded in a matrix of seemingly un-related symptoms or conditions, such as depression, panic attacks, substance misuse, somatoform disorders, and eating disorders. Young people with PTSD will often receive the wrong diagnosis: Schizophrenia, EUPD, Bipolar and neurological problems (seizures, pain and paralysis). Children can present with school refusal, conduct disorder, substance misuse and sexualised behaviour inappropriate for their age.

7.9.2 Preventing Suicide in England\(^{45}\) concludes that for high risk groups (such as "survivors of abuse or violence, including sexual abuse" [who] have been identified as a group at increased risk of suicide) a tailored approach to mental health care is necessary to reduce suicide risk.

7.9.3 The new pathway/network across the system including the voluntary sector will follow NICE guidance\(^{46}\) and will be outcome based that would:

a) Increase capacity in the range of treatment options available for you;

b) Partners will jointly develop a pathway for young people who have experience complex trauma that has:

i. Clear access points for you;

ii. Is able to accept referrals from the Sexual Assault Referral Centre (SARC);

iii. That is able to support you with low level need as well as more complex requirements;

iv. Maximises the expertise available across the different sectors; and

v. Includes clear step up/step down arrangements for young people moving between services.

c) Put in place clear clinical governance arrangements;


\(^{46}\) https://www.nice.org.uk/guidance/cg26
d) Put in place teaching and training for staff that are supporting young people who have experienced complex trauma; and
e) Be involved with case consultations across Brighton and Hove.

7.9.4 The CCG will work with the Health and Justice Commissioning (NHS England) with regards recurrent funding they are contributing for Brighton and Hove for children and young people and adults requiring talking therapy who have suffered sexual assault who come into contact with the SARC as well as the local Court Liaison and Diversion Service.

7.10 Medically Unexplained Physical Symptoms (MUPS)

This development addresses:
- Building resilience, promoting good mental health and intervening as early as possible in universal and targeted services
- Develop a service that responds to needs of individuals
- Integrated pathways across the whole system as well as all ages

7.10.1 Medically unexplained physical symptoms (MUPS) are symptoms that have no known physical pathological cause, they often cause distress and impaired functioning to the children and young people. Medical unexplained physical symptoms are also sometimes referred to as ‘somatisation’, ‘somatoform disorder’, ‘functional somatic symptoms’ and perplexing presentations.

7.10.2 Clinical presentations vary greatly both in terms of symptom type and severity, therefore this group might present to any general or speciality paediatrician and where a cause cannot be found is a diagnostic and therapeutic challenge.

7.10.3 MUPS are common, affecting 1 in 10 children and young people. Common symptoms are headaches, abdominal pain, joint pains and tiredness. Less common symptom can be syncope and other collapsing episodes, fits, severe and chronic pain, urinary symptoms, loss of limb function or abnormal gait.47 These physical symptoms can often be the manifestation of a psychological issue.

7.10.4 The CCG is currently scoping the range and numbers of medically unexplained symptoms identified within the Royal Alex Children’s Hospital and exploring best practice models of care. The intention is to take an integrated approach working across children’s and adults services (acute, primary care, and mental health) to develop an all ages pathway of care where possible.

47 Nottingham Children’s Hospital – Guideline on the Assessment and Management of Medically Unexplained Symptoms
7.11 Integrated homeless model (young people and adults)

This development addresses:
- Building resilience, promoting good mental health and intervening as early as possible in universal and targeted services
- Develop a service that responds to needs of individuals especially in crisis
- Integrated pathways across the whole system as well as all ages, especially those who are most vulnerable
- Ensure our workforce has the right experience, skills and competencies, feels part of the change and commits to the long term change required, and uses evidence-based interventions, pathways and outcomes tools

7.11.1 A national study in 2012 showed that young homeless people were twice as likely to suffer depression as their non-homeless peers. This research found that 40% of young homeless people identified themselves as being depressed whole 27% had been diagnosed with a mental health condition compared with 7% of non-homeless young people. Applying national prevalence rates of homelessness amongst young people 16-14 we estimate that there are 20 young people in Brighton and Hove sleeping rough who have mental health problems.

7.11.2 Improving the outcomes of the homeless population in Brighton and Hove is a priority within the City’s Better Care Plan. In 2014 a Homeless Integrated Health and Care Board was established with the vision to:

"Improve the health and wellbeing of homeless people by providing integrated and responsive services that place people at the centre of their own care, promote independence and support them to fulfil their potential."

7.11.3 The intention is to develop an integrated model of care for homeless (including young people) that would include prevention, personal, early intervention for those at risk and when they are homeless the support is available quickly, with a focus on rehabilitation.

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48 BHCC Housing and Support for Young People aged 16-25: needs assessment October 2012
49 CAMHS needs assessment Brighton and Hove
50 http://www.brightonandhoveccg.nhs.uk/search/site/better%20care
7.12 Review of Learning Disability/ Neurodevelopmental and Autism services for children and young people

This development addresses:
- Building resilience, promoting good mental health and intervening as early as possible in universal and targeted services
- Develop a service that responds to needs of individuals
- Integrated pathways across the whole system as well as all ages, especially those who are most vulnerable
- Ensure our workforce has the right experience, skills and competencies, feels part of the change and commits to the long term change required, and uses evidence-based interventions, pathways and outcomes tools

7.12.1 In 2015/16 the CCG plans to work with partners to scope and understand the need with regards learning disability, neurodevelopmental and autism. The review will follow the principles of the Bubb Report\(^{51}\). This will lead to the development of a business case. Any changes to the services would align with special educational needs and disabilities and education and health care plans as well as the Transforming Care plans.

8. Consultation and engagement

8.1 The development of the local Transformation Plan is being led by the CCG involving the whole system, including children, young people and their families and the community and voluntary sector. Children and young people have been included in all discussions about the redesign of services, in the spirit of No decision about me, without me\(^{52}\). There is on-going commitment of commissioners to involve you in planning and making decisions about future services, and enabling you to take more control over your lives and the services received. We recognise we particularly need to work out more effective way to engage with young men, Lesbian, Gay, Bisexual and Transgender (LGBT) and Black and Ethnic Minorities (BME) groups for example. Many of your views have been heard and noted through your involvement in the JSNA process including the steering group, and your future involvement in the partnership group and any future workshops and planning events.


8.2 This Plan has whole system support, from multiple partners, including the Health and Wellbeing Board.

8.3 The Plan is based on feedback and various audits, such as:
   a) All previous feedback in the last 2 years from a variety of organisations and agencies including Healthwatch\(^{53}\), Parent and Carers Council\(^{54}\), AMAZE\(^{55}\), Right Here project\(^{56}\), Special Educational Needs and Disabilities Review\(^{57}\), Autism Scrutiny Report\(^{58}\) and Local Safeguarding Board multi-agency audit in December 2014\(^{59}\) (see figure two below);
   b) The JSNA process (Feb-Nov 2015) has ensured the `voice` of a range of stakeholders such as Children and young people, Youth Council, Schools, Colleges, Universities, providers, parents, carers;
   c) A whole system workshop on planning for the Transformation Plan held on 12\(^{th}\) June 2015 (see appendix 3); and

Figure two: Local Safeguarding Children’s Board multi-stakeholder feedback

8.4 Children and young people and parents/ carers have provided the CCG with feedback about the services received or are receiving for mental health and wellbeing issues. Areas of concern or issues include:
   a) Access to the services such as waiting time, criteria and thresholds;

\(^{53}\) https://www.whatdotheyknow.com/request/healthwatch_brighton_hove_camhs
\(^{55}\) http://amazebrighton.org.uk/events/mental-health-wellbeing-discussion-group/
\(^{56}\) http://right-here-brightonandhove.org.uk/research/
\(^{57}\) http://present.brighton-hove.gov.uk/Published/C00000874/M00005597/AI00044015/$20150126165031_007091_0028782_finaldraf SENDReviewfullreport.docxA.ps.pdf
b) The desire for a more coordinated multi-disciplinary approach closer to home;
c) Better/clearer information about services available;
d) More emphasis on early intervention;
e) A clear pathway for crisis and out of hours; and
f) A clear pathway for transition to adult services.

8.5 We intend to continue this engagement and involvement ensuring that your voice is heard throughout this period of planning transformational change. We can do this by ensuring you are part of influential groups such as the Children and Young People’s Mental Health and Wellbeing Partnership Group, the development of service specifications and models, and other forums where decisions are made.

8.6 The CCG recognises the important role that schools and colleges play in supporting you with your mental health and wellbeing needs, and the work they already do to support you. We will continue to work with schools and colleges, Children’s Services and Public Health to ensure their direct involvement and engagement continues. The CCG plans to continue to engage with schools through various meetings and forums as well as holding a conference towards the end 2015 with representation from all schools and colleges to involve them further in development of the Transformation Plan, ensure there is clarity on roles and responsibilities and a consistent approach to support across the City.

9. **Equality and Diversity**
9.1 Equality and diversity is a key priority for the CCG in order to reduce inequalities, eliminate discrimination, harassment, victimisation and to advance opportunities.

9.2 Our current needs assessments aims to systematically identify local inequalities in terms of equalities groups, geography and socio-economic status. We have gathered quantitative data as well ‘voice’ evidence, with the online survey collecting information on equalities and focus groups for specific equalities groups where the research has highlighted higher risk of poor emotional and mental health (e.g. with LGBT young people). For example, we know through the needs assessment that levels of happiness and anxiety in the city are significantly associated with age. The percentage of pupils who are often or sometimes happy falls from 96% in 11-12 year olds to 92% in 15-16 year olds and those who are often or sometimes anxious rises from 52% in 11-12 year olds to 64% in 15-16 year olds (11% to 20% for often anxious). We also know that the following groups of students were significantly less likely to say they were often or sometimes happy: girls, those who use another word to describe their gender, young carers, those who need extra help, lesbian gay bisexual and unsure pupils, students who had truanted, those who have been excluded, been bullied or bullied someone else. There was no difference by ethnic group.

9.3 Considering how different groups are affected by mental health will help to make sure that commissioners are able to allocate resources in a way which addresses the sometimes different needs of these groups.
9.4 “There are some important indicators which demonstrate real inequality in health, particularly in infant mortality, obesity and childhood accidents as well as particular groups such as children in care (formerly looked after children), those from black and minority ethnic groups, young men and those with disabilities.” (Our Children Deserve Better: Prevention Pays – Annual Report of the Chief Medical Officer 2012).

9.5 The CCG commissions ten community and voluntary sector organisations to engage with excluded communities including Young Men, Travellers, Homeless People and Transgendered People.

9.6 The CCG has a clearly defined commissioning cycle to ensure that all the services it commissions meet the established needs of service users, are appropriate to national and local guidelines, fairly procured and monitored for continued effectiveness, value for money and sustainability. The diagram below (Figure 3) shows the cycle this strategy will need to follow and at what points service users from excluded communities can expect to be engaged.
9.7 There are four CCG goals against the Equality Delivery System as follows:
   a) Better health outcomes for all;
   b) Improved patient access and experience;
   c) Empowered, engaged and included staff; and
   d) Inclusive leadership at all levels.

9.8 Additionally we have been working to embed Equality and Diversity into the commissioning process. Processes are in place to ensure that all services are commissioned following the completion of an Equality Impact Assessment (EIA). The EIA may well identify changes necessary to the services specification, or
mitigating actions that are necessary to ensure that any negative impact on any particular protected characteristic group is removed or reduced. The CCG’s Project Management Office monitors these actions as they develop.

9.9 We have requested additional anonymous monitoring information from our service providers to better understand the whether patients with protected characteristics are accessing the services that we commission. This is necessary to ensure that services are accessible to all and if patients sharing a particular protected characteristic are unable to access services, that we take steps to improve accessibility and continue to work with our community and voluntary sector partners.

10. Immediate changes and investment of the Transformation funds

How the Transformation Plan funding will be used in 2015/16 – developing building blocks towards transformational change

10.1 The following sections of the Transformation Plan describe

a) The immediate changes and investment (2015/16) within section 10;

b) The longer term transformational changes (2016/17 onwards) within section 11;

c) The Community Eating Disorder service in section 12;

d) The perinatal mental health service within section 13;

e) The mental health liaison service within section 14; and

f) The Early Intervention in Psychosis service within section 15.

10.2 The process of allocating the Transformation Funds to CCGs in 2015/16 will be dependent on a signed off and agreed Transformation Plan. This process is likely to be completed in November 2015, and therefore Brighton and Hove CCG has assumed it will have 4-5 months to use the funds for this financial year.

10.3 In 2015/16 the CCG intends to use the funds to ensure the system builds strong foundations for transformational change, to address areas of immediate need/ gaps, and to ensure the system is ready for the change/ system readiness. The following areas have been identified:

10.4 Innovative communications and support

This development addresses:

- Building resilience, promoting good mental health and intervening as early as possible
- Develop a service that responds to needs of individuals
- Integrated pathways across the whole system as well as all ages, especially those who are most vulnerable
10.5  **Consistent access to information on-line**

10.5.1 There are multiple services across the City that provide information and support but this may not always be easy for you to find, may not always provide consistent advice and guidance and is not available in one place. The CCG intends to work with partners to scope and research effective on-line infrastructures, and develop a specification for a specialist with expertise in digital and social media to develop a system that rectifies this gap. This development may include updating current websites or developing a youth-friendly portal to link to these websites; a resource allocated to ensure we can reach young people through digital and social media; an anti-stigma media campaign, reaching out across all ages including under-5’s and primary school age.

10.5.2 This is likely to be a non-recurrent cost and will include scoping of current local and national offer, understanding what foundations already exist, leading to development of infrastructure that ensures information about services, support and guidance are easily located on-line and exploit opportunities available in digital media. This will also need to align with the current Youth Review in the City. Any on-going maintenance costs associated with this change will be allocated to the Transformation funds for 2016/17 onwards.

10.5.3 Anne Longfield, Children’s Commissioner for England recognises the high importance of investing in digital media through the development of a clear mandate for change by end of 2016, but is mindful of the risks when she stated recently;

> “*If children of today and tomorrow are to grow up digitally, we need to be sure that the rights to protection and empowerment that they enjoy in their lives, are embedded in the new digital world they inhabit.”*

10.5.4 With this in mind, a social media think tank was held in the City in June 2015 bringing together multiple stakeholders to explore the risks and opportunities available in the field of digital media. We will continue to ensure young people’s voice is heard and their experience is kept at the heart of any new developments in this area, and as such the CCG will support Public Health when they consider providing and promote a small grant for young people to develop digital media projects.

> This development will mean that I can access consistent and evidence-based information, guidance and support on mental health and wellbeing, on-line in a way that I find easily accessible, so that I get the right support at the right time.

The estimated cost is £85,000
10.6 **E-Motion**

10.6.1 Brighton and Hove has piloted on-line counselling through E-Motion. This has grown as a service with more young people accessing counselling in this way especially reaching young men and BME groups. There is more work to be done to develop and promote this service so that it can be more responsive and deliver what you would like, such as 'live' counselling and site security.

10.6.1 The CCG intends to sustain this project so that it becomes recurrent and also to invest further in its development.

_This development will mean that I can access evidence-based counselling on-line in a way that I find flexible for me and my needs so that I get the right support at the right time._

The estimated cost is £10,500 for sustaining E-Motion
The estimated cost of further development of E-Motion is £15,000

10.7 **Preparation and system-readiness for Children and Young People’s Improving Access to Psychological Therapies (CYP IAPT)**

This development addresses:

- Building resilience, promoting good mental health and intervening as early as possible
- Develop a service that responds to needs of individuals
- Integrated pathways across the whole system as well as all ages, especially those who are most vulnerable
- Ensure our workforce has the right experience, skills and competencies, feels part of the change and commits to the long term change required, and uses evidence-based interventions, pathways and outcomes tools

10.7.1 We are committed to transforming provision in Brighton and Hove to ensure it is consistent with the CYP IAPT\(^60\) principles, values and standards articulated in _Delivering With and Delivering Well_\(^61\) to improve the availability and effectiveness of mental health interventions for children and young people. CYP IAPT is an exciting initiative that involves transforming mental health services for children and young people. The programme is centred on the principles of offering effective and efficient evidence-based treatments within a collaborative therapeutic relationship.

10.7.2 In order to drive service change there is a need for widespread adherence to the values at the heart of CYP IAPT, namely an emphasis on:

a) A collaborative approach with you and all sectors of care; and

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b) A focus on your voice and feedback, service access, evidenced based delivery and outcomes focussed practice. This would include targeted training on equality and diversity and developing practitioners’ skills response/ listening/ engagement skills accordingly.

10.7.3 The CCG intends to join the South East CYP IAPT Learning Collaborative in 2015. Some members of Sussex Partnership Foundation trust who provide Brighton and Hove tier 3 CAMHS have already received training and the Trust already has some learning from East and West Sussex CCGs where CYP IAPT has been implemented. Key members of the Learning Collaborative intend to run a whole system workshop on 15th October to ensure all partners understand CYP IAPT, and are committed and engaged in making the change possible.

10.7.4 Transforming the delivery to be consistent with these values and standards requires cultural change in how our services and practitioners interact with you and place you at the centre of decision making about your care. Cultural change is also required to develop and to ensure evidence based practice is delivered across our whole system pathways and that there is rigorous scrutiny of outcomes and your feedback to improve service quality.

10.7.5 To achieve this vision we need to build our capacity and the service infrastructure to develop an evidence-driven approach to quality improvement. In year one (2015/16) we intend to work with Sussex Partnership Foundation Trust (SPFT) to build upon their learning from East Sussex and West Sussex CYP-IAPT sites and current Brighton and Hove strengths to map what is working well in relation to access; outcome measurement; evidence based practice and your participation. This work will entail an assessment of strengths and service delivery gaps to develop a strategic plan to achieve cultural change.

10.7.6 This will require resource to work alongside stakeholders across agencies within the whole system, to agree the implementation plan, foster the culture change, support workforce development and system change. We will recruit an Assistant Psychologist to analyse current outcomes data across whole system care pathways and gather baseline data to inform a quality improvement process, and a resource to develop the whole system strategic implementation plan.

This development will mean that I will be able to collaborate with the professionals who are treating me in developing my goals. This development will assure me that I am receiving evidence-based treatment that focusses on improving my outcomes.

Estimated costs for CYP IAPT preparedness are £54,000
10.8 Extending Primary Mental Health Workers in schools/ school support in general

This development addresses:
- Building resilience, promoting good mental health and intervening as early as possible especially in schools
- Develop a service that responds to needs of individuals
- Integrated pathways across the whole system
- Ensure our workforce has the right experience, skills and competencies, feels part of the change and commits to the long term change required, and uses evidence-based interventions, pathways and outcomes tools

10.8.1 We recognise the importance of the school and college role in providing emotional health and wellbeing support to you, and the work they already do to support you, such as school counselling, wellbeing initiatives and mindfulness for example. We want to continue to work with schools and colleges to strengthen that.

10.8.2 Brighton and Hove tier 2 Community CAMHS team is currently about to pilot a new model aiming to promote, protect and improve young people’s emotional health and well-being. This aligns with latest guidance on improving school readiness. In practice for the schools, that will mean implementing the whole school approach and have access to:

a) An onsite Primary Mental Health Worker (PMHW) to provide:
   - Access to appointment based/ drop-in service, reflective practice, bespoke training/ workshops;
   - Co-delivering interventions with school staff to delivering targeted early interventions and to build on the existing expertise of the schools staff;
   - Direct referral link to Tier 3 specialist community CAMHS;

b) Workshops from peer led projects, review of their PSHE curriculum, support to develop student voices and parents/carers packages; and

c) Each school will provide a named head of mental health to make links with the Primary Mental Health Worker, champion, coordinate and influence change, and ensure the right professionals are involved.

10.8.3 The CCG and partners have been successful in our application for the Joint Mental Health Training in Schools/ CAMHS Link pilot. It will provide us with the opportunity to:

a) Expand the role of mental health leads to feeder primary schools and look at impact on siblings and transitions;

b) Rolling out a training programme to meet a locally identified need; and

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c) Develop new approaches by working together to meet your needs, and reduce the need for external referrals. The joint training is an essential part of this development and the CCG has allocated some of the Transformation funds towards the training in this project.

10.8.4 The CCG also intends to invest part of the Transformation funds in extending the PMHW resource and capacity to support the transition and culture change required prior to the implementation of the all ages/family approach Wellbeing service in 2017. This service will be part of the early implementation of CYP IAPT in Brighton and Hove, adopting consistent outcome evidence-based tools and measurements and collaboratively engaging you in your care.

10.8.5 The CCG, BHCC and Public Health are committed to on-going funding for this team, and will ensure consideration is given to how this model fits with the future wellbeing service in 2017. This initiative involves joint commissioning with Children's Services, Public Health and local Schools (including Private Schools), and pooled budgets where appropriate.

10.8.6 In 2015/16 the Transformation funds will be used to begin to extend the offer to schools by extending the agreed pilot (and complement the joint training bid if successful). This includes special schools and Pupil Referral Units that are likely to move to a model of ‘unification of support’ and this new model of PMHW in schools would need to be developed flexibly to support such change.

10.8.7 The CCG would also like to engage Professor of developmental Psychology at University of Sussex, Robin Banerjee, to undertake research and evaluation on the schools pilots, as well as to understand how the workforce can be resilient and how any transformation can be sustainable especially regarding recruitment. The research and time would take place January-March 2016 and would help define and support any future CYP IAPT development plans.

\[
\text{This development will mean that I can receive support and help within my school and through a whole school approach to mental health and wellbeing I will feel more comfortable about asking for help and managing my emotions myself.}
\]

The estimated costs are £70,000 (PMHW)
The estimated costs for the schools/ CAMHS links training are £5,000
The estimated costs for general research and evaluation are £20,000
10.9 Extending the outreach counselling pilot

This development addresses:

- Building resilience, promoting good mental health and intervening as early as possible
- Develop a service that responds to needs of individuals
- Integrated pathways across the whole system
- Ensure our workforce has the right experience, skills and competencies, feels part of the change and commits to the long term change required, and uses evidence-based interventions, pathways and outcomes tools

10.9.1 An outreach counselling pilot was started by the voluntary sector in the East of Brighton which is a deprived area of the City. It is crucial that the CCG continues to ensure that you have appropriate access to mental health and wellbeing support and therefore intends to continue to invest in this service and ensure it is sustainable with additional funds as well as ensuring consideration is given to how this model fits with the future wellbeing service in 2017.

This counselling service has been important to me because I didn’t want to go to a formal setting and I wanted it close to where I live. I am pleased that it will be extended as my friends and I can continue to get support close to home where we feel comfortable.

Costs are £3,000

10.10 Development of Primary Care and engagement with schools and colleges

This development addresses:

- Building resilience, promoting good mental health and intervening as early as possible
- Develop a service that responds to needs of individuals
- Integrated pathways across the whole system
- Ensure our workforce has the right experience, skills and competencies, feels part of the change and commits to the long term change required, and uses evidence-based interventions, pathways and outcomes tools

10.10.1 Right Here Brighton and Hove are currently auditing GP Practices, establishing how young people-friendly they are, and also undertaking training needs analysis. This will align with the training needs analysis being done with schools. This proposal is to establish practical training workshops for Primary Care on Mental health presentation. to enable this key sector to be ready for changes within the Locally Commissioned Service, Wellbeing, `listening` and welcoming
seldom heard groups such as young men, LGBT and BME, and engage Primary Care in the transformational change across the whole system including the development of young people-friendly environments.\(^{63}\)

10.10.2 It is also vital that engage with schools and colleges and provide them with the opportunity to be involved in developing these plans and ensuring their voice is heard. This may be through a School Heads workshops and/ or working group. Some of this money will be allocated to engagement events for this purpose.

10.10.3 The main aim is to engage and extend knowledge of Primary Care and schools and colleges and to offer joint training wherever possible. It is also recognised that this will be most successful when we commission jointly with schools/ colleges, Public Health and Children’s Services.

It is important for me that my GP Practice is welcoming and understands what I need and how to help me, so I welcome more training and development for Practices.

Estimated costs are £10,000

10.11 Health Promotion post (4 months)

This development addresses:

- Building resilience, promoting good mental health and intervening as early

10.11.1 The CCG and Public Health intends to jointly commission to support the funding of a health promotion post that would provide support and advice and guidance for parents on handling your emotional wellbeing and also the potential to expand to sibling support. This post would develop a sustainable programme of support that can be used in the future, and train the parents to be able to continue the training once the funding finishes.

My parents and siblings also need help when I not well. I know this development will help them to support me so that I can recover more quickly but also family life is easier.

Estimated costs are £20,000

10.12 Address capacity and training in the current system

This development addresses:
- Develop a service that responds to needs of individuals
- Integrated pathways across the whole system
- Ensure our workforce has the right experience, skills and competencies, feels part of the change and commits to the long term change required, and uses evidence-based interventions, pathways and outcomes tools
- Be more transparent about the commissioning arrangements including waiting

10.12.1 In order to build strong foundations for the system to make the transformational changes required the CCG proposes to ensure capacity is used efficiently and effectively and waiting times within key pathways are reduced. This area of investment may also extend system readiness to culture change, such as training on engaging and listening to users.

Estimated costs are £45,000

10.13 Project management and clinical expertise resource (4-5months)

10.13.1 The CCG recognises that the system needs to prepare for all of these changes and will need resource and support to ensure engagement and commitment from all partners, coordinate the multiple projects and change of culture required, and develop the system so that it is ready for change, ensure projects are on time.

Estimated costs are £30,000

10.14 The funding will be allocated in 2015/16 is as follows (see table three below):

<table>
<thead>
<tr>
<th>Service development preparation</th>
<th>Cost in 2015/16</th>
<th>Recurrent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Innovative digital communications</td>
<td>£85,000</td>
<td>No</td>
</tr>
<tr>
<td>Sustaining E-Motion</td>
<td>£10,500</td>
<td>Yes</td>
</tr>
<tr>
<td>Further development of E-Motion</td>
<td>£15,000</td>
<td>No</td>
</tr>
<tr>
<td>Preparation for CYP IAPT readiness (Assistant Psychologist and project manager)</td>
<td>£28,000  £26,000</td>
<td>Yes Yes</td>
</tr>
</tbody>
</table>

I find it frustrating to have to wait for a long time for treatment and feel I get worse during this time. If services are able to reduce their waiting times I know my outcomes and recovery will be much better. This development will help this and also make me feel more listened to.
<table>
<thead>
<tr>
<th>Project Description</th>
<th>Cost</th>
<th>Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extending the PMHW/ offer to schools</td>
<td>£70,000</td>
<td>Yes</td>
</tr>
<tr>
<td>CAMHS/ Schools Link training</td>
<td>£5,000</td>
<td></td>
</tr>
<tr>
<td>Evaluation &amp; Research</td>
<td>£20,000</td>
<td></td>
</tr>
<tr>
<td>Extending outreach counselling in Youth Service settings</td>
<td>£3,000</td>
<td>Yes</td>
</tr>
<tr>
<td>Development of Primary Care &amp; Schools/ Colleges</td>
<td>£10,000</td>
<td>No</td>
</tr>
<tr>
<td>Health promotion post</td>
<td>£20,000</td>
<td>No</td>
</tr>
<tr>
<td>Address capacity in the system and system readiness</td>
<td>£45,000</td>
<td>No</td>
</tr>
<tr>
<td>Project management and clinical expertise resource</td>
<td>£30,000</td>
<td>No</td>
</tr>
<tr>
<td>TOTAL</td>
<td>£367,500</td>
<td></td>
</tr>
</tbody>
</table>

Table Three: Transformation Fund cost allocation in 2015/16

11. **Transformation Plan funds (2016/17 onwards) – long term vision and strategy**

11.1 The Transformation Plan funds available centrally to the CCG are (£372,582 annually). Following strong foundation being established in 2015/16, the CCG intends to address the following areas of need towards the transformation of children and young people’s mental health and wellbeing services:

11.2 **Crisis and out of hours care, including Urgent Help Service (UHS)**

   This development addresses:
   - Building resilience, promoting good mental health and intervening as early so that individuals cope better following a crisis
   - Develop a service that responds to needs of individuals especially in a crisis
   - Integrated pathways across the whole system
   - Ensure our workforce has the right experience, skills and competencies, feels part of the change and commits to the long term change required, and uses evidence-based interventions, pathways and outcomes tools

11.2.1 The CCG recognises that crisis care, especially out of hours (including after school hours) is insufficient for need, this is also supported by feedback from you. There are significantly higher rates of hospital admission for self-harm for young people

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aged 10 – 24 in Brighton & Hove: over the three years from 2010/13 the rate per 100,000 young people rose from 423.6 to 454.7 compared to 352.3 for England.

11.2.2 The CCG intends to build capacity across the system by investing further in crisis and out of hours resource. The exact resource will be scoped and planned for in 2015/16 and based on building on current resource, such as the Urgent Help Service (a current crisis team that works across Sussex seven days per week that can provide short intervention in people’s homes and reduce admissions to tier 4 inpatient beds). The whole system model will be developed over the next 5 years and where appropriate will be Sussex-wide and jointly commissioned with other CCGs and in partnership with NHS England.

11.2.3 This additional resource will supplement the Crisis Care Concordat local action plan\(^65\), place of safety planning, as well as the Care Quality Commission Right Here Right Now report\(^66\) and Urgent and Emergency Care review\(^67\). It will also enable us to review, as a whole system, the needs of distressed young people who don’t present with a clear mental health issue but require support, often out of hours.

\[
\text{I will have a service that can support me in a crisis, especially out of hours, when I most need it.}
\]

Estimated costs are £75,000

11.3 Continuing to support innovative communications and support

This development addresses:

- Building resilience, promoting good mental health and intervening as early as possible
- Develop a service that responds to needs of individuals
- Integrated pathways across the whole system as well as all ages, especially those who are most vulnerable

11.3.1 The CCG intends to continue to fund the sustainability and continue further development of E-Motion as outlined in paragraph 10.5 above (learning from developments in the infrastructure in 2015/16 to improve systems in 2016/17). The recurrent costs associated with this change are maintenance of the E-Motion system and the availability of on-line counsellors for “live” interaction with young people.

11.3.2 There is likely to be on-going maintenance costs associated with any improvements to digital information systems and infrastructure and ensuring that websites are maintained and updated.

\(^{65}\) http://present.brighton-hove.gov.uk/mgIssueHistoryHome.aspx?IId=44754
\(^{67}\) http://www.nhs.uk/nhsengland/keogh-review/Pages/urgent-and-emergency-care-review.aspx
Estimated costs for sustainability of E-Motion are £10,500
Estimated costs for development of E-Motion are £28,000
Estimated recurrent costs of improvements to the digital infrastructure are £12,000

11.4 Vulnerable groups (Children in Care, formally Looked After Children (LAC)) / Adopted / fostered children, and ensure young people involved in the Youth Justice System and refugee children are fully supported

This development addresses:
- Building resilience, promoting good mental health and intervening as early so that individuals cope better following a crisis
- Develop a service that responds to needs of individuals especially in a crisis
- Integrated pathways across the whole system
- Ensure our workforce has the right experience, skills and competencies, feels part of the change and commits to the long term change required, and uses evidence-based interventions, pathways and outcomes tools

11.4.1 Brighton and Hove has the 13th highest Looked After Children (LAC) per Local Authority in the UK. On 31 March 2014 there were 465 LAC in Brighton and Hove compared with 445 the previous year (a 4.5% increase), and since 2010 the number of LAC has ranged between 515 in November 2011 and 444 in December 2013.

11.4.2 Brighton and Hove does not have a separate, dedicated CAMHS team for this cohort of children and young people and their carers.

11.4.3 The CCG intends to build capacity across the system to ensure this specific need is met, to ensure proactive and preventative mental health support can be provided to these vulnerable children and young people as early as possible. This will be achieved by providing mental health professionals/ support to the BHCC Children in Care team to work as an integrated team of health and social care/ Children’s Services (to support the first level/ low level need and appropriate intervention) who could train and educate/ advise the social care staff/ Children’s Services, sign post, provide low level intervention (IAPT based) that links with CAMHS, and Virtual School as well as the Community LAC nurse.

11.4.4 Many of those young people involved with the Youth Justice System have mental health issues. In 2013/14 there were 84 First Time Entrants (FTEs) to the youth justice system, the target for 2014/15 is to reduce this to 70.

11.4.5 We work with partners (YOS, Children’s Services, Police, Liaison and Diversion, NHS England Health and Justice Commissioning) to continue to strive to address those needs, engage young people with the support offered and ensure they are integrated into local, mainstream services once they return from custody suites and
secure centres. We recognise that the pathways could be better and are committed to working with NHS England Health and Justice Commissioners to fully understand the local context, gaps and opportunities and potential improvements. We will also learn from the planned review of Youth Justice\textsuperscript{68}.

11.4.6 We are also aware of the current refugee crisis that the whole system will need to plan for. Brighton and Hove has agreed to accept 20 lone children over the next 2 months who will be supported by the LAC/ Children in Care teams.

\begin{quote}
As a child in care or a vulnerable young person within the Youth Justice System or refugees, I will receive mental health support when I need it, with mental health professionals working closely with my social worker.
\end{quote}

Estimated costs are £50,000

11.5 Seldom heard groups - extending Teenage to Adult Personal Advisor (TAPA) team (14-25 year olds)

This development addresses:
- Building resilience, promoting good mental health and intervening as early
- Develop a service that responds to needs of individuals especially those in transition from children to adult services
- Integrated pathways across the whole system
- Ensure our workforce has the right experience, skills and competencies, feels part of the change and commits to the long term change required, and uses evidence-based interventions, pathways and outcomes tools

11.5.1 The CCG intends to build capacity across the system to engage seldom heard groups, those difficult to engage in services and support young people through transition. The CCG currently commissions the TAPA service (14-25 year olds) provided by Sussex Partnership NHS Foundation Trust in partnership with the Children and Young Peoples Trust, YMCA Downlink, Impact Initiatives and Allsorts to meet the mental health needs of young people across the city who are ‘hard to reach’ by current mental health services or who themselves find current mental health services ‘hard to reach’ or `seldom heard`.

11.5.2 Support is provided through an assertive outreach approach, a more holistic person-centred approach, meaning the team will meet with you wherever you feel most comfortable and if you prefer, with a friend or worker. They work to identify any practical support needs that may also be having an effect on your mental health and support you in addressing these where possible. An assertive outreach

\textsuperscript{68} https://www.gov.uk/government/speeches/youth-justice
approach means they try and contact, communicate with you and support you in an informal, more 'user friendly' way. TAPA uses a low key, informal approach to engaging you in the least restrictive settings.

11.5.3 TAPA workers provide direct mental health work to young people and young adults and advice, consultation and training to professionals and young people. Supporting where appropriate access to mainstream mental health services.

11.5.4 Links would be made to other developments such as the pilot Crawley Pathfinder, the Stronger Families programme and the local Youth Service Review. For this reason, the resource will need to be aligned with other changes and therefore flexible to deliver the support wherever is required in the future. The CCG intends to establish a working group to develop the model that will support the need.

With this development I can access mental health treatment in an environment of my choice, in a flexible way, and receive support to help me engage in services to help my recovery.

Estimated costs are £60,000

11.6 Extending the outreach counselling pilot

This development addresses:
- Building resilience, promoting good mental health and intervening as early as possible
- Develop a service that responds to needs of individuals
- Integrated pathways across the whole system
- Ensure our workforce has the right experience, skills and competencies, feels part of the change and commits to the long term change required, and uses evidence-based interventions, pathways and outcomes tools

11.6.1 The outreach counselling pilot was started by the voluntary sector in the East of Brighton will be sustained and consideration will be given to how this model fits with the future wellbeing service in 2017.

Costs are £10,000
11.7 **PMHW in all school clusters / Community/ Primary Care**

This development addresses:
- Building resilience, promoting good mental health and intervening as early as possible especially in schools
- Develop a service that responds to needs of individuals
- Integrated pathways across the whole system
- Ensure our workforce has the right experience, skills and competencies, feels part of the change and commits to the long term change required, and uses evidence-based interventions, pathways and outcomes tools

11.7.1 The CCG intends to continue to invest part of the Transformation funds in extending the PMHW resource and capacity to support the transition and culture change required prior to the implementation of the all ages/ family approach wellbeing service in 2017. The CCG, BHCC and Public Health are committed to on-going funding for this team and will ensure consideration is given to how this model fits with the future wellbeing service in 2017.

Estimated costs are £70,000

11.8 **Continuing to develop CYP IAPT**

This development addresses:
- Building resilience, promoting good mental health and intervening as early as possible
- Develop a service that responds to needs of individuals
- Integrated pathways across the whole system as well as all ages, especially those who are most vulnerable
- Ensure our workforce has the right experience, skills and competencies, feels part of the change and commits to the long term change required, and uses evidence-based interventions, pathways and outcomes tools

11.8.1 The CCG would continue to work across the whole system to establish the principles of CYP IAPT and build on the work that will have started in 2015/16. A workforce training plan will be developed drawing on outcomes data and content analysis of service user feedback and goal-based data. We will refine processes for outcomes-focussed delivery at team meetings and in clinical supervision, across the whole system. Specific proposals/bids will be developed to address gaps in evidence-based intervention, participation and outcomes-focussed practice.
11.8.2 We will also start to evaluate multi-agency pathways, governance arrangements arising from increased integration with the voluntary sector, evaluation of triage and other service improvements.

**Estimated costs are £55,000**

11.9 A summary of 2016/17 onwards Transformation Plan funding can be seen in Table Four below:

<table>
<thead>
<tr>
<th>Service development preparation</th>
<th>Cost in 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Innovative digital communications</td>
<td>£12,000</td>
</tr>
<tr>
<td>Sustaining E-Motion</td>
<td>£10,500</td>
</tr>
<tr>
<td>Developing E-Motion further</td>
<td>£28,000</td>
</tr>
<tr>
<td>Investing in crisis and out of hours care</td>
<td>£75,000</td>
</tr>
<tr>
<td>Investing in vulnerable groups (Children in Care)</td>
<td>£50,000</td>
</tr>
<tr>
<td>Continuing with preparation for CYP IAPT readiness (Assistant Psychologist)</td>
<td>£55,000</td>
</tr>
<tr>
<td>Extending TAPA</td>
<td>£60,000</td>
</tr>
<tr>
<td>Continuing to extend the PMHW/ offer to schools</td>
<td>£70,000</td>
</tr>
<tr>
<td>Continuing to extend outreach counselling in Youth Service settings</td>
<td>£10,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>£370,500</strong></td>
</tr>
</tbody>
</table>

Table Four: Transformation Plan Funding summary 2016/17 onwards

**12. Community Eating Disorder Service for Children and Young People (CEDS-CYP)**

12.1 The Sussex CCGs (East and West Sussex and Brighton and Hove) will develop a Sussex-wide CEDS-CYP network model, with aspirations for an all ages pathway based on recent published commissioning guidance and NICE. The service will provide a comprehensive assessment and evidence-based treatment pathway for those with an eating disorder (mild - severe) using evidence based tools from CYP IAPT and MARSIPAN. The service will provide support to children, young people and their families as well as advice and guidance and awareness training for the whole system.

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70 [https://www.nice.org.uk/guidance/cg9/chapter/guidance](https://www.nice.org.uk/guidance/cg9/chapter/guidance)
12.2 The CCGs have developed a draft specification and established a clinically-led working group to finalise the model, pathways and workforce. The CCGs have engaged NHS Elect to provide data on demand and capacity modelling for eating disorders and will use that to develop an appropriate model, pathways with you, and workforce to meet need.

12.3 In 2015/16, the Sussex CCGs have agreed to use their combined allocations to jointly commission and develop strong foundations for the implementation of the service in 2016/17, this will include any recurrent costs such as equipment and workforce. Each CCG area will allocate proportionally in the following ways (see table Five below), whilst the model, specification and workforce requirements are being finalised and recruitment of staff takes place. This joint commissioning will also support the aim to reduce inpatient demand and will mean we will also work with NHS England to develop appropriate pathways.

<table>
<thead>
<tr>
<th>Service development preparation</th>
<th>Cost in 2015/16</th>
<th>Q3/Q4 spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource to do a training needs gap analysis for current Eating Disorder staff across the whole system</td>
<td>£15,000</td>
<td>Q3</td>
</tr>
<tr>
<td>Training and awareness in Primary Care, Acute Trust (RACH), schools, Colleges/ FE, Universities</td>
<td>£25,000</td>
<td>Q4</td>
</tr>
<tr>
<td>Training for current eating disorder staff on taking血液, reviewing and interpreting results</td>
<td>£25,000</td>
<td>Q4</td>
</tr>
<tr>
<td>Training for Junior Marsipan and Maudsley Model &amp; Parental resilience training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establishing systems to capture data/outcomes (EDQs) associated with CYP IAPT</td>
<td>£10,000</td>
<td>Q4</td>
</tr>
<tr>
<td>A resource to develop protocols, pathway, information, operational policy, produces evidence-based prevention toolkits and group work programmes that can be used in schools etc. This may also include a Clinical Champion time and backfill time to facilitate work with current eating disorder specialists</td>
<td>£18,000</td>
<td>Q3</td>
</tr>
<tr>
<td>Run a think tank/whole system/Sussex-wide workshop on developing the eating disorder model</td>
<td>£5,000</td>
<td>Q3</td>
</tr>
</tbody>
</table>
Equipment (ECG machines) | £20,000 | Q3
Commence employment of a GP/Nurse time to complement the mental health team (likely to be the equivalent of 1-2 sessions per week per CCG) | £30,000 | Q4

TOTAL | £148,000 | Q3 = £58,000 Q4 = £90,000

Table Five: Service development of CEDS-CYP in 2015/16

12.4 Benefits realisation plan

The development and implementation of the CEDS-CYP service across Sussex will ensure our children and young people have access to an outcomes-focussed, evidence-based clear pathway that will:

a) Provide accessible specialist assessment, support and treatment (Systemic Family Therapy) and other NICE concordant interventions based on a bio-psycho-social formulation in the community for those with an Eating Disorder;

b) Operate an all ages, tiered or stepped model of care/pathway (from moderate to severe eating disorders) across Sussex in a hub and spoke/local network model;

c) Decrease the length of time between onset of the disorder and access to appropriate levels of help;

d) Limit the physical and psychiatric morbidity, social disability and mortality levels caused by eating disorder;

e) Improve primary care management and risk assessment of Eating Disorder;

f) Improve health outcomes for children and young people with eating disorders, through reduction in relapse rates;

g) Raise awareness and support early identification in the wider community

h) Promote and encourage self-help for those with mild Eating Disorders and provide evidence-based material for their families;

i) Effectively treat people with very complex and/or serious morbidity as locally as possible;

j) Provide information and support to families and carers and to professionals who provide care in settings attended by children and young people, and ensure that referral pathways and guidelines are known to all local professional groups likely to come into contact with children and young people who may have an eating disorder;

k) Reduce the number of patients whose weight loss necessitates the need for in-patient care and/or to reduce hospital length of stay where hospitalisation is unavoidable;

l) Provide continuity through the tertiary, secondary and primary aspects of the care pathway, facilitating transition between services as appropriate;

m) Develop strong links and communication channels between services in Primary Care, Schools and Colleges, Youth Services, Paediatrics, and Adult Mental Health Services;

n) Achieve effective joint working and liaison, to manage the treatment of eating disorder across mental and physical healthcare services (inpatient and outpatient) supporting treatment in line with Junior MARSIPAN guidelines;
o) Provide training in Eating Disorders for Primary and Secondary care clinicians, schools and Colleges and Youth Services and to professionals who deliver care in settings attended by children and young people; and

p) Reduce the demand on tier 4 inpatient services.

12.5 Access targets in CEDS-CYP
The investment in a Sussex CEDS-CYP will achieve the access targets of NICE-concordat treatment should start within a maximum of 4 weeks from first contact with a designated healthcare professional for routine cases and within 1 week for urgent cases for children/young people across Sussex.

12.6 Workforce in CEDS-CYP
The CEDS-CYP for Sussex will build on workforce already available in both generic CAMHS and specific children and young people’s eating disorder services such as already in place in West Sussex. The team will also include a Primary Care professional who can support the team with medical decisions, tests and interpreting results. This is a model that currently works well within the adult Eating Disorder service.

12.7 Equality and diversity in CEDS-CYP
The CCG commissions ten community and voluntary sector organisations to engage with excluded communities including Young Men, Travellers, Homeless People and Transgendered People.

12.8 The CCG has a clearly defined commissioning cycle to ensure that all the services it commissions meet the established needs of service users, are appropriate to national and local guidelines, fairly procured and monitored for continued effectiveness, value for money and sustainability.

12.9 Additionally we have been working to embed Equality and Diversity into the commissioning process. Processes are in place to ensure that all services are commissioned following the completion of an Equality Impact Assessment (EIA). The EIA may well identify changes necessary to the services specification, or mitigating actions that are necessary to ensure that any negative impact on any particular protected characteristic group is removed or reduced. The CCG’s Project Management Office monitors these actions as they develop.

The all ages community eating disorder service will work with others in the community to recognise my issues early and develop a clear pathway to ensure I get my treatment easily. The service will support my whole family and as I get older, approaching 18 years old, the service will ensure I continue to get the treatment and support I need in the most appropriate way.
13. **Perinatal Mental health**

13.1 The CCG already commissions a specialist perinatal mental health service that is Consultant Psychiatrist-led based within the local Acute Hospital and delivered jointly by Psychiatry and Obstetrics, based on NICE guidance\(^{72}\). We have recently invested further in this service and extended the access and capacity so that a clinic can now also take place within the community and more home visits are available.

13.2 It is universally recognised that maternal mental health is a key determinant of child mental health, early years mental health services must look after adult mental health during and following pregnancy\(^{73}\). This means that infants and parents in difficulty should have improved access to mental health interventions to support attachment and avoid early trauma. This will be delivered by “…enhancing existing maternal, perinatal and early years’ health services…”\(^{74}\)

13.3 The CCG is considering how ensure mothers have a more integrated access to the mental health and wellbeing services they need across the whole pathway, from low level (universal) to high level (specialist) need. This will include how we can work with specialist commissioners of perinatal mental health in ensuring a reduced reliance on inpatient beds and where beds are required they are appropriate for mother and baby. One of the key advantages of this is that it would comprise of professionals trained in both infant development and adult mental health and contribute to:

   a) Reducing the incidence and impact of Post Natal Depression (PND), building on stepped PND Health Visitor service;

   b) Training on perinatal mental health for Midwives and Health Visitors;

   c) Contributing to an evidence base for the ‘Healthy Child Programme (0-5yrs)’ to guide professionals in supporting attachment between infant and parent;

   d) Operationalising waiting standard for ‘rapid access’ for women in pregnancy or postnatal period to treatment; and

   e) Providing an ‘Early Intervention’ pilot of services for of 0-2 year olds, complementing the work of the Stronger Families Programme and linking with the Healthy Child Programme.

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\(^{72}\) [https://www.nice.org.uk/guidance/cg45](https://www.nice.org.uk/guidance/cg45)


\(^{74}\) DoH 2015: p.17, NICE guidance on antenatal and postnatal MH, CG 192.
14. **Children and Young People’s Mental Health Liaison Service in Acute Trust**

14.1 Brighton and Hove CCG has recently invested in a mental health liaison team to be based within The Royal Alex Children’s Hospital (RACH) 7 days per week. The implementation of this change is expected to be November 2015. The service model is based on robust evidence and outcomes\(^{75, 76, 77}\).

14.2 The objectives of the service will be to:

a) Improve the quality of care for those of you experiencing mental problems whilst being cared for at RACH;

b) To support integrated mental health care with physical health care;

c) Enhance the skills of non-mental health professionals to better equip them to support patients with a mental health needs; to provide holistic care.

d) Reduce emergency mental health readmissions admissions and Emergency Department (ED) re-attendances for young people with mental health problems by:

   i. Providing a rapid access assessment and treatment for you when you are experiencing a crisis in their mental health; and

   ii. Securing onward referral to community mental health services where appropriate.

e) Provide in-patient mental health care to you when you need to be admitted to both short stay wards as well as general hospital wards, where there is concern over your mental state; and

f) Reduce your length of stay following admission by planning for discharge as soon as you are admitted.

15. **Early Intervention in Psychosis (EIP) access targets**

15.1 There is a new access target for EIP (from April 2016) stating that at least 50% of all referrals to EIP will receive NICE concordant interventions within 2 weeks. Shadow reporting will be required in quarter four of 2015/16\(^{78, 79}\).

15.2 The CCG has invested additional money in 2015/16 in the EIP service provided by Sussex Partnership Foundation Trust to achieve the access target. This service improvement is currently being monitored by a Service Development Improvement Plan.

16. **How we will measure success (KPIs)**

16.1 The Transformational change will follow Office of Government Commerce (OGC) best practice programme and project management frameworks - Managing Successful Programmes (MSP) and PRINCE2 respectively. The CCG has a Programme Management Structure (PMO) that provides advice and guidance as well as monitoring performance, progress and benefits. The PMO is part of the overall governance structure within the CCG and across the whole system.

\(^{75}\) [https://www.rcpsych.ac.uk/pdf/JCP-MH%20liaison%20(march%202012).pdf](https://www.rcpsych.ac.uk/pdf/JCP-MH%20liaison%20(march%202012).pdf)

\(^{76}\) [https://www.rcpsych.ac.uk/pdf/ALERT%20print%20final.pdf](https://www.rcpsych.ac.uk/pdf/ALERT%20print%20final.pdf)


16.2 The developments identified in this Transformation Plan will be tracked (financially and from a performance perspective in the CAMHS Assessment Data Tracker in Annex 3 under the following work-streams (see table Six below).

16.3 We will measure success through the delivery of the milestones within the project plan in 2015/16 as we ensure the system is ready for the change. In the longer term, as services are developed, KPIs will also be developed and embedded within the change. Some examples of KPIs that will be used are shown in table six below.

16.4 The CCG is assured that SPFT are collecting data within the new Mental Health minimum data set as our analysts receive regular extracts and this is monitored within our quarterly performance meetings on CAMHS, with the Trust.

<table>
<thead>
<tr>
<th>Service development preparation</th>
<th>Example KPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Innovative digital communications</td>
<td>Improved user reported experience of accessing online information and counselling</td>
</tr>
<tr>
<td>2 Sustaining E-Motion</td>
<td></td>
</tr>
<tr>
<td>3 Further development of E-Motion</td>
<td></td>
</tr>
<tr>
<td>4 Preparation for CYP IAPT readiness (Assistant Psychologist and project manager)</td>
<td>Reported CYP involvement in goal setting by all providers</td>
</tr>
<tr>
<td>5 Extending the PMHW/ offer to schools Research &amp; evaluation</td>
<td>Improved Safe and Well at Schools Survey</td>
</tr>
<tr>
<td>6 Extending outreach counselling in Youth Service settings</td>
<td>Improved access to therapeutic support for young men, LGBT and BME groups</td>
</tr>
<tr>
<td>7 Project management</td>
<td>Project milestones on track</td>
</tr>
<tr>
<td>8 Development of Primary Care</td>
<td>Using the training audit as a baseline, demonstrate improved knowledge and training gaps closed through re-audit</td>
</tr>
<tr>
<td>9 Health promotion post</td>
<td>Improved parent/ carer reported knowledge and support</td>
</tr>
<tr>
<td>10 Address capacity in the system and system readiness</td>
<td>Reduced waiting times in key pathways across the system</td>
</tr>
</tbody>
</table>

Table Six: 2015/16 work-streams
17. **Governance and assurance**

17.1 The development of the Transformation Plan has involved the whole system and has a clear governance structure in place (see figure four overleaf).

17.2 Those involved in the development of the plan include children, young people, parents, carers, providers and commissioners in the CCG and Local Authority and the Health and Wellbeing Board. The CCG Governing Body is made up of CCG Executive and senior team and also has independent and Lay members as well as Local Authority representation. The CCG committees have members from within the CCG. The JSNA steering group has representation from across the system including young people and parents. The Crisis Care Concordat working group has representation from across the system as well as the Police and NHS England Health Justice.

17.3 The CCG has established a children and young people’s mental health and wellbeing partnership group with membership from across the whole system (commissioners and providers) who will oversee the Transformation Plan, make decisions and recommendations and monitor the project plan (in bold in the diagram). The CCG is anticipating that this group will report to a current CCG performance and assurance groups, such as PMO Support Group and Performance and Governance Group. This group will also develop an informal professional network to share expertise and approaches so that we build our understanding of what issues you are struggling with.

17.4 Quality Standards and Quality Impact Assessments will be embedded within all aspects of service planning and delivery as we make the improvements outlined within this Plan. The standards are structured within the three pillars of quality; patient experience, patients safety and effectiveness, together with additional metrics such as workforce (i.e. well-led).

17.5 The quality standards reflect the NHS Standard Contract. Standards also reflect any relevant national Department of Health commissioned reports and associated findings pertaining to patient safety, quality of care and service delivery including lessons learned and recommendations from The Francis Report\(^80\).

17.6 Patient focussed outcomes arising from the standards are embedded in future service specifications and contracts associated with the changes. This will enable robust monitoring of performance of a commissioned service provider, and to provide assurance that quality standards and outcomes are being met.

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\(^{80}\) [https://www.england.nhs.uk/tag/francis-report/]
17.7 Any outcomes for inclusion in a contract will also need to be aligned to the five domains of the NHS Outcome Framework\(^\text{81}\) as follows:
- Preventing people from dying prematurely;
- Enhancing the quality of life for people with long term conditions;
- Helping people to recover from episodes of ill health or following injury;
- Ensuring people have a positive experience of care; and
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

17.8 The CCG continues to work with partners (including schools and colleges) to joint commission and pool budgets where appropriate. The CCG also has arrangements with NHS England Health and Justice Commissioning with regards the development of a complex trauma pathway.

17.9 The Transformation Plan will become embedded in the CCG commissioning and strategic intentions and mainstream planning and assurance processes. The CCG’s PMO Review Group will undertake the role of programme assurance to ensure that progress is monitored and control is maintained within the agreed boundaries and project outlines described in this Plan. The plan is in line with CCG strategy for 2016/17 in taking a transformational approach to commissioning.

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\(^{81}\) https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/

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Figure Four: CCG Transformation Plan Governance and Assurance structure
18 **Risk**
18.1 Risks will be managed at the project and programme level in accordance with the CCGs Risk Management Procedure. They will be recorded and tracked using the PMO risk log template and escalated to the Partnership Board for resolution where necessary.

18.2 The key risks identified at this time can be found in the suite of PMO documents in Appendix two, and are:
   a) Recruitment to posts in new services/ new developments, requiring a workforce strategy;
   b) Internal resource within the CCG and other agencies resources available to deliver the transformational change required;
   c) Whole system and Sussex-wide engagement may mean that change is slowed due to multiple governance and sign off; and
   d) Delivering the long term changes that interface and are inter-dependent with other major transformational changes locally that may hinder progress, outside the control of this programme of change.

19 **Delivery and Project Plan**
19.1 The CCG has developed a suite of PMO documents, including a project plan (see appendix 2) that outlines the key actions for 2015/16 across the whole system and all transformational changes required. A longer term delivery plan is available in these documents, reflecting high-level milestones for 2015-2020 and will be used to manage progress with delivery and updated accordingly.

20 **Conclusions**
20.1 This document outlines the five year, longer term vision that the CCG has for children’s and young people’s mental health and wellbeing services based on your feedback, views and involvement. The Plan also outlines the developments and spends in 2015/16, making the system ready for the changes from 2016/17 onwards.

20.2 The vision is to have a system, developed by you, that promotes wellbeing and early intervention around family systems, where you can thrive. It will be a system that is easy to navigate, understand and find information that is evidence-based and reliable that will improve your outcomes and make sure we prepare you for life’s challenges and give you the resilience and skills to flourish.
### APPENDIX ONE – service information

<table>
<thead>
<tr>
<th>Service information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name</strong></td>
</tr>
</tbody>
</table>
| **Description** | The Tier 2 Community CAMHS team offers a consultation service to parents, carers and professionals. This is where there is an opportunity to discuss concerns about a young person’s emotional wellbeing or mental health before a referral is made. Experience shows that an early consultation can often address concerns and save the need for a referral. If they are not the right service they are normally able to signpost to a more appropriate service.  

The service accepts referrals via a single point of access with Tier 3 CAMHS and referrals of children and young people with more moderate mental health issues likely to respond to short to medium term interventions will be directed to Community CAMHS. The service offers some joint working with Tier 3 CAMHS in the form of groups and focussed support.  

The service is a partnership delivered by Primary Mental Health workers employed by BHCC and family support workers from two community and voluntary sector organisations (Safety Net and SCYMCA) |
| **What outcome(s) is it aiming to achieve** | • Promotion of emotional wellbeing and building of resilience  
• Reduction of symptoms of mental ill health  
• Advice and support to professionals in managing the needs of children and young people  
• Development of self-management and coping skills |
<p>| <strong>Reach – age range</strong> | 0-18 though most referrals are of school age and upwards |</p>
<table>
<thead>
<tr>
<th>2014/15</th>
<th>Activity</th>
<th>Information</th>
<th>Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 2 CAMHS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of referrals received</td>
<td>Number of referrals accepted</td>
<td>Waiting times (referral to assessment)</td>
<td>Waiting times (assessment to treatment)</td>
</tr>
<tr>
<td>1767*</td>
<td>417</td>
<td>2 weeks (all referrals offered a telephone assessment within 2 weeks)</td>
<td>8-13 weeks (from referral date)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Total referrals for single point of access (tier 2 and tier 3)
<table>
<thead>
<tr>
<th>Service information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name</strong></td>
</tr>
<tr>
<td><strong>Description</strong></td>
</tr>
</tbody>
</table>
| | • Assessment and diagnosis of autism (over 11s)  
| | • Looked after children  
| | • Children with Chronic fatigue syndrome  
| | • Children with long term health conditions  
| | • Children with learning disabilities and associated challenging behaviour  
| | • children with neurodevelopmental conditions  
| | • Early intervention in psychosis  
| | • Young people aged 14-25 who need support with transition or struggle to access the CAMHS service (Teen to adult personal advisors (TAPA service)) |
| | There are also: |
| | • Specialist mental health nurses within substance misuse service and youth offending team  
| | • Specialist mental health practitioners in Clermont child protection unit |
| | The service also provides: |
| | • Duty response to paediatric A&E where a young person presents with serious self-harm  
| | • Urgent help service for crisis and out of hours response  
| | • 24 hour duty psychiatry advice |
| **what outcome(s) is it aiming to achieve** | |
| | • Reduction in the symptoms of mental ill health including via access to medication as needed  
| | • Promotion of wellbeing and emotional resilience  
| | • Advice and support to professionals working with children and young people with mental health issues  
| | • Support and advice to parent carers and family members in managing the mental health needs of children and young people |
• Maintaining children and young people in a community setting unless they are acutely unwell and require an inpatient admission (provided at Chalkhill Haywards Heath by SPFT and young people can also access other specialist centres as needed via referral to a specialist funding panel)

Reach – age range 5-18 (up to 25 for TAPA Service)

<table>
<thead>
<tr>
<th>2014/15</th>
<th>Activity</th>
<th>Information</th>
<th>Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of referrals received</td>
<td>Number of referrals accepted</td>
<td>Waiting times (referral to assessment)</td>
</tr>
<tr>
<td>Tier 3 CAMHS</td>
<td>1767*</td>
<td>618</td>
<td>4 weeks</td>
</tr>
<tr>
<td></td>
<td>2 WTE team leaders</td>
<td>3.3 WTE Consultants</td>
<td>4.2 WTE Psychology</td>
</tr>
</tbody>
</table>

*Total referrals for single point of access (tier 2 and tier 3)

**Local validation currently being carried out. Includes a level of vacancies that are now recruited to
<table>
<thead>
<tr>
<th><strong>Service information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name</strong></td>
</tr>
<tr>
<td><strong>Description</strong></td>
</tr>
<tr>
<td><strong>Address and contact details</strong></td>
</tr>
</tbody>
</table>
| **what outcome(s) is it aiming to achieve** | • Increased coping skills  
• Increased self-esteem/confidence  
• Reduce feelings of isolation  
• Reduced stress and anxiety  
• Signposting into other appropriate agencies  
• Assisted to better consider employment, education or training  
• Reduced drug and/or alcohol use  
• Improved relationships and ability to communicate with family/peers  
• These outcomes result in improved mental health and wellbeing, enhanced access to learning, improved school attendance, improved enjoyment of life and attainment, improved relationships at home and prevention of social disaffection through criminality, teenage pregnancy, NEET and anti-social behaviour. |
<p>| <strong>Reach – age range</strong> | 13-25 years |</p>
<table>
<thead>
<tr>
<th>2014/15</th>
<th>Activity</th>
<th>Information</th>
<th>Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of referrals received</td>
<td>Number of referrals accepted</td>
<td>Waiting times (referral to assessment)</td>
</tr>
<tr>
<td>E-Motion</td>
<td>117</td>
<td>84</td>
<td>1 week</td>
</tr>
</tbody>
</table>
### Service information

<table>
<thead>
<tr>
<th>Name</th>
<th>Right Here Project Brighton &amp; Hove</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>A youth led project that aims to promote the mental health and emotional wellbeing of young people aged 16-25, and provides free resilience building activities. The project supports engagement and participation of young people in service developments, research and publication of resources produced by young people for young people.</td>
</tr>
</tbody>
</table>

**what outcome(s) is it aiming to achieve**

Right Here aims to prevent young people from developing mental health issues through providing resilience building activities. The project should be seen primarily as a prevention and project, and secondly as an early intervention project.

Right Here is not a project that provides interventions or support to young people experiencing mental health issues.

<table>
<thead>
<tr>
<th>How is the service accessed?</th>
<th>Young people can self-refer, or can be referred.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach – age range</td>
<td>16-25 years</td>
</tr>
</tbody>
</table>

---

### 2014/15

<table>
<thead>
<tr>
<th>2014/15</th>
<th>Activity</th>
<th>Information</th>
<th>Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of referrals received</td>
<td>Number of referrals accepted</td>
<td>Waiting times (referral to assessment)</td>
</tr>
<tr>
<td>Right Here Wellbeing Manager</td>
<td>NA</td>
<td>Mental health related workshops to approx. 530 to 620 young people 8 young Men’s Health Champions consultations</td>
<td>NA</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
## Service information

<table>
<thead>
<tr>
<th>Name</th>
<th>Young People’s Centre (counselling) – Impact Initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>The Young People’s Centre aims to provide a centre that is an accessible and safe place for young people to meet, access a range of services that meet their needs, develop their skills and broaden their horizons. We provide drop-in sessions that include support, advice and information from staff and volunteers, affordable food, activities and games, a space that facilitates peer support and free access to computers and the internet. These sessions include specialist one-to-one support for young people around mental health, sexual health, education, employment and training issues and are complimented by the counselling service. We provide a range of informal education and learning opportunities.</td>
</tr>
<tr>
<td>what outcome(s) is it aiming to achieve</td>
<td>We aim to encourage and facilitate young people’s personal growth, awareness and progression and promote increased confidence, well-being, mental and emotional health. We equip and enable young people to create the changes they wish to make, empowering themselves and developing coping strategies. We work in a person centred way, using action plans, goal setting and advocacy work through one-to-ones, open access sessions and counselling.</td>
</tr>
<tr>
<td>How is the service accessed?</td>
<td>Drop In, referrals and self-referral</td>
</tr>
<tr>
<td>Reach – age range</td>
<td>13-25 year olds</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2014/15</th>
<th>Activity</th>
<th>Information</th>
<th>Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of referrals received</td>
<td>Number of referrals accepted</td>
<td>Waiting times (referral to assessment)</td>
</tr>
<tr>
<td>Young People’s Centre</td>
<td>181</td>
<td>118</td>
<td>2 weeks</td>
</tr>
<tr>
<td>Service Information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Homewood College Psycho-therapist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Homewood is a special school for children experiencing Social, Emotional, and Mental Health Difficulties. The therapist offers a range of interventions including:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Contributing to multi agency planning meetings and liaising with other agencies</td>
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<td></td>
<td>• Providing individual state of mind assessments</td>
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<td></td>
<td>• Providing weekly therapy sessions with children on site</td>
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<tr>
<td></td>
<td>• Working collaboratively with teachers at through small group work</td>
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<td></td>
<td>• Providing parent/carer and child sessions</td>
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<tr>
<td></td>
<td>• Writing reports which help inform planning and interventions for individual children</td>
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<tr>
<td></td>
<td>• Providing support to adults working within the school who need to process the impact of their work with very challenging children</td>
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<tr>
<td></td>
<td>• Being the link to any CAMHS interventions</td>
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<tr>
<td></td>
<td>• Supervising mentors for many pupils on school site</td>
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<tr>
<td></td>
<td>• Providing staff group supervision and developing their awareness and expertise in mental health and emotional well being</td>
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<tr>
<td></td>
<td>• Advising the senior leaders within the school on the development of a therapeutic approach to working with the most challenging and hardest to reach/teach children and young people attending the school.</td>
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</tr>
<tr>
<td>what outcome(s) is it aiming to achieve</td>
<td>Homewood College exists to support children in gaining the greatest possible access to learning and achievement in preparation for the responsibilities and experiences of life. To this end our therapist helps individual children, and their families to address issues that are impacting upon their emotional wellbeing and mental health, and preventing successful engagement with school. Some of these are short term interventions whilst others may be longer term depending on each child’s particular needs. The therapist works with children and families who have either failed to engage with traditional CAMHS services, or where children cannot access traditional CAMHS for other reasons, such as chaotic families and parents unable to manage their child’s behaviour in a traditional clinic. As Homewood develops its work with young people who have very complex needs, and extremes of challenging behaviour (in the past these children would have been sent to residential schools out of the city), there has been an increased need for staff to have greater expertise in mental health and emotional wellbeing. We have found that by skilling the staff group this can impact on more students than solely providing individual therapeutic sessions. Especially where our young people are suspicious of traditional ‘mental health’ professionals, and take a long time to trust adults.</td>
<td></td>
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</tr>
<tr>
<td>How is the service accessed?</td>
<td>All children attending Homewood have keyworkers responsible for regular reviews. Where it is felt a child or young person would benefit from additional therapeutic support this will be discussed with them and their family before a referral to the therapist is made.</td>
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</table>
The children can also self-refer – usually on the recommendation of another child, and parents may also ask for support either for themselves or their child.

Reach – age range
Age 7 – 16 years old

<table>
<thead>
<tr>
<th>2014/15</th>
<th>Activity</th>
<th>Information</th>
<th>Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of referrals received</td>
<td>Number of referrals accepted</td>
<td>Waiting times (referral to assessment)</td>
</tr>
<tr>
<td>Homewood College Psychotherapist</td>
<td>25</td>
<td>25</td>
<td>No more than 2 weeks</td>
</tr>
<tr>
<td><strong>Service information</strong></td>
<td></td>
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<tr>
<td><strong>Name</strong></td>
<td>Dialogue Community Counselling @ 65 – YMCA Downlink (including outreach in East Brighton)</td>
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<tr>
<td><strong>Description</strong></td>
<td>The Counselling Service at No. 65 occupies the top floor of the building offering free counselling and therapeutic support using a 12 session model for 13-25 year olds since 1995. The service has a Co-ordinator, 2 paid p/t counsellors/supervisors, 1 administrator and 6 Honorary Counsellors. Counselling is also offered in East Brighton. The main issues young people present with are Suicidal thoughts, Self-Harm, Isolation, Eating related behaviour, Bullying, Bereavement/Loss, Family Illness, Domestic Violence, Suicide Attempts, Alcohol &amp; Drug use, Suicide of a friend or family member and Arguments at Home. All paid staff are post-diploma qualified and the Honoraries are either in their final year of training or post-qualified. The service offers clients a meaningful intervention that helps them develop positive coping mechanisms that in turn enables them to address life’s challenges with greater self-awareness and resilience. The service is one of only 5 services in Sussex to be accredited by The British Association of Counselling &amp; Psychotherapy to work with Children, Young People &amp; their Families.</td>
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</tbody>
</table>
| **what outcome(s) is it aiming to achieve** | • Increased coping skills  
• Increased self-esteem/confidence  
• Reduced stress and anxiety  
• Obtained employment, education or training  
• Reduced drug and/or alcohol use  
• Improved relationships and ability to communicate  
These outcomes result in Improved Health & Well-Being, Enhanced Access to Learning, Improved School Attendance, Improved enjoyment of life and attainment, Improved relationships at home & Prevention of social disaffection through criminality, teenage pregnancy, NEET and anti-social behaviour. |
| **How is the service accessed?** | Referral by self, practitioners/professionals and parents/carers  
Phone, email and text |
<p>| <strong>Reach – age range</strong> | 13 – 25 year olds |</p>
<table>
<thead>
<tr>
<th>2014/15</th>
<th>Activity</th>
<th>Information</th>
<th>Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dialogue</td>
<td>East Brighton</td>
<td>Number of referrals received</td>
<td>Number of referrals accepted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>172</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td></td>
<td>51</td>
<td>26 (15 under 18 years)</td>
</tr>
<tr>
<td><strong>Service information</strong></td>
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<tr>
<td><strong>Name</strong></td>
<td><strong>Safety Net</strong></td>
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</tbody>
</table>
| **Description**         | **Support for Families** - Family Link project supports families with children aged 4-12 years old who attend primary schools in east Brighton with a range of parenting issues.  

**Home Safety Equipment** - Safety Net runs a home safety equipment scheme for families on low incomes across Brighton and Hove, mainly for children under 2.  

**Work with Children and Young People** - Safety Net runs projects for children and young people in schools and in the community to prevent bullying, teach children safety and assertiveness skills and involve them in safety issues in their neighbourhoods.  

**Support for community and voluntary sector groups** – We provide support to community groups to make sure that they have systems in place to keep children and young people safe. We can help with child protection training, policies and procedures and a DBS checking service.  

**Training** – Safety Net provides a range of training for individuals, schools, groups and organisations who work with children, young people and families. |
| **what outcome(s) is it aiming to achieve** | Improving children and young people safety and wellbeing at home at school and in the community.  

Projects include:  

**Individual family support** working on ‘Every child matters’ outcomes and parental wellbeing, family relationships etc. through home visiting programme working with parents and/or whole family using CAF  

**Improved Parental confidence and skills**, and outcome s for children through parent training including TRIPLE P  

**Positive transition to secondary school, Increased Safety in the community and in schools including safe from bullying – increasing children’s assertiveness and participation, Healthy eating, Active and connected lifestyles, - through a range group work opportunities for parents, for Dads, for children and young people and for families including FAST, SNAP, Playground Buddies |
How is the service accessed? | Individual family support at present is accessed through primary schools and schools and community team; All other groups are open to all and families can self-referral or access through in or through schools in Brighton and Hove

Reach – age range | Most of the services are focussed on primary school age. Assertiveness groups for children up to 13 years

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<thead>
<tr>
<th>2014/15</th>
<th>Activity</th>
<th>Information</th>
<th>Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals received</td>
<td>Number of referrals accepted</td>
<td>Waiting times (referral to assessment)</td>
<td>Waiting times (assessment to treatment)</td>
</tr>
<tr>
<td><strong>Service Information</strong></td>
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<tr>
<td><strong>Name</strong></td>
<td>Mind me UP (Mind in Brighton and Hove) - Speak your Mind Young People’s Advocacy Service</td>
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</tr>
<tr>
<td><strong>Description</strong></td>
<td>Advocacy for young people who have mental health issues, diagnosed or not. Advocacy can be for mental health services, other health services, school, college, employment, housing, or transition between services.</td>
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</tbody>
</table>
| **what outcome(s) is it aiming to achieve** | To listen to young people, help them express their opinions and request the services that are useful to them, to inform them of their rights, to ask for changes if necessary, and to help them make complaints if they do not feel they are receiving the care and treatment that they are entitled to.  
To empower young people to deal with difficult issues such as:  
- Child protection (their own and their children’s)  
- Homelessness  
- Loss of employment  
- School exclusion  
The service also works with hard to reach young people who may not be attending services and help them to engage, as well as linking with Independent Mental Health Advocates (IMHAs) for any young person detained under the Mental Health Act |
<p>| <strong>How is the service accessed?</strong> | By the referrer or young person phoning or emailing the advocate directly. |
| <strong>Reach – age range</strong> | 11-19 years |</p>
<table>
<thead>
<tr>
<th>2014/15</th>
<th>Activity</th>
<th>Information</th>
<th>Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mind me Up</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td><strong>Service Information</strong></td>
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<tr>
<td>-------------------------</td>
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<td></td>
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<tr>
<td><strong>Name</strong></td>
<td>RISE</td>
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</tbody>
</table>
| **Description** | Rise is the only independent, specialist provider of domestic violence services in Brighton & Hove (that is, independent of statutory - criminal justice and local authority – provision). A women-led organisation, the charity provides services for women, children and young people and children, parents and families affected by domestic violence, focussing on protection, provision of advocacy and support, and prevention from abuse, across Brighton & Hove.  

The Domestic Abuse Prevention and Recovery Service (DAPAR) within RISE (which includes a dedicated children and young people’s domestic violence service) is provided by independent trained domestic violence specialists who deliver a service to victims of domestic violence who are at standard-medium risk of harm from partners, ex-partners or family members.  

The service provides on-going individual support and advocacy, group-work programmes and counselling for women, children and young people living in the community or who have spent a period of time living in a refuge and are re-settling.  

Services are delivered through a combination of drop-in and peer support sessions, crisis appointments, advice, advocacy and support appointments, counselling sessions, and through more structured groups. The service aims to deliver information, advice, advocacy, practical and emotional support to survivors experiencing domestic violence across the city. |
| **what outcome(s) is it aiming to achieve** | This domestic violence counselling service will work with victim/survivors and their children (girls and boys) at medium or high risk levels of domestic violence crime, or where the experience of domestic violence crime is at chronic levels.  

The aim of the service is to reduce the risk to self (self-harm, suicidal ideation), reduce repeat victimisation, as well as the following outcomes from the RISE Outcomes Framework:  
  - Increased emotional safety; and  
  - Improved family relationships. |
<p>| How is the service accessed? | The service accepts self-referrals |
| Reach – age range | The service supports families including children under 18 years |</p>
<table>
<thead>
<tr>
<th>2014/15</th>
<th>Activity</th>
<th>Information</th>
<th>Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of referrals received</td>
<td>Number of referrals accepted</td>
<td>Waiting times (referral to assessment)</td>
</tr>
<tr>
<td>RISE</td>
<td>No new referrals received (as waiting list closed due to demand)</td>
<td>26</td>
<td>12-15 months</td>
</tr>
<tr>
<td></td>
<td>132</td>
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</table>
## Service Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Therapeutic support for children of sexual abuse (BHCC)</th>
</tr>
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<tbody>
<tr>
<td>Description</td>
<td>Provide therapeutic support for children under 14 years old and the safe caregiver, where sexual abuse is being disclosed or where there are serious concerns about child sexual abuse. To assess and deliver evidence based therapy and interventions for up to 40 children per year (up to 15 sessions each)</td>
</tr>
<tr>
<td>what outcome(s) is it aiming to achieve</td>
<td>Provide therapeutic support for children under 14 years where sexual abuse is being disclosed or where there are serious concerns about child sexual abuse</td>
</tr>
<tr>
<td>How is the service accessed?</td>
<td>Mainly social care and community Paediatrics</td>
</tr>
<tr>
<td>Reach – age range</td>
<td>14 years and under</td>
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<thead>
<tr>
<th>2014/15</th>
<th>Activity</th>
<th>Information</th>
<th>Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy for child sexual abuse</td>
<td>Number of referrals received</td>
<td>4*</td>
<td>Patient information</td>
</tr>
<tr>
<td></td>
<td>Number of referrals accepted</td>
<td>4*</td>
<td>Number of staff (WTE)</td>
</tr>
<tr>
<td></td>
<td>Waiting times (referral to assessment)</td>
<td>TBC</td>
<td>Skills and roles</td>
</tr>
<tr>
<td></td>
<td>Waiting times (assessment to treatment)</td>
<td>TBC</td>
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*Note the service commenced Jan 2015*
### Service Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Early Intervention in Psychosis Service</th>
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</table>

**Description**

Early Intervention services support individuals experiencing a first episode of psychosis who are typically presenting for the first time to mental health services and who have either not yet received any antipsychotic treatment or have been treated for less than one year. Diagnostic uncertainty characterises the early phase of a psychosis and thorough assessment is a crucial and key function of the Early Intervention Team.

**what outcome(s) is it aiming to achieve**

The purpose of this service is to provide a comprehensive, integrated package of care to young people aged 14-35 years living in Brighton and Hove experiencing or suspected to be experiencing a first episode of psychosis.

**How is the service accessed?**

Referrals are accepted from all professionals.

**Reach – age range**

14-35 years

### 2014/15 Activity Information Workforce

<table>
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<tr>
<th>2014/15</th>
<th>Activity</th>
<th>Information</th>
<th>Workforce</th>
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<tbody>
<tr>
<td></td>
<td>Number of referrals received</td>
<td>Number of referrals accepted</td>
<td>Waiting times (referral to assessment)</td>
</tr>
<tr>
<td>EIP</td>
<td>123</td>
<td>39</td>
<td>9.1 days (median)</td>
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62 NIMHE 2008
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<tr>
<th><strong>Service Information</strong></th>
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<tbody>
<tr>
<td><strong>Name</strong></td>
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<tr>
<td><strong>Description</strong></td>
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</table>
| **what outcome(s) is it aiming to achieve** | • Enhance the experience of women with perinatal mental health problems in getting their needs met and accessing appropriate support;  
• Enable women with perinatal mental health problems to have clear care plans and to facilitate consistent implementation of care plans. Where appropriate this will involve joint care plans produced by the Consultant Psychiatrist in conjunction with a Consultant Obstetrician based at the Perinatal Clinic;  
• Facilitate access to appropriate therapeutic activities and expert advice which will help individuals and their families learn more about the condition and how best to manage it;  
• Improve risk assessments of women at high risk of or suffering from perinatal mental health problems;  
• Make onward referrals for supporting parenting capacity for women who need support; and  
• Raise awareness of the service to health care professionals. |
<p>| <strong>How is the service accessed?</strong> | For mother’s high risk of or suffering from moderate to severe perinatal mental health problems from GPs, Health Visitors, Midwives, Wellbeing Services, Assessment and Treatment Service, Obstetricians and Family Nurse Partnership/ Early Help Hub |
| <strong>Reach – age range</strong> | Adults (mothers) and their babies |</p>
<table>
<thead>
<tr>
<th>2014/15</th>
<th>Activity</th>
<th>Information</th>
<th>Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perinatal Mental health</td>
<td>Number of referrals received</td>
<td>Number of referrals accepted</td>
<td>Waiting times (referral to assessment)</td>
</tr>
<tr>
<td></td>
<td>191</td>
<td>129</td>
<td>2 months</td>
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# CCG mental health and wellbeing contracts (2014/15)

<table>
<thead>
<tr>
<th>Specification</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPFT block contract</td>
<td>£2,438,964</td>
</tr>
<tr>
<td>LD CAMHS at SSV (SPFT)</td>
<td>£49,076</td>
</tr>
<tr>
<td>Neurodevelopmental psychologist at SSV (SPFT)</td>
<td>£36,000</td>
</tr>
<tr>
<td>Early Intervention Psychosis service (SPFT) (aged 14-35 years)</td>
<td>£756,000</td>
</tr>
<tr>
<td>LAC post in T2 CAMHS (BHCC)</td>
<td>£41,000</td>
</tr>
<tr>
<td>Youth Advice Centre (YMCA) - counselling (aged 14-25 years)</td>
<td>£46,000</td>
</tr>
<tr>
<td>Health &amp; Wellbeing Manager (Right Here) aged 14-25 years</td>
<td>£35,000</td>
</tr>
<tr>
<td>E-Motion (YMCA and Impact Initiatives) aged 14-25 years</td>
<td>£50,000</td>
</tr>
<tr>
<td>Wellbeing in East Brighton (YMCA) - counselling (aged 14-25 years)</td>
<td>£10,500</td>
</tr>
<tr>
<td>Young People’s Centre - Counselling (Impact) - counselling aged 14-25 years</td>
<td>£38,000</td>
</tr>
<tr>
<td>Wellbeing in East Brighton (Impact) aged 14-25 years</td>
<td>£10,500</td>
</tr>
<tr>
<td>Protective behaviours (Safety Net)</td>
<td>£43,000</td>
</tr>
<tr>
<td>Psychotherapist at Homewood College</td>
<td>£29,616</td>
</tr>
<tr>
<td>Domestic violence and child psychotherapy (RISE)</td>
<td>£40,000</td>
</tr>
<tr>
<td>Therapeutic support for children of sexual abuse (under 14 years)</td>
<td>£68,320</td>
</tr>
</tbody>
</table>
**BHCC - Children's Services mental health and wellbeing contracts (2014/15)**

<table>
<thead>
<tr>
<th>Specification</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Impact Initiatives- counselling service between 13-19</td>
<td>£19,000</td>
</tr>
<tr>
<td>Mind Brighton and Hove- advocacy service between 13-19</td>
<td>£27,596</td>
</tr>
<tr>
<td>Safety Net Ltd- family work in community CAMHS</td>
<td>£40,139</td>
</tr>
<tr>
<td>YMCA Downslink group- family work in community CAMHS</td>
<td>£67,600</td>
</tr>
<tr>
<td>SPFT- art psychotherapist post for LAC</td>
<td>£55,000</td>
</tr>
</tbody>
</table>

**BHCC - Public Health mental health and wellbeing contracts (2014/15)**

<table>
<thead>
<tr>
<th>Specification</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non- recurrent projects costs for work in primaries and in secondary's on self-harm / emotional health and wellbeing</td>
<td>£13,700</td>
</tr>
<tr>
<td>Chances for change funded projects (ends October 2015), Impact Initiatives and Food Partnership</td>
<td>£110,000</td>
</tr>
</tbody>
</table>
NHS England baseline data for Brighton and Hove CCG (2014/15)
– to be completed

<table>
<thead>
<tr>
<th>2014/15</th>
<th>Activity</th>
<th>Funding</th>
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<tbody>
<tr>
<td>TBC</td>
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</table>
Appendix Two – Brighton and Hove Transformation Plan Project Plan

B&H CCG TP Project Plan
Appendix Three – Outcomes from whole system workshop 12th June 2015
The CCG organised and implemented a whole system workshop as preparation for the changes required in developing and implementing a Transformation Plan.

Background & context of workshop

Introduction
Brighton and Hove Clinical Commissioning Group (CCG) in partnership with Brighton and Hove City Council (BHCC) have identified a need to carry out a joint strategic need assessment (JSNA) to review and service re-design the mental health and wellbeing services across the City for children and young people. This strategic priority has been identified following user and stakeholder feedback within Brighton and Hove as well as national strategic drivers, access targets and recommendations.

The JSNA and review & service re-design will encompass children and young people’s mental health and wellbeing services in Brighton and Hove 0-25 years. It will ensure services are delivered in the future, that respond to need, focus on prevention and early intervention and create a holistic, integrated, family orientated model. The process has started and should be completed by end September 2015.

Vision
There needs to be a shift of balance in children and young people’s mental health and wellbeing services from reactive, towards prevention, promoting mental health and wellbeing, and early intervention, where children and young people can thrive. The services should be based around family systems. To achieve this, there needs to be less fragmentation and more integration in a holistic way that takes account of the whole family experience and needs. These aims are reflected in the national strategy around healthcare83 and in some new, proposed models of care.84

Outcome
The outcome of the strategic review and service re-design will result in a business case outlining options for a new model of care for children and young people’s mental health and wellbeing needs in Brighton and Hove. The outcomes are based on national guidance85 and recommendations as well as user and stakeholder feedback. Essential elements of the improved model will include:

j) An improved system of care, co-designed by users and their needs;
k) Shared decision-making;
l) Greater provision of services focusing on prevention and promoting improved mental health and wellbeing within community settings;
m) Achievement of mental health access targets;
n) Effective access to urgent and specialist services when required, especially out of hours;
o) Clear information about how to access all services and what to expect clear referral criteria and consistent standards, including a named accountable clinician;
p) On-going workforce planning and appropriate skill mix;

83 http://origin.library.constantcontact.com/download/get/file/1102665899193-1598/five+year+forward+view.pdf
84 http://www.ucl.ac.uk/ebpu/docs/publication_files/New_THRIVE
q) A whole system approach to provision, ensuring care is close to home where possible;

r) Develop clear care pathways, such as Self-Harm, Eating Disorder, Perinatal, and Student Health;

s) Care pathway for behavioural problems, such as autistic spectrum disorder, attention deficit hyperactivity disorder and oppositional defiant disorder as well as those young people permanently excluded from school who may be attending a school for behavioural, emotional and social difficulties; and

t) Improved transition between services, especially between children’s and adult services (an all ages service).

**Future in Mind**

These desired outcomes echo those described in *Future in mind: Promoting, protecting and improving our children and young people’s mental health and wellbeing*, DoH, March 2015, written as an open letter to children and young people as follows:

“…we want to help you acquire the resilience and skills you need when life throws up challenges. We want you to know what to do for yourself if you are troubled by emotions or problems with your mental health. That includes knowing when and how to ask for help and, when you do, to receive high quality care. We want services to be able to respond quickly, to offer support and, where necessary, treatment that we know works, to help you stay or get back on track.”

There is a wish to tackle stigma and improve attitudes to mental illness; introduce more access and waiting time standards for services; establish ‘one stop shop’ support services in the community; improve access for children & young people who are particularly vulnerable. In summary it aims to ensure that children and young people:

a) Are resilient and achieve their desired goals;
b) Find it easy to seek help;
c) Are involved in how mental health services are developed and delivered;
d) Have help for individual needs; and
e) Receive the best possible support whenever and wherever they need it.

Key stakeholders attended from the following organisations/ agencies and representations:

| Brighton & Hove CCG               |
| Public Health                   |
| Allsorts                        |
| BICS Wellbeing service          |
| Impact Initiatives              |
| Brighton & Hove City Council    |
| YMCA                            |
| Right Here Young Person Representative |
| T2 CAMHS Service                |
| Homewood College                |
| Right Here Young Person Representative |
| PACC                            |
| Hangleton & Knoll Project       |
| Sussex Community Trust          |

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Agenda

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<thead>
<tr>
<th>Time</th>
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<td>9am</td>
<td>Arrive</td>
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<tr>
<td>1 9.15am</td>
<td>Welcome and introductions</td>
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<td>2 9.30am</td>
<td>Background and context</td>
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<td>3 9.45am</td>
<td>What good would look like’ (series of discussion opportunities)</td>
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<td>4 10.30am</td>
<td>Feedback</td>
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<td>5 10.45am</td>
<td>Tea/ coffee break</td>
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<td>6 11am</td>
<td>Principles of the model</td>
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<td>How could this be achieved/ implemented?</td>
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<td>Opportunities and barriers?</td>
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<td>7 11.30am</td>
<td>Next steps and final thoughts</td>
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<td>8 11.45</td>
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Welcome, introductions & what are attendees looking to get out of the workshop

There were many reasons why people attended the workshop:
- Time to reflect & learn from and about one another;
- To ensure the LGBT voice is heard;
- To feed in family & children’s voices;
- Focus on who does what & where gaps are;
- To focus on mental health issues;
- Using the Future in Mind document & understand how we can move this forward;
- To work through how we can support children with mental health issues;
- Be clear we’re not setting false expectations & being clear about what we can provide;
- Understand how things fit;
- Have used services & want to help develop future improvements;
- Representing 3rd sector, focusing on mental health services;
- Get an overview of services;
• Understand what’s happening locally & how transitions into adult services can be improved;
• Networking opportunity;
• Understand how early intervention service (EIP) fits in;
• See how we can support schools with EIP services;
• Making links & addressing the gaps;
• Vulnerability issues;
• Parent’s perspective – need to make services more visible;
• Work through EIP & attachment issues – family nurse partnership;
• What the future looks like;
• Transition between children’s & adult services; and
• To understand and build on the link between CAMHS & substance misuse service.

Feedback (main points)

If we knew were going to be really successful, what do we want to be different about how current mental health and wellbeing services are available to children and young people?

• Comprehensive & understandable service;
• Accessible;
• Integrated into communities and the community. Ensure services who don’t necessarily provide mental health and wellbeing support are also included;
• Based on community capacity building;
• Available to people both in virtual and real environments;
• Enhanced emergency services;
• Use the same language for both physical & mental wellbeing;
• Use of confidentiality is a barrier – sharing/linking of plans;
• Understand what parents need;
• How do we deal with families where there is no recognised/diagnosed mental illness;
• Mental health/ wellbeing as part of curriculum in schools;
• Clearer information on how to access services;
• Self-help information being better co-ordinated;
• People taking responsibility for helping people & not trying to pass on to someone else;
• Early identification of need;
• Early intervention around attachment;
• Lowering thresholds for accessing services;
• More focus on the failure of the service to engage than the young person engaging;
• Flexible & less compartmentalised approach;
• Gentle & slow transition to adult services;
• Recognising the spectrum of issues & difficulties;
• Right level of service at right time;
• Smooth transitions through from midwives to secondary schools & adult;
• Talking to children to get their views on service but also on their care;
• Social workers in schools;
• Building resilience in children;
• LGBT awareness;
• No young people falling through the gaps;
• Inclusion of whole family unit;
• Early intervention/quick assessment for hospital attendance;
• Proper early intervention/more evidence based interventions;
• Young men services and how to engage them;
• Young people training staff/peer training & support;
• Supervision/support of front line staff;
Better signposting;
Using money/ investment wisely;
Quicker responses to self-harm;
Right place for support;
Clear about what support is available;
Social media issues – cyber bullying;
Language that we use – early life help v EIP;
Transition for family & carers – clear information;
System is weakest where it needs to be strongest – transition from children’s to adults;
Services need to be designed & supported by young people – more service user involvement;
Services available at a lower level of distress;
Services need to relevant to the user and their need;
No door is the wrong door;
No stigma – services easily accessible;
Smother transitions – clearer referral pathway;
One stop information place – website (example in Australia);
Training existing staff who meet parents/children in recognising and knowing what to do about mental health;
More awareness within schools – being emotionally intelligent;
Support at pregnancy – attachment issues;
Lowering thresholds;
Teaching emotional intelligence/stress management;
GP to link parents to services;
Limiting issues of systems – failure of service not service user;
Have services based in buildings young people use – multi-agency / one stop;
Working smartly;
Relationships between services; and
Need to bring agencies & professionals (& possibly service users) together – consider anonymous case studies.

Our wishes – a few examples
Right level of service at right time
No stigma around m/h – access to services
Look at long-term – protect existing services whilst looking at new services
Relationships to be core to service delivery
Working better together and everything under one roof

Summary of key points – areas to work on
- Non-stigmatised environment, including a hub or one stop, there are natural hubs such as schools. Network/ forum; services to talk to one another, co-work with other services
- Outreach, flexible, accessible
- Engagement, involvement, co-design, if DNA, then what. What about the re-referral process? Peer support
- Whole school approaches, build resilience, talk about MH, normalise it, MH worker in schools, emotional intelligence/ mindfulness. LGBT awareness and support, young men, seldom heard not hard to reach
- From gatekeeping assessment to needs assessment
- Relationships are key, for continuity
- Lower level of distress, also need help, how?
- Immediate response, no door is the wrong door
- Family unit/ whole family approach
- Long term funding
• Early help – early intervention
• Early life help
• Working better together – coordinator, share information effectively and appropriately
• Transition
  through life course/ events
  to adult services/ preparation for adulthood and how involve parents, learn from LD and TAPA services
  other services
  18-25 years
• Clear information, signposting, social media, the language we use, one place for information
• Front line staff, training, supervision, including YP doing the training

Discussion of principles of model
• Building on what works – what’s good in the area, what’s already working;
• Clear communication – forums to discuss issues, share practice and learn about one another’s services;
• Connections – referrals rocketed when they stopped. People were based in hubs & in schools. Offered peer support over a number of years/ long term for individuals;
• Need to focus on what can be done – problem is that services become so process driven due to capacity;
• Funding issues – unless long term funding, pilots just come & go – nothing steady, need to have funding over a long period of time;
• Visibility – working within schools allows people to see mental health practitioners & be more accessible – discussion around whether young people would access more services. Stigma causes problems;
• Transition – what can we build on? In SPFT there is a cross-care forum covering pan-Sussex which covers systems & services not cases. Need to start a conversation with CAMHS services. Commissioners (children’s and adults) need to talk to each other. The Learning disability Service has a close working relationship between children’s & adults. Have a team based at The Royal Alexandra Hospital to work with in-patients. What can we learn from elsewhere; and
• Discussion around young people age issues. Consider 16-25years rather than 18-25 years.
Principles of the model

The workshop attendees considered The Future in Mind principles in any development of service improvement. A summary is below.

**Future in mind: Promoting, protecting and improving our children and young people’s mental health and wellbeing, DoH, March 2015, written as an open letter to children and young people as follows:**

“…we want to help you acquire the resilience and skills you need when life throws up challenges. We want you to know what to do for yourself if you are troubled by emotions or problems with your mental health. That includes knowing when and how to ask for help and, when you do, to receive high quality care. We want services to be able to respond quickly, to offer support and, where necessary, treatment that we know works, to help you stay or get back on track. We believe that asking people who use services what they think about what happens now is vital. They are the ones who know what needs to change. So our first thought was to ask you – children, young people and those who care for you – how things could work better?"1

**You have goals and ambitions you want to achieve, we want you to grow up to be confident and resilient to develop and realise these goals**

- You shouldn’t have to wait until you are really sick to get help
- Those around you should be understanding

**When you need help, you want to find it easily and able to trust it**

- Use of websites and apps
- Choice about where you get advice
- A welcoming place

**You are experts in your care and want to be involved in how services are delivered and developed**

- Set your own treatment goals
- We need to listen to your experience of care and ensure you have opportunity to feedback and influence change

- If you don’t keep your appointments, someone should get in touch to find out how they can help, not just leave it to you
You want to know that, whatever the circumstances, you get the best possible care and support and treatment when you need it

- People responsible for organising and delivering services know which are best to help you, and should be dedicated to offering the best mental health services, be honest and open as to how they are working to improve them

When you need help, you want it to meet your needs as an individual and be delivered by people who care about what happens to you

- You should only have to tell your story once
- All services in your area should work together so you get the right support you need at the right time and in the right place
- If you are in a crisis you should get help straightaway
- If you need to go to hospital we should ensure you keep up with your education as much as you can

Next steps

The JSNA and whole system review will be concluded in September. The findings of these two processes along with feedback and the content of this workshop will form the foundations of the future model.

The CCG, along with other commissioning partners, children, young people, their families and other stakeholders will develop a Transformation Plan for children’s mental health and wellbeing services. The draft Transformation Plan will be available for further comment in early September before the final draft at the end September. This will inform future commissioning decisions.
# Workplan Overview

**What is this document for?**

This document can be used to manage, track and report on a project and/or a programme of work. It is owned by you, but the PMO is on hand to support you to complete and maintain it. You can come and speak to the PMO team for direct support, or email us at bhccg.pmo@nhs.net.

Please read the information on this page to familiarise yourself with how to use this tool and complete the key information section.

## Key Information

<table>
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<tr>
<th>Workplan Name:</th>
<th>CYP Transformation Programme</th>
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<td>Gill Brooks</td>
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<td>Date Created:</td>
<td>22/09/15</td>
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<td>Commissioning - Mental Health &amp; Community</td>
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## Workplan Section Description

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<th>Workplan Section</th>
<th>Description</th>
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<tr>
<td>High-Level Summary</td>
<td>Captures milestones and progress, financial investment, an overall RAG rating and expected impact and KPI measurement.</td>
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<td>Risk Log</td>
<td>Captures all associated risks of any score. Risks scoring 12 and above need to be added to the corporate risk register.</td>
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<td>KPIs</td>
<td>Captures all planned KPIs, including metrics for monitoring acute, financial, operational and quality based metrics.</td>
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<td>Issues Log</td>
<td>Captures all issues currently affecting the project or programme (as opposed to a risk which may or may not impact)</td>
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<td>Detailed Plan</td>
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<td>Optional - this can be used to capture lessons learned that may help us, as an organisation, to improve delivery.</td>
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<td>Change Log</td>
<td>Optional - this can be used to track the status of major changes.</td>
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<td>Roles &amp; Responsibilities</td>
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## Impact

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<td>Performance</td>
<td>To improve key performance targets e.g. A&amp;E 4 hour standard</td>
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<td>Workforce</td>
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<td>QUICK TIPS</td>
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<td>&lt;1 month delay; 90% KPIs achieving target; risk scores &lt;9</td>
<td>You might want to take a look at the Highlight Report and Business Case templates which complement this workplan.</td>
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<td>1-2 month delay; 50-89% KPIs achieving target; risk score &gt;9</td>
<td>Click here for the Highlight Report</td>
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<td>2+ months delay; &lt;50% KPIs achieving target; risks 12+</td>
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See the PMO+ Resource Centre for the Project Essentials Handook, additional templates and resources.
Available at this link: \V:\USF\Brighton\Corporate Business\STAFF INFORMATION\PMO+ Resource Centre
## Long Term Transformation Plan

### Milestone RAG Key

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<th>Planned work</th>
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<th>At risk</th>
<th>Overdue</th>
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Type the following to automatically colour the cell:

- "p" for Planned work
- "c" for Complete
- "a" for At risk
- "o" for Overdue

### Overall RAG Rating - Scoring Key

- <1 month delay; 90% KPIs achieving target; risk scores <9
- 1-2 month delay; 50-89% KPIs achieving target; risk score >9
- 2+ months delay; <50% KPIs achieving target; risks 12+

**Please ensure you update the version control sheet upon updating.**

### Long term Transformation Plan

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<th>CATEGORY / TYPE / PROJECT</th>
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<td>Working group</td>
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<td>CCG &amp; Provider</td>
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<tr>
<td><strong>6 Crisis and Out of Hours</strong></td>
<td>Highlight as a risk</td>
<td>Commissioner</td>
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<tr>
<td><strong>7 Workforce development</strong></td>
<td>Work through issues and solutions with providers and other CCGs across Sussex</td>
<td>CCG &amp; Provider</td>
<td></td>
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<tr>
<td></td>
<td>Learn from South East networks</td>
<td>CCG &amp; Provider</td>
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**Project Team Key**
<table>
<thead>
<tr>
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<th>2017/18</th>
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<th>COMMENTS / DEPENDENCIES</th>
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<9  
1-2 month delay; 50-89% KPIs achieving target; risk score >9  
2+ months delay; <50% KPIs achieving target; risk score 12+
<table>
<thead>
<tr>
<th>Ref.</th>
<th>No.</th>
<th>ACTION/TASK</th>
<th>WHO</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>1</td>
<td>Implement CAMHS/school pilot</td>
<td>Children’s Services, Public Health, T2 CAMHS, Schools, CCG</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Working group meetings (monitor and evaluation)</td>
<td>Children’s Services, Public Health, T2 CAMHS, Schools, CCG</td>
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<tr>
<td></td>
<td>3</td>
<td>Recruitment of additional PMHW</td>
<td>T2 CAMHS</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Day one training day for CAMHS/ Schools link project</td>
<td>Children’s Services, Public Health, T2 CAMHS, Schools, CCG</td>
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<td></td>
<td>5</td>
<td>Day two training for CAMHS/ Schools link project</td>
<td>Children’s Services, Public Health, T2 CAMHS, Schools, CCG</td>
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<td></td>
<td>6</td>
<td>Evaluation of CAMHS/ Schools link</td>
<td>Children’s Services, Public Health, T2 CAMHS, Schools, CCG</td>
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<tr>
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<td>7</td>
<td>Establish a working group for developing innovative communications (link to Public Health social media action plan)</td>
<td>CCG</td>
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<tr>
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<td>8</td>
<td>Further develop of E-Motion infrastructure</td>
<td>Provider</td>
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<tr>
<td></td>
<td>9</td>
<td>Ensure Outreach Counselling sustainable</td>
<td>CCG &amp; Provider</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Develop innovative communications solutions</td>
<td>Working Group Communications</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>Develop specification</td>
<td>Working Group Communications</td>
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<tr>
<td></td>
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<td>Procure solutions</td>
<td>Commissioner</td>
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<td>12</td>
<td>Testing complete</td>
<td>Providers</td>
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<td>13</td>
<td>Implementation</td>
<td>Providers</td>
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<tr>
<td>14</td>
<td>Evaluation</td>
<td>CCGs &amp; Providers</td>
<td></td>
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<tr>
<td>15</td>
<td>Establish working group for Eating Disorder Model (Sussex-wide)</td>
<td>Sussex CCGs</td>
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<td>16</td>
<td>Ensure coordinator/ project manager in post</td>
<td>Sussex CCGs</td>
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<tr>
<td>17</td>
<td>Develop draft specification</td>
<td>Sussex CCGs</td>
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<tr>
<td>18</td>
<td>Agree specification</td>
<td>CCGs &amp; Providers</td>
<td></td>
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<td>19</td>
<td>Agree model and workforce including recruitment</td>
<td>CCGs &amp; Providers</td>
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<tr>
<td>20</td>
<td>Agree pathways and protocols especially to ensure all ages</td>
<td>CCGs &amp; Providers</td>
<td></td>
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<tr>
<td>21</td>
<td>Training and awareness plan developed to engage whole system</td>
<td>Provider</td>
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<tr>
<td>22</td>
<td>Testing complete</td>
<td>Provider</td>
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<td>23</td>
<td>Implementation</td>
<td>Provider</td>
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<td>24</td>
<td>Evaluation</td>
<td>Provider</td>
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<tr>
<td>25</td>
<td>CYP IAPT whole system workshop</td>
<td>CCG/Whole system</td>
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<tr>
<td>26</td>
<td>Whole system commitment and application to join learning collaborative</td>
<td>CCG/Whole system</td>
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<td>27</td>
<td>Appoint resources for CYP IAPT</td>
<td>CCG</td>
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<td>28</td>
<td>Map and scope current CYP IAPT principles, tools etc. in the system</td>
<td>CYP IAPT resource</td>
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<td>29</td>
<td>Gap analysis</td>
<td>CYP IAPT resource</td>
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<td>30</td>
<td>Update project according to gap analysis</td>
<td>CCG</td>
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<tr>
<td>31</td>
<td>Plan Primary Care Workshops</td>
<td>CCG</td>
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<tr>
<td>32</td>
<td>Implement Primary Care workshops</td>
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<tr>
<td>33</td>
<td>Gap analysis on skills and knowledge in Primary Care</td>
<td>CCG</td>
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<tr>
<td>34</td>
<td>Plan School / College Heads workshop</td>
<td>CCG</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>Implement School/ College Heads workshop</td>
<td>CCG</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>Gap analysis on skills and knowledge in Schools/ Colleges</td>
<td>CCG</td>
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<tr>
<td>37</td>
<td>Develop a plan for Primary Care and School/ Colleges joint workshop</td>
<td>CCG</td>
<td></td>
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<tr>
<td>38</td>
<td>Scope waiting list and training gap (capacity and system preparedness)</td>
<td>Providers and CCG</td>
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<tr>
<td>Capa</td>
<td>39</td>
<td>Develop plan to address capacity and make system ready</td>
<td>Providers and CCG</td>
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<td>40</td>
<td>Implement capacity plan</td>
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<td>Establish working group to scope crisis/ out of hours model (Sussex wide)</td>
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<td></td>
<td>42</td>
<td>Develop model including protocols, workforce</td>
<td>Working group</td>
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<td></td>
<td>43</td>
<td>Develop specification</td>
<td>CCG</td>
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<td></td>
<td>44</td>
<td>Recruitment</td>
<td>Provider</td>
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<tr>
<td></td>
<td>45</td>
<td>Testing complete (early 2016/17)</td>
<td>Provider</td>
</tr>
<tr>
<td></td>
<td>46</td>
<td>Implement new model (early 2016/17)</td>
<td>Provider</td>
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<td></td>
<td>47</td>
<td>Evaluation (2016/17)</td>
<td>Provider</td>
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<td></td>
<td>48</td>
<td>Establish working group for LAC model</td>
<td>Working Group</td>
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<td>49</td>
<td>Develop model including protocols, workforce</td>
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<tr>
<td></td>
<td>50</td>
<td>Develop specification</td>
<td>CCG</td>
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<td></td>
<td>51</td>
<td>Recruitment</td>
<td>Provider</td>
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<tr>
<td></td>
<td>52</td>
<td>Testing complete (early 2016/17)</td>
<td>Provider</td>
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<tr>
<td></td>
<td>53</td>
<td>Implement new model (early 2016/17)</td>
<td>Provider</td>
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<tr>
<td></td>
<td>54</td>
<td>Evaluation (2016/17)</td>
<td>Provider</td>
</tr>
<tr>
<td></td>
<td>55</td>
<td>Work with NHS E Health Justice partners to scope current services and pathways and how to improve them for YP known to Youth Justice System</td>
<td>CCG and partners</td>
</tr>
<tr>
<td></td>
<td>56</td>
<td>Work with partners to establish a plan for CYP refugees</td>
<td>CCG and partners</td>
</tr>
<tr>
<td></td>
<td>57</td>
<td>Establish working group for Outreach/ TAPA</td>
<td>CCG</td>
</tr>
<tr>
<td></td>
<td>58</td>
<td>Develop model including protocols, workforce</td>
<td>Working Group</td>
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<tr>
<td></td>
<td>59</td>
<td>Develop specification</td>
<td>CCG</td>
</tr>
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<td></td>
<td>60</td>
<td>Recruitment</td>
<td>Provider</td>
</tr>
<tr>
<td></td>
<td>61</td>
<td>Testing complete (early 2016/17)</td>
<td>Provider</td>
</tr>
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<td></td>
<td>62</td>
<td>Implement new model (early 2016/17)</td>
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<td></td>
<td>63</td>
<td>Evaluation (2016/17)</td>
<td>Provider</td>
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<td></td>
<td>64</td>
<td>Appoint Health Promotion post</td>
<td>CCG &amp; Public Health</td>
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<tr>
<td></td>
<td>65</td>
<td>Develop sustainable training programme</td>
<td>Trainer</td>
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<tr>
<td></td>
<td>66</td>
<td>Implement training programme</td>
<td>Trainer</td>
</tr>
<tr>
<td></td>
<td>67</td>
<td>Appoint project manager for Transformation Plan</td>
<td>CCG</td>
</tr>
<tr>
<td></td>
<td>68</td>
<td>Complete JSNA, recommendations and action plan</td>
<td>CCG &amp; Public Health</td>
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</table>
Project Team Key

[e.g. IDF - Isabella Davis-Fernandez]
**RISK LOG** [Use this log to record all project risks and ensure that they are escalated to the relevant group where necessary - see Risk Management Policy & Procedure for guidance]

**Purpose:** To capture all risks including a description, the score, risk type, owner and details of mitigating actions. Please note that risks scoring 12 and above should be added to the CCG's risk management system 'Safeguard' to ensure they can be managed at a strategic level.

<table>
<thead>
<tr>
<th>REF</th>
<th>DATE RAISED</th>
<th>DESCRIPTION</th>
<th>RISK TYPE</th>
<th>IMPACT 1-5</th>
<th>PROBABILITY 1-5</th>
<th>RAG</th>
<th>OWNER</th>
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<tbody>
<tr>
<td>1</td>
<td>25/09/15</td>
<td>There is a risk that we may not be able to recruit to posts associated with the developments in CYP mental health services. This means we may not be able to proceed according to the planned timeline.</td>
<td>Workforce</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>GB</td>
</tr>
<tr>
<td>2</td>
<td>30/09/15</td>
<td>Availability of resources to ensure the transformational change remains on track</td>
<td>Workforce</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>GB</td>
</tr>
<tr>
<td>3</td>
<td>30/09/15</td>
<td>Requirement for whole system engagement and change may slow progress on transformation</td>
<td>Communication &amp; Engagement</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>GB</td>
</tr>
<tr>
<td>4</td>
<td>30/09/15</td>
<td>Other transformational change that are inter-dependencies to this programme may hinder progress</td>
<td>Performance &amp; Quality</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>GB</td>
</tr>
</tbody>
</table>
To record all project risks and ensure they are escalated to the relevant group where necessary, see the Risk Management Policy & Procedure for guidance.

The CCG's risk management system 'Safeguard' should be used to ensure that risks scoring 12 and above can be managed at a strategic level.

### Action Plan

<table>
<thead>
<tr>
<th>ACTION PLAN</th>
<th>TARGET / CLOSE</th>
<th>OPEN / CLOSED</th>
<th>ON SAFEGUARD SYSTEM?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Advertise post outside of area (e.g. London and Kent)</td>
<td>31/03/16</td>
<td>Open</td>
<td>GB</td>
</tr>
<tr>
<td>2. Work across SE SCN for support</td>
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<tr>
<td>3. Work with other CCGs and with our providers to scope solutions</td>
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<tr>
<td>4. Scope potential local assets and develop workforce development plan</td>
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</table>

<table>
<thead>
<tr>
<th>ACTION PLAN</th>
<th>TARGET / CLOSE</th>
<th>OPEN / CLOSED</th>
<th>ON SAFEGUARD SYSTEM?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recruit project management in CCG using Transformation Funds</td>
<td>31/03/16</td>
<td>Open</td>
<td>GB</td>
</tr>
<tr>
<td>2. Ensure clinical/ expert advice and time available from provider(s) to</td>
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<tr>
<td>ensure appropriate decisions made, build commitment to change and lead</td>
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<td></td>
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<tr>
<td>change with CCG, using Transformation Funds</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTION PLAN</th>
<th>TARGET / CLOSE</th>
<th>OPEN / CLOSED</th>
<th>ON SAFEGUARD SYSTEM?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ensure clarity on all organisations authorisation and sign off processes</td>
<td>31/03/16</td>
<td>Open</td>
<td>GB</td>
</tr>
<tr>
<td>and timetable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Develop a communications plan</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTION PLAN</th>
<th>TARGET / CLOSE</th>
<th>OPEN / CLOSED</th>
<th>ON SAFEGUARD SYSTEM?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ensure PMO Support group continues to align priorities and work</td>
<td>31/03/16</td>
<td>Open</td>
<td>GB</td>
</tr>
<tr>
<td>programmes and highlight delivery risk early</td>
<td></td>
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</tr>
<tr>
<td>Domains</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Impact on the safety of patients, staff or public (physical/psychological harm)</td>
<td>NEGLIGIBLE</td>
<td>Minor injury or illness, requiring minor intervention or treatment. No time off work</td>
<td>Moderate injury requiring professional intervention. Requiring time off work for 4-14 days. Increase in length of hospital stay by 1-15 days. RIDDOR/agency reportable incident. An event which impacts on a small number of patients</td>
</tr>
<tr>
<td>Quality/complaints/audit</td>
<td>Peripheral element of treatment or service suboptimal Informal complaint/inquiry</td>
<td>Overall treatment or service suboptimal. Formal complaint (stage 1). Local resolution. Single failure to meet internal standards. Minor implications for patient safety if unresolved. Reduced performance rating if unresolved.</td>
<td>Treatment or service has significantly reduced effectiveness. Formal complaint (stage 2). Local resolution (with potential to go to independent review). Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on.</td>
</tr>
<tr>
<td>Human resources/ organisational development/staffing/competence</td>
<td>Short-term low staffing level that temporarily reduces service quality (&lt; 1 day)</td>
<td>Low staffing level that reduces the service quality</td>
<td>Late delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (&gt;1 day). Low staff morale. Poor staff attendance for mandatory/key training.</td>
</tr>
<tr>
<td>Statutory duty/ inspections</td>
<td>No or minimal impact or breach of guidance/statutory duty</td>
<td>Breach of statutory legislation. Reduced performance rating if unresolved.</td>
<td>Single breach in statutory duty. Challenging external recommendations/improvement notice.</td>
</tr>
<tr>
<td>Business objectives/ projects</td>
<td>Insignificant cost increase/schedule slippage</td>
<td>Elements of public expectation not being met. &lt;5 per cent over project budget. Schedule slippage</td>
<td>5-10 per cent over project budget. Schedule slippage.</td>
</tr>
<tr>
<td>Finance including claims Service/business interruption Environmental impact</td>
<td>Small loss Risk of claim remote Loss/interruption of &gt;1 hour Minimal or no impact on the environment Minimal or no</td>
<td>Loss of 0.1–0.25 per cent of budget Claim less than £10000 Loss/interruption of &gt;8 hours Minor impact on environment</td>
<td>Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000 Loss/interruption of &gt;1 day Moderate impact on environment</td>
</tr>
<tr>
<td>---</td>
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</tr>
</tbody>
</table>

### Likelihood Score - What is the likelihood of the impact occurring?

<table>
<thead>
<tr>
<th>Likelihood score</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>RARE</td>
<td>UNLIKELY</td>
<td>POSSIBLE</td>
</tr>
<tr>
<td>Frequency</td>
<td>This will probably never happen/recur</td>
<td>Do not expect it to happen/recur but it is possible it may do so</td>
<td>Might happen or recur occasionally</td>
</tr>
</tbody>
</table>

### Risk Scoring = Impact x Likelihood

<table>
<thead>
<tr>
<th>Impact/Consequence</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rare</td>
<td>Unlikely</td>
<td>Possible</td>
</tr>
<tr>
<td>5 Catastrophic</td>
<td>5</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>4 Major</td>
<td>4</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>3 Moderate</td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>2 Minor</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>1 Negligible</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MAJOR</strong></td>
<td><strong>CATASTROPHIC</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major injury leading to long-term incapacity/disability. Requiring time off work for &gt;14 days. Increase in length of hospital stay by &gt;15 days. Mismanagement of patient care with long-term effects.</td>
<td>Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncertain delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (&gt;5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/key training.</td>
<td>Non-delivery of key objective/service due to lack of staff. Ongoing unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training/key training on an ongoing basis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National media coverage with &lt;3 days service well below reasonable public expectation.</td>
<td>National media coverage with &gt;3 days service well below reasonable Public expectation. MP concerned (questions in the House). Total loss of public confidence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.</td>
<td>Incident leading &gt;25 per cent over project budget.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget</td>
<td>Schedule slippage.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claim(s) between £100,000 and £1 million</td>
<td>Key objectives not Met.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchasers failing to pay on time</td>
<td>Non-delivery of key objective/ Loss of &gt;1 per cent of Budget.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss/interruption of &gt;1 week</td>
<td>Failure to meet specification/ slippage.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major impact on environment</td>
<td>Payment by results Claim(s) &gt;£1 million</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent loss of service or facility</td>
<td>Catastrophic impact on environment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LIKELIHOOD</th>
<th>ALMOST CERTAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will probably happen/recur but it is not a persisting issue</td>
<td>Will undoubtedly happen/recur, possibly frequently</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>L</th>
<th>ALMOST CERTAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>16</td>
<td>20</td>
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<td>12</td>
<td>15</td>
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<tr>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
**Annex 1: Local Transformation Plans for Children and Young People’s Mental Health**

**Brighton and Hove CCG**

Developing your local offer to secure improvements in children and young people’s mental health outcomes and release the additional funding: high level summary

<table>
<thead>
<tr>
<th>Q1. Who is leading the development of this Plan?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Please identify the lead accountable commissioning body for children and young people’s mental health at local level. We envisage in most cases this will be the CCG working in close collaboration with Local Authorities and other partners. Please list wider partnerships in place, including with the voluntary sector and include the name and contact details of a single senior person best able to field queries about the application.)</td>
</tr>
</tbody>
</table>

Brighton and Hove CCG is leading the development of the Brighton and Hove children’s mental health and wellbeing Transformation Plan. This has been developed in conjunction with:

- Children and young people including the Youth Council;
- Parents and Carers;
- Mental Health and Wellbeing providers including the Community and Voluntary Sector, Primary Care and Acute sector;
- Schools and Colleges;
- The Health and Wellbeing Board for Brighton and Hove;
- Other CCG commissioners;
- Crisis Care Concordat working group;
- NHS England;
- NHS England Health and Justice; and
- Brighton and Hove City Council, specifically Children’s Services and Public Health.

The main contact for this Transformation Plan is:
Gill Brooks (gill.brooks1@nhs.net)
Q2. What are you trying to do?
(Please outline your main objectives, and the principal changes you are planning to make to secure and sustain improvements in children and young people’s mental health outcomes. What will the local offer look like for children and young people in your community and for your staff?). Please tell us in no more than 300 words

Brighton and Hove CCG will ensure there is a balance between a narrow, targeted approach and a too broad a focus in our transformation, by establishing our priorities based on need that generates energy and commitment for the change required. The transformational change is based on feedback and the Joint Strategic Needs Assessment findings. The principles of the Plan have been developed with children and young people and their families as well as key stakeholders in the system. The principles are:

- Involve children and young people;
- Foster resilience across the system;
- Prevent deterioration;
- Engage children and young people in their care;
- Reach out to where children and young people are;
- Care for the most vulnerable groups;
- Improve access;
- Intervene early;
- Best start in life;
- Prepare for adulthood;
- Build capacity across the system;
- Collaborative and joint commissioning;
- Physical and mental health issues are addressed equally; and
- Ensure access to services in a crisis especially out of hours.

In 2015/16 the CCG intends to use the funds to ensure the system builds strong foundations for transformational change, to address areas of immediate need/ gaps, and to ensure the system is ready for the change. The following areas have been identified:

- Innovative communications and support;
- Preparation and system-readiness for Children and Young People’s IAPT;
- Extending Primary Mental Health Workers in schools;
- Implementing the CAMHS/ Schools training national pilot;
- Extending outreach counselling pilot;
- Project management resource;
- Development of Primary Care and Schools and Colleges;
- Health Promotion post; and
- Address current capacity.

Building on strong foundations, the CCG intends to address the following areas of need in future years:

- Crisis and out of hours care;
- Continuing to support innovative communication;
- Vulnerable groups (Children in Care, formally Looked After Children (LAC), those involved in the Youth Justice System and Refugees);
- Seldom heard;
- Extending the outreach counselling pilot;
Community Eating Disorder Service for Children and Young People (CEDS-CYP)
Sussex CCGs (East and West Sussex and Brighton and Hove) will develop a Sussex-wide CEDS-CYP, ageless network model. The service will provide a comprehensive assessment and evidence-based treatment pathway for those with an eating disorder (mild - severe). The service will provide support to children, young people and their families as well as advice and guidance and awareness training for the whole system.

The CCGs have developed a draft specification and established a clinically-led working group to finalise the model, pathways and workforce.

Q3. Where have you got to?
(Please summarise the main concrete steps or achievements you have already made towards developing your local offer in line with the national ambition set out in Future in Mind e.g. progress made since publication in March 2015.) Please tell us in no more than 300 words

Brighton and Hove CCG will continue to work with all partners including children, young people, their parents/ carers to develop an integrated and whole system approach to change and improving children and young people’s mental health outcomes. The key areas of long term transformational change that we know we need to change and work towards over the next five years (2015 – 2020) are:

- Building resilience, promoting good mental health and intervening as early as possible including in schools
- Develop a service that responds to needs of individuals including in a crisis and out of hours
- Integrated pathways across the whole system as well as all ages where possible, with particular emphasis on the most vulnerable children and young people
- Ensure our workforce has the right experience, skills and competencies, feels part of the change and commits to the long term change required, and uses evidence-based interventions, pathways and outcomes tools
- Be more transparent about the commissioning arrangements ensuring strategic commissioning decisions are based on the needs of Brighton and Hove and work with our providers to ensure they can deliver improved outcomes

The key achievements the CCG has already made include:

- Developing a City-wide Children’s Strategy based on joint commissioning;
- Establishing a PMHW pilot in 3 secondary schools and applied for the national CAMHS School bid;
- Consultation, engagement and involvement (JSNA and whole system workshop);
- CYP IAPT arranged for October 2015 where SE Learning Collaborative members will inform and facilitate local discussions, planning and commitment to join the Collaborative;
- Developed a mental health liaison model for children and young people, implementation is due in November 2015;
- Extension of already established perinatal mental health; and
- Established a Sussex-wide CEDS-CYP clinically-led working group and a draft specification.

**Q4. Where do you think you could get to by April 2016?**
(Please describe the changes, realistically, that could be achieved by then.) Please tell us in no more than 300 words

Brighton and Hove CCG plans to have made the following progress by April 2016:
- Implemented the PMHW pilot in 3 secondary schools as well as extending the pilot if successful with national CAMHS/ Schools bid;
- Have developed a specification for innovative communications;
- Have developed a specification for an ageless Wellbeing service;
- Developed a specification for post-traumatic complex trauma pathway;
- Sustained E-Motion and outreach counselling in East Brighton;
- Started to prepare for developing CYP IAPT in Brighton and Hove;
- Establish a CEDS-CYP model and recruited resource to start to deliver the service;
- Established a mental health liaison team for children and young people at The Alex Children’s Hospital; and
- Ensure system capacity and readiness for transformational change.

**Q5. What do you want from a structured programme of transformation support?** Please tell us in no more than 300 words

Brighton and Hove CCG would welcome the following transformational support:
- Clinical expert support and advice;
- Templates for key documents;
- Evidence-based analysis;
- Benchmarking data and information;
- Quality outcomes advice and guidance;
- Support with specialist co-commissioning
- Support and development of a South East-wide workforce development plan; and
- Sharing of best practice
Plans and trackers should be submitted to your local DCOs with a copy to England.mentalhealthperformance@nhs.net within the agreed timescales.

The quarterly updates should be submitted in Q3 and Q4. Deadline dates will be confirmed shortly and are likely to be shortly after quarter end. These dates will, where possible, be aligned with other submission deadlines (eg, for the system resilience trackers, or CCG assurance process).

DCOs will be asked to submit the trackers to england.camhs-data@nhs.net for analysis and to compile a master list.
Annex 2: Self-assessment checklist for the assurance process

Brighton and Hove CCG

Please complete the self-assurance checklist designed to make sure that Local Transformation Plans for Children and Young People’s Mental Health and Wellbeing are aligned with the national ambition and key high level principles set out in *Future in Mind* and summarised in this guidance.

**PLEASE NOTE:** Your supporting evidence should be provided in the form of specific paragraph number references to the evidence in your Local Transformation Plans – not as free text.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Y/N</th>
<th>Evidence by reference to relevant paragraph(s) in Local Transformation Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Engagement and partnership</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please confirm that your plans are based on developing clear coordinated whole system pathways and that they:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Have been designed with, and are built around the needs of, CYP and their families</td>
<td>Y</td>
<td>1.7a, 1.7d, 3.6, 3.7, 3.8, 5.19.1, 5.19.2, 7.5, Section 8, 10.5.4, 10.6.1, 10.10.1, 11.2.1</td>
</tr>
<tr>
<td>2. provide evidence of effective joint working both within and across all sectors including NHS, Public Health, LA, local Healthwatch, social care, Youth Justice, education and the voluntary sector</td>
<td>Y</td>
<td>1.2, 1.7l, 5.2.1, 5.4, 5.6, 5.7, 5.8, 5.9, 5.10, 5.11, 5.12, 5.13, 5.14, 5.15, 5.16, 5.17, 5.18, 7.2, 7.5e, 7.10.4, 7.11.2, 10.5.1, 10.7.3, 10.10.3, 11.4.3, 11.4.6, figure 4</td>
</tr>
<tr>
<td>3. include evidence that plans have been developed collaboratively with NHS E Specialist and Health and Justice Commissioning teams</td>
<td>Y</td>
<td>5.1.1, 7.9.3ii, 7.9.4, 11.2.2, 11.2.3, 11.4.4, 11.4.5, 12.3,</td>
</tr>
<tr>
<td>4. promote collaborative commissioning approaches within and between sectors</td>
<td>Y</td>
<td>1.2, 7.9.3, 10.8.1, 10.10.3, 10.11.1, 11.2.2, 11.4.6, 12.2, 12.3, 17.8</td>
</tr>
<tr>
<td>Are you part of an existing CYP IAPT collaborative?</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td></td>
</tr>
<tr>
<td>If not, are you intending to join an existing CYP IAPT collaborative in 2015/16?</td>
<td>Y</td>
<td>10.7.3, 10.8.5</td>
</tr>
</tbody>
</table>

**Transparency**

Please confirm that your Local Transformation Plan includes:

1. The mental health needs of children and young people within your local population | Y | 3.1, 3.2, 3.3, 3.4, 3.5, 3.8.1, 5.19.1, 5.19.2, 7.11.1, Section 8, 10.9.1, 10.10.1, 11.2.1, 11.4.1 |
2. The level of investment by all local partners commissioning children and young people’s mental health services | Y | Section 6, table two (f), Appendix One |
3. The plans and declaration will be published on the websites for the CCG, Local Authority and any other local partners | Y | 6.2 and once agreed by NHS England and Brighton and Hove Health and Wellbeing Board |

**Level of ambition**

Please confirm that your plans are:

1. based on delivering evidence based practice | Y | 7.8.1d, 7.9.2, 7.9.3, 7.10.3, 10.5.3, 10.7.1, 10.8.3, 10.8.4, 11.3.6, 11.5.4, 12.1, 12.4a, 12.5, 13.1, 14.1, 15.1 |
2. focused on demonstrating improved outcomes | Y | 7.2, table 2, 7.8.2, 7.9.3, 10.7.2, 10.8.2, 10.8.7, 10.10.1, 12.4, 13.2, 13.3, 14.2, Annex3 (tracker) |

**Equality and Health Inequalities**

Please confirm that your plans make explicit how you are promoting equality and addressing health inequalities | Y | Section 9, 12.7, 12.8, 12.9 |

**Governance**

Please confirm that you have arrangements in place to hold multi-agency boards for delivery | Y | 17.1, 17.2 |
<table>
<thead>
<tr>
<th><strong>Measuring Outcomes (progress)</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Please confirm that you have published and included your baselines as required by this guidance and the trackers in the assurance process</td>
<td>Y</td>
<td>Section 6, table two (f), Appendix One</td>
</tr>
<tr>
<td>Please confirm that your plans include measurable, ambitious KPIs and are linked to the trackers</td>
<td>Y</td>
<td>16.2, 16.3, 16.4, table 6, Appendix 2, Annex 3 (tracker)</td>
</tr>
</tbody>
</table>

**Finance**

<p>| | |</p>
<table>
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<tbody>
<tr>
<td>Please confirm that:</td>
<td></td>
</tr>
<tr>
<td>1. Your plans have been costed</td>
<td>Y</td>
</tr>
<tr>
<td>2. that they are aligned to the funding allocation that you will receive</td>
<td>Y</td>
</tr>
<tr>
<td>3. take into account the existing different and previous funding streams including the MH resilience funding (Parity of Esteem)</td>
<td>Y</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Geraldine Hoban</td>
<td></td>
</tr>
<tr>
<td>Chief Operating Officer, Brighton and Hove CCG</td>
<td></td>
</tr>
</tbody>
</table>

Geraldine Hoban
Chief Operating Officer, Brighton and Hove CCG

Name, signature and position of person who has signed off Plan on behalf of local partners

Name, signature and position of person who has signed off Plan on behalf of NHS Specialised Commissioning.
CAMHS Assurance Data Collection Template - Instructions

Notes for completion
The completed return will require details from the person completing the plan and those who are signing off the plan

Content
Cover sheet - this includes basic contact details from the person who has completed the template, the person who is signing off the plan on behalf of the CCG and the person who is signing off the plan on behalf of the Health and Wellbeing board
Tracker sheet - this includes eating disorder and finance data
Validation Sheet - this sheet contains the details on question completion and if a user has answered each question
To note - Yellow cells require input, blue cells do not

Cover sheet
On the cover sheet please enter the following information:
The date of completion
The CCG you are completing the plan on behalf of
Details for who has completed the plan on behalf of the CCG (name, email, contact number and who has signed off the report on behalf of the CCG)
Details for who has signed off the plan on behalf of the CCG (job title, email and contact number)
Details for who has signed off the plan on behalf of the Health and Wellbeing Board (job title, email and contact number)
Details of publish date and plan location (planned publish date and web link for plan)
Name of person who has signed off the report on behalf of the HWB:
Email of person who has signed off the report on behalf of the HWB:
Contact number of person who has signed off the report on behalf of the HWB:
Name of person who has signed off the report on behalf of NHS England Specialised Commissioning:
Job title of person who has signed off the report on behalf of NHS England Specialised Commissioning:
Email of person who has signed off the report on behalf of NHS England Specialised Commissioning:
Contact number of person who has signed off the report on behalf of NHS England Specialised Commissioning:
Planned publish date (you may wish to assure your plans before publishing):
Web link for plan:

Tracker
This requires eating disorder and finance data. Please answer as at time of completion
The eating disorder section requires four questions to be completed:
Is your current Eating Disorder service for under 18s compliant with the guidelines issued by NHS England and NCCMH in 2015?
If yes please detail below how you are using the underspend of the monies allocated for Eating Disorder on crisis or self-harm
If no please indicate below how much will be used to ensure an evidence based community eating disorder services, and how the generic resources are redeployed to support self harm and crisis services for young people
Which CCGs are you working with
The finance section requires twenty questions to be completed:
It may not be possible to answer all of the questions due to the timing of the collections so please ensure you answer as many questions as possible
Description of local priority
Please select stream from which funding comes using the drop down menu
Service user group that the priority is targeted at e.g. Under 18s with Eating disorders, LAC, CYP who are sexually exploited
What is the evidence base for this intervention?
Planned spend broken down by quarter (Q1 Apr - Jun 15/16, Q2 Jul - Sep 15/16, Q3 Oct - Dec 15/16, Q4 Jan - Mar 15/16)
Main KPI
KPI baseline
KPI target
Please select a date the KPI will be achieved by using the drop down menu
Actual spend broken down by quarter (Q1 Apr - Jun 15/16, Q2 Jul - Sep 15/16, Q3 Oct - Dec 15/16, Q4 Jan - Mar 15/16)
Please select yes or no for KPI on track at end of Q3 using the drop down menu
Please select yes or no for KPI on track at end of Q4 using the drop down menu

Validation
The sheet is split into the 4 sections:
Basic details
Eating disorder
Partnering CCGs
Finance
Each section contains a table of the questions within the section, it has a Y or N depending on if the user has completed the question.
Cells that are green and contain a 'Y' mean that the question has been completed and cells that are red and contain an 'N' mean that the question has not been completed and need to have an answer inserted.

In the case of the Finance sections all cells appear blank until a question has been completed on the row, the row will only be green when all questions on that row have been completed. Cells in this section correspond exactly to those within the Finance section of the Tracker so users can see which questions have not been completed.

Support
If you have any questions about how to complete the template please contact england.camhs-data@nhs.net for support
<table>
<thead>
<tr>
<th>CAMHS Assurance Data Collection Template - Cover Sheet</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cover and basic details</strong></td>
</tr>
<tr>
<td>Submission Period:</td>
</tr>
<tr>
<td>Initial plan submission - Sep 2015</td>
</tr>
<tr>
<td>CCG:</td>
</tr>
<tr>
<td>NHS BRIGHTON AND HOVE CCG</td>
</tr>
<tr>
<td>Completed by:</td>
</tr>
<tr>
<td>Gill Brooks</td>
</tr>
<tr>
<td>Email:</td>
</tr>
<tr>
<td><a href="mailto:gill.brooks1@nhs.net">gill.brooks1@nhs.net</a></td>
</tr>
<tr>
<td>Contact number:</td>
</tr>
<tr>
<td>01273 574635</td>
</tr>
<tr>
<td><strong>Details for who has signed off the plan on behalf of the CCG</strong></td>
</tr>
<tr>
<td>Name of person who has signed off the plan on behalf of the CCG:</td>
</tr>
<tr>
<td>Geradline Hoban</td>
</tr>
<tr>
<td>Job title of person who has signed off the plan on behalf of the CCG:</td>
</tr>
<tr>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td>Email of person who has signed off the plan on behalf of the CCG:</td>
</tr>
<tr>
<td><a href="mailto:geraldine.hoban@nhs.net">geraldine.hoban@nhs.net</a></td>
</tr>
<tr>
<td>Contact number of person who has signed off the plan on behalf of the CCG:</td>
</tr>
<tr>
<td>01273 574863</td>
</tr>
<tr>
<td><strong>Details for who has signed off the plan on behalf of the Health and Wellbeing Board</strong></td>
</tr>
<tr>
<td>Name of person who has signed off the plan on behalf of the HWB:</td>
</tr>
<tr>
<td>Daniel Yates</td>
</tr>
<tr>
<td>Job title of person who has signed off the plan on behalf of the HWB:</td>
</tr>
<tr>
<td>Chair of Brighton and Hove Health and Wellbeing Board</td>
</tr>
<tr>
<td>Email of person who has signed off the plan on behalf of the HWB:</td>
</tr>
<tr>
<td><a href="mailto:Daniel.Yates@brighton-hove.gov.uk">Daniel.Yates@brighton-hove.gov.uk</a></td>
</tr>
<tr>
<td>Contact number of person who has signed off the plan on behalf of the HWB:</td>
</tr>
<tr>
<td>07808612388 on behalf of Councillor Yates (Health and Wellbeing Board Development Manager)</td>
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Please fill in every cell that relates to your current situation – so for example, in your initial submission, you will not be able to fill in actual spend for Q3 and Q4 nor whether you are on track to deliver the KPI. By the end of your final submission every column for every local funding priority should be completed

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Is your current Eating Disorder service for under 18s compliant with the No
If yes, please detail below how you intend to expand your current service for young people to meet further demand, or use the underspend of the monies allocated for Eating Disorder on crisis or self-harm for young people
If no please indicate below how much will be used to ensure an evidence based Children and Young People under 18 needs to cover a minimum population footprint of 500k total population, and receive a minimum number of 50 new cases required to provide an safe, effective and efficient team. Many CCGs will need to work with other CCGs to commission teams jointly. Please indicate

Finance

Planned spend (broken down by quarter)

Actual spend (broken down by quarter).

Service user group that the priority is targeted at e.g. Under 18s with Eating disorders, LAC, CYP who are

Please select yes or no for KPI on

What is the evidence base for this scheme

The expected outcome of the track at end of Q3 using the drop down menu

Example 1

NCCMH/NHS England guidelines 2015

ED

0 0 50,000 50,000

Supplement existing ED team to become evidence compliant

Redeploy generic staff currently seeing ED cases now seen by community team to improve access to self harm and crisis and

Reduction in self harm admissions and A&E presentation, reduction to Tier 4 admissions

Example 2

CYP who self harm or CYP presenting in crisis

NICE guidelines for self harm QNCC standards on intensive response

0 0 20,000 20,000

2 out of 80 cases

70% of presenting cases Mar-17

0 0 0 0

Early intervention for behavioral difficulties provided in schools - commissioned in anticipation of monies

Improved behaviour in home and school. Improved academic outcomes

Innovative communications

CYP with mental health & wellbeing issues

Future in Mind

0 10,000 10,000 10,000

0 15/16 Transformation funds

PMHW in schools & CAMHS/ School training project

CYP with mental health & wellbeing issues within schools

Future in Mind

15/16 Transformation funds

Local priority stream 3

E-motion sustainability & further development

CYP with mental health & wellbeing issues

Future in Mind

15/16 Transformation funds

Local priority stream 5

Project management

CYP with mental health & wellbeing issues

Future in Mind

15/16 Transformation funds

Local priority stream 6

Health promotion post (training)

CYP with mental health & wellbeing issues

Future in Mind

15/16 Transformation funds

Local priority stream 8

Eating Disorder CEDS-CYP preparedness

CYP with eating disorders

NCCMH/NHS England guidelines 2015

0 0 58,000 90,000

Local priority stream 10

Local priority stream 11

Local priority stream 12

Local priority stream 13

Local priority stream 14

Local priority stream 15

Local priority stream 16

Local priority stream 17

Local priority stream 18

Local priority stream 19

Local priority stream 20
### CAMHS Assurance Data Collection Template - Validation Sheet

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Future in mind

Promoting, protecting and improving our children and young people’s mental health and wellbeing
The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.
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Our childhood has a profound effect on our adult lives. Many mental health conditions in adulthood show their first signs in childhood and, if left untreated, can develop into conditions which need regular care.

But, too often, children and young people's emotional wellbeing and mental health is not given the attention it needs. Far too many families have experienced poor children's and adolescent mental health care. This isn't endemic, and we have made great progress in the last few years, but it remains unacceptable that not every child or young person gets the help they need when and where they need it. Some don't get any care at all, and their problems escalate to a crisis point. This isn't due to lack of good will – there are many highly skilled and highly valued staff working with children and young people who want to make a real and lasting difference to their lives but there are barriers in the system itself which prevent change.

I have been changing that system. Since 2011, my Department and NHS England have invested over £60 million in the Children and Young People's Improving Access to Psychological Therapies programme. We have funded the development of MindEd – giving more advice to health professionals about how to help young people with mental ill-health. We have put more mental health beds for young people in the system, as well as training new case workers to offer help where it is needed. But this isn't enough – we need to be ambitious if we want children and young people to live happy, healthy lives.

This is why I set up the Children and Young People's Mental Health and Wellbeing Taskforce. I wanted to identify what the problems were, what was stopping us from providing excellent mental health care for young people. The Taskforce brought together professionals from across the education, health and care system to figure this out. They also worked with charities and community organisations and, importantly, they brought in young people and their families, too. We needed a comprehensive view to understand the wide-ranging issues affecting our mental health service.

This is the Government report of the work of the Taskforce and it sets out what we need to do to overcome the status quo. We need a whole child and whole family approach, where we are promoting good mental health from the earliest ages. We need to improve access to interventions and support when and where it is needed, whether that's in schools, GP practices, hospitals or in crisis care. We mustn't think about mental health in a purely clinical fashion. We need to make better use of the voluntary and digital services to fill the gaps in a fragmented system. Crucially, we must make it much easier for a child or young person to seek help and support in non-stigmatised settings. This is where the voluntary sector can be so valuable. We need a simpler system, breaking down the barriers which tiers create, looking at some of the innovative practices which are already happening in this country and abroad.

Anyone who works with or for young people knows that this isn't just about funding. What is needed is a fundamental shift in culture. A whole system approach is needed focusing on prevention of mental ill health, early intervention and recovery. We owe this to young people. It is with their future in mind that we must all commit to, and invest in this challenge.
In the Department for Education we want all children and young people to have the opportunity to achieve and develop the skills and character to make a successful transition to adult life. Good mental health is a vital part of that. The challenges young people face are hugely varied – from stress and anxiety about exams to incredibly serious and debilitating long-term conditions. Everyone who works with children and young people has a role in helping them to get the help they need.

That is why I am so pleased to be the first minister in the Department for Education with a specific responsibility for child and adolescent mental health. And why I wanted the department to work closely with the Taskforce to look at how we can make a better offer to children and young people. I believe success in this area comes from Government departments working closely together. We want to make sure young people no longer feel that they have to suffer in silence, that they understand the support that’s available for them and that they see mental health services as something that can make a real difference to their lives.

Many schools already support their pupils’ mental health. But we can do more to help schools develop knowledge about mental health, identify issues when they arise and offer early support. That is why we have been working alongside the Taskforce to develop work on teaching about mental health with the PSHE Association, and develop a new strategy to encourage more and better use of counselling in schools.

Support can come from other places too. The voluntary sector can be especially effective in reaching out in a way that makes sense to children and young people. That is why DfE has, for the first time, identified mental health as a specific priority within its £25m voluntary sector grant scheme – from April we will be supporting a range of exciting projects. Children’s services are also looking for innovative ways to make mental health an integral part of support for the most vulnerable, and our Social Care Innovation Programme will continue to fund projects developing this work.

But not every adult who works with children and young people can be a mental health expert. Schools and children’s services often raise with me the problems with access to specialist support for children who need it, when what they can provide reaches its limits. That is why I welcome the drive to put the needs of children and young people at the heart of specialist mental health services, to break down the complex tiers of services and to establish clear responsibility for putting in place a coherent offer of services.

This report shows that real success comes from collaboration and sets a challenge to all those working with children and young people. Only by working in partnership, sharing expertise, and making best use of finite resources can we achieve the improvements in mental health outcomes that we all want to see, and make a reality of the vision.
Foreword from Simon Stevens, CEO of NHS England

There is now a welcome national recognition of the need to make dramatic improvements in mental health services. Nowhere is that more necessary than in support for children, young people and their families. Need is rising and investment and services haven’t kept up. The treatment gap and the funding gap are of course linked.

Fortunately that is now changing. However in taking action there are twin dangers to avoid. One would be to focus too narrowly on targeted clinical care, ignoring the wider influences and causes of rising demand, overmedicalising our children along the way. The opposite risk would be to diffuse effort by aiming so broadly, lacking focus and ducking the hard task of setting clear priorities. This document rightly steers a middle course, charting an agreed direction and mobilising energy and support for the way ahead. I’m pleased to give it NHS England’s full support.
A few months ago, we were asked by the Government to work out what needs to be done to improve children and young people's mental health and wellbeing. Growing up is meant to be one of the very best times in anyone's life but it can also be tough. There are many pressures and some young people, such as looked-after children and those leaving care, are exposed to situations and experiences that can make them particularly vulnerable.

Experiencing mental health concerns is not unusual. At least one in four of the population experience problems at some point in their lives. Over half of mental health problems in adult life (excluding dementia) start by the age of 14 and seventy-five per cent by age 18. Although mental health issues are relatively common, it is often the case that children and young people don’t get the help they need as quickly as they should. As a result, mental health difficulties such as anxiety, low mood, depression, conduct disorders and eating disorders can stop some young people achieving what they want in life and making a full contribution to society.

We were asked to work together and see how your mental health and wellbeing could best be supported to give you the best start in life.

That means we want to help you acquire the resilience and skills you need when life throws up challenges. We want you to know what to do for yourself if you are troubled by emotions or problems with your mental health. That includes knowing when and how to ask for help and, when you do, to receive high quality care. We want services to be able to respond quickly, to offer support and, where necessary, treatment that we know works, to help you stay or get back on track. We believe that asking people who use services what they think about what happens now is vital. They are the ones who know what needs to change. So our first thought was to ask you – children, young people and those who care for you – how things could work better.

We also knew that lots of good work had been done in the past, so we looked at previous reports and reviewed all the evidence we have. We asked a group of people with a mix of experience and expertise that included young people, parents, people working in schools, in the voluntary sector, and in services as well as people who work for the Government to come together as a ‘Taskforce’ to help look at all the information we have and think about how we could improve.

What we have come up with is a vision that we hope reflects what you as well as your parents, carers and professionals told us was needed, with ideas about how to make it happen.

We have set out the vision by describing how we think the system should work for young people. The report lays out a map of how we could make those ambitions a reality. In this report, we tell you what we think can change now, but also what we think will take more time. Not all the changes can be made straight away, some are longer term ambitions. But we believe substantial
progress can be made over the next five years if we act now to make children and young people’s mental health a priority.

Do let us know what you think about this report. You can add your comments to our blogs (see links below) and also share your opinions on Twitter using #youngmentalhealth.

And finally let’s remember that there is one change that we can all contribute to. We can all look out for those children and young people who might be struggling right now. We can confront bullying and we can make it OK to admit that you are struggling with your mental health. We can end stigma. And we can support our friends in their treatment and recovery.

Let’s make a start.

Useful links:
Jon Rouse’s blog: https://jonrouse.blog.gov.uk/
Dr Martin McShane’s blog: www.england.nhs.uk/category/publications/blogs/martin-mcshane

Dr Martin McShane, NHS England

Jon Rouse, Department of Health
You have goals and ambitions you want to achieve. We want you to grow up to be confident and resilient so you can develop and fulfil these goals and make a contribution to society. To do this we must make sure:

Your parents and carers get the help they need to support you through your childhood and into adult life. Other adults such as GPs, midwives, health visitors, teachers and other people who work in schools, should understand emotional and mental health in children and young people, and know what to do and where to go if they are worried about you or those who care for you.

If you are having difficulty, you shouldn’t have to wait until you are really sick to get help, and those around you should be understanding. Asking for help shouldn’t be embarrassing or difficult and you should know what to do and where to go.

When you need help, you want to find it easily and to be able to trust it. To make sure this happens, we need to make sure that:

There are websites and apps that you know you can trust and use to help yourself and find out information on how to get more help.

You have a choice about where you can get advice and support from a welcoming place. You might want to go somewhere familiar, such as your school or your doctor. Or you might want to go to a drop-in centre, or access the help you need online. But wherever you go, the advice and support you are offered should be based on the best evidence about what works. All the professionals you meet should treat you as a whole person, considering your physical and mental health needs together.

You are experts in your care and want to be involved in how mental health services are delivered and developed, not just to you and those who support you, but to all the children, young people and families in your area. To do this we must make sure that:

All services give you the opportunity to set your own treatment goals and will monitor with you how things are going. If things aren’t going well, the team providing your care will work with you to make changes to achieve your goals. You have the opportunity to shape the services you receive. That means listening to your experience of your care, how this fits with your life and how you would like services to work with you. It means giving you and those who care for you the opportunity to feedback and make suggestions about the way services are provided. Services should tell you what happened as a result.

When you need help, you want it to meet your needs as an individual and be delivered by people who care about what happens to you. This means that:

You should only have to tell your story once, to someone who is dedicated to helping you, and you shouldn’t have to repeat it to lots of different people. All the services in your area should work together so you get the support you need at the right time and in the right place.
If you have a crisis, you should get extra help straightaway, whatever time of day or night it is. You should be in a safe place where a team will work with you to figure out what needs to happen next to help you in the best possible way.

If you need to go to hospital, it should be on a ward with people around your age and near to your home. If you need something very specialised, then you and your family should be told why you need to travel further, and the service should stay in touch to get you home as soon as possible. And while you are in hospital, we should ensure you can keep up with your education as much as you can.

Throughout your care, there are likely to be changes so that you get the right care at the right time. You’ll have the opportunity to make informed choices about your treatment and care. You’ll keep getting help until you’re confident that you’re well enough to no longer need it.

If you need help at home, your care team will visit and work with you and your family at home to reduce the need for you to go into hospital. If you do need to go in to hospital, the team should stay in touch and help you to get home quickly.

If you need to move from one service to another, you’ll be involved in conversations to prepare you for this and to agree exactly what is happening and when. You’ll make the move when you feel ready for it. If you have to move from one area to another, the people responsible for your care will sort this out and involve you, so that you do not have to start from scratch.

You’ll keep getting help until you’re confident that you’re well enough to no longer need it, even if sometimes you can’t or don’t want to attend appointments. If you don’t keep your appointments, someone should get in touch to find out what they can do to help, not just leave you to it.

You want to know that, whatever your circumstances, you get the best possible care, support and treatment when you need it. You’ll be able to get help wherever you are in the country, and the help you get where you live won’t be worse than if you lived somewhere else. To make this happen we will need to make sure:

The people responsible for organising and delivering services to you know which services to provide to best help you and other children, young people and families in your community. The people who fund and provide your service should be dedicated to offering the best mental health services possible, and will be honest and open about how they do that as well as about how they are working to improve it.
1. Executive summary and key proposals

1.1 The Children and Young People’s Mental Health and Wellbeing Taskforce was established in September 2014 to consider ways to make it easier for children, young people, parents and carers to access help and support when needed and to improve how children and young people’s mental health services are organised, commissioned and provided.

1.2 Key themes emerged which now provide the structure of this report. Within these themes, we have brought together core principles and requirements which we consider to be fundamental to creating a system that properly supports the emotional wellbeing and mental health of children and young people.

1.3 In summary, the themes are:
- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

The case for change

1.4 Mental health problems cause distress to individuals and all those who care for them. One in ten children needs support or treatment for mental health problems. These range from short spells of depression or anxiety through to severe and persistent conditions that can isolate, disrupt and frighten those who experience them. Mental health problems in young people can result in lower educational attainment (for example, children with conduct disorder are twice as likely as other children to leave school with no qualifications) and are strongly associated with behaviours that pose a risk to their health, such as smoking, drug and alcohol abuse and risky sexual behaviour.

1.5 The economic case for investment is strong. 75% of mental health problems in adult life (excluding dementia) start by the age of 18. Failure to support children and young people with mental health needs costs lives and money. Early intervention avoids young people falling into crisis and avoids expensive and longer term interventions in adulthood. There is a compelling moral, social and economic case for change. We set this out in full in Chapter 3.

1.6 Evidence presented to the Taskforce also underlined the complexity and severity of the current set of challenges facing child and adolescent mental health services. These include:
- Significant gaps in data and information and delays in the development of payment and other incentive systems. These are all critical to driving change in a co-ordinated way.
ii. **The treatment gap.** The last UK epidemiological study\(^2\) suggested that, at that time, less than 25% – 35% of those with a diagnosable mental health condition accessed support. There is emerging evidence of a rising need in key groups such as the increasing rates of young women with emotional problems and young people presenting with self-harm.

iii. **Difficulties in access.** Data from the NHS benchmarking network and recent audits reveal increases in referrals and waiting times, with providers reporting increased complexity and severity of presenting problems.

iv. **Complexity of current commissioning arrangements.** A lack of clear leadership and accountability arrangements for children’s mental health across agencies including CCGs and local authorities, with the potential for children and young people to fall through the net has been highlighted in numerous reports.\(^3\)

v. **Access to crisis, out of hours and liaison psychiatry services are variable** and in some parts of the country, there is no designated health place of safety recorded by the CQC for under-18s.

vi. **Specific issues facing highly vulnerable groups of children and young people and their families who may find it particularly difficult to access appropriate services.**

1.7 These issues are addressed in considering the key themes that form the basis of this report and the proposals it makes.

### Making it happen

1.8 The Taskforce firmly believes that the best mental health care and support must involve children, young people and those who care for them in making choices about what they regard as key priorities, so that evidence-based treatments are provided that meet their goals and address their priorities. These need to be offered in ways they find acceptable, accessible and useful.

1.9 Providers must monitor, and commissioners must consider, the extent to which the interventions available fit with the stated preferences of young people and parents/carers so that provision can be shaped increasingly around what matters to them. Services need to be outcomes-focused, simple and easy to access, based on best evidence, and built around the needs of children, young people and their families rather than defined in terms of organisational boundaries.

1.10 Delivering this means making some real changes across the whole system. It means the NHS, public health, local authorities, social care, schools and youth justice sectors working together to:

- **Place the emphasis on building resilience, promoting good mental health, prevention and early intervention** (Chapter 4)

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• **Simplify structures and improve access**: by dismantling artificial barriers between services by making sure that those bodies that plan and pay for services work together, and ensuring that children and young people have easy access to the right support from the right service (Chapter 5).

• **Deliver a clear joined up approach**: linking services so care pathways are easier to navigate for all children and young people, including those who are most vulnerable (Chapter 6), so people do not fall between gaps.

• **Harness the power of information**: to drive improvements in the delivery of care, and standards of performance, and ensure we have a much better understanding of how to get the best outcomes for children, young people and families/carers and value from our investment (Chapter 7).

• **Sustain a culture of continuous evidence-based service improvement** delivered by a workforce with the right mix of skills, competencies and experience (Chapter 8).

• **Make the right investments**: to be clear about how resources are being used in each area, what is being spent, and to equip all those who plan and pay for services for their local population with the evidence they need to make good investment decisions in partnerships with children and young people, their families and professionals. Such an approach will also enable better judgements to be made about the overall adequacy of investment (Chapter 9).

1.11 In some parts of the country, effective partnerships are already meeting many of the expectations set out in this report. However, this is by no means universal, consistent or equitable.

**A National ambition**

1.12 This report sets out a clear national ambition in the form of key proposals to transform the design and delivery of a local offer of services for children and young people with mental health needs. **Many of these are cost-neutral, requiring a different way of doing business rather than further significant investment.**

1.13 There are a number of proposals in this report which require critical decisions, for example, on investment and on local service redesign, which will need explicit support from the next government, in the context of what we know will be a very tight Spending Review. We are realistic in this respect. At both national and local level, decisions will need to be taken on whether to deliver early intervention through an ‘invest to save’ approach and/or targeted reprioritisation, recognising that it will take time to secure an economic return for the nation.
1. Improved public awareness and understanding, where people think and feel differently about mental health issues for children and young people where there is less fear and where stigma and discrimination are tackled. This would be delivered by:
   - a hard hitting anti-stigma campaign which raises awareness and promotes improved attitudes to children and young people affected by mental health difficulties. This would build on the success of the existing Time to Change campaign; (3)
   - with additional funding, we could also empower young people to self-care through increased availability of new quality assured apps and digital tools. (5)

2. In every part of the country, children and young people having timely access to clinically effective mental health support when they need it. With additional funding, this would be delivered by:
   - a five year programme to develop a comprehensive set of access and waiting times standards that bring the same rigour to mental health as is seen in physical health. (17)

3. A step change in how care is delivered moving away from a system defined in terms of the services organisations provide (the ‘tiered’ model) towards one built around the needs of children, young people and their families. This will ensure children and young people have easy access to the right support from the right service at the right time. This could be delivered by:
   - joining up services locally through collaborative commissioning approaches between CCGs, local authorities and other partners, enabling all areas to accelerate service transformation; (48)
   - having lead commissioning arrangements in every area for children and young people’s mental health and wellbeing services, responsible for developing a single integrated plan. We envisage that in most cases the CCG would establish lead commissioning arrangements working in close collaboration with local authorities. We also recognise the need for flexibility to allow different models to develop to suit local circumstances and would not want to cut across alternative arrangements; (30)
• transitions from children’s services based on the needs of the young person, rather than a particular age. (15)

4. **Increased use of evidence-based treatments with services rigorously focused on outcomes.** With additional funding, this would be delivered by:
• building on the success of the CYP IAPT transformation programme and rolling it out to the rest of the country. (44)

5. **Making mental health support more visible and easily accessible for children and young people.** With additional funding, this would be delivered by:
• every area having ‘one-stop-shop’ services, which provide mental health support and advice to children and young people in the community, in an accessible and welcoming environment. This would build on and harness the vital contribution of the voluntary sector; (16)
• improving communications, referrals and access to support through every area having named points of contact in specialist mental health services and schools. This would include integrating mental health specialists directly into schools and GP practices. (16)

6. **Improved care for children and young people in crisis so they are treated in the right place at the right time and as close to home as possible.** This would be delivered by:
• ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat are implemented; (12)
• no young person under the age of 18 being detained in a police cell as a place of safety; (19)
• implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care. (13)

7. **Improving access for parents to evidence-based programmes of intervention and support to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour.** With additional funding, this would be delivered by:
• enhancing existing maternal, perinatal and early years health services and parenting programmes. (4)

8. **A better offer for the most vulnerable children and young people, making it easier for them to access the support that they need when, and where they need it.** This would include:
• ensuring those who have been sexually abused and/or exploited receive a comprehensive assessment and referral to the services that they need, including specialist mental health services. (24)

9. **Improved transparency and accountability across the whole system, to drive further improvements in outcomes.** This would be delivered by:
• development of a robust set of metrics covering access, waiting times and outcomes to allow benchmarking of local services at national level; (36)
• clearer information about the levels of investment made by those who
commission children and young people’s mental health services; (38)

- subject to decisions taken by future governments, a commitment to a prevalence survey for children and young people’s mental health and wellbeing, which is repeated every five years. (39)

10. Professionals who work with children and young people are trained in child development and mental health, and understand what can be done to provide help and support for those who need it.

Local Transformation Plans

1.14 Delivering the national ambition will require local leadership and ownership. We therefore propose the development and agreement of Transformation Plans for Children and Young People’s Mental Health and Wellbeing which will clearly articulate the local offer. These Plans should cover the whole spectrum of services for children and young people’s mental health and wellbeing from health promotion and prevention work, to support and interventions for children and young people who have existing or emerging mental health problems, as well as transitions between services.

1.15 In terms of local leadership, we anticipate that the lead commissioner, in most cases the Clinical Commissioning Group, would draw up the Plans, working closely with Health and Wellbeing Board partners including local authorities. All these partners have an important role to play in ensuring that services are jointly commissioned in a way that promotes effective joint working and establishes clear pathways. Lead commissioners should ensure that schools are given the opportunity to contribute to the development of Transformation Plans.

1.16 To support this, NHS England will make a specific contribution by prioritising the further investment in children and young people’s mental health announced in the Autumn Statement 2014 in those areas that can demonstrate robust action planning through the publication of local Transformation Plans.

1.17 What is included in the Plan should reflect the national ambition and principles set out in this report and be decided at a local level in collaboration with children, young people and their families as well as providers and commissioners. Key elements will include commitments to:

Transparency

- A requirement for local commissioning agencies to give an annual declaration of their current investment and the needs of the local population with regards to the full range of provision for children and young people’s mental health and wellbeing.

- A requirement for providers to declare what services they already provide, including staff numbers, skills and roles, waiting times and access to information.

Service transformation

- A requirement for all partners, commissioners or providers, to sign up to a series of agreed principles covering: the range and choice of treatments and interventions available; collaborative practice with children, young people and families and involving schools; the use of evidence-based interventions; and regular feedback of outcome monitoring to children, young people and families and in supervision.

Monitoring improvement

- Development of a shared action plan and a commitment to review, monitor
and track improvements towards the Government’s aspirations set out in this Report, including children and young people having timely access to effective support when they need it.

Next steps in 2015/16

1.18 At a national level, we will play our part to deliver the ambition by:

- delivering waiting times standards for Early Intervention in Psychosis by April 2016;
- continuing development of new access and waiting times standards for Eating Disorder;
- commissioning a new national prevalence survey of child and adolescent mental health;
- implementing the Child and Adolescent Mental Health Services Minimum Dataset, which will include the new CYP IAPT dataset;
- continuing to focus on case management for inpatient services for children and young people, building on the response to NHS England’s Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report;\(^4\)
- testing clear access routes between schools and specialist services for mental health by extending the recently established co-commissioning pilots to more areas;
- improving children’s access to timely support from the right service through developing a joint training programme to support lead contacts in mental health services and schools. This will be commissioned by NHS England and the Department for Education and tested in 15 areas in 2015/16. DfE will also support work to develop approaches in children’s services to improve mental health support for vulnerable children;
- improving public awareness and understanding of children’s mental health issues, through continuing the existing anti-stigma campaign led by Time to Change and approaches piloted in 2014/15 to promote a broader national conversation;
- encouraging schools to continue to develop whole school approaches to promoting mental health and wellbeing through a new counselling strategy for schools, alongside the Department for Education’s other work on character and resilience and PSHE.

1.19 In the medium to longer term, the Taskforce would like a future government to consider formalising at least some parts of this national ambition to ensure consistency of practice across the country. This would also give a more precise meaning to what is meant by the existing statutory duties in respect of parity of esteem between physical and mental health, as they apply to children and young people.

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2. Introduction

2.1 Children and young people’s mental health really matters, not only for the individual and their family, but for society as a whole. The evidence tells us that treating different, specific health issues separately will not tackle the overall wellbeing of this generation of children and young people. Their mental and physical health are intertwined, and at the heart of health and wellbeing are their relationships with others. They want an integrated child, youth and family friendly approach that recognises their particular needs, makes them feel supported, emphasises the positives and helps them to cope.

2.2 Over half of all mental ill health starts before the age of fourteen years, and seventy-five per cent has developed by the age of eighteen. The life chances of those individuals are significantly reduced in terms of their physical health, their educational and work prospects, their chances of committing a crime and even the length of their life. As well as the personal cost to each and every individual affected, their families and carers this results in a very high cost to our economy.

2.3 A great deal of work has been done in recent years to try to address the emotional wellbeing and mental health needs of children and young people. There is a wealth of evidence and good practice to build on. Key strategies, reports and initiatives include the National Service Framework in 2004, Every Child Matters in 2003 and the work of the National Advisory Council in 2008. More recently, the Children and Young People’s Health Outcomes Forum and Chief Medical Officer’s Annual Reports in 2012 and 2013 have maintained the focus on improving children’s mental health outcomes at national level.

2.4 The Government has made clear its commitment that mental health services for people of all ages should have parity of esteem with physical health services and called on all parts of the health system to put children, young people and their families right at the heart of decision-making and improve every aspect of health services – from pregnancy through to adolescence and beyond. A major programme of investment

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and standard-setting has laid the groundwork for significant improvements in the care that children and young people with mental health problems receive.

2.5 Good progress is being made on this agenda with the investment of:

- £60m into the Children and Young People’s Improving Access to Psychological Therapies (CYP IAPT) programme over 2011-15/16;
- £7m in an extra 50 CAMHS specialised Tier 4 beds for young patients in the areas with the least provision (as identified by the NHS England CAMHS Tier 4 Report, July 2014);
- £150 million over the next five years in England to improve services for children and young people with mental health problems, with a particular emphasis on eating disorders; and
- £3 million in the MindEd e-portal launched in March 2014. The e-portal provides clear guidance on children and young people’s mental health, wellbeing and development to any adult working with children, young people and families.
- NHS England is investing £15 million in health provision in the Children and Young People’s Secure Estate.

2.6 Achieving Better Access to Mental Health Services by 2020\(^\text{11}\) outlines the first waiting time standards for mental health and includes a standard which will ensure that by 2016, at least 50% of people of all ages referred for early intervention in psychosis services will start treatment within two weeks. This is backed by £40 million investment.

2.7 Wider cross-government service transformation initiatives such as the Troubled Families programme aimed at turning around the lives of 120,000 families with a broad range of problems have provided further traction and levers for local areas to make progress. Problems in these families often include mental health issues in either the children or the parents. In response, local authorities are working with families using integrated whole family approaches to address problems collectively for all members of the family.

2.8 The Department for Education (DfE) is leading work to improve the quality of teaching about mental health in Personal, Social, Health, and Economic (PSHE) lessons in schools, and is developing an evidence-based schools counselling strategy to encourage more and better use of counsellors in schools. In addition, DfE has invested £36 million to develop and sustain evidence-based interventions for children in care, on the edge of care or custody and adopted children and their families, such as multisystemic therapy.\(^\text{12}\)

2.9 Since 2011, the Children and Young People’s Improving Access to Psychological Therapies (CYP IAPT) programme for children and young people has supported the transformation of local services. However, there remain significant and unacceptable gaps and variations in consistency and coherence within and across services and how they are commissioned. Services have worked hard to try to keep up with increasing demand, but this has been against a backdrop of fiscal constraint, particularly for local government.

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2.10 At a service level, we know the importance of directly involving children, young people and their parents and carers in their own treatment, setting goals that have a meaning for them and using their feedback to guide their treatment and overall service development: it pays dividends in making services effective and efficient. Our knowledge about the evidence base has grown, and we have a much clearer picture of good models of care and how best to integrate services through strong collaborative working across the statutory, independent and voluntary and community sectors.

2.11 We therefore have some good work on which to build. However, this has to be set against a context of many local and specialist services struggling to cope with what benchmark surveys\(^\text{13}\) demonstrate is increasing demand in a very tight financial environment. The Taskforce also found a lack of consistency in local systems’ approach to, and prioritisation of child mental health. The next chapter of the report sets out the case for change in some detail, but we would want to make clear from the outset that there is an urgent need for change.

2.12 Last autumn, the publication of the NHS Five Year Forward View\(^\text{14}\) brought statutory organisations together around a vision for the future of health and care in England that emphasises prevention, new models of care and local determination within national frameworks.

2.13 Nowhere could these principles be more relevant than in supporting the mental health and wellbeing of children and young people. To this end, the Minister for Care and Support, supported by colleagues in other government departments, set up the Children and Young People’s Mental Health and Wellbeing Taskforce, co-chaired by the Department of Health and NHS England, to gather insights and evidence and inform this report.

2.14 The core group met five times, with a membership of over 60 participants from across health, social care, youth justice and education. Four working groups were formed, involving Taskforce members and others with specialist expertise, to look at the issues in more detail. 1600 children, young people, parents and carers were also involved through engagement activity led by YoungMinds. It is their voice and their experience which have been central to guiding and shaping this report.

2.15 This report has taken feedback from the working groups in the Taskforce, the engagement with children and young people, parents, carers and professionals and collated it with the established evidence base and previous reports. The work of the Taskforce was characterised from the outset by a shared sense of purpose that real change is necessary and, over time, achievable.

2.16 A number of key themes rapidly emerged. There is a need for good, transparent, regular data and information that is collected nationally. Prevention and early intervention are not only desirable but cost-effective. Support and treatment, especially in a crisis, need to be coordinated to make sure that different organisations and professionals know where responsibility lies and how to act effectively together. In addition, the needs of the more vulnerable should be recognised and addressed so they are not neglected or marginalised. Finally, interventions need to be evidence-based or contribute to research and evaluation so that the finite resources available are used to best effect.

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\(^{13}\) NHS Benchmarking Collaborative 2014 – see www.nhsbenchmarking.nhs.uk/index.php

2.17 These themes form the basis of this report and guide the principles it sets out and the changes it proposes.

2.18 Some of the most significant decisions will require consideration by an incoming Government with a full term ahead of them. But there is also much that can be started now. The Taskforce has found examples of existing best practice from around the country and there is plentiful scope for further local as well as national innovation.

2.19 There is no time to waste.
3. The context and case for change

3.1 The prevalence of mental health problems in children and adolescents was last surveyed in 2004. This study estimated that:\textsuperscript{15}

- 9.6\% or nearly 850,000 children and young people aged between 5-16 years have a mental disorder
- 7.7\% or nearly 340,000 children aged 5-10 years have a mental disorder
- 11.5\% or about 510,000 young people aged between 11-16 years have a mental disorder
- This means in an average class of 30 schoolchildren, 3 will suffer from a diagnosable mental health disorder\textsuperscript{16}

3.2 The most common diagnostic categories were conduct disorders, anxiety, depression and hyperkinetic disorders.

<table>
<thead>
<tr>
<th>Common mental health issues affecting children and young people</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conduct disorders:</strong></td>
</tr>
<tr>
<td>• 5.8% or just over 510,000 children and young people have a conduct disorder.</td>
</tr>
<tr>
<td><strong>Anxiety:</strong></td>
</tr>
<tr>
<td>• 3.3% or about 290,000 children and young people have an anxiety disorder.</td>
</tr>
<tr>
<td><strong>Depression:</strong></td>
</tr>
<tr>
<td>• 0.9% or nearly 80,000 children and young people are seriously depressed.</td>
</tr>
<tr>
<td><strong>Hyperkinetic disorder (severe ADHD):</strong></td>
</tr>
<tr>
<td>• 1.5% or just over 132,000 children and young people have severe ADHD.</td>
</tr>
</tbody>
</table>

3.3 Children with mental health problems are at greater risk of physical health problems; they are also more likely to smoke than children who are mentally healthy. Children and young people with eating disorders and early onset psychosis are particularly at risk, but it is important to note that many psychotropic drugs also have an impact on physical health.

3.4 Children with physical health problems also need their mental wellbeing and health supported.


\textsuperscript{16} YoungMinds Mental Health Statistics. Available at: www.youngminds.org.uk/training_services/policy/mental_health_statistics
The interface between mental and physical health

- 12% of young people live with a long-term condition (LTC) (Sawyer et al 2007).
- The presence of a chronic condition increases the risk of mental health problems from two-six times (Central Nervous System disorders such as epilepsy increase risk up to six-fold) (Parry-Langdon, 2008; Taylor, Heyman & Goodman 2003).
- 12.5% of children and young people have medically unexplained symptoms, one third of whom have anxiety or depression (Campo 2012). There is a significant overlap between children with LTC and medically unexplained symptoms, many children with long term conditions have symptoms that cannot be fully explained by physical disease.
- Having a mental health problem increases the risk of physical ill health. Depression increases the risk of mortality by 50% and doubles the risk of coronary heart disease in adults.
- People with mental health problems such as schizophrenia or bipolar disorder die on average 16–25 years sooner than the general population.

Economic argument

3.5 The economic case for addressing child and adolescent mental wellbeing is a strong one.

3.6 Mental health problems not only cause distress, but can be associated with significant problems in other aspects of life and affect life chances.

3.7 Despite this burden of distress, it is estimated that as many as 60-70% of children and adolescents who experience clinically significant difficulties have not had appropriate interventions at a sufficiently early age. Evidence shows that, for all these conditions, there are interventions that are not only very effective in improving outcomes, but also good value for money, in some cases outstandingly so, as measured by tangible economic benefits such as savings in subsequent costs to public services.

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3.8 The evidence base, both clinical and economic, for other conditions, such as eating disorders, self-harm or autistic spectrum disorders is not as strong, but the moral and ethical arguments to care, research and build an evidence base are undeniable.

3.9 The B-CAMHS surveys of mental health of children and adolescents show all forms of mental disorder are associated with an increased risk of disruption to education and school absence. Research on the longer-term consequences of mental health problems in childhood adolescence has found associations with poorer educational attainment and poorer employment prospects, including the probability of ‘not being in education, employment or training’ (NEET).

3.10 There is a strong link between parental (particularly maternal) mental health and children’s mental health. Maternal perinatal depression, anxiety and psychosis together carry a long term cost to society of just under £10,000 for every single birth in the country (see paragraph 4.4).

3.11 Social relationships can be affected both in childhood and adolescence and in adult life. Other increased risks include drug and alcohol use. Conduct disorder and ADHD are also both associated with an increased risk of offending and conduct disorder in girls with an increased risk of teenage pregnancy.

3.12 Bullying is reported by 34-46% of school children in England in recent surveys. A dose-response relationship exists, which means that children who are exposed to frequent, persistent bullying have higher rates of psychiatric disorder. Exposure to bullying is also associated with elevated rates of anxiety, depression and self-harm in adulthood.

3.13 As well as the impact on the individual child and family, mental health problems in children and young people result in an increased cost to the public purse and to wider society. Those with acute conduct disorder incur substantial costs above those with some conduct problems, but not conduct disorder. A study by Friedli and Parsonage estimated additional lifetime costs of around £150,000 per case – or around £5.3bn for a single cohort of children in the UK. Costs relating to crime are the largest component, accounting for 71% of the total, followed by costs resulting from mental illness in adulthood (13%) and differences in lifetime earnings (7%). More widely, in 2012/13, it was estimated the total NHS expenditure on dedicated children’s mental health services was £0.70bn.

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3.14 In straitened financial times, ensuring best value for the taxpayer investment is vital. The Centre for Mental Health has analysed the return on investment from addressing the four common disorders in childhood.\(^{27}\) For instance, it has been estimated that children with early conduct disorder are 10 times more costly to the public sector by the age of 28 than other children.\(^{28}\)

3.15 The impact of mental health disorders extends beyond the use of public services. Taking this wider societal viewpoint, it has been estimated that the overall lifetime costs associated with a moderate behavioural problem amount to £85,000 per child and with a severe behavioural problem £260,000 per child.\(^{29}\)

“...The strength of the mental health of our future adult population is the responsibility of all departments of society – health, education, policing etc... children and young people with mental health difficulties cost all of these departments more money – it is in everyone’s best interest to invest in the children and young people of today.”

A family support worker who took part in the Taskforce engagement exercises

3.16 The National Institute for Health and Care Excellence (NICE) documents a wide range of well-evidenced interventions that can be used to treat children and young people with mental health disorders effectively.\(^{30}\) For example, the table below details the impact of group cognitive behavioural therapy for depressed adolescents.

3.17 It is important to note that this does not include wellbeing gains, but does measure the financial benefit to an individual due to improved employment opportunities as a result of managing their condition.

3.18 The benefits included in a benefit:cost ratio are in addition to the mental health and wellbeing improvements associated with evidenced interventions. In general, measured benefits include two main elements: (i) reductions in the use of public services because of better mental health, and (ii) increases in earnings associated with the impact of improved mental health on educational attainment. In the case of conduct disorder, there are also benefits to society resulting from reduced offending, including costs to victims and the community.

3.19 The inescapable fact is that failure to prevent and treat children and young people’s mental health problems comes at a heavy price, not only for the wellbeing of the children concerned and their families, but also for taxpayers and society because of increased future costs.

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3. Group Cognitive Behavioural Therapy (CBT) for depressed adolescents

<table>
<thead>
<tr>
<th>Aim</th>
<th>Group CBT for depressed adolescents aims to improve general functioning and prevent the risk of a major depressive episode from occurring. It is a series of group sessions lead by a therapist, involving exploring ideas related to the condition and how to handle it. There is a suggested duration of three months of weekly meetings.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit Cost</td>
<td>£229</td>
</tr>
<tr>
<td>Total lifetime benefit</td>
<td>£7,252</td>
</tr>
<tr>
<td>Lifetime benefit to taxpayers</td>
<td>£3,520</td>
</tr>
<tr>
<td>Lifetime benefit to participants</td>
<td>£3,455</td>
</tr>
<tr>
<td>Lifetime benefit to others</td>
<td>£277</td>
</tr>
<tr>
<td>Lifetime benefit-cost ratio (benefits/costs)</td>
<td>31.67</td>
</tr>
</tbody>
</table>

Levels of Investment

3.20 In 2012/13, NHS expenditure on child and adolescent mental health disorders was estimated to be £700 million (ie £0.70bn) or 6% of the total spend on mental health. Between 2006/7 and 2012/13, the proportion of mental health spending on children and young people has fallen.

3.21 NHS England is taking forward work on collecting comprehensive spending data on mental health services in the NHS.

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There is no national level information on current local authority social care or education spend on children and young people’s mental health. However, from a number of surveys there would appear to be a pattern of increasing demand that local mental health services in many areas are struggling to meet.

The Department of Health and NHS England are working on improvements to overall mental health data and intelligence across the full life course.

Issues to address

Evidence presented to and discussions in the Taskforce have underlined the complexity and severity of the current set of challenges facing child and adolescent mental health services.

These include:

i. Significant gaps in data, information and system levers. There has been significant delay in national collection of outcomes metrics, access standards, development of payment and other incentive systems and their alignment across the health, education and social care systems, which are all critical to driving change in a co-ordinated way. Although there is locally collected data, there is a general lack of clarity about what is provided by whom, for what problem, for which child.

ii. Investment levels. The lack of data, information and system drivers have made Child and Adolescent Mental Health services (CAMHS) financially vulnerable. Historically, mental health services have suffered when the public sector is under financial pressure. NHS England and the Department of Health
have initiated action to address this for health services for 2014/15 and 2015/16 but local government continues to face significant financial challenges and more work is needed.

iii. The treatment gap. The last UK epidemiological study\textsuperscript{32} suggested that, at that time, less than 25\% – 35\% of those with a diagnosable mental health condition accessed support. There is emerging evidence of a rising need in key groups such as the increasing rates of young women with emotional problems and young people presenting with self-harm. In addition, there are some groups with additional vulnerabilities (see below) who, due to a range of issues, are not given the priority they need.

iv. Difficulties in access. NHS benchmarking data and recent audits reveal increases in referrals and waiting times, with providers reporting increased complexity and severity of presenting problems and a consequent rising length of stay in inpatient facilities. Since 2011, our best evidence is that these difficulties are the result of financial constraints accompanied by rising demand.\textsuperscript{33}

v. Complexity of current commissioning arrangements. A lack of clear leadership and accountability arrangements for children’s mental health across agencies with the potential for children and young people to fall through the net has been highlighted in numerous reports.\textsuperscript{34} Co-ordination across the system, particularly for those children and young people with complex needs, is challenging where there is no lead agency accountable for the child or young person, despite the large number involved in providing services.

vi. Access to crisis, out of hours and liaison psychiatry services are variable. There are variations in access to appropriate or age-appropriate inpatient care close to home and available when needed. In some parts of the country, there is no designated health place of safety recorded by the CQC for under-18s.

vii. Specific issues facing highly vulnerable groups. All children and young people may experience adverse life events at some time in their lives, but some are more likely to develop mental health disorders eg following multiple losses and/or trauma in their lives, as a result of parental vulnerability or due to disability, deprivation or neglect and abuse. These children, young people and their families may find it particularly difficult to access appropriate services, or services may not be configured to meet their psychosocial needs. In addition, they sometimes find it more


difficult to access services they may find alienating and may have a lifestyle that is not conducive to meeting regular appointments.

3.26 These issues are addressed in considering the key themes that form the basis of this report and the proposals it makes.
4. Promoting resilience, prevention and early intervention

4.1 We need to value the importance of recognising and promoting good mental health and wellbeing in all people, not just focusing on mental illness and diagnosis. There is evidence that supporting families and carers, building resilience through to adulthood and supporting self-care reduces the burden of mental and physical ill health over the whole life course, reducing the cost of future interventions, improving economic growth and reducing health inequalities.\(^{35}\)

4.2 It is therefore crucial that, locally, there is an integrated, partnership approach to defining and meeting needs. A wide range of professionals should be involved across universal, targeted and specialist services, through:

- **promoting** good mental wellbeing and resilience, by supporting children and young people and their families to adopt and maintain behaviours that support good mental health;

- **preventing** mental health problems from arising, by taking early action with children, young people and parents who may be at greater risk;

- **early identification** of need, so that children and young people are supported as soon as problems arise to prevent more serious problems developing wherever possible.

Prevention and support from birth

4.3 If we are to have the greatest chance of influencing the determinants of health and wellbeing, we should focus efforts on actions to improve the quality of care for children and families. We should start by making efforts to ensure a safe and healthy pregnancy, a nurturing childhood and support for families in providing such circumstances in which to bring up children.

4.4 There is a strong link between parental (particularly maternal) mental health and children’s mental health. For this reason, it is as important to look after maternal mental health during and following pregnancy as it is maternal physical health. According to a recent study, maternal perinatal depression, anxiety and psychosis together carry a long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK, equivalent to a long-term cost of just under £10,000 for every single birth in the country.\(^{36}\) Nearly three-quarters of this cost (72%) relates to adverse impacts on the child rather than the mother. Some £1.2 billion of the long-term cost is borne by the NHS.


Current action to improve early support for parents, carers and children from birth (1 and 4)

- The Mandate between the Government and NHS England sets an objective to work with partner organisations to ensure that the NHS reduces the incidence and impact of postnatal depression through earlier diagnosis, and better intervention and support.

- The Mandate between Health Education England (HEE) and the Government recognises the importance of maternal mental health during pregnancy and after birth – by 2017, every birthing unit should have access to a specialist perinatal mental health clinician.

- The Institute for Health Visitors is updating training given to all health visitors around mental health and the Department of Health is working with HEE, the Royal College of Midwives and the Maternal Mental Health Alliance to design training programmes for midwives.

- Public Health England is publishing an update of the evidence base for the Healthy Child Programme (0-5 years) that will guide professionals including supporting early attachment between infant and parent(s).

- Ensuring progress with these mandate requirements and workforce capability will support better mental wellbeing for children and young people into the future. In addition, Achieving Better Access to Mental Health Services by 2020 sets out that DH and NHS England will consider developing an access and/or waiting standard for rapid access to mental health services for women in pregnancy or in the postnatal period with a known or suspected mental health problem.

- In the 2014 Autumn Statement to Parliament, the Chancellor announced a 0-2 year old early intervention pilot to prevent avoidable problems later in life. The Pilots will be run jointly by DfE and DH. They will complement the work of the Early Intervention Foundation, and link closely with other activity such as the Healthy Child Programme and the Troubled Families Programme. Details of how and where the pilots will operate will be made available shortly. Government will consider the emerging evidence in relation to prevention and intervening early with mental health problems.

4.5 The transfer of commissioning of 0-5 public health services to local government in October 2015 provides a great opportunity for local authorities, working through Health and Wellbeing Boards, to create a stronger focus on mental health in the early years and beyond. Public Health England’s rapid review of the evidence base for the Healthy Child Programme (0-5) will help local services make use of the most up-to-date evidence base.

4.6 There is strong evidence of the benefits of evidence-based parenting programmes in intervening early for children with behavioural problems. These are benefits to the individual child and family, as well as producing significant cost saving to the system as a whole. Such programmes should remain

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4. Promoting resilience, prevention and early intervention

a priority for local authorities and better links developed with specialist services to work jointly on cases where families have difficulty engaging in groups or need intensive individual support before they are ready to join a group.

The role of universal services in mental health promotion, prevention and early intervention

4.7. Universal services, including health visitors, Sure Start Children’s Centres, schools, school health services including school nurses, colleges, primary care and youth centres, play a key role in preventing mental health problems. Universal services support children and young people’s wellbeing through delivering mental health promotion and prevention activities, which work best when they operate on a whole-system basis.

4.8. In our discussions with young people, they emphasised the difficulties many of them had faced in discussing their problems with their GP. Many of them also reported that their school was not an environment in which they felt safe to be open about their mental health concerns.

4.9. For their part, GPs, schools and other professionals such as social workers and youth workers often feel as frustrated as the children and their parents. They want to do the right thing, but have not necessarily been equipped to play their part or been provided with clear access routes to expertise and for referring to targeted and specialist support. Professionals working in child and adolescent mental health services are equally aware of the challenges that come from balancing identified need with available resource.

4.10. There is also a need for greater clarity about the core attributes that underpin mental health and resilience throughout life. The Department for Education is leading work to help schools ensure more pupils develop the character traits, attributes and behaviours, which, alongside academic achievement, underpin future success. The Department will work closely with all key stakeholders as this work develops, informed by insights and evidence on effective practice from its investment in character education projects and research, due in autumn 2016. Alongside this, Public Health England should continue to strengthen its work on core attributes that underpin mental health and resilience and the application of this by commissioners and service providers.

GPs

4.11. General Practice and the primary care team have an important part to play in supporting families, children and young people to develop resilience and in identifying and referring problems early. GPs take a holistic approach to the whole family registered with them and are responsible for primary physical and mental health. There is significant potential in that the GP practice is a less stigmatising environment than a mental health clinic. Many GPs have improved accessibility to young people by using the ‘You’re Welcome’ standards and self-audit. Practices such as Herne Hill Group Practice in London, working with the voluntary sector organisation Redthread Youth, have gone further by creating the Well Centre with drop-in clinics for young people where they can discuss a range of issues and have access to specialist mental health support.


4.12 There is also scope for GPs and other professionals with children and young people to consider referring for a wider range of interventions and services to support their mental health and wellbeing. The local offer could include commissioning approaches that support the ability for GPs to offer social prescribing, where activities such as sport are used as a way of improving wellbeing.

**Schools**

4.13 Many schools are already developing whole school approaches to promoting resilience and improving emotional wellbeing, preventing mental health problems from arising and providing early support where they do. Evidence shows\(^{40}\) that interventions taking a whole school approach to wellbeing have a positive impact in relation to both physical health and mental wellbeing outcomes, for example, body mass index (BMI), tobacco use and being bullied.

4.14 The vast majority of secondary schools surveyed in recent CentreForum research\(^{41}\) reported that they implement programmes to promote positive mental health universally across the student population, with 93% doing this within the context of Personal, Social, Health, and Economic (PSHE) education. The research also indicates that pupils in 86% of secondary schools surveyed have access to a trained/qualified counsellor(s), and almost all secondary schools (98%) have pastoral care services. While counselling services within schools are not intended as a substitute for other community and specialist mental health services, they can be a valuable complement to them.

4.15 We encourage all schools (including those in the independent sector) to continue to develop whole school approaches to promoting mental health and wellbeing (2). This will build on the Department for Education’s current work on character building, PSHE and counselling services in schools (see box for details). The named mental health lead for schools proposed in chapter five would also make an important contribution to leading and developing whole school approaches.

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Current action to support schools in promoting resilience and prevention of mental health problems

- The Department for Education (DfE) is leading work to improve the quality of teaching about mental health within Personal, Social, Health, and Economic (PSHE) lessons in schools, and has commissioned the PSHE Association to produce guidance for schools in teaching about mental health safely and effectively, which will be available in spring 2015. Alongside the guidance will be a series of lesson plans covering key stages 1-4 (5-16 year olds). For older pupils, they will address such topics as self-harm and eating disorders, as well as issues directly concerned with school life, such as managing anxiety and stress around exams.

- DfE is developing an evidence-based schools counselling strategy to encourage more and better use of counsellors in schools, with practical and evidence-based advice to ensure quality provision, that improves children's outcomes and achieves value for money. This will be published in spring 2015.

- DfE has invited schools, colleges and organisations to bid for a £3.5 million character education grant fund for local projects.

- School nurses lead and deliver the Healthy Child Programme (HCP) 5-19 and are equipped to work at community, family and individual levels. They can play a crucial role in supporting the emotional and mental health needs of school-aged children. School nursing services are universal and young people see them as non-stigmatising.

- Inspection is a key lever to drive improvement. The new draft Ofsted inspection framework ‘Better Inspection for All’ includes a new judgement on personal development, behaviour and welfare of children and learners.

4.16 It is important that schools tackle bullying, including cyberbullying, robustly. The Government has continued to take action when required. By law, all schools must have a behaviour policy which includes measures to tackle all forms of bullying and they are held to account by Ofsted. The best schools create an ethos of good behaviour where pupils treat each other, and staff, with respect, understand the value of education, and appreciate the impact that their actions can have on others. The Department for Education has produced advice to help schools support pupils who are severely affected by bullying.

4.17 Schools can help to contain cyber-bullying during the school day by banning or limiting the use of personal mobile phones and other electronic devices. Schools also have the power to search for, and if necessary delete, inappropriate images (or files) on electronic devices, including mobile phones.

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Developing a national conversation

4.18 We need to create the space for an open national conversation about children and young people’s mental health. Children, young people and their parents/carers need clearer awareness of what is good mental health and what is poor mental health, as well as better information about how to keep mentally and emotionally healthy.

4.19 To this end, the Taskforce proposed there could be a major national branded social marketing campaign with a mechanism for dialogue so it is a genuine two-way conversation – driven by children, young people, parents and carers (3). Options include building on the Time to Change campaign (www.time-to-change.org.uk/youngpeople) as well as looking for opportunities to address mental health and wellbeing issues with the Public Health England Rise Above44 campaign. The Time to Change programme has already been associated with greater mental health literacy as well as less stigmatising attitudes.45 In the last year or two, we have seen remarkable progress in reducing levels of stigma towards mental health conditions. It is now time we did the same for children and young people, to create a climate where there is as much interest in their emotional and cognitive development as there is in their academic development.

Harnessing digital technology

4.20 The digital world has become of utmost importance with its potential to protect and enhance the mental health and wellbeing of our children and young people. We are raising a generation of ‘digital natives’ who differ from previous generations in the way they communicate. Electronic media has some positive influences, such as improved faster information processing; conversely, there are widespread concerns about potential negative effects, including decreased attention, hyperactivity, and excessive use.46 There is high risk that children and young people are subject to harmful exposure to inappropriate material, to the risks of cyber-bullying, to potential grooming and exploitation47 and to websites that reinforce negative behaviour, such as those encouraging excessive weight loss.

4.21 We recognise there is already a significant amount of work as part of the Government response on tackling child sexual exploitation as well as more broadly under the auspices of the National Group on Sexual Violence against Children and Vulnerable People. The need to influence and protect young people has a wide reach. Thus in the new computing programmes of study, which were introduced in September 2014, e-safety will be taught at all four key stages of school. It covers responsible, respectful and secure use of technology, as well as ensuring that pupils are taught age-appropriate ways of reporting any concerns they may have about what they see or encounter online.

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4.22 We also recognise the positive role of digital technology, which provides new opportunities to deliver the right information to children and young people and reduce stigma. For example, Mind has unveiled YouTube star and teen icon Zoe Sugg as its new Digital Ambassador, who has used her blog to share open and honest accounts of her own battles with anxiety and panic attacks, and launched the initiative #DontPanicButton.

4.23 The use of apps and other digital tools can empower self-care, giving children and young people more control over their health and wellbeing and empowering their parents and carers. Harnessing the potential of the web to promote resilience and wellbeing aligns with the principles set out in Personalised Health and Care 2020 and the priority it has already given to young people. Children and young people’s mental health and wellbeing should be given the priority it deserves and the system should build on existing resources to support the intentions set out in this report – signalling the promise indicated by the National Information Board’s Framework for Action.

4.24 We propose that the Government asks the National Information Board to work in close partnership with the Government Digital Service and young people themselves to develop a single framework for harnessing the power of digital technology and protecting young people from mental harm. Within this framework, we propose that Government considers incentivising the development of new apps and digital tools; and also whether there is a need for some form of kite-marking scheme based on research evidence to guide young people and their parents on quality.

Resilience, prevention and early intervention for the mental wellbeing of children and young people – chapter 4 summary

Our aim is to act early to prevent harm, by investing in the early years, supporting families and those who care for children and building resilience through to adulthood. Strategies should be developed in partnership with children and young people to support self-care. This will reduce the burden of mental and physical ill health over the whole life course.

Much of what is needed can be done now by:

1. Promoting and driving established requirements and programmes of work on prevention and early intervention, including harnessing learning from the new 0-2 year old early intervention pilots.

2. Continuing to develop whole school approaches to promoting mental health and wellbeing, including building on the Department for Education’s current work on character and resilience, PSHE and counselling services in schools.

3. Building on the success of the existing anti-stigma campaign led by Time to Change, and approaches piloted in 2014/15, to promote a broader national conversation about, and raise awareness of mental health issues for children and young people.

With additional funding, a future government should consider:

4. Enhancing existing maternal, perinatal and early years health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour by ensuring parents have access to evidence-based programmes of intervention and support.

5. Supporting self-care by incentivising the development of new apps and digital tools; and consider whether there is a need for a kitemarking scheme in order to guide young people and their parents in respect of the quality of the different offers.
5. Improving access to effective support – a system without tiers

“You have to fit into their paths and none of their paths fit you.”

“Mental health isn’t a one size fits all treatment, it really depends on the person.”

Young people who took part in the Taskforce engagement exercises.

5.1 Our discussions with professionals who work with children and young people revealed a strong, common theme – that it is essential that children and young people are at the heart of the work they do and the services that are provided for them. However, the tiers model, a reasonable construct at its inception in 1995, defines the system in terms of the services that provide the care. In practice, this means that children and young people have to fit the services, rather than the services fitting the changing needs of the child or young person.

5.2 Furthermore, the tiers model has been criticised for unintentionally creating barriers between services, embedding service divisions and fragmentation of care. It often results in children or young people falling in gaps between tiers and experiencing poor transitions between different services. At its worst, it can even lead to commissioners and providers of different tiers of service effectively passing the buck to one another.

5.3 Many areas across the UK, such as Liverpool and Leeds, are already working to move away from the tiered structure by designing new local models which create a seamless pathway of care and support, and which address the need for the diversity of circumstances and issues with which families and young people approach mental health services. Alternative models can also be seen internationally. A further example of a more flexible needs-based model for structuring children and adolescent mental health services is the recently proposed ‘Thrive model’. We consider this model to have potential and that it should be evaluated and debated further.

5.4 The advantage of these models is that they have the potential to move away from an inflexible and restrictive system, towards one which enables agencies to commission and deliver support to allow children and young people to move more easily between services and to make collaborative choices about what would work best for them at given points in time. It obliges providers to place expertise at the front end of delivery systems to establish with children, young people and families, the intervention most appropriate to their current need. However, it is also important to note that there is no

49 The report on the Thrive model (see below) contains a description of the tiers model (page 5).

one size fits all. Models could and should be different in different types of locality; for example, a model which works well in rural Devon may fail to meet need if applied in inner-Manchester, and vice versa. This is why we have not dictated the local offer but been clear about the national ambition (6).

**Right time, right place, right offer**

“There needs to be one point of access between patients and services that the patient can approach to find out anything they wish to know about the rest of the services involved and out there.”

A young person who took part in the Taskforce engagement exercises.

5.5 The starting-point is that children and young people and their parents/carers need clearer awareness of how to recognise when they might have a mental health problem as well as where and how to get help, clarity about what help is available, what might happen when they access it, and what to do while they are waiting.

5.6 Therefore, at the heart of any good local system should be cross-sector agreement to ensure clarity in respect of how services are accessed. Many areas are already using a single point of access to targeted and specialist mental health services through a multi-agency ‘triage’ approach, including areas working within the CYP IAPT programme such as Liverpool. There is a pressing need to develop these approaches more widely (7 and 16). Common features of a single point of access system include:

- One point of contact for a wide range of universal services to access a team of children and young people’s mental health professionals for advice, consultation, assessment and onward referral.
- Initial risk assessment to ensure children and young people at high risk are seen as a priority.
- Prompt decision-making about who can best meet the child/young person’s needs (including targeted or specialist services, voluntary sector youth services and counselling services).
- Young people and parents are able to self-refer into the single point of access.

5.7 We propose the following to improve communication and access:

i. Create an expectation that there is a dedicated named contact point in targeted or specialist mental health services for every school and primary care provider, including GP practices (8 and 16). Their role would be to discuss and provide timely advice on the management and/or referral of cases, including consultation, co-working or liaison. This may include targeted or specialist mental health staff who work directly in schools/GP practices/voluntary sector providers with children, young people and families/carers.

ii. Create an expectation that there should be a specific individual responsible for mental health in schools, to provide a link to expertise and support to discuss concerns about individual children and young people, identify issues and make effective referrals (8 and 16). This individual would make an important contribution to leading and developing whole school approaches.

iii. Develop a joint training programme for named individuals in schools and mental health services to ensure shared understanding and support effective communications and referrals (9).
iv. Provide a key role for the voluntary and community sector to encourage an increase in the number of one-stop-shop services, based in the community (7 and 16). They should be a key part of any universal local offer, building on the existing network of YIACS (Youth Information, Advice, and Counselling Services). Building up such a network would be an excellent use of any identified early additional investment. There may also be a case in future for developing national quality standards for a comprehensive one-stop-shop service, to support a consistent approach to improving outcomes and joint working.

v. Enable greater access to personal budgets for children and young people (and their families) who have a longer term condition or disorder, to give them more choice and control over when and how they access which services.

vi. Ensuring there is a strategic link between children’s mental health services and services for children and young people with special educational needs and disabilities (SEND) (10). This should be matched by involvement, where necessary, of mental health professionals in co-ordinated assessment and planning (for children and young people with and without Education, Health and Care Plans.)

Use of standards

5.8 NHS England has committed to developing access and waiting time standards in mental health. By 2020, the aim would be to provide a comprehensive set of access and waiting time standards that bring the same rigour to mental health as is seen in physical health services. This applies to children and young people who will benefit in the first year with the introduction of the first ever waiting time standards in respect of early intervention in psychosis. It is important that children and young people are taken fully into account as further access and waiting time standards are considered, subject to resource availability. Careful consideration will need to be given to which conditions are prioritised, working with experts, services and commissioners and building on current work to develop standards for eating disorders and the introduction of the standard for early intervention in psychosis. (17)

A welcoming environment

“The fact that they showed human qualities helped me feel comfortable sharing.”

A young person who took part in the Taskforce engagement exercises.

5.9 There are some changes that have little cost which could be implemented straightaway. Examples include a warm
and encouraging welcome for children, young people and parents/carers when they walk through the door; enabling and encouraging their involvement in their own treatment plans and reviews; having a positive attitude and culture within services and promoting effective participation. Young people say that these interactions make an enormous difference to how they feel, to their confidence in participating, and to counteracting the stigma associated with accessing mental health services.

5.10 Some children, young people and families find the formal setting of a clinic off-putting and are unwilling to attend. This can lead to them saying that they do not wish to be referred or not turning up – particularly for some highly vulnerable groups, such as those involved with gangs or those who have been sexually exploited. As a consequence, some services experience high rates of children, young people and families not attending appointments. It is important that services monitor attendance and actively follow up families and young people who miss appointments and inform the referrer (see also paragraph 6.2). It may be necessary to find alternative ways to engage the child, young person or family.

5.11 Mental health practitioners and staff such as youth workers delivering interventions should follow existing good practice and give young people and families the choice to receive treatment away from traditional NHS mental health settings. This might mean that staff see them in public places, such as cafes and restaurants, or in schools, or home-based treatment and there are a number of areas where staff, including consultants, do so successfully. This may also help to re-engage the young person with clinical staff and to be able to attend clinical settings at a later stage. This is likely to lead to a better result than young people or families failing to attend and receiving no support.

Peer Support

“Peer mentoring is a fantastic idea as young people should be able to feel like they aren’t the only one going through these problems.”

A young person who took part in the Taskforce engagement exercises.

5.12 Young people, as well as parents or carers, also have an important role to play in informing and supporting other young people and families about mental health prevention and access. Consultations carried out through YoungMinds’ Engagement Survey and other engagement activities have shown that young people have a strong desire to hear from other young people who have accessed mental health services and CYP IAPT reports suggest this is also a priority for parents and carers. Peer support schemes should be led and designed by children and young people or by parents or carers, with careful professional support to reduce and manage risk both to peer mentors and the young people and families they are involved with. It is proposed that further work should be done with relevant education and third sector partners to audit where peer support is currently available and evaluate it, building on existing work such as the Royal Society for Public Health Youth Health Champions. Local areas can then consider closing gaps in provision. (11)
5. Improving access to effective support – a system without tiers

Digital access

“I particularly like websites that have in depth resources on conditions and treatments eg Mind and Rethink. They talk about issues objectively so sufferers don’t feel patronised, but also offer supportive information. They allow me to access information easily and whenever I want.”

A young person who took part in the Taskforce engagement exercises.

5.13 As we established in the previous chapter, children and young people and many parents and carers are digitally literate and told us they wanted better and more use made of the web. This could be expressed in a number of ways, but must be informed by the views and preferences of children and young people to be effective. The Taskforce believes a future government should look at options enabling children, young people, parents and carers to access high quality and reliable online information and support. One such option could be a national branded web based portal established using NHS Choices, in line with the recently published National Information Board framework. It could build on the successful MindEd website (www.minded.org.uk) aimed at professionals to provide national information about mental health and wellbeing in an engaging and reliable format. The NHS Choices content on adult mental health should link to the children and young people equivalent – the Youth Wellbeing Directory (youthwellbeingdirectory.com) and services are encouraged to register with the Directory.

5.14 The availability and adequacy of the right mix of specialist community health services is critical to the success of THRIVE and similar needs based ‘triage’ models. Under these models, community mental health is not just a set of services to be referred into. It becomes a joined-up team, working proactively to support other professionals in their settings as well as managing caseloads in terms of higher level interventions. This can identify children and young people who may not present until they are in crisis at an early stage and improve support after discharge.

5.15 The shape and structure of these local teams cannot be defined at national level. However, national agencies can help by providing tools and best practice guidance which enable commissioners and providers to work together to assess the capacity and
capability they require, and to enable efficient and effective prioritisation of resources, for example via www.chimat.org.uk.

Dealing with crisis

5.16 The litmus test of any local mental health system is how it responds in a crisis. For children and young people experiencing mental health crisis, it is essential that they receive appropriate support/intervention as outlined in the Crisis Care Concordat, including an out-of-hours mental health service. The challenge of supporting a child or young person in a crisis includes ensuring that there is a swift and comprehensive assessment of the nature of the crisis. There are examples around the country of dedicated home treatment teams for children and young people, but these are not universally available. Some children and young people end up in A&E, where access to appropriate and timely psychiatric liaison from specialist child and adolescent mental health services is not always available. Some are placed (not always appropriately) on paediatric or general adult hospital wards. The national development of all-age liaison psychiatry services in A&E Departments with targeted investment over this and the next financial year, as set out in the joint Department of Health and NHS England publication, Achieving Better Access to Mental Health Services by 2020, should mean that appropriate mental health support in A&E is more readily available. This needs to be carefully monitored.

5.17 For some children and young people, their route into specialist services is more extreme and is through detention by the police, under Section 136 of the Mental Health Act. Those who exhibit such distress and risk to themselves or others that a section 136 detention becomes warranted will need further support, which may not be purely from mental health services. There is broad support for legislating to ensure that no child or young person under-18 would be detained in a police cell as a place of safety, subject to there being sufficient alternative places of safety. It is also important to develop improved data on the availability of crisis/home treatment for under-18 year olds and the use of section 136 for children and young people under-18 to support better planning. CQC should be asked to carry out routine assessments of places of safety with a focus on their age-appropriateness for children and young people.

Inpatient care

5.18 While community-based mental health services have a significant role in supporting children and young people in great need, there will always be some children and young people who require more intensive and specialised inpatient care. These must be age-appropriate and as close to home for the child or young person as possible.

5.19 The access and utilisation of specialised beds is a signal of how the whole system is working and therefore cannot be addressed in isolation. As the recent NHS England Tier 4 review has demonstrated, there have been gaps in provision that NHS England is addressing. The key to commissioning the right type of care, in the right places is to adopt a whole system

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commissioning perspective compatible with the type of model we describe in this chapter. This should address the role of pre-crisis, crisis, and ‘step-down’ services alongside inpatient provision. We return later in the report to the question of how we achieve a planning and commissioning framework, and information systems that can enable the system to make much better decisions about what inpatient capacity is required and to improve outcomes for children and young people for whom inpatient care cannot be avoided. There is strong support for investing in effective targeted and specialist community provision, including admission prevention and ‘step-down’ provision. This can provide clear pathways for young people leaving inpatient care to help avoid unnecessary use of inpatient provision and shorten duration of stay by easing the transition out of inpatient care (13). In line with the NHS 5 Year Forward View, NHS England is exploring a range of options for future commissioning and more collaborative work.

Use of residential care

5.20 If we are to improve outcomes for young people, especially those with learning disabilities, we must all learn from the lessons arising from the terrible events at Winterbourne View hospital, as to how people can become institutionalised. Children and young people with challenging behaviour can too easily be admitted to residential care unsuited to supporting their long-term health and wellbeing, and which does not support preparation for transition to adulthood and independent living. This is a group of vulnerable children and young people who already face the poorest outcomes, both in terms of their health and long-term independence and security. Sir Stephen Bubb’s recent report highlighted the specific pressures which combine to force a young person into a residential setting: the lack of awareness of the individual’s needs and wishes; the complexity of joint commissioning to deliver service transformation; the absence of viable alternative community-based provision; and the resource issues which inhibit its development. 55

5.21 As highlighted in the Government’s response to the Bubb report, in 2015/16 NHS England will lead partners in developing ways to strengthen the assurance that an admission is the best approach to care. This work will involve people with learning disabilities and their families and include:

- robust admission gateway processes for those with learning difficulties;
- a challenge process to check that there is no alternative to admission; and
- the agreement of a discharge plan on admission. 56

5.22 Children and young people’s mental health services must draw on this methodology and apply similar principles. (14)

5.23 There are likely to be some children and young people with mental health needs, usually those at risk of crisis, for whom an inpatient setting will be the most suitable. The effectiveness of care provided to children and young people in crisis can be assessed by the extent to which it meets their immediate needs, whilst providing a basis for long term support and improvement. There should be systemic safeguards in place to prevent it becoming their permanent home which include:


ongoing strategic audits of admissions;

ii. a co-ordinated outcome focused care plan for each inpatient (this could be part of an Education, Health and Care plan where the child was eligible because of their learning disability);

iii. regular, comprehensive reviews of the suitability of the placement, against criteria focused on transition outcomes for the child or young person; and

iv. engagement with the young person and their family.

Managing transitions

“I had a very bad transition from CAMHS to adult services. One day I was in CAMHS with plenty of support and then the next, the only support I knew of was a crisis number. It took over 6 months for me to have a proper assessment and be assigned a care co-ordinator, by which time I had suffered a complete relapse in my condition.”

A young person who took part in the Taskforce engagement exercises.

5.24 The issue of transition for young people is longstanding, but focusing on a moment in time masks the real issue, which is how we ensure better co-ordination of mental health services for young adults.

5.25 All young people face multiple and often simultaneous transitions as they move to adulthood. This can be from school to higher or further education or work. They may be in the process of leaving home or care. The families of those in the armed forces may be particularly affected by multiple moves. Young people transferring from children and young people’s mental health services differ from those leaving physical services in that, for many, adult mental health services are either not available or not appropriate. Adult mental health services are not universally equipped to meet the needs of young people with conditions such as ADHD, or mild to moderate learning difficulties or autistic spectrum disorder.

5.26 For some young people, the nature of adult mental health services and their emphasis on working with the individual rather than a more holistic approach including the family means that young people prematurely disappear from services altogether despite needing further support. 57, 58

5.27 Youth Information Advice and Counselling Services (YIACs) usually operate over the age of transition, often up to the age of 25. We also note that in some parts of the country, such as Birmingham and Norfolk, there is a move to develop mental health services for 0-25 year olds. This new development will be watched with considerable interest.

5.28 The key components of best practice transition which are valued by both young people and clinicians should be built into Joint Strategic Needs Assessments (JSNAs), joint strategies for young people’s and adult services and into all contracts between commissioners and providers of


NHS England has published a model specification based on best practice for transitions and a transfer/discharge protocol that can be used by local areas to support better transition planning and delivery.

5.29 The Taskforce does not wish to be prescriptive about the age of transition, but does recognise that transition at 18 will often not be appropriate. We recommend flexibility around age boundaries, in which transition is based on individual circumstances rather than absolute age, with joint working and shared practice between services to promote continuity of care. (15)

5.30 Vulnerable young people, such as care leavers and children in contact with the youth justice system, may also be especially vulnerable at points of transition and local strategic planning on transition should take their needs into account.

“My university GP was wonderful and made the effort to contact my GP at home, along with former services I had used for treatment, to get full information on my history of mental health problems… this is the experience that I think everyone should be having.”
A young person who took part in the Taskforce engagement exercises

5.31 We also acknowledge the difficulty of transitions for university students as having extra complexity due to geographical relocation and transience of residence. Students may need access to mental health support both at home and at university, both from primary and secondary care services. We support the production of best practice guidance for CCGs and GPs around student transitions which encourages close liaison between the young person’s home-based and university-based primary care teams and promotes adherence to NHS guidelines on funding care for transient populations.

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59 Joint Commissioning Panel for Mental Health (2012). Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services. UK: Joint Commissioning Panel for Mental Health.


Our aim is to change how care is delivered and build it around the needs of children and young people and families. This means moving away from a system of care defined in terms of the services organisations provide to ensure that children and young people have easy access to the right support from the right service at the right time.

Much of what is needed can be done now by:

6. Moving away from the current tiered system of mental health services to investigate other models of integrated service delivery based on existing best practice.

7. Enabling single points of access and One-Stop-Shop services to increasingly become a key part of the local offer, harnessing the vital contribution of the voluntary sector.

8. Improving communications and referrals, for example, local mental health commissioners and providers should consider assigning a named point of contact in specialist children and young people's mental health services for schools and GP practices; and schools should consider assigning a named lead on mental health issues.

9. Developing a joint training programme to support lead contacts in specialist children and young people’s mental health services and schools.

10. Strengthening the links between children’s mental health and learning disabilities services and services for children and young people with special educational needs and disabilities (SEND).

11. Extending use of peer support networks for young people and parents based on comprehensive evaluation of what works, when and how.

12. Ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat are implemented.

13. Implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care.

14. Include appropriate mental health and behavioural assessment in admission gateways for inpatient care for young people with learning disabilities and/or challenging behaviour.

15. Promoting implementation of best practice in transition, including ending arbitrary cut-off dates based on a particular age.

With additional funding, a future government should consider:

16. Improving communications, referrals and access to support through every area having named points of contact in specialist mental health services and schools, single points of access and one-stop-shop services, as a key part of any universal local offer.

17. Putting in place a comprehensive set of access and waiting time standards that bring the same rigour to mental health as is seen in physical health services.

18. Enabling clear and safe access to high quality information and online support for children, young people and parents/carers, for example through a national, branded web-based portal.

19. Legislating to ensure no young person under the age of 18 is detained in a police cell as a place of safety.
6. Care for the most vulnerable

6.1 There are some children and young people who have greater vulnerability to mental health problems but who find it more difficult to access help. If we can get it right for the most vulnerable, such as looked-after children and care leavers, then it is more likely we will get it right for all those in need.

6.2 The aim is to support staff who work with vulnerable groups by providing access to high quality mental health advice when and where it is needed. Co-ordinated services should be provided in ways in which children and young people feel safe, build their resilience, so that they are offered evidence-based interventions and care, drawing on the expertise and engagement of all the key agencies involved. Children, young people and their families who have additional vulnerabilities and complex mental health needs should not have to fight for services, nor be offered services that are well-meaning, but are not evidence-based or which fail to meet their needs. The Taskforce members heard of cases where, if vulnerable young people had been able to access specialist advice and support more rapidly, it would have resulted not only in earlier and better outcomes, but also a significant saving to the public purse. In addition, not attending appointments should not lead to a family or young person being discharged from services, but should be considered as an indicator of need and actively followed up (this can apply to all children and young people – see also paragraph 5.10) (20).

6.3 Mental health services need to work effectively within and in partnership with existing service delivery structures to help vulnerable children and young people – such as Early Help Services, services for Troubled Families, Child Protection and Safeguarding Services, as well as education, youth justice services and Multi-Agency Safeguarding Hubs. Staff in mental health services need to utilise and build on existing opportunities where agencies are already working with the child – for instance, looked-after care review meetings, child protection case conferences

A flexible, integrated system to meet the needs of vulnerable children and young people

6.3 Mental health services need to work effectively within and in partnership with existing service delivery structures to help vulnerable children and young people – such as Early Help Services, services for Troubled Families, Child Protection and Safeguarding Services, as well as education, youth justice services and Multi-Agency Safeguarding Hubs. Staff in mental health services need to utilise and build on existing opportunities where agencies are already working with the child – for instance, looked-after care review meetings, child protection case conferences
or youth justice assessments and the Common Assessment Framework.

6.4 There is a clear need for appropriate and bespoke care pathways that incorporate new models of providing effective, evidence-based interventions to vulnerable children and young people to provide a social and clinical response to meeting their needs (21). The provision of mental health support should not be based solely on clinical diagnosis, but on the presenting needs of the child or young person and the level of professional or family concern (22). Some children and young people will benefit from services which tackle problems across all family members, including adult mental health, substance misuse issues or complex cases that do not have a clear clinical diagnosis.

6.5 The most effective multi-agency arrangements have in place a clear sense of purpose shared by all agencies, together with shared assessment, case management and regular multi-agency case review processes overseen by multi-agency governance boards. The fact that mental health support is required does not necessarily mean that it is mental health services that are responsible overall for managing the case.

Trauma-focused care

6.6 Experiencing or witnessing violence and abuse or severe neglect has a major impact on the growing child and on long term chronic problems into adulthood. Many mental health service users of all ages have problems directly attributable to severe neglect and/or trauma in the early years. Some vulnerable children and young people – including those who are adopted, looked-after children, those in contact with the youth justice system and substance misusing young people – are more likely to have been affected during childhood and adolescence.

6.7 Enhanced training for staff working with children and young people would lead to greater professional awareness of the impact of trauma, abuse or neglect on mental health (27). This should be coupled with effective treatment, including:

- Ensuring assessments carried out in specialist services include sensitive enquiry about neglect, violence and physical, sexual or emotional abuse. For young people aged 16 and above, as part of the Government’s response to the concerns arising about child sexual exploitation, routine enquiry in line with NICE guidelines63 (whereby every young person is asked during the mental health assessment about violence and abuse) will be introduced from 2015-1664 (23).
- Those children and young people who have been sexually abused and/or exploited should receive a comprehensive specialist initial assessment, and referral to appropriate services providing evidence-based interventions according to their need. There will be a smaller group who are suffering from a mental health disorder, who would benefit from referral to a specialist mental health service (24).
- Specialist services for children and young people’s mental health should be actively represented on Multi-Agency Safeguarding Hubs which should be used more extensively to identify those at high risk who would benefit from referral at an earlier stage (25).

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Delivering care to vulnerable groups

6.8 There are some specific models of provision that the Taskforce considered to be particularly helpful to these groups. Whatever models are adopted, the professionals involved need to specifically address the need to seek out, listen to, and respond to the voices of vulnerable children and young people.

A consultation and liaison mental health model:

6.9 Applying an approach whereby specialist services are available to provide advice, rather than to see those who need help directly to advise on concerns about mental health or neurodevelopmental difficulties is already best practice in some areas, for some very specific and highly vulnerable groups. Consultation and liaison teams can be used to help staff working with those with highly complex needs which include mental health difficulties – such as those who have been adopted or those with harmful sexual behaviour, and those in contact with the youth justice system – based on the complexity of the issues involved. These services would offer advice, troubleshooting, formal consultation and care planning, or assessment and intervention in cases where this is required above and beyond the level of existing cross-agency provision (including specialist services). There would need to be an identified specialist point of reference, including a senior clinician with specific expertise within mental health services. The roll-out of such teams could be piloted and, if successful, implemented at a sub-regional level (28).

Embedding mental health practitioners in teams responsible for groups of vulnerable children and young people

6.10 Young people who are amongst the most excluded from society, such as those involved in gangs, those who are homeless and/or looked-after children, need support from people they trust. This is a small number of young people, who may not even recognise that they have mental health problems. They benefit from having a mental health practitioner embedded in teams that have relationships with, and responsibility for such groups, such as a youth club or hostel (29). The embedded worker can develop a relationship with the young people through youth-led activities so that they are then able to respond as a familiar, trusted adult as the need arises, working with more specialist or intensive services as required. They can also impart basic mental health skills to frontline staff. This approach has been successfully developed by MAC-UK’s INTEGRATE model (see www.mac-uk.org) which also incorporates the necessary governance structures essential for success. INTEGRATE requires a highly flexible team structure which includes the regular mapping of each young person’s needs, informing a consistent and psychologically-informed approach across the team members.

6.11 A case study, Jay’s story, highlighting this approach and the value of a familiar, trusted professional in engaging the most vulnerable and difficult to reach children and young people is set out in the Vulnerable Groups and Inequalities Task and Finish group report.
Designated professionals

“We need services that understand we need to stick with young people who DNA and assertively engage them, instead of being pushed to close cases due to pressures on throughput. We also need services that can be responsive to risk and windows of opportunity for engagement, and to use these for long term work”

A CAMHS psychologist who took part in the Taskforce engagement exercises.

“I should be able to reach out to someone in any of the settings when I need, but for it all to be coordinated by one person.”

A young person who took part in the Taskforce engagement exercises.

6.12 Children and young people in vulnerable groups are amongst the most complex seen in specialist services. Systems such as appointing a lead professional through a Common Assessment Framework (CAF), Team Around the Child or Family, or the Care Programme Approach (for those with severe mental health problems) already exist in many places. For some, the consistent application of these needs to be improved – particularly for vulnerable children and young people with complex needs who require care that is well-planned and co-ordinated with information shared effectively. A designated or lead professional should be identified and their role strengthened – someone who knows the family well – to liaise with all agencies and ensure that services are targeted and delivered in an integrated way (26). This role could be allocated through a number of multi-agency processes, including the CAF or Team Around the Child or Family processes.

6.13 The decision about which plan to use will depend on the needs of the child and family, but the lead professional or Care Co-ordinator’s role is to co-ordinate support and services from across agencies to meet the needs, for example, of children and young people in contact with the youth justice system, whose care may otherwise fall between several different agencies. For young people with more severe mental health difficulties or those transitioning to adult mental health services, the Care Programme Approach may be the most appropriate approach.55

Reducing Health Inequalities and Promoting Equality

6.14 The Taskforce was told that some groups, for example, learning disabled children find it difficult to access specialist services. In addition, studies have shown marked health inequalities in relation to children and young people’s mental health, with correlations between poor mental health and disadvantage – for example, children in low income families having a three-fold increased risk of developing mental health problems.56 We know that improving children and young people’s mental health and their access to mental health services will require solutions that are tailored to the needs of children and young people from all backgrounds, of all characteristics, and from all sectors of the community.


6.15 The Equality Act 2010 requires all public and voluntary sector organisations to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people. In addition, the Health and Social Care Act 2012 introduced duties on the Secretary of State for Health, NHS England and on CCGs to have regard to the need to reduce health inequalities.

6.16 For NHS England and CCGs, the health inequalities duties mean they must consider the need to reduce inequalities in access and outcomes for patients. In meeting these duties, they will wish to demonstrate that they have considered how policies and services for children and young people vulnerable to, or receiving support for, mental health problems take account of need, not just demand, and give appropriate focus to those groups in the population which have poorer access or outcomes.

6.17 Whilst the health inequalities duties apply only to the Health Secretary and NHS, the Taskforce encourages all those involved in commissioning mental health and wellbeing services for children and young people to give the same consideration to the need to reduce health inequalities in access and outcomes (21).

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**Caring for the most vulnerable – chapter 6 summary**

Current service constructs present barriers making it difficult for many vulnerable children, young people and those who care for them to get the support they need. Our aim is to dismantle these barriers and reach out to children and young people in need.

Much of what is needed can be done now by:

20. Making sure that children, young people or their parents who do not attend appointments are not discharged from services. Instead, their reasons for not attending should be actively followed up and they should be offered further support to help them to engage. This can apply to all children and young people.

21. Commissioners and providers across education, health, social care and youth justice sectors working together to develop appropriate and bespoke care pathways that incorporate models of effective, evidence-based interventions for vulnerable children and young people, ensuring that those with protected characteristics such as learning disabilities are not turned away.

22. Making multi-agency teams available with flexible acceptance criteria for referrals concerning vulnerable children and young people. These should not be based only on clinical diagnosis, but on the presenting needs of the child or young person and the level of professional or family concern.

23. Mental health assessments should include sensitive enquiry about the possibility of neglect, violence and abuse, including child sexual abuse or exploitation and, for those aged 16 and above, routine enquiry, so that every young person is asked about violence and abuse.

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24. Ensuring those who have been sexually abused and/or exploited receive a comprehensive assessment and referral to appropriate evidence-based services. Those who are found to be more symptomatic who are suffering from a mental health disorder should be referred to a specialist mental health service.

25. Specialist services for children and young people’s mental health should be actively represented on Multi-Agency Safeguarding Hubs to identify those at high risk who would benefit from referral at an earlier stage.

26. For the most vulnerable young people with multiple and complex needs, strengthening the lead professional approach to co-ordinate support and services to prevent them falling between services.

With additional funding, a future government should consider:

27. Improving the skills of staff working with children and young people with mental health problems by working with the professional bodies, NHS England, PHE and HEE, to ensure that staff are more aware of the impact that trauma has on mental health and on the wider use of appropriate evidence-based interventions.

28. Piloting the roll-out of teams specialising in supporting vulnerable children and young people such as those who are looked after and adopted, possibly on a sub-regional basis, and rolling these out if successful.

29. Improving the care of children and young people who are most excluded from society, such as those involved in gangs, those who are homeless or sexually exploited, looked-after children and/or those in contact with the youth justice system, by embedding mental health practitioners in services or teams working with them.
7. Accountability and transparency

7.1 We have a wealth of information and many examples across the country of services moving towards greater integration and offering greater choice of evidence-based outcomes focused treatments working collaboratively with children and young people. However, this is not consistent and there is unacceptable variation.

7.2 Agreeing better models of care is not enough. Right now there are too many barriers to have confidence that such models would succeed because:

• the system of commissioning services is fragmented, with money often sitting in different budgets, in different organisations, in different parts of the system and without clear lines of accountability;

• there is limited access to the necessary information to know how a local system is working in respect of access and waiting times, how outcomes are achieved or if they provide value for money;

• there is poor information sharing within the system which hampers joint working; and

• the best practice standards, agreed as quality markers for accreditation systems, are not universally applied.

7.3 These are ingrained and systemic problems facing children and young people's mental health services that require strong leadership right across the whole system and at every level.

7.4 The recent changes to the national statutory framework for children and young people with special educational needs and disabilities (SEND) establish a platform for significant potential improvements over time for a cohort which includes some children and young people in need of mental health services. It is not possible to simply copy this model in respect of mental health, as support and treatment are quite different, but there are key features that are relevant:

• access to a wider range of local services through a transparent 'local offer';

• clarity over points of access and decision-making processes for more specialist support, including use of triage processes;

• co-ordination of assessment and planning around the individual child, involving all relevant services, facilitated by information sharing and a lead professional or key worker; and

• giving young people and parents more control, including greater use of personal budgets.

Securing the best possible service for children and young people with mental health problems

7.5 We consider that there are a number of issues that need to be addressed in the organisational and accountability frameworks if we are to achieve transformation in the service offer.
7.6 There was strong support from many members of the Taskforce to make it a requirement at the local level for there to be a lead accountable commissioning body to co-ordinate commissioning and the implementation of evidenced-based care (30). Many members of the Taskforce also favour the creation of a single, separately identifiable budget for children’s mental health services. These proposals build on the learning from those areas which are already jointly commissioning children’s mental health services between Clinical Commissioning Groups and local authorities, in some cases with pooled budgets. We envisage in most cases the CCG would establish lead commissioning arrangements working in close collaboration with local authorities. We also recognise the need for flexibility to allow different models to develop to suit local circumstances and would not want to cut across alternative arrangements.

“If we are all working towards the same outcomes, planning in an integrated way to meet them, using clear accountability structures and a person-centred planning approach, then joint ownership of outcomes is inevitable. This is not easy to do – but... we can start.”

A community services manager who took part in the Taskforce engagement exercises.

7.7 There is a need to address the ambiguity in local authorities’ role and responsibilities in respect of child mental health commissioning. Although the statutory lever under the Children Act 1989 remains in place, along with responsibilities regarding looked-after children and care leavers, the financial position that local authorities are facing is challenging and there is no longer any ring-fenced budget for this provision within local authorities. As a result, we are seeing very different patterns of commitment and contribution across both public health and children’s social care budgets. At the least, there should be full transparency in terms of individual local authorities’ contribution.

7.8 The work of the lead commissioner should be based upon an agreed local plan for child mental health services, agreed by all relevant agencies and with a strong input from children, young people and parents/carers (30). The local plan itself should be derived from the local Health and Wellbeing Strategy which places an onus on Health and Wellbeing Boards to demonstrate the highest level of local senior leadership commitment to child mental health. Health and Wellbeing Boards have strategic oversight of the commissioning of the whole pathway or offer regarding children and young people’s mental health and wellbeing. As some individual commissioners and providers, including schools, are not statutory members of Health and Wellbeing Boards, they should put in place arrangements to involve them in the development of the local plan, drawing on approaches already used in some areas such as Mental Health Advisory Panels or Children’s Partnership Boards.

7.9 Key drivers for the quality of any local offer should be the local Health and Wellbeing Board’s Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy. The JSNA should address children and young people’s health and wellbeing, including mental health (31). Health and Wellbeing Boards, supported by the local government-led health and wellbeing system improvement programme and Public Health England, should ensure that both the JSNA and the Joint Health and Wellbeing Strategy address children and young people’s mental health needs effectively and comprehensively.
7.10 As well as drawing on the local plan, we consider that the local offer should be guided by a national ambition that clearly sets out the expectations and requirements for securing the best possible outcomes for children and young people's mental wellbeing. This will avoid the dangers of a postcode lottery while still ensuring a high degree of local flexibility. Over time, Government should consider whether elements of the national ambition should be placed on a more formal footing to ensure consistency of practice across the country.

7.11 Developing an effective local system of care and support requires access to diverse and flexible services. In adult social care, there is a now a statutory duty on local authorities to shape the market to ensure adequacy of local provision. While the situation is not precisely analogous in children and young people’s mental health, our assessment is that those local areas exhibiting best practice have access to a range of providers, and, in particular, have harnessed the strength of the voluntary and community sector.

7.12 There is a particular need to coordinate the commissioning of community health and inpatient services (32). Within the current statutory system, the former is the responsibility of local commissioners and the latter the responsibility of the national commissioner, NHS England. If we are serious about moving away from a tiered model, then this commissioning needs to be joined up. This need for co-commissioning has been recognised by NHS England. At the same time, however, we want to avoid the mistakes of the past where we ended up with a patchwork quilt of intensive community crisis support and inpatient services.

7.13 The National Institute for Health and Care Excellence has a crucial role to play in framing a national ambition through the development of Quality Standards as well as guidance for health and social care, which are commissioned by the Secretaries of State for Health and Education (33). The quality standards will need to describe cost-effective evidence-based practice. They should provide clear descriptions of high priority areas for quality improvement. They will help organisations by supporting comparison of current performance, using measures of best practice to identify priorities for improvement. Though not mandatory, they are an important driver for change in the new arrangements for commissioning and service delivery in health and social care. It would be helpful if their recommendations could include further advice regarding implementation across the whole care pathway.

7.14 In supporting implementation and delivery of high quality care, we consider that CQC and Ofsted – with their distinct roles and responsibilities in health and education – should develop a joint cross inspectorate view of how the health, education and social care systems are working together to improve children and young people’s mental health outcomes and how this area should be monitored in future (34).
However, this is still not enough without access to information. Measurement is crucial to support continuous improvement. Support and services should be based on high quality, accurate data, but there are significant gaps in relation to children’s mental health. The last children and young people’s mental health prevalence survey was done over a decade ago, although the Department of Health has just started the process of commissioning the next one (35). We propose the commissioning of a regular prevalence survey of child and adolescent mental health every 5 years, giving particular consideration to including under-5s and ages over 15 (39). In addition, and in response to the growing international evidence base, the survey should be expanded to cover:

- New disorder codes (DSM 5, ICD-11) and conditions or issues that have grown in prominence since 2004, eg eating disorders, self-harm and the impact of social media and experience of cyberbullying; and
- The ability to analyse data by characteristics such as ethnicity and deprivation or whether a child is adopted or in care.

“If data collects meaningful information that can be useful for clinicians and patients alike to monitor their progress, data collection becomes part of the therapy.”

A CAMHS psychologist who took part in the Taskforce engagement exercises.

At the same time, levels of investment in mental health services for children and young people should be transparent. Accurate information on current levels of spend on children’s mental health across agencies is a key gap. NHS England is working to improve the quality of data on adult mental health spend from April 2015 so that it will be able to identify the overall spend in primary and community care as well as mental health services and specialist commissioning. This has been built into the NHS planning process at CCG level. We propose that, in the future, this activity is extended to cover children’s mental health spend by the NHS. It is also proposed that further work is undertaken to improve understanding of child and adolescent mental health funding flows across health, education, social care and youth justice to support a transparent, coherent, whole system approach to future funding decisions and investment (38).

The CAMHS Minimum Dataset, already in development, will allow specific outcome metrics by condition, activity and evidence-based interventions to support evaluation of
the effectiveness of the care commissioned (35). To build on this work, it is important that routine data collection of key indicators of child and adolescent mental health service activity, patient experience and patient outcomes are properly co-ordinated and incentivised.

7.18 Data from the CAMHS Minimum Data Set will begin to flow no later than January 2016. It is likely that early data will be flawed and will take time for data completeness and quality to be such that conclusions can be drawn about access and waiting times. The Minimum Data Set does not cover investment levels. The implementation in 2015 and central flow of data through the Health and Social Care Information Centre (HSCIC) must be a key priority for implementation at a national and local level. This includes ensuring that commissioners are placing into contracts the requirements for meaningful data collection, including outcomes monitoring.

7.19 NHS England has committed to developing access and waiting time standards in mental health. This applies to children and young people who will benefit in the first year with the introduction of the first ever waiting time standards in respect of early intervention in psychosis. In developing any access and waiting time standards, it should be a requirement that access to services is reported as time to different events in a pathway of care linked to delivery of NICE concordant treatment and measurement of outcomes (36 and 37).

7.20 In the meantime, many providers are already collecting data that can be used by commissioners, for instance:

- Members of the NHS Benchmarking Collaborative.
- Outcomes data collected by members of Children’s Outcomes Research Consortium (CORC).
- The CYP IAPT datasets and outcome measures.
- Data collected for CAMHS Currencies.
- Health and Justice data.

7.21 Commissioning Support Units and Academic Health Science Networks should therefore be supporting commissioners to analyse local data collections, share best practice and pool knowledge and skills, mentoring new commissioners and delivering learning sets. This should include promoting the use of existing benchmarking tools by commissioners, for example, the Fingertips tool on the Mental Health Intelligence Network and the service snapshots and other information supplied by Public Health England.
To be accountable and transparent – chapter 7 summary

Far too often, a lack of accountability and transparency defeats the best of intentions and hides the need for action in a fog of uncertainty. Our aim is to drive improvements in the delivery of care, and standards of performance to ensure we have a much better understanding of how to get the best outcomes for children, young people and families/carers and value from our investment.

Much of what is needed can be done now by:

30. Having lead commissioning arrangements in every area for children and young people’s mental health and wellbeing services with aligned or pooled budgets by developing a single integrated plan for child mental health services in each area, supported by a strong Joint Strategic Needs Assessment.

31. Health and Wellbeing Boards ensuring that both the Joint Strategic Needs Assessments and the Health and Wellbeing Strategies address the mental and physical health needs of children, young people and their families, effectively and comprehensively.

32. By co-commissioning community mental health and inpatient care between local areas and NHS England to ensure smooth care pathways to prevent inappropriate admission and facilitate safe and timely discharge.

33. Ensuring Quality Standards from the National Institute for Health and Care Excellence (NICE) inform and shape commissioning decisions

34. By Ofsted and CQC working together to consider how to monitor the implementation of the proposals from this report in the future.

35. The Department of Health fulfilling its commitment to complete a prevalence survey for children and young people’s mental health and wellbeing, and working with partner organisations to implement the Child and Adolescent Mental Health Services dataset within the currently defined timeframe.

36. Developing and implementing a detailed and transparent set of measures covering access, waiting times and outcomes to allow benchmarking of local services at national level, in line with the vision set out in Achieving Better Access to Mental Health Services by 2020.

37. Monitoring access and wait measurement against pathway standards – linked to outcome measures and the delivery of NICE-concordant treatment at every step.

38. Making the investment of those who commission children and young people’s mental health services fully transparent.

And subject to decisions taken by future governments:

39. Committing to a prevalence survey being repeated every five years.
8. Developing the workforce

8.1 Professionals working with and supporting children and young people want to make a real and lasting difference to their lives.

8.2 The national vision is for everyone who works with children, young people and their families to be:

- ambitious for every child and young person to achieve goals that are meaningful and achievable for them;
- excellent in their practice and able to deliver the best evidenced care;
- committed to partnership and integrated working with children, young people, families and their fellow professionals;
- respected and valued as professionals.

There is consistency in children and young people’s views about the workforce qualities and behaviour they would like to see:

- A workforce which is equipped with the skills, training and experience to best support children and young people’s emotional and mental wellbeing.
- Staff who are positive, have a young outlook, are relaxed, open-minded, unprejudiced, and trustworthy.
- Behaviour that is characterised by fairness, and a willingness to listen to, trust and believe in the child or young person.
- Everybody should work from a basis of asking and listening, being prepared to be helpful in creating understanding among other members of the workforce.
- Their processes should be transparent, honest, and open to being both inspected and clearly explained. Visible actions should result from such scrutiny, enabling children to voice their opinions.
- The workforce should provide real choice of interventions supported by enough resources to follow through, whilst remaining honest and realistic.
A workforce with the right mix of skills, competencies and experience

8.3 Professionals across health, education and social care services need to feel confident to promote good mental health and wellbeing and identify problems early, and this needs to be reflected in initial training and continuing professional development across a range of professions (40). Professionals need to be trained to be able to:

- Recognise the value and impact of mental health in children and young people, its relevance to their particular professional responsibilities to the individual and how to provide an environment that supports and builds resilience.
- Promote good mental health to children and young people and educate them and their families about the possibilities for effective and appropriate intervention to improve wellbeing.
- Identify mental health problems early in children and young people.
- Offer appropriate support to children and young people with mental health problems and their families and carers, which could include liaison with a named appropriately trained individual responsible for mental health in educational settings.
- Refer appropriately to more targeted and specialist support.
- Use feedback gathered meaningfully on a regular basis to guide treatment interventions both in supervision and with the child, young person or parent/carer during sessions.
- Work in a digital environment with young people who are using online channels to access help and support.

Universal settings

8.4 Anybody who works with children and young people in universal settings such as early years provision, schools, colleges, voluntary bodies and youth services, should have training in children and young people's development and behaviours, as appropriate to their professional role.

8.5 This does not mean that professionals working in universal services should step in where a more specialised service is needed. But it does mean that, for example, a teacher who sees that a child is anxious, in a low mood, not eating or socialising as children and young people usually do, is withdrawn or behaving uncharacteristically, understands this child may need help. MindEd (www.minded.org.uk) is a useful resource for promoting this level of awareness in all staff who work with children and young people.

Targeted and specialist services

8.6 Staff who work in targeted and specialist services come from a range of professional backgrounds: social work, occupational therapy, nursing, clinical and educational psychology, psychotherapy, child and adolescent psychiatry and, with a growing number of 0-25 services, general adult psychiatry.

8.7 Staff in paediatric services make an important contribution to targeted and specialist mental health services for children and young people. Their role is likely to increase with a move towards greater integration between children's mental health provision and community paediatrics. The move towards 0-25 service models and integrated services means that, although discipline-specific training will remain the core of most professionals' training, interdisciplinary training and practice and cross-agency working will become increasingly important.
8.8 Basic training in all disciplines should include an understanding of the interface between physical and mental health. These interactions indicate the need for: greater awareness of mental health problems amongst paediatric staff; greater awareness of physical health problems amongst mental health staff and the development of services models (such as paediatric liaison) which recognise the interaction and overlap between physical and mental health. A paediatric nurse working with young people with diabetes, for example, should be able to identify whether that young person also requires emotional or mental health support. All of these recommendations have significant implications for the training of staff in the children and young people’s workforce. Enhanced, multi-professional training across the physical and mental health interface will be a key part of improving the experience of children and young people with physical and mental health problems.

8.9 Effective access to support requires improved communication between universal, targeted and specialist services, backed by a clear shared understanding of roles and responsibilities across all those involved in the system, so that children and young people do not fall between services, and receive timely and appropriate support. This implies the use of local reciprocal multi-agency and multi-professional training programmes for those involved in children and young people’s services. A good example is the reciprocal training programme between practice nurses and local community mental health trust nurses in Health Education England North Central & East London which is now available to be rolled out nationally.

8.10 The workforce in targeted and specialist services need a wide range of skills brought together in the CYP IAPT Core Curriculum. All staff should be trained to practise in a non-discriminatory way with respect to gender, ethnicity, religion and disability. This was considered in detail by the Vulnerable Groups and Inequalities Task and Finish Group. In addition, there are skills gaps in the current workforce around the full range of evidence-based therapies recommended by NICE. The CYP IAPT programme was commissioned with a modest budget to deliver training for a limited range of therapies to a prescribed group as a part of its transformation role. There are gaps in the training of staff working with children and young people with Learning Difficulties, Autistic Spectrum Disorder, and those in inpatient settings. Counsellors working in schools and the community have asked for further training to improve evidence-based care.

8.11 Skills and capabilities audits in the North West have shown not only deficits in terms of competencies but also gender and age issues that need to be addressed. 48% of staff in the survey were found to be due to retire in the next 10 years, and 90% were female.

8.12 The Taskforce highlighted a number of initiatives in progress which could and should contribute to supporting professional capabilities.
Current action to develop workforce skills and competencies includes:

For schools, the Carter Review of Initial Teacher Training\(^6^8\) (ITT) reported in January. It recommended commissioning a sector body to produce a framework of core content for ITT which would include child and adolescent development (41).

The revised Foundation Programme curriculum for doctors (covering the first two years of postgraduate training for doctors qualifying in the UK) will give increased prominence to mental health, and 45% of foundation trainees will rotate through a psychiatry post during their two years from 2016 to ensure that more doctors (many of whom will become GPs) have experience of working with patients with mental health issues. The opportunity should be taken to review whether a greater emphasis on children and young people’s mental health could be incorporated.

The CYP IAPT programme currently works with partnerships covering 68% of the 0-19 population. The Service Transformation programme includes training for existing service leaders, supervisors and therapists in the NHS, social care and voluntary sector in a range of evidence-based programmes, with a Mandate commitment for both Health Education England and NHS England to plan further roll-out (44).

The social work reform programme is placing a much stronger focus on the skills and competencies needed by child and family social workers. This includes identifying child development, physical and mental health and education needs and working in partnership with other professionals and organisations to provide the help a child or young person needs.

The Think Ahead initiative will provide a new cadre of top graduates training to specialise in adult mental health social work, including work with young adults.

The sector skills councils such as Skills for Care & Development will also play an important role in shaping education and training for the workforce in support of the children and young people’s mental health agenda.

Developing a strategic approach to workforce planning

8.13 Adopting new commissioning arrangements with new models of contracting and performance monitoring would be a key driver to securing collaborative and co-ordinated working across local areas.

8.14 The established and proven CYP IAPT transformation initiative gives a platform on which to build and align the creation of a children and young people’s mental wellbeing workforce across agencies that is fit for purpose.

8.15 Planning for mental health services for children and young people in the future requires a bottom-up consideration of the current competencies and capabilities of the existing workforce as well as an understanding of the capacity that will be required to deliver a workforce fit for the future. The role of Health Education England and Local Education and Training Boards will be crucial to establish local requirements and local practice through locally led needs assessments of current workforce capability and capacity.

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8. Developing the workforce

“[We need] designated leaders to drive change across service and agency boundaries, and trained commissioners who know and understand how this would work and what they need to be commissioning. The Health Select Committee CAMHS report showed that many local authorities still do not consider children’s emotional health and wellbeing and mental health as their core business. But of course it is! Their activity and priorities are the very foundation of building resilience and emotional intelligence in children.”

Office of the Children’s Commissioner as part of the Taskforce engagement exercises.

8.16 It is proposed that the Department of Health and Department for Education should work together with HEE, the Chief Social Worker for children and others, to design and commission a census and needs assessment of the current workforce working across the NHS, local authorities, voluntary sectors and independent sector as the first stage in determining a comprehensive cross-sector workforce and training strategy (45).

Training for commissioners

8.17 Traditionally, especially in the NHS, investment in training has focused on the provision of services. There is, however, no recognised standard training programme for commissioners of children’s services or mental health services for children and young people. The recent mental health commissioning and leadership programme developed by NHS England and Academic Health Science Networks is organised around the principles of: data for commissioning, the use of the evidence base and leadership. All programmes include a module on child and adolescent mental health provision, and attendance at these accredited courses should be a requirement for all those working in commissioning of children and young people’s services (42).
Developing the workforce – chapter 8 summary

It is our aim that everyone who works with children, young people and their families is ambitious for every child and young person to achieve goals that are meaningful and achievable for them. They should be excellent in their practice and able to deliver the best evidenced care, be committed to partnership and integrated working with children, young people, families and their fellow professionals and be respected and valued as professionals themselves.

Much of what is needed can be done now by:

40. Targeting the training of health and social care professionals and their continuous professional development to create a workforce with the appropriate skills, knowledge and values to deliver the full range of evidence-based treatments

41. Implementing the recommendations of the Carter Review of Initial Teacher Training (ITT) to commission a sector body to produce a framework of core content for ITT which would include child and adolescent development.

42. By continuing investment in commissioning capability and development through the national mental health commissioning capability development programme.

With additional funding, a future government should consider:

43. Extending the CYP IAPT curricula and training programmes to train staff to meet the needs of children and young people who are currently not supported by the existing programmes.

44. Building on the success of the CYP IAPT transformation programme by rolling it out to the rest of the country and extending competencies based on the programme’s principles to the mental wellbeing workforce, as well as providing training for staff in schools.

45. Developing a comprehensive workforce strategy, including an audit of skills, capabilities, age, gender and ethnic mix.
9. Making change happen

9.1 This report sets out a vision for a comprehensive approach to promoting, supporting and treating our children and young people’s mental health, and to supporting their families. We have made a set of proposals to enable this vision to be translated into national and local frameworks. There is undoubtedly an urgency to act and in this section we set out how we might make a start.

Building the evidence base

9.2 Throughout the report, we have emphasised the paucity of good quality national information about meaningful outcomes as well as outputs in respect of child mental health services and how this can be corrected over the next few years, building on the early successes of the CYP IAPT programme.

9.3 If we are continuously to improve the mental health care and wellbeing of children and young people, we need data and evidence with which to do so (49). Good information is the foundation for commissioning; to understand need, to plan, secure and monitor services. In some areas, evidence is weak or entirely lacking as to the best interventions. Although lack of evidence should not be used as an excuse for lack of care, it is unethical and a waste of taxpayers’ money to invest in interventions that have no evidence base – unless they are subject to rigorous evaluation.

9.4 This is one of the hardest challenges the system has: to secure acknowledgment of the limitations of our knowledge and not assume that interventions are without harm. There is good evidence that well-meaning interventions, with the best of intentions, can do more harm than good. A classic paper illustrating this is the McCord study of a multi-disciplinary approach to child delinquency. In the 30 year follow up of the two groups, control versus active, every outcome was worse in the active group.69 Another was the mixed impact of suicide prevention in adolescents.70 These examples illustrate the necessity to use an evidence base wherever possible and, if one is lacking, to ensure that research capacity is deployed to fill the gap.

9.5 This re-emphasises the importance of NICE guidance and Quality Standards for those who plan, commission or provide services, and also the need for a world class research programme in child mental health and wellbeing supported by regular detailed prevalence surveys and reliable routinely collected comprehensive outcomes data.

Making a start

9.6 There are a number of proposals in this report directed at a national level that can only be properly considered during the next Parliament. However, we are keen that progress is made during 2015/16. Many of our proposals require a different way of doing business rather than further significant investment.

9.7 National organisations must play their part but we believe that even more progress can be made rapidly at the local level.

9.8 This will require local leadership and ownership. We therefore propose the development and agreement of Transformation Plans for Children and Young People’s Mental Health and Wellbeing which will clearly articulate the local offer (46). These Plans would cover the whole spectrum of services for children and young people’s mental health and wellbeing from health promotion and prevention work, to support and interventions for children and young people who have existing or emerging mental health problems, as well as transitions between services.

9.9 We would anticipate that the lead commissioner, in most cases the Clinical Commissioning Group, would draw up the Plans, working closely with Health and Wellbeing Board partners including local authorities. All these partners have an important role to play in ensuring that services are jointly commissioned in a way that promotes effective joint working and establishes clear pathways.

9.10 To support this, and in line with the announcement at the time of the Autumn Statement 2014, NHS England can make a specific contribution by prioritising further investment in those areas that can demonstrate robust action planning through the publication of local Transformation Plans that accord with the principles and ambitions set out in this report.

9.11 What is included in the Plan should be decided at a local level in collaboration with children, young people, families as well as provider and commissioner representatives and should address as many of the principles and proposals set out in the report as possible.

9.12 At the same time, NHS England and the Department of Health have recently invited proposals from CCGs to lead and accelerate co-commissioning arrangements for children and young people’s mental health. The national response to this invitation was hugely encouraging and indicative of the potential to be harnessed by this report. Although only a limited number of areas could be chosen, as these projects develop, they will provide good examples of what can be achieved, alongside other relevant initiatives such as the Social Care Innovation Fund and the Department for Education’s Voluntary and Community Sector Fund (48).

9.13 Lead commissioners should ensure that schools are given opportunities to contribute to the development of local Transformation Plans. The Department for Education is already leading work to improve the quality of teaching about mental health in Personal, Social, Health, and Economic (PSHE) lessons in schools, and is developing an evidence-based outcomes focused schools counselling strategy to encourage more and better use of counsellors in...
Making Change Happen – chapter 9 summary

Much of what is needed can be done now by:

46. Establishing a local Transformation Plan in each area during 2015/16 to deliver a local offer in line with the national ambition. Conditions would be attached to completion of these Plans in the form of access to specific additional national investment, already committed at the time of the Autumn Statement 2014.

47. Establishing clear national governance to oversee the transformation of children’s mental health and wellbeing provision country-wide over the next five years.

48. Enabling more areas to accelerate service transformation.

With additional funding, a future government should consider:

49. The development of an improved evidence base, on the safety and efficacy of different interventions and service approaches, supported by a world class research programme.
10. Conclusion

10.1 The work of the Taskforce has revealed great potential to meet the desire for children and young people to have better support and care for their mental health. The economic argument and evidence for effective interventions make a strong case for putting national energy and effort into supporting the expectations that have emerged.

10.2 We have described a vision for our country in which child mental health and wellbeing is everybody’s business, where our collective resilience and mental strength is regarded as an asset to the nation in the same way as we prize our levels of attainment, creativity and innovation.

10.3 We can start by doing what we know works, indeed already is working in some areas of the country, but is not being applied consistently.

10.4 The second step is to deliver the commitments already made and the initiatives already started that give us the fundamental building blocks that will help justify securing the third element.

10.5 With better data, transparency and accountability, the value of investment in mental wellbeing and care for child and young people can, and we believe will, be demonstrated and justified. A cycle of virtue can be created where, for each taxpayer’s pound invested, the benefit for the individual and society can be realised with confidence.

10.6 In the meantime, there are targeted opportunities if resources can be identified through re-prioritisation and/or on an ‘invest to save’ basis. These have been set out clearly in the report and are illustrated by the additional money already identified for eating disorder services from April this year. And, of course, any local area can make a decision to re-prioritise its resources in favour of child mental health on the basis of existing national and local evidence of need and efficacy.

10.7 The work of the Taskforce has reconfirmed that we are by no means alone in the international community in grappling with how to give our children and young people a better start, to keep them safe and to help their mental health and resilience. It would be a hallmark of our progress if by 2020 we could truly say that England is leading the world in improving the outcomes for children and young people with mental health problems. We know that it is possible. But it will only happen if we decide with resolve and determination to place such a goal at the heart of the economic and social vision for our nation.
### Glossary and Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
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<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
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<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
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<tr>
<td>CCGs</td>
<td>Clinical Commissioning Groups</td>
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<tr>
<td>CORC</td>
<td>CAMHS Outcomes Research Consortium</td>
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<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
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<tr>
<td>CYP IAPT</td>
<td>Children and Young People's Improving Access to Psychological Therapies Programme</td>
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<tr>
<td>DfE</td>
<td>Department for Education</td>
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<tr>
<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>DSM-5</td>
<td>Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition</td>
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<tr>
<td>HCP</td>
<td>Healthy Child Programme</td>
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<tr>
<td>HEE</td>
<td>Health Education England</td>
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<tr>
<td>HSCIC</td>
<td>Health &amp; Social Care Information Centre</td>
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<td>H&amp;WBs</td>
<td>Health and Wellbeing Boards</td>
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**ADHD**
Neurodevelopmental disorder identified by behavioural symptoms that include inattentiveness and impulsiveness.

**CQC**
Independent regulator of all health and social care services in England.

**CYP IAPT**
Children and Young People's Improving Access to Psychological Therapies Programme

**CCGs**
Statutory bodies clinically led that include all of the GP practices in their geographical area. The aim of this is to give GPs and other clinicians the power to take commissioning decisions for their patients. Each CCG has a constitution and is run by its governing body, and is overseen by NHS England.

**DSM-5**

**H&WBs**
Statutory bodies based on upper-tier and unitary authorities in England drawing together members of CCGs, local HealthWatch and the Local Authority. They are charged with assessing the needs of their local population producing Joint Strategic Needs Assessments and agreeing a Joint Health and Wellbeing Strategy. The board also has responsibility for promoting integration of health and care services.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ITT</td>
<td>Initial Teacher Training</td>
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<tr>
<td>LTC</td>
<td>Long Term Condition. A health problem for which there is currently no cure, but the symptoms of which may be managed with medication and other treatment. Examples include asthma and diabetes.</td>
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<tr>
<td>MUS</td>
<td>Medically Unexplained Symptoms. Persistent physical complaints for which medical examination does not reveal an obvious cause.</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
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<tr>
<td>Ofsted</td>
<td>Office for Standards in Education, Children's Services and Skills</td>
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<tr>
<td>PHE</td>
<td>Public Health England</td>
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<tr>
<td>PSHE</td>
<td>Personal, Social and Health Education. Programme of learning that aims to equip young people with the knowledge, understanding and skills they need to manage their lives healthily, safely, productively and responsibly.</td>
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<tr>
<td>SEND</td>
<td>Special Educational Needs and Disabilities</td>
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<tr>
<td>YIACS</td>
<td>Youth Information, Advice and Counselling and Services</td>
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Taskforce Membership

<table>
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<tr>
<th>Name</th>
<th>Job Title</th>
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</table>
During its work, the Children and Young People’s Mental Health and Wellbeing Taskforce has consulted and learned from a wide range of people and organisations, including health, education and care professionals, academics, young people, parents and carers and policy experts. We have benefited greatly from their expertise and we would like to thank them all for their input and contributions to the report.

We would also like to thank Leanne Walker, GIFT Young Sessional worker, for providing illustrations.
Dear colleagues

**Pilot Project: Improving mental health and wellbeing in secondary schools**

At the last meeting of the Secondary and Continuing Education Partnership Meeting on 17 April 2015, there was a discussion about mental health and an acknowledgment on all sides of the very considerable and escalating challenges that schools can face in meeting the emotional and mental health needs of pupils.

It was also acknowledged that the capacity of current CAMHS services to meet needs can be very stretched and that there is a need to support the development of skills and resilience in schools to deal with emotional and mental health needs at an early and preventative stage, plus to offer more direct on-site support to school staff and families where this is appropriate.

In response, Public Health and Children’s Services, working in partnership, are proposing to pilot a new way of working, which if successful will be rolled out to all secondary schools and primary clusters subject to available resources. Once pilot schools have been identified, there will be some preliminary work needed this term with a formal commencement from the beginning of the autumn term.

**Aim of the pilot**

To promote, protect and improve young people’s emotional health and wellbeing through piloting immediate access to onsite specialist community mental health support and the enhancing of a whole school approach to building resilience, in secondary schools.

This whole school approach will be achieved through:

- Promoting good mental wellbeing and resilience by supporting young people and families to adopt and maintain behaviours that support good wellbeing and mental health
- Prevent wellbeing and mental health problems from arising by taking early collective action with young people and parents who may be at risk
- Early identification of need, so that young people and families are supported as soon as possible to prevent more serious problems arising

Telephone: 01273 290000
www.brighton-hove.gov.uk
Printed on recycled, chlorine-free paper
• Referring appropriately into specialist services that keep young people and families safe and well

It is of course essential that children and young people with higher level mental health needs continue to be referred to Tier 3 CAMHS service.

**Wider context of a whole system review of mental health**

The CCG and Council have identified a need for a review and service redesign of mental health and wellbeing services as a key strategic priority for 2015/16. This pilot will feed into this review and form part of the evidence based implementation that will inform redesign. We will therefore be looking for evidence that this pilot:

• Increase evidence of effective prevention in the community.
• Reduces the need for CAMHs support provided through the Single Access Point.

**Pilot Offer from Community CAMHS and Public Health to Pilot Schools**

• **CCAMHS**: An experienced Primary Mental Health Worker 0.5fte on site per week – term time.

The following menu of intervention will be made available and negotiated at project start:

- Book-in appointments for students, staff and parents, to provide support of mental health issues within the school. Pre-booked appointments in a safe and confidential space could provide, pre-referral consultations, booked-in individual support for students and parents who wish to discuss any mental health concerns.
- Reflective practice for staff where the PMHW can provide practical skills-based suggestions in support of, working with students presenting with emotional and psychological issues.
- Bespoke training / workshops for staff and parents where information and knowledge can be shared supportively on a variety of subjects and issues pertaining to student mental health and wellbeing.
- The provision of preventative mental health interventions for students with workshops and small groups that address specific mental health presentations. (Anxiety, Depression, Emotional Regulation, Loss and Bereavement, Self-esteem, Bullying, Self-harm for example)

• **Public Health**: Project co-ordination and management in partnership with Children’s Services, including support to evaluate outcomes and link to the wider systems review of mental health being carried out by the CCG

**Requirements of the Pilot Schools:**

• A named head of mental health and wellbeing to co-ordinate and make links with the PMHW and other Mental Health and Wellbeing agencies working
within the school. (School counsellors, Dialogue trainers, YMCA etc) as well as the curriculum where emotional health and wellbeing is delivered.

- Identification of staff capacity to manage and carry out the pilot project and particularly to:
  - Review and develop a policy and guidance document for mental health and wellbeing
  - Attend half termly meetings to discuss and develop the project at the school and provide the point of contact for the PMHW, the manager of Community CAMHS and other involved partners.
  - To map the offer in schools of support available and review the referral processes as part of this project.
  - To review the effectiveness and co-ordination of the school offer as part of this pilot, e.g. counselling, PSHE, student voice.
  - To make staff available for training as appropriate
  - To be responsible for recruiting / promoting attendance at workshop for parents / young people
  - To build the voice of young people into the whole school approach.
  - To arrange suitable venues for the PMHW to provide.
  - One-to-one consultations, groups and workshops.

Submission of interest:

We ask schools to submit an expression of interest that is not more than 500 words, taking into account the 'requirements of schools' section above.

We do not want to cause unnecessary effort or paperwork for schools and as a reminder, if this pilot is successful as anticipated, the offer will be extended to all schools over the next academic year, subject to sufficient council and school resource being identified.

However in terms of the initial pilot, schools who are most readily able to identify resources to work with the CCAMHS team and Public Health as above are likely to be in the best position to work with us in the first instance.

Please email your submission of interest to lisa.a.brown@brighton-hove.gcsx.gov.uk by Tuesday 30th June.

With very best wishes

Regan Delf
Assistant Director (Children’s and Adult Services)
Brighton and Hove LA

Kerry Clarke
Strategic Commissioner
Public Health
Brighton & Hove City Council

cc: Dr Jo Lyons, Assistant Director, Children’s Services (Education and Inclusion)
Child and Adolescent Mental Health Service and Schools Link Pilot Scheme

NHS England and the Department for Education are inviting proposals from CCGs working with partners, to apply to become a pilot to improve joint working between school settings and child and adolescent mental health services (local NHS funded CAMHS). Grants of up to £50,000 are available per CCG taking part in the pilot. CCGs will be required to match fund this amount. Up to £3,500 is also available to each school taking part in the pilot. Additional funding of up to £100,000 per CCG will also be available for a small number of CCGs, to opt in to an extension of the pilots which will look at developing models of how to better integrate with children’s services that are delivering support to vulnerable children.

Background

Improving children and young people’s mental health and wellbeing is one of this Government’s key priorities as part of the drive to put mental health on an equal footing with physical health. This pilot is part of the strategic vision for shaping sustainable system wide transformation, to close the treatment gap and ensure support is built around the needs of children and young people.

In September 2014, the Government established the Children and Young People’s Mental Health Taskforce. This brought together experts on children and young people’s mental health including children and young people themselves, with leaders from key national and local organisations across health, social care, youth justice and education sectors. The aim of the Taskforce was to identify what needs to be done to improve children and young people’s mental health and wellbeing, with a particular focus on making it easier to access help and support, and to improve how children and young people’s mental health services are organised, commissioned and provided.

The Taskforce report *Future in Mind*, published in March 2015, identified that the current system has unintentionally created barriers between services and can result in children and young people falling between gaps, and experiencing poor transition between services. It highlighted some key principles about how to make it easier for children and young people to access high quality mental health care when they need it.

The report outlined a number of actions to help improve access to effective support for children and young people. The actions included the establishment of a named point of contact within CAMHS and a named lead within each school. The named lead in schools would be responsible for mental health, developing closer relationships with CAMHS in support of

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1 *Future in Mind*: promoting, protecting and improving our children and young people’s mental health and wellbeing (March 2015)
timely and appropriate referrals to services. The report also recommended the development of a joint training programme for named school leads and CAMHS.

NHS England and the Department for Education propose to run pilots during 2015-16 to test the named lead approach and to trial a joint training programme for these lead roles.

Outline of the pilot

NHS England and the Department for Education propose to work with pilot CCGs to test the named lead approach and the training programme. NHS England and the Department for Education are additionally recruiting a training organisation to develop and deliver the joint training programme.

The aims of the training are to:

• raise awareness and improve knowledge of mental health issues amongst school staff;
• improve CAMHS understanding of specific mental health and well-being issues within schools; and
• support more effective joint working between schools and CAMHS.

We expect the length of the training to be around 2 days. The training might be delivered on consecutive days or split over time. There may also be a requirement to take part in online training.

We anticipate that the training will be delivered from September 2015 and completed by March 2016. The evaluation is expected to last for a longer period of time. Schools and CCGs may be asked to take part in follow up surveys and questionnaires up to one year after the pilots are completed.

At a national level, NHS England is working with the Department for Education to ensure that this initiative is closely aligned with other service developments in child and adolescent mental health services which are already underway.

This includes:

• work to take forward recommendations in the CAMHS Tier 4 Report;
• further roll out of the Children and Young People Improving Access to Psychological Therapies (CYP IAPT) programme;
• an access and waiting time standard for individuals experiencing first episode psychosis, the majority of whom are aged between 16 and 25, as well as further work to develop a waiting time standard on eating disorders and other mental health conditions;
• developing model service specifications for CAMHS provision at targeted and specialist levels, for Tier 4 inpatient services to improve the experience of transition for young people leaving CAMHS; and

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2 Child and Adolescent Mental Health Services (CAMHS )Tier 4 Report (July, 2014)
• implementation of the new Special Educational Needs and Disability (SEND) arrangements.

CCG and schools involvement

We are now looking for expressions of interest from CCGs across the country to work with the training organisation to test this programme and the development of named leads within schools.

NHS England and the Department for Education are looking for 15 CCGs to apply to be a part of the pilot programme. Each CCG will be required to select a CAMHS lead and identify 10 or more local schools to take part in the pilot. The CAMHS lead should ideally be someone who has good existing links with local schools. Each school will need to nominate a lead person who has an overview of mental health issues within schools and who will be able to fully participate in the training and the development of the joint working models. This might be a member of the leadership team but could also be someone who has a mental health or wellbeing role, for example, school counsellors, special educational needs coordinators (SENCOs), staff with a pastoral lead or educational psychologists where they are employed by the school. Up to two additional staff from schools may also be nominated to attend the training.

Funding is also available to extend the pilots to look at developing models of better integration with services delivering support to vulnerable children including those who are adopted and looked after children. We would expect to support up to 4 CCGs to additionally cover this element, working in a specific partnership with local children’s services.

CCGs will need to:
• commission CAMHS to link with schools; and
• support the testing of the training programme with the training organisation, building in a local element to help support relationships and reflect local circumstances through the CAMHS lead.

CAMHS will need to:
• identify and support CAMHS named leads to work with each school;
• test the named lead approach;
• commit to relevant staff attending training; and
• participate in the process and impact evaluations of the pilot, for example by taking part in baseline and follow-up surveys, interviews and providing other data including after the end of the pilot.

The schools lead will need to:
• commit to working collaboratively with the training organisation including attending training; and
• participate in the process and impact evaluations of the pilot, for example, by taking part in baseline and follow-up surveys, interviews and providing other data including after the end of the pilot.
CCGs, CAMHS and schools will also need to collaboratively develop local protocols for joint working across schools and CAMHS.

Benefits for pilot areas

CCGs and schools participating in this project will benefit by:

• being part of a pilot initiative, which will test new ways of working with the aim of improving outcomes for children and young people;
• having the opportunity to help to develop and influence a joint training programme which will support improvements in outcomes for children and young people adapted to local circumstances and need;
• receiving mental health training, which will include core information about mental health and well-being, identification tools and potential interventions;
• receiving specific training to support effective joint working between CAMHS and schools;
• receiving support in developing and agreeing locally determined approaches; and
• support with local transformation - participation in the pilot should be included in Local Transformation Plans [link to guidance] as an indicator of robust local planning across agencies.

Applications will need to demonstrate a strong commitment to partnership working at a local level and a drive to lead and accelerate change to improve outcomes for children and young people.

If you would like to be considered as a pilot site for the CAMHS and Schools Link Scheme, complete the Expression of Interest form below, addressing the required criteria to harriethamilton@nhs.net by midnight 31st July 2015.

If you have any queries, please contact michelle.place1@nhs.net

Child and Adolescent Mental Health Service and Schools Link Scheme Selection Criteria, Process and National Support for Pilot Sites

Expression of Interest Application form

Within the application please demonstrate:

• sign up from at least 10 local schools. This should include a mix of primary and secondary schools and could reflect local arrangements, for example, secondary schools and their feeder schools. Each school will need to identify a named lead and demonstrate a commitment to release the named lead and ideally up to two further staff to attend the training;
• support from local CAMHS – with agreed named point of contact;
• an identified mental health lead within your CCG;
• commitment to being involved in the evaluation of the pilot; and
  1. how this work will fit with your local Children and Young People’s Mental Health Transformation Plan.

“High quality care for all, now and in future generations”
If you are also applying for the funding to look at models of engaging with services for vulnerable children, you should provide details in the application form which shows an understanding of the local situation for vulnerable children and proposals for how these pilots could be extended to improve the identification and treatment of mental health issues suffered by vulnerable children. If applying for this, CCGs should demonstrate engagement with a specific [local authority or VCS] service or services for vulnerable groups and the practice to be supported.

**Selection process**

The selection process will be fair and transparent and will be assessed against the selection criteria using a scoring system. The assessment process will also take account of the location of CCGs applying to take part with the aim of achieving a good regional spread.

Expressions of interest must be submitted by a lead CCG (which would act as a funding recipient).

Potential pilot areas should return their expression of interest applications to Harriet Hamilton harriethamilton@nhs.net by midnight Friday 31st July.

The selection panel of representatives from the Department of Health, Department for Education and NHS England will review all EoIs. The successful pilots will be announced in August 2015.

### Child and Adolescent Mental Health Service and Schools Link Scheme

#### Selection Criteria, Process and National Support for Pilot Sites

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<thead>
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<th>Name of lead CCG</th>
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<td>Brighton and Hove CCG</td>
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<th>Contact details to discuss this application</th>
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<td><strong>Telephone</strong></td>
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<td><strong>Address</strong></td>
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</tbody>
</table>
CAMHS involved in the application - please detail service and include contact details of named point of contact email address and telephone

**Tier two Community CAMHS team:**
Paul Goodwin, Service Manager
EPaCC, Kings House
Grand Avenue
Hove
BN3 2LS
Tel 01273 294411 Direct line 01273 294653 07825113917
Email: paul.goodwin@brighton-hove.gcsx.gov.uk

**Tier Three Specialist CAMHS team:**
Peter Joyce
General Manager East Sussex and Brighton & Hove CYPD.
Sussex Partnership NHS Foundation Trust
CAMHS
Aldrington Centre,
35 New Church Road
Hove
BN3 4AG
Tel 01273 718680
Mobile 07917 558009
Email peter.joyce@sussepartnership.nhs.uk

**Schools involved in the application - this should detail the names of head teachers and contact details of school including email address and telephone**

**Secondary Schools**
Annette Kelly,
Deputy Head, Cardinal Newman Catholic School, Tel : 01273 558551
Email: a.kelly@cnecs.co.uk

Suzanne Lewis
Deputy Head, Dorothy Stronger Secondary School. Tel: 01273 852222
Email: LEW@dorothy-stringer.co.uk

Paula Sargent
Head Teacher, Patcham High School, Tel: 01273 503908
Email: PSargent@PatchamHigh.org.uk

**Primary Schools**
Julie Aldous
Headteacher, Middle Street Primary School. Tel : 01273 323184
Email: juliealdous@middlestreet.brighton-hove.sch.uk;

Wendy King
Headteacher, Bevendean Primary School, Tel: 01273 681292
Email: wendyking@bevendean.brighton-hove.sch.uk

“High quality care for all, now and in future generations”
Sarah Clayton,
Headteacher, St Marys Catholic Primary School. Tel: 01273 418416
Email: sarahclayton@stmarys.brighton-hove.sch.uk

Jonathan Whitfield, Headteacher, Woodingdean Primary School Tel: 01273 680811
Email: jonathanwhitfield@woodingdean.brighton-hove.sch.uk

Jonathan Cooper,
Headteacher, St Luke's Primary School Tel No: 01273 675080
Email. jonathancooper@stlukes.brighton-hove.sch.uk

Janis Taylor
Headteacher, Hove Juniors. Tel No: 01273 388800
Email janistaylor@hovejuniors.brighton-hove.sch.uk

Rachel Holland
Headteacher, Cottesmore Catholic Primary. Tel No: 01273 555811
Email: rachelholland@cottesmore.brighton-hove.sch.uk

CCGs wishing to extend the pilot to include models of engaging services for vulnerable children – please describe how you plan to extend the pilot and to which services (no more than 700 words)

Not applicable

Please set out what you aim to achieve in your local area through the CAMHS and Schools Link Scheme please include how this work will link with your Transformation Plan (no more than 700 words)

The CAMHS and Schools Link Scheme is an exciting opportunity to build on the work started in Brighton and Hove to improve the emotional and mental health outcomes for children and young people, and be part of the national pilot contributing and learning from others.

Brighton and Hove has a high number of self-harm A&E attendances and admissions. In 2012/13 there were 281, 0-24 year olds admitted to hospital for self-harm and for 12 to 17 year olds in recent years from 2010/11 of 72 admissions to 2013/14 of 156 admissions. In 2014/15, partners joined under the Public Health Schools programme to develop a whole school approach to self-harm. Partners have trialled and reviewed approaches to:

• Improve PSHE curriculum;
• Review access to one to one support;
• Provide peer led group work programmes;
• Support parents/carers;
• Increase the use of student voice; and
• Improve Workforce.

http://fingertips.phe.org.uk/search/self%20harm#gid//pat/6/ati/102/page/0/par/E12000008/are/E06000036

“High quality care for all, now and in future generations”
A series of focus groups with young people and parents / carers alongside an online survey has ensured we develop a response around the needs of the young people and their families. This system is now available in the schools for the CAMHS and Schools links scheme.

In September 2015, a pilot project with 3 secondary schools in the City starts, aiming to promote, protect and improve young people’s emotional health and well-being. In practice for the schools, that will mean implementing the whole school approach and have access to:

- An onsite Primary Mental Health Worker to provide:
  - Access to appointment based/ drop-in service, reflective practice, bespoke training/ workshops;
  - Co-delivering interventions with school staff to delivering targeted early interventions and to build on the existing expertise of the schools staff;
  - Direct referral link to Tier 3 specialist community CAMHS;
- Workshops from peer led projects, review of their PSHE curriculum, support to develop student voices and parents/carers packages; and
- Each school will provide a named head of mental health to make links with the Primary Mental Health Worker, champion, coordinate and influence change, and ensure the right professionals are involved.

If successful with our CCG submission for the CAMHS and Schools Link Scheme, it will provide Brighton and Hove with the opportunity to:

- Expand the role of mental health leads to feeder primary schools and look at impact on siblings and transitions;
- Rolling out a training programme to meet a locally identified need; and
- Develop new approaches by working together to meet the needs of children and young people, and reduce the need for external referrals.

The schools and CAMHS partners are keen to use the funding to:

- Release a senior leadership team member of staff from school to attend the training and lead on the testing of new models of working within schools;
- Release other staff to attend training, such as SENCO, SEND leads, learning mentors, pastoral support; and
- Recruit a Tier 2 CAMHS worker dedicated to this role and supported by the existing Community CAMHS staff.

We will bring to the national pilot:

- An annual schools survey that can be used to measure changed reported by young people from key stage 2 to 4;
- Schools and partners that have demonstrated their commitment to improvement;
- Experience of the use of sociograms to assist in early identification of emotional wellbeing and mental health need in Key Stage 2-3 transition (developed by Professor Robin Bannerjee at Sussex University);
- Training programmes that will provide a strong platform to build upon. The programmes include:
  - Basic awareness of self-harm, resilience and mindfulness (universal offer)
  - ‘Strategies and interventions for schools, when responding to young people who are affected by self-harm’. (developed by Dr Pooky Knightsmith, nationally recognised Child and Adolescent Mental Health
Specialist)

- Educational Psychology training in attachment

The CCG is currently carrying out a Joint Strategic Needs Assessment of children and young people’s mental health and wellbeing (0-25 years), and developing the Transformation Plan for Children and Young People’s Mental Health and Wellbeing services. The Plan is being developed with children, young people, parents/ carers, schools and other providers of the services.

The results from this pilot will inform the Transformation Plan, fostering resilience across the system and preventing children and young people who feel anxious or stressed from developing an enduring mental health need. This would be achieved by ensuring all involved with children and young people’s care are better able to identify a child or young person in difficulty and at risk of developing a mental health problem or disorder. A more skilled school workforce would be better placed to support them and know what to do if things escalate.

**Please demonstrate below how you meet the selection criteria (no more than 700 words)**

We have plenty of evidence of need within our City demonstrating to commissioners the requirement to foster resilience in mental health and emotional wellbeing in our schools. Our data systems are able to reflect change/impact. So we know:

1. The annual Safe and Well at Schools Survey, secondary schools report (2014) show that many of our young people enjoy or feel safe at school however 21% do not and more than half feel anxious sometimes or often:
   a. 79% of students report they enjoy coming to school, a 2% increase from 2013.
   b. 91% reported they feel safe at school, a 1% increase from 2013
   c. 94% reported they feel happy often or sometimes at school, a 1% increase from 2013
   d. 56% reported they are anxious often or sometimes, a 6% increase from 2013.

2. Brighton and Hove has seen an increase in A&E attendances with a flag for ‘self-harm’ for 12 to 17 year olds in recent years from 2010/11 of 72 admissions to 2013/14 of 156 admissions.

3. Secondary schools are confirming that they have seen an increase in self harm reported during the same period, some saying they deal with incidents as much as 6 / 7 times a day on some days.

4. Community CAMHS (Tier 2) has approximately 4% of referred cases where self-harm is a key presenting issue. Normally Specialist CAMHS (Tier 3) would offer CHOICE appointment and refer to counselling service or Tier 2 CAMHS. When Tier 2 CAMHS took a snapshot of 204 open cases with self-harm present in 2012, 17% of young people were reporting current self-harm, 6% historical self-harm, 9% suicidal ideation, 3% of cases referred to Tier 3 due to level of risk.
The CCG expression of interest fulfils the criteria as follows:

1. There will be 10 schools involved including secondary and primary schools and this mix has been selected because the lead and training will impact on health improvements and:
   a. schools transition arrangements between primary and secondary;
   b. Schools cluster working systems;
   c. Further expand the commitment and understanding to the impact of improved health outcomes on attendance, behaviour and attainment;
   d. Their understanding of the positive picture this provides during any potential Ofsted Inspection; and
   e. Will put forward a senior leader as the name lead in schools and have agreed to ensure 2 further staff will be released for training either SENCO, SEND leads, counsellors, learning mentors (supported by the £3,500 for back fill).

2. The CCG has identified a Tier 2 Community CAMHS lead, whose team already has well established relationships with the City’s schools and experience of delivering training, and a commitment from Tier 3 to support this initiative;

3. Public Health, Children Services and Schools are building on the work attached to schools PE and sports, which will include the links with emotional health and wellbeing;

4. The CCG, Public Health, Children’s Services and the schools involved all agree to commit to the training and participation in the pilot as well as evaluation;

5. The match funding of £80,000 will be provided by Public Health in Brighton and Hove; and

6. Strong robust links with the CCG Transformation Plan whose principles of the Transformation Plan are:
   a) Involve children and young people;
   b) Foster resilience across the system
   c) Prevent deterioration;
   d) Engage children and young people in their care;
   e) Reach out to where children and young people are;
   f) Care for the most vulnerable groups;
   g) Improve access;
   h) Intervene early;
   i) Best start in life;
   j) Prepare for adulthood;
   k) Build capacity across the system;
   l) Collaborative and joint commissioning;
   m) Physical and mental health issues are addressed equally; and
   n) Ensure access to services in a crisis especially out of hours.
Please confirm you will, if selected

☑ Share the learning from your work nationally and locally

Electronic signatures of Directors of Commissioning /CEO of relevant organisation

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
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<tbody>
<tr>
<td>Geraldine Hoban</td>
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<td>Chief Executive</td>
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<td>Brighton &amp; Hove CCG</td>
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<td>Pinaki Ghoshal</td>
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<td>Executive Director</td>
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<td>Children’s Services</td>
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<td>Tom Scanlon</td>
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<td>Director of Public Health</td>
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<td>Brighton &amp; Hove City Council</td>
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Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. **The Future Model of Care for Community Short Term Services Beds**

1.1 This paper can be seen by the general public.

1.2 20th October 2015

1.3 Keith Hoare, Commissioning Manager, Brighton and Hove CCG
Keith.hoare@nhs.net
Jane MacDonald, Commissioning Manager, Brighton and Hove CCG
Jane.Macdonald@brighton-hove.gcsx.gov.uk

2. **Decisions, recommendations and any options**

2.1 The Health and Wellbeing Board is recommended to approve the proposed outcomes set for the model of care for Community Short Term Service beds, and the procurement of this model.

3. **Relevant information**

3.1 **Current Service Model**

3.1.1 The current CSTS model comprises a range of bed based and home based services that provide rehabilitation and reablement support for people to help them retain or maintain their independence. The service aims to support the prevention of admission to and discharge from hospital, and also the prevention of admission to longer term care.

3.1.2 The CSTS bed units currently in use are detailed below.
<table>
<thead>
<tr>
<th>Bed Unit</th>
<th>Provider</th>
<th>Number of Beds</th>
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<tbody>
<tr>
<td>Craven Vale</td>
<td>City Council</td>
<td>24</td>
</tr>
<tr>
<td>Knoll House</td>
<td>City Council</td>
<td>20</td>
</tr>
<tr>
<td>Highgrove</td>
<td>Victoria Nursing Homes</td>
<td>21</td>
</tr>
<tr>
<td>Chartwell &amp; Chatsworth</td>
<td>Victoria Nursing Homes</td>
<td>12</td>
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<tr>
<td>(extra capacity)</td>
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3.1.3 Please see Appendix A for comprehensive details of the current service model and the issues identified with this model.

3.1.4 The Health and Wellbeing Board should note that in order to ensure the best use of all short term beds in the city the CCG and the City Council are now exploring options for the future model of care with regard to a wider range of community beds than previously presented in the March 2015 report. Moving forward we will include within our considerations the 12 beds provided by Sussex Partnership Foundation Trust at The Lindridge which support people awaiting longer term care, and also the beds currently operating from the council run services at Ireland Lodge & Wayfield Avenue.

3.2 Engagement and Review

3.2.1 At their meeting of the 24th March 2015 the Health and Wellbeing Board approved the City Council and CCG undertaking preliminary engagement with potential providers in the city to explore a new model of care for CSTS beds.

3.2.2 Potential providers were invited in April to put forward their ideas for what the new model of care could look like. These were submitted in May and meetings were then held with all interested providers to explore their ideas in more detail.

3.2.3 A total of 6 providers submitted their ideas and met with City Council and CCG commissioners. These included existing and new providers.

3.2.4 Full details of the ideas and options proposed following this exercise are contained in Appendix B.

3.2.5 To further inform recommendations for the new model of care, present and past service users and their families/carers were consulted at sessions held at Craven Vale and Knoll House in early September. These sessions focused on the following areas and a full summary of their thoughts and comments is contained in Appendix C:

- The assessment of their need for a CSTS bed
• The way in which they were admitted to the bed unit
• The provision of care and rehabilitation while they were in the bed unit
• The process for discharging them from the bed unit

3.2.6 Similarly we engaged with the care, support, nursing, therapy and medical staff who work at the 3 CSTS bed units at 5 open sessions in September, giving them the opportunity to recommend improvements to the model of care, and again their thoughts and comments are contained in a summary in Appendix D.

3.2.7 We have been developing links with Portsmouth City Council and CCG this year and from this we have had the opportunity to review their model of care for community rehabilitation beds, including a visit to one of their bed units, Spinnaker House. A summary of the learning from their service model is contained in Appendix E.

3.2.8 We have also reviewed the findings of the 2014 National Audit of Intermediate Care to identify other models of care in England that deliver improved performance and that if adopted could meet the challenges facing Brighton and Hove. The key learning from this review are contained in Appendix F.

3.2.9 Finally, we have reviewed the findings of the Ernst & Young ‘Demand & Capacity Review’ of acute and community provision in Brighton and Hove, recently commissioned by the CCG. This review has highlighted the potential to reduce average lengths of stay and increase occupation rates in CSTS bed units, and the potential gains from consolidating CSTS bed units on fewer sites and co-locating these units with outreach acute services to support hospital admission avoidance.

4. **Recommended Model of Care**

4.1.1 From the engagement and research completed it is clear that there are a range of potential options for improving the model of care for CSTS beds, and for this reason the CCG and City Council are recommending that the specification for the new model of care be outcomes focused with commissioners setting minimum requirements for service delivery. This will allow providers the freedom to present to commissioners their proposals for dialogue regarding how these outcomes and minimum requirements can be most effectively met.

4.1.2 The key outcomes that commissioners want from the new model of care are that beds support a wider range of health and social care needs than at present, and that there is increased access to step up beds for people living in the community who need short term support to avoid unnecessary admissions to hospital or long term care.

4.1.3 The following summarises the outcomes and minimum requirements that commissioners want the new model of care to deliver.
4.2. **Number of Beds**

4.2.1 Given our strategic focus on reducing reliance on beds and supporting more people at home, and the concomitant increase in local investment for community based health services, we do not plan to increase the number of community beds in the system. It is our intention to commission the same number of beds that we currently have in the system but to work with the future provider to reduce the number of beds over time by decreasing the average length of stay and increasing occupation levels.

4.2.2 There are a number of factors that we need to take into account regarding future demand for community beds.

4.2.3 If we achieve a reduction in the average length of stay for CSTS beds down to the 2013/14 national average for intermediate care beds of 28 days this would enable us to reduce the number of beds by 12.5%, given the higher average length of stay in Brighton and Hove. Also, if we scale up the local Discharge to Assess programme in acute hospital beds this will reduce demand for step down beds where rehabilitation and re-enablement is not required i.e. the beds currently provided at The Lindridge for those awaiting long term placements or packages of care.

4.2.4 Yet, if we are to widen our eligibility criteria and provide step up and step down beds for people beyond those with short term rehabilitation needs (see section 4.7) this may increase demand for bed numbers. Also, if we are to support people with increasing complexity and dependency this will restrict our ability to reduce lengths of stay and improve flow through the beds. And finally, the recent Ernst and Young work undertaken on behalf of the CCG looking at capacity and demand for community beds identified the need to increase the numbers of beds in the city by 11% by 2020/21, as a result of the ageing community and increasing complexity of needs.

4.2.5 Commissioners will work with Public Health colleagues over the coming 2 months to assess future demand for community beds, broken down by the different cohorts of people that will be eligible for the service. This assessment of demand will inform future decisions regarding the configuration of bed provision i.e. generic or dedicated units for specific cohorts.

4.3. **Location of Bed Units**

4.3.1 Any future provision will need to be located within the Brighton and Hove boundary to ensure minimal impact on the people admitted as well as their families and carers.

4.3.2 Given the number of beds we need to procure we are prepared to consider proposals for provision of beds on either a single site or multiple sites as long as providers can assure us they will deliver the outcomes specified for the service, though we can envisage some potential gains in locating all resources on a single site.
4.3.3 The City Council will consider proposals from providers regarding the leasing of their existing two units, Craven Vale and Knoll, for the future provision of CSTS beds, but commissioners will also consider proposals for delivering community beds on alternative sites.

4.4. **Lead Provider**

4.4.1 To ensure clear lines of accountability for service delivery and performance we recommend that commissioners hold the contract with one single lead provider, where that one provider directly employs the majority of the health and social care staff required to deliver the service, but with the option of sub-contracting specialist staff if accountability can be maintained i.e. medical cover.

4.4.2 The lead provider will be held accountable by commissioners for the delivery of all aspects of care and support in the new model, whether they sub-contract for services or directly provide them.

4.5. **Stronger Health Role but Continued Support for Social Care**

4.5.1 In order to meet the increasing complexity and dependency of people who require CSTS beds the future model should be more health led with nursing, therapy and medical staff having greater control over managing access to placements, the delivery and co-ordination of care, and discharge planning. We know from experience that the care home model with nursing in-reach 8-8pm fails to meet the needs of many service users, so the future model of care will need to comprise nursing staff 24 hours a day.

4.5.2 While recognising a need to have increased input from health staff we need to retain a strong focus on the existing aims of the service, and recognise that a high proportion of future bed occupation will be by people who require short term rehabilitation and re-enablement. Also the future model of care needs to support the adult social care agenda of enabling people to stay at home with community beds utilised as both a step up and step down resource, helping to reduce admissions to long term placements and minimise long term packages of care.

4.5.3 The provider will need to specify how they will ensure equity of access to beds for step up and step down, and how they will balance the needs of the local health system with those of adult social care.

4.6 **Medical Staff Input**

4.6.1 Given the need to support a broader cohort of people with increasingly complex needs providers will need to describe what role Care of the Elderly Consultants (COTEs) and GPs will have in assessing the need for beds and determining admissions to beds, and also how they will work in partnership to deliver medical care for service users following admission, and provide support for other health and social care staff. For example, involvement in multi-disciplinary team meetings.
4.6.2 Medical cover will need to be available 7 days a week but providers will be required to define the level of medical input they require and whether they will directly employ or sub-contract for these services.

4.6.3 We have taken advice from the CQC on the delegation of assessment and admission rights for access to beds, and their advice is that the Registered Manager will always retain ownership and accountability for admissions but that assessments and recommendations can be undertaken by trusted persons, whether internal or external to the service, as long as they comply with the agreed eligibility criteria for the service. It is also vital that future CSTS beds are registered appropriately with CQC for the purposes that they are designed to meet as this will determine those that Registered Managers can and cannot admit.

4.7. Eligibility Criteria

4.7.1 In order to meet the full range of needs for access to short term beds we need to extend the current eligibility criteria for CSTS beds (with a narrow focus on rehabilitation), to cover the following people with a need for step up and step down beds:

i. People who need to step up or step down for rehabilitation and re-enablement for a short term period where it is deemed unsafe for them to return to or stay at home with care and support, and where this supports the outcomes for the service (section 4.14)

ii. People who need to step down for a short term period of on-going care, recovery and review following an acute stay i.e. sub-acute and non-weight bearing, where it is deemed unsafe for them to return home with care and support

iii. People with complex social and physical/mental health needs who have questionable rehabilitation potential and require short term stay in a bed unit to allow for review of their needs, where it is deemed unsafe for them to return home with care and support

iv. People who need to step up for a short term period to avoid re-admission and allow time for further assessment following an unsuccessful discharge home from the acute

v. People who need to step up for a short term period to avoid a potential hospital admission, following a new illness or deterioration of an existing condition(s), where it is deemed unsafe for them to stay at home with care and support

vi. People who are awaiting long term placements but cannot be safely cared for at home pending their placement

vii. People with mental health or learning disability needs that require support from specialist services but whose primary need is for short term physical care where it is deemed unsafe for them to stay at home to receive this

viii. People in hospital who are not end of life but require an assessment of their CHC needs and can be stepped down for this pending decisions on their longer term care
4.7.2 The defining features of the new model of care will be the requirement for people to access a bed for a short term period, and for beds to support delivery of the integrated frailty care pathway in Brighton and Hove and the key outcomes defined for the service in section 4.14, whether stepping up from the community or stepping down from the acute.

4.7.3 As now the beds would be accessible to people aged 18 years and over who are registered with Brighton and Hove GPs.

4.7.4 The above eligibility criteria will require support for, amongst others, the following categories of service user and need:

- Frail People i.e. those with multiple long term conditions
- Cognitive impairments e.g. dementias and functional mental health needs whose primary needs are for physical care
- Orthopaedic
- Post-surgical e.g. FNOF
- Non-weight bearing
- Bariatric
- Intravenous therapy
- Urinary tract and chest infections
- Catheterisation and catheter management
- Wound care

4.7.5 The following would not be eligible for the new service:

- People who require acute care
- People with symptoms of new onset stroke, on the basis that there is an existing pathway of care and support for this group

4.7.6 Providers will need to define how their proposals will ensure the flexibility that the health and social care system requires to support demands across the health and social care system, whether they be for hospital discharges, avoiding hospital admissions, or reducing demand for longer term care. The options could be to make all future CSTS beds accessible to each of the above cohorts of service user, to designate separate bed units for specific cohorts, or to have dedicated wings within a single unit that are for specific cohorts.

4.7.7 To ensure the effective use of future CSTS beds commissioners will work with Public Health colleagues to project the relative demand for beds from the above cohorts of people, as this will be needed to ensure equitable step up and step down access to beds in the future in support of both health and social care aims.

4.8 Staff Competencies

4.8.1 In order to support the above eligibility criteria and offer greater flexibility in meeting local needs we will require future providers to evidence that support, care, therapy and nursing staff possess the necessary core competencies to
meet these needs. For example, all staff will need to be trained in person
centred care and re-enablement working, while nursing and care staff will
require competencies in IV therapy, tracheostomy care, catheter care and
wound management.

4.8.2 Also, given that the new model of care will be accessible to people with
mental health conditions and learning disabilities providers will need to
describe how they will effectively meet the needs of these service users for
short term physical care. For example, will employ staff with specialist skills
and competencies or establish agreements with specialist providers.

4.9. Equipment and Facilities

4.9.1 We will require the provider to offer appropriate profile beds to accommodate
people with varied mobility and in line with the latest Care Home Policy for
the Integrated Community Equipment Service to stock the necessary
amounts of basic aids and equipment that support activities of daily and
personal living for their residents.

4.9.2 It is also recommended that future CSTS bed units offer accommodation that
provides a range of communal facilities which aid social and functional
rehabilitation. Facilities also need to include accessible kitchen, bathroom
and gym facilities (including plinth, hoist, parallel bars and steps) for the
delivery of Occupational Therapy and Physiotherapy.

4.10. Assessments and Admissions

4.10.1 To avoid the delays in admissions experienced by the current service as a
result of having separate providers complete assessments and manage bed
units, with the new model of care the single lead provider will have ultimate
responsibility for both assessing eligibility and deciding on admissions.

4.10.2 Given the need to support a broader cohort of people with increasingly
complex needs and the subsequent need to prioritise referrals providers will
need to describe how they will internally manage assessments and
admissions to ensure appropriate levels of access to beds for step up and step
down purposes. They will also need to describe who from their internal team
will undertake assessments and how this will inform care delivery and
discharge planning following admission. For example how and when will
adult social care staff be involved in assessments to ensure planning for
discharge can start as soon as possible.

4.10.3 Providers will also need to describe how they will ensure suitable levels of
access to beds for key health and social care professionals or teams working
in acute and community settings where their aims fit with those of the
service i.e. to reduce hospital admissions and demand for longer term care.
For example, to whom and how will they entrust assessment rights for beds,
while ensuring compliance with their CQC registration. Also given the need
to ensure support for adult social care in reducing demand for longer term
4.10.4 As now assessments and admissions will be required 7 days a week with admissions up to at least 6.30 pm. With the present model of care there are too many admissions from hospital late in the afternoon or early evening when staffing levels make it harder to settle in and assess needs. Providers will be required to describe how they will work with acute and community partners to ensure admissions to future bed units during times of the day when they have adequate levels of staff on duty to safely admit and settle people in and also complete an initial assessment of immediate needs.

4.10.5 As a minimum providers will be required to offer a single point of contact (phone number / fax / e-mail) for all referrals to CSTS beds.

4.10.6 Providers will be required to describe the key information that referrals should contain regarding potential service uses as this is key for determining the decision to admit and will inform the future delivery of care and support for people who are admitted.

4.11. Delivery of Care & Discharges

4.11.1 The future provider will ultimately be responsible for holding nursing, therapy and social care staff to account for the effective delivery of therapy and care plans and for timely discharge planning.

4.11.2 The provider will be required to ensure that prior to or immediately after admission that suitable goals are set for all service users, discharge planning commences and an expected discharge date is set. These goals will need to be based on both the professional assessment of need and the desired outcomes of each service user, and will need to be shared with family or informal carers given their potential role in helping to meet these goals.

4.11.3 Staff engagement highlights that support staff are not fully aware of the therapy goals set for service users by qualified therapists nor what they are already capable of, and this can lead to support staff doing things to and for people rather than supporting them to do things themselves. Providers will therefore be required to describe how all staff working in the bed units will be made fully aware of the goals set for each service user, what their role is in delivering those goals, and how care and discharge planning is co-ordinated between staff. For example, how will they organise shift handovers, multi-disciplinary team meetings, board rounds and discharge planning meetings, and who will they involve in these. Also will they identify named care co-ordinators for care delivery and discharge planning for each service user or dedicated staff to lead on discharge planning and liaison with external agencies. And finally what IT and other systems will they establish to ensure ready access to care and support plan documentation for all key staff.

4.11.4 Along with 24 hour nursing cover, in order to ensure a stronger focus on the achievement of personal goals in support of the aim of reducing lengths of
stay the provider will need to ensure that rehabilitation is delivered by therapists 7 days a week, with care and nursing staff empowered by therapists to support the re-enablement of service users. As such providers will be required to describe how they will build a culture promoting self-management within the new model of care so that rehabilitation and re-enablement work becomes part of the daily routines of life within the bed units (including the role of family members or informal carers).

4.11.5 People should only stay in community beds for as long as needed, and if they are safe to return to their usual place of residence with on-going care and support provided there then they should be discharged from bed units. Providers will therefore be required to describe how they will ensure that the goals set for service users that will trigger discharge are focused on enabling people to return home safely, in order to avoid people remaining in bed units for longer than is necessary.

4.11.6 We know that mental wellbeing has an impact on motivation and that this can subsequently impact on the speed of physical recovery, so we will require providers to describe how they will ensure service users do not become socially isolated or demotivated while staying in bed units, whether through the effective use of staff time, or the engagement of volunteers, family and friends.

4.11.7 Given the proposed eligibility criteria for the new model of care providers will be required to describe how they will provide effective care for people with a range of functional and organic mental health needs, and whether they will directly employ specialist staff or establish agreements with specialist providers to offer this support.

4.11.8 With the CCG and City Council’s expectation that average lengths of stay decrease over time providers will be required to describe what systems they will set up to robustly manage discharges. As a minimum this will require the regular review of service users who are ready for discharge i.e. their rehabilitation is complete and they are safe to return home with a package of care.

4.11.9 In support of this providers will be required to describe how they will work in partnership with community health and social care partners to apply Discharge to Assess principles to their service, ensuring that any long term care and therapy needs of service users are assessed in their home rather than in a bed unit. This will require the provider to assess the short term care and therapy needs of service users prior to a formal review by community partners.

4.11.10 Given the often complex social situations facing service users who need short term beds providers will be required to describe how they will work in partnership with, amongst others, housing, welfare benefit, environmental health, substance misuse and carer support services that may be able to support them in effective care delivery and discharge planning.
4.11.11 In support of effective discharge planning providers will be required to describe how they will develop close working relationships with the local community and voluntary sector to ensure their support for the re-integration of service users back into their community and reduce any potential negative impacts of social isolation.

4.11.12 Similarly providers will be required to describe how they will engage with community based health and social care services e.g. nursing teams and homecare providers to facilitate effective and timely discharge.

4.11.13 To ensure flow through the bed units and reduce the average length of stay commissioners may include incentives in the contract for the lead provider to discharge people as soon as they are ready (while recognising that some delays may be beyond their control), and to avoid this becoming a perverse incentive we will include penalties in the contract for failed discharges that result in hospital admission or re-admission to a CSTS bed.

4.12 Access to Care Records

4.12.1 To ensure the effective co-ordination of care and support providers will be required to describe how they will ensure ready access to service user care records by all health and social care staff working in the bed units.

4.12.2 They will also be required to establish integrated IT systems that enable electronic communication with, and access to status reports for, acute and community based health and social care staff working in support of CSTS bed units.

4.13 Added Value of Bed Units on a Single Site

4.13.1 If the future service were provided on a single large site there could be the following additional benefits:

4.13.2 The unit could operate as a base for Community Responsive Services for the city i.e. multi-disciplinary therapy, nursing and care teams.

4.13.3 The unit could operate as a base for the city’s Night Service comprising out of hours nursing and care teams and the night sitting service.

4.13.4 Finally, there could be potential for developing a partnership with a commercial pharmacy to operate on-site.

4.1.5 Providers will be required to describe what added value their proposed model of care will deliver for the health and social care system.

4.14 Key Service Outcomes

4.14.1 If we deliver the above operational outcomes the model of care for future community short term service beds will achieve the following key service outcomes for health and social care commissioners:
4.14.2 Optimal levels of independence for people discharged from hospital or needing support in the community, as a result of the following:

- More efficient assessment and admission processes for access to beds
- Improved co-ordination and responsiveness of care by acute and community professionals working within or aligned to community beds
- Adoption of Discharge to Assess principles when people are ready to leave community beds

4.14.3 Avoidance of admissions to long term care.


4.14.5 Avoidance of admissions to hospital.

4.14.6 Reduced lengths of stay in hospital.

5. **Recommended Procurement Method**

5.1 Given the range and complexity of needs that the future CSTS beds service will need to address commissioners are able to define the minimum requirements and desired outcomes for the service but not the full detail of what is required to meet these.

5.2 The City Council will consider proposals from providers regarding the leasing of their existing two units, Craven Vale and Knoll, for the future provision of CSTS beds, but commissioners will also consider proposals for delivering community beds on alternative sites.

5.3 Due to the complexities as set out above there is a need for an element of dialogue with bidders. This dialogue will form part of the procurement process and will be used as an opportunity to further explore and develop the proposals put forward by potential bidders.

5.4 We anticipate that procurement will commence in January 2016 with a new model of care delivered from 1st October 2016.

5.5 Because we are commissioning an outcome focused service, with only minimum requirements set at this stage, the detail of the model of care will only be decided following dialogue with providers during the procurement process. This means that the required staffing structure, roles and numbers to deliver the new model of care have yet to be determined and the impact and implications for existing employees delivering current services are not yet known. At this stage existing employees may see their employment and role either TUPE transfer to a new provider and/or be retained & reviewed by their current employer and/or ended as existing services cease. The implications for existing staff will be communicated in due course as they emerge in the procurement process.
6. Risks

6.1 The following risks are acknowledged for the procurement of a new model of care for CSTS beds:

i. Co-ordination of Care – the separation of bed and home based community short term services, with the latter focused on rehabilitation and the former meeting a wider range of needs, could negatively impact on pathways of care for people – in order to overcome this the future provider will be required to evidence how they will work in partnership with home based community short term services to ensure a smooth pathway between the two

ii. Finance - there are pressures on both health and social care budgets and therefore it is vital that the new model of care represents value for money. As a jointly commissioned service the model of care will largely determine the balance of funding between health and social care. A shift towards a more health led model will impact on the City Council’s four year service and financial plans. The pressures on both the CCG and the City Council’s future commissioning budgets may impact on procurement of the new model of care.

iii. Timescale – there are significant pressures on the health and social care system in Brighton and Hove at present and these will escalate over the coming Winter, but the procurement exercise for CSTS beds will take months so these pressures will remain in the system – to address these pressures we are jointly exploring options for enhancing the capacity of existing CSTS bed units to meet local needs and speed up the flow of people through bed units

iv. CQC Regulations – commissioners do not support an NHS registered community hospital type unit (given impact this could have on access to step up beds by community health and social care professionals) but equally we are keen for key community and acute professionals and teams to have access rights to beds. We have taken advice from the CQC on the delegation of assessment and admission rights for access to beds, and their advice is that the Registered Manager will always retain ownership and accountability for admissions but that assessments and recommendations can be undertaken by trusted persons, whether internal or external to the service, as long as they comply with the agreed eligibility criteria for the service. It is also vital that future CSTS beds are registered appropriately with CQC for the purposes that they are designed to meet as this will determine those that Registered Managers can and cannot admit.
7. **Important Considerations and Implications**

7.1 **Legal**

7.1.1 It is a function of the Health and Wellbeing Board to make decisions concerning the provision of jointly funded and commissioned health and social care in the City. The Care Act 2014 requires agencies to co-operate in ensuring adults with care and support needs have their eligible assessed needs met within the overarching duties to promote wellbeing and prevent, reduce or delay needs. Reference is made in the body of the report to potential employment law issues which may or may not require clarification following the development of the procurement process and new model. The procedure for procuring the services will be subject to the Public Contract Regulations 2015 which provide a “light touch” regime shall apply to such procurements over the value of £650,000. The City Council may elect to use the open, restricted and competitive procedures with negotiation for the award of contracts, or may use a variation of those procedures providing the process is fair and transparent.

Sandra O'brien Senior Solicitor

7.2 **Finance**

7.2.1 The new model of care for CSTS beds will need to be funded within the agreed future joint commissioning budget envelope.

7.2.2 This budget envelope will be determined by the budget plans of the CCG and the city council and will be based on ensuring delivery of the outcomes specified for the service and achieving best value for money. The balance of funding between health or social care will be determined by the new model of care and the extent to which it delivers against health and social care service plans. The final model of care and the staffing required to deliver it will be determined following procurement of the new model, which is expected to commence in January 2016.

7.2.3 Any investment by the City Council will be dependent on the 2016/17 and further 3 year financial plans agreed by Budget Council in March 2016. Equally any investment by the CCG will be dependent on the financial plans for 2016/17 and beyond.

7.2.4 The budget for commission and providing the service in 2014/15 was as follows.

<table>
<thead>
<tr>
<th></th>
<th>BHCC £000</th>
<th>BHC CG £000</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Craven Vale(24)</td>
<td>£695</td>
<td>£1,171</td>
<td>£1,866</td>
</tr>
<tr>
<td>Knoll House (20)</td>
<td>£990</td>
<td>£615</td>
<td>£1,605</td>
</tr>
</tbody>
</table>
7.3 **Equalities**

7.3.1 The recommended more flexible model of care for CSTS beds will meet a wider range of identified priority needs in the city, but with older people primarily benefiting given the prevalence of these needs amongst those aged 65 years plus.

7.3.2 An Equality Impact Assessment has been completed on the recommended new model of care – see Appendix G – which indicates that there will be no negative impacts for people with protective characteristics who currently receive the service as long as we include within the specification the need to ensure that the provider can meet the diverse cultural needs of the increasing number of people from minority ethnic communities, and also the mental health and learning disability needs of people who require CSTS bed placements.

7.4 **Sustainability**

7.4.1 The council’s One Planet Council approach to sustainability based on the ten One Planet principles was used as a checklist and will be reviewed as the project develops.

7.5 **Health, Social Care, Children’s services and Public Health**

7.5.1 Known Health, Social Care, Children’s services and Public Health implications are covered in the report.

8. **Supporting documents and information**

8.1 There are no supporting documents.
Appendix A

Current Service Model and Issues

The service is jointly commissioned by Brighton and Hove City Council (BHCC) and Brighton and Hove Clinical Commissioning Group (BHCCG), and is jointly delivered by a partnership of providers comprising BHCC, Sussex Community NHS Trust (SCT), Victoria Nursing Homes (VNH), Integrated Care 24 (IC24) Ltd, Brighton and Sussex University Hospital Trust (BSUH) and Age UK.

Dependent on needs the service supports people either in their own home or in one of three dedicated bed units, two of which are owned by BHCC and one by an independent provider, VNH. These units provide a total of 65 beds.

- Craven Vale – BHCC – 24 beds
- Knoll House – BHCC – 20 beds
- Highgrove Nursing Home – Victoria Nursing Home – 21 beds

Craven Vale and Knoll House are registered as residential care homes. The social care and support of people at Craven Vale and Knoll House is provided by BHCC while nursing and therapy is provided by SCT, and medical support by IC24 Ltd and BSUH on an in-reach basis.

Highgrove is a Nursing Home and VNH provide social care, support and nursing, while therapy is provided by SCT and medical cover by IC24 Ltd and BSUH.

Since October 2014 Victoria Nursing Homes have also provided 12 extra capacity CSTS beds at two of their other nursing homes, with therapy and medical support delivered as described above for Highgrove.

Also, since January 2015 Sussex Partnership Foundation Trust have been commissioned by the CCG to provide 12 beds at their Lindridge Care Home to enable discharge from hospital of people awaiting longer term care, where therapy is provided on an in-reach basis by SCT.
Finally the City Council provides a number of re-ablement or transitional beds at their Ireland Lodge and Wayfield Avenue care homes and the CCG are exploring with them the potential for inclusion of these beds as part of the new model of care for community short term service beds.

In total there are nearly 100 beds in the city that support admission avoidance (hospital and longer term care) and discharge from hospital.

The national and local strategic approach is for care to be provided in people’s own homes wherever possible reducing avoidable admissions to the hospital or care homes. Since 2012 a higher proportion of people are being discharged from hospital straight to their own home with support from community short term services.

Whilst it is positive that more people are able to return to their own homes the impact of this is that the comparatively smaller proportion of people that do require care in one of the bedded units are the most dependent and have the most complex needs.

The number of people supported at home has increased over the past three years while the number supported in bed units decreased significantly between 2012/13 and 2013/14 and again in 2014/15, such that only 24% of CSTS clients were supported in bed units in 2014/15 compared to 32% in 2012/13.

Table 1

<table>
<thead>
<tr>
<th>Year</th>
<th>CSTS Beds</th>
<th>CSTS Home</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>805 (32%)</td>
<td>1702 (68%)</td>
<td>2507</td>
</tr>
<tr>
<td>2013/14</td>
<td>683 (27%)</td>
<td>1855 (73%)</td>
<td>2,538</td>
</tr>
<tr>
<td>2014/15</td>
<td>643 (24%)</td>
<td>1991 (76%)</td>
<td>2,634</td>
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</table>
Note: The above figures relate only to the core 65 CSTS beds provided at Craven Vale, Knoll House and Highgrove.

The length of stay (LoS) in CSTS beds has also increased over the past 27 months, ostensibly as a result of the increasing complexity of needs and dependency of clients.

Table 2

<table>
<thead>
<tr>
<th>Year</th>
<th>Quarter</th>
<th>LoS No. of days</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-14</td>
<td>Qtr1</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Qtr2</td>
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<td></td>
<td>Qtr3</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Qtr4</td>
<td>30</td>
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<tr>
<td>2014-15</td>
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</tr>
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<td></td>
<td>Qtr2</td>
<td>31</td>
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<td></td>
<td>Qtr4</td>
<td>33</td>
</tr>
<tr>
<td>2015/16</td>
<td>Qtr1</td>
<td>34</td>
</tr>
</tbody>
</table>

Note: LoS is average no of days of stay of people discharged within the quarter. The data in this table differs to that reported to the Board in March 2015 because of the addition of backdated Victoria Nursing Homes data.

The current service specification for CSTS beds has been in place since 2012 but increasingly CSTS beds fail to meet the needs of people with high levels of complexity and dependency. In particular the social care led model at Craven Vale and Knoll House (with health support provided on an in-reach basis) increasingly does not align to fully meeting the needs of many of the people who require an admission into a CSTS bed. The impact of this is that admissions to CSTS beds cannot always be accepted, people may remain for unnecessarily long periods in hospital, and if admitted to a bed unit people may then stay longer than necessary.

Also, since the CSTS bed service was reviewed in 2012 there has been an
increased focus within the local NHS on the delivery of proactive care in support of frail people with multiple conditions. In order for primary care GPs and local community teams to support frail people to avoid admission to hospital or long term care (the key aim of the proactive care agenda) they will require access to short term service beds in the community where their patients cannot be safely supported at home. Therefore, the future model of care for CSTS beds needs to support this agenda and offer suitable ‘step up’ provision for primary and community care.

Appendix B

Proposed Options for New Model of Care

A wide range of ideas for the re-modelling of CSTS beds were proposed by interested providers in May 2015. The following summarises these with regard to the various elements of the model of care.

Single or Multiple Site Provision

The future provision of CSTS beds could be delivered on a single site, with redevelopment of the City Council’s Craven Vale proposed by one provider, or it could be delivered at multiple sites, with either the retained use of Craven Vale and Knoll House or provision at alternative sites in the city as identified by prospective providers. In considering these options the timescale for delivery is a major factor given the need to address current financial constraints on the joint commissioning budget within the next 12 months.

Lead Contractor or Partnership

Generally providers expressed a preference for a lead contractor/provider model where one organisation contracts with the City Council and CCG as the accountable agency, and where they directly employ the majority of health, care and support staff and sub-contract for other elements, notably medical cover. It was widely held that this would enhance accountability and improve the management and delivery of care and support within CSTS beds.

One provider did propose that a formal partnership between multiple providers could be effective, but only if there was still a lead provider, thereby ensuring accountability and control. This same provider also advised that they could directly employ salaried GPs to provide required medical cover.
**Health or Social Care Lead**

There was unanimous opinion that future beds should be health led as opposed to social care led, with nursing and/or medical staff managing CSTS beds. This was argued on the basis of the higher nursing and medical acuity and increasing complexity of the needs of clients requiring short term service beds which social care staff would find more challenging to respond to.

The options proposed for the delivery of this health led care were primarily nursing homes but the potential for development of a community hospital was also proposed.

**Flexibility in Eligibility**

Similarly, there was universal support for increasing flexibility in the eligibility criteria for CSTS beds, moving beyond ‘rehabilitation’ criteria to cover the following broader range of more complex care needs:

- Intravenous therapy
- Urinary tract and chest infections
- Cognitive impairment
- Post-operative care for FNOF
- Surgical patients
- Non-weight bearing
- Frailty and Emergency care
- Stroke patients

There was varied opinion as to whether there should be dedicated beds for specific cohorts of service users i.e. frail and orthopaedic, or whether all beds should be open to all cohorts. The latter would offer greater flexibility in the use of the limited beds available but the former could enable closer alignment of staff resources to needs.

**Step Up and Step Down**

Alongside support for increased flexibility in eligibility criteria providers also recommend that future CSTS beds offer step up as well as step down beds (at present the vast majority of beds are used for step down).
It was proposed that step up beds would support the effective delivery of the frailty pathway, with GPs, CRRS and Nursing Homes (community) as well as HRDT and RACOP (acute) able to refer clients to CSTS beds, thereby avoiding admissions.

Assessment and Access to Beds

A range of options were suggested for improving the assessment of needs and for accessing beds more promptly than is the case now.

Trusted assessors could be established with the right of direct access to beds, e.g. RACOP, GPs and SECAmb.

CSTS assessors could be based within HRDT enabling early identification of suitable clients and a single assessment of needs within the acute setting (two stage process at present).

The development of ‘transfer to assess' working from hospital to CSTS beds, with full MDT assessment taking place in a community bed unit as opposed to in an acute setting.

The assessment criteria and process for access to CSTS beds should be the same as for Discharge to Assess, ensuring consistency in the principles that underpin discharges from the acute setting.

Managing Care within and Discharges from CSTS Beds

Similarly, a range of options were suggested for improving the management of care within and discharges from CSTS beds in order to improve the flow of service users and reduce length of stay.

There should be daily MDT board rounds held to review the care and discharge plans for all residents.

Consultant Geriatricians should be more engaged in overseeing the delivery of care for service users, attending MDT board rounds and undertaking formal case reviews.

MDT Co-ordinators should be employed to ensure the effective and timely delivery of care and discharge plans.
CSTS beds should directly employ Advance Nurse Practitioners to work closely in partnership with GPs and Geriatricians, in order to effectively monitor the health of residents, manage more complex cases, and enable local prescribing.

The focus of all care should be on self-directed support and re-ablement, in order to empower clients to maximise their independence and care for them as much as possible. Closer working with community and voluntary sector providers would further this agenda and support the re-integration of clients back into their community while also reducing the negative impacts of social isolation.

Specialist mental health nurses should work as part of the team to ensure effective care of clients with functional or organic mental health issues.

CSTS beds should employ dedicated Social Workers to ensure consistency and continuity in discharge planning.

One provider suggested that CSTS bed units (whether single or multiple sites) could be supported by future community based Cluster MDTs that are currently being developed in the city, enabling a degree of continuity in the care of clients in bed units and in the community.

Team Working and Staff Skills

It was widely argued that a lead provider model with direct employment of support, social care, nursing and therapy staff as a minimum would improve the integration of service delivery and overcome the present silo nature of working within CSTS bed units.

It was also argued that all team members should possess core competencies to optimise the capacity of MDTs to manage presenting needs.

Added Value

A range of other options were also suggested that could add value to any future model of care.

Alongside physical bed units the service should offer ‘virtual’ beds with MDTs wrapped around clients in their usual place of residence, enabling a reduction in the number of bed units required.
Any future CSTS bed unit(s) could operate as a base for all Intermediate Care services in the city i.e. therapists, nurses and care staff supporting people at home, and also the Community rapid response service.

Similarly the unit(s) could operate as a base for a Night Service comprising out of hours nursing, night sitting and care staff.

If a single site were developed this might also enable a partnership with a commercial pharmacy.

Appendix C

Engagement with Service Users & Family/Carers

A total 16 service users and carers were consulted with across August and September 2015 regarding the current CSTS beds service.

The feedback from this exercise was generally very positive regarding the quality of care delivered by all staff, and the fact that people were largely involved in decision making related to their care.

It was recommended that the service have more substantive staff on duty at weekends and during the night (concern over staffing levels and use of agency staff), that if staff had more time they could support service users to socialise more in communal areas which would be useful for their rehabilitation, that staff should deliver more consistent care, and that goal setting could be clearer.

Appendix D

Engagement with Staff

A total of five sessions were held with staff during September 2015. These sessions highlighted a range of issues to consider for the future model of care.

People could be assessed in CSTS beds to free up hospital beds.

The provider of the bed units should complete assessments, not a separate provider.
Whoever completes assessments they need to clearly state the goals agreed with each service user and clarify what areas people need support with, so staff can focus their efforts on these. Too often staff know too little about service users and end of doing everything for them rather than just what is needed.

There is a need for core aids and equipment to be held on-site to speed up admissions. Specialist bariatric equipment is often required and there could be merits in having a dedicated bariatric room or equipment held on site.

Admissions need to take place before 5pm as after then staff are getting ready for meal times and the evening handover which this can have negative impact on setting people in.

Regular board rounds enable Social Workers to identify the ideal time to get involved with service users i.e. on admission, while therapy on-going or after therapy complete, as the information shared at board rounds enables them to use their professional judgement to determine this.

But daily board rounds can be repetitive and ineffectual, and setting expected dates of discharge is good but we need to recognise that these need to be flexible as circumstances change.

Nursing and therapy staff should be involved in morning handover meetings (not just support staff) as this would help with co-ordination of team efforts during the day and enable qualified therapists to inform the work of care workers.

Given increasing needs of users nursing should be 24 hours not 8am-8pm as now.

An integrated health and social care IT system would reduce time spent by Social Workers travelling from one bed unit to another to review paperwork (as would a single site development for the new model of care).

Given negative impact on care for other service users there would be benefits in having a separate unit or wing for people with dementia.

Care staff lack the time to always work in a re-enabling way, so there would be benefits in having dedicated re-enablement staff i.e. band 2 Healthcare Assistants in support of the work of qualified therapists.
This would be particularly beneficial in the morning when there are delays in getting people up and about, reducing the time available for qualified therapists to get on with their work plans for service users. Alternatively night staff could overlap with day staff to assist with getting people up, enabling therapists to get on the floor quicker.

All service users should have a named care co-ordinator who is responsible for the co-ordination and delivery of care plans and discharge planning. This co-ordinator could be a nurse, therapist, carer or social worker.

Qualified therapy staff could provide more guidance for support staff on how they can help them to deliver their rehabilitation goals.

Family members could be utilised more effectively to help service users meet their rehabilitation and reablement goals.

Care staff need more training so they can provide support for wound, catheter, stoma, end of life and dementia care.

If MCA/DOLs assessments were completed sooner by Social Workers this would speed up discharge planning.

Discharge Planning Meetings should be called soon after admission to plan for discharge, and they should be called promptly once concerns are raised regarding a service user’s discharge and not at the point of discharge (as often happens).

Each unit should have a dedicated Discharge Co-ordinator who leads on co-ordinating the discharge of all service users, involving internal liaison with nursing, therapy and care staff and external liaison with homecare or care home providers or community health services. At present there is no one person leading on discharges which can cause delays.

Need for good partnership working with housing and substance misuse services as these are often the cause of delayed discharge.

It is becoming more important that the service can meet the diverse cultural needs of people given the increasing number of service users from ethnic minority communities.

Talking Therapists or volunteer befrienders would be of real benefit as opposed to having more mental health professionals on board, given that simply talking to someone can help in the motivation of people to engage in physical rehabilitation.
Appendix E

Learning from Portsmouth Community Beds Model of Care

Brighton and Hove CCG have recently developed links with Portsmouth CCG and City Council to benchmark community services (including rehabilitation services) and learn from each other in order to enhance local service performance.

In support of these links Commissioning Managers from Brighton and Hove CCG and City Council visited Spinnaker House, a rehabilitation bed unit run by Solent NHS Trust in partnership with Portsmouth Hospital NHS Trust, which reported an average length of stay for patients of 20 days in 2014/15, and an average of nearly 80% of patients discharged back to their usual place of residence. The figures for Brighton and Hove are 32 days and 60% respectively.

The key message from the matron at Spinnaker House is that the short length of stay is due to the high level of medical decision making and on-site presence from the Consultant Geriatrician and Senior House Officers employed by Portsmouth Hospital NHS Trust. In particular the Consultant Geriatrician assesses and decides on a high percentage of referrals, and also conducts twice weekly board rounds to support discharge planning.

Alongside this medical input Solent NHS Trust employ their own in-reach nursing team who review on a daily basis patients on the Medically Ready for Discharge list in the acute hospital, helping to pull patients out into the bed units. And as an NHS run unit Spinnaker House employs only NHS staff, aside from a dedicated Social Worker employed by the City Council.

The Spinnaker House unit clearly operates on a health model, so its performance on length of stay and discharge destinations cannot be compared on a like for like basis with the current CSTS bed units in Brighton and Hove. However the unit does evidence that there is scope to significantly improve the flow of residents through CSTS bed units in Brighton and Hove if the model of care is health led.

The potential limitations of the Spinnaker House model are that it has only admitted 5 patients over three years on a step-up basis, so there is clearly minimal primary care access, and it only offers 16 beds so there is a question mark over whether it could achieve the same performance with 20 plus beds which is a minimum we would expect for the new mode of care in Brighton and Hove.
We do not have access to the budget for Spinnaker House but as an NHS run unit with a high level of senior medical and nursing input it is likely that the overall cost per bed is higher compared to Brighton and Hove CSTS bed units, though the shorter length of stay at Spinnaker will have a positive impact on its unit cost per client.

**Appendix F**

*Learning from National Audit of Intermediate Care 2014*

From the findings of the latest national audit it would appear that Brighton and Hove invests more than the national average for Community Short Term Service bed units, at £1.7million per 100,000 people compared to £1.2million nationally, and as such that there is scope to reduce the unit cost for bed units in the city.

If we exclude the interim 12 extra capacity beds that were recently procured Brighton and Hove commissions slightly less than the national average number of beds per 100,000 – at 23 beds compared to 24 nationally.

Nationally 65% of beds are used for step up and 35% for step down, while in Brighton and Hove the number of admissions to beds for step up is minimal, at less than 5%.

Nationally 32% to 43% of beds are located in community hospitals and use of residential and nursing homes is limited, so again this differs considerably to the model of care in Brighton and Hove.

The average length of stay in CSTS beds in Brighton and Hove in 2013/14 was very close to the national average – 29 days compared to 28 nationally - but in 2014/15 and 2015/16 the lengths of stay in Brighton and Hove have risen to over 30 days.

There is national evidence that dependency levels are increasing for people in bed units, which clearly fits with the Brighton and Hove experience.
Appendix G

Equality Impact Assessment – brief guidance and template\(^1\) (2013)

Public sector bodies need to be able to evidence” that they have given due regard to the impact and potential impact on all people with ‘protected characteristics\(^3\) in shaping policy, in delivering services, and in relation to their own employees.

The following principles, drawn from case law, explain what is essential in order for the Public Sector Equality Duty to be fulfilled. Public bodies should ensure:

- **Knowledge** – everyone who is a member of, or works for, the CCG must be aware of our Equality Duties and apply them appropriately in their work

- **Timeliness** – you must comply with the duty at the time of considering options for service change/development and/or before a final decision is made.

- **Real consideration** – you must consider the aims of the Equality Duty as an integral part of your decision making process. The duty is not about box-ticking, it should be done properly, with rigour and an open mid to it influences your final decision.

- **Sufficient information** – you must consider the information you have and what further information is needed to give proper consideration to the Equality Duty.

- **No delegation** – the CCG is responsible for making sure that any providers of commissioned services can comply with the Duty, are required in contracts to comply and to comply in practice. It is a duty which cannot be delegated.

- **Review** – we must have regard to the aims of the Duty not only when we develop/review services, but when services are implemented and reviewed. The Equality Duty is a continuing duty.


\(^2\) To CCG members & staff, patients, carers and the public, community and voluntary sector groups.

\(^3\) Protected characteristics are: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation (also marriage and civil partnership but only in relation to eliminating discrimination)
Proper Record Keeping – We must keep records of the process of considering the Equality Duty and the impacts on protected groups. This encourages transparency and proper completion of Equality Duties. If records are not kept, it may be harder for us to evidence that we have fulfilled our equality duties.

EIA’s are about making services better for everyone and value for money· getting services right the first time.

1. Template

<table>
<thead>
<tr>
<th>Title of EIA</th>
<th>Future Model of Care for Community Short Term Service Beds</th>
<th>Ref No.</th>
</tr>
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<tbody>
<tr>
<td>Commissioning Team</td>
<td>Primary and Community</td>
<td></td>
</tr>
<tr>
<td>Focus of the EIA</td>
<td>Impact of New Model of Care</td>
<td></td>
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</tbody>
</table>

Consider:
- How to avoid, reduce or minimise negative impact (if you identify unlawful discrimination, including victimisation and harassment, you must stop the action and take advice immediately).
- How to promote equality of opportunity. This means the need to:
  - Remove or minimise disadvantages suffered by equality groups
  - Take steps to meet the needs of equality groups
  - Encourage equality groups to participate in public life or any other activity where participation is disproportionately low
  - Consider if there is a need to treat disabled people differently, including more favourable treatment where necessary
- How to foster good relations between people who share a protected characteristic and those who do not. This means:
  - Tackle prejudice
| Age | This service is accessible to those aged 18 yrs and above. Over 90% of service users Jan-Aug 2015 were over 65 years of age, with over 45% over 85 years of age. We intend to support more people at home so the age of those requiring beds is likely to increase. | Staff feedback highlights that more older people with cognitive impairments are now accessing the service. | The new model of care will support a wider range of people with a need for both step up or step down short term support. The impact of this on the age profile of service users is not yet fully understood but we anticipate that the majority of service users will continue to be over 65 yrs of age. |

| **Data**\(^2\) that you have (Current Service) | Summary of service user and/or staff feedback\(^2\) (Current & Future Service) | Impacts identified from analysis (actual and potential)\(^3\) (Future Service) | Potential actions to:  
- advance equality of opportunity  
- eliminate discrimination &  
- foster good relations |

\(^2\) ‘Data’ may be monitoring, patient feedback, equalities children achieved offer monitoring, survey responses…  
\(^3\) Either on-going links with community and voluntary groups, service user groups, or one off engagement sessions you run  
3 If data or engagement are missing and you can’t define impacts then your action will be to collect the missing information
| **Disability** | None – this data is not captured for the service  
Service users have rehabilitation and re-enablement needs but not necessarily registered disabilities though there are increasing numbers with cognitive impairments and some with learning disabilities. | No specific feedback | The new model of care will offer support to people with learning disabilities or mental health conditions as well as those with physical disabilities where they have an assessed need for a short term bed placement to support hospital discharge or avoid admission  
The service specification for the new model of care will require staff to be competent in the effective care and support of people with cognitive impairments, other mental health conditions and learning disabilities. |
| **Gender reassignment** | None – this data is not captured for service users | No specific feedback | The new model of care will be fully accessible for people who have gone through gender reassignment  
Given that access to the service will be based on need (as now) and not protected characteristics no specific actions are required re: gender reassignment |
| **Pregnancy and maternity** | Not Applicable to this service | No specific feedback | The new model of care will be fully accessible for pregnant women.  
Given that access to the service will be based on need (as now) and not protected characteristics no specific actions are required re: pregnancy and maternity |
| **Race** | None – this data is not captured for this service | Staff feedback highlights that more people now access the service from black and minority ethnic communities where communication and cultural understanding is important for the effective delivery of service i.e. food | Although Brighton and Hove has a smaller ethnic minority community as a proportion of the whole population compared to the national average the size of this population grew considerably from 2001 to 2011 and again although the ethnic minority community has a younger age profile than the White British community it is ageing and as a result we can expect to see increased demand for the new model of care. | The service specification for the new model of care will require staff to be trained and understanding of how to deliver effective care and support for people from ethnic minority communities. |
| **Religion or belief** | None – this data is not captured for this service | Staff feedback highlights that more people now access the service from black and minority ethnic communities where religious understanding is likely to be important for the effective delivery of service | As we see an increasing number of people from non-white British communities accessing the new model of care the service will need to respond to be understanding of religious beliefs and practices | The service specification for the new model of care will require staff to be understanding and accommodating of religious beliefs and practices |
| **Sex/Gender** | Majority of service users are women. | No specific feedback | The new model of care will support a wider range of people with a | Given that access to the service will be based on need (as now) and not |
| Safe Spaces | 65% of service users Jan-Aug 2015 were female and 53% male. | need for both step up or step down short term support. | The impact of this on the gender profile of service users is not yet fully understood but we anticipate that the majority of service users will continue to be women. | protected characteristics no specific actions are required re: gender |
| Sexual orientation | None – this data is not captured for this service | No specific feedback | The new model of care will be fully accessible to people of all sexual orientations | Given that access to the service will be based on need (as now) and not protected characteristics no specific actions are required re: sexual orientation |
| Marriage and civil partnership | None – this data is not captured for this service | No specific feedback | The new model of care will be fully accessible to people, whether married, in civil partnerships or not. | Given that access to the service will be based on need (as now) and not protected characteristics no specific actions are required re: marital status |
| Community Cohesion | This service is delivered based on need and brings together people with diverse characteristic in bed units where | Service user and staff feedback highlights that people are made to feel welcome in bed units but that more could be done to support social | The new model of care will need to improve opportunities for social interaction and avoid the potential for isolation and boredom | The service specification for the new model of care will require the provider to ensure opportunities for social interaction for service |
they have the opportunity to mix interaction during stays, as this can have a detrimental impact on people’s motivation for physical recovery

Other relevant groups eg: Carers, people experiencing domestic violence, substance misusers, homeless people, ex armed forces personnel, looked after children etc

None – this data is not captured for this service

The service is accessible to all persons aged 18 yrs and above with a need for short term rehabilitation and re-enablement

Carer feedback is that they are made to feel welcome in the bed units.

Staff feedback is that family members could be more engaged in supporting the recovery of service users

If the new model of care is to be as inclusive as we intend the provider will need to develop effective working relationships with a wide range of agencies to support the diverse needs of service users.

The service specification will require the provider to explore opportunities for family members and carers to support the recovery of service users.

The service specification will state that access to the service is based on the need for a short term bed to support discharge or avoid admission, whatever the circumstances of service users.

This will require the provider to develop links with a range of support agencies including housing, substance misuse and carers

Cumulative impact

The limited data we have would suggest Staff feedback is that the needs of people The new model of care needs to ensure it can The service specification will require the provider
| that the new model of care will support an increasingly aged population with a slowly increasing number from ethnic minority communities. | accessing short term service beds have increased in complexity and dependency and that they now support more people from ethnic minority communities. | support the increasing needs of ageing service users and a growing number of people from ethnic minority communities. | to ensure staff are trained and skilled in providing effective care and support for a wide range of primary and secondary needs, ensuring access for people with protected characteristics. |
## 2 Prioritised Action Plan

NB: you should also highlight here if there is potential for cumulative impact across the service or for a specific group.

<table>
<thead>
<tr>
<th>Specific Action</th>
<th>Evidence of progress/milestones</th>
<th>Lead</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>The key action required is that the service specification for the new model of care needs to specify a range of requirements of the provider in order to ensure equality of access and effectiveness of service delivery, comprising the following:</td>
<td></td>
<td>Keith Hoare and Jane MacDonald</td>
<td>December 2015 (post Policy and Resources Committee)</td>
</tr>
<tr>
<td>• Staff competencies to care for ageing service users with high levels of complexity and dependency</td>
<td>This action will be evidenced in the agreed specification for the service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Staff competencies to care for people with cognitive impairments, other mental health conditions and learning disabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Staff understanding to ensure effective care and support for people from ethnic minority communities, covering food, culture and religion</td>
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<td></td>
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<tr>
<td>• Opportunities for social interaction with and between service users</td>
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<td></td>
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<tr>
<td>• Support for family members and carers to proactively assist in the rehabilitation and recovery of service users</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Effective joint working with other agencies that can offer support re: housing, substance misuse,</td>
<td></td>
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</tr>
</tbody>
</table>
domestic violence and carers

We will also require (via service specification) the provider to improve their collation of protected characteristic data for future service users to ensure compliance with the law.

Signing of EIA:-

Patient and Public Engagement Manager: Date:

Lead Commissioner: Keith Hoare Date: 1/10/15

Senior Manager: Date:

You must also complete and submit a summary of the EIA in the Publication Template (see below)
## 3. List detailed data and/or community feedback which informed your EIA.

<table>
<thead>
<tr>
<th>Title (of data or engagement)</th>
<th>Date</th>
<th>Gaps in data (identify how you will fill these gaps in future, in your action plan)</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly performance reports and associated data from existing providers</td>
<td>On going</td>
<td>Only age collated for one bed unit and age/gender only for two units. No data collated on other protected characteristics. We will require the future provider to improve collation of protected characteristic data</td>
<td>Keith Hoare</td>
</tr>
<tr>
<td>Consultation meetings (x2) and conversations (x9) with service users/carers</td>
<td>Aug - Sept 2015</td>
<td>A total of 17 service users/carers were consulted on and a range of issues were covered so there is no need for further action</td>
<td>Keith Hoare</td>
</tr>
<tr>
<td>Engagement meetings (x5) with care domestic, management, therapy and mental health nurse</td>
<td>Sept 2015</td>
<td>A total of 29 front line staff were engaged with on a range of issues so there is no need for further action</td>
<td>Keith Hoare</td>
</tr>
<tr>
<td>Feedback from medical staff (Roving GP and COTEs) captured via conversation / e-mail</td>
<td>Sept 2015</td>
<td>Two of the lead COTEs submitted their thoughts for the new model of care as well as the mgr of the Roving GP service, so there is no need for further action</td>
<td>Keith Hoare</td>
</tr>
<tr>
<td>Feedback from Registered Managers captured via discussions and report</td>
<td>Sept 2015</td>
<td>Each of the Registered Mgrs has given their thoughts so there is no need for further action</td>
<td>Keith Hoare</td>
</tr>
</tbody>
</table>
**4 Equalities Impact Assessment Publication Template** (please keep this to one page)

<table>
<thead>
<tr>
<th>Name of EIA:</th>
<th>Future Model of Care for Community Short Term Service Beds</th>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning Team</td>
<td>Primary and Community</td>
<td>Date EIA completed 1/10/15</td>
</tr>
<tr>
<td><strong>Summary of EIA:</strong></td>
<td>This EIA has highlighted the lack of data collection / reporting by the current service re: protected characteristics. It has also highlighted the need for the provider of the new model of care to ensure that their staff are adequately trained to meet the diverse needs of future service users, and that in order to do this effectively they will need to develop joint working arrangements with a range of local agencies.</td>
<td></td>
</tr>
<tr>
<td><strong>Summary of relevant data:</strong></td>
<td>There is limited reported data from current providers to inform this EIA but what is available from this and the local JSNA would suggest that the service will need to support an increasingly aged population with a growing number of service users from ethnic minority communities.</td>
<td></td>
</tr>
<tr>
<td><strong>Summary of consultation:</strong></td>
<td>There has been a comprehensive engagement exercise comprising meetings and one to one conversations with service users/carers and staff that will inform the service specification for the new model of care.</td>
<td></td>
</tr>
</tbody>
</table>
### Assessment of impact and key follow-up actions:

The new model of care will not have any negative impacts on people with protected characteristic since access will be based on the clinically assessed need for a short term bed to support discharge or avoid admission. In fact we will improve the effectiveness of the new service by ensuring (via the service specification) that the provider has suitably trained staff to meet the needs of a more diverse range of service users, including people with mental health conditions and substance misuse issues, from ethnic minority community, and with housing and social support needs.

### For further information on the EIA contact:

Keith Hoare, Commissioning Manager, 01273 574773, [keith.hoare@nhs.net](mailto:keith.hoare@nhs.net)
Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. **Better Care Fund Section 75 Quarterly Performance Update**

1.1 This paper can be seen by the general public.

1.2 This paper is for the Health & Wellbeing Board meeting on the 20th October 2015.

1.3 Authors of the paper and contact details:
   Ramona Booth, Head of Planning and Delivery
   Brighton and Hove Clinical Commissioning Group,
   ramona.booth@nhs.net
   Alistair Hill, Consultant in Public Health,
   Brighton and Hove City Council,
   alistair.hill@brighton-hove.gcsx.gov.uk

2. **Summary**

2.1 The £5.3bn Better Care Fund (formerly the Integration Transformation Fund) was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is one of the most ambitious ever programmes across the NHS and Local Government. It creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.
2.2 The Health and Wellbeing Board oversee the City’s Better Care Fund. This £20m fund is supported by a Section 75 pooled budget. The Government requires the Board to sign off the Better Care Fund quarterly performance prior to submission.

2.3 At the last Board meeting there was a request for further information on the various ‘schedules of work’ that make up the Better Care Fund. Included in this paper is further information on a key schedule of work within the city: homelessness.

2.4 It is proposed that subsequent quarterly reports should be considered by the officer board and any exception issues reported to the Health & wellbeing Board. An annual report will also be prepared for the Health & Wellbeing Board which will include an update on a schedule to provide further insight in the delivery and impact that makes up the submission paper.

3. **Decisions, recommendations and any options**

3.1 This paper is presented to the Health and Wellbeing Board for:

   a) Approval of the quarterly submission;
   b) To note the information on homelessness;
   c) To approve the proposed change for an Annual report and any exception reports to be submitted to the Board.

4. **Relevant Information**

4.1. The submission paper will be considered in detail at the officer board prior to being submitted and any exception issues identified and reported to the Board in due course.

5. **Important considerations and Implications**

5.1. The provision of an annual report to the Board and any exception reports will meet the requirements for reporting matters to the Board prior to a submission paper being submitted.

6. **Supporting documents and information**

6.1. Better Care Finance and Performance Report September 2015 has been appended.
6.2. A paper on the homeless care work-stream has been appended as an example of the further work being undertaken as requested at the last Board meeting.
This report provides the Better Care Board and the Health and Wellbeing Board with an overview of the Better Care programme. The report is in three sections; finance, performance and programme delivery.

2.1 Section 75 Pooled Budget

At month 5 the year to date position is an underspend of £571k with an overspend of £360k being forecast for the year end. The key points to note are below and a summary table is contained in Appendix 1.

The Integrated Delivery workstream is currently underspent by £278k, with a forecast year end underspend of £27k. Progress against plans is currently being reviewed to establish whether in-year delays will result in additional underspends at the end of the year.

The Personalisation workstream is also underspent at month 5 (£240k), but is currently forecast to overspend by £100k. This is due to lower than anticipated savings on equipment, under the councils current contract for community equipment (a 30% reduction was expected). There is a risk that this overspend will increase as we progress through the year and transition to the new service provider.

At month 5 the Protecting Social Care workstream is overspending by £249k, with a forecast overspend for the year of £287k, due to significant pressures on the Disabled facilities grant budget. The position is under close review with a cost reduction program being put in place to bring costs back in line with the budget.

Some plans within the Keeping People Well workstream are in the process of being finalised and therefore there is an underspend of £303k at Month 5. Currently we are reporting that these budgets will be fully spent, but plans are currently being reviewed to assess the impact of delays on the outturn position.

2.2 Better Care Fund Enablers

The schedule contained in Appendix 2 details the funding earmarked in CCG budgets (outside of the pooled fund) to support the establishment of Better Care schemes and the position at Month 5. The total amount allocated to the enabler fund is £1971k.

Due to delays in the implementation of some work programmes, we are anticipating underspends across a number of budgets (£675k). The Finance & Performance group as part of the ongoing review of performance of projects and the resulting achievement of targets will consider whether any funds should be diverted to alternative use and will provide an update in this regard to the Better Care Board in October 2015.

2.3 Payment for Performance

Nationally £1bn of the total Better Care Fund was tagged as being a payment for performance – the achievement of planned Non-Elective activity levels. For Brighton & Hove this is circa £5m.
There has been a lack of guidance or clarification of how this will work in practice, particularly given the overperformance against Non-Elective activity plans, being experienced nationally in the final quarter of 14/15.

Initial guidance suggested that the performance payment, rather than being available for the pooled fund would be allocated directly to the CCG to be spent outside of the pool to ensure that funds were available to cover the additional costs of the overperformance.

As shown in the performance section of this report, we are currently achieving our target for Non-Elective activity levels and therefore expecting to receive the full payment for performance.

The Finance & Performance group is keeping this issue under review.

Performance Overview

3.1 National Targets

There are 5 national metrics which relate to the Better Care programme. The delivery of the Brighton and Hove Better Care Plan is forecast deliver the following improvements in the 5 national metrics:

1. Reduce non elective admissions by 1.9% (478)
2. Reduce permanent admissions to care homes by 13.3% (32)
3. Proportion of older people who were still at home 91 days after discharge from hospital into reablement services 89.1%
4. Reduce delayed transfers of care by 5.2% (308)
5. Increase dementia diagnosis rate to 67%

There are 4 programmes of work, supported by 3 enabling workstreams, which collectively will deliver these improvements.

3.2 Performance against the national targets

The current performance against the national targets is contained in the table below and summarised in the following narrative:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Actual</th>
<th>Period</th>
<th>RAG</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total non-elective admissions in to hospital (general &amp; acute), all ages</td>
<td>-1.9%</td>
<td>-6.8%</td>
<td>Q1 15/16 YTD</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000</td>
<td>545.9</td>
<td>850.3</td>
<td>Q1 15/16 YTD</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services</td>
<td>85%</td>
<td>82%</td>
<td>14/15</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+)</td>
<td>610.3</td>
<td>1177.6</td>
<td>Q1 15/16 YTD</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Dementia diagnosis rates</td>
<td>67%</td>
<td>58%</td>
<td>Mar-15</td>
<td>A</td>
<td></td>
</tr>
</tbody>
</table>

Please note the table above shows performance in the nationally mandated format. The sections below describe the targets in more detail.
3.2.1 Non elective admissions:

• Admission numbers in July 2015 continued to fall against the same period last year (-145) and is now showing a reduction of 6.7% year-to-date.
• Admissions are forecasted to be -5.6% against plan by the end of Q3 2015/16.

3.2.2 Care home admissions:

• In Q1 2015/16, there were 81 admissions against a target of 52. Provisional figures for July showed a significant reduction as the number halved from the previous month from 32 to 15.
• An analysis of admissions data followed by discussions with key staff within adult social care has been completed. A summary report of findings is available.
• The key areas for further action to reduce the level of admissions have been identified as:
  1. Focus on admissions from the community; these are 73% of the total admissions
  2. Review the reablement/community short term services offer to people in the community at risk of being admitted to long term residential and nursing home care and whether the pathways into this service are effective
  3. Continue to work with housing colleagues to review the pathways between extra care and sheltered housing and residential/nursing home care. Specifically consider the needs of people with dementia
  4. Give priority to review people entering residential and nursing home care within 6 weeks of placement
• The analysis also noted that other factors include
  1. An increase in the number of people who initially funded their own residential and nursing home care and whose funds have depleted
  2. The increasing complexity of need which can result in care at home costs significantly more than the cost of a residential and nursing home placement. Managers are making case by case judgements when considering such circumstances
• Number of care home admissions forecasted to be 277 for 2015/16. Target is 208. This could amount to a financial pressure of £1.8m.

3.2.3 Reablement:

• 2014/15 performance improved against the previous year and was close to meeting the 85% target. The key reason for under performance in previous years was because more people had died once they had gone home.
• The council will seek to run a report this year on the reasons people were no longer living at home after 91 days. The indicator that needs to be monitored alongside this is the proportion of people going into reablement/rehabilitation against all hospital discharges for over 65s. 2014/15 performance for this was 6.6% and has been performing well consistently over the last 3 years and places Brighton in the top quartile nationally.
• Performance is forecasted to be 77% in 2015/16

3.2.4 Delayed Transfers for care:

• In Q1 2015/16, there were 2,717 total bed days delayed against a target of 1,575. In last 3 months, delays have started to decrease and will require further monitoring to see if this trend will continue.
• Whereas the number of non-acute delays rose steeply in the second half of 2014/15, they began to fall from May 2015.
• In previous months, there were a large proportion of delayed days due to residential home placements. However this has seen a decrease from 616 days in April 2015 to 186 in July 2015.
• For 2015/16, days delayed forecasted to be 12,049 against a target of 5,644.

3.2.5 Dementia diagnosis:

• School House Surgery carried out checks and confirmed that all patients diagnosed by the MAS have been recorded on QOF. However more practices need to carry out the same exercise to provide a sufficient sample size and confirm our hypothesis.
• Based on current data, we estimate that clearing the 130 patients on the MAS waiting list will increase the diagnosis rate to 59% and therefore have minimal effect. This is based on 60% of referrals resulting in a diagnosis and of that 1 in 3 appears in QOF (26 in total).

Local Programme Delivery

4.1 Integrated Care Update

<table>
<thead>
<tr>
<th>Integrated Care</th>
<th>Target</th>
<th>Actual</th>
<th>Period</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients contacted within 2 weeks of identification</td>
<td>95%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients receive F2F assessment within 4 weeks of identification</td>
<td>95%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDT meetings include a GP from the patient’s GP practice</td>
<td>95%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients see an improvement in their wellbeing and independence</td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

i. **Milestones** - Delivery against key milestones all on track - phased implementation of the proactive care model in General Practice has commenced with roll-out to cluster one complete
ii. **Risk** - Risk to delivery is a delay in the start of care coach roles due to recruitment, which have now commenced
iii. **Finance** - currently underspent by £278k, with a forecast year end underspend of £27k.

4.2 Homeless Update

<table>
<thead>
<tr>
<th>Homeless</th>
<th>Target</th>
<th>Actual</th>
<th>Period</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in homeless A&amp;E attendances</td>
<td>&lt;477</td>
<td>406</td>
<td>Q1 15/16</td>
<td>G</td>
</tr>
<tr>
<td>Reduction in homeless non-elective admissions</td>
<td>-5</td>
<td>-13</td>
<td>Q1 15/16</td>
<td>G</td>
</tr>
</tbody>
</table>

i. **Milestones** - Development of the Homeless ‘Hub & Spoke’ service model is on track, with expected sign-off in in October 2015
ii. **Metrics** - Both A&E attendances and emergency admissions are achieving the target for Q1
iii. **Risk** - Current risk resulting from a reduction in funding for homeless services in city, which could result in increased pressure on the Better Care homeless model
iv. **Finance** - Actual vs. planned spend is on track
4.3 Personalisation Update

<table>
<thead>
<tr>
<th>Personalisation</th>
<th>Target</th>
<th>Actual</th>
<th>Period</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHB – number of active CHC PHBs</td>
<td>3</td>
<td>7</td>
<td>Q2 15/16</td>
<td>G</td>
</tr>
</tbody>
</table>

i. **Milestones** - Key milestones have been met across all four projects

ii. **Metrics** - The number of active Personal Health Budgets (PHBs) for CHC patients is on track with a target of 12 by the end of the year, and the first PHB within the Homeless cohort established

iii. **Risk** - Current risk around access to patient activity data in order to monitor the impact of Personal Health Budgets being reviewed against Information Governance advice

iv. **Finance** - underspent at month 5 (£240k), but is currently forecast to overspend by £100k.

4.4 Protecting Social Care Update

i. **Milestones** - Programme has delivered almost 97% of the Care Act deliverables and a plan is in place for the remaining areas. Homecare Hospital Discharge and Additional Social Workers in Access Point fully delivered and reporting positive impact

ii. **Risk** - Financial modelling being undertaken to mitigate the financial risk resulting from the 2016 Care Act funding reforms

iii. **Finance** - Protecting Social Care workstream is overspending by £249k, with a forecast overspend for the year of £287k, due to significant pressures on the Disabled facilities grant budget.

4.5 Dementia Update

<table>
<thead>
<tr>
<th>Dementia</th>
<th>Target</th>
<th>Actual</th>
<th>Period</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia diagnosis rates</td>
<td>67%</td>
<td>58%</td>
<td>Mar-15</td>
<td>A</td>
</tr>
</tbody>
</table>

i. **Milestones** - 1 GP Practice has checked and confirmed all diagnoses made by MAS are recorded on their QOF

ii. **Metrics** – Performance is currently below target and is forecast to remain below target.

iii. **Risk** – Planned improvements to the MAS are unlikely to deliver target diagnosis rates therefore further actions are required to improve performance.

iv. **Finance** - Actual spend of £13k is below the planned £83k in Month 4

**Recommendation**

The Better Care Board are asked to note current performance and approve the report for submission to the Health and Wellbeing Board.
### Appendix 1 – Section 75 Pooled Budget Month 5

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Budget</th>
<th>Year End</th>
<th>Variance</th>
<th>Budget</th>
<th>Year End</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Integrated Delivery Workstream</strong>&lt;br&gt;Natasha Cooper (CCG)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 Integrated Care (Sarah Bartholomew)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proactive Care (Primary Care)</td>
<td>1,500,000</td>
<td>326,844</td>
<td>317,255</td>
<td>9,589</td>
<td>1,500,000</td>
<td>0</td>
</tr>
<tr>
<td>Additional Care Managers working across the City localities 7 days per week</td>
<td>145,000</td>
<td>60,417</td>
<td>53,834</td>
<td>6,583</td>
<td>130,000</td>
<td>15,000</td>
</tr>
<tr>
<td>Additional Mental Health nurses (IPCT)</td>
<td>100,000</td>
<td>41,667</td>
<td>41,667</td>
<td>0</td>
<td>100,000</td>
<td>0</td>
</tr>
<tr>
<td>Additional therapy capacity (IPCT)</td>
<td>150,000</td>
<td>62,500</td>
<td>62,500</td>
<td>0</td>
<td>150,000</td>
<td>0</td>
</tr>
<tr>
<td>Additional nursing capacity (IPCT)</td>
<td>160,000</td>
<td>66,667</td>
<td>66,667</td>
<td>0</td>
<td>160,000</td>
<td>0</td>
</tr>
<tr>
<td>Additional therapy in Integrated Primary Care Teams</td>
<td>283,392</td>
<td>118,080</td>
<td>118,080</td>
<td>0</td>
<td>283,392</td>
<td>0</td>
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<tr>
<td>Social Workers in IPCT’s</td>
<td>120,000</td>
<td>50,000</td>
<td>50,000</td>
<td>0</td>
<td>108,000</td>
<td>12,000</td>
</tr>
<tr>
<td>Baseline IPCT’S</td>
<td>7,076,532</td>
<td>2,948,555</td>
<td>2,948,555</td>
<td>0</td>
<td>7,076,532</td>
<td>0</td>
</tr>
<tr>
<td>SCT increase in IPCT late shift nursing to support Collaborative working with CCCRS</td>
<td>111,000</td>
<td>46,250</td>
<td>46,250</td>
<td>0</td>
<td>111,000</td>
<td>0</td>
</tr>
<tr>
<td>SCT in-reach IPCT Frailty Co-ordinator E300K</td>
<td>100,000</td>
<td>41,667</td>
<td>41,667</td>
<td>0</td>
<td>100,000</td>
<td>0</td>
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<tr>
<td>Incentivising care homes and homecare providers to respond 7 days per week</td>
<td>69,000</td>
<td>26,750</td>
<td>26,750</td>
<td>0</td>
<td>69,000</td>
<td>0</td>
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<tr>
<td>Pharmacy (IPCT)</td>
<td>105,288</td>
<td>43,870</td>
<td>43,870</td>
<td>0</td>
<td>105,288</td>
<td>0</td>
</tr>
<tr>
<td>1.3 Homeless Model (Linda Harrington)</td>
<td>607,000</td>
<td>252,917</td>
<td>247,730</td>
<td>5,187</td>
<td>607,000</td>
<td>0</td>
</tr>
<tr>
<td><strong>2 Personalisation Workstream</strong>&lt;br&gt;Neil Francis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3 Integrated Comm. Equipment (Anne Richardson-Locke)</td>
<td>1,388,784</td>
<td>557,827</td>
<td>496,986</td>
<td>61,748</td>
<td>1,388,784</td>
<td>100,000</td>
</tr>
<tr>
<td>2.4 Supporting Carers (Gemma Scambler)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carers Reablement Project (previously known as Carers Befriending)</td>
<td>40,000</td>
<td>16,667</td>
<td>16,667</td>
<td>0</td>
<td>40,000</td>
<td>0</td>
</tr>
<tr>
<td>Alzheimer’s Society – Information, Advice and Support for Carers</td>
<td>50,000</td>
<td>20,833</td>
<td>20,833</td>
<td>0</td>
<td>50,000</td>
<td>0</td>
</tr>
<tr>
<td>Alzheimer’s Society – Dementia Training for Carers</td>
<td>10,000</td>
<td>4,167</td>
<td>4,167</td>
<td>0</td>
<td>10,000</td>
<td>0</td>
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<tr>
<td>Sussex Community Trust – Carers Back Care Advisor - SLA ???</td>
<td>14,000</td>
<td>14,000</td>
<td>14,000</td>
<td>0</td>
<td>14,000</td>
<td>0</td>
</tr>
<tr>
<td>Amaze – Carers Card Development</td>
<td>10,000</td>
<td>4,167</td>
<td>4,167</td>
<td>0</td>
<td>10,000</td>
<td>0</td>
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<tr>
<td>Carers Centre – Adult Carers Support</td>
<td>128,000</td>
<td>53,333</td>
<td>53,333</td>
<td>0</td>
<td>128,000</td>
<td>0</td>
</tr>
<tr>
<td>Carers Centre – Young Carers Support</td>
<td>32,000</td>
<td>13,333</td>
<td>13,333</td>
<td>0</td>
<td>32,000</td>
<td>0</td>
</tr>
<tr>
<td>Crossroads – Carers Support Children and Adults</td>
<td>47,000</td>
<td>19,583</td>
<td>19,583</td>
<td>0</td>
<td>47,000</td>
<td>0</td>
</tr>
<tr>
<td>Carers SDS Breaks and Services – spot purchase budget</td>
<td>25,000</td>
<td>10,417</td>
<td>10,417</td>
<td>0</td>
<td>25,000</td>
<td>0</td>
</tr>
<tr>
<td>Carers Centre – End of Life Support</td>
<td>16,000</td>
<td>7,500</td>
<td>7,500</td>
<td>0</td>
<td>16,000</td>
<td>0</td>
</tr>
<tr>
<td>Amaze – Parent Carers Survey</td>
<td>1,000</td>
<td>417</td>
<td>417</td>
<td>0</td>
<td>1,000</td>
<td>0</td>
</tr>
<tr>
<td>Dementia</td>
<td>22,000</td>
<td>9,167</td>
<td>9,167</td>
<td>0</td>
<td>22,000</td>
<td>0</td>
</tr>
<tr>
<td>Carers SDS Breaks and Services – spot purchase budget</td>
<td>100,000</td>
<td>41,667</td>
<td>41,667</td>
<td>0</td>
<td>100,000</td>
<td>0</td>
</tr>
<tr>
<td>Crossroads – Carers Health Appointments (previously known as Carers Prescriptions)</td>
<td>75,000</td>
<td>31,250</td>
<td>31,250</td>
<td>0</td>
<td>75,000</td>
<td>0</td>
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<tr>
<td>Working Carers Project – ASC Supported Employment Team</td>
<td>60,000</td>
<td>25,000</td>
<td>25,000</td>
<td>0</td>
<td>60,000</td>
<td>0</td>
</tr>
<tr>
<td>Hospital Carers Support – IPCT Carers Support Service</td>
<td>54,000</td>
<td>22,500</td>
<td>22,500</td>
<td>0</td>
<td>54,000</td>
<td>0</td>
</tr>
<tr>
<td>Carers Support Service - Integrated Primary Care Team (ASC Staff)</td>
<td>185,000</td>
<td>77,083</td>
<td>78,214</td>
<td>1,131</td>
<td>185,000</td>
<td>0</td>
</tr>
<tr>
<td>Carers</td>
<td>554,000</td>
<td>230,833</td>
<td>66,582</td>
<td>165,251</td>
<td>554,000</td>
<td>0</td>
</tr>
<tr>
<td><strong>3 Protecting Social Care Workstream</strong>&lt;br&gt;Anne Hagan</td>
<td></td>
<td></td>
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## Supporting Workstreams 2015/16

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Appendix 2 Supporting Workstreams Month 5
Appendix A:

Title: Better Care Homelessness workstream: Update for Brighton and Hove Health and Wellbeing Board

Date: 20 October 2015

Authors: Alistair Hill, Consultant in Public Health, BHCC
Linda Harrington, Commissioning Manager, Brighton & Hove CCG

1. Background and context

The Brighton and Hove Better Care Plan describes how services for our frail and vulnerable population will be improved to help them stay healthy and well, and will be more pro-active and preventative, and promote independence. In Brighton & Hove a broad definition of ‘frailty’ has been adopted. As part of this broad approach improving health and care outcomes for homeless people was identified as a priority.

In 2014 The Homeless Integrated Health and Care Board was established as part of the Better Care programme. Membership of the Board includes representatives of BHCC (public health, adult social care, housing), the CCG and NHS Trusts, GPs, community and voluntary sector, Substance Misuse services, Sussex Police and service users.

The Board agreed their vision to:

“Improve the health and wellbeing of homeless people by providing integrated and responsive services that place people at the centre of their own care, promote independence and support them to fulfil their potential”.

It was agreed that the programme of work will focus primarily on the 'single homeless' as evidence indicates this group has a high level of complex, and often unmet, health needs as well as difficulties accessing healthcare. Single homeless people are those who are not usually owed a duty by local authorities for housing. Many will live in the following settings:

- Rough sleepers;
- Hostel residents;
- People in emergency and temporary accommodation;
- The ‘hidden homeless’, which will include sofa surfers and people in squats;

Although the focus is on single homeless, it is recognised that services to improve access to healthcare of excluded groups need to be inclusive and flexible to meet individuals’ needs.
2. Needs Analysis: homelessness and health

The Joint Strategic Needs Assessment\(^1\) highlights that Brighton & Hove has a younger than average population with high mental health and substance misuse needs, which can be risk factors for, and are associated, with homelessness.

Affordable housing in the city is limited. The market is characterised a large private rental sector with rents unaffordable to most on average or low incomes. The number of people on the social housing register increased from 11,400 in 2010 to 21,000 in 2015.

It is difficult to precisely estimate the size of the single homeless population but the following data describe the number of people in some relevant settings:

- The city has seen an increase in the official count for rough sleeping from 14 in 2010 to 50 in 2013 (3rd highest in England), falling back to 41 in 2014. However services estimate that more than 130 people are rough sleeping on a typical night in the city.
- The city has 288 hostel places for single homeless people, with a current waiting list of 125 people.
- There are approximately 400 single homeless people in emergency and temporary accommodation.
- The number of single homeless people who are sofa surfing or in other insecure accommodation is not known.
- Brighton Homeless Healthcare, a specialist GP practice commissioned by NHS England to provide primary healthcare service for those who are homeless and not registered with a city GP, has a list size of approximately 1,400 patients, of whom the majority are adult males aged below 65.
- Establishment of monitoring for this project has provided estimates of the use of unplanned healthcare by people who are homeless. In 2014/15 there were an estimated 861 unplanned admissions and 1,629 A&E attendances. Due to challenges in recording homeless status in health services these are likely to be underestimates.

People who are homeless often have complex needs with a high prevalence of mental ill-health, physical ill health and drug and alcohol dependency (often in combination). They experience some of the greatest health inequalities and evidence shows they have poorer health outcomes and a significantly lower life expectancy than the overall population. The national average age of death for a homeless person is 47 years old compared to 77 for the general population.

People who are homeless also often experience difficulties in accessing preventive and planned healthcare and nationally it is estimated that the use of inpatient hospital care

\(^1\) Brighton & Hove JSNA http://www.bhconnected.org.uk/content/needs-assessments
by people who are sleeping rough or living in insecure accommodation (such as hostels) is eight times higher than in the general population aged 16-64.

In Brighton & Hove a Homeless Health Audit\(^2\) of single homeless people was conducted in 2013-14 (as part of the Joint Strategic Needs Assessment Programme overseen by the Health and Wellbeing Board). Of the 302 respondents:

- 84% reported at least one physical health problem
- 85% reported at least one mental health issue (nearly four in ten had been diagnosed with depression)
- 40% reported that they were a drug user or recovering from a drug problem
- 39% had attended A&E (including many multiple attendances) and 25% had been admitted to hospital at least once in the last six months

3. Current position: development of services

Locally the number of homeless people has increased and services are under increasing demand. The complexity of need requires a coordinated response and alignment of services across health, housing, public health and social care.

Currently services are not configured to provide an integrated response. Many specialist homeless health services in the city are commissioned according to setting, rather than focusing on individuals’ needs, and some universal health services are not accessible to those who are homeless.

Over the past two years additional investment has enabled pilot projects to develop more appropriate service responses. Significant progress has been made during these interim years in terms of: better co-ordination of care, improving hospital discharge, facilitating access to primary and community health and increasing flexibility in terms of service delivery.

Key projects have included the following:

**Pathway Plus (funded as part of Better Care)**
This service has built on the Pathway service that previously had short term national funding. It provides specialist care and discharge planning for people in hospital delivered through GP in-reach, nursing and engagement workers.

**Hostels Collaborative Project (funded as part of Better Care)**
Since 2013 Sussex Community NHS Trust has provided a community specialist team to in-reach to the city’s homeless hostel residents (covering all 7 hostels from 2015). Since June 2015 this team has been co-located with Brighton Homeless Healthcare at Morley Street. From November 2015 to March 2016 the team will be piloting approaches in order to engage with the street population.

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\(^2\) Available at: http://www.bhconnected.org.uk/sites/bhconnected/files/Brighton%20and%20Hove%20Homeless%20Health%20Needs%20Audit%20FINAL.pdf
Mental Health Homeless Team
To date the Sussex Partnership NHS Trust service has been primarily working with street homeless and emergency accommodation. From October 2015 an extension to the team will run a pilot of mental health in-reach to hostel residents to inform development of a future mental health model of support for the homeless, including links with existing services.

Complex Homeless Multidisciplinary Team meetings
Primary care led fortnightly meetings were established in June 2015. The team identify the homeless who will most benefit from a multiagency review and coordinated proactive management. Initial evaluation of the MDT meetings has been very positive.

Most of the funding for these projects is short term and the service coverage is not comprehensive resulting in some inequality in current service provision.

4. Proposed hub and spoke model

The Board agreed an overarching model based around a service hub with outreach to spokes. Development of the model was informed by
- national evidence and service standards\(^3\)
- review of best practice and models elsewhere
- consultation with local partners and homeless people

The key elements of the business case to support the model are:
- An enhanced Primary Care service
- A ‘hub’ which will bring together a multi-disciplinary team including primary care, community nursing and allied health professionals, health improvement services, mental health assessment and support, drug and alcohol assessment and support (as a setting for the Pavilion service), social work, housing assessment and engagement workers
- Delivery of outreach in to users in settings (‘spokes’) including hospital, day centres and hostel accommodation and to the street population and also to support specialist support and consultation offered to mainstream GPs and their clusters.
- Alignment of this service with other homelessness services across the City including hostels and the rough sleepers team

A key objective of the specialist service will be to facilitate and improve access to mainstream services. The specialist service will support service users and mainstream health services to achieve this.

\(^3\) Including The Faculty for Homeless and Inclusion Health (2013) Standards for commissioners and service providers
Longer term investment will be required to deliver this model.

5. Outcomes for homeless people

High level metrics have been agreed for the Better Care programme, including a reduction in A&E attendances and non-elective admissions. The programme is currently graded green for performance. However these indicators are subject to fluctuation over time and improved identification of homeless people in the hospital setting may result in an apparent increase in hospital attendances and admissions.

As part of the development of the local service specification a more holistic outcomes framework will be produced. This will be informed by the Health Outcomes Framework for Single Homeless People, currently being developed by Public Health England, and will reflect person centred outcome measures as well as health service (including length of stay), social care, housing and public health outcomes.

6. Key risks

A risk register is maintained as part of the programme. The most significant current risk relates to the overall reduction in funding for homeless services in the city which could result in increased unmet needs and increased pressure on establishing this model.

7. Next steps

The key next steps are:
- finalise an outline service specification based on the model
- conduct an equalities impact assessment
- develop a business case for submission
- confirm the timetable and plans to current service providers who have contracts that end on 31 March 2016

The actions above need to be aligned with the forthcoming review of Primary Medical Services (PMS) GP practices, which will include Brighton Homeless Healthcare. The CCG has contacted NHS England to request to request early involvement in this process. It is planned that changes in commissioning will take place in 2016/17 as part of a phased implementation.

8. Recommendations

The Health and Wellbeing Board are asked to note the development of the Better Care workstream to improve the health and wellbeing of people who are homeless.
Figure 1: Integrated health and social care for the homeless
Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. **Mental Health and Wellbeing Strategy – progress report on year 1 and action plan for year 2 and 3 of the strategy.**

1.1 This paper can be seen by the general public.

1.2 20 October 2015

1.3 Author of the Paper and contact details:
Paula Murray, Assistant Chief Executive
Brighton & Hove City Council
Paula.Murray@brighton-hove.gcsx.gov.uk
01273 292534

2. **Summary**

2.1 In July 2014 the Health and Wellbeing Board (HWB) approved publication of the Mental Health and Wellbeing Strategy. The strategy is for 3 years and included a 1 year action plan with a commitment to revisit this plan at the end of the first year. This paper updates the HWB on the actions included in the first year of the strategy and seeks approval to the actions proposed for years 2 and 3.

2.2 This paper provides an update against the 1st year of the action plan included in the Brighton and Hove Mental Health and Wellbeing Strategy. It also asks the HWB to note the proposed action plan for years 2 and 3 of the strategy.
2.3 The recommendations in this paper affect the residents of Brighton and Hove.

3. Decisions, recommendations and any options

The Health and Wellbeing Board is asked to:

3.1 To note the progress of delivery of the actions included in the first year of the mental health and wellbeing strategy

3.2 To note the action plan for the second and third year of the strategy

4. Relevant information

   Background

4.1 Last July the CCG and BHCC published Happiness: Brighton and Hove Mental Health and Wellbeing Strategy. The strategy described the rationale for combining wellbeing and mental health in one strategy and described the action that the CCG and BHCC would be taking during the first year to improve the mental health and wellbeing of the residents of Brighton and Hove.

4.2 The strategy followed on from the Director of Public Health’s Annual Report 2012: ‘The pursuit of happiness’. It covers all ages and was developed in line with the ‘No health without mental health’ national strategy and takes a preventative approach by addressing the wider factors that influence mental wellbeing as well as ensuring we have high responsive high quality services and support available.

   Year 1 action plan and key highlights

4.3 Consequently the breadth of the strategy is considerable and the year 1 action plan included actions that ranged from making changes to acute services that supported patients being discharged from Millview Hospital, through to raising the awareness of mental health issues amongst employers. A summary of the progress against the year 1 action plan is included at annex A.

4.4 Highlights of achievements in the first year include:

   - Increasing the investment in community mental health services which has enabled us to expand the hours and capacity of the mental health rapid response service, recruit
additional psychological support for community services, and appoint link workers to facilitate the discharge of patients from hospital to the community.

- Embedding psychological provision in physical health services including the new musculoskeletal service and the dermatology service.

- The appointment of 9 Happiness Champions who have been tasked with raising the profile of mental health and wellbeing in different sectors. Happiness Champions are a network of local influencers and innovators, who can help us to make Brighton & Hove a happier city. The champions are people who are in a position to influence others in their sector and who are enthusiastic about promoting mental health and wellbeing for everyone who lives and works in the city. The champions have used opportunities such as speaking engagements, meetings, blogging and business planning to keep the conversation going and to build on the momentum that has already been generated through the strategy. They represent diverse interests in the city: sport, the arts, gardening, health, employers and criminal justice. Each one brings their own creative approach to the role.

- Investing £245k in 61 community and neighbourhood projects that are supporting Brighton and Hove residents to increase their resilience and wellbeing. Examples include a singing project that visit the patients on the dementia ward at BSUH; a collaborative project between Varndean school and Age UK where older people are teaching students to garden and students are teaching older people how to use Skype and Facebook to enable them to keep in touch with their friends and families; and workplace based mindfulness projects.

There will be a continuous process of evaluating and measuring the impact of the different actions in the strategy but already we know:

- That the number of people being sectioned by the police and taken to custody is at an all-time low in Brighton – this can be attributed to a renewed commitment for the police to work with mental health services but also could be as a result of the additional investment in the urgent care pathway.

- Brighton & Hove residents report wellbeing approximately in line with national averages, and the proportion with low scores has been falling though this difference is not
4.5 The profile of mental health and wellbeing issues has been raised locally and the conversation about what can be done by employers, the arts, councils services such as leisure services and green spaces is taking place. The Happiness Champions have been instrumental in this. It is also the case that the profile of mental health and wellbeing has been raised nationally (the Crisis Care Concordat, additional funding for children mental health services, increased focus on IAPT targets have all helped). There is a real sense that the messaging about looking after your wellbeing and the positive benefits this can have on your mental and physical health is becoming more mainstream.

**Action plan for year 2 and year 3**

4.6 Attached at annex B is an action plan for years 2 and 3 of the strategy. Some of the actions build on work that started in the first year of the strategy, for example, the community navigator programme and the ongoing integration of mental health services with physical health services. Through developing a joint communications strategy, and celebrating mental health calendar events such as World Mental Health Day, we will do what we can to reduce the stigma attached to people with mental health problems.

4.7 There are 2 key new themes for treatment services for this next iteration of the plan:

- The aspiration to commission more ageless mental health services so that we remove the cliff edge that children often face when they turn 18.

- The commitment to create more parity in crisis services for young people so that they have access to the same level of response that adults can access when they are experiencing a mental health crisis

4.8 Another key feature of the strategy for the next 2 years will be the work that will be taking place in both the BHCC and CCG to improve the wellbeing of staff. Both organisations will be developing aiming to secure Time to Change accreditation – this is a national scheme that requires organisations to develop action plans setting out what they will do to support the wellbeing of staff and support staff with mental health problems. In addition the CCG has
developed a Wellbeing Charter, will be offering mental health awareness training at work and is providing lunchtime yoga.

4.9 The Public Health Schools Programme will continue to increase the support available for children and young people, their families and school staff, as they tackle concerns about emotional wellbeing and mental health.

4.10 We are in the process of securing additional happiness champions: we have recently appointed a representative from Albion in the Community and another from Fabrica Gallery.

4.11 There will be a second round of the Innovation Fund: we have identified social isolation as the theme for this and are aiming to have awarded up to 15 grants by Christmas.

4.12 The action plan does not include every aspect of work that commissioners and BHCC will be working on over the next two years - it is the headline messages of the activity that we know will be taking place. CCG and BHCC plans for mental health will take account of developments such as the Fairness Commission, any changes in national targets and priorities as they emerge.

5. Important considerations and implications

Legal
5.1 This paper and the attached strategy documentation do not have any legal implications.

Finance
5.2 Funding for addressing the gaps identified in the consultation that underpinned the development of the strategy originally have been secured from CCG budget - £50k for financial advice for people with mental health problems and £70k for bereavement support. From public health, an additional £15k has been invested in public mental health to address gaps. The CCG and BHCC are jointly funding the innovation fund. This year the CCG is contributing £25k and BHCC is contributing £30k.

Equalities
5.3 A full equalities and impact assessment was carried out when the strategy was first developed and published as part of the strategy.
Sustainability

5.4 There are no sustainability implications associated with this paper or the proposed action plan.

Health, social care, children’s services and public health

5.5 The strategy is joint between BHCC and the CCG and covers both adults and children and has therefore been developed collaboratively across the organisations.

6 Supporting documents and information

6.1 The following documents are attached:

Annex A Introductory letter and progress report against year 1 of the action plan
Annex B Action plan for years 2 and 3
Introduction
There has been a sea-change recently in our approach to mental wellbeing. Parity of importance between physical health and mental health has become a key aspiration. More people are engaged in the conversations about how to improve mental health, and organisations that might not have seen this as their business in the past are now exploring the impact their work has on positive mental health. Our network of champions in the arts, sport and business reflect this wider commitment and interest. Links between physical health and mental health have been developed. Local schools have reported that emotional wellbeing is one of their top priorities. The mental wellbeing innovation fund has supported over 60 small, innovative projects which provide opportunities for people from many backgrounds and neighbourhoods to put the Five Ways to Wellbeing into practice. Waiting times for talking therapies have reached the targets set. Mental health crisis services have been extended and work with Sussex Police has helped to identify individuals with mental health problems and to offer them better options than custody in a police cell.

More information is available about self-reported wellbeing as well as mental illness across the country, and we can see how we compare. Though Brighton & Hove continues to have higher than average rates of mental ill-health, our self-reported happiness is slowly increasing.

We have made good headway in the first year since our strategy for mental wellbeing in the city was launched in August 2014. The report on our first year describes our progress in detail, against our initial commitments.

There is still a long way to go, and the action plan for Years 2 and 3 sets out our priorities for the near future. There is new funding to support vulnerable groups, including people who have been bereaved and people who have suffered trauma such as torture or abuse. A second round of the innovation fund will target social isolation. There is also a commitment to new treatment services, including more psychological support and crisis support for people with a learning disability as well a mental health problem. A major review of children's mental health services is underway with the aim of improving options for children and young people, and easing the transition into adult services. All of this work builds on the Annual Report of the Director of Public Health 2014/15, addressing the inequalities that arise from and are caused by mental health problems, and acknowledging the need for support for vulnerable groups.

Mental and physical wellbeing are intertwined; there really can be no health without mental health.

Paula Murray
Assistant Chief Executive
Brighton & Hove City Council

Christa Beesley
Accountable Officer
NHS Brighton & Hove
### Progress with the first year action plan August 2014 to August 2015

**You told us**

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<td>1</td>
<td>The Five Ways to Wellbeing work well and are effective for you. You would like more information about how to put the Five Ways into practice - Connect, Keep learning, Be active, Take notice and Give.</td>
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</table>

**In the first year:**

Both the City Council and CCG launched webpages in 2014/15 with information about the Five Ways, and about mental wellbeing. The Council’s webpages include short films by City College students to illustrate how they work for local people. The City Council provides information about mental wellbeing, support and events at: [http://www.brighton-hove.gov.uk/content/health/mental-health-and-wellbeing](http://www.brighton-hove.gov.uk/content/health/mental-health-and-wellbeing). The CCG also provides information about mental wellbeing at: [http://www.brightonandhoveccg.nhs.uk/your-health/mental-health-and-wellbeing](http://www.brightonandhoveccg.nhs.uk/your-health/mental-health-and-wellbeing) as well as mental health services at: [http://www.brightonandhoveccg.nhs.uk/your-local-services/mental-health-services](http://www.brightonandhoveccg.nhs.uk/your-local-services/mental-health-services).

A Five Ways to Wellbeing leaflet has been developed, designed and distributed to primary care (GP surgeries and pharmacies).

The My Life webpages provide more information about local services at [http://www.mylifebh.org.uk/health-services/mental-health-services/](http://www.mylifebh.org.uk/health-services/mental-health-services/), as well as information about specific conditions including depression, eating disorders and anxiety: [http://www.mylifebh.org.uk/health-conditions/](http://www.mylifebh.org.uk/health-conditions/). Information about children and young people’s mental health is included at: [http://www.mylifebh.org.uk/health-services/childrens-services/](http://www.mylifebh.org.uk/health-services/childrens-services/).

**Already in place:**

Mind in Brighton & Hove is commissioned to provide comprehensive, up to date information and advice about mental health services and support. This can be accessed in person, on the phone, via email or on their website at: [http://www.mindcharity.co.uk/advice-information](http://www.mindcharity.co.uk/advice-information).

The Fed’s website, It’s Local Actually, continues to provide information about different types of activity within range of any location within the city. The link to the website is here [http://www.thefedonline.org.uk/services/out-and-about/its-local-actually](http://www.thefedonline.org.uk/services/out-and-about/its-local-actually).

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<td>2</td>
<td>You want more opportunities to build your own mental health</td>
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The mental wellbeing innovation fund was launched in October 2014. It offered one year’s funding of up to £5,000 for innovative projects linked to the Five Ways, giving priority to projects for people with specific needs for support, such as disabled, unemployed or minority ethnic groups. The themes for the year were: gardening and growing; arts and crafts; workplace...
### You told us

Wellbeing. You feel that sometimes it is easier to access services that are targeted at people like you.

### In the first year:

112 applications were received, and 61 projects were funded. The Fund total for 2015 was £261,000; £125,000 was sourced from a national underspend at Public Health England. Matched funding with a total value of £238,340 was provided. Guidance on evaluation using the Shorter Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) was sent out to all project leads; projects have a deadline for final reports at 31 January 2016.

### Already in place:

Small projects that aim to reduce isolation and address mental wellbeing, among other outcomes, are also funded through the Community Health Fund and the Healthy Neighbourhood Scheme.

### 3 You want to keep mental health and wellbeing high on everyone’s agenda.

A high profile network of Happiness Champions has been established, to promote awareness of mental health and wellbeing within their professional roles. There are nine members currently:

- Annie Alexander, lead for Public Health Older People’s programme, City Council
- Vic Borrill, Director, Brighton & Hove Food Partnership
- Andrew Comben, CEO, Brighton Dome and Brighton Festival
- Darren Emilianos, GP at Woodingdean Medical Centre
- Becky Jarvis, GP at St Peters Medical Centre and also Clinical Lead for Mental Health at the CCG
- Tony Mernagh, Brighton Business Forum
- Dave Padwick/Jo Grantham, Chief Inspectors for Brighton & Hove, Sussex Police
- Tom Scanlon, Director of Public Health, City Council
- Liz Whitehead, Co-Director, Fabrica

Two meetings with all the champions have been held. Achievements to date include: an evening event for local employers; events at the Brighton Festival which highlight mental health issues; a major evaluation of the impact of community gardens on mental wellbeing; sharing of Police data on suicides with Public Health to identify high risk locations, and a joint approach with the CCG to arrests and safe custody to identify individuals with mental health needs.

Health Trainers and Healthwalk leaders also have a key role in promoting understanding of mental wellbeing. Last year, the Royal Society of Public Health Understanding Emotional Wellbeing course was delivered to the Health Trainers team and
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<td>Healthwalks manager, to help them hone their skills in this aspect of their work.</td>
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<td>4</td>
<td>The CCG has implemented a staff wellbeing programme which to date has included the availability of yoga classes and mindfulness in the office and a lunch time visit from MIND as part of the Time to talk programme.</td>
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<td>The Council has offered both physical activity (Reaching Rio) and cultural activities (64 Million Artists) to staff in 2014/15. Through the Wave (the internal staff website), staff are also regularly alerted to mental health events and to opportunities to meet others, volunteer, join courses or be active. Feedback from the staff survey has been widely disseminated and acted on.</td>
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<td>The Public Health Schools Programme has worked with schools to promote the health and emotional wellbeing of all staff. So far:</td>
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<td>• 48 schools have expressed interest in an online health and wellbeing assessment and 17 have completed these.</td>
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<td>• 4 schools have participated in programme of health and wellbeing checks provided by health trainers, with support to access further health support or 6 week behaviour change sessions.</td>
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<td>• 2 schools have begun work on the Workplace Wellbeing Charter.</td>
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<td>The Council and CCG have both committed to signing organisational pledges to the Time to Change campaign, and will be submitting action plans in 2015/16.</td>
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<td>5</td>
<td>Mental health calendar events such as World Mental Health Day, Mental Health Awareness Week and Time to Talk Day provide opportunities to communicate widely about mental health and wellbeing. We want to promote the message that mental health and wellbeing are important to us all, and that mental health problems are common.</td>
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<td>5</td>
<td>World Mental Health Day in October 2014 was supported by programme of debates and events organised by The Basement. In addition, a public event at The Level was organised by Mind, offering information, advice and activities. Mental Health Awareness week falls in the second week of May, when the Festival is running. Andrew Comben, one of our Happiness Champions, took the opportunity to discuss mental health and the arts on Radio Sussex. Time to Talk day was promoted and supported by Mind in Brighton &amp; Hove.</td>
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| **6** You want help in finding the right opportunities and support for your particular circumstances, especially if you have translation needs, if you don’t have easy online access or if you feel isolated particularly as a result of older age. | The SICK! Festival, in March 2015, focussed on themes of suicide, abuse and ageing, using film, debate, theatre, comedy and performance. The Basement, who organise the festival, aim to challenge stereotypes and promote debate about mental health. The new My Life website provides information about the range of opportunities to support people with specific conditions as well as local services. The CCG and BHCC websites also provide lots of information about support options and online help. As part of the Age Friendly City and Older People’s public health programme:  
- Two consultation forums for older people meet regularly.  
- 26 organisations have worked together to find solutions around transport and older people.  
- Nine specific actions to support older people have been included in the new housing strategy.  
- Locality hubs facilitate access to a wide range of activities: over 1000 activities are available citywide for older people.  
- Fabrica’s Growing an Older Audience programme provided 1000 events, projects and courses.  
- 30 new projects for older people were funded by the Healthy Neighbourhood Fund. The Community Health Fund also funds small projects to improve health, many of which also improve mental wellbeing and reduce isolation: 28 projects were supported in 2014/15. Healthy living pharmacies promote the Five Ways to Wellbeing and can signpost to mental health advice, support and services; libraries promote Books on Prescription. |
<p>| <strong>7</strong> You see the link between financial stability and mental wellbeing and feel it is important that more people can access financial and benefits advice. | A procurement exercise commenced in August to secure additional financial advice for people with mental ill health. MoneyWorks was launched in the autumn of 2014 as planned. It provides a one stop shop for advice on managing money, debt and benefits for anyone struggling to make ends meet: <a href="http://www.advicebrighton-hove.org.uk/moneyworks/">http://www.advicebrighton-hove.org.uk/moneyworks/</a> The Citizens Advice Bureau provides advice about managing money in five GP surgeries. |
| <strong>8</strong> You feel that GPs are essential to care being | Community navigators have been piloted in 16 GP practices. Community navigators are supporting patients to access services, helping patients to refer themselves and where necessary accompanying patients to initial appointments. The pilot has been |</p>
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<td>provided in the community, but you understand that it is not possible for them to know about all the different support options that could be available to help you.</td>
<td>extended until March 2016 and a decision will be made shortly about what will happen once the pilot has ended.</td>
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<td>NHS checks: Residents in Brighton &amp; Hove’s most deprived quintile postcodes are offered an extended NHS health check which includes screening for depression and advice on positive mental wellbeing, including the Five Ways.</td>
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<td>Specialist mental health triage is part of the new Referral Management Service – this was trialled with the previous provider and will be key to ensuring that people are referred to the right service the first time.</td>
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<td>9 You want a more joined up approach from health, social care and voluntary services.</td>
<td>The Better Care Programme is progressing and multi-disciplinary teams have been piloted in two GP practices. This approach is being extended to further GP practices, enabling more people to receive more integrated care.</td>
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<td>New contracts are in place with BSUH for dermatology and with BICS for the musculoskeletal service and both services include the provision of psychology support.</td>
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<td>There are now two mental health nurses, based in the integrated primary care teams supporting the mental health needs of individuals who are housebound.</td>
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<td>The dual diagnosis strategy has established much closer coordination between services for substance misuse and mental illness, and is aiming for sharing of records, co-location of teams and shared assessment tools.</td>
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<td>10 You value services which support you as a whole person, responding to your specific needs.</td>
<td>Gaps in commissioning identified through review of No Health Without Mental Health have been addressed in the new services referred to throughout this report.</td>
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<td>The CCG is commissioning additional support for people who are bereaved. It is also commissioning additional financial advice for people who have mental ill health.</td>
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<td>The retender of Public Mental Health Contracts provided for two new vulnerable groups needing support – the transgender community (the local needs assessment identifies high level of distress and mental ill health); and vulnerable men (the city has a</td>
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<td>high suicide rate and men are particularly at risk).</td>
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<td>A Needs Assessment (JSNA) for children and young people (0-25 years) for mental health and wellbeing will conclude at the end 2015 and will identify young people with specific needs that will be addressed within an action plan.</td>
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<td>11 You would like us to ensure there is training available for frontline staff across health, social care and the community and voluntary sector. This training should raise awareness of mental health issues and enable professionals to treat you with more dignity and respect.</td>
<td>Grassroots training programme continues to provide a range of courses for frontline staff working with groups at higher risk of mental ill health, including people who are living in deprivation, homeless or insecurely house, care leavers, bereaved, military veterans, victims of abuse, offenders, are physically unwell, misuse alcohol or substances, have learning disabilities, are new parents, lesbian, gay or bisexual, identify as transgender or who are from some BME groups. This training includes suicide and self-harm awareness. Further training on mental health awareness or mental health first aid is being commissioned in 2015/16. All secondary schools have received basic awareness-raising training about self-harm from the Community Child and Adolescent Mental Health Services (CAMHS) team. As a follow-on, Public Health has commissioned a training package: Self-harm: strategies and interventions for school staff responding to self-harm. This will be available to school staff and school nurses from September 2015. During May and June 2015, six focus groups were conducted with local young people and parents/carers affected by young people’s self-harm, to ensure the training is based on real life experiences and meets the needs of local families. Seminars for GPs and practice nurses on a range of mental health issues are provided by Sussex Partnership NHS Foundation Trust, and practices have been required to attend these if they participate in the Severe Mental Illness Local Enhanced Service (SMILES). This requirement is also likely to be built into the revised version of the service, the Mental Health Locally Commissioned Service.</td>
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| 12 Schools and colleges have expressed concern about the mental wellbeing of children and young people. They have said they are finding it difficult to | The CCG is now responsible for commissioning children and young people’s mental wellbeing/ CAMHS (as of 1 October 2014). A whole system review and JSNA have started with publication in the winter 2015/16. The review will include the provision in schools and colleges and the rest of the system. The review will consider the roles and responsibilities of Tier 2 Community CAMHS teams with regards to support in schools. A pilot to develop a whole school approach to mental health and emotional wellbeing now confirmed with three secondary schools from September 2015. During 2014/15, the Public Health Schools Programme worked with all the secondary schools to develop a whole school }
You told us

access services for the increasing numbers of young people needing support – the threshold for services means the needs of their young people have to escalate to get a service.

There has been a reduction in support directly available on school sites for young people.

There are young people presenting with anxiety problems, sleeplessness, exam stress, anger management, self-harm, behavioural problems and peer bullying.

There are also young people who are living with low level mental health issues within the family that impact on parenting but do not meet the thresholds for

In the first year:

approach to self-harm. Different schools tried different aspects to enable us to test approaches.

In primary schools:
- Public Health and the School Travel Team worked with 20 schools to adapt their assembly to incorporate the Five Ways message.
- Public Health and Libraries have produced a mood boosting books resource for children. Three focus groups were completed, asking children to share their favourite mood-boosting books and to lead an activity asking other pupils in the schools. Special educational needs coordinators were consulted to establish priority issues in each school, and booklists have been agreed, chosen by pupils and categorised according to issues (e.g. friendship). These will be made available to schools in 2015/16.

In secondary schools:
- A PHSE curriculum framework for Emotional Health and Wellbeing has been developed, and supported by training for all secondary and special schools.
- CAMHS have delivered self-harm basic awareness training to 9 of 10 secondary schools in the city. 90% of secondary schools have signed up to attend the follow-on course (see 11, above) to equip frontline staff with strategies and interventions when responding to self-harming behaviour.

Support for families:
- At three schools, CAMHS and the school nurse have offered on-site support groups for parents/carers of children affected by self-harm on a half-termly basis.
- At one school, self-harm workshops have been delivered to parents at evening sessions.
- Right Here have developed a film ‘Self-harm & Young People: a Guide for Parents & Carers’ to inform and reassure parents, carers and anyone who may be concerned about a young person who is self-harming.

Group work:
- At one school, the Music Hub has delivered a 10 week course ‘building resilience’ for young people identified by the school as emotionally vulnerable.
- Right Here at YMCA Downslink have planned and developed a series of peer led mental health workshops.
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<td>adult services.</td>
<td>Additional support:</td>
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<td>- Children’s services and Public Health have jointly commissioned additional primary mental health support in three secondary schools. In addition, they have secured a national pilot to increase links and understanding between schools and CAMHS at the three secondary schools and 7 primaries.</td>
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<td>- A think tank event on the impact of social media on young people has been completed and the summary report identifies actions to address emotional wellbeing as a key priority.</td>
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<td>- Six innovation fund projects are based in schools.</td>
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<td>13 You would like increased access to counselling, talking therapies and mindfulness.</td>
<td>The Wellbeing Service has cleared the historic waiting list that it inherited for talking therapies including mindfulness based CBT; the service is now able to offer initial appointments in line with national standards for access times. It has also adapted the service so there are more appointment slots outside of core hours at a wider range of venues. In addition, the process supporting self-referral has been improved. Five innovation fund projects involve provision of mindfulness, for carers and for frontline staff.</td>
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<td>14 You want to be able to choose treatment and support that complements traditional health services.</td>
<td>Since October 2014 personal health budgets have been offered to all patients in receipt of continuing health care in line with national guidance. To date, six patients have taken up a personal health budget. Personal health budgets are being extended to people in hostels, people with long term conditions and people supported by the Better Care programme.</td>
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| 15 That sometimes health professionals are better equipped to manage your physical health than your mental health. And sometimes when you are in receipt of mental health services, you feel your physical health is neglected. | We are embedding support for individuals’ mental health into physical health services e.g. having mental health nurses in integrated primary care teams that support the housebound, by incorporating the provision of psychological support into new contracts for physical health services and by providing integrated care through the multi-disciplinary teams under the Better Care programme.  

The Sussex Partnership Foundation Trust has developed a physical health strategy which includes greater provision of physical health screening for conditions such as diabetes and hyper tension and greater communication with patients GPs regarding their physical health.  

See also 9, above. |
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| 16 You prefer to be treated in the community rather than in hospital and you want alternatives to A&E to be available when you experience a crisis in your mental health. | Additional investment has been made in community services. This funding has been used to:  
- Increase the number of care co-ordinators.  
- Enhance the Crisis Resolution and Home Treatment Team.  
- Expand the capacity and increase the hours of the mental health rapid response service.  
- Increase the provision of psychology capacity for people with psychosis.  
- Expand the capacity of the Lighthouse Service that supports people with personality disorder.  
- Put in place additional posts to support people when they are discharged from the acute mental health hospital to community services. |
| 17 That leaving hospital after a mental ill health episode is sometimes daunting and frightening and you don’t always feel properly supported when you return home. | Two additional nurses have been appointed to the assessment and treatment service and it is their role to support people who are being discharged from the acute hospital to community based services. Specifically they will be supporting people to make the transition and working closely with patients to support them to remain in community services.  

Additional psychology posts in the Crisis Resolution and Home Treatment Team and at Millview hospital are also working with community teams to help patients to be cared for in community settings. |
| 18 Young people need help as soon as a problem is identified and need support within their families. | E-Motion online counselling has been established with YMCA and Impact Initiatives. Through the Transformation Fund, the CCG is able to sustain this service recurrently.  

Public Health, Tier 3 CAMHS, Tier 2 CAMHS and voluntary sector have been working together to develop up-to-date information that can be added to websites and clearer, more consistent information to be more readily available for children and young people and parents/families available online. This is likely to be funded and developed through the Transformation Fund.  

The CCG re-launched its website and this now includes children’s mental health and wellbeing pages. This also involved a re-launch of the current pathway aimed at referrers and users. |
The Early Help hub was established in September. It has many functions, but also includes early advice and information to professionals, that ultimately can be passed on to children, young people and families as well as used in their treatment. The team should have evaluation and first data available in 2015. Information packs for children and young people and their families are being made available within each service area.

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| 19 Young people have told us they are worried about the increase in self-harm in the city. | The CCG has commissioned a mental health liaison team within The Royal Alex Children’s Hospital (RACH) that will provide support to those who attend and/or are admitted with mental health crises including self-harm, those who need support in discharge and also support to staff at RACH. The aim is for this to include out of hours support. This will be launched in November 2015. In youth settings:  
  • Right Here have developed and delivered a series of four emotional health and wellbeing workshops across a variety of youth settings.  
  • There has been increased distribution of self-harm leaflets. The self-harm working group for the Suicide Prevention Strategy has set priorities and work on reducing self-harming behaviour. In addition to the actions listed above, further priorities are:  
  • To address the demand of young people attending A&E, particularly for self-harm, to implement a mental health liaison team at RACH.  
  • Understand the need and gap in Primary Care knowledge around self-harm through Protected Learning Scheme days and Needs Assessments.  
  • Explore further use of Safety Plans held by individuals, such as the one used by Grassroots. |
| 20 Young people who had accessed CAMHS services said that they would have valued more sessions and that there was the need for greater information about | A whole system review parallel to the JSNA has started and should report in November 2015. Some service improvements may be possible within that year but it is anticipated that most changes will happen in 2016/17 as part of the Transformation Plan. Children and young people have contributed to this review through the various forums and consultation and engagement events. National examples of good practice models have been used to inform this work, as referred to in *Future in Mind* (Department of Health, March 2015). The CCG is developing a local Transformation Plan in accordance with the recommendations in Future in Mind. The JSNA for children and young people’s mental health & wellbeing will also inform the process and children and young people will |
| services. They also asked for some changes within services, for example, professional attitudes to young people were at times felt to be patronising. | be able to contribute to this.
Feedback from service users in touch with MIND, AMAZE, the Right Here Project, schools and Healthwatch will inform the JSNA and whole system review, and ensure children and young people’s views are taken into account. |
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<td><strong>You told us</strong></td>
<td><strong>In the first year:</strong></td>
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| **21** That the transition from being supported by CAMHS to being supported by services for adults can be difficult to navigate and more support is needed to help young people whilst they make this transition. | MIND has reviewed transition as part of their consultation programme with children and young people.
Learning from the SEND review and implementation plan has been incorporated into plans for services up to 25 years old.
As above, the whole system review and JSNA for children and young people’s mental health & wellbeing will inform the model or pathway with regards transition stages and transition to adult services.
Feedback from users (MIND, AMAZE, Right Here Project, schools, Healthwatch etc.) will inform any model or pathway developed for transition.
Our plans build on the Transition Policy developed by SPFT CAMHS services and include how this can be improved and implemented with Adult services. They also reflect the national service specification on Transition and whole system review outcomes. The CCG is considering how to commission an all ages Wellbeing Service in 2017 and intends to commission an all ages eating disorder service in 2016.
The Child Sexual Abuse therapeutic service commenced in January 2015 and will need to link to the future development of a complex trauma pathway which will be 14 years upwards.
We will respond to key recommendations in Adult Social Care scrutiny report that are relevant to transition, to CAMHS and to children and young people’s mental health and wellbeing. |
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<tr>
<th>Aims of the strategy</th>
<th>What we will do from September 2015</th>
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| 1 Support people to develop their resilience; promote the Five Ways to mental wellbeing. | Continue the mental wellbeing innovation fund:  
• Evaluate the 61 first year projects in the spring of 2016 and circulate the summary report.  
• Launch the second round of funding in October 2015 and confirm awards by Christmas 2015. The theme for 2016 will be promoting social connections and addressing loneliness.  
Continue to work with local voluntary and community organisations to provide and publicise opportunities for Five Ways activities (Connect, Be active, Keep Learning, Take notice, Give):  
• Celebrate mental health calendar events: World Mental Health Day, Time to Talk day and Mental Health Awareness week.  
• Promote positive mental health especially for vulnerable groups in the city and in more deprived communities, through commissioning by both the Council and CCG.  
• Increase opportunities for older people to access activities and groups through the Locality Hubs.  
• Continue to support the wide range of community and voluntary groups and activities for specific neighbourhoods and communities of interest. |
| 2 Keep mental health and wellbeing high on everyone’s agenda including employers and ensure they are best able to support people. | Develop the Happiness Champions network:  
• Continue to work with this group of leaders to raise awareness of mental health issues among the public.  
• Expand the champions’ network into different sectors.  
Time to Change organisational pledges:  
• Both the City Council and the CCG will launch their pledges to Time to Change during 2015/16.  
• Both organisations will implement their action plans during 2016.  
Extend the workplace health offer to more schools and colleges, embedding and expanding work with the Workplace Charter, online assessments and with Health Trainers. |
The public health team plans to commission further training for frontline staff and local organisations on mental health awareness and emotional wellbeing in 2015/16. This training includes mental health at work.

Mind in Brighton & Hove have a specific section on their website to support local employers: [http://www.mind.org.uk/workplace/](http://www.mind.org.uk/workplace/)

### Aims of the strategy

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<th>Aims of the strategy</th>
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| Improve access to information about mental health support. | Continue to update and improve current key websites:  
  - Mind in Brighton & Hove is commissioned to provide comprehensive, up to date information and advice about mental health services and support. This can be accessed in person, on the phone, via email or on their website at: [http://www.mindcharity.co.uk/advice-information](http://www.mindcharity.co.uk/advice-information).  
  - The City Council provides information at mental wellbeing, support and events at: [http://www.brighton-hove.gov.uk/content/health/mental-health-and-wellbeing](http://www.brighton-hove.gov.uk/content/health/mental-health-and-wellbeing).  
  - Develop more consistent online information for children and young people and families or carers seeking help, advice and support for mental health and wellbeing, and harness opportunities on social and digital media. |
| Make it easier to access mental health | Patients supported by the multi-disciplinary teams under the Proactive Care programme will continue to be |
services .. supported by care coaches who will help them access local services – this will include local mental health services and other services that support people with mental health problems. The pilot sites for community navigators will be extended until March 2016 and will be evaluated over the autumn; a decision will be made about future arrangements from April 2016 onwards.

The Brighton and Hove Wellbeing service will continue its programme of supporting people to self-refer into the service and is raising awareness of the service with groups that do not currently access the service. The service is also offering more appointments outside of office hours to enable working patients access it without the need to take time off work.

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<tr>
<td>Make it easier to access mental health services</td>
<td>We will explore how an all ages Wellbeing Service can be developed and further increase access and support to mental health services for children and young people. We will be Increasing the availability of mental health services to people in hostels.</td>
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| Address gaps in services and build capacity in services | The CCG will be putting investment in the following services to increase their capacity:  
  • The perinatal service which supports women with mental health problems during their pregnancy and after the birth of their child.  
  • The neuro-behavioural service which supports people with autism and adults with ADHD and Tourettes.  
  In addition the following new services and pathways will be procured and/or developed during 2015/16/17:  
    • Bereavement support.  
    • Support for people who have survived complex trauma such as domestic and sexual abuse.  
    • Financial advice for people with mental health problems.  
    • Psychological support for people with medically unexplained symptoms.  
    • Psychological support for people whose needs don’t meet the criteria for either primary or secondary mental health services.  
    • Children’s mental health liaison service at RACH.  
    • An all ages community eating disorder service. |
- Crisis support for people with a learning disability.
- The Brighton and Hove Wellbeing Service will be delivering psychological therapies to people in hostels.

The new mental health Locally Commissioned Service will support GP practices in delivering a higher quality service to patients with mental health problems.

This strategy builds on the Public Health Annual Report, 2014/15, in seeking to address inequalities across the city. Public health commissions a programme of mental health promotion services in the most deprived areas. Both public health and the CCG commission support for particularly vulnerable groups such as young people who identify as lesbian, gay, bisexual or transgender, some BME communities, recently discharged prisoners. Public health has issued an invitation to quote for provision of a Men’s Shed project in 2016 to support retired or unemployed men in making and mending.

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<td>6 Create more joined up services that support individual needs; create stronger links between voluntary and statutory services.</td>
<td>The CCG will establish a new diabetes service which incorporates psychological support. NHS ‘extended’ checks are being offered in the most deprived areas of the city. These include screening for depression and advice about mental wellbeing and how to use the Five Ways to Wellbeing to maintain positive mental health. This pilot will be evaluated and the results will inform the future of the scheme. The Health Trainer team is being expanded during 2015-16. In 2015, training on emotional wellbeing was provided for the existing team. During 2016, further training will be provided for the new staff members. The CCG has identified the need to support and strengthen GP practices across the City and reinforce the holistic family care approach. A programme of work (Locally Commissioned Service or LCS) is underway to support collaborative approaches amongst Practices in order to improve health outcomes (including mental health) for children and young people. This will involve closer working relationships across health, Children’s Services, Schools and Public Health and will be a key part of more integrated working in the future.</td>
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<td><strong>We will strengthen the pathway between voluntary and statutory services, for example through training sessions, opportunities for networking and improved web-based information.</strong></td>
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<td><strong>We will explore options for closer integration and joint delivery of services between the IAPT service and the Recovery College.</strong></td>
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<td><strong>7 Where appropriate commission an all ages mental health and wellbeing services, tailored to the individual’s needs and capacity</strong></td>
<td><strong>As part of the transformation plan for children’s mental health and wellbeing services and the re-commissioning of the adult Improving Access to Psychological Therapies (IAPT) service we will consider whether there is scope for commissioning an all ages IAPT service.</strong></td>
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<td><strong>The CCG is currently scoping the development of an all ages eating disorder service.</strong></td>
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<td><strong>8 Transform mental health and wellbeing services for children and young people.</strong></td>
<td><strong>The Needs Assessment (JSNA) for Children and Young People’s mental health and wellbeing will be published. We will use the recommendations to inform the development of the Transformation Plan for children and young people’s mental health and wellbeing services during 2015/16.</strong></td>
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<tr>
<td><strong>Aims of the strategy</strong></td>
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<td><strong>..Transform mental health and wellbeing services for children and young people</strong></td>
<td><strong>The principles of the Transformation Plan are as follows:</strong></td>
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<td>a) Involve children and young people;</td>
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<td>b) Foster resilience across the system;</td>
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<td>c) Prevent deterioration;</td>
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<td>d) Engage children and young people in their care, including personalisation;</td>
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<td>e) Reach out to where children and young people are;</td>
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<td>f) Care for the most vulnerable groups;</td>
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<td>g) Improve access;</td>
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<td>h) Intervene early;</td>
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<td>i) Best start in life;</td>
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<td>Aims of the strategy</td>
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| 9 | Support other key linked strategies | Ensure the Happiness Strategy links to and complements other relevant strategies in the City such as the Joint Health and Wellbeing Strategy, Children’s Strategic Commissioning Strategy, multi-agency Dual Diagnosis Strategy, Proactive Care Programme, Public Health Older People’s Programme and investment in communities & neighbourhoods. Two strategies of particular relevance are:  
1. The public health schools programme. Plans for 2015/16 include:  
   - Delivery of training in 90% of secondary schools to equip frontline staff with strategies and interventions when responding to a young person who is self-harming.  
   - Roll-out of the mind-boosting books project to 80% of primary schools.  
   - Evaluation by Sussex University of the Emotional Health Improvement project at three secondary schools will be completed.  
   - Evaluation of a national pilot at 10 schools to improve links between CAMHS and schools will also be completed.  
   - Social media: a local action plan has been developed and will be implemented; targets and indicators will be monitored.  
2. The suicide and self-harm prevention strategy. Plans for 2015/16 include:  
   - The multi-agency Suicide Prevention Strategy group will be supporting an application for accreditation as a Suicide Safer City, led by Grassroots Suicide Prevention, a local voluntary organisation. This work supports more open conversations about suicidal thoughts, including the Tell Me campaign, and builds on other aspects of local work listed below. |
- Training for frontline staff in suicide and self-harm prevention, including use of safety plans.
- Learning from clinicians’ meetings following a death by suicide; and other learning from local information such as Coroner’s records, including identification of hotspots and clusters.
- Improved support at A&E for people who attend following self-harm.
- Development of online and paper self-help and signposting resources.
- Outreach to men.
- Support for World Suicide Prevention Day on 10 September.
Happiness: Brighton & Hove Mental Health Strategy – Year 1 update and plans for Years 2 & 3.
Introduction

There has been a sea-change recently in our approach to mental wellbeing. Parity of importance between physical health and mental health has become a key aspiration. More people are engaged in the conversations about how to improve mental health, and organisations that might not have seen this as their business in the past are now exploring the impact their work has on positive mental health. Our network of champions in the arts, sport and business reflect this wider commitment and interest. Links between physical health and mental health have been developed. Local schools have reported that emotional wellbeing is one of their top priorities. The mental wellbeing innovation fund has supported over 60 small, innovative projects which provide opportunities for people from many backgrounds and neighbourhoods to put the Five Ways to Wellbeing into practice. Waiting times for talking therapies have reached the targets set. Mental health crisis services have been extended and work with Sussex Police has helped to identify individuals with mental health problems and to offer them better options than custody in a police cell.

More information is available about self-reported wellbeing as well as mental illness across the country, and we can see how we compare. Though Brighton & Hove continues to have higher than average rates of mental ill-health, our self-reported happiness is slowly increasing.

We have made good headway in the first year since our strategy for mental wellbeing in the city was launched in August 2014. The report on our first year describes our progress in detail, against our initial commitments.

There is still a long way to go, and the action plan for Years 2 and 3 sets out our priorities for the near future. There is new funding to support vulnerable groups, including people who have been bereaved and people who have suffered trauma such as torture or abuse. A second round of the innovation fund will target social isolation. There is also a commitment to new treatment services, including more psychological support and crisis support for people with a learning disability as well a mental health problem. A major review of children's mental health services is underway with the aim of improving options for children and young people, and easing the transition into adult services. All of this work builds on the Annual Report of the Director of Public Health 2014/15, addressing the inequalities that arise from, and are caused by, mental health problems, and acknowledging the need for support for vulnerable groups.

Mental and physical wellbeing are intertwined; there really can be no health without mental health.

Paula Murray, Assistant Chief Executive
Brighton & Hove City Council

Dr Christa Beesley, Accountable Officer
Brighton & Hove Clinical Commissioning Group
Progress with the first year action plan August 2014 to August 2015

You told us
The Five Ways to Wellbeing work well and are effective for you.
You would like more information about how to put the Five Ways into practice – Connect, Keep learning, Be active, Take notice and Give.

What we did in the first year
Both the City Council and CCG launched webpages in 2014/15 with information about the Five Ways, and about mental wellbeing. The Council’s webpages include short films by City College students to illustrate how they work for local people. The City Council provides information about mental wellbeing, support and events at: www.brighton-hove.gov.uk/content/health/mental-health-and-wellbeing. The CCG also provides information about mental wellbeing at: www.brightonandhoveccg.nhs.uk/your-health/mental-health-and-wellbeing as well as mental health services at: www.brightonandhoveccg.nhs.uk/your-local-services/mental-health-services.

A Five Ways to Wellbeing leaflet has been developed, designed and distributed to primary care (GP surgeries and pharmacies).

The My Life webpages provide more information about local services at www.mylifebh.org.uk/health-services/mental-health-services/, as well as information about specific conditions including depression, eating disorders and anxiety: www.mylifebh.org.uk/health-conditions. Information about children and young people’s mental health is included at: www.mylifebh.org.uk/health-services/childrens-services/.

Already in place:
Mind in Brighton & Hove is commissioned to provide comprehensive, up to date information and advice about mental health services and support. This can be accessed in person, on the phone, via email or on their website at: www.mindcharity.co.uk/advice-information.

Other useful websites include It’s Local Actually www.theonline.org.or.uk/service/out-and-about/its-local-actually which gives information about different types of activity with range of any location in the city. www.wheretogofor.co.uk provides information for young people.
What we did in the first year
The mental wellbeing innovation fund was launched in October 2014. It offered one year’s funding of up to £5,000 for innovative projects linked to the Five Ways, giving priority to projects for people with specific needs for support, such as disabled, unemployed or minority ethnic groups. The themes for the year were: gardening and growing; arts and crafts; workplace initiatives; children and young people.

112 applications were received, and 61 projects were funded. The Fund total for 2015 was £261,000; £125,000 was sourced from a national underspend at Public Health England. Matched funding with a total value of £238,340 was provided.

Guidance on evaluation using the Shorter Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) was sent out to all project leads; projects have a deadline for final reports at 31 January 2016.

Already in place:
Small projects that aim to reduce isolation and address mental wellbeing, among other outcomes, are also funded through the Community Health Fund and the Healthy Neighbourhood Fund.

Progress with the first year action plan August 2014 to August 2015

You told us
You want more opportunities to build your own mental wellbeing. You feel that sometimes it is easier to access services that are targeted at people like you.

What we did in the first year
A high profile network of Happiness Champions has been established, to promote awareness of mental health and wellbeing within their professional roles.

There are nine members currently:
- Annie Alexander, lead for Public Health Older People’s programme, City Council
- Vic Borrill, Director, Brighton & Hove Food Partnership
- Andrew Comben, CEO, Brighton Dome and Brighton Festival
- Darren Emilianos, GP at Woodingdean Medical Centre
- Becky Jarvis, GP at St Peters Medical Centre and also Clinical Lead for Mental Health at the CCG
- Tony Mernagh, Brighton Business Forum
- Dave Padwick/Jo Grantham, Chief Inspectors for Brighton & Hove, Sussex Police
- Tom Scanlon, Director of Public Health, City Council
- Liz Whitehead, Co-Director, Fabrica

Two meetings with all the champions have been held. Achievements to date include: an evening event for local employers; events at the Brighton Festival which highlight mental health issues; a major evaluation of the impact of community gardens on mental wellbeing; sharing of Police data on suicides with Public Health to identify high risk locations, and a joint approach with the CCG to arrests and safe custody to identify individuals with mental health needs.

Health Trainers and Healthwalk leaders also have a key role in promoting understanding of mental wellbeing. Last year, the Royal Society of Public Health Understanding Emotional Wellbeing course was delivered to the Health Trainers team and Healthwalks manager, to help them hone their skills in this aspect of their work.

You told us
You want to keep mental health and wellbeing high on everyone’s agenda.
**What we did in the first year**
The CCG has implemented a staff wellbeing programme which to date has included the availability of yoga classes and mindfulness in the office and a lunch time visit from MIND as part of the Time to talk programme.

The Council has offered both physical activity (Reaching Rio) and cultural activities (64 Million Artists) to staff in 2014/15. Through the Wave (the internal staff website), staff are also regularly alerted to mental health events and to opportunities to meet others, volunteer, join courses or be active. Feedback from the staff survey has been widely disseminated and acted on.

The Public Health Schools Programme has worked with schools to promote the health and emotional wellbeing of all staff. So far:

- 48 schools have expressed interest in an online health and wellbeing assessment and 17 have completed these.
- 4 schools have participated in a programme of health and wellbeing checks provided by health trainers, with support to access further health support or 6 week behaviour change sessions.
- 2 schools have begun work on the Workplace Wellbeing Charter.

**You told us**

That it is really important for employers to take the mental health and wellbeing of their staff seriously.

**What we did in the first year**
The Council and CCG have both committed to signing organisational pledges to the Time to Change campaign, and will be submitting action plans in 2015/16.

Mental health calendar events such as World Mental Health Day, Mental Health Awareness Week and Time to Talk Day provide opportunities to communicate widely about mental health and wellbeing. We want to promote the message that mental health and wellbeing are important to us all, and that mental health problems are common.

World Mental Health Day in October 2014 was supported by a programme of debates and events organised by The Basement.

In addition, a public event at The Level was organised by Mind, offering information, advice and activities.

Mental Health Awareness week falls in the second week of May, when the Festival is running. Andrew Comben, one of our Happiness Champions, took the opportunity to discuss mental health and the arts on Radio Sussex. Time to Talk day was promoted and supported by Mind in Brighton & Hove.

The SICK! Festival, in March 2015, focussed on themes of suicide, abuse and ageing, using film, debate, theatre, comedy and performance. The Basement, who organise the festival, aim to challenge stereotypes and promote debate about mental health.
What we did in the first year

The new My Life website provides information about the range of opportunities to support people with specific conditions as well as local services. The CCG and BHCC websites also provide lots of information about support options and online help.

As part of the Age Friendly City and Older People’s Public Health programme:
- Two consultation forums for older people meet regularly.
- Befriending services are now available across the city.
- 26 organisations have worked together to find solutions around transport and older people.
- Nine specific actions to support older people have been included in the new housing strategy.
- Locality hubs facilitate access to a wide range of activities: over 1000 activities are available citywide for older people.
- Fabrica’s Growing an Older Audience programme provided 1000 events, projects and courses.
- 30 new projects for older people were funded by the Healthy Neighbourhood Fund.

Healthy living pharmacies promote the Five Ways to Wellbeing and can signpost to mental health advice, support and services; libraries promote Books on Prescription.

You told us

You want help in finding the right opportunities and support for your particular circumstances, especially if you have translation needs, if you don’t have easy online access or if you feel isolated particularly as a result of older age.

You see the link between financial stability and mental wellbeing and feel it is important that more people can access financial and benefits advice.

What we did in the first year

A procurement exercise commenced in August to secure additional financial advice for people with mental ill health.

MoneyWorks was launched in the autumn of 2014 as planned. It provides a one stop shop for advice on managing money, debt and benefits for anyone struggling to make ends meet: www.advicebrighton-hove.org.uk/moneyworks/

The Citizens Advice Bureau provides advice about managing money in five GP surgeries.
What we did in the first year
Community navigators have been piloted in 16 GP practices. Community navigators are supporting patients to access services, helping patients to refer themselves and where necessary accompanying patients to initial appointments. The pilot has been extended until March 2016 and a decision will be made shortly about what will happen once the pilot has ended.

Residents in Brighton & Hove’s most deprived quintile postcodes are offered an extended NHS health check which includes screening for depression and advice on positive mental wellbeing, including the Five Ways.

Specialist mental health triage is part of the new Referral Management Service – this was trialled with the previous provider and will be key to ensuring that people are referred to the right service the first time.

You told us
You feel that GPs are essential to care being provided in the community, but you understand that it is not possible for them to know about all the different support options that could be available to help you.

What we did in the first year
The Better Care Programme is progressing and multi-disciplinary teams have been piloted in two GP practices. This approach is being extended to further GP practices, enabling more people to receive more integrated care.

You told us
You want a more joined up approach from health, social care and voluntary services.

What we did in the first year
New contracts are in place with BSUH for dermatology and with BICS for the musculoskeletal service and both services include the provision of psychology support.

There are now two mental health nurses, based in the integrated primary care teams supporting the mental health needs of individuals who are housebound.

The dual diagnosis strategy has established much closer coordination between services for substance misuse and mental illness, and is aiming for sharing of records, co-location of teams and shared assessment tools.
Progress with the first year action plan August 2014 to August 2015

You told us
You value services which support you as a whole person, responding to your specific needs.

What we did in the first year
Gaps in commissioning identified through a review of No Health Without Mental Health have been addressed in the new services referred to throughout this report.

The CCG is commissioning additional support for people who are bereaved. It is also commissioning additional financial advice for people who have mental ill health.

The re-tender of Public Mental Health Contracts provided for two new vulnerable groups needing support – the transgender community (the local needs assessment identifies high level of distress and mental ill health); and vulnerable men (the city has a high suicide rate and men are particularly at risk).

A Joint Needs Assessment (JSNA) for children and young people (0–25 years) for mental health and wellbeing will conclude at the end of 2015 and will identify young people with specific needs that will be addressed within an action plan.

You told us
You would like us to ensure there is training available for frontline staff across health, social care and the community and voluntary sector.

This training should raise awareness of mental health issues and enable professionals to treat you with more dignity and respect.

What we did in the first year
Grassroots training programme continues to provide a range of courses for frontline staff working with groups at higher risk of mental ill health, including people who are living in deprivation, homeless or insecurely housed, care leavers, bereaved, military veterans, victims of abuse, offenders, are physically unwell, misuse alcohol or substances, have learning disabilities, are new parents, lesbian, gay or bisexual, identify as transgender or who are from some BME groups. This training includes suicide and self-harm awareness. Further training on mental health awareness or mental health first aid is being commissioned in 2015/16.

All secondary schools have received basic awareness-raising training about self-harm from the Community Child and Adolescent Mental Health Services (CAMHS) team. As a follow-on, Public Health has commissioned a training package: Self-harm: strategies and interventions for school staff responding to self-harm. This will be available to school staff and school nurses from September 2015. During May and June 2015, six focus groups were conducted with local young people and parents/carers affected by young people’s self-harm, to ensure the training is based on real life experiences and meets the needs of local families.

Seminars for GPs and practice nurses on a range of mental health issues are provided by Sussex Partnership NHS Foundation Trust, and practices have been required to attend these if they participate in the Severe Mental Illness Local Enhanced Service (SMILES). This requirement is also likely to be built into the revised version of the service, the Mental Health Locally Commissioned Service.
You told us
Schools and colleges have expressed concern about the mental wellbeing of children and young people.
They have said they are finding it difficult to access services for the increasing numbers of young people needing support – the threshold for services means the needs of their young people have to escalate to get a service.

There has been a reduction in support directly available on school sites for young people.

There are young people presenting with anxiety problems, sleeplessness, exam stress, anger management, self-harm, behavioural problems and peer bullying. There are also young people who are living with low level mental health issues within the family that impact on parenting but do not meet the thresholds for adult services.

What we did in the first year
The CCG is now responsible for commissioning children and young people’s mental wellbeing services and CAMHS (as of 1 October 2014). A whole system review and JSNA have started with publication in the winter 2015/16. The review will include the provision in schools and colleges and the rest of the system.

The review will consider the roles and responsibilities of Tier 2 Community CAMHS teams with regards to support in schools. A pilot to develop a whole school approach to mental health and emotional wellbeing is now confirmed with three secondary schools, starting in September 2015.

During 2014/15, the Public Health Schools Programme worked with all the secondary schools to develop a whole school approach to self-harm. Different schools tried different aspects to enable us to test approaches.

In primary schools:
- Public Health and the School Travel Team worked with 20 schools to adapt their assembly to incorporate the Five Ways message.
- Public Health and Libraries have produced a mood boosting books resource for children. Three focus groups were completed, asking children to share their favourite mood-boosting books and to lead an activity asking other pupils in the schools. Special educational needs coordinators were consulted to establish priority issues in each school, and booklists have been agreed, chosen by pupils and categorised according to issues (e.g. friendship). These will be made available to schools in 2015/16.

In secondary schools:
- A PHSE curriculum framework for Emotional Health and Wellbeing has been developed, and supported by training for all secondary and special schools.
- CAMHS have delivered self-harm basic awareness training to 9 of 10 secondary schools in the city. 90% of secondary schools have signed up to attend the follow-on course (see 11, above) to equip frontline staff with strategies and interventions when responding to self-harming behaviour.
Progress with the first year action plan August 2014 to August 2015

Support for families:
• At three schools, CAMHS and the school nurse have offered on-site support groups for parents/carers of children affected by self-harm on a half-termly basis.
• At one school, self-harm workshops have been delivered to parents at evening sessions.
• Right Here have developed a film ‘Self-harm & Young People: a Guide for Parents & Carers’ to inform and reassure parents, carers and anyone who may be concerned about a young person who is self-harming.

www.youtube.com/watch?v=T-7hms54sF8

Group work:
• At one school, the Music Hub has delivered a 10 week course ‘building resilience’ for young people identified by the school as emotionally vulnerable.
• Right Here at YMCA Downslink have planned and developed a series of peer led emotional health workshops.

Additional support:
• Children’s services and Public Health have jointly commissioned additional primary mental health support in three secondary schools. In addition, they have secured a national pilot to increase links and understanding between schools and CAMHS at the three secondary schools and 7 primaries.
• A think tank event on the impact of social media on young people has been completed and the summary report identifies actions to address emotional wellbeing as a key priority.
• Six innovation fund projects are based in schools.

You told us
You would like increased access to counselling, talking therapies and mindfulness.

What we did in the first year
The Wellbeing Service has cleared the historic waiting list that it inherited for talking therapies including mindfulness based CBT; the service is now able to offer initial appointments in line with national standards for access times. It has also adapted the service so there are more appointment slots outside of core hours at a wider range of venues. In addition, the process supporting self-referral has been improved.

Five innovation fund projects involve provision of mindfulness, for carers and for frontline staff.
What we did in the first year
Since October 2014 personal health budgets have been offered to all patients in receipt of continuing health care in line with national guidance. To date, eight patients have taken up a personal health budget. Personal health budgets are being extended to people in hostels, people with long term conditions and people supported by the Better Care programme.

You told us
You want to be able to choose treatment and support that complements traditional health services.

What we did in the first year
We are embedding support for individuals’ mental health into physical health services e.g. having mental health nurses in integrated primary care teams that support the housebound, by incorporating the provision of psychological support into new contracts for physical health services and by providing integrated care through the multi-disciplinary teams under the Better Care programme.

The Sussex Partnership Foundation Trust has developed a physical health strategy which includes greater provision of physical health screening for conditions such as diabetes and hypertension and greater communication with patients’ GPs regarding their physical health.

See also 9, above.

You told us
That sometimes health professionals are better equipped to manage your physical health than your mental health. And sometimes when you are in receipt of mental health services, you feel your physical health is neglected.

What we did in the first year
We are embedding support for individuals’ mental health into physical health services e.g. having mental health nurses in integrated primary care teams that support the

You told us
You prefer to be treated in the community rather than in hospital and you want alternatives to A&E to be available when you experience a crisis in your mental health.

What we did in the first year
Additional investment has been made in community services. This funding has been used to:

- Enhance the Crisis Resolution and Home Treatment Team.
- Expand the capacity and increase the hours of the mental health rapid response service.
- Increase the provision of psychology for people with psychosis.
- Expand the capacity of the Lighthouse Service that supports people with a personality disorder.
- Put in place additional posts to support people when they are discharged from the acute mental health hospital to community services.
Progress with the first year action plan August 2014 to August 2015

You told us
That leaving hospital after a mental ill health episode is sometimes daunting and frightening and you don’t always feel properly supported when you return home.

What we did in the first year
Two additional nurses have been appointed to the assessment and treatment service and it is their role to support people who are being discharged from the acute hospital to community based services. Specifically they will be supporting people to make the transition and working closely with patients to support them to remain in community services.

Additional psychology posts in the Crisis Resolution and Home Treatment Team and at Millview hospital are also working with community teams to help patients to be cared for in community settings.

You told us
Young people need help as soon as a problem is identified and need support within their families.

What we did in the first year
E-Motion online counselling has been established with YMCA and Impact Initiatives. Through the Transformation Fund, the CCG is able to sustain this service recurrently.

Public Health, Tier 3 CAMHS, Tier 2 CAMHS and voluntary sector have been working together to develop up-to-date information that can be added to websites and clearer, more consistent information to be more readily available for children and young people and parents and families online. This is likely to be funded and developed through the Transformation Fund.

The CCG re-launched its website and this now includes children’s mental health and wellbeing pages. This also involved a re-launch of the current pathway aimed at referrers and users.

The Early Help hub was established in September. It has many functions, but also includes early advice and information to professionals, that ultimately can be passed on to children, young people and families as well as used in their treatment. The team should have evaluation and first data available in 2015. Information packs for children and young people and their families are being made available within each service area.
Progress with the first year action plan August 2014 to August 2015

**You told us**
Young people have told us they are worried about the increase in self-harm in the city.

**What we did in the first year**
The CCG has commissioned a mental health liaison team within The Royal Alex Children’s Hospital (RACH) that will provide support to those who attend and/or are admitted with mental health crises including self-harm, those who need support in discharge and also support to staff at RACH. The aim is for this to include out of hours support. This will be launched in November 2015.

In youth settings:
- Right Here have developed and delivered a series of four emotional health and wellbeing workshops across a variety of youth settings.
- There has been increased distribution of self-harm leaflets.

The self-harm working group for the Suicide Prevention Strategy has set priorities for work on reducing self-harming behaviour. In addition to the actions listed above, further priorities are:
- Assess options for the introduction of brief interventions in A&E for adults and children
- Understand the impact of social media on self-harm
- Understand the need and gap in Primary Care knowledge around self-harm through Protected Learning Scheme days and Needs Assessments.
- Explore further use of Safety Plans held by individuals, such as the one used by Grassroots Suicide Prevention.

You told us
Young people who had accessed CAMHS services said that they would have valued more sessions and that there was the need for greater information about services. They also asked for some changes within services, for example, professional attitudes to young people were at times felt to be patronising.

What we did in the first year
A whole system review parallel to the JSNA has started and should report in November 2015. Some service improvements may be possible within that year but it is anticipated that most changes will happen in 2016/17 as part of the Transformation Plan. Children and young people have contributed to this review through the various forums and consultation and engagement events.

National examples of good practice models have been used to inform this work, as referred to in Future in Mind (Department of Health, March 2015). The CCG is developing a local Transformation Plan in accordance with the recommendations in Future in Mind.

The JSNA for children and young people’s mental health & wellbeing will also inform the process and children and young people will be able to contribute to this.

Feedback from service users in touch with MIND, AMAZE, the Right Here Project, schools and Healthwatch will inform the JSNA and whole system review, and ensure children and young people’s views are taken into account.
Progress with the first year action plan August 2014 to August 2015

You told us
That the transition from being supported by CAMHS to being supported by services for adults can be difficult to navigate and more support is needed to help young people whilst they make this transition.

What we did in the first year
MIND has reviewed transition as part of their consultation programme with children and young people.

Learning from the SEND review and implementation plan has been incorporated into plans for services up to 25 years old.

As above, the whole system review and JSNA for children and young people’s mental health & wellbeing will inform the model or pathway with regards transition stages and transition to adult services.

Feedback from users (MIND, AMAZE, Right Here Project, schools, Healthwatch etc.) will inform any model or pathway developed for transition.

Our plans build on the Transition Policy developed by SPFT CAMHS services and include how this can be improved and implemented with Adult services. They also reflect the national service specification on Transition and whole system review outcomes. The CCG is considering how to commission an all ages Wellbeing Service in 2017 and intends to commission an all ages eating disorder service in 2016.

The Child Sexual Abuse therapeutic service commenced in January 2015 and will need to link to the future development of a complex trauma pathway which will be for people aged 14 years upwards.

We will respond to key recommendations in the Adult Social Care scrutiny report that are relevant to transition, to CAMHS and to children and young people’s mental health and wellbeing.
### Action plan for years 2 and 3:  
**Sept 2015 – Sept 2017**

<table>
<thead>
<tr>
<th>Aims of the strategy</th>
<th>What we will do from September 2015</th>
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</table>
| Keep mental health and wellbeing high on everyone’s agenda including employers and ensure they are best able to support people. | **Happiness champions:**  
- Continue to work with this group of leaders in their fields to raise awareness of mental health issues.  
- Expand the champions’ network into different sectors.  

**Time to Change organisational pledges:**  
- Both the City Council and the CCG will launch their pledges to Time to Change during 2015/16.  
- Both organisations will implement their action plans during 2016.  

**Workplace mental health:**  
Extend the workplace health offer to more schools and colleges, embedding and expanding work with the Workplace Charter, online assessments and with Health Trainers.  

The Public Health team plans to commission further training for frontline staff and local organisations on mental health awareness and emotional wellbeing in 2015/16. This training includes mental health at work.  

Mind in Brighton & Hove have a specific section on their website to support local employers: [www.mind.org.uk/workplace](http://www.mind.org.uk/workplace) |
| Support people to develop their resilience; promote the Five Ways to mental wellbeing. | **Continue the Mental Wellbeing Innovation Fund:**  
- Evaluate the 61 first year projects in the spring of 2016 and circulate the summary report.  
- Launch the second round of funding in October 2015 and confirm awards by Christmas 2015. The theme for 2016 will be promoting social connections and addressing loneliness.  

**Continue to work with local voluntary and community organisations to provide and publicise opportunities for Five Ways activities (Connect, Be active, Keep Learning, Take notice, Give):**  
- Celebrate mental health calendar events: World Mental Health Day, Time to Talk day and Mental Health Awareness week.  
- Promote positive mental health especially for vulnerable groups in the city and in more deprived communities, through commissioning by both the Council and CCG.  
- Increase opportunities for older people to access activities and groups through the Locality Hubs and stay connected with their communities. |
### Action plan for years 2 and 3: Sept 2015 – Sept 2017

<table>
<thead>
<tr>
<th>Aims of the strategy</th>
<th>What we will do from September 2015</th>
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<tbody>
<tr>
<td>Improve access to information about mental health support.</td>
<td>Continue to update and improve current key websites:</td>
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<td></td>
<td>• Mind in Brighton &amp; Hove is commissioned to provide comprehensive, up to date information and advice about mental health services and support. This can be accessed in person, on the phone, via email or on their website at: <a href="http://www.mindcharity.co.uk/advice-information">www.mindcharity.co.uk/advice-information</a>.</td>
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<td>• The City Council provides information about mental wellbeing support and events at: <a href="http://www.brighton-hove.gov.uk/content/health/mental-health-and-wellbeing">www.brighton-hove.gov.uk/content/health/mental-health-and-wellbeing</a>.</td>
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<td>• The My Life webpages provide more information about local services at <a href="http://www.mylifebh.org.uk/health-services/mental-health-services/">www.mylifebh.org.uk/health-services/mental-health-services/</a>, as well as information about specific conditions including depression, eating disorders and anxiety <a href="http://www.mylifebh.org.uk/health-conditions">www.mylifebh.org.uk/health-conditions</a>. Information about children and young people’s services is at: <a href="http://www.mylifebh.org.uk/health-services/childrens-services">www.mylifebh.org.uk/health-services/childrens-services</a>.</td>
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<td>Develop more consistent online information for children and young people and families or carers seeking help, advice and support for mental health and wellbeing, and harness opportunities on social and digital media.</td>
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<tr>
<td>Aims of the strategy</td>
<td>What we will do from September 2015</td>
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| Make it easier to access mental health services. | Patients supported by the multi-disciplinary teams under the Proactive Care programme will continue to be supported by care coaches who will help them access local services – this will include local mental health services and other services that support people with mental health problems. The pilot sites for community navigators will be extended until March 2016 and will be evaluated over the autumn; a decision will be made about future arrangements from April 2016 onwards.  

The Brighton and Hove Wellbeing service will continue its programme of supporting people to self-refer into the service and is raising awareness of the service with groups that do not currently access the service. The service is also offering more appointments outside of office hours to enable working patients to access it without the need to take time off work.  

We will explore how an all ages Wellbeing Service can be developed and further increase access and support to mental health services for children and young people.  

We will be increasing the availability of mental health services to people in hostels. |
### Aims of the strategy

<table>
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<tr>
<th>Address gaps in services and build capacity in services.</th>
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### What we will do from September 2015

The CCG will be putting investment into the following services to increase their capacity:

- The perinatal service which supports women with mental health problems during their pregnancy and after the birth of their child.
- The neuro-behavioural service which supports people with autism and adults with ADHD and Tourettes.

In addition the following new services and pathways will be procured and/or developed during 2015/16/17:

- Bereavement support.
- Support for people who have survived complex trauma such as domestic and sexual abuse.
- Financial advice for people with mental health problems.
- Psychological support for people with medically unexplained symptoms.
- Psychological support for people whose needs don’t meet the criteria for either primary or secondary mental health services.
- Children’s mental health liaison service at RACH.
- An all ages community eating disorder service.
- Crisis support for people with a learning disability.
- The Brighton and Hove Wellbeing Service will be delivering psychological therapies to people in hostels.

The new mental health Locally Commissioned Service will support GP practices in delivering a higher quality service to patients with mental health problems.

This strategy builds on the Public Health Annual Report, 2014/15, in seeking to address inequalities across the city. Public Health commissions a programme of mental health promotion services in the most deprived areas. Both Public Health and the CCG commission support for particularly vulnerable groups such as young people who identify as lesbian, gay, bisexual or transgender, some BME communities and, recently discharged prisoners. Public Health has issued an invitation to quote for provision of a Men’s Shed project in 2016 to support retired or unemployed men in making and mending.
<table>
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<tr>
<th>Aims of the strategy</th>
<th>What we will do from September 2015</th>
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<tr>
<td>Create more joined up services that support individual needs; create stronger links between voluntary and statutory services.</td>
<td>The CCG will establish a new diabetes service which incorporates psychological support.</td>
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<td>NHS ‘extended’ checks are being offered in the most deprived areas of the city. These include screening for depression and advice about mental wellbeing and how to use the Five Ways to Wellbeing to maintain positive mental health. This pilot will be evaluated and the results will inform the future of the scheme.</td>
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<td>The Health Trainer team is being expanded during 2015-16. In 2015, training on emotional wellbeing was provided for the existing team. During 2016, further training will be provided for the new staff members.</td>
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<td></td>
<td>The CCG has identified the need to support and strengthen GP practices across the City and reinforce the holistic family care approach. A programme of work (LocallyCommissioned Services or LCS) is underway to support collaborative approaches amongst Practices in order to improve health outcomes (including mental health) for children and young people. This will involve closer working relationships across health, Children’s Services, Schools and Public Health and will be a key part of more integrated working in the future.</td>
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<td>We will strengthen the pathway between voluntary and statutory services, for example through training sessions, opportunities for networking and improved web-based information.</td>
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<td>We will explore options for closer integration and joint delivery of services between the IAPT service and the Recovery College.</td>
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<tr>
<td>Where appropriate commission all ages mental health and wellbeing services, tailored to the individual’s needs and capacity.</td>
<td>As part of the transformation plan for children’s mental health and wellbeing services and the re-commissioning of the adult Improving Access to Psychological Therapies (IAPT) service, we will consider whether there is scope for commissioning an all ages IAPT service.</td>
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<td></td>
<td>The CCG is currently scoping the development of an all ages eating disorder service.</td>
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</table>
### Aims of the strategy
Transform mental health and wellbeing services for children and young people.

<table>
<thead>
<tr>
<th>What we will do from September 2015</th>
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<tr>
<td><strong>The principles of the Transformation Plan are as follows:</strong></td>
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<tr>
<td>a) Involve children and young people;</td>
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<td>b) Foster resilience across the system;</td>
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<tr>
<td>c) Prevent deterioration;</td>
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<tr>
<td>d) Engage children and young people in their care, including personalisation;</td>
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<td>e) Reach out to where children and young people are;</td>
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<td>f) Care for the most vulnerable groups;</td>
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<td>g) Improve access;</td>
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<td>h) Intervene early;</td>
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<tr>
<td>i) Best start in life;</td>
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<tr>
<td>j) Prepare for adulthood;</td>
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<tr>
<td>k) Build capacity across the system;</td>
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<tr>
<td>l) Collaborative and joint commissioning;</td>
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<td>m) Physical and mental health issues are addressed equally; and</td>
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<tr>
<td>n) Ensure access to services in a crisis especially out of hours.</td>
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</tbody>
</table>
### Aims of the strategy

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<th>Support other key linked strategies.</th>
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### What we will do from September 2015

Ensure the Happiness Strategy links to and complements other relevant strategies in the City such as the Joint Health and Wellbeing Strategy, Children’s Strategic Commissioning Strategy, multi-agency Dual Diagnosis Strategy, Proactive Care Programme, Public Health Older People’s Programme and investment in communities & neighbourhoods.

#### Two strategies of particular relevance are:

1. **The Public Health schools programme.**

   Plans for 2015/16 include:
   - Delivery of training in 90% of secondary schools to equip frontline staff with strategies and interventions when responding to a young person who is self-harming.
   - Roll-out of the mind-boosting books project to 80% of primary schools.
   - Evaluation by Sussex University of the Emotional Health Improvement project at three secondary schools will be completed.
   - Evaluation of a national pilot at 10 schools to improve links between CAMHS and schools will also be completed.
   - Social media: a local action plan has been developed and will be implemented; targets and indicators will be monitored.

2. **The suicide and self-harm prevention strategy.**

   Plans for 2015/16 include:
   - The multi-agency Suicide Prevention Strategy group will be supporting an application for accreditation as a Suicide Safer City, led by Grassroots Suicide Prevention, a local voluntary organisation. This work supports more open conversations about suicidal thoughts, including the Tell Me campaign, and builds on other aspects of local work listed below.
   - Training for frontline staff in suicide and self-harm prevention, including use of safety plans.
   - Learning from clinicians’ meetings following a death by suicide; and other learning from local information such as Coroners’ records, including identification of hotspots and clusters.
   - Improved support at A&E for people who attend following self-harm.
   - Development of online and paper self-help and signposting resources.
   - Outreach to men.
   - Support for World Suicide Prevention Day on 10 September.
Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. **Brighton & Hove Local Health Economy Cold Weather Plan 2015**

1.1. The contents of this paper can be shared with the general public.

1.2. This paper is for the Health & Wellbeing Board meeting on the 20th October 2015.

1.3. Contact Officers:
Name: Kevin Claxton
Tel: 01273 574731 E: kevin.claxton@brighton-hove.gcsx.gov.uk

2. **Summary**

2.1. Each year a plan is drafted that brings together related work streams which form the local response to the national Cold Weather Plan for England.

2.2. The Cold Weather Plan (CWP) for England is a framework intended to protect the population from harm to health from cold weather. It aims to prevent the major avoidable effects on health during periods of cold weather by alerting services and residents to the negative health effects of cold weather, and enabling them to prepare and respond appropriately. The CWP also aims to reduce pressure on the health and social care system during the winter through improved anticipatory actions with vulnerable people.
2.3 The CWP for England is a collaborative plan supported by Public Health England, NHS England, the Local Government Association, the Met Office and the Department of Health.

2.4 The CWP for England recommends a series of steps to reduce the risks to health from cold weather for:
- the NHS, local authorities, social care, and other public agencies
- professionals working with people at risk
- individuals, local communities and voluntary groups.

2.5 The Brighton & Hove Local Health Economy Cold Weather Plan 2015 details the winter planning arrangements to protect the local population from harm to health from cold weather, based on the Cold Weather Plan for England.

2.6 An accompanying paper, ‘Fuel Poverty and Affordable Warmth Strategy for Brighton & Hove’ (to be tabled after the current paper), describes a related work stream that addresses the excess winter deaths and illness related to fuel poverty and cold housing.

3. **Decisions, recommendations and any options**

3.1 That the Health and Wellbeing Board note the contents of this report, the Cold Weather Plan for England and the Brighton & Hove Local Health Economy Cold Weather Plan 2015, attached as Appendix 1.

3.2 That the Health and Wellbeing Board note the ongoing winter planning work streams within the city, as detailed and referenced within the Brighton & Hove Local Health Economy Cold Weather Plan 2015.

4. **Relevant information**

4.1 There is a strong evidence base on the risk to health from cold weather and the effects on health are predictable and mostly preventable. Negative health effects start at relatively moderate outdoor temperatures of around 5-8°C. This means that action to prevent excess winter death and illness should be carried out throughout the winter period.

4.2 Winter weather has a direct effect on the incidence of heart attack, stroke, respiratory disease, flu, falls and injuries and hypothermia. Indirect effects include mental health problems and risk of carbon
monoxide poisoning. Key factors that increase the risk of ill-health from cold include (for full list, see Brighton and Hove LHE Cold Weather Plan 2015):

- Older age: especially those over 75 years old, or those living on their own who are socially isolated
- Chronic and severe illness: including heart and circulatory conditions, asthma, COPD, depression and anxiety, diabetes and arthritis
- Children under the age of five
- Homeless people / rough sleepers

4.3 There are around 25,000 excess winter deaths (EWD) each year in England. Excess winter deaths are the observed total number of deaths in winter (December to March) compared to the average of the number of deaths over the rest of the year. EWD are not just deaths of those who would have died anyway in the next few weeks or months due to illness or old age. There is strong evidence that some of these winter deaths are indeed ‘extra’ and are related to cold temperatures, living in cold homes and infectious diseases such as influenza. Even with climate change, cold related deaths will continue to represent the biggest weather-related cause of mortality.

4.4 Although there are several factors contributing to winter illness and death, simple preventative action could avoid many of the winter deaths, illnesses and injuries. Many of these measures need to be planned and undertaken in advance of cold weather.

4.5 The CWP for England operates a system of cold weather alerts, developed in collaboration with the Met Office. This operates in England from 1 November to 31 March each year. The cold weather alert service comprises five levels (Levels 0-4), from year-round planning, to a major national emergency. Each alert level aims to trigger appropriate actions which are detailed in the plan.

4.6 There are also five key messages that are recommended:

1. All local organisations should consider the CWP for England and satisfy themselves that the suggested actions and cold weather alerts are understood across the system, and that local plans are adapted as appropriate to the local context.
2. NHS and local authority commissioners should satisfy themselves that the distribution of cold weather alerts will reach those that need to take action.

3. NHS and local authority commissioners should satisfy themselves that providers and stakeholders take appropriate action according to the cold weather alert level in place and their professional judgements.

4. Opportunities should be taken for closer partnership working with the Voluntary and Community Sector to help reduce vulnerability and support the planning and response to cold weather.

5. Long-term, year-round planning and commissioning to reduce cold-related harm is considered core business by HWBs and should be included in joint strategic needs assessments and joint health and wellbeing strategies.

5. Important considerations and implications

Legal

5.1 As this report is for noting, there are no significant legal implications to draw to the Board’s attention at this time. Legal Officer Natasha Watson.

Finance

5.2 The resources to deliver against the cold weather plan are funded from service budgets and through partners as required. There is provision for Winter Planning within the Council’s budget. Finance Officer Anne Silley 07/10/15

Equalities

5.3 The vast majority of excess winter deaths in England occur among those aged 65 or over. As in previous years in England and Wales, there were more excess winter deaths in females than in males in 2012-13.

Equalities

5.4 Admissions for chronic obstructive pulmonary disease increase as temperatures fall, particularly in those most socio-economically deprived.
Sustainability

5.5 The aims of the Brighton & Hove Local Health Economy Cold Weather Plan have a significant impact on improvements to the health and wellbeing of some of the city’s most vulnerable residents.

5.6 Action to improve cold homes has the potential to reduce CO2 emissions from the city’s housing, which currently makes up the largest proportion (42%) of the city’s total emissions.

Health, social care, children’s services and public health

5.7 Hospitals and social care commonly face winter pressures. These often result from a high demand for beds and difficulties in discharging patients. This may be compounded by staff shortages due to illness.

5.8 It is estimated that GP visits for respiratory illness increase by up to 19% for every 1°C drop below 5°C of the mean temperature.

5.9 Strategically addressing harm to health from cold weather in Brighton and Hove, particularly in vulnerable groups, will contribute to the reduction of pressure on the health and social care system during the winter; prevention of excess winter deaths, illnesses and injuries; reduction of health and social inequalities and improvement in wellbeing and quality of life in the local population.

6. Supporting documents and information

6.1 Appendix 1 - Brighton and Hove Local Health Economy Cold Weather Plan 2015.
This Cold Weather Plan is the overarching plan for the Local health Economy. It describes work-streams and governance arrangements for multi-agency partners, oversight by the Director Of Public Health, and coordination arrangements led by B&H Health Protection Forum.
Mandatory / Statutory guidance Requirements

- Civil Contingencies Act 2004
- Preparation & Planning for emergencies: roles of responders
- NHS EPRR Framework & associated guidance
  http://www.england.nhs.uk/ourwork/gov/eprr/
  tbc
- Annual seasonal influenza (flu) vaccination programme
- Keep Warm Keep Well - NHS Choices (www.nhs.uk)
  http://www.nhs.uk/Livewell/winterhealth/Pages/KeepWarmKeepWell.aspx
- Excess winter deaths and morbidity and the health risks associated with cold homes
  https://www.nice.org.uk/guidance/ng6

Version Control

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<th>Date</th>
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<td>K Claxton</td>
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Plan Ends
1. Introduction
1.1 In recent previous years there have been significant periods of severe and sustained cold weather. This has highlighted again the need to have effective plans in place to mitigate the effects of cold weather on health.

1.2 Over the last 20 years the average mortality rate has risen by some 18% in the winter months in England. Every year, there are an average of approximately 25,000 more deaths in England between the months of December and March than during the rest of the year. These ‘excess winter deaths’ (EWDs) are almost three times higher in the coldest quarter of housing than in the warmest quarter. Older people (65yrs+), young children and people with pre-existing medical conditions, are most at risk of ill-health from cold weather. In many northern European countries with much colder weather than ours a rise of such magnitude is not observed. Furthermore, many more people present to GPs and hospitals in winter with a range of cold weather-related conditions.

1.3 The EWD Index is excess winter deaths as a percentage increase of the expected deaths based on non-winter deaths. For 2012-13 the EWD Index in Brighton & Hove was 19%, equivalent to 130 Excess Winter Deaths. This is similar to both the South East (18.9%) and England (19.8%) (Brighton & Hove Joint Strategic Needs Assessment, currently being updated)

1.4 The Cold Weather Plan for England 2015 ‘landing page’ is at (to be added when available)

This page contains links to a cover letter, the national plan, a supporting ‘making the case’ document, all action cards for differing types of health providers and (shortly) an abbreviated 4 page summary document.

1.5 The cover letter to the National plan is addressed to Local Authority Chief Executives, Directors of Public Health, NHS E Area Teams and CCG Executives is cc’d to NHS Trust and NHS funded executives, GP’s, Emergency Planning Officers and others. This summarises key changes to the 2016 Plan as follows: (to be added when available).

2. Aim

2.1 The aim of this plan is to set out the procedures and work-streams to be implemented within the Local Health Economy (LHE) of Brighton and Hove in support of the national Cold Weather Plan for England.

3. Objectives

3.1 The objectives of this plan are to:

- To define the partners engaged within the LHE
• To ensure the requirements of the national plan care complied with locally, by clearly stating the work-streams agreed to be relevant and those partners engaged in their delivery.

• To set out the coordination and oversight / assurance arrangements in support of the plan.

• To mitigate as far as possible the impact of cold weather on the community.

4. ‘Level 0’ planning implications and needs for B&H

4.1 The planning implications for the LHE resulting from this year’s National plan and other known circumstances are:

• Strong local leadership and partnership working at all levels across sectors continues to be vital to tackle the range of causes and reduce the number of “excess” deaths that are observed each winter.

• B&H planning arrangements are supporting the importance recognised in the plan of long-term and strategic planning and commissioning to reduce cold-related harm is considered core business by HWBs and joint strategic needs assessments (JSNAs), as evidenced by the inking of these arrangements to the Health Protection Forum and HWB.

• The need to ensure that the action cards are disseminated widely to all City stakeholders as appropriate for:
  - Commissioners & LA
  - GP’s & Practice Staff
  - Community & Voluntary Sector
  - Frontline health & Social Care staff in community & care facilities
  - Provider Organisations
  - Individuals.

• The link to the City’s Vulnerable People plan.

• The Pub health Outcomes Framework includes indicators to reduce excess winter deaths and address fuel poverty.
  - No specific Warm Homes / Healthy People Fund.

• Working with partners to ensure that a strategic approach to the reduction of excess winter deaths (EWDs) and fuel poverty is taken across the local health and social care economy. In particular:
  - To develop a shared understanding of EWDs and what partners can do to reduce them
  - To identify those most at risk from seasonal variations
  - To improve winter resilience of those at risk via a locally agreed and funded program.
To ensure a local, joined-up programme is in place to support improved housing, heating and insulation, including uptake of energy-efficient, low-carbon solutions

To achieve a reduction in carbon emissions and assess the implications of climate change

To consider how winter plans can help to reduce health inequalities, how they might target high-risk groups and address the wider determinants of health

To ensure that organisations and staff are prompted to signpost vulnerable clients onwards (e.g. for energy efficiency measures, benefits or related advice)

To work with partners and staff on risk reduction awareness (e.g. flu vaccination for staff), information and education

To engage with local CVS organisations for planning and implementation of all stages of the plan

5. Cold Weather Alerts

5.1 The plan is implemented via a system of cold weather alerts – linked to the existing winter weather warning system developed by the Met Office ‘National Severe Weather Warning Service’ (NSWWS) – which will trigger appropriate actions up to a major incident. The Cold Watch period runs from 1st November to 31st March annually. The alerts will confirm the current Cold weather level in relation to expected cold weather temperatures and snow and ice warnings.

5.2 Recommended indoor temperatures

<table>
<thead>
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<th>Indoor temperature</th>
<th>Effect</th>
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<tr>
<td>21°C (70°F)</td>
<td>Minimum recommended daytime temperature for rooms occupied during the day</td>
</tr>
<tr>
<td>18°C (65°F)</td>
<td>Minimum recommended night-time temperature for bedrooms. No health risk, though may feel cold</td>
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*Fig 2.1 Indoor room temperatures.*

5.3 The Cold Weather Plan sets out actions at five Cold Weather Alert Levels

The 5 alert levels are shown in Fig. 2.2 below as being:

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<thead>
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<th>Cold Weather Plan Levels</th>
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<td>Long-term planning</td>
<td>Winter preparedness programme</td>
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<td></td>
<td><em>All year</em></td>
<td><em>1 November–31 March</em></td>
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Level 2 | Severe winter weather is forecast – Alert and readiness
Mean temperature of 2°C and/or widespread ice and heavy snow are predicted within 48 hours, with 60% confidence

Level 3 | Response to severe winter weather – Severe weather action
Severe winter weather is now occurring: mean temperature of 2°C or less and/or widespread ice and heavy snow

Level 4 | Major incident – Emergency response
Central Government will declare a Level 4 alert in the event of severe or prolonged cold weather affecting sectors other than health

Fig. 2.2 Cold Weather Plan alert levels

5.4 Definitions (See the national plan for full details).

Cold Weather Alert - An alert for snow and ice will be issued when there is a high likelihood (more than 60%) that there will be snow or widespread ice affecting one or more regions. A level 2 will be issued when this weather is forecast, and a level 3 when the snow and ice is occurring. An NSWWS warning is highly likely to have been issued as well.

Heavy snow – Snow that is expected to fall for at least two hours. Geographic extent is not considered, and sometimes the event can be quite localised.

Widespread ice – Ice forms when rain falls on surfaces at or below zero; or already wet surfaces fall to or below zero. The ice is usually clear and difficult to distinguish from a wet surface. The term “widespread” indicates that icy surfaces will be found extensively over the area defined by the Met Office in the alert.

Cold Weather Plan levels.

Level 0: Long-term planning to reduce harm from cold weather
This emphasises that year-round planning is required to build resilience and reduce the impact of cold weather. This level of alert relates to those longer-term actions that reduce the harm to health of cold weather when it occurs (e.g. housing and energy efficiency measures, and long-term sustainable approaches to influence behaviour change across health and social care professionals, communities and individuals).

Level 1: Winter preparedness and action
Level 1 is in force throughout the winter from 1 November to 31 March and covers the moderate temperatures where the greatest total burden of excess winter death and disease occur. This is because the negative health effects of cold weather start to occur at relatively moderate mean temperatures (5-8°C depending on region) and there are normally many more days at these temperatures each winter.

Level 2: Alert and readiness
Level 2 is triggered when the Met Office forecasts a 60% chance of severe winter weather, in one or more defined geographical areas within 48 hours. Severe winter weather is defined as a mean temperature of 2°C or less and/or heavy snow and widespread ice.
Level 3: Severe weather action
This is triggered as soon as the weather described in level 2 actually happens. It indicates that severe winter weather is now happening and an impact on health services is expected.

Level 4: National emergency
This is reached when cold weather is so severe and/or prolonged that its effects extend outside health and social care, and may include for example power or transport problems, or water shortages, and/or where the integrity of health and social care systems is threatened. At this level, multi-sector response at national and regional levels will be required.

The decision to go to a level 4 is made at national level and will be taken in light of a cross-government assessment of the weather conditions, co-ordinated by the Civil Contingencies Secretariat (Cabinet Office).

5.5 Detailed Arrangements & Action Cards.
Detailed arrangements, requirements and action cards are found in the national plan. Action cards for the key groups, (being Commissioners & LA’s, GP’s & Practice Staff, Community & Voluntary Sector, Frontline health & Social Care staff in community & care facilities, Provider Organisations and Individuals), are also available with the national cold weather plan.

6. Risk of Cold Weather (governance and assurance) at B&H LHE

6.1 The health, social, economic and environmental risks associated with a Severe Cold Weather spell have been assessed by the Sussex Local Resilience Forum (SRF) (Ref H18) and included on the Sussex Community Risk Register. A risk description can be found on the Sussex Local Resilience Forum website at: http://www.sussexemergency.info/media/srf/severe%20weather.pdf

The SRF is also running a ‘Get Ready For Winter’ Workshop in Sussex on the 14th October, and learning will be incorporated into this plan.

6.2 It is the responsibility of the NHS England South (South-East) and for Sussex D’sPH to engage with providers and multi-agency partners via the Local health Resilience Partnership, (LHRP), a body linked to the SRF to assess risks and to ensure plans are in place to protect the communities of Sussex from health-related vulnerabilities.

6.3 The Director of Health for Brighton and Hove ensures that local plans are in place within the B&H LHE, and will ensure that coordination arrangements are in place with NHS &NHS funded providers, and other stakeholders, to ensure that all partners understand their responsibilities and have organisational plans in place in line with the Action cards as set out at Appendix 1. Oversight of these arrangements will be provided by the Brighton and Hove Health Protection Forum, which reports to the Health & Wellbeing Board, in line with the national cold weather plan.
6.4 LHE partners include:
- BHCC (Public Health, Adult Social Care, Children’s Services, Highways, Communications, Housing, Parks, Sea Front and Emergencies & Resilience Team)
- Brighton & Hove CCG (Commissioning Teams / Winter Pressures, Communications)
- NHS England South (South-East) (Primary Care Commissioner)
- Brighton and Sussex University Hospitals Trust (Secondary care Provider)
- Sussex Community Trust (Community Services Provider)
- Sussex Partnership Foundation Trust (Mental Health services provider)
- South East Coast Ambulance (is also the NHS 111 provider).
- IC24 (Out of Hours – OoH - Provider).
- Community Voluntary Services Forum (CVSF)

6.5 LHE planning meetings (coordinated by LA Public Health & the Emergencies and Resilience Team, on behalf of the Health protection Forum), will identify local work-streams which support these arrangements. These are detailed at Paragraph’s 11 and 12

7. Cascading Cold Weather Level Alerts

7.1 The Level will be publicly displayed on the Metrological office website at http://www.metoffice.gov.uk/health/professionals/cold-weather-alerts.

7.2 Other typical arrangements for alerting via email etc. are detailed in the diagram below at Fig.2.5
Figure 2.5 Typical cascade of cold weather alerts

Winter Resilience Network

Civil Contingencies Secretariat Department of Health Other government departments and agencies

Prisons

NHS Choices

Ambulance trusts

Pharmacies

GP\'s and district nurses

Hospital trusts

Walk-in centres

Community health service providers

Mental health trusts

Care and nursing homes

NHS England

Corporate team (National)

Regional teams

Area teams\(^\d\)

Local authority (CE/DASS/DCS/ emergency planner) and directors of public health* Including local resilience forums (and local health resilience partnerships\(^\d\))

Clinical commissioning groups\(^\d\)

Health and wellbeing boards\(^\d\)

Notes:

\(^\d\) NHS England area teams and CCGs should work collaboratively to ensure that between them there is a cascade mechanism for cold weather alerts to all providers of NHS commissioned care both in business as usual hours and the out-of-hours period in their area.

\(^*\) PHE centres would be expected to liaise with directors of public health to offer support, but formal alerting would be expected through usual local authority channels.
8. Local cascade Arrangements within B&H LHE

8.1 Local cascading within the B&H LHE is as per the diagram above except that:
- All cat 1 providers (incl SCT / hospital trusts / SECAmb etc) also receive alerts direct from the Met Office (but these are also by the PH resilience Manager, on behalf of the CCG)
- The NHS England South (South-East) have now confirmed that they are able to cascade to pharmacies, as well as to GP practices.
- BHCC ASC have provided assurance that they would inform ALL B&H care & rest homes.
- The CCG / PH Resilience Manager disseminated alerts to Public Health, CCG staff (on-call managers, agreed primary care staff and Communications), and to IC24 (LHE Out Of Hour’s provider), and to Sussex Partnership Foundation Trust, (SPFT) and to the British Red Cross.

It is therefore confirmed that systems are in place to ensure that all who need to receive cold weather alerts are doing so within the LHE.

9 At-risk groups

9.1 These include examples of sub-categories, as well as living conditions and health conditions which may place people at risk to the potential of their vulnerability in relation to the cold weather. These include the homeless, the elderly, those with long-term illnesses and the disabled, the socially dis-enfranchised, and others.

9.2 It is recognised that the B&H LHE has an old housing stock, with areas where many properties do not conform to modern standards of insulation. The LHE also has areas with large numbers of households falling within the definition of being ‘fuel poor’.

9.3 Full details are found in the Joint Strategic Needs Assessment for Brighton and Hove (currently being updated)

9.4 At risk Groups (as defined by the national plan) are detailed in fig 2.5 below.

| Over 75 years old |
| Frail |
| Pre-existing cardiovascular or respiratory illnesses and other chronic medical conditions |
| Severe mental illness |
| Dementia |
| Learning difficulties |
| Arthritis, limited mobility or otherwise at risk of falls |
| Young children |
| Living in deprived circumstances |
| Living in homes with mould |
| Fuel poor (needing to spend 10% or more of household income on heating home) |
| Elderly people living on their own |
| Homeless or people sleeping rough |
| Other marginalised groups |

*Fig. 2.5 At risk groups*
10 Level 0 Planning & Action card Implementation.

10.1 Action cards for all partner groups are contained at Appendix 1.

10.2 All provider Trusts have provided assurance to the CCG and to the DPH that Trust winter planning arrangements have been updated in line with the 2015 national plan, and latest guidance.

10.3 The DPH and the CCG will ensure that this plan is forwarded to the Brighton & Hove Health Protection Forum, a sub-group of the Health & wellbeing Board with specific responsibility for health protection, for joint sign-off.

10.4 The CCG is working with member GP practices in Brighton Hove to embed the requirements of the action card for GP practices. Previously, the Resilience Manager has attended a Practice Managers Forum. The CCG suggests that practices can create a list of known vulnerable people by commencing with their 'house-bound' and 'palliative care' lists, and this work also features in the developing ‘EPIC’ scheme.

10.4 The CCG has produced a plan which describes its role and that of partners in the local coordination of winter pressures and escalation measures, which are designed to manage local surge arrangements. These are fully documented in the ‘Operational Resilience and Capacity Plan for 2015/16’. (See Appendix 2) which is accompanied by a ‘B&H LHE Operational Contact Rota’.

11 Consolidation of previous work.

11.1 The following work was consolidated into winter planning in B&H during recent year’s winters:
- (Further to the ending of the national WHHP fund from previous years), this work-stream now receives funding from the PH budget, enabling the prevention of EWD’s to be continued as part of these arrangements.
- Enhancing B&H Community Resilience via the commencement of a project lead by Local Area Teams across the City.
- Clarity agreed regarding who a lead on B&H comms messages (as listed in the national CWP but with a local slant). It has been accepted this will be BHCC or CCG comms.
- CCG development of a smartphone ‘app’ which signposts GP’s and others towards a range of available services for use of practices and frontline staff.
- A B&H Vulnerable People Plan has been agreed. This plan defines vulnerabilities which may make people vulnerable, and contains a ‘list of lists’ of agencies who are likely to hold data reading peoples vulnerabilities, and which may assist to contact them during a response or emergency, so that they have be evacuated or otherwise assisted and protected. The plan links to an SRF ‘information sharing protocol’ which has been drafted and is close to being agreed.

12 Winter Planning Group / Areas of City winter planning
A winter planning group has been re-established, and meets as required. This year’s plan has been provided to the partners listed for consultation, emendation and agreement. An update on issues linked to winter preparedness for 15/16 as follows:

12.1 Brighton and Sussex University Hospitals Trust.
Plans have been reviewed at BSUHT, and whilst there is little change to comment on, the Trust has fully participated in the LHE ‘Operational Readiness Capacity Plan’ ‘ORCP’ (see App 2), and has a director in place who manages system capacity of a daily basis. It is recognised that the Trust is often at a higher state of response, but the issues are being actively managed with the support of other organisations.

The Trust will ensure that any changes in procedures requires by the 2015 Cold weather plan are put in place, and is committed to raising staff flu vaccination levels etc. BCP’s are also being updated.

12.2 Sussex Community Trust.
SCT provides out-patient clinics on-site and teams of healthcare staff who deliver frontline community health services to patients in the community, across B&H and in W Sussex. The Trust maintains 130 BCP’s and has 4 4x4 vehicles to deliver its role during severe weather. Staff are directed towards a severe weather page on the Trust intranet, and staff and patients are asked to “Keep warm – keep well”.

12.3 BHCC Adult Social care
Both Domiciliary and bed-based services are delivered by the directorate, which has well-rehearsed BCP’s. It also has service level agreements with both the Seafront Team and City Parks at BHCC, who will assist with 4x4 vehicles and drivers when necessary. The whole team also works closely with (the Out Of Hours provider) IC24, to ensure the minimum of duplicity with District nurse teams etc. All are working hard to raise levels of flu vaccine uptake amongst staff.

12.4 Public Health
Prevention of excess winter deaths is a priority. With the removal of the national Warm Homes Healthy People fund, partnership working with other BHCC departments, local NHS teams and Community and Voluntary Sector organisations has been a priority to enable the continuation of the annual Brighton & Hove Warm Homes Healthy People (WHHP) Programme.

An application has been made by the City to the British Gas Energy Trust Healthy Homes Fund 2015-2016 (See details under ‘BHCC Housing’ below) to increase the scope and reach of the WHHP Programme in response to the recent NICE guidelines, ‘Excess winter deaths and morbidity and the health risks associated with cold homes’.

The winter planning group are asked to consider where further quantities of winter-based room thermometer cards could be placed to target high risk areas including:
- Those aged 65+ (especially those who are 75+), or those living on their own who are socially isolated
- Chronic and severe illness: including heart conditions, circulatory disease, asthma, COPD, depression and anxiety, diabetes and arthritis
- Children under the age of five
Public Health staff have worked with the primary care team at BHCCG, and have urged GP practices to obtain a stock of grit / salt if not already held, via ‘Primary Care News’.

12.5 BHCC Seafront Team
The City recognises that numbers of rough-sleepers across the city have risen, and this is a particular problem for the seafront area. The team is liaising with the Police, CRI and various other stakeholders across a number of for a. It has been acknowledged that advice to traders re flood defences etc can be obtained from the YouGov website at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/292943/geho1009brdl-e-e.pdf A number of products such as flood sacks etc can be locally obtained from B&Q and Travis Perkins etc.

Events such as the B&H ‘Christmas Day Swim’ are kept under review. The team put out public safety signage, and the event will be cancelled if weather forecasts warrant it. Following good experience in recent years, the team now has a productive relationship with the swimming club.

12.6 IC24 (NHS Out of Hours Provider).
IC24 provides GP services to B&H and to E Sussex, as well as a GP at BSUHT, a walk-in service and other facilities. The organisations fleet has been updated, but no longer includes 4x4 vehicles. The organisation has good and effective links with Adult Social care and other providers, sharing r4esources i.e. in response to severe weather.

12.7 Cityclean
Cityclean staff working for BHCC become the gritting team during inclement or severe weather, and operate under the direction of the BHCC ‘Winter Duty Officer’ who will advise on weather and road conditions, and on action required by the team. There are 5 priority areas of work which do include primary routes, city centre and hospital entrances. Gritters (including a pavement gritter) have been serviced and are ready for winter.

12.8 The BHCC Highways Winter Service Plan 2015-16
This plan states the Council’s roads gritting and monitoring arrangements. It is available on the council’s public website, and via the following link: http://present.brighton-hove.gov.uk/Published/C00000823/M00005176/AI00041438/$20140926115311_006148_0026144_CommitteeReportTemplate100614newsavedformat.docx.pdf

This plan has previously been sent out to the Local Authority’s ‘Major Incident Support Team’ and to local stakeholders as a draft for comment prior to the final document going to Committee.

The Local Authority also maintains an information page on the council’s public website, which provides advice on winter weather (see http://www.brighton-hove.gov.uk/content/parking-and-travel/roads-and-highways/winter-weather ) and driving and ‘what you can do’ as well as on ‘what the Council does’. The link to this page is:
The Head of Highways has confirmed that the highways plan ensures that roads to the 2 NHS hospitals are gritted, as well as the ambulance stations in both. The clearance of pavements leading to those hospitals are also on the ‘Priority 1’ list. The Winter Duty Officer can be contacted via the head of the Highways Department or via the Emergencies and Resilience Team.

It was confirmed that all B&H Bus Company routes are on City ‘primary routes’. It was acknowledged that grit and salt is good at combating ice but that the addition of the buses and other heavy transport is needed to make the grit work in snow. It was important to keep the buses running where possible to break up snow, but that is an operational decision for the bus company.

12.9 BHCC Flood Management
The City’s focus is on groundwater, (as the Environment Agency retains responsibility for other areas). The approach is to reduce (not eliminate) risk. Groundwater levels are currently higher than in recent years, but the situation is being closely monitored. There has been preliminary discussion regarding a Patcham flood defence scheme, following receipt of money from an Environment Agency grant.

12.10 BHCC Housing.
The team has responsibility for the City’s stock of social and sheltered housing, and a shelter under the Severe Weather Emergency Protocol (SWEP – temperature below minimum for 48 hours). Recently this has been extended to include heavy rain, and includes the notion of ‘No 2nd night out’.

Areas of concern include the elderly, vulnerable and socially isolated. There are good links to other BHCC departments and other stakeholders. There is also a temporary accommodation and homeless team. In times of severe weather etc, the team is committed stop non-urgent work and to re-deploy housing officers to other services who need extra support.

The Housing Dept is also working with Public Health to produce a Fuel Poverty and Affordable Warmth Strategy and draft action plan in response to the NICE guidance on ‘Excess winter deaths and morbidity and the health risks associated with cold homes’ (March 2015 – see https://www.nice.org.uk/guidance/ng6 ). This went to the Housing Committee in Sept 15 and is also coming to the HWB’s October meeting.

Housing & Public Health staff are also awaiting the outcome of a significant bid, led by CAB, for a city wide referral system for cold housing. If successful, this programme will build on learning and cross sector partnerships established through the B&H Warm Homes Healthy People Programmes and recent Public Health Warmth for Wellbeing project, to implement a large portion of the recommendations within the recent NICE guidelines. It will run from Nov 2015 – Dec 2016, providing a single-point-of-contact health and housing referral service to:

1. Identify vulnerable people at risk of ill health and death from fuel poverty and cold housing
2. Provide holistic needs and home assessment of vulnerable clients
3. Provide tailored solutions that build resilience to fuel poverty and cold housing
The BHCC contractors Mears & PH Jones also run out of hours services. They maintain winter contingency stock including heaters etc. Out of hours the duty housing officer is contactable via the Emergencies and Resilience Team or via Carelink.

12.11 BHCC Emergencies and Resilience / Public Health resilience.
BHCC has sold the Hove Park Depot and stocks of winter grit etc are likely to be located at the Stanmer Park depot. Transport hub arrangements have been reviewed as below.

Contact details for the group will be circulated together with the National plan link, this updated plan, and any other relevant information, (including the NHS ORCP (see App 2).

12.12 The Brighton & Hove Transport Hub
The B&H Transport Hub results from an MOU arrangement between partners to support BHCC in running a hub facility during periods of severe weather. This will:
Ensure an overview is maintained on weather conditions.
Liaise with the BHCC Highways department and media sources to understand the impacts of the severe weather on the cities road’s network.
Understand the implications of the weather falling on roads on transport providers including buses and taxis.
Coordinate available 4 x 4 resources (including via the NHS MOU with Sussex 4x4 Response), from partner organisations and local community volunteers and
Match local prioritised tasking’s for 4x4’s against 4x4 availability.

The transport hub is managed and staffed via the MOU, (which partners have committed to as documented), and by an operational document. Both of these have been updated for this coming winter, and the BHCC list of ‘I can help’ volunteers will be similarly updated.

12.13 Seasonal Flu
Immunisation of at risk groups
The CCG is engaged with all key agencies to ensure preparedness for the 2015/16 flu season, and to improve the local uptake of the flu vaccine. Last year Brighton and Hove achieved an uptake in rates but an improvement is still needed. The responsibility for commissioning flu vaccination programmes has passed to NHS England South, (South-East), and close contact with NHS E EPRR staff is maintained via the LHRP.

The CCG has recognised that the efforts or previous years were not as successful as we wished, and has now agreed to fund further investment through enhancement of the Directly Enhanced Service which should provide additional nursing staff to target people who are housebound and who are most likely to miss out through their mobility problems.

A key difference for this coming winter will be the vaccination of school infant children. It is anticipated that vaccinating these ‘super-spreaders’ will have a clear
impact on the ability of seasonal flu viruses in the community, and will therefore significantly reduce the incidence of influenza this winter.

Building on work from last year, NHS E requires the maintaining of the vaccination programme in acute hospital settings for patients with long term conditions. Monitoring of vaccine ordering in primary care is also being carried out by NHS England, and B&H seeks assurance that these processes are working successfully, via the B&H health Protection Forum.

Flu publicity will be led by Public Health England and Brighton and Hove City Council with a national campaign being distributed locally.

12.14 Immunisation of frontline staff

Main providers with the system are expected to deliver a significant improvement in staff vaccination rates this year moving towards a compliance rate of 75% for 2015/16.

Last year’s rates were not at these levels, and every provider in the LHE is aware of the need to do more in this area, as having staff vaccinated reduces their own vulnerability, increases the resilience of the provider, and reduces the threat of transmission to patients. (This has also been the subject of discussion at the Cities Health protection Forum). Staff vaccination programmes are in place across local provider organisations.

Although uptake will be monitored by NHS England, we are also planning to monitor local providers via the Urgent Care Task Forces and Performance and Quality Boards. In particular we will be seeking assurances that providers have: Sourced sufficient levels of vaccinations based on an assumption that uptake rates will increase significantly this rather than last year’s outturn Developed appropriate improvement plans that are over and above actions taken last year and informed by best practice e.g. use national resources such as NHS Employers Flu Fighters materials

Working in partnership with the local authority, we are also encouraging all Care Homes with Nursing to vaccinate their residents this year. The City Council has made arrangements with the Healthy Living Pharmacies for their directly employed frontline staff to be offered vaccination. The negotiated rate per vaccine will also be available for staff of other private health and social care organisations if their employers chose to use the service. The communications teams from the various organisations will be working jointly to promote the programme.

13 Communication

13.1 There are three areas of communication: Awareness, Warning & informing and Advising the public.

13.2 Awareness – pre 1st November each year. This will be done by NHS E / PHE Communications Teams centrally, by informing and educating the public about the
risks of cold weather, and how people in the identified vulnerable groups can prepare themselves.

Additionally the CCG is supporting traditional NHS winter campaigns, including The National ‘Choose Well Campaign’.

The 2015 NHS Winter Campaign will run as planned in October. This year’s single integrated campaign produced jointly by NHS England, PHE, the Department of Health, the NHS Trust Development Agency and Monitor, brings together their insight and expertise into one focused behaviour change programme.

The campaign will help people avoid preventable emergency admission to hospital via A&E this winter. Campaign activity will begin in October 2015 and run until March 2016 focusing on people with long-term conditions, older people over 65 years of age, carers, pregnant women and parents of children under 5 years. The campaign will focus on key actions that people can take to stay well such as getting their flu vaccination, keeping their house warm and seeking advice at early signs of illness. This is particularly relevant for people who are vulnerable to winter illness.

It will be delivered through a variety of partners and media including TV, radio, outdoor and social media, as well as via campaign materials for local teams to use. Campaign creative assets and toolkits will be available to download from the PHE Campaign Resource Centre from 17 September 2015.

The CCG has also commissioned and is running its own hugely successful ‘Great Choices Make Heroes’ Campaign (See http://www.wecouldbeheroes.nhs.uk/)

13.3 Warning – at each change of cold weather level. The Met Office will communicate to the public any change in levels and what the changes means, taking into specific account the local weather warnings.

13.4 Local Warning and Informing – Immediately Level 2 and above is reached.PH staff and the LA Civil Contingencies Team will liaise with CCG and BHCC Communications staff to agree a local interpretation of public messages, based on then Public Health messages below at para 13, (as taken from the national plan).

13.5 Staff information.
All partner agencies will ensure that suitable messages are also passed to staff, detailing warnings where appropriate, actions to be taken, and measures in line with their Business Continuity Plans, which must be kept up to date. (This may include the need to re-deploy staff during severe weather, and arrangements for home-working where appropriate.

13.6 De-Briefing & Support.
Post incident, a de-briefing should be held to ensure lessons are identified and learnt, and also partners should ensure that support is offered to staff in appropriate cases.

14. Key public health messages

Get your flu jab if you:
• Are aged 65 or older
- Are pregnant
- Have a serious medical condition such as chronic heart, lung, neurological, liver or kidney disease or diabetes
- Have a weakened immune system due to HIV or treatments that suppress the immune system such as chemotherapy
- Have had a stroke or transient ischaemic attack (TIA) or post-polio syndrome
- Are living in a long-stay residential care home or other long-stay care facility (not prison or university halls)
- Are the main carer for an elderly or disabled person whose welfare may be at risk if you fall ill
- Contact your GP or pharmacist if you think you, or someone you care for, might qualify for a free flu jab (see Seasonal flu vaccination winter 2013-14 – who should have it and why)

Keep your home warm, efficiently and safely:
- Heat your home to the right temperature: your living room should be 21°C (70°F), and your bedroom and the rest of the house heated to 18°C (65°F). Above this and you may waste money; below this you may risk your health. This will keep your home warm and may lower your bills
- If you can’t heat all the rooms you use, heat the living room during the day and your bedroom just before you go to bed
- Get your heating system and cooking appliances checked and keep your home well ventilated
- Use your electric blanket as instructed and get it tested every three years. Never use a hot water bottle with an electric blanket
- Switch your appliances (such as TVs and microwaves) off rather than leaving them on standby
- Do not use a gas cooker or oven to heat your home; it is inefficient and there is a risk of carbon monoxide poisoning and this can kill
- Make sure you have a supply of heating oil or LPG or solid fuel if you are not on mains gas or electricity – to make sure you do not run out in winter

Keep the warmth in by:
- Fitting draught proofing to seal any gaps around windows and doors
- Making sure you have loft insulation. And if you have cavity walls, make sure they are insulated too
- Insulate your hot water cylinder and pipes
- Draw your curtains at dusk to help keep heat generated inside your rooms
- Make sure your radiators are not obstructed by furniture or curtains

Look after yourself:
- Food is a vital source of energy and helps to keep your body warm so have plenty of hot food and drinks
- Aim to include five daily portions of fruit and vegetables. Tinned and frozen vegetables count towards your five a day
- Stock up on tinned and frozen foods so you don’t have to go out too much when it’s cold or icy
- Exercise is good for you all year round and it can keep you warm in winter
- If possible, try to move around at least once an hour. But remember to speak to your GP before starting any exercise plans
• Wear lots of thin layers – clothes made from cotton, wool or fleecy fibres are particularly good and maintain body heat
• Wear good-fitting slippers with a good grip indoors and shoes with a good grip outside to prevent trips, slips and falls
• Make sure you have spare medication in case you are unable to go out

Look after others:
• Check on older neighbours or relatives, especially those living alone or who have serious illnesses to make sure they are safe, warm and well

Get financial support:
• There are grants, benefits and sources of advice to make your home more energy efficient, improve your heating or help with bills. It’s worthwhile claiming all the benefits you are entitled to before winter sets in.

15 Awareness, Training and Exercising

15.1 Staff that has an active part to play in the cold weather response will require awareness training in this plan, its requirements and implementation. All partners will ensure that this is made available.

15.2 Opportunities for testing and exercising this plan and associated arrangements will be considered by executives from partners as listed to validate the plan and any subsequent major alterations required.

Appendix 1 – Cold Weather Plan Action Cards.

Action Cards for the Cold Weather Plan for England are available for the following:
• Commissioners & LA’s,
• GP’s & Practice Staff,
• Community & Voluntary Sector,
• Frontline health & Social Care staff in community & care facilities,
• Provider Organisations
• Individuals


Appendix 2 . BSUHT LHE Escalation Protocol.

(To be updated when this year’s plan becomes available).
Operational Resilience and Capacity Plan for 2014/15

Brighton and Hove LHE

V1.15

Contributing Organisations:

Brighton and Hove Clinical Commissioning Group (BHCCG)
Brighton and Sussex Universities Hospitals NHS Trust (BSUH)
Brighton and Hove City Council (BHCC)
Sussex Partnership Foundation Trust (SPFT)
Sussex Community NHS Trust
Integrated Care 24
South East Coast Ambulance Service Foundation Trust
Horsham and Mid Sussex CCG
High Weald Lewes Haven CCG

SEE FULL ORIGINAL DOCUMENT FOR DETAILS
<table>
<thead>
<tr>
<th>Type of contact</th>
<th>Organisation</th>
<th>On Call Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usual daily contact</td>
<td>B&amp;H CCG</td>
<td>Anthony Flint 01273 274687</td>
</tr>
<tr>
<td></td>
<td>BSUH</td>
<td>Rich Strang 07803 252532</td>
</tr>
<tr>
<td></td>
<td>SCT</td>
<td>Louise Mayan 01273 586011 Mob 07748768721</td>
</tr>
<tr>
<td></td>
<td>ASC</td>
<td>Brian Laukhy 07781 405620</td>
</tr>
<tr>
<td></td>
<td>IC24</td>
<td>Gemma Smith (Head of Clinical Services) 01233 505450</td>
</tr>
<tr>
<td></td>
<td>NHS 111</td>
<td>Emergency Operations Centre Manager (EOCM) 01273 486465</td>
</tr>
<tr>
<td></td>
<td>SECAMB</td>
<td>Emergency Operations Centre Manager (EOCM) 01273 486465</td>
</tr>
<tr>
<td></td>
<td>SPFT</td>
<td>John Child</td>
</tr>
<tr>
<td>2nd line contact/senior manager</td>
<td>B&amp;H CCG</td>
<td>Wendy Young 01273 574688</td>
</tr>
<tr>
<td></td>
<td>BSUH</td>
<td>Sandy Spencer 07803 455458</td>
</tr>
<tr>
<td></td>
<td>SCT</td>
<td>Annie Hampson 01273 586011 Mob 07833239498</td>
</tr>
<tr>
<td></td>
<td>ASC</td>
<td>Paul Martin 07796 358132</td>
</tr>
<tr>
<td></td>
<td>IC24</td>
<td>Gemma Smith (Head of Clinical Services) 01233 505450 or Kevin Evans (newly appointed Operations Director) on the same number 01233 505450</td>
</tr>
<tr>
<td></td>
<td>NHS 111</td>
<td>Duty Silver senior operations manager 01273 486465</td>
</tr>
<tr>
<td></td>
<td>SECAMB</td>
<td>Duty Silver senior operations manager 01273 486465</td>
</tr>
<tr>
<td></td>
<td>SPFT</td>
<td>Lindsay Toads 07795343133</td>
</tr>
<tr>
<td>On call/escalation out of hours</td>
<td>NHS England</td>
<td>Please see contact details for Area Team Director on Call information</td>
</tr>
<tr>
<td></td>
<td>CCG on call</td>
<td>On Call Manager through switchboard 01273 696655</td>
</tr>
<tr>
<td></td>
<td>BSUH</td>
<td>On Call Senior Manager via switch 01273 696655</td>
</tr>
<tr>
<td></td>
<td>SCT</td>
<td>On Call Senior Manager via switch 01273 696655</td>
</tr>
<tr>
<td></td>
<td>ASC</td>
<td>Duty On Call Manager via Candrika 01273 555555</td>
</tr>
<tr>
<td></td>
<td>IC24</td>
<td>Duty Manager for the East locality which is on a rota - contact the despatch line on 01233 505510 and they can escalate to the Senior Manager or Duty Manager on call</td>
</tr>
<tr>
<td></td>
<td>NHS 111</td>
<td>Duty Silver or Gold (Exec) on-call 01273 486465</td>
</tr>
<tr>
<td></td>
<td>SECAMB</td>
<td>Duty Silver or Gold (Exec) on-call 01273 486465</td>
</tr>
<tr>
<td></td>
<td>SPFT</td>
<td>On Call Manager/Director via Amberstone Switchboard 01323 440022</td>
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</tbody>
</table>
Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. **Fuel Poverty and Affordable Warmth Strategy for Brighton & Hove**

1.1. The contents of this paper can be shared with the general public.

1.2. This paper is for the Health & Wellbeing Board meeting on the 20th October 2015.

1.3. Contact Officers:
   Name: Miles Davidson  
   Tel: 29-3150  
   E: [Miles.davidson@brighton-hove.gov.uk](mailto:Miles.davidson@brighton-hove.gov.uk)
   Name: Sarah Podmore  
   Tel: 29-6578  
   E: [Sarah.podmore@brighton-hove.gov.uk](mailto:Sarah.podmore@brighton-hove.gov.uk)

2. **Summary**

2.1 The National Institute for Health and Care Excellence (NICE) released guidance in March 2015 entitled ‘Excess winter deaths and morbidity and the health risks associated with cold homes’. The guidance provides evidence based recommendations on how to reduce the risk of death and ill health associated with living in a cold home. The health problems associated with cold homes are experienced during ‘normal’ winter temperatures, not just during extremely cold weather. The guidelines propose that year round planning and action by multiple sectors is needed to reduce these risks. Accordingly the guidelines are aimed at commissioners, managers, housing providers and health, social care and voluntary
sector practitioners who deal with vulnerable people who may have health problems caused, or exacerbated, by living in a cold home.

2.2 The NICE guidelines recommend that Health & Wellbeing Boards are best placed to develop a ‘strategy to address the health consequences of cold homes’. A draft action plan in response to the guidelines and recommendations is attached as Appendix 1. The action plan builds on existing good practice and partnership working between the Housing and Public Health departments, with local NHS and community and voluntary sector organisations, such as the Citizen’s Advice Bureau and Age UK, and identifies where this activity could be scaled up and accelerated.

2.3 In response to the NICE guidelines and the recent national fuel poverty strategy for England, ‘Cutting the cost of keeping warm’, a Fuel Poverty and Affordable Warmth Strategy for Brighton & Hove is being developed. The Housing and Public Health departments, working with key partners in the city, will develop this over the coming months with a final draft ready in early 2016.

3. Decisions, recommendations and any options

3.1 That the Health and Wellbeing Board note the contents of this report, the NICE guidelines and recommendations and the draft action plan for Brighton & Hove attached as Appendix 1.

3.2 That the Health and Wellbeing Board notes the ongoing work to develop a wider Fuel Poverty and Affordable Warmth Strategy, a draft of which will be brought to a future meeting for approval.

4. Relevant information

4.1 Public Health England’s 2014 Cold Weather Plan states that winter weather has a direct effect on the incidence of heart attack, stroke, respiratory disease, flu, falls and injuries and hypothermia. Indirect effects include mental health problems such as depression, and the risk of carbon monoxide poisoning if boilers, cooking and heating appliances are poorly maintained or poorly ventilated.

4.2 A wide range of people are vulnerable to the cold, including:
- people with cardiovascular conditions
- people with respiratory conditions (in particular, chronic obstructive pulmonary disease and childhood asthma)
• people with mental health conditions
• people with disabilities
• older people (65 and older)
• households with young children (from new-born to school age)
• pregnant women
• people on a low income.

4.3 The UK has a relatively high rate of Excess Winter Deaths (EWD), based on international comparisons that use this definition. The EWD Index expresses excess winter deaths as a percentage increase of the expected deaths based on non-winter deaths. The number of EWD varies between years with an average of 25,000 in England each winter. The Brighton & Hove Joint Strategic Needs Assessment (JSNA) 2015 identifies the health risks of cold homes including winter deaths. For 2012-13 the EWD Index in Brighton & Hove was 19%, equivalent to 130 Excess Winter Deaths.

4.4 EWD are almost three times higher in the coldest quarter of housing than in the warmest quarter, with an estimated 40% of all EWD being attributable to inadequate housing. The majority of EWD occur in those aged 65+ with 93% of EWD in England occurring in this age group during 2012-2013.

4.5 The NICE guidelines make recommendations, with the aim to:
• Reduce preventable excess winter death rates
• Improve health and wellbeing among vulnerable groups
• Reduce pressure on health and social care services
• Reduce fuel poverty and the risk of fuel debt or being disconnected from gas and electricity supplies
• Improve the energy efficiency of homes.

4.6 A household is defined as being in fuel poverty if it:
• has an income below the poverty line (including if meeting its required energy bill would push it below the poverty line); and
• has higher than average energy costs.

4.7 In Brighton & Hove the 2015 Housing Strategy aims to create 'Decent Warm & Healthy Homes' under the priority of improving housing quality; however the housing stock in Brighton & Hove presents a number of challenges to improving its energy efficiency. The 2008 House Condition Survey showed that the age profile of the
total private housing stock differs from the average for England in that there is a substantially higher proportion of pre 1919 stock at 40% compared to the national average of 25%. Overall the stock profile is older than the national picture with 66% built before 1945 compared to 43% in England as a whole. Many private sector properties are labelled ‘hard to treat’ (e.g. those with solid walls) in relation to standard energy efficiency measures.

4.8 The 2011 census showed that the size of the private rented sector in Brighton & Hove has increased by 37% since 2001 with an extra 10,691 homes. Two out of every seven households in the city are now renting from a private landlord, with the city having the 9th largest private rented sector in England & Wales with a total of 34,081 private rented homes.

4.9 The factors outlined above can consequently impact on the ability of homeowners, landlords and tenants to improve the energy efficiency of properties and therefore on occupiers to live in warm and healthy homes. The most recent annual fuel poverty statistics report estimated that nearly 15,000 (11.9%) of the city households were estimated to be living in fuel poverty in 2013, higher than the average for the south east region (8.1%). The report also estimated that across England as a whole the level of fuel poverty is considerably higher in the private rented sector (19% of all households in this tenure are fuel poor). This tenure is associated with relatively poor energy efficiency ratings and relatively low incomes which are key drivers of fuel poverty.

4.10 Led by the Council’s Housing and Public Health departments, a steering group will be established over the coming months, to include representatives from relevant NHS partners, housing, social care and community and voluntary sector organisations to oversee the development of an over-arching Fuel Poverty and Affordable Warmth Strategy for the city. The aim will be to ‘embed’ the recommendations contained in the NICE guidelines into relevant organisation systems, processes and service delivery where possible. This strategy will also reflect the objectives within the national Fuel Poverty Strategy, at a local level for Brighton & Hove.

4.11 There is no additional council capital or revenue funding, or other resource outside that already in place, identified to implement the strategy and associated action plan. The draft action plan has been developed to reflect this, as will the strategy. It is envisaged that delivery will be through existing work streams, focussing on fuel poverty, affordable warmth and energy efficiency, within the city council, NHS and the community and voluntary sector. There are
also clear links with those actions being delivered through the wider financial inclusion work in the city. Together with partners in the city, officers we will continue to explore external funding opportunities to support this work ensuring that they do not impose any undeliverable obligations on the city council or partners.

4.12 It is proposed that a draft of the new Fuel Poverty and Affordable Warmth Strategy will be presented to the Housing & New Homes Committee on the 13th January 2016 and to the Health & Wellbeing Board on the 22nd March 2016.

4.13 To support the recommendations within the NICE guidelines and subsequent actions in the Council’s own action plan, along with partners across the city, we continue to look for possible funding streams to support and escalate work to support vulnerable householders across the city. A bid, co-ordinated by Brighton & Hove Citizens Advice Bureau, was submitted to the British Gas Energy Trust Warm Homes Fund 2015-16. The Council has supported this bid to ensure it fits with the strategic challenges and approach outlined above. The outcome of the bid will be confirmed in October 2015.

4.14 Further to the NICE recommendations outlined in the attached action plan, addressing energy inefficient housing and bringing homes up to a minimum standard of thermal efficiency would have the greatest impact on the most vulnerable households. The Council continues to explore options and different models for the delivery of investment into the city’s housing, across all tenures. This includes the work we have carried out with partners in Your Energy Sussex and emerging models that enable the Council to lever in new investment outside of both the general fund and HRA capital investment programmes. Further work will be carried out to explore these options and different models of delivery and reported back as appropriate. Many private sector landlords in the city are keen to work with the council to increase investment in the local housing stock to improve quality; we will work closely with this group to explore the most effective way to achieve this with the aim of increasing levels of energy efficiency.

5. Important considerations and implications

Legal

5.1 As this report is for noting, there are no significant legal implications to draw to the Board’s attention at this time.
Lawyer Consulted: Name Liz Woodley Date: 28/09/15

Finance

5.2 There are no direct financial implications of this report. The Fuel Poverty and Affordable Warmth Strategy, once drafted, will be assessed for financial implications prior to implementation and reported as part of the budget monitoring process or separate report to Committee as necessary.

Finance Officer Consulted: Name Monica Brooks Date: 17/08/15

Equalities

5.3 A full Equalities Impact Assessment will be carried out alongside the development of the Fuel Poverty & Affordable Warmth Strategy.

The vast majority of EWD in England occur among those aged 65 or over. As in previous years in England and Wales, there were more excess winter deaths in females than in males in 2012-13.

In 2013, households in England where the oldest person in the household was aged 16-24 were more likely to be fuel poor. However people aged 75+ experienced the deepest levels of fuel poverty.

Fuel poverty is a contributor to social and health inequalities. In 2013, all fuel poor households in England came from the bottom four income decile groups. Unemployed households in England have the highest rates of fuel poverty across all economic activity groups and lone parent households have consistently been more likely to be in fuel poverty. People who have a long term illness or disability are also more likely to be fuel poor than those who do not.

For Gypsies and Travellers living on site accommodation or travelling, trailers with little insulation combined with the expense of Calor gas can cause higher than average heating costs and fuel poverty. Fuel poverty strategy and interventions may need to be tailored to reach Gypsy Traveller communities.

Some groups at risk of fuel poverty lack awareness and/or understanding of existing sources of support and programmes to help improve home energy efficiency. Lack of understanding can restrict those that are aware to adopt such interventions. This is likely to vary across different groups, for example for people with
language barriers (such as minority ethnic communities), and those who have limited social networks and connections with their local community, such as isolated older people and people with learning disabilities.

Sustainability

5.4 The most effective way to tackle fuel poverty and address the issue of cold homes and impacts on health for the long term is to improve the energy efficiency of the city’s homes. This also has the potential to reduce CO2 emissions from the city’s housing, which currently makes up the largest proportion (42%) of the city’s total emissions.

The aims of the strategy and action plan have a significant impact on improvements to the health and wellbeing of some of the city’s most vulnerable residents.

Health, social care, children’s services and public health

5.5 Strategically addressing cold homes and fuel poverty in vulnerable groups will contribute to the prevention of ill health and excess winter deaths, reduce health and social inequalities, and improve wellbeing and quality of life.

6. **Supporting documents and information**

6.1 Appendix 1 - Draft Action Plan
6.2 Appendix 2 – Extract from the proceedings of the Housing & New Homes committee
Excess winter deaths and morbidity and the health risks associated with cold homes

Brighton & Hove City Council Action Plan in Response to NICE Guidelines

Proposed schedule of meetings
- 1st June 2015 - Health Protection Forum
- 7th July 2015 & 9th November 2015 - Strategic Housing Partnership
- 23rd September 2015 & 13th January 2016 - Housing Committee
- 20th October 2015 & 22nd March 2016 – Health & Wellbeing Board

Recommendation | Who should take action | What we are doing | Further action to explore
---|---|---|---
1. Develop a strategy | Health & Wellbeing Board (HWB) | Risks and challenges are reflected in the following key documents; | 1.1 Pull together relevant work streams, existing policy and sections of relevant existing strategy to develop an overarching Fuel Poverty & Affordable Warmth Strategy for B&H

  - Cold Weather Plan (CWP)
  - Joint Strategic Needs Assessment (JSNA)
  - Housing Strategy
  - Housing Revenue

  | 1.2 Set into HWB annual reporting timetable
  | 1.3 Establish cross sector Fuel Poverty & Affordable Warmth working group to...
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Who should take action</th>
<th>What we are doing</th>
<th>Further action to explore</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider how the issues and actions identified are reflected in health and wellbeing and other relevant local strategies or plans and ensure actions take account of other local and national strategies. Ensure the strategy includes monitoring and evaluation. Also ensure any evaluation is used to improve the strategy and is made publicly available.</td>
<td>- Account (HRA) capital programme</td>
<td>- Director of Public Health Annual Report</td>
<td>deliver related action plan and monitor progress. Potential membership to include BHCC Housing, Public Health, ASC &amp; Children’s Services; NHS/CCG; CVS; ESFRS; Landlords, including RPs (housing associations); Gas network operator (SGN); District Network Operator for electricity (EDF).</td>
</tr>
<tr>
<td>2. Ensure there is a single-point-of-contact health and housing referral service for people living in cold homes</td>
<td>- One Planet Living Sustainability Action Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure the referral service:</td>
<td>- Takes account of existing services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Involves face-to-face contact, if necessary, with the person using the service, their families and their carers.</td>
<td>- Involves face-to-face contact, if necessary, with the person using the service, their families and their carers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Works with the person and their carers to identify problems caused by living in a cold home and the possible solutions.</td>
<td>- Works with the person and their carers to identify problems caused by living in a cold home and the possible solutions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Makes it clear to the person and their carer what actions are planned (or taking place) and coordinates activities to minimise disruption in the home.</td>
<td>- Makes it clear to the person and their carer what actions are planned (or taking place) and coordinates activities to minimise disruption in the home.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Encourages self-referrals using a free phone number.</td>
<td>- Encourages self-referrals using a free phone number.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Monitors and evaluates the impact of actions taken and gives feedback to the practitioner or agency that originally referred the person.</td>
<td>- Monitors and evaluates the impact of actions taken and gives feedback to the practitioner or agency that originally referred the person.</td>
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<tr>
<td>2.1 Report findings and learning from WfW and identify potential longer term funding for city-wide scheme/single point of contact for cold home referrals</td>
<td>- Support and advice to Citizens Advice Bureau bid to British Gas Energy Trust, for funding to implement single-point-of-contact health and housing referral service.</td>
<td>- Compiling learning from the Warmth for Wellbeing (WfW) pilot project</td>
<td>2.1 Report findings and learning from WfW and identify potential longer term funding for city-wide scheme/single point of contact for cold home referrals</td>
</tr>
<tr>
<td>2.2 Ensure learnings form DECC funded trials of ‘Warmth on Prescription’ schemes are used to inform any future local development (Explore any potential future funding from this source)</td>
<td>- Advice and support on fuel poverty and cold homes through</td>
<td>- Advice and support on fuel poverty and cold homes through</td>
<td>2.2 Ensure learnings form DECC funded trials of ‘Warmth on Prescription’ schemes are used to inform any future local development (Explore any potential future funding from this source)</td>
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<tr>
<td>2.3 Consider review</td>
<td>- Consider review</td>
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<td>2.3 Consider review</td>
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</tbody>
</table>

**Table Note:**
- **HRA:** Health and Residential Affairs
- **HWB:** Health and Wellbeing
- Accounts (HRA) capital programme and Director of Public Health Annual Report are responsibilities of the Local Authority. One Planet Living Sustainability Action Plan deliver related action plan and monitor progress. Potential membership to include BHCC Housing, Public Health, ASC & Children’s Services; NHS/CCG; CVS; ESFRS; Landlords, including RPs (housing associations); Gas network operator (SGN); District Network Operator for electricity (EDF).
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<th>Recommendation</th>
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<th>What we are doing</th>
<th>Further action to explore</th>
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<tr>
<td>the Welfare Benefits Advice Service in selected general practices</td>
<td>• Refer-all into Private Sector Housing (PSH), part of Council Housing department, previously trialled&lt;br&gt;• Links with community and voluntary sector (CVS) and Advice Partnership through Warm Homes Healthy People (WHHP) Programme &amp; CWP&lt;br&gt;• Brighton &amp; Hove Energy services Company (BHESCO) help desk operates on an ad hoc basis dependent on available resource and funding.&lt;br&gt;• Moneyworks commission</td>
<td>current Moneyworks commission to establish scope for this to be single-point-of-contact (SPoC)</td>
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<td>Recommendation</td>
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<tr>
<td>3. Provide tailored solutions via the single-point-of-contact health and housing referral service for people living in cold homes</td>
<td>HWB; BHCC; housing providers; energy utility and distribution companies; faith and voluntary sector organisations</td>
<td>Includes giving advice on fuel poverty, debt and welfare benefits</td>
<td>3.1 Ensure any review of Housing commissioning including review of Home Improvement Agency takes into account need to have robust housing options service in place that is advertised to partners across the city</td>
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<td></td>
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<td></td>
<td>3.2 Consider commission of new service or develop Moneyworks commission</td>
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<td>3.3 Ensure any opportunities presented by changes to ECO funding are maximised by BHCC/YES</td>
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<tr>
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<td></td>
<td>3.4 Explore funding streams from national government/ EU and other sources as they become available to assist in funding measures for Brighton &amp; Hove residents</td>
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<td></td>
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<td>3.5 Further exploration of energy switching, Sussex</td>
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</table>

Solutions should include:
- Housing insulation and heating improvement programmes and grants. Programmes should be led, or endorsed, by the local authority and include those available from energy suppliers
- Advice on managing energy effectively in the home and securing the most appropriate fuel tariff and billing system (including collective purchasing schemes, if available)
- Help to ensure all due benefits are being claimed
- Registration on priority services registers
- Advice on how to avoid the health risks of living in a cold home
- Access to, and coordination of, services that address common barriers to tackling cold homes. For example, access to home improvement agencies that can fix a leaking roof, or to voluntary groups that can help clear a loft ready for insulation.
- Short-term emergency support in times of crisis (for instance, room heaters if the central heating breaks down or access to short-term credit)
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<th>Recommendation</th>
<th>Who should take action</th>
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<th>Further action to explore</th>
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</thead>
</table>
| **4. Identify people at risk of ill health from living in a cold home**  
Primary health and home care practitioners should: | Primary health and home care practitioners | • Annual WHHP programme provides advice and information to workers across BHCC, NHS & CVS to increase awareness and facilitate identification of at risk patients and clients.  
• Previous fuel poverty awareness training sessions  
• Work with CCG, GPs and clinical teams to identify and refer at risk patients through WHHP Programmes and previous WfW pilot project.  
• Liaising with CCG Clinical Lead for Sustainability re. opportunities to utilise the newly | **Energy Tariff**  
4.1 Address data sharing issues as part of broader arrangements  
4.2 Further engagement with health and care providers across the city  
4.3 Engage with Home Care practitioners, review guidance from DECC re. data sharing  
4.4 Develop e-learning package / training strategy and enable provision to a broad range of local practitioners  
4.5 Engage with health provider Learning & Development teams |
<table>
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<tr>
<th>Recommendation</th>
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<th>Further action to explore</th>
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</table>
| **5. Make every contact count by assessing the heating needs of people who use primary health and home care services** | Primary health and home care practitioners | Developed risk stratification tool to identify vulnerable patients. | 5.1 Embed training into corporate / Adult Social Care (ASC) training programmes  
5.2 Engage with health provider L&D teams  
5.3 Work with CCG, Community NHS trust (including through the ‘Better Care’ programme) to engage relevant health professionals/GP practices/teams to assess and refer on |
| | | | |
| | | | |

Primary health and home care practitioners should:

- At least once a year, assess the heating needs of people who use their services, whether during a home visit or elsewhere, taking into account the needs of groups who are vulnerable to the cold.

- Use their time with people to assess whether they (or another member of the household) are experiencing (or are likely to experience) difficulties keeping their home warm enough.

- Be aware that living in a cold home may have a greater effect on people who have to spend longer than an average amount of time at home. This could include those with chronic health conditions (including terminal illnesses) or disabilities.

- Be aware that people may not want to admit they are having difficulties paying for heating and may try to hide this. (For instance, they might only put the heating on when expecting a scheduled home visit.)

- Give people at risk, and their carers, information about how living in a cold home can affect their health. They should also tell them about services that can help and refer them if necessary.
<table>
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<th>Recommendation</th>
<th>Who should take action</th>
<th>What we are doing</th>
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<tr>
<td>necessary. Ensure recipients can understand and act on the information they are given.</td>
<td></td>
<td>People who do not work in health and social care services but who visit people at home, for instance: to carry out housing repairs, to read or install meters (including the installation of smart meters), or to provide general fuel poverty training to front line practitioners from a range of services.</td>
<td>6.1 Train relevant ESFRS staff</td>
</tr>
<tr>
<td>• If a cold home is a risk to someone's health and wellbeing, assess the likely effect and identify how the situation could be improved. Make sure relevant services are aware who will take action and when. This could include:</td>
<td></td>
<td>• Fuel poverty training to front line practitioners from a range of services</td>
<td>6.2 Train and share information with contractors in the Your Energy Sussex supply chain</td>
</tr>
<tr>
<td>o referral to the local health and housing service</td>
<td></td>
<td></td>
<td>6.3 Work with Green Growth Platform and the Sustainable Business Partnership to train and inform local businesses</td>
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<td>o referral to a health service (for instance, to ensure the person is offered flu vaccinations at the start of the winter).</td>
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<td>• Record assessments and actions in the person's notes or care plans. Make this information available to other practitioners, while respecting confidentiality.</td>
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</table>

6. Non-health and social care workers who visit people at home should assess their heating needs

People who do not work in health and social care services but who visit people at home (see who should take action?) should:

• Refer anyone who needs help with the problems of living in a cold home to the local single-point-of-contact health and housing referral service, if they give their consent (see recommendations 2 and 3).

• Give people who may be vulnerable to the cold information on the effect that living in a cold home can have on their
<table>
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<tr>
<td>health and what can be done to remedy this.</td>
<td>support or to socialise. This includes: faith and voluntary sector organisations; energy utility and distribution companies; housing professionals; installation and maintenance contractors</td>
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7. Discharge vulnerable people from health or social care settings to a warm home

Those responsible for arranging and helping with someone’s discharge from a health or social care setting (see who should take action?) should:

- Assess whether the person is likely to be vulnerable to the cold and if action is needed to make their home warm enough for them to return to. This assessment should take place at any time of the year, not just during colder weather, and well before they are due to be discharged to allow time for remedial action. For instance, it could take place soon after admission or when planning a booked admission.

- As part of the planned discharge, coordinate the efforts of all the practitioners involved to ensure the home is warm enough. This could include simple measures such as turning on the heating before discharge, providing advice on the ill

Secondary healthcare practitioners; social care practitioners

To confirm current discharge planning with BSUH NHS Trust

7.1 Provide information to workers involved in discharge process at Brighton & Sussex University Hospitals NHS Trust on risks and support available to patients and carers

7.2 Engage relevant workers to make early referrals for housing improvements
<table>
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<th>Recommendation</th>
<th>Who should take action</th>
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<td>effects of cold on health, or providing advice on how to use the heating system. (It could also involve more complex measures – see below.)</td>
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<td>• If needed, refer the person to the local single-point-of-contact health and housing referral system (see recommendations 2 and 3). For example, refer them if the heating system needs replacing or the property needs insulating, or to prevent or address fuel debt. (The latter may accrue during someone’s stay in health or social care accommodation.)</td>
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<td>• Ensure any heating issues are resolved in a timely manner, so as not to delay discharge from hospital.</td>
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<td>8. Train health and social care practitioners to help people whose homes may be too cold</td>
<td>NHS England, universities and other training providers. This includes: accredited agencies that train practitioners in environmental health, nursing and allied professions, medicine and para-medicine, environmental health and housing</td>
<td>Previous WHHP fuel poverty awareness training • NEA training • BESN training delivered by BHESCO</td>
<td>8.1 Embed training into corporate / ASC training programmes and explore options for sharing this with 3rd sector and private providers 8.2 Engage with Brighton and Sussex Medical School and University of Brighton nursing and midwifery to check forms part of syllabus</td>
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<tr>
<td>Training providers for health and social care practitioners (see who should take action?) should:</td>
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<tr>
<td>• Ensure training to support continuing professional development includes detail on the effect on health and wellbeing of living in a cold home and the benefits of addressing this issue (for example, insulation could save money on heating bills).</td>
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<td>• Ensure ongoing training programmes raise awareness of local systems and services to help people who are living in homes that are too cold for their health.</td>
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<td>• Ensure practitioners can raise the issue of living in a home</td>
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</table>
**Recommendation**

that is too cold. They should also be able to advise on sources of support and help and know how to refer someone, if necessary.

**9. Train housing professionals and faith and voluntary sector workers to help people whose homes may be too cold for their health and wellbeing**

Training providers for housing professionals and for people working in the faith and voluntary sector (see who should take action?) should:

- Ensure those in contact with people who may be vulnerable:
  - are aware of how cold housing can affect people’s health and wellbeing
  - can spot when and how someone is at risk of being too cold at home
  - know of local services designed to address these problems
  - understand how to refer someone for help.

| Training providers including: Chartered Institute of Environmental Health, Chartered Institute of Housing, National Council for Voluntary Organisations, National Association for Community and Voluntary Action, National Housing Federation, Board Development Agency, further education colleges and accredited NVQ training agencies, universities |
| Previous WHHP fuel poverty awareness training |
| NEA training |
| Big Energy Saving Network training delivered by BHESCO |
| HRA staff trained and engaged in schemes targeted at Council Housing Tenants |

9.1 Work through the Strategic Housing Partnership to share learning and training opportunities amongst all housing workers

9.2 Explore opportunities to share learning/training packages with local CVS groups through Community Works and local faith networks
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<tr>
<td>10. Train heating engineers, meter installers and those providing building insulation to help vulnerable people at home</td>
<td>Employers who install and maintain heating systems, electricity and gas meters and building insulation; training providers including energy utility and distribution companies, further education colleges and accredited NVQ training agencies</td>
<td>Through Your Energy Sussex, Green Growth Platform and Sustainable Business Partnership work with local supply chain to ensure heating engineers have information on support available and referral options</td>
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<tr>
<td>Recommendation</td>
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<td>What we are doing</td>
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<tr>
<td>11. Raise awareness among practitioners and the public about how to keep warm at home</td>
<td>HWB; Public Health England; the Department of Energy and Climate Change</td>
<td>- Previous WHHP fuel poverty awareness training and outreach workshops&lt;br&gt;- Information and advice leaflets and room thermometer cards provided through WHHP&lt;br&gt;- NEA training&lt;br&gt;- BESN training delivered by BHESCO&lt;br&gt;- BHCC web pages</td>
<td>11.1 Build on previous WHHP Programmes to run annual public awareness campaigns&lt;br&gt;11.2 Work with healthy living pharmacies in the city to link with related winter campaigns such as flu.&lt;br&gt;11.3 Utilise Public Health England NHS Winter Campaign and associated marketing and resources.</td>
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<tr>
<td>12. Ensure buildings meet ventilation and other building and trading standards</td>
<td>Building control officers; housing officers; environmental health officers; trading standards officers</td>
<td>- Private Sector Housing team inspections and visits, advice on condensation and mould leaflet&lt;br&gt;- Previous promotion</td>
<td>12.1 Target training and information at housing officers, building control and trading standards officers&lt;br&gt;12.2 Ensure alignment to new regulations on Energy Efficiency in Private...</td>
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<tr>
<td>Recommendation</td>
<td>Who should take action</td>
<td>What we are doing</td>
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<td>respect to ventilation (see the government’s Planning portal).</td>
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<tr>
<td>• Use existing powers to identify housing (particularly in the private rented sector) that may expose vulnerable residents (see recommendation 5) to the cold. Existing powers fall under both the housing health and safety rating system and trading standards legislation (in relation to energy performance certificates).</td>
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<td>Ensure any relevant problems are addressed.</td>
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| | | | Rented Sector and monitoring of this locally |
| | | | |

441
1. **Fuel Poverty & Affordable Warmth Strategy for Brighton & Hove – Extract from the proceedings of the Housing & New Homes Committee**

1.2 The extract is has been included for information.

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BRIGHTON & HOVE CITY COUNCIL

HOUSING & NEW HOMES COMMITTEE

4.00pm 23 SEPTEMBER 2015

FRIENDS MEETING HOUSE, SHIP STREET, BRIGHTON

MINUTES

Present: Councillor Meadows (Chair); Councillors Hill (Deputy Chair), Mears (Opposition Spokesperson), Gibson (Group Spokesperson), Atkinson, Barnett, Lewry, MacCafferty, Miller and Moonan.

28 **FUEL POVERTY & AFFORDABLE WARMTH STRATEGY FOR BRIGHTON & HOVE**

28.1 The Committee considered the report of the Acting Executive Director Environment, Development and Housing which informed Members that the National Institute for Health and Care Excellence (NICE) released guidelines in March 2015 entitled ‘Excess winter deaths and morbidity and ill health associated with living with cold homes’. The guidance provided evidence based recommendations on how to reduce the risk of death and ill health associated with living in a cold home. The guidelines proposed that year round planning and action by multiple sectors was needed to reduce these risks. In response to the NICE guidelines and the recent national fuel poverty strategy for England, ‘Cutting the cost of keeping warm’, a Fuel Poverty and Affordable Warmth Strategy for Brighton & Hove was being developed with an associated action plan. The action plan in response to the NICE guidelines was attached as appendix 1. The report was presented by the Housing
Sustainability Contracts Manager. The draft strategy would be presented to the Committee in January 2016.

28.2 Councillor Mears found the report very interesting. She referred to paragraph 7.7 relating to travellers and gypsies. She was concerned about the safety issues raised by having calor gas canisters in vehicles on the highway and was not sure interventions would work with travellers. The Housing Sustainability Contracts Manager agreed to send Councillor Mears information on this subject.

28.3 Councillor Atkinson considered the report to be very important and stressed that it was vital to give people the best advice. He asked how the council would evaluate whether the strategy was a success or not. The Housing Sustainability Contracts Manager replied this would be from looking at the numbers of excess winter deaths but this would vary from year to year. Officers were reliant on national statistics but there was an 18 month time lag. There would be interventions and an action plan. For example, there would be a number of interventions with regard to financial advice. A key consideration would be to properly manage, review and decide how outcomes were reported.

28.4 Councillor Gibson found it a useful report. He stressed that there were two sides to fuel poverty. One was poverty and the other was hard to heat homes. With regard to the poverty there was now a living wage but there was a need to see what more could be done.

28.5 RESOLVED:-

(1) That the contents of the report and the NICE guidelines and recommendations be noted.

(2) That the ongoing work to develop a wider Fuel Poverty and Affordable Warmth Strategy be noted. A draft of the strategy will be brought to a future meeting for approval.
Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. **Brighton & Hove Local Health and Social Care Surge and Capacity Plan 20116**

1.1. The contents of this paper can be shared with the general public.

1.2. This paper is for the Health & Wellbeing Board meeting on the 20th October 2015.

1.3. Contact Officers:
   Name: Geraldine Hoban,
   Chief Operating Officer, B&H CCG
   geraldine.hoban@nhs.net

2. **Summary**

2.1. Every year the local health and social care system around Brighton and Sussex University Hospitals NHS Trust (BSUHT) is required to develop detailed surge and capacity plans. The aim of the plan is to ensure that planned or elective as well as urgent care services operate as effectively as possible all year round but also over the winter period.

2.2. The plan is overseen by the System Resilience Group (SRG), a chief officers group chaired by Dr Christa Beesley. Whilst it focuses primarily on Brighton and Hove, it is also cross referenced with plans developed by our neighbouring CCGs in Horsham and Mid Sussex and High Weald Lewes Havens, all of whom look to BSUH as an acute hospital provider.

2.3. The plan has been informed by national good practice guidance also local reviews such as those conducted by the Emergency Care
Intensive Support Team (ECIST) and a demand and capacity review commissioned from Ernst and Young. The local system is also one of 27 across the country to be part of a new national improvement programme around emergency care called ECIP.

2.4. The plan also makes reference to cold weather and flu plans described in complimentary papers.

2.5. There will not be any centrally allocated resilience funding available this year. Instead, it is assumed that resilience plans are funded via CCG baselines at a level equivalent to the Tranche 1 funding received last year. For Brighton and Hove, this is equates to £1.8m. Alongside this resilience allocation, other CCG non recurrent funds have been used to support the plan. Hence the total cost of the plans is greater than £1.8m. A detailed breakdown of how the resilience funding is being used to deliver the plan is attached at Appendix One.

2.6. The plan includes the following key elements.

*Delivery of a whole system improvement programme*

2.6.1 The main objective of this programme is to achieve sustainable improvement in the 4 hours A&E service standard and a reduction in ambulance handover delays. Current performance against this key service standard is 83.43% at BSUH and an improvement trajectory has been agreed which means the hospital will achieve the service standard consistently by the end of March 2016.

2.6.2 This programme addresses a number of challenges in the system including:

- increasing our community based crisis response services so that only those who need to go to hospital do go
- the integration of entry points to the urgent care system such as NHS 111 so that what is a complex system for patients, makes sense and means they get a timely response by the person best able to meet their needs
- improved pathways for patients who do need acute hospital care, such rapid access surgical and medical assessment clinics
- increased capacity and new models of care to support hospital discharge, so that patients are able to go home as quickly as possible with the right support to maximise their chances of recovery and regaining their independence.

2.6.3 A summary of the work-streams contained within the programme is attached at Appendix Two.
Ensuring sufficient capacity across acute and community services

2.6.4 A key focus of the plan is to ensure that there is sufficient capacity in the system to manage expected levels of demand including surges caused by flu or bad weather. Resilience funding is being used to create additional beds and placements in acute and community services. A capacity and demand workshop was held on the 6th October to map out proposed plans and ensure they deliver the required resilience across the system. The outputs of the workshop are attached in the form of a capacity table attached as Appendix Three. Proposed plans include additional beds within the acute hospital and community services, improvements in services to free up capacity, for example, by reducing length of stay and extended operating times for some services, for example, the Community Rapid Response Service (CRRS).

System Escalation

2.6.5 We have also reviewed our current system wide escalation processes i.e. the framework or rules within which we all operate to manage periods of increased demand. The expected output of this review is that the system has a more proactive response to predicted peaks in demand and that all partners respond in a consistent way. A surge scenario event was held on the 22nd September to test out current plans and identify areas for improvement.

Public Awareness Campaigns

2.6.6 We have developed a comprehensive communications campaign that aligns with national messaging around winter but also promotes public awareness of the NHS 111 service.

2.6.7 Delivery of the overall surge and capacity plan is overseen by the System Resilience Group and a Project Management Office (PMO) provides day to day support and oversight to ensure plans are on track. The system is also expected to present the plans to NHS England for sign off.

2.6.8 A number of high level risks to delivery of the plan have been highlighted and these are monitored at the SRG. They include:

<table>
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<tr>
<th>Risk</th>
<th>Mitigation</th>
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<tr>
<td>Delivery of the overall plan given its scale and complexity</td>
<td>SRG oversight including regular meetings with provider to monitor progress. Project Management Office (PMO) approach to delivery of work streams.</td>
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<td>Workforce – inability to recruit additional staffing</td>
<td>Some staff recruited on a substantive basis. Use of agency and locum staff to provide backfill whilst recruitment ongoing.</td>
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</table>
3. **Decisions, recommendations and any options**

3.1 That the Health and Wellbeing Board note the contents of this report.

4. **Relevant information**

4.1 There is no other information to be considered.

5. **Important considerations and implications**

   **Legal**

5.1 As this report is for noting, there are no significant legal implications to draw to the Board’s attention at this time.

   **Finance**

5.2 There are no financial implications for the report.

   **Equalities**

5.3 The partners from the Local Health Economy are keenly aware of sustainability issues. There are no perceived negative sustainability implications associated with this report and the documents and plans it draws from.

   **Sustainability**

5.4 There are no sustainability considerations.

   **Health, social care, children’s services and public health**

5.5 There are no issues to report.
Supporting documents and information

Appendix One  ·  Proposed Use of Resilience Funds
Appendix Two  ·  Whole System Improvement Plan
Appendix Three ·  Capacity Plan
<table>
<thead>
<tr>
<th>Project</th>
<th>Work Programme</th>
<th>£ 15/16</th>
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<tr>
<td><strong>SCT</strong></td>
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<td>CRRS Additional Nursing</td>
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<td>SCT Admission and Discharge Co-ordination Team.</td>
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<td>£ 220,000</td>
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<td>CHC assessor for IPCT’s and CRRS</td>
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<td>£ 50,000</td>
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<td>Discharge to assess pilot</td>
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<td>£ 477,000</td>
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<tr>
<td>Discharge to assess pilot - Red Cross</td>
<td></td>
<td></td>
<td>£ 45,000</td>
</tr>
<tr>
<td><strong>SPFT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.5 WTE Social work post for Millview</td>
<td></td>
<td>£ 23,000</td>
<td></td>
</tr>
<tr>
<td>SPFT homecare Liaison post</td>
<td></td>
<td>£ 75,000</td>
<td></td>
</tr>
<tr>
<td><strong>ASC</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Block contract of care workers</td>
<td></td>
<td>£ 99,000</td>
<td></td>
</tr>
<tr>
<td>Urgent home care linked with specialist end of life care</td>
<td></td>
<td>£ 200,000</td>
<td></td>
</tr>
<tr>
<td>Care link response for Fallers</td>
<td></td>
<td></td>
<td>£ 50,000</td>
</tr>
<tr>
<td>7 day social work coverage in HRDT</td>
<td></td>
<td></td>
<td>£ 60,000</td>
</tr>
<tr>
<td>BSUH Care home liason post</td>
<td></td>
<td></td>
<td>£ 75,000</td>
</tr>
<tr>
<td><strong>BSUH</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional handover nursing at PRH ED</td>
<td></td>
<td>£ 46,740</td>
<td></td>
</tr>
<tr>
<td>Nursing staff to assist with ambulance handovers</td>
<td></td>
<td>£ 28,500</td>
<td></td>
</tr>
<tr>
<td>72 hour short stay capacity and frailty unit</td>
<td></td>
<td>£ 250,000</td>
<td></td>
</tr>
<tr>
<td>Enhancement to HRDT</td>
<td></td>
<td></td>
<td>£ 486,000</td>
</tr>
<tr>
<td><strong>OTHER</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NPS/ club drugs A&amp;E Liaison Worker</td>
<td></td>
<td>£ 40,000</td>
<td></td>
</tr>
<tr>
<td>Age UK additional support for CRRS</td>
<td></td>
<td>£ 20,000</td>
<td></td>
</tr>
<tr>
<td>Urgent Communications Plan</td>
<td></td>
<td></td>
<td>£ 20,000</td>
</tr>
<tr>
<td>Continuation of Safe Space service</td>
<td></td>
<td></td>
<td>£ 25,000</td>
</tr>
<tr>
<td>GP in Emergency Despatch Centre &amp; GP OOH service</td>
<td></td>
<td>£ 100,000</td>
<td></td>
</tr>
<tr>
<td>Alamac system (activity system measure)</td>
<td></td>
<td></td>
<td>£ 72,000</td>
</tr>
<tr>
<td>Enhanced Ambulance capacity</td>
<td></td>
<td></td>
<td>£ 100,000</td>
</tr>
<tr>
<td><strong>NEW</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEW Additional Community Bed Capacity</td>
<td></td>
<td>£ 1,000,000</td>
<td>£ 1,835,240</td>
</tr>
</tbody>
</table>

**FORECAST SPEND**

12/10/15

E:\moderngov\Data\AgendaItemDocs\8\6\4\A100048468\$rxzumjci.xlsm\Resilience Plans

451
Whole System Plan and Monitoring of Delivery via PMO

Programme Management Supported by BH CCG PMO

Whole System Plan and Monitoring of Delivery via PMO

Unscheduled Care Improvement Plan

Programme Summary Report to SRG

Project Highlight Reports to the UC ORG (South and North)

Updates on the “big ticket” projects and programme risk

Urgent Care Improvement Programme

Community Based Crisis Response

Integrated Front Door

Hospital Flow and Effective Discharge

Reablement and Intermediate Care

Co-location of GP Out of Hours in both EDs

Right Care Right Place Most Time - implementation of good practice discharge principles across all hospitals services.

Discharge to Access for all patients going home from hospitals with complex needs (Brighton and Hove)

Acute Floor = Implementation of comprehensive acute assessment pathways across both acute sites.

Improving ambulance handover delays

Right Care Right Place Each Time - implementation of good practice discharge principles across all hospitals services.

Discharge to Access for all patients going home from hospitals with complex needs (Brighton and Hove)

Non-acute sub-acute beds and hospital at home

Integrated Discharge Team and Triage to Access (Horsham and Mid Sussex)

Re-procurement of Patient Transport Services

Enablers

Workforce

Demand and Capacity Mapping

System Management and Escalation

Future of Care: Transformation of primary, community and social care in the West Sussex/C CCG

Improving flow in current community beds capacity maintenance and new (including 24 additional capacity beds)

Re-procurement of Community Rehabilitation beds in Brighton and Hove

Additional community beds (Horsham and Mid Sussex)

Procurement of a new 111 service that is integrated with the local urgent care system

Development of One Call Hub to support alignment with prioritisation of NHS 111 and out of hours

Extending operating times of Community Rapid Response Service

Expansion of non-conventional pathways with community mobile and urgent treatment services aligned to primary care

High Level Prevention of Admission programmes including Community Geriatrician, Self Management, Practice Pharmacists in Horsham and C CCG (including rifampicin)

Alternative 999 for Carelink callers who have fallen

Care Home Support and intervention schemes (Horsham and Mid Sussex, IW)

IC24 resilience including pharmacy capacity to manage repeat prescription activity
<table>
<thead>
<tr>
<th>Organisation</th>
<th>Plan</th>
<th>Capacity</th>
<th>Bed Equivalent</th>
<th>Timescales</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSUH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FGCH - perceived shortfall is 64</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub acute capacity</td>
<td>10 beds</td>
<td>20</td>
<td></td>
<td>Oct Nov Dec Jan Feb March</td>
</tr>
<tr>
<td>Sub acute capacity - hospital at home</td>
<td>10 places</td>
<td>20</td>
<td></td>
<td>Oct Nov Dec Jan Feb March</td>
</tr>
<tr>
<td>Surgical assessment unit - 24/7</td>
<td>5 beds</td>
<td>6</td>
<td></td>
<td>Oct Nov Dec Jan Feb March</td>
</tr>
<tr>
<td>Reduced length of stay from roll out of discharge good practice programme</td>
<td>12 beds</td>
<td>12</td>
<td></td>
<td>Oct Nov Dec Jan Feb March</td>
</tr>
<tr>
<td>Extension of Hospital Rapid Discharge Team</td>
<td>Reduction in numbers on delayed transfers of care list tbc</td>
<td></td>
<td></td>
<td>Oct Nov Dec Jan Feb March</td>
</tr>
<tr>
<td>PRH - no significant bed gap</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hampton beds - step down or medically fit patients</td>
<td>21 beds</td>
<td>20</td>
<td></td>
<td>Oct Nov Dec Jan Feb March</td>
</tr>
<tr>
<td>Balcombe ward additional beds</td>
<td>4 beds</td>
<td>4</td>
<td></td>
<td>Oct Nov Dec Jan Feb March</td>
</tr>
<tr>
<td>Reduced length of stay from roll out of discharge good practice programme</td>
<td>To be quantified</td>
<td>To be quantified tbc</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub total BSUH</td>
<td>82</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Social Care - Brighton and Hove</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managing increased dependency and reducing length of stay in bed based services</td>
<td>Reduced length of stay in Craven Vale by 20%</td>
<td>16 additional admissions (5 month pye)</td>
<td>4.3</td>
<td>Oct Nov Dec Jan Feb March</td>
</tr>
<tr>
<td>Increased admissions to Kneill House by 15%</td>
<td>15 additional admissions (5 month pye)</td>
<td>2.2</td>
<td></td>
<td>Oct Nov Dec Jan Feb March</td>
</tr>
<tr>
<td>Sub total ASC</td>
<td>6.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCFT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brighton and Hove</td>
<td>Full roll out of discharge to assess at FGCH - phase 1</td>
<td>224 bed days freed up in BSUH per month</td>
<td>6.7</td>
<td>Oct Nov Dec Jan Feb March</td>
</tr>
<tr>
<td>Roll out of phase 2 of discharge to assess - patients going home with just care</td>
<td>76 bed days freed up in BSUH per month</td>
<td>11</td>
<td></td>
<td>Oct Nov Dec Jan Feb March</td>
</tr>
<tr>
<td>Extension of Community Rapid Response Service until 10pm 7 days a week</td>
<td>151 additional referrals based on 2 per day (5 month pye)</td>
<td>2</td>
<td></td>
<td>Oct Nov Dec Jan Feb March</td>
</tr>
<tr>
<td>Horsham and Mid Sussex</td>
<td>Hospital Rapid Discharge Team support staff</td>
<td>To be quantified</td>
<td>To be quantified tbc</td>
<td>Oct Nov Dec Jan Feb March</td>
</tr>
<tr>
<td>Interim beds increase from 15</td>
<td>7 beds</td>
<td>7</td>
<td></td>
<td>Oct Nov Dec Jan Feb March</td>
</tr>
<tr>
<td>System and flow roles</td>
<td>Mobile devices in responsive services ie admission avoidance service</td>
<td>To be quantified</td>
<td>To be quantified tbc</td>
<td>Oct Nov Dec Jan Feb March</td>
</tr>
<tr>
<td>Sub total SCFT</td>
<td>24.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SECAMB</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tactical plan around key dates over winter to match capacity with demand</td>
<td>Plans resources to match demand by hours of day and day per week</td>
<td></td>
<td>Oct Nov Dec Jan Feb March</td>
<td></td>
</tr>
<tr>
<td>Annual leave and training restriction over key periods</td>
<td>Driving conveyance rates down even further</td>
<td></td>
<td>Oct Nov Dec Jan Feb March</td>
<td></td>
</tr>
<tr>
<td>Response capable operational managers available to respond</td>
<td></td>
<td>Oct Nov Dec Jan Feb March</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IC24</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To provide resilience to service over peak periods and mitigate shift fill issues</td>
<td>Annual leave restrictions over key periods</td>
<td></td>
<td>Oct Nov Dec Jan Feb March</td>
<td></td>
</tr>
<tr>
<td>Homeworking for clinicians</td>
<td>Multi shift incentives to mitigate impact of indemnity costs for GPs</td>
<td></td>
<td>Oct Nov Dec Jan Feb March</td>
<td></td>
</tr>
<tr>
<td>2 Pharmacists to manage repeat prescription activity</td>
<td>Additional GP in Emergency Department out of hours</td>
<td></td>
<td>Oct Nov Dec Jan Feb March</td>
<td></td>
</tr>
<tr>
<td>GRAND TOTAL (BED CAPACITY)</td>
<td>113.2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. **Brighton & Hove Safeguarding Adults Board Annual Report 2014/15**

1.1. The contents of this paper can be shared with the general public.

1.2. This paper is for the Health & Wellbeing Board meeting on the 20\textsuperscript{th} October 2015.

1.3. Michelle Jenkins, Head of Adult Safeguarding  
Tel: 01273 96271  
michelle.jenkins@brighton-hove.gcsx.gov.uk

2. **Summary**

2.1. This is the annual report of the Brighton & Hove Safeguarding Adults Board for 2014/15. It outlines the work of the Board during this period, and how partner agencies have worked together to improve the safety of adults at risk of harm and abuse, and it sets out future priorities. It also provides data on the number, type, source and demography of safeguarding referrals, and the outcomes of subsequent investigations.

3. **Decisions, recommendations and any options**

3.1. That the Health and wellbeing Board notes the safeguarding work carried out in 2014/15, and the priorities for 2015/16.

3.2. The Health and Wellbeing Board agree the report for circulation.
4. Relevant information

4.1 Brighton & Hove City Council Adult Social Care is the statutory lead for the co-ordination of work for safeguarding adults at risk from harm and abuse. If there is a concern or an allegation made that an adult at risk may be being harmed, the lead role for co-ordinating any enquiry into this rests with Adult Social Care.

4.2 The Brighton & Hove Safeguarding Adults Board is multi agency with representation from all statutory organisations, and representation from local groups and organisations who have an interest in safeguarding issues for adults at risk. The Board is co-ordinated by Adult Social Care, and the Board takes a strategic lead in planning work to ensure vulnerable citizens are safeguarded from harm, abuse or exploitation.

4.3 The Safeguarding Adults Board Annual report outlines work carried out across the City during the period of 2014/15, and notes the priorities for 2015/16. The report is published on the Brighton & Hove City Council website, and circulated to all member organisations of the Safeguarding Adults Board.

4.4 On April 2015 the Care Act came into force, making Safeguarding Adults Boards statutory, with 3 statutory member organisations, Police, Clinical Commissioning Groups and the Local Authority. A requirement under the Care act is for Safeguarding Adult Boards to produce a yearly progress report, so the Brighton & Hove Safeguarding Adults Board annual report produced next year for 2015/16 will be the first statutory annual report.

5. Important considerations and implications

5.1 Legal
It is the responsibility of the Health and Wellbeing Board to oversee and approve functions in relation to Adult Social Care. As highlighted in the body of this Report Safeguarding, (including the requirement to produce and annual report) has been placed on a statutory footing from April 2015 by virtue of the Care Act 2014.

Sandra O’Brien Senior Lawyer  Date 08/10/2015
5.2 Finance
Resources to support Safeguarding are funded through the Council and partner organisations. The increased responsibility and awareness through the Care Act is putting pressure on budgets and will be considered as part of the four year service and financial planning process.

Finance Officer consulted: Anne Silley Date 05/10/15

5.3 Equalities
There are no specific equalities issues for the HWB in relation to this report. An Equality Impact assessment has been carried out for safeguarding work. Positive joint working in this area will ensure that the most vulnerable citizens are supported to access the justice system, and will improve prevention of harm and abuse.

5.4 Sustainability
There are no sustainability issues for the HWB in relation to this report.

5.5 Health, social care, children’s services and public health
The annual report addresses these issues.

6 Supporting documents and information

6.1 Brighton & Hove Safeguarding Adult Board annual report 2014/15.
Brighton & Hove Safeguarding Adults Board

Annual Report
2014/15
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Appendix 1: From Sussex Multi-Agency Policy and Procedures for Safeguarding Adults at Risk 2.4.1
1. **Foreword from Denise D'Souza, Chair Brighton & Hove Safeguarding Adults Board.**

It is my pleasure to introduce the 2014/15 Safeguarding Adults Annual Report on behalf of the Brighton & Hove Safeguarding Adults Board. I hope that you find it an interesting and useful document. The annual report outlines the work of the Board during 2014 to 2015, and how partner agencies have worked together to improve the safety of adults at risk of harm and abuse. It also recognises issues for future work and sets out the future priorities of the Board. The report describes how the Board’s agencies work, both jointly and independently, to ensure the safety of those adults within Brighton & Hove who are deemed to be most at risk of harm. It contains statistical breakdowns which show the number, type, source and demography of safeguarding referrals, and the outcomes of the subsequent investigations.

2015 is a very significant year for safeguarding adults. The Care Act comes into force and with it come new legal duties for Local Authorities and partners in protecting adults at risk of abuse or neglect. It is now a statutory duty for the Local Authority to make enquiries if it believes someone with care and support needs is at risk of harm or abuse, and they are unable to protect themselves. However, I think it is important to say that this new legislation brings with it wider changes than the new duties. The Statutory guidance for the Care Act indicates a real step change in the whole approach to adult safeguarding practice, with an enhanced focus on the individual’s outcomes, on prevention and on the well-being of the person. This has meant continuing the work from last year’s Making Safeguarding Personal pilot, and embedding that change in practice.

Much of the Board’s focus, therefore, this year has been on preparing for the Care Act, ensuring the Board is well placed to meet its new duties, but also ensuring the start of this new approach. In order to be able to meet these new legislative requirements, but also new practice expectations, it was agreed across all 3 Sussex Safeguarding Adults Boards that the safeguarding procedures were to be rewritten and relaunched. This piece of work has been completed, and the task for the year ahead is to evaluate the impact of this, and to ensure genuine practice change and evaluate the impact of this in making a difference to the experience of people we work with and support.

The Care Act also puts safeguarding adults boards on a strong statutory basis, better equipped both to prevent abuse and to respond when it occurs. Following the review of the Board in 2014, the Board has committed to having an Independent Chair. I am very pleased to announce that Graham Bartlett, who is currently the Chair for our Local Children’s Safeguarding Board, has taken up this role for the adults board too, and will start his Chairing duties this year. He has also taken up the Chairing role in East Sussex for their adults’ board. This brings with it lots of positive opportunities for joint working with the B&H Children’s Board and the East Sussex Safeguarding Adults Board, as well as giving us independent scrutiny for our board and the work that it does.

I see this as a new beginning for adult safeguarding, and a real opportunity for change. We can build on the foundations we have of good partnership working, in order to stretch ourselves further to meet the new challenges and new approach. We have started well with a real commitment to meet new requirements and in the year ahead we must all continue with this opportunity. These are challenging times for adult safeguarding, but I believe we have the commitment and foundations in place to achieve our goals.


Executive Director Adult Services / Chair Brighton & Hove Safeguarding Adults Board
2. National Developments

2.1 A number of key developments related to health and social care have had a major impact on adults safeguarding work nationally and locally.

The Care Act
The Care Act received royal assent in May 2014, and came into force in April 2015. It modernises and consolidates the laws on adult care into one statute. Key changes include the introduction of a national eligibility criteria, a right to independent advocacy, and a strengthening of the rights of carers. The Care Act also places adult safeguarding on a statutory basis for the first time. New Duties include the Local Authority’s duty to make enquiries, or cause them to be made, where abuse of an adult with care and support needs is suspected or known to have taken place, and the person is unable to protect themselves. There is a Duty for a Local Safeguarding Adults Board to be established, statutory members being the local authority, Clinical Commissioning Groups and the police. Safeguarding Adults Boards must publish an annual report and a strategic plan, and must arrange Safeguarding Adult Reviews in specific circumstances to learn lessons for the future, with a duty on agencies to cooperate with the review. The statutory guidance for the Care Act replaces the ‘No Secrets’ guidance, and describes in detail the expectations on all partner organisations in working together to prevent and stop the risk and experience of abuse and neglect, whilst promoting the person's wellbeing and rights.

Deprivation of Liberty Safeguards (DoLS)
The Supreme Court Judgment at the end of 2013/14 clarified the criteria for assessing whether a person lacking capacity regarding decisions for their care and support is being ‘deprived of their liberty’ in a care home, hospital or other care setting. This has resulted in a significant increase in authorised deprivations nationally and locally. The judgment also widened the scope for DoLS to include adults living in the community, requiring such cases to be put to the Court of Protection.

Nationally DoLS applications have increased by 10 times since the ruling. Locally referrals have risen proportionally higher than national figures, from 2 in March 2014 to 121 in March 2015. This has had a huge impact on workload and resources, and has required a speedy reaction locally in order to meet this increasing demand, through reallocating and identifying specific resources, and increasing training and awareness.

Care Quality Commission (CQC)
In 2014/15 the Care Quality Commission started delivering on their planned new approach to regulation and inspection of health and social care providers: NHS acute, mental health and community trusts; adult social care; and GP practices. This includes a sector-specific approach to inspection, including specialist advisors with expertise in the area being inspected. The new approach is a shift in focus from judging only whether providers meet legal standards, to increased professional judgement and encouraging providers to improve, with a focus on services being safe, effective, caring, responsive and well-led. Following each inspection, each service is rated: Outstanding, Good, requires Improvement or Inadequate. The new standards of care launched on 1 April 2015 include new enforcement powers for the CQC that allows them to go straight to prosecution when they find the most serious failings in care, without issuing a Warning Notice first. They also include new requirements; the ‘duty of candour’ and ‘fit and proper person’ for directors, to hold leadership to account for poor care. Where they identify serious failures in care CQC will place a provider in special measures, to ensure improvement.

Social Work Reform Agenda
“Social workers in adult services are working with greater complexity, increasing demand and higher expectations of the citizens with whom we work. The present public sector financial challenges require, more than ever, creative and innovative social work approaches to empower people to achieve the best outcomes.” (Lyn Romeo, Chief Social Worker For Adults, October 2014)

There have been a number of developments both nationally and locally within the profession. 2014-15 saw the first full year of the Chief Social Worker for Adults, providing a new platform for driving
forward social work reform and development and providing independent expert advice to ministers on social work reform and the contribution of social work and social workers to policy implementation more generally. We have seen social work taking a prominent role in the Care and Support Statutory Guidance to the Care Act 2014 and this year also saw a strengthening of the national network of Principal Social Workers, led by the Chief Social Worker and providing a national influential forum for improving standards and practice.

Locally, and in response to these national drivers, the primary focus has been on social work practice development in order to meet expectations of the Care Act and its statutory guidance. Social Workers in Brighton and Hove have led the development of a more personalised approach to safeguarding practice in line with the principles of ‘Making Safeguarding Personal’ (Local Government Association 2014). We have developed the social work role to ensure that our statutory duties under Section 42 of the Act are professionally led to ensure that the social work skills and knowledge are at the heart of new practice models designed to improve the experience and outcomes of people using safeguarding services in Brighton and Hove. The appointment of two Advanced Social Workers has enabled practitioners in adult services to develop and embed the practice development strategy and to drive forward a significant grass roots and practice led movement. The priority for the year ahead is to continue to support social workers to develop the skills, knowledge and confidence to undertake the Council’s statutory safeguarding duties and to respond to related areas of complex practice such as the Mental Capacity Act and Care Act duties. This will be achieved through a programme of practice development groups (led by the Advanced Social Workers) and the embedding of new local standards for professional supervision and practice governance which align more closely with the Social Work Reform partner’s ‘Standards for Employers of Social Workers’ (Local Government Association 2014).

The important role of social work in the successful delivery of services which safeguard adults is reflected in the ‘Knowledge and Skills Statement’ for Adult Social Workers (Department of Health 2015) which, for the first time, articulates the expectations of Social Work in this area of practice. The statement provides a blueprint for practice development for newly qualified social workers and a baseline for all social workers undertaking the new safeguarding duties on behalf of the council.

**Prevent Duties**
The Counter Terrorism and Security Bill was introduced in the Parliament on 26th November 2014 and received Royal Assent on 12th February 2015. The Counter Terrorism and Security Act, 2015 has created a general Prevent Duty on specified authorities, which ‘must in the exercise of its functions, have due regard to the need to prevent people from being drawn into terrorism’. The Prevent Duty comes into effect in July 2015. The Act creates a new ‘Prevent Duty’ for ‘specified authorities’, which ‘must in the exercise of its functions, have due regard to the need to prevent people from being drawn into terrorism’.

Unitary authorities are included in the list of specified authorities, as are county and district local authorities, schools, colleges, universities, police, probation, prisons, young offenders’ institutions and the health sector.

**Modern Slavery**
The Modern Slavery Act received Royal Assent on 26th March 2015. The Act consolidates the current offences relating to trafficking and slavery. The act will give law enforcement the tools to fight modern slavery, ensure perpetrators can receive suitably severe punishments and enhance support and protection for victims. The Act establishes an Anti-Slavery Commissioner, appointed by the Home Office, with a UK-wide remit, ensuring that modern slavery issues are tackled in a coordinated and effective manner across the whole of the UK.

**Serious Crime Act**
The Serious Crime Act 2015 received Royal Assent on 3 March 2015. The Act brings in new powers in dealing with organised, serious and gang related crime, and makes a number of changes to the civil and criminal law to enhance the protection of vulnerable children and adults, including strengthening the law to tackle female genital mutilation (FGM) and domestic abuse. It brings in FGM Protection Orders to protect potential victims. These orders will operate in a similar
way to Forced Marriage Protection Orders.

The Crime Act also includes criminalising patterns of repeated or continuous coercive or controlling behaviour where perpetrated against an intimate partner or family member, causing victims to feel fear, alarm or distress. The new offence comes after the government ran a consultation over the summer seeking views on whether the law on domestic abuse needed to be strengthened. The Home Office said that 85% of the participants in that consultation said domestic violence law at the time did not provide sufficient protection to victims. Coercive and controlling behaviour can include the abuser preventing their victim from having friendships or hobbies, refusing them access to money and determining many aspects of their everyday life, such as when they are allowed to eat, sleep and go to the toilet.

Clare’s Law
The Domestic Violence Disclosure Scheme (known as Clare’s Law), a scheme allowing police to disclose details of an abusive partners’ past, was rolled out across England and Wales on International Women's Day, March 2014. Clare’s Law provides victims with information that may protect them from an abusive situation before it ends in tragedy. The scheme allows the police to disclose information about a partner’s previous history of domestic violence or violent acts. The roll out followed a 14 month pilot in 4 police force areas.

Domestic Violence Protection Orders (DVPOs) were introduced on the same day, also following a pilot. This new power enables police and magistrates’ courts to provide protection to victims in the immediate aftermath of a domestic violence incident, by preventing perpetrators of domestic violence from returning to their home for up to 28 days, giving the victim time to consider their options.

The Anti-Social Behaviour, Crime and Policing Act 2014
The Anti-social Behaviour, Crime and Policing Act received royal assent on 13 March 2014. The act introduces simple, more streamlined powers to tackle anti-social behaviour. The new community trigger and community remedy empowers victims and communities by giving them a greater say in how agencies respond to complaints of anti-social behaviour, and in out-of-court sanctions for offenders. It strengthens the protection afforded to the victims of forced marriage by making forced marriage a criminal offence and criminalising the breach of a forced marriage protection order.

2.2 Progress on Key Priorities Identified by the Safeguarding Adults Board for 2014-15

Implementation of the Care Act was the key priority for this year. The safeguarding sections of the Act brought in new legislation and duties for safeguarding adults, making local changes a priority to ensure that we are meeting legal requirements. The statutory guidance brought in new expectations as to how adults are supported to keep safe from harm and abuse. All the safeguarding statutory requirements were met for 1st April 2015.

Sussex Multi Agency Policy and Procedures for Safeguarding Adults at Risk required a full review so as to reflect the new duty to enquire, and other duties under the Act such as the right for an adult at risk to have access to advocacy in certain circumstances, as well as the new expectations under the statutory guidance. This review significantly changes the process for safeguarding adults locally, changing not only the language used, such as 'investigation' to 'enquiry', but also the process and pathway for safeguarding concerns. The revised Policy and Procedure has been agreed by all 3 Safeguarding Adults Boards across Sussex, and from April 2015 replaces the previous procedures.

'Making Safeguarding Personal'; the Care Act statutory guidance puts an emphasis on safeguarding being individual to each person’s need, engaging with the person in how best to respond to their situation. The new Policy and Procedures reflect this throughout and ensure that the focus is not on the process but on the person, how to ascertain and meet their goals and desired outcomes.
Staff Training and Awareness: the new Policy and Procedures have been launched through the B&H Safeguarding Adults Board to all stakeholders. All Board member organisations have considered and revised internal Policy and Procedures accordingly. Changes have been made to staff training programmes, to the recording and documentation for safeguarding adults and to quality monitoring and audit processes.

Brighton & Hove Safeguarding Adults Board: the Care Act puts Local Safeguarding Adults Boards on a statutory footing in line with Safeguarding Children’s Boards. This includes a duty for certain organisations to be represented, a statutory requirement for the Board to publish a yearly strategy and to produce a yearly progress report on this strategy. Safeguarding Adults Boards must also conduct Safeguarding Adults Reviews either under specific circumstances such as if an adult in its area dies as a result of abuse or neglect (known previously as Serious Case Reviews) or any case the Board considers appropriate. A key recommendation from a review of the Brighton & Hove Board was for the recruitment of an Independent Chair to be considered. This was agreed by the Board this year, with funding from statutory Board members (BHCC, CCG, Police). An Independent Chair for the Safeguarding Adults Board has been recruited, Graham Bartlett. Graham is also the chair for B&H Safeguarding Children’s Board, and for East Sussex Safeguarding Adults Board, which offers good opportunities for learning from other areas, as well as joint working.

2.3 Key Priorities for 2015-16

The Safeguarding Adults Board’s vision is that we will all work together to enable people in Brighton & Hove to live a life free from fear, harm and abuse. The Board has identified five priorities that will support the vision to become a reality.

- Embed practice change and improvement aligned with statutory arrangements implemented from Care Act 2014
- Develop and strengthen quality assurance
- Focus on Prevention
- Community Awareness and Capacity Building
- Locate the work of the SAB in wider structures.

Brighton & Hove Safeguarding Adults Board (SAB)
Graham Bartlett is starting in the role of Independent Chair for the Board in June 2015. A key priority for the year ahead will be for the Board to work together with the Independent Chair to develop the Board in order to ensure it meets its new statutory requirements, and work on continued assurance of local safeguarding arrangements. This will include developing and confirming the Board strategy, agreeing the new business plan, reviewing the Board governance and infrastructure, and agreeing resourcing of the Board. Opportunities for joint working within the Board partnerships, and with the Local Children’s Board, and the East Sussex Adults Board, will also be explored. This will consider joint opportunities for training, for development of practice, and for taking forward key priorities.

Safeguarding Statutory Requirements and Quality Assurance
All the safeguarding statutory requirements were met by the 1st April, with new processes and procedures starting on that day. The task for the year ahead will be to monitor compliance with the procedures, and to evaluate the impact of this. A new quality assurance framework is to be developed for assessing the quality of safeguarding enquiries undertaken. This will inform ongoing training requirements. The Care Act Statutory guidance and the Sussex Safeguarding Adults procedures put an expectation on safeguarding being person centred, and outcome focussed. Feedback from individuals worked with will need to be sought and used as part of practice development.

Mental Capacity and Deprivation of Liberty Safeguards (DoLS)
Local arrangements for DoLS will continue to be developed so as to continue to meet legal requirements, and best practice, and to meet ongoing increased demand. Training and awareness will
continue, with opportunities for joint training and joint working being explored, such as increasing numbers of Health staff becoming Best Interest Assessors. There will be a focus on training in regards to Restrictive Practice, ensuring compliance with the Mental Capacity Act and the principles of least restriction.

A review of current DoLS Legislation is being undertaken by the Law Commission. We will supply a local response to the consultation on the proposals, and consider how any future changes to the law can be prepared for locally.
3. Performance and Practice 2014-15

3.1 Summary of Main Points to Note

1) The total number of safeguarding alerts raised due to suspected harm or abuse of an adult at risk in Brighton and Hove for the year 2014-15 (April –end March) is 1,716. Last year the total was 1,861, so this is a decrease from 2013-14 of 7.8%. Last year there was a very slight decrease of 0.8%, which started the trend of decrease in numbers. Previously to that, and in general since 2004, when data collection started, there has been a yearly increase of between 20-60%.

2) Alerts and investigations are logged in Adult Social Care teams, such as teams working with people with a learning disability, or people with physical disabilities or frailty, and in Mental Health and Substance Misuse teams, which includes people with dementia. Mental Health and Substance Misuse Services are integrated teams, and have been managed within Sussex Partnership Foundation Trust (SPFT). This year the number of alerts received in Adult Social Care services (ASC) is 1,137, a 2.3% increase from last year. The number of alerts received in Mental Health and Substance Misuse Services is 579, a 22% decrease from last year. This continues the trend of an increase of alerts logged as received in ASC services, and a decrease in alerts logged in Mental Health and Substance Misuse Services.

3) The number of alerts which required a safeguarding investigation this year totalled 738. Last year there were 845 investigations, so a 12.6% decrease. Last year there was a 1.5% decrease, so the trend of a decrease in investigations undertaken under the safeguarding procedures has continued. Previous years have shown between a 5% - 20% increase. 738 investigations breaks down to 14.1 safeguarding investigations per week.

4) The percentage of alerts which required to be investigated under the safeguarding procedures last year was 45%. This year it is 43%, showing a fairly steady approach, and has remained near this figure for the last few years. In Adult Social Care Services (ASC) 384 investigations were undertaken. Therefore 34% of alerts received by ASC services required an investigation under the safeguarding procedures, exactly the same percentage as last year. In Mental Health and Substance Misuse Services 354 investigations were undertaken. Therefore 61% of alerts received by these services required an investigation under the safeguarding procedures. This was 62% last year, so again a similar proportion to the previous year.

5) In summary, last year’s trend of an overall decrease in number of alerts and investigations has continued, but more sharply. This last 2 years has bucked the previous several years trend of ongoing increases in numbers. Changes to the safeguarding procedures in 2015 will make any future comparison difficult, and there will no longer be reporting on number of alerts and investigation, but on number of ‘enquiries’ for which there is a different threshold to previous expectations. The Brighton & Hove Safeguarding Adults Board will be considering what additional data is required and how this is to be analysed, and what ongoing quality monitoring is needed to ensure consistency. The trend of a higher proportion of alerts requiring investigation with SPFT teams has continued. This was first shown last year, and some quality monitoring was undertaken to ensure consistency. This did not find any concerns with practice. Alerts raised within dementia services result in a higher number of investigations, which is to be expected given the vulnerability of this client group, and the number of people who may lack capacity to protect themselves. Improved data collection within these services over the last 2 years is likely to have revealed the truer numbers of investigations than in previous years.
6) The table below shows some additional information available from alerts which resulted in an investigation.

<table>
<thead>
<tr>
<th>Additional Information</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is alert related to care delivered via a Direct Payment?</td>
<td>14</td>
</tr>
<tr>
<td>Is this alert linked to domestic violence?</td>
<td>59</td>
</tr>
<tr>
<td>Is this alert linked to hate crime?</td>
<td>9</td>
</tr>
<tr>
<td>Is this alert linked to anti-social behaviour?</td>
<td>21</td>
</tr>
<tr>
<td>Is the adult at risk an informal carer?</td>
<td>20</td>
</tr>
<tr>
<td>Is the person alleged responsible the main informal carer?</td>
<td>83</td>
</tr>
<tr>
<td>Does the person alleged responsible live with adult at risk?</td>
<td>70</td>
</tr>
<tr>
<td><strong>What was the result of action taken under safeguarding?</strong></td>
<td></td>
</tr>
<tr>
<td>Criminal investigation / prosecution</td>
<td>11</td>
</tr>
<tr>
<td>Serious incident investigation (Health Process)</td>
<td>5</td>
</tr>
<tr>
<td>Referral to professional body</td>
<td>17</td>
</tr>
<tr>
<td>Referral to Disclosure and Barring Service</td>
<td>11</td>
</tr>
<tr>
<td>GP / Health Notified</td>
<td>198</td>
</tr>
</tbody>
</table>

The number of investigations regarding care delivered via a Direct Payment has increased since last year, from 7 to 14.

There has been a drop in number of investigations related to Domestic Violence, from 78 to 59. This requires exploration through audit, and figures may continue to change due to the new safeguarding procedures, though it is not clear at this point what the impact may be.

The number of investigations which resulted in a criminal investigation has significantly dropped, from 44 to 11. Criminal investigation will be defined as a much more separate process from enquiries under the new procedures, and numbers will no longer be monitored by Adult Social Care, so additional monitoring will be required if this data is to be collected.

The number of safeguarding investigations for which there was also a Health led Serious Incident investigation continue to be low, 10 last year and 5 this year. This will require further local decisions as to how clinical investigations will relate to enquiries, and how this will be monitored.

The Care Act creates new expectations regarding monitoring concerns which involve members of staff, with new Designated Adult Safeguarding Manager (DASM) roles within key organisations. Locally it will need to be decided how the DASM’s will collate any relevant information such as referrals to the Disclosure and Barring service, or to professional bodies, and how this information is shared and acted upon.

7) The following data below is taken from 560 completed investigations during the period of 1st April 2014 to 31st March 2015 inclusive.

<table>
<thead>
<tr>
<th>2014-15 End of Year DATA</th>
<th>Care Assess</th>
<th>SPT</th>
<th>SMS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Alerts in period</td>
<td>1137</td>
<td>505</td>
<td>74</td>
<td>1716</td>
</tr>
<tr>
<td>Number of alerts that went into investigation</td>
<td>384</td>
<td>311</td>
<td>43</td>
<td>738</td>
</tr>
<tr>
<td>Completed Investigations</td>
<td>297</td>
<td>223</td>
<td>40</td>
<td>560</td>
</tr>
</tbody>
</table>

| 2013-14 End of Year DATA |
### 3.2 Performance Data 2014 – 2015

<table>
<thead>
<tr>
<th></th>
<th>Care Assess</th>
<th>SPT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Alerts in period</td>
<td>1130</td>
<td>752</td>
<td>1882</td>
</tr>
<tr>
<td>Number of alerts that went into investigation</td>
<td>397</td>
<td>469</td>
<td>866</td>
</tr>
<tr>
<td>Completed Investigations</td>
<td>305</td>
<td>295</td>
<td>600</td>
</tr>
</tbody>
</table>

#### Figure 1: Percentage of Investigations by Primary Support Reason of Adult at Risk

Since last year new reporting requirements have changed the reporting categories for this graph from Primary Need to Primary Support Reason, so direct comparisons are not possible. However, people who require physical support and memory cognition support remain the largest group of adults for whom a safeguarding investigation is required. Although some of the categories have changed, and the terminology has changed, in the main proportion of investigations for support reasons remains very similar from the previous year.
In 0.4% of all client groups the adult at risk was receiving services for their caring role only. In 3.6% of investigations, the adult at risk was also an informal carer, though they may also be receiving services for their own care and support needs.

In figure 2 we can see that risk of harm increases proportionately into older age, particularly for those over 85 years.

In figure 3 we can see the distribution of investigations by gender and primary support reason of adults at risk.
In figure 3 we can see the number of investigations undertaken divided into the gender and the primary need of the adult at risk. Out of a total of 560 completed investigations 340 of the adults at risk were female, and 220 were male. As a percentage that is 61% women, 39% men. This is a very slight increase of men to women (last year 67% women, 33% men).

![Completed Investigations by Ethnicity of Adult at Risk](image)

**Figure 4: Number of Investigations by Ethnicity of the Adult at Risk**

Information from the 2011 census shows that one out of five Brighton & Hove residents (53,351 people, 19.5%) are from a BME background, an increase of 23,668 people (79.7%) compared to the 2001 census.

In figure 4 investigations for adults at risk White British ethnicity category from obtained data stand at 89%, all others 7%. Not obtained/Refused 4%

From this we can see that investigations for adult at risk from black or minority ethnic (BME) groups is low compared to the percentage of residents from BME groups as a whole at 19.5%. However, this data does not take into account ages. A high percentage of safeguarding investigations is regarding people of 65 years and over, and this age group locally includes fewer people from BME groups. Census data shows BME groups for 80-84 years is at 6.4%, and for over 85 years is at 5.3%.
Figure 5 shows investigations by category of harm or abuse. Categories of harm or abuse remain proportionate to the previous year. It must be noted that this data is based on the first type of abuse recorded in each investigation to provide an idea of the spread. Multiple categories of abuse can be noted as part of one investigation.

Figure 6: Percentage of investigations by level of investigation.
In 2014/15 Sussex safeguarding investigations procedures require each investigation to be assigned a level of investigation. Levels are 1 to 4, with Level 1 and 2 indicating harm, Level 3 indicating significant harm. Level 4 is an allegation that requires an investigation for more than 1 adult at risk. This year Level 1 and level 2 investigations stand at 83% of all investigations, which is in line with last year’s figures. From April 2015 Sussex safeguarding procedures have changed, to meet the requirements of the Care Act. Levels of investigation are no longer part of the safeguarding procedures, so this is the last year that this information has been gathered.

![Completed Investigations by Referral Source](image)

<table>
<thead>
<tr>
<th>Number of Investigations by Referral Source</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domiciliary Staff</td>
<td>30</td>
<td>5.4</td>
</tr>
<tr>
<td>Residential Care Staff</td>
<td>70</td>
<td>12.5</td>
</tr>
<tr>
<td>Nursing Home care Staff</td>
<td>46</td>
<td>8.2</td>
</tr>
<tr>
<td>Day Care Staff</td>
<td>10</td>
<td>1.8</td>
</tr>
<tr>
<td>Social Worker / Care Manager</td>
<td>91</td>
<td>16.3</td>
</tr>
<tr>
<td>Housing Staff</td>
<td>39</td>
<td>7</td>
</tr>
<tr>
<td>Personal Assistant</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>Acute Hospital Staff</td>
<td>64</td>
<td>11.4</td>
</tr>
<tr>
<td>Acute Mental Health Hospital Staff</td>
<td>27</td>
<td>4.8</td>
</tr>
<tr>
<td>Community Health Staff</td>
<td>38</td>
<td>6.8</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>12</td>
<td>2.1</td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>10</td>
<td>1.8</td>
</tr>
<tr>
<td>Police</td>
<td>21</td>
<td>3.8</td>
</tr>
<tr>
<td>Self- referral</td>
<td>14</td>
<td>2.5</td>
</tr>
<tr>
<td>Family Member</td>
<td>16</td>
<td>2.9</td>
</tr>
<tr>
<td>Friend/Neighbour</td>
<td>3</td>
<td>0.5</td>
</tr>
<tr>
<td>Care Quality Commission</td>
<td>12</td>
<td>2.1</td>
</tr>
<tr>
<td>Other</td>
<td>56</td>
<td>10</td>
</tr>
</tbody>
</table>

**Figure 7: Completed Investigations by Referral source**
In figure 7 the data shows the source of alerts which went on to be investigated under the safeguarding procedures.

51% alerts came from Social Care and Housing staff, which includes the voluntary and independent sector.

27% came from Health Staff, 3.8% police.

2.5% were self-referrals from the adult at risk, which is a decrease from last year (4.5%). When alerts from family members/friends are included it makes 5.9% of all alerts (11.5% last year).

The category of ‘other’ at 10% includes;

- Anonymous referrals
- Other local authorities
- Probation
- Independent Community Services such as Citizens Advice Service

These proportions remain similar in the main to last year's data, with some exceptions. A decrease to consider is self-referrals and referrals from family members. This had slightly increased over the last 2 years, possibly due to an awareness campaign in 2012/13. This year the numbers have started to decrease quite rapidly, so further awareness of how to raise concerns for the public will need to be considered.

The category of ‘other’ has increased again this year, from 4% to 10%. This requires some scrutiny, as may be a staff training issue regarding understanding of the categories, or may be that the category choices do not adequately reflect the true situation of where concerns are being referred from.

Last year there were no alerts raised by Personal Assistants, this year 1, so work will need to continue regarding raising awareness amongst Personal Assistants. As these arrangements are generally organised between the person and the carer directly, training and awareness of safeguarding is not always assured. However, work has been done in this area, with additional support now being offered from The Fed, the Centre for Independent Living, to people employing carers via Direct Payments, which will hopefully increase awareness in this area.

Alerts from GP’s have increase from 1% to 2.1%.

This data will no longer a requirement for collection in 2015/16 for the Local Authority. The Safeguarding Adults Board will consider what local information is required.
In figure 8 we can see that the person’s own home is the most likely place for abuse to be alleged to have taken place, at 36% of all other logged locations. Last year this figure was 33%.

If Care Homes and Care Homes with Nursing are combined, they come to 34.8%. (2013/14 26% 2012/13 30% 2011/12 30%, 2010/11 31%).

Acute and Community Hospitals are at 8% (7% last year), Acute Mental Health at 4.8% (5% last year). Supported accommodation 7.6% (6% last year).

The Safeguarding Adults Board may need to consider how best to collect this information in future, so that it gives meaningful information in relation to an enquiry, as opposed to an investigation. An enquiry is likely to be considering a variety of factors which affect a person, and is less likely to be regarding an incident in a particular location. For example, if someone is being exploited by people they know in their community in a variety of ways, the location may not be so easily defined, and could be a combination of locations such as ‘own home’, ‘public place’ and ‘other person’s home.’
Figure 9: Percentage of Investigations by Alleged Source of Risk

- 41% Social Care Support or Service Provider
- 55% Other -Known to individual
- 4% Other -Unknown to individual/Stranger

<table>
<thead>
<tr>
<th>Completed Investigations by alleged source of risk</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social care Support or Service provider</td>
<td>220</td>
</tr>
<tr>
<td>Social care Support or Service provider-voluntary</td>
<td>8</td>
</tr>
<tr>
<td>Relative/ family carer</td>
<td>85</td>
</tr>
<tr>
<td>Individual-known but not related</td>
<td>40</td>
</tr>
<tr>
<td>Primary Health Care</td>
<td>33</td>
</tr>
<tr>
<td>Secondary Health Care</td>
<td>16</td>
</tr>
<tr>
<td>Other Private Sector</td>
<td>8</td>
</tr>
<tr>
<td>Other Adult at risk</td>
<td>124</td>
</tr>
<tr>
<td>Stranger</td>
<td>9</td>
</tr>
<tr>
<td>Primary Health Care</td>
<td>1</td>
</tr>
<tr>
<td>Secondary Health Care</td>
<td>2</td>
</tr>
<tr>
<td>Other Public sector</td>
<td>3</td>
</tr>
<tr>
<td>Other Private sector</td>
<td>1</td>
</tr>
<tr>
<td>Other Voluntary</td>
<td>2</td>
</tr>
<tr>
<td>Other Adult at risk</td>
<td>8</td>
</tr>
</tbody>
</table>

Figure 9 shows the percentage and number of investigations broken down by the alleged source of risk to the person affected.

The data collection required has significantly changed from 2013/14, thus giving only 2 years of comparison.

If the data regarding alleged abuse from a partner, family member, neighbour or friend are combined, this comes to 22% of all investigations. (28% last year)

Allegations about Social Care Staff, including staff from the independent and voluntary sector come to 40% (last year 32%), and Health Care Workers 8.7% (last year 7.5%).
The source of risk being another adult at risk was 18.5% last year, this year 22%. The risk alleged from a person unknown to the adult affected is 4.6%. (4.8% last year).

Another way to consider this data is to break down the figures of source of risk, whether known to the individual or not into a professional relationship, which comes to 52.5%, and a non-professional relationship such as family member or another adult at risk is 47.5%. This information is specified by national data reporting requirements. It currently lacks any local detail, so the Safeguarding Adults Board will need to decide what further information is required to aid local decision making and priorities.

![% of Completed Investigations by Case Conclusion](chart)

**Figure 10: Percentage of Completed Investigations by Case Conclusion**

Case conclusions of safeguarding investigations under the safeguarding adults procedures are based on the ‘balance of probabilities’ and an allegation will have one of four possible outcomes determined:

- **Substantiated**: the allegation has been founded 38% (last year 33%)
- **Partially Substantiated**: where more than one concern of harm/abuse was investigated, at least one is founded 12% (last year 14%)
- **Not substantiated**: the allegation has not been founded 18% (last year 19%)
- **Inconclusive**: it is not possible to determine from the information gathered whether the allegation is founded or unfounded 21% (last year 23%)
- **Investigation ceased at individuals request**: 11% (last year 11%)

Investigations that were Inconclusive have decreased slightly from 23% to 21%. This figure is being monitored as part of the performance indicators for the Assessment Service, and the target last year was 25% or less, which has been achieved.

This is the last year that this data will be collected, as under the new procedures the outcomes for safeguarding work will no longer be monitored as to whether harm or abuse were substantiated or not, but by individual outcomes for the person affected, and whether the person feels that their identified outcomes have been met.
4. Safeguarding Adults Board Member Organisation Reports

4.1 Brighton & Hove City Council Adult Social Care Assessment Services

General overview of the year 2014-15:
The year was a story of out with the old and in with the new! The year being dominated by preparation for new duties and responsibilities with the Care Act being implemented in April 2015, and the continued focus on meeting our statutory responsibilities in relation to Deprivation of Liberty Safeguards (DoLS)

Against this background of increasing amount of complex work and increasing demands and activity around DoLS, we have continued to strengthen our response by bolstering management and social work capacity throughout assessment services with a particular focus upon the Access Point. In addition we have seconded an experienced Mental Health Social Worker to work within Access to provide effective triage of Mental Health cases and to provide advice and support to colleagues on Mental Health issues. A decision was taken that all appropriately experienced and qualified workers should qualify as Best Interest Assessors (BIA’s) and a rolling programme of training and qualifying is underway. This will place the Council in a good position to meet the expected demands when the Law Commission produces its proposals in 2017. Numbers of DoLS applications for authorisation remains high averaging at around 30 per week and it is a credit to all staff involved that we have been able to keep on top of this important area of work with minimal breaches of timescales. Deprivations in Community settings will provide a new and ongoing demand as we move forward. Additional funding has been made available to employ additional BIA’s and legal staff to meet this demand

We began preparation for implementation of the Care Act which means review and restructure our workforce to meet the new demands, including the new focus on Safeguarding Enquiries and related duties under the Act. This will require, in Brighton & Hove, a strengthening of our qualified and registered social work complement. The Care Act also highlights the importance of the Mental Capacity Act (MCA) as a key component in work as we move forward, so will require an increased focus on this area, and ongoing training for staff. The experience of being involved in the Making Safeguarding Personal (MSP) pilot has proved invaluable as a precursor to the Care Act which focusses on outcomes for the user rather than process and procedure

We have continued the process of undertaking audits of safeguarding investigations, with one quarter dedicated to evaluating alerts which do not result in an investigation. It is pleasing to note 100% compliance with the process. The outcome of audits are discussed by the Management Team on a quarterly basis with the Head of Safeguarding. The general quality of the work being audited has demonstrated increased compliance with procedures and the quality of work. In light of this and the implementation of the Care Act it is now timely to review this process with a greater focus on outcomes and MSP, and this will be taken forward this year.

Future plans / priority areas for 2015/16:

- Ensuring Care Act compliance
- Continue to respond to DoLS and training of BIA’s
- Implement new audit arrangements
- Workforce redesign to meet implication of the Care Act and new duties and responsibilities.
- Workforce development focus upon the new duties and responsibilities enshrined in the Care Act, MCA, and DoLS.
- Disseminate learning from complex cases

Brian Doughty
Head of Assessment Services
Brighton & Hove City Council
4.2 Sussex Police

General overview of the year 2014-15:

- Over the last year, Sussex Police have invested in experts to work alongside serving officers and staff to create a vision for our new local policing model. One of our challenges is financial. We have already had to make savings of around £50 million and further savings of £57 million may be required over the next four years. But we also know that policing has to adapt to changing demands. Sussex has long been a safe place to live and work – levels of reported crime, including burglary and vehicle crime have fallen considerably over the last 10 years. However, reporting of other crime types, including domestic violence and abuse and sexual abuse, have increased suggesting that victims may be more confident in reporting to police.

- To ensure that we can continue to provide an effective response these serious crimes, including working with partners to support those who have experienced or been impacted by them, we have undertaken a major piece of work to restructure our Public Protection teams. This has involved the creation of single Safeguarding Investigation Units (SIUs) in each Division, combining the previous Child Protection, Adult Protection, and Anti-victimisation teams. During the final phase of this work, the SIUs will take on responsibility for the investigation of all reports of Rape and Serious Sexual Offences, while the creation of a Complex Abuse Investigation Unit (CAIU) will improve our ability to manage larger, more complex, investigations.

- Each of the force’s three Safeguarding Investigation Units is headed by a Detective Chief Inspector (DCI) reporting to the Head of Public Protection, Detective Superintendent Paul Furnell. This central line management enables us to share good practice and encourages consistency. Each of the SIU DCIs also holds a force-wide portfolio - DCI Richard Bates is responsible for the Brighton and Hove SIU and is also Head of Adult Safeguarding.

- In addition to our organisational change, Sussex Police developed a Domestic Abuse Improvement Plan following the HMIC audit last year. The objective of this plan is to set out a vision and ambition for Sussex police to provide an effective service and response to victims of domestic abuse and recognising that to do so requires a sustained, robust and dynamic approach from the organisation and our partners. Most of the actions and recommendations have been completed. However we will continue to monitor the progress of these.

- One of many key focuses for 2014 – 2015 is raising awareness of Harmful Practices, this includes: Female Genital Mutilation (FGM), Honour Based Abuse (HBA), Force Marriage and Modern Slavery. We have already carried out a considerable amount of work in accomplishing this, such as training and awareness events. These have been challenging areas of business to tackle due to the lack of people within the communities willing to talk about the cultural practices; however with the correct approach this has improved.

Specific developments, achievements & work undertaken in 2014-15:

- A representative from the force Public Protection Branch has attended the Safeguarding Adults Board and relevant sub groups throughout the year.

- The force has developed a domestic abuse training package for front line officers. This is to help officers get a better understanding of positive action and safety planning. We are half way through the roll out of this course; positive feedback has been received so far.
• We have developed police operations to provide an enhanced response to Domestic Abuse over key times of the year. Operation Cureen was run over the period of the World Cup in June – July 2014 and Operation Ribbon was run over Christmas, New Year, and Easter. With the support and active involvement of partners, these operations enabled us to provide effective police response to reports of domestic abuse, whilst also improving the support we were able to offer to victims and survivors.

• Sussex Police introduced the Single Combined Assessment of Risk Form (SCARF) in August. This has replaced the Vulnerable Adult at Risk (VAAR) form and once completed by an officer or member of staff will be forwarded to the relevant Local Authority. The Vulnerable Adult section of the form implemented several of the recommendations from the VAAR audit. Positive feedback has been received about the new form. The new form avoids any duplication and double keying and allows officers and staff the opportunity to provide more information about the adult at risk. The Policy and Audit Team undertake regular dip checks to ensure the forms are being completed and sent to partner agencies.

• Last year Sussex Police introduced Operation Signature (scam mail fraud) and Operation Edisto (courier fraud) as the force’s operational response to identify and support vulnerable, and often elderly, victims of these types of fraud within Sussex. There is a section on the SCARF for Operation Signature so referrals can be made and we also have a dedicated Police Constable within the Economic Crime Unit who solely focuses on this Operation. Information about Operation Signature is available for victims on the Sussex Police internet page. The Public Protection branch also takes part in Safeguarding road-shows organised by the local authorities to raise awareness of these crimes and the support available to victims.

• Sussex Police have taken steps to raise awareness of Harmful Practices within the force and in the local communities. This includes updates to our intranet pages and training of both specialist officers and front line officers. We have also organised awareness events at universities and colleges which received excellent feedback.

Future plans / priority areas for 2015/16:
• We will review the force’s Safeguarding Vulnerable Adults policy and procedures to ensure that it aligns with the new Care Act.

• The Care Act establishes a new role of Designated Adult Safeguarding Manager (DASM). DCI Richard Bates is the DASM for Sussex Police and will be working with DASMs from our statutory partners to develop this role and embed it into our safeguarding approach. Work will also be undertaken to raise awareness of the new act amongst officers and staff, particularly specialist officers and new officers.

• The domestic abuse training is to be completed and we will continue monitor actions from the Domestic Abuse Improvement Plan.

• Sussex Police will continue to raise awareness of Harmful Practices. We recognise the importance of raising this awareness amongst our officers and staff as well as our local communities. We will also ensure our force policy is aligned with the new legislation.
Future plans for staff competency through training and other means:
In support of the wider restructure of Public Protection teams into single Safeguarding and Investigation Units, a training review is currently underway. This review will inform a future training strategy to ensure that our officers and staff have the necessary core skills, whilst also ensuring the appropriate spread of specialist skills within the unit.

Detective Chief Inspector Richard Bates
Head of Adult Safeguarding
Sussex Police

4.3 Brighton & Hove Clinical Commissioning Group (CCG)

1. Executive summary

NHS Brighton and Hove CCG safeguarding named leads and professionals have worked closely throughout the year with partners on the Safeguarding Adult Board (SAB), as a member of the Safe in the City Partnership Board and on the relevant subgroups for Violence and Against Women and Girls (VAWG), and Mental Capacity and Deprivation of Liberty.

Throughout the year we have been working in preparation for the new responsibilities encompassed in the Care Act 2014 enacted on 1st April 2015.

There has been publication of a new Assurance and accountability Framework for the NHS regarding the monitoring of compliance with safeguarding adults and children which is linked to the CCG assurance process.

Although accountability for the Deprivation of Liberty Safeguards (DoLS) Authorisation process passed to local authorities on 1st April 2013, CCGs remain responsible for assuring that NHS contracted providers were compliant with the Mental Capacity Act (MCA) (2005) including the appropriate application of the DoLS, and are knowledgeable regarding the Act and its application.

B&H CCG as a NHS statutory body also has responsibilities to comply with the requirements by having a Named Lead for safeguarding adults and MCA, and to ensure its own staff are appropriately trained to competently undertake their roles and to have safeguarding policies and procedures in place relevant to its function.

This report is a summary of B&H CCG activity in the field of safeguarding adults and MCA (2005) over the 2014/15.

2. Brighton & Hove CCG – Activity and Achievements 2014/15:

The CCG has now increased its capacity and expertise to support the Adult Safeguarding agenda by employing a Safeguarding Adult Practitioner with a specific focus on supporting primary care and to support the processes for providing a collaborative whole system approach to support those at risk or having suffered from Domestic Violence (DV).

All CCG staff are required to complete an introduction to adult safeguarding level 1 and Mental Capacity Act training with further training requirements according to roles and responsibilities.

Training is available as e-learning. Face to face sessions combine Children and Adult safeguarding and MCA awareness, provided by the Designated Children’s and Adult Safeguarding leads. The Governing Body received a specific session during the year.
The importance of the PREVENT agenda has increased with the unrest across the world with increased incidents of radicalisation. The Quality and Governance Team has an accredited Prevent trainer.* NHSE had disbanded their regional PREVENT support however this has now been reinstated and we are working closely with the lead.

*PREVENT is one of the work strands of CONTEST, the United Kingdom counter terrorism strategy. The PREVENT strategy focuses on stopping people becoming terrorists or supporting terrorism. PREVENT in health is aligned to the safeguarding process. The health sector’s contribution to PREVENT focuses on objectives 2 and 3:

• Prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support;

• Work with sectors and institutions where there are risks of radicalisation which we need to address.

NHSE has now restructured again and we are now a part of the Kent Surrey Sussex area which is part of the South East Region that continues to have a safeguarding network.

3. Adult Safeguarding alerts and investigations

Brighton and Hove CCG has continued to work with Brighton and Hove City Council (BHCC) supporting the safeguarding team with clinical expertise for Health Investigations throughout the year. Alongside this we have been working to ensure the Safeguarding Adults Board and its partners would be compliant with the Care Act 2014 enacted 1st April 2015.

3.1 Health Officer Investigations undertaken by B&H CCG 14/15

Referrals are received by the Quality team from the Local Authority requesting a Health Investigating Officer (HIO), where significant Safeguarding concerns are raised that need clinical oversight, e.g. medicines related, pressure damage, nutrition, end of life care etc. A member of the team is assigned to each case and attends a strategy meeting which is facilitated by the Local Authority Investigating Manager. This meeting sets out responsibilities for each member of the team to carry out their part of the investigation. For the Quality team this usually includes visiting the Home concerned and the hospital records if appropriate. A report is produced on the findings and a Case Conference is held with the inclusion of relatives, the resident concerned, CQC and the Home Manager. It is decided whether from all the evidence if the case is substantiated, unsubstantiated or inconclusive.

22 HIO investigations have been undertaken by the team during the year. The majority of these have been in Care Homes with Nursing, with a small number of cases requiring investigation in other independent providers such as IC24. Large organisations such as NHS Trusts have their own investigation systems in place, and the Quality team therefore do not carry out investigations, although may be involved in strategy meetings and case conferences in their role as commissioners of these services.

The team are often contacted in cases where Safeguarding concerns have been raised in relation to GPs. These cases are passed onto NHS England as they have responsibility for ensuring engagement of Primary Care in Safeguarding investigations.

3.2 Preparation for the implementation of the Care Act 2014 from 1st April 2015

BHCC commissioned on behalf of the SAB an external review of the processes and effectiveness of the Board.
All partners contributed to the review and the review of the key findings

A workshop with members of the Board, local council members and partner organisations was held in February to consider the implications of the Care Act on the local SAB and its workings.

A meeting of representative of the three statutory partners of the SAB – Police, Health (CCG) and Local Authority was held in February to agree the recruitment of an independent Chair of the B&H SAB. This is advisory under the Care Act Guidance not compulsory however it was also supported as best practice from our external review. The CCG agreed a financial contribution of £12,000.


4.1 CCG statutory responsibilities

The CCG retains responsibilities as commissioners of healthcare for providing assurances that the MCA (2005) and supplementary DoLS legislation is applied by the services it commissions and that staff are knowledgeable in its application.

We have been working with BHCC MCA team and providers to ensure the CCG has access to information on providers (Hospitals, Hospice – NHS and Private) in the locality, to the number and outcome of applications for DoLS assessment and use of IMCA service and appropriateness and now receive reports from the BHCC team and IMCA service. Further work regarding providers reporting continues.

4.2 Recent case law implications for health providers

Recent rulings in the court of protection continue to have implications for health providers in relation to the cohort of patients receiving care in health environments who may now be considered to require an assessment under the DoLS legislation. In brief the ruling resulted in an increase in individuals who would need to have an assessment. The Department of Health & NHS England reviewed the ruling and the Ministry of Justice is reviewing the findings. A final determination of recommendation of any changes is not anticipated before 2016.

4.3 CCG Actions to monitor and support providers with the application of the MCA (2005) and DoLS legislation.

B&H CCG was successful in a bid for £112,500k from the Chief Nursing Officer for England’s fund for MCA/DoLS training in 2014, and from October 2014 it has been working with partners to develop a city wide training program which is accessible to acute, community, primary care, local authority and independent providers and we have secured funding to continue the program through until March 2015.

5. Wider safeguarding adults’ initiatives

Other elements of the safeguarding agenda are supported via subgroups of the Safe in the City Partnership Board.

5.1 Violence against Women and Girls (VAWG) Program Board

Working in collaboration with City partners the pathways to support individuals who have been affected or are at risk of domestic or sexual violence have been reviewed. The service is out to Tender to ensure a more comprehensive joined up approach. Trauma pathways provided by the NHS have also been reviewed to ensure that resources committed right across the journey of an individual are
cost effective and collaborative.

5.2 The Brighton & Hove Black and Minority Ethnic Domestic Violence Peer Education Project

The CCG contributed to commissioning, with community partners, to support the second stage of a project and its evaluation aimed at empowering and informing Black and Ethnic Minority communities about domestic violence. This project has now been completed and published with some very positive results. Further work informed by this project is being taken forward by BHCC.

6. Domestic Homicide Review (DHR)

The Safe in the City Partnership has a statutory duty to conduct domestic homicide reviews, where a death of a person has or appears to have resulted from abuse or neglect by a former or current intimate partner or a member of the same household. An Authority may also decide to use a DHR to review “near misses” where there may be relevant learning. The Statutory Guidance requires that the membership of the DHR panel includes identified statutory agencies which include the CCG. Brighton and Hove CCG Director for Clinical Quality is the named representative.

6.1 DHR Activity 14/15

3 DHR and 1 near miss DHR in the City were completed during 14/15

7. Mental Health Homicide Investigation (MHHI)


Brighton and Hove CCG are supporting one MHHI at present underway.

8. Care Act 2014, implications for the NHS

Previously mentioned is the impact the changes implemented with the Care Act will have on the Safeguarding Adults Board and its statutory partners of which the NHS Brighton and Hove CCG are one. However there are further implications in a number of areas which will require work over the next few months.

- The role of Health Investigators will change significantly in light of the personalisation of safeguarding. This will need to be considered in relation to the proactive support and monitoring of quality.
- The role of case management and its relationship to the Care Act 2014 and safeguarding and Mental capacity Act for the Continuing Health care team.
- The increased focus on commissioning services and supporting vulnerable individuals in particular the quality and patient safety monitoring of services for people with learning disability, autism and or challenging behaviours – Transforming Care programme.
- Work with partners to ensure robust response via Serious Case Review referral panel to referrals
- Work with partners including NHSE Mental health Homicide investigation team to ensure robust put proportionate responses to incident which complement existing investigation processes established in the NHS.
9. Discussion

The increased demand for safeguarding resources and expertise has continued to grow through 2014/15, requirements for safeguarding adults has been more extensive than was originally expected and we have responded by increasing the teams capacity. B&H CCG Quality team continues to hold a good level of expertise within it and has developed good working relationships with other colleagues across CCGs, Local Authorities and NHSE.

The evidence continues to support that healthcare delivery will increasingly be to a population who are frail and vulnerable, with increasing levels of cognitive disability and dementia not only in hospital and care home environments but in their own homes, this brings with it increased safeguarding risks and issues.

Recent CQC inspections across all organisations including Primary care continue to note issues with capacity and compliance with safeguarding and MCA (2005) but feedback and evaluation of our system wide MCA DoLS training is positive.

The elements and crimes which come under adult safeguarding is extensive, the focus on crime types such as sexual exploitation, female genital mutilation and radicalisation has increased through the year and been informed by the world and national policy and UK investigations such as but not exclusively by the Rotherham inquiry (Rotherham Metropolitan Borough Council 2015) https://www.rotherham.gov.uk/inquiry

Health providers and commissioners will increasingly need to consider how supporting preventative initiatives and early intervention reduces the burden of physical and mental ill health in the population and the positive impact that early recognition and support could have on quality of life of individuals and the financial burden to statutory providers.

9. B&H CCG Priorities 15/16

A great deal has been achieved and B&H CCG has continued to developed its expertise and processes to support its responsibilities in the area of patient safety and safeguarding, further work to be completed includes.

- Agree a Sussex Safeguarding Benchmarking Policy setting in place rigorous quality and safety systems and processes in order to achieve continuous improvement. (Completed and awaiting ratification at time of writing report)
- Further improve data capture of NHS commissioned services application of DoLS
- Further Improve data capture of NHS commissioned services use of Independent Mental Capacity Advocate (IMCA) Services
- Implement the assurance framework with all commissioned services
- Continue to deliver in partnership with providers focused multi-agency training in Dementia, MCA & DoLS across the City with measurable outcomes.
- Work with providers to build expertise with increased numbers of Health Best Interest assessors
- Ensure continued focus and support for initiatives which prevent safeguarding alerts by commissioning services which support individuals and carers in a way which reduces stressors known to increase incidents and invests in staff training.
10. Conclusion

This is a summary of the activity B&H CCG has been involved or lead in the field of safeguarding adults over the 14/15. There has been a large amount of work undertaken but we know there is still more to do. Our priorities listed for 15/16 aim to continue to move us to the ambition of being a partner with patients, carers, and providers working together to provide safe and proactive services to the most vulnerable populations.

Soline Jerram
Lead Nurse, Executive Director of Clinical Quality and Primary Care
Brighton and Hove CCG

4.4 Adult Social Care Commissioning & Performance Team

General overview of the year 2014-15:
What has worked well:

- There are a range of key themes across the sector where there is an opportunity for improvement actions. In 2014/15 this included continence promotion, falls prevention, MCA, Restrictive Practices and Deprivation of Liberty Safeguards (DoLS). There has been extensive work or training delivered to providers in these areas.
- A programme of actively promoting quality through Dignity Champion groups and Quality Assurance groups has continued. These groups have addressed the topic areas of dignity in care for people with sensory loss, social and recreational activity, hydration, working with carers and families as full care partners, continence promotion; sex, personal relationships and sexuality in care homes; communication within care homes; risk assessing whilst respecting rights; nutrition and menus for special diets; and infection control.
- The Care Quality Commission (CQC) Compliance reports have now introduced ratings, and these reports inform the Team’s level of monitoring activity on the services these reports relate to, as do all other forms of intelligence coming into the Unit.
- Healthwatch have been undertaking more enter and view visits comprising two older people care homes, one learning disability care home, a nursing home and a mental health day centre. The purpose of these visits is to get a ‘service user perspective’ on the services. The primary focus of these particular visits was on the provision of meaningful activities for the users of the services, and suggestions in the reports as to how these could be improved.
- The risk based approach to monitoring providers has continued, with reactive visits to services where there are concerns given priority within the timetable of visits. Through 2014/15 there were 29 monitoring visits to care homes, 14 to nursing homes, and 13 to home care providers. Other providers were also visited, including supported living providers (19), community support providers (9), and a range of Council run services (12).

Challenges:

- The Electronic Care Monitoring System (ECMS) continues to be a significant component in the monitoring of home care provision, with the production of quarterly reports which cover a range of quality areas including continuity of care and timekeeping. However, the compliance levels have not improved significantly, and in some instances have got worse. The Team will continue to adopt corrective action to improve compliance levels.
- The number of services suspended due to poor quality in 2014/15 comprised three nursing homes, and two home care services. However, with the support of the Contracts Unit, improvements were made in these services and the suspensions were eventually lifted.

Specific developments, achievements & work undertaken in 2014-15:

- The benchmarking tools have been finalised to work with providers around the various quality areas, e.g. staffing, medication, care planning; along with a series of templates to support audit activity and create more consistency of report writing throughout the team.
- The Team is yet to publish quality information about care providers in City in line with the Care Act
2014, as the consistency of written reports is still being worked through. Though the number of written reports is predicted to fall in the coming year following the restructure of the Team (see below), this remains an important priority and is included on the Unit’s Business Plan.

- Information sharing processes with Healthwatch have been confirmed, and a rep from Healthwatch is routinely invited to the Care Governance Board.
- The delivery of draft audit reports to provider within 10 working days to 85 percent, has been achieved, and exceeded in 2014/15.
- The quarterly quality reports produced for the Care Governance Board have been reviewed and now include additional information on quality themes emerging from audit activity, the activity of the Quality Monitoring Officer, and activity in the Service Improvement Panel.
- A key quality theme for 2015/16 will be the promotion of continence in care homes, and this has been taken up more strategically through the Care Governance Board so that all partner agencies are involved in promoting this.
- Intended improvement themes for 2015/6 will also include, risk assessing whilst ensuring minimal restrictive practices, communication with service users, communication within services and the provision of information about the quality of services.

**Future plans / priority areas for 2015/16:**

- To publish quality information about care providers on in City providers on the Council Website in line with the Care Act 2014.
- To further review the quality monitoring reports produced for the Care Governance Board to specifically look at what impact the quality monitoring activity of the Unit has had on the quality of adult social care services in the City.
- To move towards intelligence led risk based monitoring comprising a desk top review of services. This may or may not prompt further intervention, including a visit to the provider to monitor the service further. The above will need to allow for reactive visits to care homes where quality concerns arise.
- The continued development of joint working and robust communication links between the Team, and the CCG regarding quality information
- The continued development of joint working and robust communication links between the Team, and the CQC regarding quality information
- To rationalise the provision of provider forums.
- To continue to log Safeguarding activity, and also to log those quality concerns which historically would have been dealt with under the Safeguarding umbrella, in order to evaluate the impact this is having on the workload in the Unit.

**Review of staff competency through training and development during year 2014/15:**

- Commissioned services continue to access Council training. This is monitored by the Unit through their audit activity.
- Competency of staff working in the Commissioning & Contracts Team is reviewed each year through Professional Development Plans (PDP) and supervision with the expectation that all staff are competent and training and development are facilitated where required.

**Future plans for staff competency through training and other means:**

All staff in the Unit have received mandatory training, e.g. MCA, DoLS, Safeguarding, and will continue to do so at the point this requires updating. As the needs of the Unit change following the implementation of the new structure, further training needs will be identified around the changing needs of the service.

Anne Hagan
Head of Commissioning & Contracts Adult Social Care
Brighton & Hove City Council
4.5 Partnership Community Safety Team (PCST)

General overview of the year 2014/15
The Partnership Community Safety Team, along with other partners, support the Safe in the City Partnership in Brighton & Hove to:

- reduce crime and anti-social behaviour, especially around issues that matter most to people;
- improve feelings of safety and meet the needs of victims;
- take early action to prevent crime and disorder;
- tackle underlying causes of offending and reduce harm from drugs and alcohol; and
- reduce reoffending and achieve visible justice, including offenders participating in restorative justice

In the last year, we have continued to develop shared priorities and outcomes and expand integrated working practices, specifically in relation to:

- Maintained and developed partnership working across Sussex with the Sussex Police and Crime Commissioner and through the Sussex Criminal Justice Board
- Working towards joint commissioning of victim and witness services and Restorative Justice
- Establishing a new model of working for responding to domestic and sexual violence & abuse, as well as other forms of violence against women & girls (including female genital mutilation, forced marriage and so-called ‘honour based violence)
- Supported pan-Sussex commissioning, including of the Adult Sexual Assault Referral Centre (SARC) and the development of a Child SARC
- Realigning the structure for managing offenders so it is ‘fit for purpose’ in light of national policy changes (Transforming Rehabilitation)
- Establishing victim & witness service standards to reduce vulnerability around anti-social behaviour and hate incidents and extending the use of a risk-based case management system (E-CINS) across partners city-wide
- Supporting the Racial Harassment Forum and the Black and Ethnic Minority Community Partnership to manage the development of city-wide services for BME communities

Specific developments, achievements & work undertaken in 14/15
The provision of an immediate access duty service by the community safety casework team is improving access to reporting and support for victims. It has also been promoted to professionals for specialist advice and guidance on how to manage Anti-Social Behaviour (ASB) and hate cases and is regularly being used by them.

During 2014/15 the Partnership Community Safety Team (PCST) has developed a pooled budget to support a domestic violence & abuse, rape, sexual violence & abuse service across Brighton & Hove and East Sussex¹. In addition to contributions from across the council, there are a number of other Associate Commissioners are participating in the pooled budget, including: East Sussex County Council, Brighton & Hove Clinical Commissioning Group (CCG), Kent, Surrey and Sussex Community Rehabilitation Company (CRC) and Sussex Police & Crime Commissioner (PCC).

Future plans / priority areas for 15/16

• Continue to support the development of local partnership working to resolve local crime and safety problems.

• Carry out a project to enhance the existing Local Action Team framework and resilience, assisting with early intervention and prompt resolution of local community concerns and priorities.

• Disrupt drug markets through targeted enforcement. Increase intelligence and keep abreast of developments and local markets in new psychoactive substances to better inform education, treatment services and police activity.

• Sustain Operation Reduction which disrupts drug supply and engages users and offenders to encourage them into treatment.

• Develop a partnership ‘Through the Gate’ strategy, working closely with local prisons for men and women.

• Extend casework standards to all agencies to risk assess, reduce vulnerability and harm (incl. Registered Social Landlords)

• Continue case management of high risk victims through Multi-Agency Risk Assessment Tasking Group, linking with the Youth Offending Service, housing, the Integrated Team for Families, mental health and adult social care, and achieve behaviour change of perpetrators

• Introduce and promote a new smartphone app which makes reporting (of hate crimes) easier and more effective

• Create a ‘due diligence’ process to prevent use of public resources for extremist purposes.

• Provide consistent, high quality care in safe environments for victims of modern slavery, whether they are adults or children, male or female.

• Provide accessible and integrated services for victims/survivors of domestic and sexual violence & abuse and their children. To include meeting safety needs, support through the criminal justice system and access to therapeutic interventions.

Peter Castleton
Temporary Head of Community Safety,
Partnership Community Safety Team

4.6 Brighton & Hove City Council Adult Social Care Provider Services

General overview of the year 2014-15:

We have improved our management team over-sight of safeguarding practice and training for all staff, including our in-house agency staff, by our management team. We have also improved practice and training for staff in DoLS/MCA in response to the Supreme Court Judgement.

Our challenge has been to change our practice in relation to the requirements for depriving people of their liberty and the additional significant workload that this has created especially in our short term and mental health services.
Specific developments, achievements & work undertaken in 2014-15:

During 2014/15 we have:

- Trained and briefed staff in preparation for changes to practice brought about by The Care Act.
- Reviewed our medication policy and practice
- Reviewed mandatory training and frequency of refresher training
- Trained staff in line with the changes brought about by DoLS case law, and reviewed our policies and practice in line with these changes.
- Started our work to achieve autism accreditation for some specialist Learning Disability Homes.

Future plans / priority areas for 2015/16:

- To ensure all staff are trained in the new safeguarding policies and procedures and that we are working in compliance with the Care Act.
- To ensure that staff are trained as appropriate in deprivation of liberties and that we are making appropriate referrals where DoLS apply.
- To introduce a new medication policy in line with NICE guidance.
- Achieve autism accreditation within our specialist residential homes.

Review of staff competency through training and development during year 2014/15:

223 staff attended safeguarding training and 3 staff attended self-neglect awareness training.

27 staff attended DoLS briefings/update training.

2 staff attended Domestic Violence and Abuse training

18 staff attended “managing risk and behaviours safely with least restrictive practice” training

78 staff attended MCA training

Future plans for staff competency through training and other means:

Training targets 2015/16:
- Safeguarding Basic Awareness Training- target 85% of all staff
- MCA training- 60% of all staff
- DoLS- 60% of all staff.

Karin Divall
Head of Provider Services
Brighton & Hove City Council
4.7 Brighton and Sussex University Hospital NHS Trust (BSUH)

General overview of the year 2014-15:

- The Adult Safeguarding Team worked well with other partner organisations in readiness for 1st April 2015 and The Care Act 2014, with regular discussions about the changes to safeguarding and learning from cases as they occur.

- In readiness for 1st April 2015 a Making Safeguarding Personal – RSCH Raising Adult Safeguarding Concerns template has been developed in conjunction with the Lead Nurse, Safeguarding Adults and B&H Adult Social Care Team. The template focuses staff to engage with the patient regarding outcome from the outset and to consider any concerns regarding capacity to consent.

- Governance arrangements have been reviewed with the Deputy Chief Nurse to ensure they are fit for purpose and support a timely and proportionate response to all concerns.

- Brighton and Sussex University Hospital’s Safeguarding Adults Policy is being updated to ensure it complies with the Care Act. This will be approved by the appropriate committee on 07/07/2015. The new Sussex Safeguarding Adults Policy and Procedures are available for staff on the BSUH intranet.

- In common with many Acute trusts Brighton and Sussex University Hospital has faced significant challenges with regard to bed occupancy, patient flow and staffing over the winter months. Safeguarding concerns relating to the Acute Medical Unit, which has been exceptionally busy and acute due to the issues outlined above, has used the learning from these incidents to develop a 6 month improvement plan with actions for nursing, medical and operational staff. Positive changes have been made and ongoing improvements continue to take place.

- An overseas and national nurse recruitment programme has successfully offered employment to 350 nurses.

- The Learning Disability services have highlighted the difficulties for the transition of patients from child to adult services. People with a learning disability sometimes remain in the Royal Alexandra Children’s Hospital after the age of 18 years due to them remaining in education. This is agreed individually for each patient by their consultant. To develop a clear protocol for transition is part of their work plan for 2015 / 16. The Learning Disability Liaison nurses and the Adult Safeguarding Team provide monthly training for staff in the Royal Alexander Children’s Hospital in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.

- The Adult Safeguarding Team continues to work closely with the Dementia Champion / Nurse Specialist. They provide joint training and support for staff in bespoke areas to implement the learning from safeguarding investigations, complaints and Serious Incidents.

- The impact of ‘Cheshire West’ ruling has seen an increase in the need for Deprivation of Liberty Safeguards authorisations. The Adult Safeguarding Team continues to deliver training and provide direct support to staff in clinical areas. For the period 01/04/2014 to 31/03/2015 Brighton and Sussex University Hospital applied 90 Deprivation of Liberty Safeguards authorisations
Specific developments, achievements & work undertaken in 2014-15:

Learning and Improvement:

• The Adult Safeguarding Team, Dementia Champion and Learning Disability Liaison team in conjunction with Sussex Partnership were actively involved in the development and implementation of the Joint Health Economy ‘Are you confident’ training for the Mental Capacity Act and Deprivation of Liberty Safeguards. A full time Safeguarding/Mental Capacity Act trainer has been successfully appointed and continues to support the ongoing delivery of the Joint Health Economy training as well as internal training for all clinical staff.

• A draft template to improve the quality of documentation regarding capacity assessments and best interest decision has been developed. This is to be taken forward as an ongoing piece of work supported by the medico legal team.

• Both the Adult and Children’s safeguarding leads have been working together to develop an action plan following the recommendations and learning from 4 Domestic Homicide Reviews.

• Following the recommendations of a Serious Case review a new policy for the Observation of Adult Patients with Mental Health Problems has been developed. Training for staff will be implemented by the Safeguarding/Mental Capacity Act Trainer in conjunction with the Mental Health Liaison Team – Older People’s Mental Health.

Governance:

• A joint monthly Serious Safeguarding and Complaints Meeting has been implemented to review serious and complex cases, actions and learning. The meeting is attended by the Chief Nurse; Deputy Chief Nurse Patient Experience; Deputy Medical Director Safety; Head of Complaints; and the Lead Nurse Safeguarding Adults. This committee reports to the Trust Executive Safety and Quality Committee.

• All directorates discuss Safeguarding as part of their Safety and Quality meetings. Learning from Safeguarding is shared at the Nursing and Midwifery Management Board.

• The Adult Safeguarding Team continues to work closely with Adult Social Care, often in discussion on a daily basis, and both organisations attend monthly joint case review meetings.

• Monthly review meetings of all current cases in the Adult Safeguarding Team is being commenced with the Deputy Chief Nurse from July 2015

• Attendance at the quarterly Safeguarding Committee has been reviewed to ensure senior nurse representation from all directorates.

Future plans / priority areas for 2015/16:

• A programme for site and service reconfiguration is now underway. Initial changes include the Neck of Femur pathway from Royal Sussex County Hospital to Twineham Ward Princess Royal Hospital. Twineham have implemented a dedicated bay for patients with dementia. The Dementia Specialist Nurse and Adult Safeguarding Team have provided focused training for staff regarding The Butterfly Scheme and the Mental Capacity Act / Deprivation of Liberty Safeguards. Dementia Competences are in development for pilot on Twineham.

• Richard Beard 3Ts Head of Communication and Engagement will present the hospital new build to the Best of Health Event for People with a Learning Disability on 25th June at The King Alfred Leisure Centre, Hove.

• Ongoing work to improve the data collection and monitoring of the use of Deprivation of Liberty Safeguards authorisations within Brighton and Sussex University Hospital, in partnership with the Local Authority. An internal BSUH DoLS in-box is being set up and the Safeguarding Adults Team are developing a ‘Handy Hints’ guide to support staff with the completion of DoLS paperwork.

• Ongoing training for clinical staff regarding Adult Safeguarding and the Mental Capacity Act/Deprivation of Liberty Safeguards. Two members of the Adult Safeguarding Team have
undertaken WRAP 3 training. A PREVENT training strategy is currently in development in conjunction with NHS England.

**Review of staff competency through training and development during year 2014/15:**

**Numbers of staff trained in Safeguarding Adults**

![Graph showing the number of staff trained in Safeguarding Adults over the year 2014/15.](image)

Safeguarding Adults awareness is provided during the induction programme for new volunteers within BSUH.

PREVENT awareness continues to be included in Safeguarding Adults training.

**Number of staff trained in Mental Capacity Act and Deprivation of Liberty Safeguards**

![Graph showing the number of staff trained in Mental Capacity Act and Deprivation of Liberty Safeguards over the year 2014/15.](image)

In addition to the above internal training, the Lead Nurse Safeguarding Adults, the Safeguarding/MCA trainer and the Learning Disability Liaison Nurse continue to be actively involved in the delivery of the Joint Health Economy ‘Are you confident’ training for Mental Capacity Act and DoLS. BSUH staff are encouraged to attend although availability of spaces has been highlighted as an issue.

**Future plans for staff competency through training and other means:**

**Safeguarding Adults:**

- Face to face Safeguarding Adults training continues to be provided during Nursing and Midwifery Induction and as part of mandatory training for doctors. A workbook is available for all staff requiring update training.
• Bespoke departmental training is provided on request and as an outcome of safeguarding investigations to enhance opportunities for learning.

• Training is being revised to reflect changes in relation to The Care Act – revised workbook and e-learning module in development

• Safeguarding Adults team to attend WRAP 3 training. Prevent training strategy in line with NHS England competency framework to be developed.

• Safeguarding module for health care assistants to be incorporated into the competencies for the Care Certificate

Mental Capacity Act and Deprivation of Liberty Safeguards

• Face to face MCA and DoLS training continue to be provided during Nursing and Midwifery Induction and as part of mandatory training for doctors.

• Additional Mental Capacity Act & DOLS training for all staff is provided monthly across RSCH and PRH sites.

• Bespoke departmental sessions provided on request or as an outcome following safeguarding concerns or feedback from HM Coroner

• Review of Joint Health Economy ‘Are you confident’ training - revise presentation and fulfil training requirements as agreed

Any other information / areas / issues:
The Lead Nurse Safeguarding Adults and the Learning Disability Liaison Nurse attended the RCN Older Persons conference in March 2015. In conjunction with CCG colleagues they presented the Joint Health Economy ‘Are you confident’ MCA and DoLS training as a good practice example of multidisciplinary partnership education and learning.

In line with the service reconfiguration programme Twineham Ward will have a dedicated bay for patients with dementia requiring orthopaedic surgery. A dementia focused individual risk assessment and care plan is in development - to be piloted on Twineham Ward from July 2015.

A bruising protocol for staff and a pressure damage booklet for wards to give to patients are being developed

Sherree Fagge
Chief Nurse
Brighton and Sussex University Hospital NHS Trust

4.8 Brighton & Hove City Council Housing

General overview of the year 2014-15:
• Housing continued to meet regularly with the Head of Adult Safeguarding to get updates on changes to procedures - especially in light of the Care Act.
• Housing completed a review of safeguarding procedures and training.

Seniors Housing
• The new policies and procedures have been welcomed by staff and attendances by Adult Social Care staff at seniors housing staff meetings have embedded the change within the service.
• The challenge for staffs has been to cope with the sense that some people may make unwise decisions and may still wish to engage with risky activity or relationships. The former procedure had a greater sense of certainty for professionals.

Specific developments, achievements & work undertaken in 2014-15:
• A new action plan for safeguarding was written to update goals.
• An autism champion was appointed.
• New procedures were written regarding adult safeguarding and child protection.
• We signed the information sharing protocol for the Safeguarding Adults Board.
• Regular articles about the Care Act have appeared in Housing Update (the staff magazine).
• We worked closely with the Fire Service to improve safeguarding.
• Specific training on the Care Act has been provided for staff in Housing Needs.

Seniors Housing
• Seniors housing staff attended the safeguarding conference in December 2014 and posters and carry cards have been circulated to staffs to promote issues of safeguarding.

• The seniors housing service has promoted the Care Act amongst staff and all staff have access to the new policies and procedures. Local administration has been changed to reflect the changes. Staff from Adult Social Care have been visiting staff meetings to promote the new act and its implications for safeguarding issues.

• The seniors housing service has promoted the council’s self-neglect policy and used this in two cases of complex need where older tenants were at risk of harm through self-neglect. The inter-agency approach has helped address issues of risk and in one case, the resident has re-engaged with the deep cleaning of their home.

• The seniors housing service has recognised the importance of strengthening the support to carers, particularly as many residents in schemes are carers themselves. The service has promoted carer’s week through its internal staff bulletins and attendance at the carers event at the Brighthelm Centre in May 2015. The service is now ensuring that all staff are in contact with the Carer’s Centre, with meetings being arranged at coffee mornings to promote carers support.

Future plans / priority areas for 2015/16:
• Briefings on the Care Act to be given to frontline teams that are involved in raising safeguarding concerns.
• Training for managers that will work with Adult Social Care on implementing the new safeguarding procedures.
• Training and meetings with Adult Social Care to work towards making safeguarding more personal and outcome focused.
• Housing Management will embark on an extensive communication strategy in regard to the Care Act with all staff and their partners. This will include printing posters and giving every employee a ‘credit card’ style reminder of the how to raise safeguarding concerns.
• Plans for a more integrated ‘risk management’ action plan will be examined.

Review of staff competency through training and development during year 2014/15:
• A review of staff training was undertaken (over 90% of staff have attended safeguarding training).
• Reminders were sent (via Housing Update) to employees who had started recently that safeguarding training is mandatory and must be arranged.
• We worked with the Lead Practitioner for the Mental Capacity Act to provide more information on issues of mental capacity.
Future plans for staff competency through training and other means:

- The take up of training will be monitored with workforce development to make sure the numbers of trained staff remain very high (over 90% of Housing Management staff).
- Managers involved in the enquiry process with Adult Social Care are to undertake training in undertaking an enquiry under the Care Act and improve multi-agency working.
- Training in dementia will be rolled out to selected staff in general needs housing - not just in seniors schemes.
- Competence remains the responsibility of the individual team manager.

Any other information / areas / issues:
Housing has designated casework teams who are used to working with clients to achieve agreed safeguarding outcomes. We have a close working relationship with Adult Social Care which should ensure the successful implementation of the Care Act within Housing.

Safeguarding procedures are embedded within Temporary Accommodation and Housing Support Service processes. We work in partnership with our emergency accommodation providers to ensure awareness of adult safeguarding issues and alerts raised as appropriate.

Housing Support Service attached to Temporary accommodation provide immediate support and referral to other services for those households at high risk and who have complex needs.

Patrick Odling-Smee
Head of Housing
Brighton & Hove City Council

4.9 South East Coast Ambulance Service (SECAmb)

An Overview of 2014/15:
South East Coast Ambulance Service NHS Foundation Trust (the Trust) is committed to promoting and safeguarding the welfare of all vulnerable people; recognising that everybody has the right to be protected from harm, exploitation and neglect within the context of the law and personal civil liberties.
During 2014/15 the Trust has undertaken a review of its safeguarding arrangements and the safeguarding team has seen an increase in capacity during this period. Referral rates have continued to rise with an overall increase of 18% from 2013/14 across the whole Trust area. Unfortunately it is not possible to break down the reporting figures by local authority area due to data entry challenges, however, it is anticipated this will be addressed during 2015/16.

Three Key Achievements in 2014/15:

a) Appointment of a full-time Safeguarding Support Officer adding resilience and capacity to the safeguarding team

b) Re-introduction of a Domestic Abuse (DA) pilot in Sussex with increased DA awareness training across the whole Trust

c) Successful pilot for an on-line reporting process across the whole Trust

Impact of Achievements on Service Users:
The additional capacity in the team has enabled the Trust to have a greater presence at the local Safeguarding Boards which has the benefit of ensuring that the Trust continues to play an active role within each local area.
The Trust undertook a Domestic Abuse (DA) project in 2012/13 which ended due to the cessation of short term project funding. However, with the support of the Office of the Police and Crime Commissioner, and associate commissioners in East Sussex County Council and West Sussex County Council, additional funding was secured enabling the project to be re-introduced from December 2014 for a twelve month period, and expanded to cover the whole of Sussex (previously this was restricted to West Sussex and Brighton and Hove). As a result, all areas of the Trust have benefitted from DA training and the post-holder has secured referral pathways to specialist DA organisations across Sussex (with signposting to the national helpline in non-pilot areas) and made direct contact with a number of patients identified through the referral process.

The Trusts on-line referral process was successfully piloted in Kent during 2014 and subsequently rolled out to all staff across the Trust from April 2015. Improved clarity of concerns and data being gathered will enable greater scrutiny of demographics and ensure that training needs can be identified and mapped to enable targeted training to be delivered in future.

Three Key Challenges in 2014/15:

a) A significant backlog of data entry for vulnerable person (VP referrals) due to legacy departmental capacity issues made reporting and analysing referrals for the year challenging. This has since been rectified at the end of Q4 and into Q1 2015/16.

b) Lack of capacity within the team during the first half of the year meant it wasn’t possible to properly engage with local safeguarding boards across the region. This has improved following the appointment of additional staff in the team.

c) Understanding how the 111 service differed from the 999 service provided across the Trust and the unique challenges faced by staff who do not see the patient with regards to making referrals was a core requirement.

Future Plans 2015/16:

The safeguarding team will continue to roll out the electronic reporting across all Trust sites (including both 111 sites) leading to improved monitoring and analysis of the information being gathered.

The DA pilot will continue as per the commissioned plan, including project review and evaluation to assist the development of business case proposals for its sustained continuity beyond December 2015.

The team will continue to work with 111 to improve the understanding of safeguarding referral requirements and referral data analysis.

A significant volume of safeguarding and DA reporting metrics have been agreed with lead commissioners for reporting where possible during 2015/16.

In partnership with learning and development colleagues, the team will progress the delivery of MCA training to all clinical staff in accordance with the Trusts key skills plan (including application of capacity assessments, obtaining consent to treatment and use of control and restraint techniques) supported if appropriate by a tier of Mental Health expertise available to operational staff.

Jane Mitchell
Safeguarding Lead
South East Coast Ambulance Service NHS Foundation Trust
4.10 Sussex Community NHS Trust (SCT)

During August 2014 the Chief Nurse commissioned an independent review of safeguarding to consider what current systems and processes exist to safeguard both adults and children and if the systems already in place are robust, effective and sufficient for future requirements. The review also considered how the Trust worked in partnership with Brighton and Hove Adult Safeguarding Board. The review identified good work undertaken in children safeguarding this was not always reflected in adults due to lack of identifiable resources and a dedicated team to support SCT staff.

The independent review used mixed methodologies of evidence from SCT policies and procedures, national and local evidence of good practice, research findings and 29 interviews with internal and external stakeholders. A total of 22 recommendations were made, all accepted by the Trust as part of the Quality Improvements in line with preparation for CQC inspection. The Chief Nurse included adult safeguarding training on the risk register. As a result after a successful business case additional resource of a Head of Safeguarding (children and adults) and 2 specialist nurse posts for adult safeguarding were identified. During the year the senior locality nurses led on adult safeguarding, supporting staff on concerns and liaising with partners in the local authority during investigations.

This year SCT have identified both the depth and breadth of safeguarding changes, this is most evident with the implementation of the Care Act 2014. Changes in our communities demands that SCT staff are supported, well trained and aware of safeguarding concerns in areas such as anti-radicalisation, dementia, Modern Day Slavery and Mental Capacity. Areas of safeguarding overlap between children and adults and it is important for staff to see safeguarding on a continuum, for example in Domestic Abuse and Mental Capacity.

The Adult Safeguarding model of delivery for Sussex Community NHS Trust is:

1. Clinical Leadership

The Director with responsibility for safeguarding is the Chief Nurse. The Head of Safeguarding reports to the Chief Nurse and deputises in Local Safeguarding Adult Boards.

2. Safeguarding Adult Advice & Case Consultation

The senior locality nurses continued to support frontline staff in safeguarding. During the year as the Head of Safeguarding and a specialist nurse in safeguarding adults were in post, the advice and support has increased to staff.

3. Supervision

All SCT frontline staff has supervision, additional supervision is being offered where SCT staff has direct contact with safeguarding concerns. These may be as a result of care home closures or specific individual cases and by their nature can be distressing for those in direct contact.

4. Safeguarding Training & Development

SCT staff have mandatory training in adult safeguarding, the content has been reviewed and updated during the year to prepare of the implementation of the Care Act 2014.

5. Safeguarding Adults Inspections

The CQC inspection in December found the trust had in place policies and procedures to Safeguard adults together with key contact numbers. CQC reported the Trust worked in partnership with statutory agencies. The CQC had not received any direct notification of safeguarding events or concerns raised by staff in the past year.
6. Clinical Audits

SCT has been involved in the multi-agency case files audits from the West Sussex Safeguarding Adults Board. An audit of the Rapid Response teams in SCT was completed in January 2015.

7. Quality & Governance

The Safeguarding Adults Delivery Groups are well established and meet monthly. Reporting to the Safeguarding Steering Committee, chaired by the Chief Nurse

Mental Capacity and Deprivation of Liberty

A policy for Mental Capacity and Deprivation of Liberty has been established for SCT staff during 2014 alongside additional training has been offered for all frontline SCT staff. There was an increase of 12 applications authorised in 2014/15 compared to 4 applications authorised in 2013/14

Safeguarding Standards for Adults

A task and finish group of frontline staff and Head of safeguarding established the standards that the Trust will embed into the work of all frontline staff. These are:

1. Acknowledging that neglect and abuse of an adult can happen and that it is every person's right to live free from abuse and neglect.

2. Having good systems in place for effective identification of neglect and abuse of an adult, taking prompt action.

3. Ensuring staff are aware of their responsibilities and know who they can access for support, guidance and advice and use reflective practice in supervision.

4. Have supportive policies and procedures in place to assist staff through safeguarding processes

5. Develop a culture where staff feel able to discuss the abuse of vulnerable adults with partner organisations in an open and transparent way, within the scope of Trust confidentiality guidelines.

6. Providing a training programme that equips staff with the knowledge and skills to safeguard adults in line with the Sussex Policy and Procedures for Safeguarding Adults

7. Sharing and learning from incidents and developing change to improve future outcomes

8. Develop and strengthen relationships with partner organisations to enhance service provision, working together to keep adults safe from harm by training health enquiry officers.

9. To work towards a culture of prevention to keep adults at risk safe from harm

10. Provide information for service users to help them understand the process and how they can be involved to make safeguarding personal.

Jennie Harmston
Head of Safeguarding (Adults & Children)
Sussex Community NHS Trust
4.11 Sussex Partnership NHS Foundation Trust (SPFT)

General overview of the year 2014-15:
In 2014/15 we continued to undertake adult safeguarding activity on behalf of the local authority as a part of the section 75 agreement that establishes integrated health and social care provision in mental health services. We have an established structure to support this with a local management and quality assurance group meeting regularly and bringing together managers and safeguarding leads. In addition we have a Trust wide governance structure and provide regular reports including data reports to our Quality Committee. An annual safeguarding report is presented to the Trust Board.

We worked closely with the local authority and other key partners in preparing for the implementation of the Care Act 2014 including a significant number of staff attending local authority and in-house training.

We are a signatory to the new Sussex Safeguarding Adults Policy and Procedures, and have representation on the 3 Sussex Safeguarding Adults Boards.

A comprehensive and independent internal audit of safeguarding was undertaken by Baker Tilly and completed in October 2014. The report covering both Adult and Children’s Safeguarding gave an overall rating of amber/green and concluded that ‘the Trust Board can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.’

Regular audits of safeguarding investigations were undertaken and the outcomes fed back to Investigating Managers and Investigating Officers. These are used to improve quality and are directly reported back to the Quality Review meetings which are chaired by the Service Director and attended by the Head of Safeguarding at Brighton and Hove City Council. The audit process is currently being reviewed in the light of the Care Act and a qualitative audit of cases will be undertaken in Quarter One.

With regards to the MCA a full review of local procedures covering restrictive practice is being undertaken by BHCC. The BHCC policy has been updated in the light of the Care Act and local training is being held for all social workers and care managers, and this will include staff in the integrated mental health service. MCA champion roles are being identified.

We are continuing to work very closely with the private residential and nursing home sector in relation to safeguarding work. Sussex Partnership work collaboratively with BHCC colleagues to undertake safeguarding investigations, and were heavily involved in two high level extensive investigations in 2014/15. This required a coordinated and sensitive approach and the service managed to work successfully with the providers, CQC and primary care colleagues to facilitate an effective outcome. Sussex Partnership continues to work closely with the residential and nursing home providers in the locality by offering specific support via our Care Home In-Reach Service and also our Care Homes Mental Health Liaison Nurse.

The CQC inspection of services in January 2015 provided positive feedback around the systems we have in place to support safeguarding of vulnerable adults. As part of the visit inspectors spoke to staff across local services to test their knowledge and understanding and found a good level of assurance. Further work is required to raise awareness of MCA and DoLS and to ensure information about staff accessing and completing mandatory safeguarding training is more robust. Actions around both these areas are being taken forward as a priority as part of our improvement plans. The “My Learning” learning management system has now been introduced to support completion and recoding of all mandatory training for our staff. In addition to this there is a specific commitment with regards to Brunswick Dementia ward to ensure MCA and DoLS awareness training is reviewed and a more comprehensive programme introduced and completed during 2015.

Specific developments, achievements & work undertaken in 2014-15:
Working closely with the Local Authority we have revised all Adult Safeguarding policies and procedures to ensure Care Act compliance. Training and briefing session have been provided to staff
at all levels, and briefing papers have been presented to our Quality Committee and Board. Information available on our internal website has been updated.

In 2014 we were selected to be one of two Mental Health Trusts nationally to host a project led by AVA (Against Violence and Abuse) Stella to improve our policy and practice with regards to Domestic Abuse. A Trust wide steering group has been established with representation across all care groups. Initial training sessions have been provided and a training plan is being developed including a specific induction slot. A new and comprehensive Domestic Abuse policy has been drawn up and is currently at the committee approval stage.

There were 579 alerts received by adult mental health, substance misuse and dementia services city wide in 2014/15, of these 10 related to Sussex Partnership (5 in adult mental health and 5 in dementia services). There were no alerts at levels 3 or 4 relating to Sussex Partnership.

**Future plans / priority areas for 2015/16:**

- To ensure compliance with the Care Act 2014
- To embed the principles of Making Safeguarding Personal into safeguarding practice
- To raise staff awareness in relation to domestic abuse, self-neglect and modern slavery
- To raise staff awareness in relation to the Prevent Duty and the Channel process
- To develop more integrated systems for recording and monitoring safeguarding concerns and MCA work linking to the new Sussex Partnership clinical recording system – Carenotes.

A forum for Social Workers involved in Safeguarding work is being established across all BHCC assessment services and social workers from the integrated mental health service will be included in this.

**Review of staff competency through training and development during year 2014/15:**

Adult Safeguarding is part of the Induction training for all Sussex Partnership staff. In addition an e-learning module re: safeguarding is available. Staff in the integrated services are also able to access the safeguarding training provided by BHCC and this has included extensive training with regards to new roles and responsibilities as outlined in the Care Act.

Trust wide training is provided in relation to MCA and DoLS. In addition we have taken part in the Joint Health Economy project led by the Brighton and Hove CCG which provided further training re: MCA and DoLS Sussex wide. Our essential training programme has been revised and the new My Learning system will ensure accurate reporting and compliance with training requirements

A social work supervision policy is being developed by the BHCC Principal social worker this will be rolled out to all social workers including in the integrated mental health service and will ensure that the Professional Capability Framework is embedded with supervision and professional development.

**Future plans for staff competency through training and other means:**

The Induction training module is being developed to include extended elements in relation to the Prevent duty and also in relation to domestic abuse. Training for Mental Capacity Act and DoLS will be provided Trust wide. Staff will have access to BHCC safeguarding training and MCA training. Safeguarding training is currently being reviewed in the light of the Care Act. The first round of Lead Enquiry Officer training was rolled out in May and the feedback is being used to develop further training sessions. MCA awareness training is being reviewed and a bespoke programme developed for staff in the integrated mental health service.

**Andy Porter**  
Deputy Director of Social Work  
Sussex Partnership NHS Foundation Trust
4.12 East Sussex Fire and Rescue Service (ESFRS)

**General overview of the year 2014-15:**
ESFRS has appointed a Partnership and Inclusion Coordinator in the City specifically to develop joint working and ensure the service reaches vulnerable groups. 60 Partners are signed up to the Care Providers Scheme. This year ESFRS has conducted 9346 Home Safety Visits, with 2895 in Brighton and Hove, 85% of which were delivered to vulnerable adults.

The ESFRS Health and Wellbeing Volunteer Scheme, in conjunction with 3VA, is now up and running. This project has 3 year funding and is focussed on reducing social isolation and health inequality within the deprived areas of Brighton and Hove. ESFRS volunteers visit clients over the age of 50 and have a guided conversation, and support them to access an activity or service. They can also refer for the Home Safety Visit, and are trained to identify safeguarding issues.

A new operational meeting group has been set up, the Community Initiatives Meeting, chaired by the ESFRS City Borough Commander, which has brought partners together to develop a shared understanding of the nature of vulnerability within our City and develop specific projects to ensure appropriate services reach those who need them.

**Specific developments, achievements & work undertaken in 2014-15:**
ESFRS has continued to work with partners sharing information for those who are most vulnerable to fire risk in our communities. Referrals for home safety visits are now received from the hospital smoking cessation team, Federation hospital link-worker, and Integrated Team for Families. Learning from incidents where there has been death or injury in result of a fire are shared with appropriate partners including Adult Social Care.

ESFRS provides a range of equipment for vulnerable adults including lap blankets and flame retardant bedding where appropriate to reduce risk. Sprinklers have been fitted in the homes of those considered at highest risk. In an initiative with BHCC sprinklers are being retro-fitted into a block of flats where there are a number of vulnerable residents.

ESFRS works closely with Public Health via the Safer Homes Networks and now delivers smoking cessation messages and promotes Health Checks during Home Safety Visits. Where fire crews encounter health and wellbeing issues these can now be referred into the ESFRS volunteer scheme for a visit.

ESFRS continues to attend the MARAC, Modern Slavery Meeting, Suicide Prevention Meeting, Safe in the City Meeting, Citywide Connect Board and Safeguarding Adults Board. This joint working has led to information sharing and increased proportions of visits to vulnerable adults.

Suicide Prevention Training is being rolled out for all fire crews. Crews have been briefed on modern slavery and a referral mechanism is in place.

**Future plans / priority areas for 2015/16:**
- Continue to increase the number and proportion of Home Safety Visits delivered to vulnerable adults.
- Develop specific projects with partners via the City Initiatives group to identify and respond to risk in relation to hoarding; Alzheimer’s and dementia; and resettlement into the community
- Continue to raise awareness of the specific risks associated with age, reduced mobility and smoking, ensuring effective prevention services are delivered.
- Continue to develop effective and appropriate data sharing with other agencies.

**Review of staff competency through training and development during year 2014/15:**
Service wide training to key members of staff has been delivered to improve awareness in safeguarding and wellbeing. In 2014/15, 31 staff were trained on Safeguarding by an External
trainer and 24 members of staff completed the Kwango e-learning course, which will continue on a rolling programme. The training has given confidence to staff to report safeguarding issues to the correct staff within ESFRS and to know what to look for when concerns are shown. 2014/15 proved to be a difficult year to organise training due to a large number of occasions when there was periods of industrial action.

ESFRS do not cover the Mental Capacity Act and Deprivation of Liberty Safeguards and look to partner providers for their expertise.

**Future plans for staff competency through training and other means:**
A number of courses are being sought for 2015/16 from external providers for key staff within the organisation.

**Andy Reynolds**
Director of Prevention and Protection
East Sussex Fire and Rescue Service

### 4.13 Practitioners Alliance for Safeguarding Adults (PASA)

The Practitioners Alliance for Safeguarding Adults (PASA) is made up of practitioners from the statutory, voluntary and private sectors. It is a forum for debate, support, updates and discussion about safeguarding adults.

The Brighton and Hove PASA Group is in its 9th year and meets quarterly. Meetings are attended by representatives from a wide range of organisations with an interest in Safeguarding Adults who take the opportunity to network, share information and good practice, receive updates on legislation and procedure and hear from a diverse range of speakers.

The terms of reference of the Group include increasing skills, knowledge and awareness of Safeguarding Adult issues. Input from the Brighton & Hove City Council’s Head of Adult Safeguarding provides an opportunity for practitioners to liaise, raise concerns and share local practice. A PASA group representative sits on the Safeguarding Adults Board.

**Activities in the year**
The group was involved in supporting workshops for the yearly safeguarding conference.
PASA had member representation at the Safeguarding Adults Board review day in February 2015.
A PASA member attended a Senior Social Work Forum, to enhance links between the Independent and Voluntary sector and the assessment team.

Updates were given on the Care Act and the new safeguarding procedures, with group members participating in feedback at draft stage.

Discussion topics included: feedback on alerting and investigations, training, Deprivation of Liberty Safeguards and a briefing on Safer Care Networks.

### 4.14 Mental Capacity Act

**MCA DoLS sub group**
This group (established 2007) continues to be a useful forum for networking, information sharing and identifying areas for development. The year 2014/5 followed the landmark Deprivation of Liberty Supreme Court judgment ruling in March 2014 leading to a significant increase in demands on resources for some core member organisations. Also of significance for member representatives was the outcome of the House of Lords scrutiny of the Mental Capacity which evidenced inconsistent understanding and application of the Act in Practice across organisations, and the
challenges of responding to this.

The group continues to be facilitated and chaired by BHCC with a structure of core membership and additional specialist contributors by arrangement with a task and finish group approach outside of group meetings to complete specific pieces of work. Identifying/securing appropriate representation needs further consideration. The independent review of the SAB may lead to a further review of governance and remit.

In May 2014 a task and finish group was set up with a focus on MCA/DoLS awareness in provider settings (May 2014). Following this, a series of 4 Managing Authority and Supervisory Body 1 day DoLS update ‘learning events’ took place between October 2014 and January 2015, with a total of 76 participants made up of Best Interest assessors, provider managers, and signatories which both supported greater understanding of different roles within and across agencies and also reinforced compliance of Mental Capacity Act as the responsibility of all organisations. Further events for Managing authorities are being planned following the success of these sessions.

A task and finish group was also set up to consider ‘best practice’ approach to potential deprivations of liberty in hospital settings – in particular dementia wards and ITU at BSUH. There has been an initial meeting and subsequent sharing and seeking of information, and further work is needed in this area to include SPFT partners, in relation to informal patients who are deprived of liberty in psychiatric wards.

In the previous year 2013/14 the group developed a set of Gold Standards for MCA/DoLS as a benchmark for future audit and qualitative analysis. The standards were ratified by the Safeguarding Board in March 2014, and Board member organisations are working towards meeting the standards in their areas.

Data Collection

Mental Capacity Assessments (MCA’S)
A system is in place to collect MCA data from Care Assess (Adult Social Care database) on a monthly basis. This shows a small increase in mental capacity assessments formally recorded across Adult Social Care from 309 (2012/2013) to 335 in 2013/2014, and 341 in 2014-2015. These figures do not include assessments undertaken by staff seconded to Sussex Partnership Trust (SPFT) who do not use Care Assess. A manual data collection process for MCAs undertaken by SPFT seconded staff was established but could not be resourced and an alternative reporting system is to be developed.

A method of and arrangement for qualitative analysis and audit has not yet been introduced so interpretation remains superficial.

Assessments under the Deprivation of Liberty Safeguards (DoLS) (figures in brackets show the 2013 – 2014 figures as a comparison)

The Supreme Court Judgement in P v Cheshire West and Chester Council and P& Q v Surrey County Council handed down in March 2014 led, as anticipated, to a considerable increase in the numbers of people considered to be deprived of their liberty for the purpose of receiving care and treatment.

In 2014-2015, the 6th Year of the Safeguards, there were a total of 693 (38) requests for authorisation under DoLS. 117 (17) were from hospital settings and 576 (20) requests were from nursing and residential homes.

Of the requests processed in 2014/5 a total of 9% of applications were not authorised compared to 43% in 2013/14. Further details can be provided on request.
This significant increase in requests for authorisations led to an urgent review of resources and systems to meet the demand. As a result the pool of Best Interest assessors was increased from 22 to 30, including the appointment of 2 full time Best Interests Assessors. An operational manager, senior social worker for DoLS, and admin staff are in post. This, combined with commissioning Independent BIA’s, has led to the number of breaches (assessments not completed within prescribed timescales) to being below 5%, compared to a significantly higher (40% +) national average. BHCC is supporting an approach where all experienced registered social workers will undertake Best Interest Assessor training. A DoLS governance group made up of senior managers, the Principal Social Worker and MCA DoLS Practice Manager has been established to oversee arrangements and manage competing demands and related risks.

PoHwer continues to provide the Independent Mental Capacity Advocacy (IMCA) service for the City. The increase in eligibility for IMCA support following the Supreme Court Judgement exceeded resources available to meet the demand and following work with commissioners in BHCC West and East Sussex, and PoHwer to address the implications of this, funding for additional advocacy was agreed.

**Training**

BHCC continues to offer a suite of MCA and DoLS related training including ½ day briefings, and 1 day more in in depth programmes for practitioners involved in the more complex aspects of this work.

Whilst there has not been a formal audit process established, there continues (consistent with the findings of the House of Lords’ scrutiny) to be variation in how practitioners have experienced training in terms of increasing skills and confidence in this area of work. The Care Act 2014 has augmented the position of the Mental Capacity Act within wider statutory duties, and a review of training to incorporate this is underway.

Brighton and Hove continues to actively support, with our South East regional colleagues via the 2 x yearly South East Best Interest Assessor Forum as an important platform for networking, legal updates practice development and learning for Best Interest Assessors who are both social care and health professionals. In September 2014 BHCC hosted the forum with speakers from CQC and a Court of Protection judge.

The council also continues to subscribe to MHA and MCA law on line which both BHCC and SPFT staff can access for regular updates on case law and related guidance notes. It also provides a discussion forum where practitioners can explore issues with a wide pool of other subscribers from different disciplines and backgrounds.

**Future plans / priority areas for 2014/2015:**

- Review of terms of reference of the MCA/ DoLS sub group in light of the independent review of the safeguarding adults board.
- Securing of consistent multi- agency representation on the MCA Sub group
- Informal carer and general public awareness raising of the MCA and DoLS
- MCA related data reports (BHCC and SPFT seconded staff)
- Review of application of the MCA Capability Framework across BHCC and seconded staff and development of the MCA Gold standards across agencies.
- Further development and evaluation of the MCA gold standards across agencies.
- Securing of appropriate and consistent multi- agency representation on the MCA Sub group

Edwina Sabine
Practice Manager (DoLS/MCA)
Brighton & Hove City Council
4.15 Safeguarding Adults Multi-Agency Training Strategy Sub Group

The Safeguarding Adults Multi Agency Training Strategy Sub Group is under review and has therefore not met in full during this period. The future of this group will be considered as part of the review of the infrastructure of the B&H Safeguarding Adults Board. It is expected that the sub group will be reformed, with new Terms of Reference, with opportunities to link with the Local Children’s safeguarding Board, and the adults boards in East and West Sussex being explored. Training data continues to be available, as shown in the table below.

The year 2014-2015 saw 1646 places commissioned by the BHCC workforce development team covering safeguarding adults, the Mental Capacity Act and related subjects (e.g. self-neglect). This is a reduction of 7% from the preceding year. The year saw the publication of the Care Act statutory guidance and consequential re-write of the safeguarding procedures. There was an agreed reduction in training delivery at the end of 2014 whilst the course content was revised and re-written to reflect the new procedures. The safeguarding courses have been updated, with training reflecting the new procedures being delivered from April 2015.

The year also saw the Supreme Court ruling on Cheshire West and Mig & Meg. This led to a huge increase in deprivation of liberty safeguards applications. Four learning events were held bringing together managing and supervisory authorities to provide an update on the safeguards, encourage effective working between the managing and supervisory authorities and to clarify roles and responsibilities. Additionally the course content on the deprivation of liberty safeguards was updated to reflect the Supreme Court ruling.

136 people from across a range of agencies attended the annual safeguarding adults conference. Speakers included Claire Crawley from the Department of Health considering the Care Act; the Care Quality Commission as well as a range of workshops including self-neglect, health investigations, violence against women and girls, DoLs and making safeguarding personal.

For 2015/16 the usual safeguarding conference event will be delivered in a different way. The Safeguarding Adults Board, Safeguarding Children’s Board and the Safe in the City Partnership are working together to hold a fortnight of learning events in November and December in 2015.

Tim Wilson
Development Manager
Organisational and Workforce Development
Brighton & Hove City Council
4.16 Safeguarding, MCA, DoLS and related training places provided by BHCC Workforce Development Team 2014 - 2015

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5. **Brighton & Hove Safeguarding Adults Board Members 2015**

The Safeguarding Adults Board is the multi-agency partnership that leads the strategic development of safeguarding adults work in Brighton & Hove.

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<tr>
<th>Name</th>
<th>Title</th>
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<td>Deb Austin</td>
<td>Head of Safeguarding (Children)</td>
<td>Brighton &amp; Hove City Council</td>
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<tr>
<td>Vincent Badu</td>
<td>Strategic Director of Social Care &amp; Partnerships</td>
<td>Sussex Partnership NHS Foundation Trust</td>
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<tr>
<td>Cllr Karen Barford</td>
<td>Lead Member Adult Social Care</td>
<td>Brighton &amp; Hove City Council</td>
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<tr>
<td>Graham Bartlett</td>
<td>CHAIR B&amp;H Safeguarding Adults Board</td>
<td>Brighton &amp; Hove City Council</td>
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<td>Nicky Cambridge</td>
<td>Brighton &amp; Hove Healthwatch</td>
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<td>Peter Castleton</td>
<td>Commissioner – Community Safety</td>
<td>Partnership Community Safety Team</td>
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<tr>
<td>Richard Cattell</td>
<td>Principal Social Worker (Adults)</td>
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<td>Karin Divall</td>
<td>Head of Provider Services</td>
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<td>Brian Doughty</td>
<td>Head of Assessment Services</td>
<td>Brighton &amp; Hove City Council</td>
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<tr>
<td>Denise D'Souza</td>
<td>Executive Director Adult Social Chair Brighton &amp; Hove Safeguarding Adults Board</td>
<td>Brighton &amp; Hove City Council</td>
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<tr>
<td>Sherree Fagge</td>
<td>Director of Nursing</td>
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<td>Paul Furnell</td>
<td>Detective Superintendent</td>
<td>Sussex Police</td>
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<td>Gail Gray</td>
<td>CEO, RISE</td>
<td>Domestic Violence Forum</td>
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<td>Jackie Grigg</td>
<td>Money Advice &amp; Community Support Brighton Housing Trust</td>
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<td>Michelle Jenkins</td>
<td>Head of Safeguarding (Adults)</td>
<td>Brighton &amp; Hove City Council</td>
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<td>Soline Jerram</td>
<td>Lead Nurse, Executive Director of Clinical Quality and Primary Care</td>
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<td>Susan Marshall</td>
<td>Chief Nurse</td>
<td>Sussex Community NHS Trust</td>
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<td>Director of Offender Management</td>
<td>Kent Surrey and Sussex Community Rehabilitation Company</td>
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<tr>
<td>Andrea Saunders</td>
<td>Head of Probation, Sussex</td>
<td>National Probation Service</td>
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Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Local Safeguarding Children Board Annual Report 2014-15

1.1 A final draft of the report was discussed at full Board on 22 September 2015 and agreed. It will be publically available including on the LSCB web site http://www.brightonandhovelscb.org.uk/

1.2 20 October 2015

1.3 Mia Brown, LSCB Business Manager
Email mia.brown@brighton-hove.gcsx.gov.uk
Telephone 07584217256

2. Summary

2.1 This paper is presented for information.

2.2 The LSCB is required to produce an annual report that outlines the progress it has made over the last year in respect to safeguarding and promoting the welfare of children and young people.

2.3 The report covers the period 1 April 2014 to 31 March 2015 and briefly summarises all the activity undertaken by, and on behalf of the Board over the past year. What we have done and what we will do is presented to you. This year has seen significant changes in the way we have approached Child Sexual Exploitation.

2.4 Throughout the year a number of agencies that comprise the Board have faced challenges including the organisational churn and
change of structural reform. The Board have worked hard to ensure that the inevitable evolution of the public and voluntary sector does not take place at the expense of the quality of practice and the Section 11 challenge and multi-agency audits, as presented in the Annual Report, are designed to support organisations to retain an external focus and continue to strive to improve the lives and opportunities of children.

2.5 Each year the LCSB faces a number of challenges and while ours are listed out fully in page 9 of the report we would like to highlight:

- We have improved the breadth of our lay membership which has helped the Board and agencies receive challenge from a comprehensive section of our communities.
- We have seen an increase in the influence of the Board from strengthening relationships with other key strategic groups, e.g. the Health & Wellbeing Board and the Safeguarding Adult Board.
- Work of the Board has been informed by clear agreed priorities and underpinned by an up to date and well-structured Business Plan, as recognised by the Ofsted Review.
- We have made significant headway in supporting the identification, assessment and safeguarding intervention of children at risk of sexual exploitation through the establishment of the multi-agency operational group, Red Operation Kite and the LSCB Subcommittees to scrutinise operational and strategic responses.

2.6 In 2015/16 we know that the LCSB will continue to face challenges. Ours are fully listed in pages 10 and 52 of the annual report. However we would like to highlight:

- The LSCB multi-agency training programme has been an area that has needed attention for two years. The absence of the LSCB Training Manager has considerably delayed this work and will a top priority going forward.
- It may be necessary to spend to tackle the significant issue of child sexual exploitation and ensure responses are robust and services adequately resourced. Linked to this are changes to the Safeguarding Investigations Unit which will mean there are more Detective Constables who will be working in many different areas. We must be assured that this an effective approach and that skilled staff to manage CSE are a ring fenced resource.
• Despite quarterly scrutiny of the reduction of the high number of repeat referrals and child protection plans, the LSCB must continue to scrutinise and influence these high numbers.

3. **Decisions, recommendations and any options**

3.1 It is recommended that the Board notes the report and supports the City Council in their contribution to keep children safe from abuse and neglect.

3.2 It is recommended that the Board note LSCB achievements on page 9 and the challenges for the LSCB in 2015-16, on page 10.

4. **Relevant information**

4.1 It is a statutory requirement for the LSCB to publish an annual report evaluating the effectiveness of safeguarding arrangements for children and young people in the local area.

4.2 The LSCB continues to work in partnership with member agencies to protect children from abuse and neglect, and to minimise any adverse consequences of abuse. The annual report provides an assessment of the effectiveness of local arrangements to safeguard and promote the welfare of children.

5. **Important considerations and implications**

Legal:

5.1 The Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB). There is a requirement under the Children Act 2004 (as amended by the Apprenticeship, Skills, Children and Learning Act 2009) that at least once in every 12 month period, a LSCB must prepare and publish a report about safeguarding and promoting the welfare of children in its local area. The report is to be submitted to the Children and Young People’s Committee, the Brighton & Hove Health and Wellbeing Board, and all member agencies.

5.2 Section 14(1) of the Act defines the objective of an LSCB as (a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established, and
(b) to ensure the effectiveness of what is done by each such person or body for those purposes. Whilst the LSCB has a role in coordinating and ensuring the effectiveness of local individuals' and organisations' work to safeguard and promote the welfare of children, it is not accountable for their operational work. Each Board partner retains its own existing lines of accountability for safeguarding and promoting the welfare of children by their services.

5.3 The report sets out consideration of partner agencies effectiveness in meeting their safeguarding obligations under the Children's Act 1989 and 2004.

Natasha Watson Managing Principal Lawyer  09/10/2015

Finance

5.4 No uplifts in funds were requested by the Independent Chairperson in 2014 – 15. The LSCB has been without a Training Manager for much of 2014 – 15 which has resulted in an unusual underspend on the training line of approx. £15k.

5.5 The full financial breakdown, plus the budget forecast for 2015 -16, can be read in Appendix 1 of the annual report. It is important to note that the LSCB budget does not represent the true costs of the Board’s business and development work and some ‘hidden’ costs are subsumed within the City Council and other partners’ budgets.

5.6 There are no financial implications directly resulting from the recommendations of this report. The financial information presented in the LSCB Annual report is accurate and a true reflection of the LSCB financial position within Brighton & Hove City Council’s accounts.

Brian McGonigle, Senior Finance Officer  09/10/2015

Equalities

5.7 The LSCB through the City Council and other partner agencies will continue to work to ensure all children and families have access to safeguarding services – particularly those who are less able to communicate due to age, disability, language or for other reasons. The work of the Board contributes to improved community cohesion. Throughout the year there was been much public engagement work and the Board has developed a new website and other
communication methods to increase community engagement with the work of the Board.

Sustainability

5.8 The LSCB is a statutory requirement and must be resourced over the forthcoming year.

Health, social care, children’s services and public health

5.9 One of the key objectives of the LSCB is to improve outcomes and health and wellbeing for children and young people from diverse communities and groups, and for those who live in deprived geographical communities.

6 Supporting documents and information

6.1 Annual Report 2014 – 15
Introduction by Graham Bartlett, Independent Chairperson

Once again I am very pleased to present this year’s Annual Report on behalf of all the agencies represented on the Brighton & Hove Local Safeguarding Children Board. You will find information about these agencies throughout this report. The LSCB is required to produce an annual report that outlines the progress it has made over the last year in respect to safeguarding and promoting the welfare of children and young people. The report covers the busy period 1 April 2014 to 31 March 2015 and briefly summarises all the activity undertaken by, and on behalf of the Board over the past year.

As Independent Chair I try to make sure that all Board members have the opportunity to contribute to Board business. This year we have made some significant changes in the way we have approached Child Sexual Exploitation and this has been an example of every agency and every Board member pulling together to ensure that we have a complete and thorough governance and assurance framework geared towards reducing the prevalence of this dreadful phenomenon.

Our new Lay Members have really come into their own this year and have kept professionals sharply focused on the impact their activity has on the people that need them most – our children. They have added real value too to the work of our subcommittees especially in providing an independent voice to case reviews and audit.

Every year all agencies that comprise the Board face huge challenges either through cases or structural reform. We have worked hard to ensure that the inevitable evolution of the public and voluntary sector does not take place at the expense of the quality of practice and our Section 11 challenge and multi-agency audits are designed to support organisations to retain an external focus and continue to strive to improve the lives and opportunities of children.

Just after the end of the year I report on here we received our long awaited Ofsted Review. This was a thorough process undertaken alongside the Local Authority’s Inspection. We were delighted to have been among the 30% of LSCBs in the country to be graded as Good. This is a reflection of all the hard work by everyone involved in the Board but provides us to with a clear agenda to continue to do even more to keep our children safe.
Reflections from Lay Members

"It has been a busy year as Lay Members, not least with our involvement in Ofsted meetings and individual interviews! A lot of hard work by so many contributing to a very positive outcome.

In June we were warmly welcomed by Portsmouth LSCB to our first Lay Member Conference. Three of our five lay members from Brighton & Hove were able to attend. We discovered during the course of the day that the model of our LSCB and lay member presence and involvement in subcommittees is regarded by others as forward thinking and likely to be most effective. Having five Lay Members was also considered a particular strength. This of course reflects the openness and self-reflection of the LSCB itself, which has been very welcoming of us.

It was a useful experience that we would recommend to other lay members at any stage of their contribution. Discussions around the role and function of the lay membership were particularly helpful and helped us to reflect on our own contributions in Brighton & Hove.

Our individual roles and collective identity as a stand-alone subcommittee are developing steadily, but there is much for us to learn as we go. The complexity of the structure of the LSCB, as well as the range of issues, makes it daunting to get to grips with. However we keep a strong focus on challenging the Board to actively seek out the voices of children and young people to influence its work, and we are keen to bring in voices from other stakeholders too. Particularly those who may not know quite how to engage.

Our roles to bring external, public scrutiny to the work of the board create frequent, welcomed opportunities for us to bring our own very varied skills, expertise and areas of particular interest as a resource to Brighton & Hove LSCB"

“A child's voice, however honest and true, is meaningless to those who have forgotten how to listen”
Albus Dumbledore
LSCB Vision & Values

Working together to keep children & young people safe in Brighton & Hove

The following shared values underpin and guide the work of the LSCB and are promoted by all Board Members.

- All children should be safe from abuse and neglect
- We prioritise the safety of children over everything else we do
- We are committed to the changing needs of all children in Brighton & Hove, particularly those who are vulnerable to risk
- We collaborate with agencies and challenge them in a shared responsibility to safeguard children
- We are dedicated to early help
- We listen to children, young people, families, our practitioners and their managers – their involvement shapes what we do
Safeguarding Children is Everyone’s Responsibility
Brighton & Hove Local Safeguarding Children Board Annual Report 2014-15 Executive Summary

This Executive Summary summarises the Brighton & Hove LSCB Annual Report covering 1 April 2014 to 31 March 2015. It describes the Board’s structure, activity and progress during 2014-15 with a focus on the priority areas as outlined in the Brighton & Hove LSCB Business Plan 2013-16. The report also sets out priorities and challenges for 2015-16.

About Brighton & Hove (page 12) Read these pages to find out more about your city.

The city of Brighton & Hove spans 87.54 km². At the time of the 2011 census it was England's most populous seaside resort with a population of 273,369. There are an estimated 54,100 (ONS 2014 midyear estimates) children and young people under 18 years of age living in the City.

Deprivation is higher in Brighton & Hove than it is on average across England.

Children and young people from minority ethnic groups account for 21% of all children living in the area, compared with 21.5% in the country as a whole.

31,947 pupils attend our schools. Nearly 30k of these pupils attend maintained settings, 78 pupils attend the two Pupil Referral Units (PRU) and 1,943 pupils attend academy or free schools. There are currently 294 known home educated children.

Role of the Board and Governance & Accountability (page 13) This section outlines the role and purpose of Brighton & Hove LSCB, describing how it is made up of statutory and voluntary partners including representatives from Health, Education, Children's Services, Police, Probation, Children and Family Court Advisory and Support Service (Cafcass), Youth Offending, the Community & Voluntary Sector as well as Lay Members.

Our purpose is to make sure that all children and young people in our city are protected from abuse and neglect. Children can only be safeguarded from harm if agencies work well together, follow procedures and guidance based on best practice and are well informed and trained.

This section of the report describes positive advances in the role of the LSCB in challenging partners and in the ongoing development of links across key strategic partnerships.

The Children Act 2004 places a duty on every Local Authority to establish a Local Safeguarding Children Board (LSCB). The Government's Statutory Guidance, Working Together to Safeguard Children (2015) defines safeguarding and promoting the welfare of children as: Protecting children from maltreatment; Preventing impairment of children's health or development; Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; Taking action to enable all children have the best life chances.

This is to enable children to have optimum life chances and enter adulthood successfully.
LSCB Finances & Resources (page 15) This section provides information about funding to and expenditure by the LSCB. The full financial breakdown can be read in appendix 1.

The Board is independent of any of the partners, funded by the majority of them and hosted and supported by Brighton & Hove City Council.

Monitoring & Evaluation (page 16) This section provides some analysis of the quality assurance activity that has taken place over the last year to test out agencies safeguarding and child protection systems. In this section are summaries of some of the key learning arising from multi-agency themed audits regarding child sexual exploitation, child sexual abuse and domestic violence and abuse. It talks about how the views of children and young people have informed service delivery.

Other activity discussed within this section includes Section 11 Audits, Private Fostering, Management of Allegations of Adults working with Children and Complaints Regarding Child Protection Conferences.

Ofsted Review (page 26) No Ofsted inspection was undertaken of the Local Authority or LSCB within the timeframe captured within this report. However, a review did take place from 14 April 2015 – 8 May and Ofsted judged the arrangements we have in place to evaluate the effectiveness of what is done by the local authority and Board partners to safeguard and promote the welfare of children as good. Read more about this on these pages.

Child Death Overview Panel (page 27) This part of the report contains a summary of the work of the Child Death Overview Panel (CDOP) during the year. Brighton & Hove CDOP review the deaths of all children normally resident in Brighton & Hove. During the last 12 months 16 children died in our area. The panel looks to identify any issues that could require a Serious Case Review (SCR); any matters of concern affecting the safety and welfare of children in the area; or any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area; and will make specific recommendation to the LSCB.

Learning from Case Reviews (page 29) No serious case reviews were published in 2014-15. In the year three Serious Case Reviews were initiated and findings are pending as at 31 March 2015. Two Learning Reviews were initiated and completed. Read more about the learning from reviews in this section.

LSCB Business Plan 2013 – 2016: An update on #yourLSCB’s key priorities (page 30) See these pages to read more about how the LSCB has tackled child sexual abuse, child sexual exploitation and neglect and how early help has been delivered in in Brighton & Hove.

Participation & Engagement (page 42) Read this section to see how the LSCB has ensured that; the views of children and young people, parents and carers are contributing to learning and practice, how parents, carers and members of the public have been supported to have an improved understanding of the values and statutory function of the LSCB partnership to work together and finally how staff and managers have been informing learning and improvement.
Early Help (page 47) Read this section to see how the Board has been involved in ensuring that there is a prompt and assured response when referrals are made or new information is received about child care concerns. As arrangements for early help have only been in place since 1 September 2014 we are keen to wait a year until the LSCB reviews the impact of the wide range of early help services. We will want to be assured that there is well-timed, good quality and noticeable involvement by everyone necessary that demonstrates that children’s welfare is promoted and that they are safeguarded from harm.

Board Accountability (page 49) Refer to this section to find out about how the Board has improved in fulfilling its function and duties over the past year. This has included changes to Subcommittees and the introduction of new systems to assist with communications across these Subcommittees.

LSCB Challenge (page 52) This section contains some examples of challenges that have been to and from the LSCB over the year.

How safe are our children? (page 53) Performance management has been a key priority for 2014-15. This section provides you with a general analysis of data collected over the year in relation to safeguarding children. Data in this section relates to: Referrals, Single Assessments, Section 47s Enquiries Initial Child Protection Conferences, Children in Need, Looked After Children and Children with a Child Protection Plan.

Missing (page 63) Brighton & Hove LSCB continues to provide a unified multi-agency approach to make sure the needs of these children and young people are met appropriately and effectively. Read more about this work on these pages.

Learning & Development (page 64) Brighton & Hove LSCB has a responsibility to develop policies and procedures in relation to: “… training of persons who work with children or in services affecting the safety and welfare of children … to monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children”. (Working Together, 2015). This section looks at the work of the LSCB’s Learning & Development Subcommittee.

Safeguarding in schools (page 67) Each year schools have an opportunity to self-assess their safeguarding arrangements by completing a safeguarding audit. This helps them to review their current safeguarding and child protection practice against the most recent national guidance. This year findings can be found within this section.

Members Annual Reports (page 68) This section provides an update on safeguarding and child protection activity that has been underway in each of our partner agencies over the past year.
Summary of Achievements 2014-15

We have improved the breadth of our lay membership which has helped the Board and agencies receive challenge from a comprehensive section of our communities.

We have continued to actively seek the views of children and young people on safeguarding issues.

We have kept up a stream of communications about Board business with professionals and the wider public.

We have seen an increase in the influence of the Board from strengthening relationships with other key strategic groups, e.g. the Health & Wellbeing Board and the Safeguarding Adult Board.

Work of the Board has been informed by clear agreed priorities and underpinned by an up to date and well-structured Business Plan, as recognised by the Ofsted Review.

The Monitoring & Evaluation function has gone from strength to strength with a varied multi-agency audit programme that has included children and young people and professionals and we have demonstratively used findings to drive improvement.

We have raised the profile of Brighton & Hove LSCB by; developing and maintaining our new website, disseminating LSCB newsletters, bulletins, board briefings, managers briefings and establishing a presence on Twitter.

The Early Help, MASH and Threshold document have been launched.

We have made significant headway in supporting the identification, assessment and safeguarding intervention of children at risk of sexual exploitation through the establishment of the multi-agency operational group, Red Operation Kite and the LSCB Subcommittees to scrutinise operational and strategic responses.

We have developed a more effective multi-agency dataset which, whilst still a work in progress, is used to routinely scrutinise partners performance, and challenge and audit where necessary.

The LSCB has been able to demonstrate, via the creation of a challenge log, that it consistently provides challenge to partners and holds partners to account to improve safeguarding outcomes for children and young people.

Subcommittees have been able to effectively communicate across one another through the continued scrutiny provided by the Leadership Group and by the introduction of the Referral Form system.

Despite not having a Training Manager in place for much of 2014-15 we have continued to deliver specialist child protection training across the partnership.
Summary of Challenges for 2015-16 (page 52)

This section discusses how safeguarding activity is progressing well but outlines a number of challenges, these include:

- Information sharing has remained a critical issue from Case Reviews both national and local. It is recognized that agencies cannot be complacent and that further work is required to ensure that practitioners across all agencies are aware of their responsibilities to share information where appropriate.
- In addition a focus needs to be maintained to ensure lessons are being learnt and agreed procedures are being followed.
- We now need to collate & analyse information from missing return interviews.
- Now that Early Help & MASH arrangements have become embedded, the LSCB will need to build an improved understanding of the effectiveness of early help assessments and interventions. We will want to be assured that the provision of early help is happening early enough and that the LSCB and our partners can evidence the difference for children, particularly those who are most vulnerable in making sure they receive the help they need before things escalate into child protection.
- Despite quarterly scrutiny of the reduction of the high number of repeat referrals and child protection plans, the LSCB must continue to scrutinise and influence these high numbers.
- Following Ofsted’s Review, the LSCB will look to improve links with the corporate parenting panel and better understand why thresholds for care or accommodation are reached.
- The most recent revision of the LSCB management information report has only been in use for six months, so there are inevitably issues in the presentation of data and the consistency of the commentary within it, given the number of managers across several agencies who contribute to it. We will need to achieve greater consistency in 2015/16.
- It is important that audits include feedback from service users and from practitioners and we would like to be able to evidence our commitment to ensuring partners are capturing the experiences of children, young people and families to inform service improvement. In 2015-16 we will increase efforts to hear the voice of children, young people, families and practitioners.
- The LSCB multi-agency training programme has been an area that has needed attention for two years. The absence of the LSCB Training Manager has considerably delayed this work and will a top priority going forward.
- The LSCB has made huge steps in terms of engaging with the public and raising the profile of the LSCB but we still need to consider, as challenged to do so by our Lay Members, how we can better engage the public in safeguarding children.
- It may be necessary to spend to tackle the significant issue of child sexual exploitation and ensure responses are robust and services adequately resourced. Linked to this are changes to the Safeguarding Investigations Unit which will mean there are more Detective Constables who will be working in many different areas. We must be assured that this an effective approach and that skilled staff to manage CSE are a ring fenced resource.
Messages for Board

- Work effectively to share information appropriately
- Identify & act on child protection concerns
- Collectively make decisions about how best to intervene in children’s lives where their welfare is being compromised, & collectively monitor the effectiveness of those arrangements.
- Continue the work to ensure looked after children receive appropriate, high quality and timely services

Staff working in Board Partner Agencies

- Book onto LSCB Multi agency training and learning events pertinent to your role
- Be familiar with the Pan Sussex Safeguarding Procedures
- Be familiar with the Threshold document to ensure an appropriate response to children and families
- Use your agency representative (see who this is on page 109) to make sure the voices of the workforce, children & young people are heard
- Be aware of the needs of privately fostered children.

Staff working in Board Partner Agencies

- Show Brighton & Hove LSCB that your agency is committed to a culture of safeguarding
- Ensure your workforce contributes to the provision of LSCB multi agency safeguarding training
- Have an open dialogue about any barriers that may impact on your organisations ability to safeguard children and young people.
- Every agency’s contribution to the work of the LSCB must be categorised as the highest priority in the allocation of time & resources.
- Help the LSCB to understand the impact of any organisational restructures on the capacity to safeguard children and young people in Brighton & Hove.

The Community

- You are in the best place to look out for children and young people and to report any of your concerns
- Safeguarding children and keeping them free from harm is everyone’s responsibility, if you are worried about a child or young person please follow the steps on Brighton & Hove LSCB’s website: www.brightonandhovelscb.org.uk

Local Politicians

- Continue to complete your section 175/157 self-assessments
- Help Brighton & Hove LSCB respond to the voices of vulnerable children & families in your ward
- Keep the protection of children and young people at the forefront of thinking when scrutinising and challenging any plans for Brighton & Hove

Children & Young people

- You are at the heart of the child protection system.
- We want to make sure that your voices are heard and that we know how you are experiencing the services in our Board partner agencies. If you would like to know more about how you can influence the work of Brighton & Hove LSCB please contact us at www.brightonandhovelscb.org.uk/contact

Commissioners

- Scrutinise and challenge governance and planning arrangements by your providers for children, young people and their families in Brighton & Hove
- Discharge safeguarding responsibilities fully to ensure services are commissioned for the most vulnerable children
- Monitor how information is shared across and between your providers
- Ensure that the SARC achieves a quality service

Schools

- Ensure your staff have an awareness of all safeguarding concerns – including self-harm
- Make certain staff are recruited safely
- Book onto LSCB Multi agency training and learning events pertinent to your role
- Be familiar with the Pan Sussex Safeguarding Procedures
- Help Brighton & Hove LSCB respond to the voices of vulnerable children & families in your ward
- Keep the protection of children and young people at the forefront of thinking when scrutinising and challenging any plans for Brighton & Hove
About Brighton & Hove

The city of Brighton & Hove spans 87.54 km². At the time of the 2011 census it was England’s most populous seaside resort with a population of 273,369. There are an estimated 54,100 (ONS 2014 midyear estimates) children and young people under 18 years of age living in the City.

On average over the year ending March 2015, 2,235 of our children received support from children’s services. There are approximately 309 children who have a child protection plan, and approximately 481 children in care in our City. There is more about safeguarding and child protection information on pages 53 of the report.

Deprivation
Deprivation is higher in Brighton & Hove than it is on average across England. In 2003, 54% of the city’s population lived in wards included in the 40% most deprived areas in the country, and just 5% lived in wards considered to be in the 20% most affluent in the country. These figures have changed little in recent years. Approximately 19.6% of the local authority’s children are living in poverty. Under the current definition, a child is considered to be in poverty if it lives in a household where the total income is 60 per cent of the national average.

Children registered in schools
We currently have 31,947 pupils attending our schools. Of these, 29,926 pupils attend maintained settings, 78 pupils attend the two Pupil Referral Units (PRU) and 1,943 pupils attend academy or free schools. Currently there 294 known home educated children. 4,953 children attend Independent Schools.

Special Educational Needs
We currently have 20.9% of our pupils with special educational needs (SEN), which is above the National figure of 16.6%. 2.9% (941) of our pupils have a Statement or Education, Health & Care Plan (National 2.8%) 17.9% of our pupils have SEN without a statement or Education, Health & Care Plan (National 15.1%) The SEN Framework changed with effect from Academic year 2014/15 and the old categories of school action and school action plus have been replaced with one category of SEN Support and changed at the termly review.

Information in this section is an annual local authority level summary of trends over the last few years of the termly School Census. The information is provided by Brighton & Hove maintained schools, 3 Academies and 2 Free Schools and the comparisons are to the latest published national benchmarking data.

Black and minority ethnic children
Children and young people from minority ethnic groups account for 21% of all children living in the area, compared with 21.5% in the country as a whole.

The largest minority ethnic groups of children and young people in the area are Any Other White Background (4.1%) and White and Asian 2.9%. The percentage of under 18s in the city who are not White British has risen from 11.4% in 2001 to 21% in 2011.

Children with disabilities
1,704 0-19 year olds were registered on the Children’s Disability Register, The Compass, at 31st March 2015.

This suggests that at least 2.8% of children in Brighton & Hove have a physical, learning or mental disability or long term illness that significantly affects daily life.
Governance & Accountability

Brighton & Hove LSCB is made up of statutory and voluntary partners. These include representatives from Health, Education, Children’s Services, Police, Probation, Children and Family Court Advisory and Support Service (Cafcass), Youth Offending, the Community & Voluntary Sector as well as Lay Members.

Our main role is to coordinate what is done locally to protect and promote the welfare of children and young people in Brighton & Hove and to monitor the effectiveness of those arrangements to ensure better outcomes for children and young people.

The efficacy of Brighton & Hove LSCB relies upon its ability to champion the safeguarding agenda through exercising an independent voice.

Our purpose is to make sure that all children and young people in our City are protected from abuse and neglect. Children can only be safeguarded from harm if agencies work well together, follow procedures and guidance based on best practice and are well informed and trained.

**Regulation 5 of the Local Safeguarding Board Regulations 2006** sets out the functions of the LSCB as per section 14 of the Children Act 2004.

**The Children Act 2004** places a duty on every local authority to establish a Local Safeguarding Children Board (LSCB).

The Government's Statutory Guidance, *Working Together to Safeguard Children (2015)* defines safeguarding and promoting the welfare of children as:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- taking action to enable all children to have the best life chances

This is to enable those children to have optimum life chances and enter adulthood successfully.

The Board met 6 times during the year. Where there has been insufficient attendance or engagement at the Board, this has been challenged by the Independent Chair.
LSCB Finance and Resources

All LSCB member organisations have an obligation to provide LSCBs with reliable resources (including finance) that enable the LSCB to be well organised and effective. In principle, members should share the financial responsibility for the LSCB in such a way that a disproportionate burden does not fall on one or more partner agencies. Locally, the City Council has contributed around 70% of funding.

There is no set formula on how LSCBs are funded, as each is different. It is not really possible to compare like for like and many contributions may be given in kind but not recorded in the budgets.

No uplifts in funds were requested by the Independent Chairperson in 2014 – 15. The LSCB has been without a Training Manager for much of 2014 – 15 which has resulted in an unusual underspend on the training line (The recruitment process for this post has since concluded.) An agency Training Administrator had to be appointed in the absence of the Training Manager to assist with the ongoing delivery of multi-agency training. This year the LSCB declared an underspend of £-9261.

The full financial breakdown, plus the budget forecast for 2015 -16, can be read in Appendix 1

Serious Case Reviews (SCRs) or Learning continue to be a financial pressure as and when these are agreed. In 2014-15 the LSCB spent £18,000 on SCRs and Learning Reviews.

It is important to note that the LSCB budget does not represent the true costs of the Board’s business and development work and some ‘hidden’ costs are subsumed within the City Council and other partners’ budgets.

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Monitoring & Evaluation

The LSCB has a key role in achieving high standards in safeguarding and promoting welfare, not just through coordinating, but also by evaluation and continuous improvement. Under Working Together to Safeguard Children (2015) LSCBs must quality assure practice, including through joint audits of case files involving practitioners and identify lessons to be learned. The Monitoring and Evaluation Subcommittee support the Brighton & Hove Learning and Improvement Framework to strengthen and support a learning culture across partner agencies. This Subcommittee, through its scrutiny and challenge role, is instrumental in assisting the Board to create a culture of openness and facilitate effective and regular challenge to all partner agencies.

The main focus of the subcommittee's work in 2014-15 has been continuing to oversee a programme of multi-agency audits, revising the management information provided to the LSCB, consolidating the LSCB’s Quality Assurance Framework (QAF), including dissemination of findings from audits and tracking action plans.

Management Information Report
During 2014-15, changes were made to the LSCB’s management information report. It adopted the format used by LSCBs in the North West of England, which consists of core data from key agencies and thematic data. The intention is to look at thematic data in depth, alongside multi-agency audits. This proved successful for the CSE audit when quantitative information about child sexual exploitation was considered alongside the qualitative audit data. It was not so successful for the domestic violence and abuse audit, as agencies struggled to retrieve the data requested.

Quality Assurance Framework (QAF)
The drafting of the LSCB QAF, led by Quality Assurance Manager, was completed early in 2014-15 and it was subsequently approved by the LSCB.

Multi-Agency Audit
In 2014-15 four multi-agency audits were presented to the Subcommittee:

- child sexual abuse cases and strategy meetings - see page 31 for findings
- domestic violence and abuse audit - see page 60 for findings
- thematic review of young parents and domestic violence - see page 60 for findings
- child sexual exploitation audit - see page 34 for findings

Summaries of findings from audits have been shared with staff in ‘Managers Briefings’ and a tracking system is in place to track all actions from LSCB audits and learning reviews.
Single Agency Audits

All agencies were asked to select a couple of single agency audits conducted in 2014 – 2015 which focused on safeguarding and child protection, and provide a summary of the learning and implications. At its March meeting the Subcommittee received the majority of these. No returns were received by the deadline from Sussex Police, Youth Offending Service, Probation, or the Community Rehabilitation Company (CRC). They were all challenged about their nil returns.

Throughout 2014-15, Children’s Services shared many single agency audits with the Subcommittee. These included audits on children in care, initial contacts with children’s services and core groups. These have been useful to inform the focus of multi-agency audits planned for 2015-16. Children’s Services also shared the Youth Advocacy Project survey of young people missing from care, which supported the design of the survey of young people at risk of child sexual exploitation.

Section 11 Audits

Section 11 of the Children Act 2004 requires agencies to make arrangements to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children.

The most recent Section 11 audits were completed by 31 March 2014, with a ‘Section 11 Challenge Event’ taking place on 30 May 2014 (read more about this on page 49 and progress against the standards agencies had not considered themselves compliant against was reported at March 2015 Board. Agencies were also asked for evidence against two additional standards regarding a) consideration of significant adults when gathering family information and b) data management systems and performance reporting to support effective safeguarding. These standards related to findings from a not yet published a serious case review. The majority of agencies have gone from Amber to Green across deficit areas. However some gaps remain.

Some measures concerned with recognition and response to the risk of child sexual exploitation and the consideration of fathers and other significant adult males continue to be reported as deficit areas for some agencies.

Most agencies do not assess their systems for gathering information about all significant adults as robust as they could be. This is particularly noted as a challenge in cases of separate families and absent fathers.

Most agencies report challenges with IT data management systems which do not always ensure robust management oversight to assist effective safeguarding of children.
Voice of the child
The Monitoring and Evaluation Subcommittee had intended to include the voices of children/young people and their families in its audits in 2014-15. However, this did not prove viable until the child sexual exploitation audit. As part of this audit, three young people agreed to be interviewed by the Youth Advocacy Project. Although a small sample, they gave some valuable feedback about whether they felt they had been listened to and made suggestions about what help could be useful for them and other young people in a similar situation.

Management Information: Monitoring & Evaluation’s Areas of Concern

The continued high number of children subject to repeat child protection plans in Brighton and Hove. Children’s Services believe this is largely due to recurrences of domestic abuse, so the working group arising from the domestic violence and abuse audit has been addressing ways to improve strategy and practice in this area, as well as the impact of the ‘toxic trio’ of domestic abuse, parental substance misuse and parental mental illness on repeat plans.

The high number of referrals and repeat referrals to Children’s Services. The introduction of a Multi-Agency Safeguarding Hub (MASH) and Early Help Hub (EHH) in September 2014 was intended to address some of the issues that had been identified as contributing to the high numbers. Now that the changes have had six months to bed in, the Monitoring & Evaluation subcommittee plans to focus closely on data analysis of the nature and outcome of referrals and audit of MASH and the EHH.

The high number of teenagers presenting to A&E following self-harm. This matter was brought to the attention of the LSCB Chairperson and the Leadership Group in May 2014, and Public Health have been requested to provide an in-depth analysis to look at the story behind the figures.
Private Fostering

A private fostering arrangement is one that is made privately (without the involvement of a local authority) for the care of a child under the age of 16 years (under 18 if disabled) by someone other than a parent or close relative, in their own home, with the intention that it should last for 28 days or more.

Current arrangements for the regulation of private fostering originate from concern following the death of Victoria Climbé in 2000. Victoria was privately fostered by her great aunt.

Given concerns about the level of ‘hidden’ private fostering, local authorities are required to raise public awareness of the requirement to notify the local authority of private fostering arrangements and therefore to reduce the number of ‘unknown’ private fostering arrangements.

In 2014-15 a range of initiatives were undertaken to highlight the notification arrangements to existing and potential private foster carers, voluntary and statutory agencies, and members of the public as follows:

1. Private Fostering materials have all been updated and re-printed to include the MASH contact details. The BHCC Private Fostering web page has also been refreshed.
2. Information about Private Fostering has been circulated via the Primary Care bulletin.
3. A Private Fostering briefing has been circulated to all Children’s Service staff as part of the Social Work: Our Story.
4. Information about Private Fostering has been included in the School Governors Briefing.
5. Posters and leaflets have been emailed to GPs via the Brighton & Hove Clinical Commission Group.
6. The LSCB multi-agency private fostering training has been refreshed and delivered to Safeguarding Designated Persons (schools). Multi-agency training has previously been cancelled due to low registration. In future the Private Fostering training will be included in wider training on ‘Hidden Groups’ which should encourage more professionals to sign up.
7. Information about private fostering will be included in the BHCC School Admissions booklet (both primary & secondary).
8. The LSCB continues to raise awareness about Private Fostering with members of the public and professionals via social media and regular tweets.
Monitoring Compliance with Duties and Functions

The number of privately fostered children is constantly changing as new arrangements are referred and children move on - sometimes back to their parents - or when they reach 16 years (or 18 years if disabled).

Private Fostering activity has increased again in 2014-15.

At the start of the year (1 April 2014) there were 19 children reported as living in private fostering arrangements. During the year, 26 new notifications were received and 26 were confirmed as being private fostering within the definition.

All new notifications received an initial visit, with 88% taking place within 7 working days. This is better than the England average for 2014/15 is 80%.

Again, we saw an increase in the percentage of cases where visits to children were carried out within the timescales required by Regulation 8 of the Private Fostering legislation (which is at least 6 weekly in the first year). Visits were on time for 41 out of 45 cases which is 91%. This is better than the England average of 67%.

In 2014/15 of the 26 new private fostering arrangements, 24 children are aged 10 to 16, one child is aged 5-9 and one child is under 5. Two children were born in the UK and twenty four children were born overseas.

Twenty nine arrangements ended during the year, leaving a total of 16 children in Private Fostering arrangements at 31 March 2015.

<table>
<thead>
<tr>
<th>Reason why the Arrangement Ended:</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overseas child returned voluntarily to country of origin</td>
<td>9</td>
</tr>
<tr>
<td>Overseas child returned to country of origin via Home Office intervention</td>
<td>0</td>
</tr>
<tr>
<td>UK born returned to parents</td>
<td>2</td>
</tr>
<tr>
<td>Became 'looked after child'</td>
<td>0</td>
</tr>
<tr>
<td>Educational/sporting/vocational opportunity ended</td>
<td>0</td>
</tr>
<tr>
<td>Child turned 16 (or 18 if disabled)</td>
<td>12</td>
</tr>
<tr>
<td>Moved to another private fosterer</td>
<td>2</td>
</tr>
<tr>
<td>Other *</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
</tr>
</tbody>
</table>

* Other - 4 yp moved into College Residence
Management Allegations of Adults Working with Children

The management of allegations should been seen in the wider context of safer employment practices, which has three essential elements:

- Safer recruitment & selection practices
- Safer working practices
- Management of allegations or concerns

Although this report will primarily focus on the third element, this activity is interlinked with the work undertaken by the LADO in respect of safer recruitment, employment and guidance to support safer working practices across the children’s workforce and within the private and voluntary sector.

The aim of the LADO is to provide a more consistent and appropriate scrutiny across diverse workforces and voluntary bodies, to contribute to a greater level of safeguarding to children and natural justice to staff and to enable appropriate referrals being made for barring decisions, to build a safer workforce by removing practitioners who are likely to present a risk. The structure of the process was designed to bring independent advice to decision making.

Employee groups include;

**Voluntary Organisations** – such as community groups, Scouts, Brownies, dance clubs, some after school playschemes and charitable organisations.

**Sports Organisations**- such as football clubs etc.

**Early Years Services** – include nurseries, pre-schools, childminders, nannys (domestic), private and independent providers and Children’s Centres.

**Transport** - refers to transport provided by services through a contract (e.g. DTS) such a bus/taxi drivers and/or escorts

**Other**-refers to individuals from non voluntary/charitable organisations not affiliated with the LSCB.

**Children’s Social Work Services**- include allegations against BHCC and non BHCC staff, including social workers and those providing a range of family interventions.

**Schools**- refers to all staff including non teaching staff (NTS) and in maintained (Main) and non-maintained (NonMain) schools, language schools and Further Education (F.E) colleges.
Overall the total for 2014-15 is 239, which represents an increase of 20 from the previous year. This trend continuing into 2015-16 with 122 referrals as of 1st September 2015 compared to 88 by 1st September 2014. The increase in referrals is reflected by the numbers of referrals to the MASH and mirrored by the continuing increase in referrals to LADO colleagues in the South East.

There is still no current nationally agreed data set for allegations against people working with children, making comparison of data between Local Authorities unreliable. The South East Network of LADO’s now exchange data, but again comparison is made difficult by inconsistent recording, in particular some not referring to ‘suitability’ or Initial Evaluations that lead to No Further Action.

The main trends for this period relate to an increase in the numbers of allegations involving the suitability of both early years employees, taxi drivers and teaching staff.

The first being new DfE statutory guidance - ‘Disqualification under the Childcare Act 2006, published in February 2015. This is referred to as Risk by Association (RBA). This extended previous guidance for Early Years settings to include schools with pre-school and reception classes for under 5yrs, but also schools who organise or host pre-school and after school care for children under 8 yrs. Staff are required to declare if they are living in a household with an individual convicted of certain offences that are not considered spent conviction (Rehabilitation of Offenders Act 1974). This being the case, then staff have to seek a Waiver from Ofsted/DfE to continue working in such settings.

The second has been a review of safeguarding processes regarding the licensing of Taxi Drivers within the Hackney Carriage Licensing Team, where drivers ‘suitability’ and whether an individual is considered ‘a fit and proper person’ is being scrutinised more robustly post Rotherham and other Local Authority investigations. The title of LADO was omitted from WT’15. It stated Local authorities should have ‘designated a particular officer, or team of officers (either as part of a multi-agency arrangement or otherwise), to be involved in the management and oversight of allegations against people that work with children.’ LADO colleagues at the National LADO Conference on 13th March 2015 unanimously referred to as LADO’s and referred to this title within their LSCB procedures.
The review outcome in respect of the use of restraint concluded that ‘Staff face significant challenges in terms of verbal and physical abuse. The boundaries being imposed are very necessary to the management of this’ and that ‘A reduction in the number of incidents of positive handling over time should be expected.’

It is reassuring to comment that for the period April to September 2015, there have only been 3 referrals regarding use of restraint, one of which involved an EYS setting.

**Timescales – At Point of Conclusion:**
The start date for counting will be the date the allegation was referred to the LADO, Children’s Social Work Service or the Police. The conclusion date is the point at which there is no further action to be taken by the employer, Children’s Social Work Service, the Police or Courts regarding the allegation.

Target timescales have been met, those ongoing cases reflect lengthy police investigations, court cases and disciplinary procedures. It is the view of the LADO that having a dedicated role, not only provides greater continuity but also enables more timely responses, the ability to track cases, review them and chase up professionals with their outcomes.

It is in everyone’s interest to resolve cases as quickly as possible consistent with a fair and thorough investigation. All allegations should be investigated as a priority to avoid any delay. Target timescales are shown below: the time taken to investigate and resolve individual cases depends on a variety of factors including the nature, seriousness and complexity of the allegation, but these targets should be achieved in all but truly exceptional cases. It is expected that 80 per cent of cases should be resolved within one month, 90 per cent within three months, and all but the most exceptional cases should be completed within 12 months.

**Keeping Children Safe in Education**

- < 1 Month: 80%
- < 3 Months: 11%
- < 1 Year: 6%
- ongoing: 3%
Allegation Outcomes
The proportion of substantiated, unsubstantiated and unfounded allegations vs false and malicious indicate that referrals to the LADO are being made appropriately.

The revised DfE statutory guidance continues to protect teaching staff against ‘malicious’ allegations despite the actual numbers being relatively low.

HR Outcomes
The use of alternatives to suspension is actively discussed at Strategy Meetings and this message is reinforced by the updated Department for Education Guidance, Keeping Children Safe in Education 2015. Of the 44 individuals ‘suspended’, 16 were ‘reinstated’ while the remaining either resigned, were dismissed or the employer ceased to use their services. There has been one instance of a pupil exclusion regarding an allegation against staff deemed to be ‘malicious’ in a school.

Cessation of use: This usually applies to cases involving volunteers or non-contracted staff. Ceasing to use services, sometimes with immediate effect, is not covered by employment legislation.

Deregistration: This would occur when a foster carer and child minder are considered unsuitable to care for children and their registration is revoked.

Referral to DBS for Barring Consideration: Refers to the Disclosure and Barring Service.

Referral to regulatory body: For example, Ofsted, the NCTL, Health and Care Professionals Council (HCPC), General Medical Council (GMC) etc.
The high number of Initial Evaluations with schools that led to an Internal Disciplinary Investigation rather than formal allegations management procedures, indicate that safeguarding regarding staff in schools appears well embedded.

The LADO has received 66 referrals from Schools, 95 from Children’s Social Work Services, 29 from EYS, 19 from the Police, 9 from Other agencies, 7 from Health, 6 from Faith organisations, 4 from Ofsted, 3 from Community and Voluntary Organisations and 1 from CAFCASS.

Conclusion
The Allegation Management Procedure within Brighton and Hove appears to be well embedded in a range of statutory and voluntary organisations. The LADO received positive comments in the Ofsted Inspection Report of the Local Authority June 2015; ‘Good arrangements are in place to respond to cases when allegations are made about professionals who work with children. The local authority designated officer’s (LADO) comprehensive awareness-raising activity has resulted in a range of referrals from various statutory and non-statutory agencies, including sports groups and faith organisations. Some recent joint working initiatives with the council’s licensing department are also raising awareness of the LADO role. Good quality multi-agency work underpins all work by the LADO and helps to protect children.’

No further action after Initial Evaluation: Refers to the initial discussion with the referrer, and this may include Children’s Social Work Services and/or the Police about whether the alleged incident falls within the scope of these safeguarding procedures. Following the initial discussion/inquiries there may be no need for further action under these procedures. It does not mean further assessment or investigation may be undertaken in accordance with other Regulatory frameworks such as the Assessment of Children in Need (Section 17 C.A’89), or via an employer’s disciplinary procedures.

<table>
<thead>
<tr>
<th>Referral Outcomes</th>
<th>Strategy Discussion</th>
<th>Section 47</th>
<th>Police</th>
<th>Charge</th>
<th>Conviction</th>
<th>Internal Investigation</th>
<th>Initial Evaluation NFA</th>
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<tr>
<td>Children Social Work Services</td>
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<td>1</td>
<td>1</td>
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<tr>
<td>EYS</td>
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<td>6</td>
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<td>1</td>
<td>34</td>
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<tr>
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<td>Residential LA</td>
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<td>1</td>
<td></td>
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<tr>
<td>Residential non LA</td>
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<td>Schools</td>
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<td>2</td>
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<td>Sports Org</td>
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<td>1</td>
<td>2</td>
<td>1</td>
<td></td>
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<td>Voluntary Org</td>
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<tr>
<td>TOTAL</td>
<td>52</td>
<td>23</td>
<td>48</td>
<td>10</td>
<td>5</td>
<td>138</td>
<td>118</td>
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</tbody>
</table>
Ofsted Review

No Ofsted inspection was undertaken of the Local Authority or LSCB within the timeframe captured within this report. However, a review did take place from 14 April 2015 – 8 May and Ofsted judged the arrangements we have in place to evaluate the effectiveness of what is done by the local authority and Board partners to safeguard and promote the welfare of children as good. Next year's annual report will update on progress against the recommendations.

Findings: Governance
- constitution and compact underpins the new arrangements
- Board identifies & shares cross-cutting intelligence & knowledge about particularly vulnerable groups of children (radicalisation & CSE)
- constructive relationships with other key strategic boards
- multiagency section 11 challenge event rigorously tested compliance of partner agencies with core safeguarding policies

Findings: Quality Assurance
- tenacious efforts to develop a multi-agency dataset
- audit findings & recommendations systematically & comprehensively disseminated across partnership
- intelligence from audits, serious case reviews & learning reviews used effectively to inform content of specialist multi-agency training programmes
- good Quality Assurance Framework supported by a complementary Learning Improvement Framework
- audit recommendations rigorously pursued & repeat audits scheduled

Findings: Serious Case Reviews & Child Death Overview Panel
- targeted and achievable action plans.
- implementation of action plans is closely monitored
- learning from reviews is appropriately cascaded to the workforce
- CDOP effective in scrutinising serious incident notifications & has strong links with Case Review Subcommittee

Recommendations & Shortfalls:
- LSCB to collate & analyse information from missing return interviews
- LSCB to build better understanding of the effectiveness of early help assessments and interventions
- LSCB to continue to scrutinise and influence the reduction of the high number of repeat referrals and child protection plans
- LSCB to improve links with the corporate parenting panel and better understand why thresholds for care or accommodation are reached
- Business Plan to provide focus on children looked after living outside the LA
- Further refinement of performance information needed

Graham Bartlett, Independent Chairperson
“There’s always room for improvement when it comes to keeping children safe and it’s vital for the city that there is an independent body that co-ordinates the work and makes sure it is to the right standard. The LSCB does a lot of important work identifying areas that could be improved in the interests of children and helping different agencies to achieve those improvements, especially by working together and communicating information more effectively”

Ofsted Review
“…transparent, learning-focused multi-agency LSCB”
“…rigorous approach to evaluating the effectiveness of safeguarding arrangements in all of its partner agencies”
“The LSCB is an active and influential participant in informing and planning services for children and young people”
“The good quality LSCB annual report reflects the board’s learning and self-evaluative ethos”
“Serious case reviews commissioned in accordance with statutory criteria & thresholds applied correctly”
Child Death Overview Panel

The Child Death Overview Panel (CDOP) is the inter-agency forum that meets bi-monthly to review the deaths of all children normally resident in East Sussex and Brighton & Hove. It is a subcommittee of the two Local Safeguarding Children Boards (LSCBs) for Brighton & Hove and East Sussex and is therefore separately accountable to the two LSCB Chairs.

The purpose of the review is to determine whether the death was deemed preventable, that is one in which there are identified modifiable factors which may have contributed to the death. These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be prevented. If this is the case the panel must decide what, if any, actions could be taken to prevent such deaths in future.

The CDOP met 4 times during 2014-15 to discuss child deaths in Brighton & Hove and a further 2 times for the neonatal panels.

Of the 16 Brighton & Hove reviews completed in 2014/15, ten were completed within six months. This lower rate in performance can be partly explained by the long term sickness of some key CDOP panel members over the course of the year.

During 2014-15 there were no recommendations made to the LSCBs regarding the need for a serious case review. They did recommend that Brighton & Hove LSCB:

- That the LSCB seek re-assurance from Brighton & Sussex University Hospital Trust that their services are operating in accordance with NICE guidance on Feverish Illness in Children (2013) and how this is being monitored. LSCB to request the Clinical Commissioning Group and NHS England Area Team to provide a reminder to all health professionals of the importance of listening to parents when they report that their children are acutely unwell and that they encourage parents to bring the child back for further assessment if the child’s health does not improve or deteriorates.

- That the LSCB should request regular updates from the Clinical Commissioning Group on the implementation of the Action Plan relating to communication difficulties between community services, local hospital and tertiary centre until all the recommendations are achieved.

There were additional recommendations made regarding particular agencies which related to issues specific to particular case histories, which do not have general relevance so have not been included here.

During 2014-2015 there were a total of 16 deaths of children who were resident in Brighton & Hove notified to the CDOP. If during the process of reviewing a child death, the CDOP identifies: an issue that could require a Serious Case Review (SCR); a matter of concern affecting the safety and welfare of children in the area; or any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area, a specific recommendation is made to the relevant LSCB.

Of the 16 Brighton & Hove reviews completed, 56 (one in five) have been identified as having factors which may have contributed to the death and could be modified to reduce the risk of future deaths. 34 of the 56 deaths reviewed during these years, where modifiable factors where identified related to babies and the factors included inappropriate sleeping arrangements for babies and high risk pregnancies where there were problems withthe obstetric and midwifery care. During the past year there were 10 deaths reviewed that identified modifiable factors and five of them were Sudden Unexplained Deaths in Infancy and all of these babies at the time of their deaths were in sleeping arrangements that were not in line with current safe sleeping guidance for babies.
Child Death data

Deaths notified to CDOP in East Sussex decreased last year whilst Brighton & Hove had a similar number of deaths.

The age distribution in deaths in children follows an expected pattern linked to national trends with most deaths being seen in children in the first month of life followed by deaths in the first year of life, with a slight increase in deaths during adolescence.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-27 days</td>
<td>68</td>
</tr>
<tr>
<td>28-364 days</td>
<td>19</td>
</tr>
<tr>
<td>1-4 years</td>
<td>7</td>
</tr>
<tr>
<td>5-9 years</td>
<td>7</td>
</tr>
<tr>
<td>10-17 years</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>118</td>
</tr>
</tbody>
</table>

National Developments

Following consultation the government has updated and replaced the current statutory guidance Working Together to Safeguard Children revised and published in 2013. The revisions include changes to:

- the referral of allegations against those who work with children;
- notifiable incidents involving the care of a child
- the definition of serious harm for the purposes of serious case reviews.

There were some minor changes to the definition of a modifiable death for the purpose of national data collection however as yet, these have not significantly impacted upon the processes of the CDOP.

In 2013 the Government commissioned research which reported that ‘There was a clear and vociferous call from CDOP staff and chairs for a proper national system of collecting, analysing and reporting CDOP data which would enable appropriate alerts and alarms to be issued and which would provide a focus for national information sharing and learning.’ To date the Government has not responded to this report. Further research has however been commissioned by the Health Care Quality Improvement Partnership on behalf of NHS England and the Scottish Government. The purpose of this research is ‘To investigate whether and how it would be possible to develop a ‘national’ database to collect information from child death reviews from all CDOPs’.

This research will relate to England and Scotland. The Chair of the Brighton & Hove and East Sussex CDOP has contributed to this project which will report in June 2016.

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1 This may in part be due to the fact that this is a larger age group 1-4 & 5-9 both span 5 years whereas 10-17 is an age group spanning 8 years. These age bands are determined by the DfE
2 Jennifer J Kurinczuk & Marian Knight National Perinatal Epidemiology Unit University of Oxford Child death reviews: improving the use of evidence Research Brief DfE October 2013
LSCB Serious Case & Learning Reviews

As per Working Together to Safeguard Children (2015), LSCBs are required to consider whether to initiate a serious case review when a child dies (including death by suspected suicide) or is seriously injured, and abuse or neglect is known or suspected to be a factor. The main purpose of a serious case review is to learn lessons to improve the way in which agencies and professionals work both individually and collectively to safeguard and promote the welfare of children.

In Brighton & Hove, Learning Reviews take place when, after an initial review of the case, it is decided that there are lessons to be learnt, but the threshold for a SCR is not met. The Learning Review consists of professionals from each agency involved with the child or family, meeting together, to share information, identify good practice and missed opportunities. Learning which might help to prevent similar events in the future is identified.

No serious case reviews were published in 2014-15.

Ben’s Story

From the age of 11 Ben was reported to be self-harming. These reports of self-harming continued to be raised during the two years prior to an episode where he attempted to hang himself. Following the hanging incident Ben was left with life changing brain injuries and Sadly Ben died in 2015.

Learning
- Knowledge of & response of professionals to self-harming behaviours
- Professionals’ assumptions of parents’ ability to cope and respond to difficulties
- Need to review Pan Sussex Self-Harm Procedure
- Information sharing when not in Child Protection arena
- Emotional well-being and mental health support offered to young people
- Listening to young people
- Involving wider family and friends in Learning Reviews

Child J’s Story

Child J was found hanging in the family home shortly after his 18th birthday. J had received services from children’s social work, mental health services, drug services and youth services two years prior to his untimely death.

Learning
- Importance of information sharing – even without consent
- Understanding the inter-link between mental health issues & drug and alcohol misuse
- Engaging with young people
- Normalisation of risky adolescent behaviour
- Transfer between children & adult services
- Process for repeat prescriptions
LSCB Business Plan 2013 – 2016 Key Priorities

The Business Plan reflects key objectives and actions needed in order to help make children and young people safer in Brighton & Hove. The Board selected these priority areas due to either their prevalence in the cases agencies see or because we believe them to be unseen or hidden forms of abuse which we need to work together to tackle.

The next few pages will cover what activity has taken place over the year to drive forward the following four priority areas.

**Priority Area 1:** Responses to Specific Safeguarding Concerns

- Neglect
- Sexual abuse
- Sexual exploitation

**Priority Area 2:** Participation & Engagement

- The views of parents, carers, children and young people are contributing to learning and practice.
- Parents, carers, members of the public, staff and managers have an improved understanding of the LSCB.
- Staff and managers are informing learning and improvement.

**Priority Area 3:** Service Responses

- The process for the early help assessment and the type and level of early help services to be provided is effective in meeting the needs of children and families.
- There is a prompt and assured response when referrals are made or new information is received about child care concerns.

**Priority Area 4:** Accountability

- The Board is better coordinated and ensuring the effectiveness of what is done by partner agencies.

Children and young people in Brighton & Hove are protected effectively from:

- Neglect
- Sexual abuse
- Sexual exploitation

- The process for the early help assessment and the type and level of early help services to be provided is effective in meeting the needs of children and families.
- There is a prompt and assured response when referrals are made or new information is received about child care concerns.
Priority Area 1: Child Sexual Abuse (CSA)

Sexual abuse of children thrives on secrecy and lies and needs to be taken out of the corner dusted down, not hidden away. Helping to make sure that children and young people in Brighton & Hove are protected from sexual abuse (CSA) is a key priority area for the LSCB.

What we did:

**Multi-Agency Quality Assurance Activity**
Twelve cases were audited, which revealed improvements since a previous audit in 2012 in the following areas:

- in most cases there were fewer concerns about the quality of recording;
- there was no longer a theme about missing information on Carefirst;
- there was no longer a concern about lack of checks on siblings;
- in all cases, therapeutic support was discussed with the child or parents, where relevant;
- although there was an improvement in the number of children offered medical assessments, this audit revealed that there remained some cases where discussion with a paediatrician had not taken place.
- following the audit Multi Agency Meetings (MAM’s) are now held weekly at the Multi-Agency Safeguarding Hub attended by Named Nurse, Named Doctor or Designated Doctor.

**Single Agency Audit**
Sussex Community NHS Trust undertook a single agency CSA Health Audit. This was a retrospective review of 12 months looking at a total of 34 cases (4 of which were forensic cases). These concerned 85% female ranging from 18 months – 13 years. 70% of referrals were from Children’s Social Work, 15% had had prior Achieving Best Evidence (ABE) interviews. All alleged perpetrators were male and 62% of cases disclosures were made. 32% were on Child Protection or Child In Need Plan. In 17% of cases there was documented domestic violence. Psychological follow up or protective behaviours support was recommended in 47% cases. Recommendations from the audit where to continue to request ABE prior to a CSA Health Assessment and to recommend psychological follow up, where relevant.

**Training**
Planning for a multi-agency Child Sexual Abuse and Harmful Sexual Behaviours Conference took place in 2014-15. This one day conference took place in May 2015 and full feedback will be provided in next year’s annual report. It afforded professionals an opportunity to hear the latest information to best help those with whom they work. The Conference was the start of a series of events to explore how we can best work together to end abuse and support victims in our city. There were a number of engaging talks covering a range of topics and professionals were able to choose from a choice of seminars in the afternoon, You can find out more about this event at [www.brightonandhovelscb.org.uk/child-sexual-abuse-harmful-sexual-behaviours-conference](http://www.brightonandhovelscb.org.uk/child-sexual-abuse-harmful-sexual-behaviours-conference)

Of the 2770 single assessments completed in 2014-15, **140 (5.1%)** identified sexual abuse as a factor at the end of the assessment compared to **6.1%** in 2013-14.

Of the **309** children subject of a Child Protection Plan as of 31 March 2015, **18 (5.8%)** had Child Sexual Abuse recorded as a category of abuse compared to **6.9% (20 children)** at 31 March 2014.
Planning for launch of paediatric sexual assault referral centre (SARC)
Planning for the SARC, a multi-agency partnership service provided by health, social care and the police, led by NHS England, took place in 2014-15. The SARC offers services, advice and support to clients aged 14 and over following a rape or sexual assault. The LSCB considered the SARC uplift to existing provision and focused on the four following areas when considering the new service specification.

**Clinical**
Managed Clinical Network with a central hub in Brighton and linked spokes in East Sussex and West Sussex for children and young people up to and including the end of the 13th year or between the ages of 14-18 if disabled.

The LSCB were assured the proposal was based on a clinically sound model with a good holistic approach.

**Forensic**
Comprehensive forensic examination available between 9am and 5pm, arranged appropriately after discussion with all involved.
Commitment to ensuring response times are appropriate for the child and family, taking into consideration their wishes / best interest, and the forensic timeframe
Two appropriately trained Paediatricians or doctors with recent clinical and forensic skills for children and young people undertake forensic examinations.

The LSCB were confident that this is a forensic model that reflects good practice.

**Psychological Therapies**
Offer and referral to a Child Independent Sexual Violence Advisor (CISVA) and associated counselling provision.
Uplift of counselling provided by Clermont now functional for children.

Where forensic medical examination undertaken, the Paediatricians/Doctors provide impartial and objective assessment to identify need for onward referral and signposting to other medical as well as psychological help and support.

The LSCB felt this was the beginning of a journey for the SARC and have been reassured of a commitment to make this accessible for all ages.

**Wider Safeguarding**
Paediatric assessment to include immediate health assessment including assessment of injuries from a medical viewpoint.
Risk assess for self-harm, vulnerability and sexual health; with immediate access to emergency contraception, post-exposure prophylaxis after sexual exposure (PEPSE) or other acute, Mental Health or other health services and follow-up as needed.

The LSCB felt confident the service as described is a good safeguarding provision; which aims to support joint working and build on existing arrangements.
Child Sexual Abuse Bulletin
In November 2014 the LSCB produced a bulletin for professionals on child sexual abuse. Its aim was to spread awareness of CSA, help professionals to spot the signs and symptoms, risk factors associated with CSA, provide clarification on harmful sexual behaviours, and to advise on where and how to access help and services and provide an update on the work undertaken in the City to stop this abuse and support victims.

What we will do:
The MASH Health Partner arrives in April 2015. This will involve discussion and decision making in relation to referrals related to CSA – and will be a named contact within the MASH who will liaise with named Doctors to initially flag and review cases referred to social care where CSA is a noted concern. This should add a further layer of checks and balances within the system.

The Child Sexual Abuse Pathway will be reviewed to take account of the issue of historical allegations not directly concerning the subject child.

We will update in next year’s annual report the impact of the new arrangements brought about by the SARC.

The LSCB will be developing a resource pack for professionals working with children.

Re-audit of Child Sexual Abuse (to include historical abuse pathway) planned for Q4 2015-16.

“Child Sexual Abuse remains under recognised and under reported on a national scale. We remain concerned about the difficulties for children disclosing sexual abuse, and want to ensure that we respond quickly and appropriately to support them and their families whilst pursuing perpetrators. Much consideration was given to this while planning for the new Paediatric SARC (Sexual Assault Referral Centre) which opened in Brighton in April 2015, and we are looking forward to evaluating the impact of this service.

We are encouraged that the recognition of children exhibiting harmful sexual behaviours and acknowledgment of need to support for them is improving, and we are working with colleagues in East and West Sussex to adopt guidance on harmful sexual behaviour for the Pan Sussex Procedures to better equip professionals to manage this difficult issue.

This year I co-ordinated the LSCB Conference on Child Sexual Abuse & Harmful Sexual Behaviours, which took place in May 2015 and was positively received. We opened with an inspiring and thought provoking talk by Sue Berelowitz, and then had a breadth of local professionals delivering presentations or seminars on how they work together to support victims of this abuse in Brighton & Hove.

This year I have also taken on the position of chair of a new LSCB Subcommittee CSE: Prevent & Early Identification. It is important to remember that Sexual Exploitation is Child Sexual Abuse, and this group are working to raise awareness and help professionals recognise and intervene to support vulnerable children & young people.”

Dr Jamie Carter, Designated Doctor for Child Protection and as Board Lead for CSA
Priority Area 1: Child Sexual Exploitation (CSE)

The LSCB reflected in last year’s annual report that data surrounding children at risk of sexual exploitation (CSE) was not sufficiently robust and we committed to putting this right. To help us to achieve this, a snapshot dataset was developed and scrutinised at the Board meeting in March 2015 alongside findings from a multi-agency audit.

There have been a number of recent investigations of CSE that have attracted national media coverage of the subsequent trials (Rotherham, Rochdale and Oxfordshire) and Serious Case Reviews (SCR’s). CSE is a significant issue for local authorities and with additional factors including levels of deprivation and the A23 Corridor making the potential for increased CSE activity in Brighton & Hove a real concern.

The complexities of CSE mean that it is not a straightforward challenge to address or one that can be dealt with quickly or by a single agency, which is why in Brighton & Hove, we have a partnership approach. There is information about this work, including the Pan Sussex CSE Strategy, available on the LSCB website. In Brighton & Hove we are well aware of the challenges we are facing. As a partnership we are working hard together to protect children and young people who may be at risk of CSE, to disrupt the activity of potential perpetrators and to obtain convictions wherever possible.

CSE cannot be looked at in isolation. There is an umbrella of manifestations which vulnerable children, particularly adolescents, fall under including missing from home and care and we must avoid compartmentalising vulnerabilities. The LSCB have discussed challenges in responding to CSE; the capacity in the system to apply sufficient focus to children who are considered ‘less risky’ (prevention), third sector commissioning arrangements and where strategic responsibility most appropriately sits.

What we did:

Response to the Rotherham Inquiry
In September 2014 the Detective Chief Inspector and Head of Safeguarding for the Brighton and Hove Division of Sussex Police summarised the main issues and recommendations arising from the Independent Inquiry into Sexual Exploitation in Rotherham, 1997-2013. In Brighton & Hove a clear pathway has now been established which provides a robust, multi-agency response with clear operational management oversight for working with suspected victims of CSE. The Independent Chairperson challenged all agencies working with children and families in Brighton & hove to rate themselves against the Rotherham Inquiry recommendations.

Number of children known to Red Op Kite= 14 (as at 22nd April 2015)

Number of CSE police operations/investigations = From 1st April 2014 – 31st March 2015, 19 CSE Risk Management Files (which was implemented in April 2015) have been created in Brighton and 61 occurrences with the CSE marker have been created on the crime recording system.

Number of Child Abduction Warning Notices (CAWNS) = 8
Governance
Changes to the governance arrangements for CSE in the City came about as a result of discussions that took place at two multi-agency CSE meetings in September and December 2014. There was consensus that the current governance arrangements were not as clear as they could be. It was proposed that:

- overall governance for the prevention, protection and pursuit of CSE moved from the Violence Against Women & Girls Board to the Local Safeguarding Children’s Board
- the LSCB Vulnerable Children Strategy Group take overall leadership for CSE supported by two operational groups working to it: the CSE Prevent & Early Identification and the CSE Protect & Pursue Subcommittees
- decisions relating to the commissioning of additional external CSE services be delegated to the MASH Steering Group which includes the Local Authority, Sussex Police and the Clinical Commissioning Group
- a report be taken to the Health & Wellbeing Board which explains how partners are responding to CSE in Brighton & Hove and which provides an opportunity for the city as a whole to assure itself that this matter is taken seriously and have the right interventions in place to tackle it.

In March 2015 the Board approved these recommendations and there will be an update in next year’s annual report.

Brighton & Hove has joined with Oxfordshire and Sandwell in a research project commissioned by the Office of the Children’s Commissioner to evaluate the effectiveness of the ‘See Me, Hear Me’ CSE framework that they have developed. You will hear more about this in next year’s annual report.

Quality Assurance Activity
As described in last year’s annual report a multi-agency audit of a sample of Red Op Kite cases took place this year. It looked in depth at six cases of young people at risk of CSE. The audit team comprised representatives from ten agencies, including the Behaviour and Attendance Service, the Youth Service, and Ru-Ok (Young People’s Substance Misuse Service).

There were a number of positive findings:
- in most cases information sharing across agencies was timely and of a good standard
- in most cases risks had been appropriately assessed and acted upon
- as a result of Operation Kite and the dedicated CSE social worker, response to recent concerns were more effective than earlier practice

Learning included:
- the need for a more robust response to the needs of boys and young men
- the need to be more proactive in identifying young people at risk of CSE through the regular review of child protection & child in need plans
- the need to adapt support services for young people so that they are assertive, flexible and accessible
- the need to continue to raise awareness of CSE in all agencies

As described earlier in this report the voice of the child was captured in this audit via interviews with young people. The action plan from this audit is overseen by the LSCB Vulnerable Children Strategic Group. You will hear more about this group later in the report.

Do you know why people are worried about you?

When I get back so late and I don't answer my phone. They are thinking if I am alright after what happened last year. 15 yr old female

Because I'm young, I run away and no-one knows where I am going. 15 yr old female
Safeguarding Sussex Conference
A pan Sussex LSCB Conference took place in January 2015 in partnership with East Sussex LSCB & West Sussex LSCB. There was a focus on CSE and Missing with speakers including Shelia Taylor from the National Working Group, Junior Smart from the St Gile’s Trust’s SOS Project, and Sussex Police’s Missing Person & CSE Team working in West Sussex. The WiSE Project, Barnardos and Catch 22 ran seminars on the work that they undertake locally to support young people who are at risk of CSE or who go missing.

The conference was attended by 100 professionals from across the county and provided an opportunity to focus on Sussex wide Practice to further improve services and responses to children & young people in the county.

Data Mining
A data mining exercise has been undertaken to explore patterns and trends around CSE across the city, identifying ‘hot spots’ as appropriate supports could be put in place. Using the warning signs and vulnerability indicators developed by the Office of the Children’s Commissioner and cross referencing with data available from children’s social work, schools, and the Youth Offending Service, those young people with four or more indicators of CSE have been identified. In addition to testing the reliability of the current identification process, this data trawling highlighted young people who might otherwise not be known in the context of CSE to statutory services.

Strategic Profile & Red Operation Kite
A scoping exercise and strategic profile was undertaken in February 2014 relation to CSE, which has collated multi-agency intelligence to provide a picture of the problem in Brighton & Hove. Police and Partnership data has identified 110 young people within Sussex currently at risk of, or suffering, Sexual Exploitation. Victims are predominately white females aged 14 to 16 yrs. The majority of reports of CSE involve a lone offender, likely to be a white British male between the ages of 16-21 years of age. Crime data indicates a growing use of the internet and social media to groom/incite victims. The monthly multi-agency operational meeting (Red Operation Kite) which was launched in May 2014 has continued to meet. The purpose is to share information among relevant agencies and identify those children and young people (age 12 - 25) in Brighton & Hove at high risk of sexual exploitation.

At the June 2014 Board meeting members discussed the challenges in responding to CSE. There was a sense that there may be an organisational and individual lack of understanding about what being a young person in 2014 is like and the need for ‘evidence’, as opposed to suspicion of CSE was discussed as a barrier to timely interventions. Some Board members wondered if staff were ‘scared to ask’ or did not have enough professional curiosity or knowledge of the right questions to ask about CSE with the young people they come into contact with.

Ofsted Review
Ofsted noted there was an effective child sexual exploitation strategy in place, achievable plans to improve identification of children at risk of CSE at earlier stages and commented that the newly established CSE Prevent & Early Identification Subcommittee is well positioned to progress this and reported that the LSCB thoroughly evaluates intelligence & cross-cutting themes regarding particular groups of vulnerable children through CSE & Vulnerable Children Strategic Group.

"The current numbers of Red Op Kite cases are part of an upward trend that is expected to continue as recognition of the issues around CSE increase among professionals in the city. The nature of CSE in the city results in more incoming referrals that are not easily or quickly resolved by alleviating the risk. The result is that numbers of Red Op Kite are likely to rise with new referrals outnumbering opportunities to downgrade the risk attached existing cases. The cases are predominantly female with an underrepresentation of boys”

Head of Safeguarding – Children Services
LSCB Vulnerable Children Strategic Group
In 2014 the Brighton & Hove LSCB Vulnerable Children Monitoring Group was established. This was set up initially to scrutinise the operational responses made by a number of groups in the City whose work supports a specifically vulnerable cohort of children. After careful consideration the remit of this group has been expanded and later in 2014 it became the Vulnerable Children Strategic Group.

This group now monitors and challenges the work across the City in respect of CSE, Missing (Home, Education & Care); children involved in or at risk of Harmful Practices (including Female Genital Mutilation, Forced Marriage and Honour Based Abuse), Modern Slavery (including trafficked children, domestic servitude, and labour exploitation), Radicalisation (both in terms of general religious, political or ideological extremism and those at risk of being drawn into terrorist activity as described by the PREVENT agenda), Private Fostering, and any other risk groups.

Its purpose is to support the LSCB in fulfilling its statutory duty to monitor and challenge the effectiveness of the strategic activity undertaken by the partnership to safeguard and promote the welfare of the particularly vulnerable children and young people listed above. You will read about the progress of this group in next year’s annual report.

Training
The WiSE Project has continued to provide ‘Preventing and Disrupting the Sexual Exploitation of Children & Young People’ training for frontline professionals on behalf of the LSCB. The number of professionals who have received training in 2014/15 is 94.

Due to demand The WiSE Project has built on this basic CSE training to provide staff with further confidence and skills to work with young people around issues relating to CSE. By 31 March 2015 45 professionals have attended this advanced session CSE: Working with Young People at Risk.

Boys and young men and CSE
The identification of boys and young men who are victims of CSE is thought to be nationally under-reported. Within Brighton & Hove a task and finish group has been established with partners from across both statutory and voluntary sectors to devise ways of working together to improve early identification and prevention to this cohort of young people.

Pan-Sussex Domestic Violence and Sexual Abuse Executive Group
Sussex Police have developed a Pan-Sussex Domestic Violence and Sexual Abuse Executive Group to have overall oversight of a range of issues across the police area, including CSE.

Specialist Missing and CSE Team
Following the success of seconding a senior social worker to the Operation Pipeline CSE investigation team, in February 2015 Children’s Services launched a specialist Missing and CSE team which is co-located with the Police Missing Co-ordinator and CSE lead at the MASH. This team work with the most complex children and young people identified as either persistently missing and/or at high risk of CSE. The team take an assertive outreach approach to their work with young people, in recognition that this cohort can be some of the most difficult children & young people to engage.

Protect & Pursue Subcommittee
The CSE Operational group met three times between April and November 2014, before being reformed as ‘Protect & Pursue’; it has met three times since.

Much of the early focus of the group was to support the development of the wider CSE meeting structures (CSE Intelligence meeting and the ‘red’ and ‘amber’ Op Kite meetings) and specialist services such as the Paediatric Sexual Assault and Referral Centre. Attendance was also considered and further invitations were extended to partners, including Child and Adolescent Mental Health Service, WiSE, and Mankind.

The Operation Kite meeting structures and supporting processes are now well established, thereby achieving the key objectives set out within the terms of reference. With the establishment of CSE Prevent and Identification Group it is now timely to review the Terms of Reference and strategic objectives to ensure they continue to support our work in this field. Work is now underway to review and align the Terms of Reference for both the Protect & Pursue and Prevent & Early Identification groups; this will include consideration of any changes we might seek to make to the attendance at these meetings.
The WiSE Project is a service for 13-25 year olds who are experiencing sexual exploitation or are at risk of experiencing it. The project is also a point of call for advice and guidance for those working with young people who have suffered from sexual exploitation.

In 2014-15 28 young people were directly supported by WiSE with case work, and the service provided ongoing professional support for a further 23 young people.

CSE & Schools
There is a Relationships and Sex Education Curriculum framework for primary school PSHE education lessons developed in partnership with WiSE that signposts schools to resources for teaching about safe touch, consent and gender stereotyping. All schools are offered training in the delivery of effective relationships and sex education.

In secondary schools there is a Relationships and Sex Education Curriculum framework with lessons developed in partnership with WiSE that signposts schools to resources for teaching about CSE and related issues such as consent and healthy relationships.

Children’s Services have commissioned Alter Ego theatre company to perform ‘Chelsea’s Choice’, an acclaimed play which highlights the serious and emotional impact of CSE, in the city’s high schools during March 2015. These performances were supported by specialist social workers and police officers, to ensure that children were in receipt of appropriate supports and services afterwards.

Communications
In April 2014 the LSCB produced a bulletin for professionals on child sexual exploitation. Its aim was to spread awareness of CSE, help professionals to spot the signs and symptoms, highlight risk factors that may make children & young people vulnerable to this type of abuse and where and how to access help and services, and to provide an update on the work that is being done in our City to stop CSE, disrupt perpetrators and protect victims. Following the audit on CSE a Manager Briefing was disseminated across the partnership.

In November 2014 the Chief Executive of Brighton & Hove City Council, the Executive Director of Children’s Services, the Chief Superintendent Sussex Police and the LSCB Chairperson gave a joint response to Brighton & Hove Independent about arrangements to tackle CSE in the City. You can read this here.

There appears to be a correlation between media coverage of CSE and referral rates. CSE dominated the national print and television news in August 2014 and the WiSE Project saw a steep increase in referrals for casework as well as enquiries in October and November 2014. At times it has been necessary to operate a waiting list but this has been no longer than 6 weeks from referral to first meeting. A well-known problem with young people who are experiencing CSE is that they are commonly unlikely to accept or understand that they are being exploited. As a result of this a large number of referrals do not result in active 1-1 work and may instead involve largely professional consultation and support.

Project Coordinator, The WiSE Project

#Helping Hands
At a Board meeting in March 2015 Members were asked to draw on the snapshot dataset and multi-agency audit findings and reflect on how much has been done across the Partnership in relation to CSE, how well it has been done and what difference it has made. As the Board meeting coincided with the National Child Sexual Exploitation Awareness Day Members were asked to make a personal commitment.

You can read these here and read our tweets here.
Establish the Prevent & Early Identification Subcommittee in recognition that action to tackle sexual exploitation should be proactive, focusing on prevention, early identification and intervention, as well as on protecting children, disrupting activity and prosecuting perpetrators. This group will focus on prevention and early identification of victims and potential victims of CSE, sit beside the LSCB CSE: Protect and Pursue Subcommittee and report into the LSCB CSE & Vulnerable Children Strategic Group.

A Brighton & Hove CSE & Vulnerable Children Strategy will be developed. This will support there being a robust, co-ordinated multi-agency strategic approach to tackling CSE & issues impacting other groups of vulnerable children under the following five key objectives;

1 Strategic Commitment - Across all Agencies
2 Identification - Improve Awareness, Understanding and Recognition
3 Prevention - Communication
4 Protection - Improve Effectiveness of Interventions
5 Disruption - Improve the prosecution of perpetrators

There will be a continuation of City wide meetings to challenge and monitor CSE strategy, action plan and commissioning.

Re-audit of Child Sexual Exploitation planned for Q4 2015-16.

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**Priority Area 1: Neglect**

Neglect takes many forms. Although all may result in a child’s developmental needs not being met it would probably be rare for a child to experience only one form of neglect. For example, many children who experience poor physical care also experience inadequate supervision, inadequate medical treatment, and may not be encouraged to attend school. Each of these would clearly be regarded as a form of neglect, although we have no additional label which can succinctly encapsulate the cumulative effects on a child who experiences all four forms in combination. (Ventress 2009)

Equally, it is also important to remember that many children experience other forms of abuse alongside their neglect. Neglect can represent an event or a process or both. The LSCB has reflected that professionals in Brighton & Hove are recognising neglect, but can struggle to work with families to effect meaningful change.

**What we did:**

**Quality of Care Assessment Tool**

Brighton & Hove’s Quality of Care Assessment Tool was developed to support practitioners to focus, reflect, analyse and make appropriate child focussed plans in cases where there is concern about the quality of parental care. The tool has been designed to open up consideration of the whole spectrum of a parent’s care, whilst holding the complexity of five areas of care in mind. In April 2014 the tool was piloted, with a half day training session on the use of the tool for practitioners from Health Visiting, School Nursing & Social Work. This was a three month pilot with the Principal Social Worker & Named Nurse for Sussex Community Trust (and LSCB Neglect Lead) leading on this and strengths and challenges of the tool were identified from Health Staff but feedback from Children’s Social Work is awaited. The Principal Social Worker for Children’s Services was away from work due to unplanned long term absence (& subsequently retired) leading to a delay in progressing this work.

From February 2015 to the time of writing this report Social Workers have been piloting the Quality of Care Tool in Child In Need & Assessment Teams and have been requested to complete an evaluation form with feedback informing the final version of the tool.

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Multi-Agency Quality Assurance Activity

As described in last year’s annual report a multi-agency neglect audit was undertaken in October 2013 which was a baseline audit with the purpose of providing a snapshot and evaluating multi-agency practice before putting in place the Quality of Care Assessment Tool. The audit was presented to Board in March 2014 and was met with a number of challenges. The lack of participation from Education colleagues was noted with the Board Member representative from BHCC Education committed to ensuring the Education Team would assist with taking forward learning. The interventions offered were discussed and challenges made about the impact of these and evidence that they had made a difference.

In 2014-15 a multi-agency audit under the umbrella of neglect was undertaken to look at domestic violence and abuse (DV&A). It looked in depth at six cases, and the auditing team comprised nine agencies including the MARAC and RISE.

Positive findings included:
- overall, there is an effective multi-agency response to the risk to children from domestic violence and abuse and all agencies are systematic in making relevant checks and referrals to other agencies when safeguarding concerns are identified;
- on the whole, information sharing and communication between agencies is timely and effective;
- there is evidence that the voice of the child/young person has informed the work undertaken with the family and that the children remain the focus of the plan in terms of their safety and emotional needs

Areas for development included:
- no DV&A alert system in place in GP records for children and adults
- some assessments did not adequately consider the impact and significance of historical DV&A
- concerns about the use of written agreements in DV&A cases
- improved coordination between MARAC and child protection processes
- the take up of specialist DV&A services and outcomes achieved for adults perpetrating or affected by DV&A

An extensive action plan was developed and a time limited multi-agency group was set up to take forward the actions. By March 2015, much of this work remains ongoing, but improvements have been made to the use of written agreements by Children’s Services and to flagging systems on GP records, and training provided for health visitors and school nurses.

Training

A LSCB multi-agency Neglect Training Course was to be delivered throughout 2014-15. However, the absence of an LSCB Training Manager and the lack of progress with the Quality of Care Assessment Tool delayed this work. To fill this gap, the Social Care Institute of Excellence (SCIE) ran a pilot training offer on neglect in January 2015. This was a blended training offer, consisting of an introductory elearning package and followed by a scenario based training day which encouraged participants to use a systems approach to identify issues which may hinder the local response to neglect. The pilot of the Neglect training with SCIE was well evaluated and in March 2015 the LSCB agreed to commission SCIE to deliver further training.

What we will do:
- Modify & agree Quality of Care Tool & Assessment in light of evaluations
- Development of Neglect Champions
- Development of Reflective practice group on Neglect
- Provide eight two hour sessions on use of the Quality of Care Assessment Tool
- Deliver two further SCIE Neglect training offers
- Undertake a Parental Substance Misuse Deep Dive - There is evidence of parental substance misuse in 57% of serious case reviews (of serious or fatal child abuse). Serious Case Reviews highlight that professionals often focus on the issues faced by parents who misuse substances without considering the impact on their children.
- LSCB safeguarding Bulletin featuring audit findings, information and updates for professionals on City wide activity in response to Neglect to be distributed.

Priority Area 2: Participation & Engagement

The Participation & Engagement Subcommittee brings to life Priority Area 2 of the LSCB Business Plan, which includes improving awareness of LSCB activity by children & young people, parents & carers, members of the public and staff & managers. It leads on the implementation and evaluation of the local communication strategy.

Brighton & Hove LSCB’s Learning & Improvement Framework describes Participation & Engagement as a key building block which underpins the LSCB’s challenge and scrutiny role. This encompasses children & young people, parents & carers, and frontline staff & managers to make sure we have an extensive range of experiences to draw upon.

The Subcommittee supports the Board to create a culture of openness and facilitate effective and regular challenge to all partner agencies. This year it has played an instrumental role in supporting the communication and collaboration of the work of each LSCB Subcommittee (notably the Learning & Development, Monitoring & Evaluation and Serious Case Review Subcommittees) so the output of one Subcommittee informs the input to another as per our Learning & Improvement Framework. The Board has continued to try and better incorporate the views of parents and carers, children and young people into multi-agency learning and practice. Audits and other programmes evidence a link between quality assurance and feedback from children and young people, parents and carers.

What we did:

Quality Assurance
The LSCB Quality Assurance Framework makes clear the importance of capturing feedback from children and young people and their families. This year’s Domestic Violence & Abuse audit asked for evidence that the family were involved throughout the process (including the abusing parent, where appropriate & safe to do so) and asked for evidence that the views of the child/young person had informed the work plan. It also prompted auditors to consider if the weight given to the child/young person’s wishes & feelings had been balanced with risk factors. Similarly, the Child Sexual Exploitation audit asked auditors to comment on how parents had been consulted and kept informed of the outcome of assessments and decisions and how the child/young person was involved in decisions made in respect of them.

Consultation Work
This year the Participation & Engagement Subcommittee has undertaken consultation work with parents and young people on our communications which lead to changes to our website content when we moved to a new provider in November 2014. The new site allows for better two-way communication and improved navigation. This year young people who are engaged with local charity, Right Here, produced LSCB webpages on Self-harm for parents, young people and professionals. Young Carers from Brighton & Hove also produced a LSCB Bulletin in honour of Carers Week which you can read here.
Lay Members
This year the LSCB appointed four additional new lay members who have their own Subcommittee. We decided to adopt this approach to provide improved peer support and to further allow LSCB arrangements to be opened up to increased public scrutiny, with an aim of supporting stronger public engagement in, and understanding of, children’s safeguarding issues. It is also motivated by awareness that local representatives can add a great deal of value to otherwise exclusively professional discussions, helping everyone to stay in touch with local realities, and the issues of concern in our communities.

The Lay Member Subcommittee has supported the LSCB Communication Strategy by communicating what the LSCB does and seeking to understand from the public what the key child safeguarding issues are within the Brighton & Hove community and their preferred solutions. This has included:

- Improving the use of the LSCB webpages as a means of communicating messages and receiving feedback
- Supporting the LSCB use of social media as a means of communicating messages and receiving feedback
- Developing links and building relationships with existing parents’ and carers’ groups, forums and services
- Raising awareness of safeguarding issues amongst parents and carers
- Challenging Board partners to demonstrate how the voice of children and young people and parents and carers influences their work

Lay Members have coordinated the following inter-related activity to ensure the Learning & Improvement Framework has been effectively implemented by:

- Being a member of a standing LSCB Subcommittee & feeding back Subcommittee activity to fellow lay members to support subcommittee interaction
- Making challenges to Subcommittees about progress against their workplans
- Attending on a rotational Chair basis the Leadership Group & LSCB Meeting

Designs are showcased on LSCB multi-agency training slides and the winning designs uploaded to our website.

Head teachers in primary and secondary schools in the City were encouraged to work the themes into PHSE lesson plans, form time, or included as part of take home work.

First prize was a day at Preston Circus fire station with the East Sussex Fire and Rescue Service duty watch! Read more about this here or view all the entries at www.brightonandhove-lscb.org.uk/drawing-competition-2015
LSCB Website
The new look website developed this year includes section for professionals, parents & carers and children and young people. The comment function facilitates two-way feedback. Minutes from LSCB meetings are now published on our website.

Board Briefings
We want to help parents, carers, members of the public, staff and managers to have an improved understanding of the LSCB so we developed Board Briefings. These summarise the discussions held at each main LSCB meeting, are distributed by partner agencies and hosted on the LSCB website. These are aimed at both professionals and general members of the public. These can be read at www.brightonandhovelscb.org.uk/board-briefings

Safety Net and LSCB Parent Newsletter
This year the LSCB has collaborated with Safety Net on a termly parents’ newsletter. This newsletter promotes two-way communication and 10,000 copies are sent to parents of primary school aged children and contains multi-agency safety messages and news. These collaborative editions can be read at www.brightonandhovelscb.org.uk/parents/safety-rocks-newsletters

LSCB Newsletters
These are primarily aimed at anyone working with children, young people & families and include updates on national policy and developments in safeguarding, learning from national serious case reviews and focus on a particular area of concern each edition. Professionals from across the Partnership contribute to the newsletters. In 2014-15 this has included a focus on fathers, pre-birth assessments and Early Help. Newsletters encourage two-way communication and can be read at www.brightonandhovelscb.org.uk/prof_newsletters

LSCB Bulletins
These are produced on areas of priority concern and are designed to be a more lasting resource than newsletters. In 2014-15 themes have included Child Sexual Exploitation, Young Carers and Child Sexual Abuse. Professionals from across the Partnership contribute to the newsletters. Bulletins encourage two-way communication and can be read at www.brightonandhovelscb.org.uk/prof_newsletters

Managers Briefings
These succinct briefings are aimed at managers and designated leads who work with children and families in Brighton & Hove. They present key findings and recommendations from recent quality assurance activity and can be read at www.brightonandhovelscb.org.uk/manager-briefings

Case Review Briefings
These short briefings summarise what local case reviews have shown about the child protection system in Brighton & Hove. It is important if Brighton & Hove is to become a safer place for children to live for everyone to embrace learning from reviews and take the necessary steps to help put right the issues identified. Safeguarding is everyone’s responsibility and everybody can contribute to safeguarding and promoting the welfare of children. We also produce summaries of key learning from national SCRs to help professionals consider the implications for practice and these can be read at www.brightonandhovelscb.org.uk/serious-case-reviews

“The Board has made meaningful progress with effective and innovative initiatives to improve the engagement of children, young people and their families and also to increase public understanding of the Board’s work”

Ofsted Review

‘…….accessible, informative & interactive website’
Ofsted Review
Twitter

Brighton & Hove LSCB have been tweeting as @LSCB_Brighton since January 2014 and now have over 900 followers and have posted over 2100 tweets.

Who follows us?

- Schools and teachers
- Social Workers, Academics and students
- Other LSCBs and the Association of LSCB Independent Chairs
- Local Brighton & Hove Groups and businesses
- Partner agency organisations and our Board members
- Police accounts and individual police officers
- Youth Workers and youth organisations
- Parent Groups
- Local counsellors
- National organisations for children, young people & families

Our reach varies from month to month, but from April 2014-March 2015 we had a mention reach of over 450,000, with 255 mentions, and a retweet reach of 1.96 million through 1000 retweets. To promote our culture of openness we will tweet about what we are doing when preparing for a meeting. Many of our Board and Subcommittee members will also tweet before or after our meetings.
What we will do:

We will work with our Lay Members to:
- better develop links and **build relationships** with existing children and young people’s groups and forums
- **raise awareness** of safeguarding issues amongst children and young people
- promote the **direct participation and input** of children and young people in the work of Brighton & Hove LSCB at a strategic and operational level

Future audits will continue to capture the views and experiences of children, young people, parents and carers

Communications with parents of children and secondary schools and colleges will be improved.

Facilitating Feedback

The LSCB Quality Assurance Framework highlights that it is important to the LSCB to have a constant feedback loop from the frontline to keep senior management and those with governance responsibilities ‘reality-based’; not just in terms of what is or is not working, but to assist with ideas for improvement so that changes can be made systematically. Through our communications we encourage professionals to share their thoughts, feedback and comments on accessibility and content of all LSCB resources.

If you have any comments or suggestions please email us at LSCB@brighton-hove.gov.uk
Priority Area 3: Service Responses

What we did:

Early Help Hub (EHH) and Multi-Agency Safeguarding Hub (MASH)
The Early Help Hub (EHH) and the Multi-Agency Safeguarding Hub (MASH) became operational on 1 September 2014.

The MASH is a co-located multi-agency team consisting of social work staff, police, and staff from Early Help, Housing, Education, Youth Offending and a range of health providers. The Early Help Hub is a team of officers from a range of council services. It offers a new route for enquiry and referral and supports professionals to target, coordinate and provide early help interventions to families that need additional support.

The Threshold Document, produced alongside the launch of MASH and the Early Help Hub, provides guidance for professionals and services users to help them:

- Identify and assess levels of individual need
- Clarify the circumstances in which a child might need referring to the Early Help Hub, the MASH or other specific agency to address their individual needs

LSCB multi-agency training has been updated to be reflective of local changes to services and pathways.

Performance Data
Working Together 2015 specifically outlines a responsibility for LSCBs to ‘use data’ to ‘assess the effectiveness of the help being provided to children and families, including early help’. With this in mind, the Board has routinely been presented with progress reports on MASH and Early Help. At Board in December 2014 we were told that since its launch in September there has been a large volume of enquiry and referral to the Early Help Hub. It was noted that there has been a high proportion of clients with a previous Children in Need (CIN) episode and that there are fewer than anticipated numbers of referrals being made for the primary age group.
What we will do:

A combined Referrals & Thresholds Multi Agency Audit & Early Help - Child’s Journey - Multi Agency Audit will take place in Q3 2014-15 to support the Board to build a better understanding of the effectiveness of early help assessments and interventions to ensure that children and young people with additional needs receive timely responses and that emerging difficulties are addressed at an early stage.

Alongside the quality assurance activity will be a thematic look at an Early Help dataset to support the Board’s understanding of the story behind statistics.

Quarterly updates on single agency quality assurance activity will be scrutinised by the Monitoring & Evaluation Subcommittee on a quarterly basis and exception reported to Board as appropriate.

Produce an LSCB Bulletin on Early Help, encapsulating the views and experiences of those who work in and access Early Help services.

Develop a ‘Safeguarding in 2016’ Advanced training session which will have a focus on the impact of Early Help.

Jointly run, with the Local Authority, an Early Help Conference in December 2015. This will be an opportunity to assess how well it is doing and how the LSCB and LA are demonstrably ‘dedicated to early help’. It will consider if the City’s early help systems are understood and used consistently by all agencies working with children, young people and their families. At the end of the session ideas for how to move forward as a City should have been discussed and agreed, so as to move on to construct and consolidate clearer integrated early help pathways and effective integrated early help services.

“Last year we set up a co-located MASH and Early Help Hub. This was to ensure consistency across thresholds and referrals and to tackle the confusion about where agencies with concerns about children and families can go for advice and support. There continues to be overlaps between the MASH and the EHH which need to be smoothed out, but more importantly our key task this year is to ensure that our early help support pathways are clear and make a difference - helping to address the needs of children and families without requiring a more intensive intervention. There is still much to do here.”

Pinaki Ghoshal – Executive Director of Children’s Service, Brighton & Hove City Council
Priority Area 4: Accountability

Review of Board arrangements

Subcommittees
This year has seen the development of the Vulnerable Children Strategic Group (replacing the Vulnerable Children Monitoring Group) and the development of the CSE Protect & Pursue Group (replacing the CSE Operational Group).

All Terms of Reference have been reviewed and membership and representation changes have been made as appropriate to ensure Subcommittees continue to be diverse, stable and active. We have seen lay members become standing members of the Monitoring & Evaluation Subcommittee, Serious Case Review Subcommittee, Learning & Development Subcommittee and the Participation and Engagement Subcommittee.

Section 11 Challenge Event
On 30 May 2014 the LSCB held its first Section 11 Challenge Event. This is where we brought together the Chief Executives or deputies of the LSCB agencies to challenge each other’s services on how their organisation embeds safeguarding in their policies, procedures and structures. The Section 11 Challenge Event helped the LSCB to ensure the effectiveness of what is done by partner agencies to keep children safe in Brighton & Hove, as well as providing agencies with an opportunity to feedback how the Board can be better coordinated.

Table Discussions
The table discussion approach to Board meetings has provided a positive way to cover Board business and provide a greater opportunity for participation, reflection and challenge amongst members. At one Board meeting in 2014-15 a discussion about school’s access to mental health services for students and the capacity to respond appropriately and effectively to the current level of need led to a table top discussion at a subsequent meeting with representatives from Sussex Partnership NHS Foundation Trust, Public Health, Cafcass, Youth Offending Service and Children’s Social Work chaired by the Designated Doctor for the CCG to further tease out concerns. Challenges regarding age restrictions, transition from child to adult mental health services and fragmentation across the city kick-started brainstorming: if we were to start again, what would mental health services for children and young people look like, and does the Mental Wellbeing Strategy support a more creative approach? The Board has agreed it will want to contribute and inform ongoing discussions about this.

Subcommittee Referral Forms
Referral forms to make recommendations/ challenges to, or to request action from, another LSCB Subcommittee were put in place in 2014-15. This has supported the LSCB to better communicate across Subcommittees and to better document and evidence how the inputs and outputs of the groups are informing one another, as per the Learning & Improvement Framework. The approach has helped formalise the relationships between the subcommittees and demonstrate how issues being managed by each subcommittee are linked with wider LSCB activity. All requests and recommendations are tracked and an update is provided at each Leadership Group. As at March 2015, 20 referrals have been made. These have included the Learning & Development recommending to the SCR Subcommittee that a wider range of frontline staff be involved in action planning following a Learning Review, and the Board asking Monitoring & Evaluation to include the voice of children & young people in audit activity.

LSCB Constitution & Members Compact

The LSCB has revised its governance arrangements to clarify and improve the rigour and accountability of its sub-structure and leadership group.

Ofsted Review

The LSCB has a rigorous approach to evaluating the effectiveness of safeguarding arrangements in all of its partner, community and voluntary agencies.

Ofsted Review
At the December 2014 Board, a Constitution was agreed by all partners; this document sets out the purpose, objectives and arrangements for the LSCB and makes clear the commitment to partnership working. By each agency agreeing the Constitution, they have formally signed up to the LSCB multi-agency audit programme demonstrating their commitment to support it at a senior level and to take forward lessons learnt into their own organisations.

Board Members have signed a Member’s Compact; this seeks to enable agencies, professionals and volunteers to understand their vital role in supporting children and young people to be safe and to thrive. You can read the Constitution and Members Compact here.

Outcome Based Accountability (QAF)
Throughout 2014-15 the LSCB has focused on effectively implementing the Outcome Based Accountability informed Quality Assurance Framework (QAF). As you have read throughout this report multi-agency audits have been undertaken using this approach. In the case of the child sexual exploitation multi-agency audit the QAF supported us to know how children and young people feel treated by the professionals and agencies they interact with.

Learning & Improvement Framework (LIF)
The Learning & Improvement Framework has been kept under review and updated when Working Together to Safeguard Children (2015) was revised. The LSCB Independent Chair has continued to meet, via the Leadership Group, with the subcommittee Chairs to drive the LSCB’s Business Plan and manage the interface between the work of the subcommittees. Lay Members also provide additional scrutiny and challenge to progress against subcommittee workplans and ultimately the LSCB Business Plan.

Throughout 2014-15 the LSCB has been importing learning from, and exporting learning to, other bodies, including the Health & Wellbeing Board, the Adults Safeguarding Board and through the Association of Independent LSCB Chairs.
Core data requirements

Working Together to Safeguard Children (2015) specifically outlines the responsibility for the LSCB to use data to undertake the following:

- Assess the effectiveness of the help being provided to children and families, including early help
- Assess whether LSCB partners are fulfilling their statutory obligations

Robust performance management is at the heart of any drive to secure continuous improvement and delivery of high quality services. It involves taking action to ensure that outcomes are better than they would otherwise be. Page 16 talks about the development of the Management Information Report (MIR). We have since tightened up our scrutiny of this report which is reviewed bi-monthly by the Monitoring & Evaluation Subcommittee and considered quarterly at Board meetings during the Table Discussions segment. Board partners are asked to reflect on three questions in relation to the dataset. At our last Board meeting partners were asked;

1. What are the top three indicators of concern?
2. For these indicators of concern, does the commentary adequately explain the current position and do the actions explain the improvement activity required?
3. What does the data tell us about the child’s journey across services?

What we will do:

Repeat the LSCB Performance and Effectiveness Survey to better gauge how Board members rate the efficacy of the Board.

Hold a Development Day to reflect on the progress made on the 2013 – 2016 Business Plan and start planning our commitments for the next three years. The LSCB must draft new, or refine existing, priorities which will further drive improvement with a clear focus on continuing improvement in the field of improving outcomes for children. The Business Plan will need to be developed with contributions from strategic Board members along with recommendations from case reviews, local performance information, needs analysis generated from the Section 11 audits and findings from the Ofsted review. The LSCB will want to consult with children and young people during the generation of priorities.
LSCB Challenge

Over the last year the LSCB has made 56 documented challenges, these are recorded on the LSCB challenge log and examples shared at Leadership Group.

Examples include

- **Repeat prescribing in the city and what safeguards are in place**
- **The closure of local GP Surgeries and the impact on families with vulnerable children**
- **Psychological support for male victims of CSA**
- **Sexist bullying at a local school**
- **The high numbers of hospital admissions due to alcohol specific conditions, self-harm substance misuse as well as attendance at A&E of 0-4 year olds**
- **Accessibility of paper or historical files to inform risk assessments and safety planning**

Challenges to agencies:
- Single-agency audit activity
- Requests for data and performance information
- Areas rated compliant in Section 11 returns not being sufficiently evidenced
- Independent return from missing interviews

Challenges from Lay Members:
The Lay Member Subcommittee has provided additional challenge the LSCB’s progress against the Business Plan and Learning and Improvement Framework. Examples include:

- What is current position with training provision and timetable?
- What steps need to be taken to ensure training provision is in place and meeting needs of agencies?
- What expectations are there about ‘two way communication’?
- Could communications be extended to secondary schools?
- How could the principle of two way communication apply to youth groups in the City, so that these groups are invited to participate and contribute to shaping the direction and focus of the Board to reflect their views consistently and accurately?
- How does the LSCB interface with the public at present, and how does this need to be improved and extended?
How safe are children and young people in Brighton & Hove?

Child Protection in Brighton & Hove

Referrals – Number and Rates
There were 7,283 referrals during the year ending 31\textsuperscript{st} March 2015, a significant increase from 4,232 during the year ending 31\textsuperscript{st} March 2014. The rate of referrals per 10,000 children aged 0 to 17 is up from 838.5 last year and significantly above the 2013-14 England average (573) and statistical neighbour average (524.7).

<table>
<thead>
<tr>
<th>Referrals</th>
<th>Linear (Referrals (CM))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-14</td>
<td>371</td>
</tr>
<tr>
<td>May-14</td>
<td>498</td>
</tr>
<tr>
<td>Jun-14</td>
<td>625</td>
</tr>
<tr>
<td>Jul-14</td>
<td>602</td>
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<tr>
<td>Aug-14</td>
<td>412</td>
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<tr>
<td>Sep-14</td>
<td>751</td>
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<td>Oct-14</td>
<td>670</td>
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<td>Nov-14</td>
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<td>Dec-14</td>
<td>560</td>
</tr>
<tr>
<td>Jan-15</td>
<td>615</td>
</tr>
<tr>
<td>Feb-15</td>
<td>691</td>
</tr>
<tr>
<td>Mar-15</td>
<td>863</td>
</tr>
</tbody>
</table>

27% of referrals received were from the Police (23.9% nationally), 15.6% were from schools (13.1% nationally) and 13% were from Health Services (14% nationally).
Re-referrals

Position
The rolling year (the last 12 months) re-referral rate (a referral within 12 months of a previous referral) was 32% for the year ending 31st March 2015, up from 29% last year and above the 2013/14 national average (23.4%) and statistical neighbour average (19.9%).

Commentary (Head of Service: MASH & Assessment)

Referral rates are high and are increasing. The high level of referrals should be considered in light of where the City lies in relation to deprivation. The city is relatively deprived, ranked 66th out of 324 local authorities (unitary or district local authorities) in England.

The increase in referral rates has been affected by improvements in referral pathways and a change in recording practices regarding referrals in September 2014. Since the 1st September 2014, and the introduction of the Early Help Hub, any initial contacts that are re-directed to Early Help are counted as a referral. Of the referrals received by the MASH, on average 30% of referrals per month are re-directed to the Early Help Hub for support. The MASH and the Early Help Hub are working closely together to support those referring to gain clarity and seek to ensure that every child referred receives a service that is proportionate to their needs.

Almost half of the referrals made, were children aged 10-17 years old. As with other areas of the country, Brighton & Hove has seen an increase in referrals in relation to concerns about adolescents within the local community. There is a developing awareness of Child Sexual Exploitation and other challenges facing adolescents in the city.

It is recognised that the overall increase in referrals to Children’s Social Work is a picture that has been echoed nationally. Locally, a number of factors are considered to be contributing to the increased demand upon the service, namely the impact of benefit reforms, the withdrawal of legal aid in respect of contact dispute and mediation, and as previously mentioned the increased awareness of Child Sexual Exploitation and potential radicalisation of young people for example.
Single assessments

Position
Of the 2,770 single assessments completed during the year ending 31st March 2015, 1,299 (47%) were completed after more than 45 working days, up from 17.4% last year and above the 2013/14 national average of 17.7% and statistical neighbour average of 15.8%. The median duration for single assessments completed is 45 days, up from 30 last year and above the 2013/14 national average of 25 days. There has been a decline in timeliness of assessments.

Commentary
Actions have been taken to improve the timeliness of assessments:

- Practice Managers detailing their Management Decisions within the assessment and more closely track, monitor and manage timescales
- Social workers were provided with guidance regarding the scoping of their assessments prior to visiting a family to assist them and their Manager in planning what is required
- Additional agency social workers have been recruited to assist in addressing the incoming work to permit permanent social workers to address the need to write up their assessments.

The implementation of the MASH has established clear timescales for decision making and has provided a forum for pro-active seeking and sharing of information with safeguarding partners. Decision making in the initial stages has seen improvement.
Section 47 Enquiries – Number and Rate

Position
There were 832 section 47s completed during the year ending 31st March 2015 compared to 815 during the previous 12 months. Of the section 47s completed in the last 12 months, 203 (24.4%) had an outcome of No Further Action, 276 (33.2%) had an outcome of More Information Required and 353 (42.4%) had an outcome of Case Conference Required.

The rate of section 47s per 10,000 children aged under 18 is 164.8 for the year ending 31st March 2015, above the 2013/14 England average of 124.1 and statistical neighbour average of 120.6.

Commentary (Head of Service MASH & Assessment)

There has been an increase in the overall number of s.47’s enquiries generated which correlates with an overall increase in referral rates to Children’s Social Care. In the past year referral rates, converting to assessments have increased by 13%. With more children being referred into the service there is a corresponding rise in relation to the number of children at risk of harm.

Work is being conducted to analyse and review the use of s.47’s in conjunction with that related to the increasing numbers of children subject to Child Protection Plans in the city.

To tackle this the Quality Assurance team are analysing the data around the increase in number of children who have become subject to Child Protection Plans in the last six months. The Team Managers for the Assessment Service, ChiN and STC continue to sign off all completed s.47’s to assure quality and consistency in decision making. Team Managers within Assessment Service to be requested to make comment and feedback via Quality Assurance team regarding s.47’s they judge to have been initiated unnecessarily and to address with Practice Managers who initiated the s.47 to develop consistency of practice and thresholds in relation to new managers to the service.
As at 31 March 2015 there were 2,475 cases open to Children’s Social Work. This represents 4.9% of the 0-17 population. Nationally, 3.5% of the 0-17 population were a Child In Need as at 31 March 2014.

Position
679 children required a Child in Need Plan at year end, a rate of 134 per 10,000 children aged under 18.

Children requiring a CIN plan represent 29% of the total number of client open to social care. 79% of Children requiring a CIN plan are allocated to the CIN/CP team 19% are allocated to the disability team.

29% of the children requiring a CIN plan are under 5 years old, 43% are between 5 and 12 years old and 28% are between 13 and 17 years old.

Commentary (Deb Austin - Head of Safeguarding/Interim Head of ChIN Service)
The CIN plan reduction of 14% during Q4 is related to the review of such cases within the ChIN Service and Children’s Disability Service to ensure appropriate threshold to this work has been applied. This was an action from Q3 commentary.

Work is currently being undertaken by the Safeguarding & Review Service to review all cases where a CIN plan has been in place for more than 9 months in order to assure that the work being undertaken is proportionate to the need. This will have contributed to the drop in the numbers. Regular reviews on CIN plan work to continue to ensure children are being worked with within the right framework.
CPP numbers have increased by 8.4% during 2014-15, with 453 Initial CP Conferences being held compared to 415 during 2013-14. This is within the context of increasing referrals into the MASH and Assessment Service, an increase of 80.7% from Q1 14-15 (1494) to Q4 (2169). National figures for 14-15 are not available until Oct 2015 but anecdotal evidence is that the local picture reflects a national trend, with high profile cases in Rotherham and Oxfordshire contributing to this increase.

There were 309 children subject of a Child Protection Plan at year end, up from 285 last year. This represents 0.61% of the 0-17 population. Nationally, 0.42% of the 0-17 population were subject of a Child Protection Plan as at 31 March 2014.

Position
3 in ten children (28.8 per cent) who were subject of a Child Protection Plan in March 2015 were not White UK/British. 21% of children aged under 18 in Brighton and Hove were not White British at the time of the 2011 census

Below is a comparison of the age profile of children subject of a child protection plan compared with the 2013/14 national average.

- 5% are unborn compared to 2.1% nationally.
- 13% are aged under 1 compared to 11% nationally.
- 24% are aged between 1 and 4 compared to 29.2% nationally.
- 29% are aged between 5 and 9 compared to 29.7% nationally.
- 26% are aged between 10 and 15 compared to 25.3% nationally.
- 4% are aged 16 and over compared to 2.8% nationally.
- The number of children subject of a child protection plan aged 16 and over has risen from 0 in April 2014 to 11 in March 2015

The percentage of children subject of a child protection plan with a category of emotional abuse is 46% at 31st March 2015, down from 48.3% last year but above the national average of 35.6%. The percentage with a category of Neglect has fallen from 33% last year to 30.7% at 31st March 2015, below the national average of 42.7%.
Children in Care

55.2% of children are placed outside of Brighton & Hove, with 13.4% of children placed more than 20 miles and 7% are placed outside of Sussex. The percentage of looked after children placed within 20 miles of their home address has increased. A number of children continue to live outside the geographical boundaries of Brighton & Hove (some for reasons of safety or to remain in the care of relatives/existing carers) and work continues to take place with providers to increase local placement options particularly in relation to residential care for children with specific/complex needs.

- 38 children live in residential children’s homes, 92.1% live out of the authority area with 13.2% outside of Sussex.
- 7 children live in residential special schools, all of which are out of the authority area and 42.9% outside of Sussex.
- 379 children live with foster families, of whom 56.2% live out of the authority area (5.3% outside of Sussex)
- 7 children live with parents, of whom 14.3% live out of the authority area and outside of Sussex.
- 9 children are unaccompanied asylum-seeking children.

In the year ending 31 March 2015 there were 51 children adopted and 24 children ceasing to be looked after through becoming subject of a special guardianship order (SGO). A total of 179 children ceased to be looked after.

Commentary (Head of Service Support Through Care)

The number of children looked after rose from 463 as at 31st March 2014 to 471 as at 31st March 2015. Audit activity has not revealed any set of circumstances which did not warrant a child or young person becoming looked after. There have been some changes in the profile of looked after children compared to the previous 12 months, there has been an increase in the numbers of children aged 1 to 4 but a more significant increase in the numbers aged 5 to 9.

The numbers of children ceasing to become looked after show a significant increase in the number adopted with a reduction in the numbers who have returned to live with parents or relatives. In terms of the legal status of looked after children there is a slight increase in the numbers who are looked after by parental agreement Section 20, and a slight increase in the numbers subject to Interim Care Orders.
Children Exposed to Domestic Violence

**Children exposed to domestic violence and abuse**
It is estimated that 6,435 women and girls aged 16-59, and 4,110 men and boys are estimated to have experienced domestic violence and abuse in the last year. However, in making these estimates, it is important to note that while both women and men experience incidents of interpersonal violence, women are considerably more likely to experience repeated and severe forms of violence. Of the cases heard at the Multi-Agency Risk Assessment Conference, 240 involved victims with children. In total, there were 361 children associated with these cases. Over half of children subject of a child protection plan had Domestic Violence/Abuse recorded as contributory factor for becoming subject of a child protection plan.

**Rape, sexual violence & abuse**
It is estimated that 1813 women and girls aged 16-59, and 467 men and boys aged 16-59 experienced some form of sexual assault (including attempts) in the last year. In relation to children and young people, Children's Services lead on this area of work, but specialist services represented at the Forum are often supporting both young people and adults affected by sexual violence, and there are also strong links with specialist services working directly with children, including WiSE. A key development locally has been the child Sexual Assault Referral Centre (SARC), which began providing a specialist service for children and young people under the age of 14 who are victims of rape, sexual violence & abuse from April 1st 2015.

**Children exposed to Harmful practices**
There is limited data available on harmful practices, such as Female Genital Mutilation (FGM), Forced Marriage (FM) and Honour-based violence (HBV), and their impact locally, and much of the work this year has focused on better understanding the issues around these crime types. An Interagency Forum hosted by the Safe in the City Partnership and the LSCB in May 2014 helped raise awareness of FGM.

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**Multi-Agency Quality Assurance Activity**
A multi agency audit in relation to domestic violence and abuse (DV&A) looked in depth at six cases. The auditing team comprised nine agencies including the MARAC and RISE (voluntary sector agency). There were a number of positive findings:
- overall, there was an effective multi agency response to the risk to children from domestic violence and abuse and all agencies were considered systematic in making relevant checks and referrals to other agencies when safeguarding concerns were identified;
- on the whole, information sharing and communication between agencies was seen to be timely and effective;
- there was evidence that the voice of the child/young person informed work with the family and that children remained the focus of the plan in terms of their safety and their emotional needs.

Areas for development were identified:
- no DV&A alert system in place in GP records for children and adults
- some assessments did not adequately consider the impact and significance of historical DV&A
- concerns about the use of written agreements in DV&A cases
- improved coordination between MARAC and child protection processes
- the take up of specialist DV&A services and outcomes achieved for adults perpetrating or affected by DV&A

An extensive action plan was developed and a time limited multi agency group was set up to take forward the actions. By April 2015, much of this work remained ongoing, but improvements had been made to the use of written agreements by Children’s Services and to flagging systems on GP records, and training had been provided for health visitors and school nurses.
Brighton & Hove Violence against Women and Girls Forum (VAWG)
The VAWG Forum aims to raise awareness of VAWG crime types and enable practitioners to stay up to date with local, regional and national policies that impact on the sector. Its role includes:

- Networking - providing mutual support and encouragement and developing a strong & effective partnership
- Sharing effective practice and good news stories
- Working together to overcome barriers to local delivery
- Keeping up to date with, and helping to inform, Brighton & Hove, Sussex and national policy in relation to VAWG and related themes
- Providing strategy advice, feedback and support to the VAWG Programme Board, as well as influencing and lobbying for VAWG and wider policy developments.

The Forum’s role in relation to the LSCB is to ensure that domestic violence and abuse, rape, sexual violence & abuse and harmful practices remain a priority. This includes:

- Contributing to the development and evaluation of safeguarding children policies, procedures and practices
- Promote greater awareness of VAWG issues, developments and services, and to disseminate information, policies and procedures to LSCB members
- Participating in LSCB meetings and development days, and supporting other LSCB activities and committees
- Identify gaps in service provision and training needs for members of both forums
- Promote effective communication between the LSCB and members of the Forum
- The VAWG Forum Chair attends the Safeguarding Adults Board providing a link between adult and child safeguarding issues from a VAWG perspective

Summary of Activities for 2014 - 2015
The Forum Chair regularly attends and contributes at LSCB meetings, and Forum members undertake a range of other roles in the city, including:

- Delivering training on domestic violence and abuse and sexual exploitation as part of the LSCB training programme. Forum members also deliver training in other context around rape, sexual violence and abuse
- Delivering a range of programmes to support women/parents, and children and young people, affected by domestic and sexual violence, substance misuse and alcohol and child sexual exploitation
- Participated and shared practice and learning with European Colleagues as part of the Daphne funded “Child to Parent Violence” initiative
- Participating in Domestic Homicide Reviews. During 2014-15 the Safe in the City Partnership published a ‘Summary of Learning in Brighton & Hove 2012 & 2013’ from three domestic homicides and one near miss review. This can be accessed at [www.safeinthecity.info/domestic-homicide-reviews](http://www.safeinthecity.info/domestic-homicide-reviews)
- Participating in a Themed Review (Young Parents and Domestic Violence), as well as a Deep Dive Audit
- VAWG Forum members have been involved in the development of the Multi-Agency Safeguarding Hub (MASH) and Early Help Hub
What difference has the VAWG Forum / Members made to Safeguarding Children?

- Ensured that the safety of children and young people affected by VAWG is recognised
- Raised awareness of the impact of VAWG on children and young people, including supporting contributed work in schools
- Raised awareness of services providing support to survivors of VAWG, as part of a revised ‘Amber Card’ (www.safeinthecity.info/faq/what-is-the-amber-card)
- Raised awareness of services providing support to specific communities, such as survivors from BME communities or those who identify as LGB or T
- Raised awareness of services providing support to perpetrators of domestic violence
- Raised awareness of preventative / early help interventions and programmes working across the range of VAWG crime types
- Provided a forum for information sharing and sharing of good practice for professionals.

What we will do next

- Violence against Women and Girls crime types VAWG continue to be a priority in the Community Safety and Crime Reduction Strategy 2014-2017, with a particular focus on
- Early help for Children and Young People
- Increased awareness among residents
- Consistent care pathways delivered by a skilled workforce

During 2015/16, Brighton & Hove City Council is procuring a future specialist service to support survivors of domestic and sexual violence, and is also developing activity around communications and training. The Forum will continue to provide a space to develop this work, as well as refreshing its monthly newsletter and guest speakers to provide opportunities for its members to keep up to date and share effective practice.

Gail Gray, Chief Executive of RISE and VAWG Forum Chair
James Rowlands, Strategic Commissioner
Missing Children

Children missing from their home or placement are at higher risk of exploitation by others (e.g. sexual exploitation; radicalisation), missing out on their education, engaging in criminal behaviour and being exposed to other risk-taking behaviours.

What we have done:
Brighton & Hove LSCB continues to provide a unified multi-agency approach to make sure the needs of these children and young people are met appropriately and effectively. The Missing Children policy and protocol was approved by Board in March 2014. This was agreed to be a solid operational policy that looks at what puts children & young people at risk of going missing, and is proactive in approach. It reflects the statutory guidance released in January 2014 and joins together the three strands of children missing from home, care & education. Deb Austin, Head of Safeguarding, Children’s Services, remains the Single Point of Contact (SPOC).

The Missing procedures cover:
- what steps to take to prevent children going missing
- what to do when a child is reported missing, and the route to getting them to safety
- what to do when a child returns, to find out why they went missing, and lessen the possibility of a recurrence

What we will do:
The Missing Children procedures will be reviewed in Autumn 2015 to ensure they reflect current best practice

Provision for Independent Return Home interviews will be established in the Kite (CSE & Missing) team from September 2015

Discussions will continue with Sussex Police and East & West Sussex regarding a pan Sussex Independent Return Home interview provision for 16/17

There were 361 missing episodes between 1 October 2014 – 31 March 2015, with 104 children going missing during that period.

291 missing episodes related to children looked after. (Please note that this timeframe has been used as the Missing Episode document was launched in September 2014.)
Learning and Development Subcommittee

What did we did:

During the last 12 months the Learning & Development Subcommittee has monitored the delivery of the LSCB Training Strategy including the multi-agency training programme delivered by Brighton & Hove LSCB during 2014-15. Issues from national Serious Case Reviews (SCRs) and other case reviews were analysed, considered and incorporated to ensure that the content of the training programme related to emerging issues of concern, as well as to core safeguarding learning, that all practitioners working with children and their families need to understand.

The learning & development budget was underspent in 2014/15, however it is anticipated that the entire budget for 2015-16 will be spent on developing specialist courses. The Subcommittee are committed to ensuring all that all courses represent value for money.

The LSCB annual training programme for 2014-15 was planned but unfortunately due to staffing issues not all the courses could be delivered. However, courses deemed to be high priority were successfully delivered.

From April 2014-March 2015 24 multi-agency child protection courses (Level 2) were delivered with 380 practitioners attending, compared with 22 core courses delivered in 2013-14 with 420 practitioners attending. A further 18 specialist courses (Level 3) were delivered with 373 practitioners attending, compared to 22 specialist courses delivered in 2013-14 with 326 practitioners attending.

| Brighton & Hove LSCB: Multi-Agency Training Attendance for 2014-15 |
|--------------------|-----------------|----------------|
|                     | Courses     | Attendees   |
| **Level 2**        |             |             |
| Core Child Protection Courses |
| Developing a Core Understanding | 11 | 180 |
| Assessment, Referral and Investigation | 6 | 109 |
| Child Protection Conferences and Core Groups | 7 | 91 |
| **Level 3**        |             |             |
| Specialist Child Protection Courses |
| Domestic Violence and Abuse | 5 | 66 |
| Preventing and Disrupting the Sexual Exploitation of Children & Young People | 3 | 49 |
| CSE: Working with Young People at Risk | 3 | 45 |
| Joint Investigation for Social Workers 4 days | 1 | 8 |
| Multi Agency Public Protection Arrangements (MAPPA) | 1 | 10 |
| Safeguarding Children with Disabilities | 1 | 10 |
| Learning from SCR Seminars | 2 | 93 |
| Interagency Forum: FGM | 2 | 92 |

‘Brighton & Hove LSCB has a responsibility to develop policies and procedures in relation to the 'training of persons who work with children or in services affecting the safety and welfare of children…to monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children’

*Working Together, 2015*
## Attendance at Brighton & Hove LSCB Core Training Courses by Agency 2014-15

<table>
<thead>
<tr>
<th>Agency</th>
<th>Developing a Core Understanding</th>
<th>Assessment, Referral &amp; Investigation</th>
<th>Core Groups &amp; Child Protection Conferences</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brighton &amp; Hove City Council</td>
<td>48</td>
<td>27</td>
<td>31</td>
<td>106</td>
</tr>
<tr>
<td>Community &amp; Voluntary Sector</td>
<td>34</td>
<td>14</td>
<td>9</td>
<td>57</td>
</tr>
<tr>
<td>Sussex Community NHS Trust</td>
<td>8</td>
<td>6</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>Sussex Partnership NHS Trust</td>
<td></td>
<td>3</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Brighton &amp; Sussex University Hospitals</td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Brighton &amp; Hove CCG</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
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<tr>
<td>NSH England</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Probation</td>
<td>16</td>
<td>4</td>
<td>7</td>
<td>27</td>
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<td>Schools</td>
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<td>28</td>
<td>21</td>
<td>89</td>
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<td>Early Years Childcare</td>
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<td>22</td>
<td>16</td>
<td>65</td>
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<td>Foster Care</td>
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<td>3</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
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<td>2</td>
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</tr>
<tr>
<td>Total</td>
<td>180</td>
<td>107</td>
<td>89</td>
<td>380</td>
</tr>
</tbody>
</table>

### Findings from Ofsted Review

- The multi-agency annual training programme ensures training content is carefully designed to deliver specialist courses that complement learning priorities in Business Plan and the Learning and Improvement Framework.
- Practitioners are aware of LSCB training offer and many spoken to during the review have recently attended training.
- Staffing difficulties have impeded plans to improve post-course evaluations and impact of training on improved practice.
The Learning & Development Subcommittee continued to report to the main LSCB regularly on the progress to deliver the multi-agency training programme and developments for discussion and resourcing.

The strong commitment that is evident from across the partnership continues. The attendance of the Subcommittee has maintained a good representation from the majority of Board partner’s agencies. The group has also benefited from the attendance of a Lay member who has brought a new dimension to the group.

The unfortunate absence of a LSCB training manager for much of the last 12 months has had an impact on the support available for the Trainers within the LSCB pool and the progression of a number of actions regarding new courses that had been planned but could not be taken forward.

What we will do:

- Develop the Training Programme for 2015-2016 – including a review of the three core training offers
- Support & further develop the Training Pool
- Deliver training on Enabling & Supporting Compliance: Working with Disguised Compliance & Forceful Counter Argument in Safeguarding
- Evaluate the impact and effectiveness of multi-agency safeguarding training needs so that its effectiveness can be assessed & improved
- Undertake work to understand the reach and impact of our training, learning from case reviews and outcome of audit so as to be assured they are improving the lives of children
- Private Fostering training to be included in wider training on ‘Hidden Children’
- Hold a Learning Together to Safeguard the City fortnight of learning events and briefing sessions in partnership with the Adult Safeguarding Board and the Safe in the City Partnership.
- Deliver training on Neglect in association with SCIE

‘I found the varied delivery methods brilliant, I learnt new skills, ideas for interacting with young people”

**Participant: CSE – Working with Young People at Risk**

‘Great to have the opportunity to meet professionals from other agencies and understand their roles in keeping children safe. Informative and productive group discussions were a highlight for me”

**Participant: Developing a Core Understanding**

‘Activities were engaging. Trainers were very knowledgeable and hearing other people’s own experiences helped my understanding”

**Participant: Assessment, Referral & Investigation**
Safeguarding in Schools

At Board in June 2014 during a table discussion the updated statutory guidance was considered (this can be, which can be read here). This was aimed at head teachers, teachers and education staff as well as governing bodies and proprietors across all schools, including independent and free schools. The table discussed the benefits and challenges of the new guidance which set out what schools and colleges must do to safeguard & promote the welfare of children & young people under the age of 18.

At Board in December 2014 during a table discussion about safeguarding in schools, the Head of Behaviour & Attendance Children’s Services, Education and Inclusion, presented a report to update the LSCB on the results of the annual schools safeguarding audit and other related schools safeguarding matters. Schools are required to have their own policies, procedures and practice in relation to child protection and safeguarding. Ofsted inspectors will scrutinise these. Each year schools have an opportunity to self-assess their safeguarding arrangements by completing a safeguarding audit. This helps them to review their current safeguarding and child protection practice against the most recent national guidance. Whilst this is not a statutory requirement we were impressed to hear that there was a 100% response rate in Brighton & Hove. This gives reassurance that there is a climate of self-awareness and challenge within our schools.

Findings included

The majority of the ratings were GREEN and this reflects the priority that safeguarding is given by schools.

9 primary schools reported that the Head Teacher has been identified as the Designated Person. This is against Brighton & Hove policy.

Only four schools reported a RED rating on any aspect of the audit.

Next Steps: All schools submitting an audit have completed an Action Plan highlighting AMBER and RED areas with clear actions, timescales and responsible persons for each action. Schools that were not able to meet either GREEN or AMBER will be contacted to provide advice and guidance.
Brighton & Hove City Council: Children’s Service

What have we done

New Ways of Working

- Working with Partners, we have implemented the MASH (Multi Agency Safeguarding Hub) and EHH (Early help Hub) supported by protocols which clearly identify what the thresholds for additional support or intervention. The Education Safeguarding Officer is now co-located at the MASH.
- In Nov 2014 we established a Care Planning Panel to ensure that the right children enter and exit care at the right time.
- The functions of IRO and Child Protection Conference Chairs were separated in September 2014 to increase the contribution of IROs to safeguard children and young people and to improve the effectiveness of Independent Reviewing Officers in achieving positive outcomes for children and young people in care.
- Building on the work with social workers about their vision of excellent social work and listening to the views of children & young people about what constitutes excellent practice, a relationship model of practice has been established which prioritises the relationship between the social worker and the family as the main vehicle to facilitate change. It is being introduced in a measured way and during 14-15 this has involved constructive engagement with staff.
- A Education Safeguarding Officer role has been added to the Education & Inclusion Team, working with colleagues taking forward work ensuring that the statutory duties placed upon schools and local authorities, via their education functions, are carried out effectively. This officer is linked to various networks through attending meetings such as the CPLG and Red Op Kite, amongst others, and liaising regularly with the LADO and HR for Schools for example.
- The Professional Network for schools based Designated Persons has been re-established.
- An Education Subgroup has been created, to provide strategic overview of the Designated Persons’ Network, ensuring that statutory developments are integrated into operational practice
- Independent schools are being engaged with, via the Designated Persons Network and the Safeguarding Audit Tool.
- The protocol regarding looked after young people in the criminal justice system has been reviewed with pan Sussex partners
- There are linked YOS workers into the MASH and Kite team.
- From September 2014, the legal framework around SEND changed and a large scale task of converting approximately 1000 ‘Statements of SEN’ to ‘Education, health and care plans’ is underway. A significant number of these young people are known to social work and some are subject to child protection plans or in care. The legislation requires considerably greater input and involvement of health and social care colleagues in constructing with families plans to meet the holistic needs of children. Where there are safeguarding needs, the new process is facilitating enhanced communication and joint planning across agencies and families’
Performance Management and Quality Assurance

- Across Children’s Services a shared ownership for targets and outcomes through a more analytical approach to performance management.
- Service business plans have been developed with participation featuring at all levels of our teams. This allows us to learn from our knowledge of our current performance; feedback from staff, children and families, other agencies and from data.
- The Children’s Social Work Quality Assurance Framework (QAF) was revised in 2014 to reflect new legislation, guidance, learning from reviews and also changes to services. The QAF will be revised again in 2015-16 to ensure that social workers and service users are at the centre of QA activity and to strengthen the feedback and remedial action process.
- The existing Safeguarding Audit Tool for schools has been updated to reflect the recent updates to guidance, such as Keeping Children Safe in Education: March 2015 and Working Together to Safeguard Children: March 2015, as well including a greater focus on areas such as CSE, FGM and Radicalisation. The format of the audit has also been adapted to allow even greater citywide analysis of the results.
- The YOS team conducted a section 11 audit assessing their safeguarding arrangements.

Communications

- We produced ‘Our Social Work Story’ which has been used as a tool to;
  - Understand our services, activity, data and performance
  - Ensure that staff and partners understand the interconnectivity across services and the range of work and to develop a shared ownership
  - Engage staff at all levels in developing a vision

Strategic Vision

- Discussions have taken place to develop a strategy for working specifically with adolescents who are troubled and who are currently accessing a range of additional services
- A new strategy for Brighton & Hove Virtual School has been developed following two reviews and the appointment of a new Virtual Headteacher in Aug 2014. This includes aligning the Virtual School with school improvement and a strategy to raise attachment awareness across the city and further afield.

Learning Reviews and training

- The Youth Offending Service (YOS) has conducted 2 internal learning reviews, and implemented actions as a result following the death of a young person known to the YOS and a suicide attempt by a known young person.
• A training programme on the criminal justice system has been offered to all social work teams and YOS staff have received training on Child Sexual Exploitation (CSE).
• The YOS team have trained 2 managers in supervision staff who work with sexual offenders and trained another member of staff to do this work.
• A newsletter goes out to school staff informing them of learning from SCRs and Learning Reviews

Looking ahead to 2015/16
A significant rise in demand on our services has created pressure throughout the system. This is being monitored and action will to be taken to address this in 2015/16.

How well have we done it?
• The introduction of the MASH and the Early Help Hub has ensured that there is good information-sharing between agencies so that prompt and appropriate decisions can be made about whether families require social work or early help services.
• Children most at risk of becoming looked after are considered at the Care Planning Panel, which determines whether additional work is required or whether to initiate a legal planning meeting. This means that children are looked after where it is in their best interests and thresholds for children to become looked after are appropriately and consistently applied.
• Additional IROs are now in post, which has resulted in manageable caseloads of around 70 children per IRO. As a result, IROs carry out their core duties effectively and also engage with children looked after outside of their reviews to establish meaningful relationships and monitor the progress of their care plans. Children at greatest risk benefit from challenging independent oversight by child protection chairs.
• The education of children looked after is supported well by the virtual school, resulting in high school attendance and no permanent exclusions. Educational attainment for children looked after at Key Stages 2 and 4 is strong. Children looked after have positive health outcomes as a result of good quality health assessments and plans.
• The quality assurance framework is robust with learning routinely identified and disseminated from a range of sources. An example of quality assurance activity completed in 2014-15 is the independent audit of 105 cases (following the journey of the child). This audit found that the overall effectiveness of social work practice is good and most interventions are clear, timely & child centred.
• A continuing theme for improvement from all QA activity is the quality and timeliness of recording and compliance with recording standards (ChIN Team). This is a priority area for improvement in 2015-16.
• One of the ways that we measure how well we have provided services is through regular service user feedback. An example of the feedback we have received in 2014-15 is as follows;
The MASH & Assessment Service feedback from parents (collected through questionnaires) overall feedback is positive. For example, 79% of parents felt that the contact with the social worker was positive and 69% felt that the work they did with their Social Worker was successful.

Feedback from parents and other family members regarding Child Protection Conferences is also positive. For instance, 80% of parents said that their child having been subject to a child protection plan had been positive for their family.

Educational representation within the MASH has contributed towards its successful launch during the last year. Having a single point of contact within the MASH has improved the quality and the consistency of information sharing with schools, within a multiagency framework.

Beyond the MASH, within the wider professional community, having an Education Safeguarding Officer regularly attending other networks and meetings has equally improved the quality and the consistency of information sharing within these contexts.

The first Network Meeting for schools based Designated Persons, in May 2015 was attended by 48 people, representing schools across all phases, including the maintained and independent sector. A further 22 people expressed interest but were unable to attend. Feedback for this meeting was positive and colleagues were pleased to see the group re-established. These meetings are now scheduled on a termly basis for the 2015-2016 academic year.

The Education Subgroup had its first meeting in March where it was planning a future network meeting, looking at updates on CSE, Disqualification by Association and Private Fostering Arrangements.

All maintained schools within the city have responded to this years Safeguarding Audit, and the results of this are currently being analysed. Feedback will be provided to schools and good practice celebrated. Any areas of development identified will be addressed through the Designated Persons’ Network, as well as recommendations being made to the Local Authorities Training Offer. Where necessary, praise, challenge and support will be provided to individual schools around their Safeguarding Practice, as evidenced from the Safeguarding Audit, throughout the year.

Safeguarding Audits have already been completed by five independent schools within the city. The remaining establishments will be supported to complete theirs during the next academic year.

There is increased joint working between the YOS and social work teams.

100% of YOS staff have received CSE training.

Section 11 audit showed that overall the YOS are doing well in addressing safeguarding however there are areas for development, particularly in relation to working with fathers.
What difference did it make?

- Increasing awareness of child sexual exploitation by professionals from a range of agencies is leading to increased referrals to MASH and enabling help to be provided to children at an earlier stage.

- Following extensive consultation the relationship model of practice within social work will be implemented in September 2015. The impact of this new approach on the outcomes for children and young people will be carefully monitored by the Senior Leadership Team in 2015-16 and beyond.

- Recommendations from quality assurance activity have led to changes in practice, policy and procedure, service development for example, a finding from an audit completed by the Children’s Disability Service led to an early help pathway being developed for children and families that were below the CIN safeguarding pathway/ a recommendation made following observations of IRO practice in LAC Review led to Rate My Review (feedback) cards being given to children following their review.

- In future we will improve the effectiveness of quality assurance through learning through the involvement of social workers in quality assurance activity and the dissemination of findings through the ‘Learning from Practice Seminars’ delivered to social workers by the QA Managers and the Principal Social Worker.

- The current arrangements for safeguarding children in education would appear to be providing an even more coordinated and consistent approach than previously and schools are engaging positively with the processes which are being put in place. Trust, confidence and capacity are being built within the school based professional community.

- There is comprehensive data around schools, from which strategic future planning can now be formulated.

- Risk management around young people involved with YOS has increased due to greater joint plans and decision making with social work teams and an increase in stability in their lives has been seen.
There is a strong commitment and willingness within Brighton & Hove for partner agencies to work together in order to tackle CSE and ensure children are effectively safeguarded.

When children are identified as being at risk of child sexual exploitation, they are quickly referred to the MASH and escalated to social work teams. The MASH has provided an improved framework for agency information to be shared in respect of children and more effectively piece aspects of the jigsaw together to inform better decision making regarding risk. This additionally is contributing to higher and earlier CSE identification rates.

Working with partners we have established the Kite Team which is a specialist Missing and CSE team which works closely with the Police Missing Co-ordinator and CSE leads. This team work with the most complex children identified as either persistently missing and/or at high risk of CSE. The team take an assertive outreach approach to their work in recognition that this cohort of children can be some of the most difficult to engage.

All young people identified as being at risk of child sexual exploitation are presented to the monthly Multi Agency Child Sexual Exploitation (MACSE) meeting and the level of risk is agreed. These arrangements ensure that plans to reduce risk and support young people are routinely considered by a multi-agency group, including a local authority senior manager, who chairs the meeting. In addition, the meeting supports good information-sharing between agencies.

Children's Services commissioned Alter Ego theatre company to perform Chelsea's Choice, an acclaimed play which highlights the serious and emotional impact of CSE, in the city’s High Schools during March 2015. These performances have raised the awareness of the boyfriend model of CSE abuse and over 2,200 Year 8 children have seen the production. The performances were and will continue to be supported by specialist social workers, the youth service and police officers, to ensure that children are in receipt of appropriate supports and services afterwards.

CSE awareness training has been provided to 66 children's social work staff between 01.10.14 and 06.01.15. In addition, 35 attendees have attended a half-day multi-agency training course on Preventing and Disrupting CSE. This has provided front line staff with the necessary skills to recognise and act upon CSE in their work, thereby contributing to the continued safety and welfare of children within the city.

Schools Safeguarding Audit Tool adapted to highlight CSE as a priority area.

Staff from Education & Inclusion attend and contribute at Red Op Kite, discuss CSE as a standing item on the Behaviour and Attendance Panel Agenda and it features within the training offer to all schools around safeguarding.

YOS staff are now part of the WISE team, offering additional support to young people who are at risk of CSE. We have developed and delivered group work programme, that has also been adapted to work with individual young women to build their self-esteem and resilience and support them away from CSE.
A joint agency CSA Pathway from the point of referral to ongoing support for the child and family has been devised as is now in action.

Therapeutic support from the Clermont CSA is now routinely on offer for every child and family where an alleged sexual assault of a child has been made.

The link with MASH, through the Education Safeguarding Officer, maintains the focus on this area. Also through the Designated Persons Network and the Education Safeguarding Subgroup.

Staff attended the LSCB CSA Conference.

YOS Staff attended the CSA training event and have been trained to undertake work with sex offenders.

YOS has also worked with the police around crime prevention and identifying young people who may be at risk of committing sexual offences through cyber crime, such as sexting and worked with those young people and their families.

What my agency has done to tackle child sexual abuse

Children’s social work teams continue to review and challenge performance in this area, there does not appear to be a significant or service-wide gap in practice regarding the identification, or response, to neglect.

To ensure that social workers have the right training and tools to support them to recognise the indicators of neglect and the impact it has for children we provide the in-house and LSCB training programme. However, we recognise the need for the training offer to be strengthened in this area.

The Quality of Care Assessment tool which will support professionals to identify and assess neglect was evaluated by social workers in the Assessment and CIN teams (Feb – May 2015). The tool will be rolled out in 2015-16.

The link with MASH, through the Education Safeguarding Officer, maintains the focus on this area. Also through the Designated Persons Network and the Education Safeguarding Subgroup.

Candidates identified through the Designated Persons Network, to participate in Child Neglect Training

LSCB Member Agencies’ Safeguarding Reports 2014-5

What my agency has done to tackle child neglect
Community & Voluntary Sector

Brighton and Hove has a vibrant, active and diverse Voluntary and Community Sector VCS). The last Taking Account Survey 2014 showed that there are at least 2,300 CVS organisations and groups in the city of which 11% (253) define their main activity as working with children and young people.

These groups are often engaging and supporting the most vulnerable, marginalised and disadvantaged children, young people and families. For example; young carers, LGBTU young people, BME young people and their families, children and young people with special needs and disabilities and gypsy and traveller families. The sector also offers specialist support in relation to families affected by domestic violence, bullying, emotional well-being and mental health, and substance misuse.

Brighton and Hove has a well-established infrastructure organisation – Community Works, which provides a mechanism for bringing together the voice and concerns of the Third sector. The Children and Young People’s Network operates under the umbrella of Community Works to provide a forum for organisations across the city who are providing services and support to children, young people and families.

Community Works Safeguarding Activity in 2014 - 5

- Over the last year Community Works (CW) has worked with Safety Net, local children’s safety charity to undertake the Simple Quality Protects (SQP) quality assurance scheme around safeguarding and achieved the bronze level award
- Changes have been implemented to their membership form to include gathering safeguarding information from its (419) members
- Safeguarding questions have been included on the volunteering opportunities forms completed by organisations to identify if they have safeguarding policies in place
- Safeguarding training and support services provided by local organisation Safety Net have been actively promoted as well as other local learning opportunities around safeguarding including that of Children and Young People workforce development
- Between March 2014 and April 2015 2268 workers and volunteers from the CVS attended child protection training provided by Safety Net
- CW and Safety Net planned a safeguarding conference to update and get feedback from CVS groups on safeguarding developments and the LSCB priority areas.
- CW worked with Safety Net to audit the safeguarding learning needs of their membership and developed appropriate learning opportunities in response.
The safeguarding quality mark Simple Quality Protects (SQP) scheme co-ordinated by Safety Net was promoted to CW members with 11 bronze and 2 silver awards achieved during the year. CW built a policy bank that includes the policies which underpin safeguarding and therefore supports groups to approach safeguarding in a holistic way.

The CVS continues to be an active member of the LSCB. Terri Fletcher from Safety Net is the current elected representative. Community Works is a member of the Participation and Engagement group for the Local Safeguarding Children Board (LSCB) – disseminating relevant information to the sector on their behalf, and supporting the sector to engage in the LSCB safeguarding audit ‘Section 11’.

Community Works has Co-ordinated the Voluntary and Community Sector reference group for the Early Help and MASH developments in Children’s Services; advising on its development and how to involve the Voluntary and Community Sector. VCS staff also form part of the partnership teams for the MASH and Early Help Hub.

Case Studies:

Brighton & Hove WISE – Sexual Exploitation Service for Children & Young People

In 2014-15, YMCA Downslink Group’s WiSE project delivered training to 638 professionals across different sectors; provided direct casework support to 28 victims of CSE, or those at significant risk; provided ongoing professional support for a further 23 children and young people; and provided 141 professional consultations.

Through the WiSE Up night time economy campaign, WiSE:

- Developed resources aimed to help people in the night time economy identify CSE and to know how to report it ('How 2 Spot' and 'How 2 Report' cards)
- Worked with young people to design promotion materials that encourage their peers to think about healthy relationships in social situations, including interactive beer mats which provoke questions and discussion around consent, control and keeping safe
- Delivered 12 training and awareness raising campaign briefings to 292 professionals and staff working in the night time economy, including police, door staff, and taxi drivers
- Delivered outreach awareness raising visits to 23 bars and night clubs, 7 fast food/take away businesses and 3 hotels and also engaged 114 people drinking in 8 venues through outreach using beer mats to facilitate discussion and raise awareness of CSE
- Engaged 115 university students at 2 university wellbeing events
The Brighton Oasis Project (BOP) is a charity offering a woman-only substance misuse treatment service in the City of Brighton and Hove. The **Parenting Our Children – Addressing Risk (POCAR) Programme** is one element of the BOP delivery model. New Economics Foundation (NEF) Consulting were commissioned to undertake an evaluation of the BOP model and the POCAR programme, primarily to determine the extent to which it improves outcomes and brings about lasting change for POCAR clients and their children; Keys findings from the evaluation were:

- The POCAR Programme helps reduce the number of cases with Child Protection Plans by 53% by 3 months after clients have finished the programme and by 85% by 12 months after clients have finished the programme.

- The POCAR programme supports significant numbers of parents towards caring for their own children safely and averts the need for them to become looked after by the Local Authority.

- Changes arising from the POCAR programme occur swiftly, with the majority of transitions in social care status taking place within 3 months of completing the programme.

**Safety Net Feeling Good, Feeling Safe Group for Survivors of sexual abuse**

This is a Protective Behaviours based group work programme for young people aged 11 – 19 who have experienced or who are considered at risk of sexual abuse. The service has strong links with key networks and partners in Brighton and Hove (WISE, the Early Help Hub, Local Secondary Schools, the Integrated Team for Families) who are key referrers.

This year has seen an increase in the number of participants taking part in the project;

- 5 sets of group work programmes were attended by 33 young people
- 31 x 1:1 sessions for 10 young people.
- 2 Residential weekends were attended by 18 young people, this was an effective method of engaging young people in the project who might not otherwise do so. These have proved particularly popular with boys who have been referred to the project.

Evaluation indicates that young people who have engaged with the support have reported increases in their resilience, self-esteem.
Brighton & Hove Clinical Commissioning Group

What have we done?
As a Statutory Board Member the CCG has worked closely with the LSCB throughout the past year
The CCG employ and host the Designated Professionals, Doctor and Nurse for the Brighton and Hove System. We employ and host the Named GP supporting primary care.

CCG Executive and designated and named professionals support the work of the LSCB by Chairing Serious Case Review, Learning & Development and Child Sexual Exploitation Subcommittees and in addition sit on numerous Subcommittees, providing clinical expertise and advice.

CCG staff work closely with local authority, public health and CCG commissioners to ensure learning from case reviews influences strategic commissioning plans and the monitoring of existing provider contracts

To support new integrated ways of working we have provided leadership and pump prime funding to employ a nurse working across BSUH, SPFT and SCT in the MASH

We have employed an adult safeguarding named nurse with specific focus on supporting primary care in recognising and contributing to supporting victims of domestic violence specifically where children are in the family.

How well have we done it?
The recent Ofsted inspection judged the LSCB to be good of which the CCG is a statutory partner

Liaison nurse and admin in post supporting the MASH and improving the information supplied from health agencies

Contributed to the development and introduction of the NHS pan Sussex assurance tool for monitoring provider compliance against safeguarding matrix

What difference did it make?
There is Strategic leadership in place for named professionals, and safeguarding leads of independent health providers.

MASH has the support of dedicated healthcare professional in early decision making.
Learning from LSCB cases and other programs such as Transforming Care (Winterbourne) has influenced the CCG commissioning of services for children and young people. For example a new pathway of care for supporting those traumatised by sexual and domestic violence, leading to a review of services to support the pathway from childhood for individuals with learning disabilities, and a review of CAMHS services.
The CCG sit on Pan Sussex Strategic Board.

The CCG safeguarding training includes ensuring all commissioning staff have an introduction to what is child sexual abuse and how to refer.

Commissioned a therapeutic pathway for victims requiring specialist support.

The Designated Doctor led on the LSCB Child Sexual Abuse conference that took place in May 2015.

As Commissioners we monitor providers of NHS services adherence to Pan Sussex policies.

We have worked with National Health South England (NHSE) supporting the development and commissioning through them of the Paediatric SARC and the Designated professionals have identified and raised significant concerns about the processes and investigation of cases of CSA.

The Designated Professionals and Head of safeguarding have been key in ensuring Neglect is raised at appropriate strategic levels.

The Designated Nurse has supported the LSCB to plan a training programme on Neglect in association with Social Care Institute of Excellent.

Information on Neglect has been raised with independent providers.

Strategic lead for named professionals ensured independent providers are aware of the issues.

Designated Doctor chairs the LSCB CSE: Prevent & Early Identification Subcommittee.

The Designated Nurse and Doctor provide supervision for all named professionals across the Brighton and Hove NHS providers and support the Health Advisor Group (HAG) and meet with independent providers where awareness raising and discussion of this issue takes place.
Sussex Community NHS Trust

What have we done
During June 2014 the Chief Nurse commissioned an independent review of safeguarding (adult and children) across the Trust. This included interviews with partner agencies. All 22 recommendations were presented to the Board and accepted to be implemented during 2014/15.

SCT continues to fulfil its statutory responsibility to safeguard children and promote the welfare of children and to be compliant with the CQC outcome 7. This includes a commitment to resources for staff to undertake safeguarding including reviews of child deaths.

SCT children safeguarding team have continued to be integrated into the Brighton and Hove Children and Families Service with a clear model of delivery of safeguarding.

Senior SCT staff are represented at the LSCB Board

How well did we do it?
The Children Safeguarding model of delivery is;

Clinical Leadership
The Director with responsibility for safeguarding is the Chief Nurse. The Head of Safeguarding reports to the Chief Nurse and deputises in Local Safeguarding Children Boards. The Named Nurses in partnership with the Named Doctors provides clinical leadership for all aspects of safeguarding children and takes a lead role to ensure that overall professional systems are set up to ensure standards are set and maintained. These standards are laid down in Working Together (2015).

Safeguarding Children Advice & Case Consultation
Brighton & Hove Safeguarding Children team are available to all SCT staff to offer advice and support on a daily basis from the Safeguarding team. Work has progressed in the development of the Multi Agency Safeguarding Hub, the health worker will be hosted by SCT

Supervision
The Named Nurse clinically supervises Children Centre Managers, and School Nurse Managers individually and in monthly workshops who in turn give clinical and managerial supervision to health visitors and school nurses, which include Safeguarding Children, on a 4 – 6 weekly basis. Live supervision sessions are undertaken by the Brighton & Hove team to assure the quality of the managers’ levels of supervision.
Training & Development
The children safeguarding team provides assurance that arrangements are in place for Safeguarding Children training and development of all relevant staff at the appropriate level of competencies in line with the Intercollegiate document (March 2014). The Safeguarding Children teams provides a range of level 1 to level 4 training and development opportunities for all health staff.

Domestic Abuse Pathways
The Safeguarding Children Teams researches the information and attends the MARAC (Multi Agency Risk Assessment Conference) meeting on a fortnightly basis to enable Health Visitors and School Nurses to contribute to this process and distribute the SCARFs (police contact forms) to the relevant practitioners.

Clinical Audits
The safeguarding team provides an annual NHS audit program and in addition has a role in completing and monitoring the relevant actions from the Section 11 audit and LSCB audits. The audits undertaken by SCT staff during 2014/15
- Health needs identified in initial child protection plans by school nurses and the outcomes
- LSCB multi-agency audit in Domestic Violence and Abuse
- Child Protection Processes in Children Centres
- LSCB Child Sexual Exploitation

Case Reviews
The Named Nurse has a key role in undertaking Internal Management Reviews (IMR) or SCIE Learning Reviews or Serious Case Reviews in complex cases which meet the criteria for an internal or partnership review.

Quality & Governance
The Safeguarding team has a key role in developing a range of relevant Safeguarding Children policies and service specific guidelines for health practitioners to ensure safe practice and a role in promoting and monitoring good practice. Both teams report to the Head of Safeguarding, there are quarterly SCT Children Safeguarding Delivery Group and a Steering Committee chaired by the Chief Nurse.

What difference did it make?
SCT has responded to the requests from the Board to support serious case review Baby Liam and Learning Review for Child G. Training to SCT staff has ensured they understand their duty to safeguard. Both Named Doctor and Named Nurse offer specialist clinical advice and support to SCT staff working in Brighton and Hove.
Clinical support, advice and treatment is offered by SCT Named Doctor and other paediatricians. The Named Nurse and Specialist nurse support and advise SCT staff on the appropriate response and processes when dealing with child sexual abuse cases.

Work to set up and prepare for the Sussex Paediatric SARC which will be located on the SCT site at Brighton General Hospital has been a focus during 2014/15 with a commencement date of 1 April 2015.

The Named Nurse in SCT is leading on the LSCB theme on Neglect. The work undertaken includes:

April 2014 **Quality of Care Assessment Tool Pilot**. A trainer from West Sussex commissioned to run a half day training on the use of the tool for 24 practitioners from Health Visiting, School Nursing & Social Work. There was then a 3 months pilot – Principal Social Worker & Named Nurse meet up with Group half way through and at a final evaluation workshop in July.

Strengths & Challenges identified from Health Staff. No feedback from Social Care.

Jan 2015 **Social Care for Excellence (SCIE) pilot training in Neglect**:
This was offered to those who had been involved in Quality of Care pilot with an understanding that after attending training they would support the LSCB with further neglect training, assist in development of tools and be a neglect champion for their team.

The Training consisted of an introductory elearning package which had to be completed a week before the training day and the participants reflections were used in the session. This comprised of three modules;

1. Understanding Neglect based on Quality of Care Tool,
2. 'Systems approach' – intro to concepts of systems approach to professional practice
3. 'Applying systems thinking' - to working with child neglect

The scenario based mutli agency training day was attended by 11 SCT staff and the session used a systems approach to identify factors that may hinder the local response to neglect. There was a positive response to this training from practitioners, and the SCIE Trainers attended the LSCB Learning & Development Subcommittee meeting in February 2015 to give feedback on the training and the systems factors identified which may hinder effective work with Neglect.

March 2015 LSCB have agreed that LSCB can spend some of its budget on Neglect training.
Sussex Partnership NHS Foundation Trust

What have we done?
In the last year we have revised our Safeguarding Nurse structure and now have a substantive Nurse Consultant who works four days each week as Named Nurse for Brighton and Hove and West Sussex as well as having a divisional lead role for nursing in Children and Young People Services (ChYPS) which ensures links with the service. This has reinforced the stability of our safeguarding structures and increased the availability of senior advice.

We have launched a new, Trust-wide e-learning system which enables staff to undertake Level two Safeguarding training wherever they work, and at a time convenient to them.

We also reviewed and updated our safeguarding training and all of our training, including Level one training now includes sections on Child Sexual Exploitation, Female Genital Mutilation, the prevent strategy and Child Trafficking.

In addition, we have arranged our training so that all clinical staff have Level three training as set out in the intercollegiate document. We have therefore developed Level three core training which is a four hour training session for all clinical and some non-clinical staff where appropriate. We also have a 7 hour level three specialist training which is for all ChYPS clinical staff & includes sessions from staff from partner agencies.

The Named Nurses are currently reviewing and updating the safeguarding strategy for the Trust.

How well did we do it?
The new Named Nurse role has been well received and has made a clear and positive difference to the level at which the Trust can be both represented and engaged in multi-agency safeguarding activity.

The e-learning system has been in place since April 2015 and feedback from those who have undertaken the Level two training has been positive.

The Level one course has been consistently positively evaluated by participants who say that it makes a difference to how they would assess and respond to a range of safeguarding scenarios. The level three core and specialist training receive positive evaluation from participants.

What difference did it make?
Each of the elements above contribute to the rolling programme of strengthening and updating our safeguarding activity key to which, is every single member of our staff, recognising that safeguarding is everybody’s business. We can see a shift in staff response in that safeguarding is part of the ethos of the Trust and as a consequence, clinical staff are more aware of their responsibilities and are bringing safeguarding issues to the attention of internal Named staff on a more frequent basis.
What my agency has done to tackle child sexual abuse

We have circulated both national and local information on CSE and discussed the importance of awareness of the issue in our safeguarding training. We have also ensured that on-line safety is part of our ongoing safeguarding training in order to raise awareness of the different types of exploitation.

We have used the learning from a recent SCR in West Sussex to disseminate information regarding child sexual exploitation to our staff, this has formed part of the level three specialist training and also the training to our safeguarding link practitioners across the Trust who have links with non-ChYPS services and can raise awareness in their teams.

The Named Nurse for Brighton & Hove and West Sussex attends the CSE sub group in West Sussex and so is kept updated on current issues.

What my agency has done to tackle child neglect

We have undertaken an audit of the effects on children of parental hospitalisation for mental health issues and have used the outcome of the audit to facilitate discussion about changing practice in adult mental health. One of the Matrons in Adult Mental Health Services (AMHS) is undertaking a project as part of a leadership training that will look at the embedding of standards into AMHS. The Named Nurse for B&H has met with the Consultant Nurse in Secure and Forensic services and discussed the updating of their assessment paperwork to reflect the need for an awareness of the effect of parental mental health issues on children. It will also emphasise the need to develop more appropriate liaison with both internal and external colleagues.

What my agency has done to tackle child sexual exploitation

We have circulated both national and local information on CSE and discussed the importance of awareness of the issue in our safeguarding training. We have also ensured that on-line safety is part of our ongoing safeguarding training in order to raise awareness of the different types of exploitation.

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The Named Nurse for Brighton & Hove and West Sussex attends the CSE sub group in West Sussex and so is kept updated on current issues.

We have raised awareness of operation Kite in Sussex to staff across the Trust and highlight in our training the factors that make children more vulnerable to exploitation.

Bamardo’s have regularly led sessions at our level three training to raise awareness of the issues and highlight the fact that CSE is a local as well as a national issue.
Brighton & Sussex University Hospitals Trust

What have we done
The BSUH Safeguarding Children Committee has continued its responsibility to ensure that the internal governance arrangements and statutory requirements for safeguarding children and child protection are met. The systems, processes and policies are constantly under review to ensure that they comply with local and national guidance and an action plan which addresses local issues and actions from national & local serious case reviews. The Annual Safeguarding Children Report 2014-2015 will be presented to the Board in the autumn of 2015.

The year on year increase of child protection work has stretched the Named professionals but they continue to support the work of the LSCB and participate in the sub groups, SCR and learning reviews as well as the audits undertaken within the monitoring and evaluation group.

Nationally, there is a perception that the number of Child Protection Medicals is increasing: In 2014 the hospital conducted 170 medicals at RACH and at midpoint 2015 the number has slightly increased.

The hospital onsite social work service has been moved off site to the MASH and since April 2015 a health professional has been incorporated into the MASH team to facilitate information sharing.

The onsite specialist safeguarding liaison nurse employed by Sussex community trust for the past 22 years has been amalgamated into the BSUH safeguarding team. The challenge has been to continue the excellent communication with the community with reduced personnel and the new role will take effect from Sept 2015. Discussions have taken place with the health visiting and school nurse services to ensure efficient risk assessment and communication continues. The liaison with social work team continues and has been improved by the introduction of scanned documents being sent by confidential e mail.

Since April 2014 NHS hospitals have been required to record & report if a patient has had FGM or any family history or any FGM related procedures carried out. BSUH has developed a process for this data collection and are linking with the Brighton VAWG (Violence against women and girls) to ensure a strategic approach. Subsequently this has been enhanced by the national risk assessment tool and developing a pan Sussex multi-agency pathway.

The highly publicised child sexual exploitation scandals have resulted in increased awareness and developing services within the locality. BSUH is involved by their representation at the ‘Operation Kite’ risk and planning meetings. In the light of the Saville report the Trust has commissioned a review of safeguarding to ensure a quality service is maintained and the report recommendations are addressed.

A monthly safeguarding newsletter is circulated for staff to raise awareness and to be used as a discussion prompt. The newsletter is discussed at the monthly nursing meeting.
BSUH has been involved with the B&H SCR and learning from national SCR and learning has been incorporated into the safeguarding action plan including:

1. Improving the maternity information gathering documentation relating to fathers.
2. Ensuring all staff are aware of how to access safeguarding advice and support throughout the day.
3. Continuing to make urgent referrals (in and out of hours) to local social services of serious, life threatening injuries, even if the child is being retrieved to a tertiary unit for continuation of care.

Parent Information leaflets Introduced- explaining about unusual injuries, tests that may be undertaken and the processes involved.

How well did we do it?

- Daily safeguarding ward visits continue at RACH enabling improved case discussion & safeguarding planning for nurses & doctors on approximately 450 children pa.

- To ensure a consistent and quality approach the Named Doctor continues to give safeguarding supervision to medical staff on a case by case basis, and participates in the Monday teaching sessions and the Thursday peer review meetings. The Named nurse gives supervision to teams with complicated caseloads and the safeguarding midwife supports the midwives who have complex cases.

- The named Dr has had a recent publication in paediatric literature (ENT injuries and non-accidental injury) demonstrating her commitment and expertise.

- In June 2015 a raising awareness session organised by the named Nurse was attended by 80 multi-agency staff and was well evaluated, so a second one is planned for Oct 2015.

- An audit is near completion is looking at imaging in children with suspected non-accidental injury, which shows an improvement in reporting times.

- The named Nurse has managed the introduction of the FGM monitoring process & raised awareness.

- The safeguarding children training within BSUH is undertaken as mandatory requirement and a variety of techniques are employed including taught sessions, e learning & newsletter communication. 805 of the paediatric and maternity staff have attended.

- Audits of referral documentation and identification of risk show that it is of a good quality and records indicate that hospital staff have made 293 referrals between July 2014 –June 2015.
What difference did it make?

The Section 11 audit has provided reassurance that Brighton & Sussex University Hospitals Trust continues to be able to demonstrate a safe service, although there are challenges such as the rising numbers of complex children with safeguarding issues and the issue of adapting to the changing provision and organisation of social care and community liaison services.

The audits have shown that care is of a good quality with documentation and risk assessment also being of a good standard and staff are able to demonstrate they know who to contact if they had a concern about a child.

Examples of support or referrals include:-

- parents who have taken an overdose and staff have ensured the safety of their children
- young people who have self harmed and require CAMHS and social work support
- families where there is domestic abuse who have been referred to RISE and the health IDA based at the hospital
- referrals related to physical injuries and those of a sexual nature
- links strengthened with Red op kite

There have been changes to practice brought about by working with the multi-agency partners including the risk assessment form in children’s emergency department, the pathway for children who attend having been bitten by a dog, the pathway for children who self harm and improved information gathering related to fathers.

Clinical Staff are involved in the Strategic and operational multiagency groups and awareness of neglect & Child Sexual exploitation has been incorporated into all safeguarding children training programs.

Continued attendance at the MARAC has ensured information is shared and files are updated to help care planning.

The contact details of professionals working with a young person discussed at the red op kite meeting has been incorporated into the young person’s medical folder to enable better communication relating to these vulnerable young people.

The ongoing flagging of all children with a CP plan has ensured that staff are aware of the issues and information sharing between agencies promotes joined up planning.

The patient information leaflets have been created to improve understanding of the safeguarding processes within the hospital.
The highly publicised child sexual exploitation scandals have resulted in increased awareness and developing services within the locality. BSUH is involved by their representation at the 'Operation Kite' risk and planning meetings. Information is included in the young person’s notes to alert staff of the Key professionals involved in their safety planning.

The Claude Nichol staff have participated in the LSCB sexual exploitation sub group forum.

The Claude Nichol staff have an electronic risk assessment tool which incorporates questions relating to sexual exploitation.

Awareness of Child Sexual exploitation has been incorporated into all safeguarding children training programs including asking staff for key factors to look out for to enable them to recognise the risks.

The monthly BSUH safeguarding children newsletter has multiple entries about sexual exploitation over the past year including links to the LSCB newsletter and various serious case reviews and Government documents/reports.

Awareness of Neglect & Child Sexual exploitation has been incorporated into all safeguarding children training programs.

Staff have referred children to the Community paediatricians for review of injuries to the genital area or if there are indications of sexual abuse. There are new links with the Brighton SARC.

This is an ongoing process not a specific issue for this year.

Awareness of Neglect & Child Sexual exploitation has been incorporated into all safeguarding children training programs.

There are existing hospital pathways for children who are failing to thrive.

There are pathways for children who parents do not bring them for appointments.

The Named Nurse has attended a SCIE neglect training day and is sharing the learning.

The hospital dental team are aware of the contribution neglect has in tooth decay and the number of children who require multiple extractions. They give health education related to healthy eating and dental care.

The staff who work in the adult areas of the hospital are aware of the impact of parental mental health, domestic abuse and substance misuse and make referrals when parents attend A&E and their condition may affect the safety of the child.
South East Coast Ambulance Service

South East Coast Ambulance Service NHS Foundation Trust (the Trust) is committed to promoting and safeguarding the welfare of all vulnerable people; recognising that everybody has the right to be protected from harm, exploitation and neglect within the context of the law and personal civil liberties. During 2014/15 the Trust has undertaken a review of its safeguarding arrangements and the safeguarding team has seen an increase in capacity during this period. Referral rates have continued to rise with an overall increase of 18% from 2013/14 across the whole Trust area. Unfortunately it is not possible to break down the reporting figures by local authority area due to data entry challenges, however, it is anticipated this will be addressed during 2015/16.

Three Key Achievements in 2014/15

- Appointment of a full-time Safeguarding Support Officer adding resilience and capacity to the safeguarding team
- Re-introduction of a Domestic Abuse (DA) pilot in Sussex with increased DA awareness training across the whole Trust
- Successful pilot for an on-line reporting process across the whole Trust

Impact of Achievements on Service Users

The additional capacity in the team has enabled the Trust to have a greater presence at the local Safeguarding Boards which has the benefit of ensuring that the Trust continues to play an active role within each local area.

The Trust undertook a Domestic Abuse (DA) project in 2012/13 which ended due to the cessation of short term project funding. However, with the support of the Office of the Police and Crime Commissioner, and associate commissioners in East Sussex County Council and West Sussex County Council, additional funding was secured enabling the project to be re-introduced from December 2014 for a twelve month period, and expanded to cover the whole of Sussex (previously this was restricted to West Sussex and Brighton and Hove). As a result, all areas of the Trust have benefitted from DA training and the post-holder has secured referral pathways to specialist DA organisations across Sussex (with signposting to the national helpline in non-pilot areas) and made direct contact with a number of patients identified through the referral process.

The Trust’s on-line referral process was successfully piloted in Kent during 2014 and subsequently rolled out to all staff across the Trust from April 2015. Improved clarity of concerns and data being gathered will enable greater scrutiny of demographics and ensure that training needs can be identified and mapped to enable targeted training to be delivered in future.
Three Key Challenges in 2014/15

- A significant backlog of data entry for vulnerable person (VP referrals) due to legacy departmental capacity issues made reporting and analysing referrals for the year challenging. This has since been rectified at the end of Q4 and into Q1 2015/16.

- Lack of capacity within the team during the first half of the year meant it wasn’t possible to properly engage with local safeguarding boards across the region. This has improved following the appointment of additional staff in the team.

- Understanding how the 111 service differed from the 999 service provided across the Trust and the unique challenges faced by staff who do not see the patient with regards to making referrals was a core requirement.

Future Plans 2015/16

The safeguarding team will continue to roll out the electronic reporting across all Trust sites (including both 111 sites) leading to improved monitoring and analysis of the information being gathered.

The DA pilot will continue as per the commissioned plan, including project review and evaluation to assist the development of business case proposals for its sustained continuity beyond December 2015.

The team will continue to work with 111 to improve the understanding of safeguarding referral requirements and referral data analysis.

A significant volume of safeguarding and DA reporting metrics have been agreed with lead commissioners for reporting where possible during 2015/16.

In partnership with learning and development colleagues, the team will progress the delivery of MCA training to all clinical staff in accordance with the Trusts key skills plan (including application of capacity assessments, obtaining consent to treatment and use of control and restraint techniques) supported if appropriate by a tier of Mental Health expertise available to operational staff.
Sussex Police

What have we done?
The Public Protection Branch is now nearing the end of a significant restructure through which the existing Child Protection Team and Adult Protection Team have been brought together into a single specialist team – the Safeguarding Investigation Unit (SIU). Brighton’s SIU, led by a Detective Chief Inspector, is one of three such teams located across Sussex Police.

The SIU brings together trained detectives, with expertise and experience in investigating child abuse, together with other specialist roles, such as dedicated Sexual Offence Liaison Officers (SOLOS), missing person co-ordinators, and domestic abuse case workers. This approach ensures we can deliver effective and timely investigations as well as providing appropriate support to victims.

In the final stage of the restructure, in October this year, we will increase the number of detectives within the unit and extend the team’s remit to include the investigation of all reports of rape and serious sexual offences.

The final stage of the restructure will also see the creation of a complex abuse investigation unit (CAIU) which will support divisional teams by providing a specialist, force-wide, provision for the investigation of more complex or larger scale investigations, including CSE.

In addition to the change programme, we have worked to continue to develop and embed Operation Kite into daily business. As a result we now have a well established meeting structure through which we work with partners to target police activity and multi-agency support towards those assessed as being at most risk of CSE.

The CSE Operations group has now also evolved into a Pursue and Protect group, chaired by DCI Richard Bates, and a Prevent and Identification group chaired by Dr Jamie Carter. These two groups, reporting into the vulnerable children strategy group will support the continued development of our multi-agency approach to tackling CSE.

How well did we do it?
With officers working alongside partners in the Multi-agency Safeguarding Hub (MASH), we are now able to receive and assess referrals from officers and immediately.

Sixty-six victims and potential victims of CSE, together with 22 perpetrators and suspected perpetrators have now been managed through the multi-agency Operation Kite process.
In addition to investigations concerning individual victims/perpetrators there have been two significant investigations, Operation Sandhurst and Operation Pipeline, for which multi-agency operational groups were formed. Operation Sandhurst resulted in the conviction (in August 2015) of one of the main perpetrators, with the investigation ongoing into another suspect.

Five men have been charged and are now remanded in custody, awaiting trial in relation to Operation Pipeline.

**What difference did it make?**

The multi-agency Operation Kite process is now firmly established as an effective approach to tackling and responding to CSE and this is reflected in our response to new reports of suspected CSE. However, the full benefits of the new SIU structure are anticipated once the implementation process is complete and will be reported in the future.

The police have continued to respond to all allegations of sexual abuse whether made by children concerning current abuse, or adults reporting earlier abuse. All reports are taken seriously and it should be emphasised that any victim making an allegation will be listened to, and where appropriate a criminal investigation initiated.

The police have continued to respond to referrals of neglect and contribute to joint investigations.

What my agency has done to tackle child sexual exploitation

3. The police response to child sexual exploitation (CSE) has continued to develop, working in close cooperation with partners. This has included the introduction of multi-agency “bronze” group, (In Brighton this is called Operation Kite), where the issues concerning CSE and children who go missing are considered. Children who are identified as high risk are referred for joint agency strategy meetings to coordinate a response, and thereby minimise the risk to these children and young people. A single referral risk assessment form has been developed using the Barnado’s risk assessment template, and referrals are considered with partners and a level of risk agreed.

The response to CSE locally is subject to on-going scrutiny by the LSCB, and across the whole Force area a pan-Sussex operational group exists to ensure a consistency of practice across all three LSCB areas.

A multi-agency CSE Intelligence Assessment has been completed and recommendations will be implemented in the year ahead.

CSE has been embedded as a standing item in Force and divisional tactical assessment planning, and a divisional intelligence meeting process implemented, that has improved the identification of CSE hotspots and suspected perpetrators. A new post of a dedicated CSE analyst has been agreed and will be in post in during 2015, focussing on the identification of vulnerable victims and perpetrators.
National Probation Service

What have we done?

During 2014 / 15 the probation service has gone through a major re-organisation and transformation programme. The National Probation Service holds responsibility for all high risk of harm offenders, which will include a significant proportion that presents a risk to children through physical, sexual and emotional abuse.

With organisational transformation come new opportunities to build on the previous good work of Surrey Sussex Probation Trust. During the year we have further enhanced our quality of practice and positive outcomes for children.

We have therefore continued as a high priority the training and development of our front line staff in child protection matters. A priority this year has been placed on Child Sexual Exploitation in response to the chastening findings from national inquiries and in support of Sussex Police’s Operation Kite.

As part of this process we ensured ongoing workshops concerning CSE have been arranged for staff and ongoing opportunities for discussion, review and support in our supervision of staff with our emphasis on reflective practice.

We continue to prioritise NPS staff attendance at Child Protection Conferences and reviews and fully participate as required in core groups and professionals meetings. Additionally we ensure the welfare of the child remains paramount when exercising our duties as the Responsible Authority within Mapp arrangements and is at the heart of all our sentence and risk management planning.

The NPS has further increased its involvement in prevention of domestic violence by working alongside Sussex Police in our Multi Agency Domestic Abuse Panel and at MARAC. A Probation Officer from our local team is regularly based with Police Safeguarding Investigations Unit colleagues and we continue develop our working arrangements with the Multi Agency Service Hub.

During the year we have fully engaged in the Channel initiative to protect vulnerable young people from becoming radicalised. We continue to work closely with all our partner agencies in the wider Prevent strategy to safeguard children from harm and abuse from exposure to extremist views.

We continue to work closely with our Community Rehabilitation Company colleagues in the delivery of specific programmes with our offenders and with our other partners in addressing issues with regard to substance misuse, mental health difficulties, our personality disorder pathway, statutory and voluntary housing agencies and Inspire.
How well did we do it?
As with any major organisational transition, significant challenges have been presented over the year to introduce new systems, processes and ways of working. The NPS has completed successfully it’s transition period of he year, whilst remaining as a clear objective continuous improvement in our service delivery in relation to child safeguarding work.

New partnership working arrangements have been established and indeed NPS has taken on additional multi agency commitments over the year.

We have continued to support our staff in accessing development training and ensured that safeguarding matters remain at the centre of practice, supported by quality assurance processes, regular staff supervision and staff development workshops.

Offender cases are regularly reviewed and good practice examples and learning points are shared with staff through our usual communication channels and good practice discussions.

NPS continues its senior management involvement with LSCB.

What difference did it make?
There are numerous examples of good practice in terms of probation activity in the support of safeguarding children in Brighton and Hove. This was endorsed from our recent HMI Probation Inspection and audits of Multi Agency protection Panel Work.

Whilst not complacent we will continue to build on the good practice the National probation Service is developing over the coming year to further strengthen our contributions to child safeguarding in the City.
A Senior Probation Officer and Quality Development Probation Officer within the Brighton Local Offender Management Team have developed specialist knowledge in this field of work. They have taken forward the learning from Baroness Jay’s report into sexual exploitation to imbed into day to day probation practice. Staff within the local Offender Management Team have attended internal training workshops and staff development days specifically concerning Child Sexual Exploitation as well as receiving support through supervision.

Child Sexual Exploitation now features as a core element of development in the training programme of our trainee probation officers.

In addition, all front line NPS staff are expected to attend LSCB training and a significant number have attended this year Parts 1 and 2 of the WISE training workshops.

The National Probation Service undertakes frequent home visit checks with offenders under our supervision. A core aspect of all our work will be to consider and observe the circumstances of the offender and their immediate family and other close relationships.

We have established systems and processes to identify concerns with regard to neglect that escalates to management for further oversight, review and response.
Kent Surrey & Sussex Community Rehabilitation Company

What have we done?

Following on from the establishment of the Kent Surrey and Sussex Community Rehabilitation Company (KSS CRC) on 1 June 2014, KSS CRC appointed the Deputy Chief Executive as the designated lead for safeguarding, a qualified and registered Social Worker and experienced Senior Manager with extensive experience in safeguarding both children and vulnerable adults, including strategic oversight across the organisation.

The prevention of domestic abuse remains a priority for KSS CRC and we continue to work alongside partner agencies through the MARAC and the Early Help Hub. We also deliver direct interventions for perpetrators of domestic abuse.

We fully support the Channel Initiative and the wider Prevent strategy and are fully committed to the preventing young people becoming radicalised. Ensuring our front line staff are equipped with the necessary skills to identify and manage potential CSE is a priority for KSS CRC going forward.

Our delivery of Through the Gate ensures that, for the first time, all those who receive a custodial sentence of 1 day or more can access resettlement services in custody and through the gate. Delivery focuses on 4 key areas; accommodation, employment, finance, benefit and debt and support for sex workers and victims of domestic and sexual violence.

KSS CRC recognises the unique needs to female within the criminal justice system and is committed to delivering services which meet these needs and which address the issues that matter to women.

The following have been identified as on-going areas for development for the CRC:

- CRC wide review of safeguarding policies, procedures, practices and documents
- Continue to promote and encourage staff attendance at Local Safeguarding Board Events
- Identify further safeguarding training for staff where gaps identified
- Understand, identify and manage potential CSE cases
How well did we do it?
KSS CRC safeguarding policies, procedures and practices and currently under review. This review is due for completion at the end of September 2015.

The Deputy Chief Executive and the Operational Directors represent KSS CRC at the Safeguarding Children Boards.

All operational staff have access to Local Safeguarding Board events and all staff are aware of how to check course availability and book. Staff are prompted to attend these events by their line managers and through the weekly Learning and Development bulletin on the intranet.

KSS CRC has a supervision policy which applies to all employees. One to one supervision is provided to all front line staff by their line manager every 4/6 weeks as a minimum.

An internal audit programme is in place which includes case file audits to sample safeguarding practices to be measured against local policies and procedures, currently being updated.

What difference did it make?
Having one designated lead for safeguarding and aligning safeguarding policies, procedures and practices will ensure that all staff are working in the same way across KSS CRC with regard to safeguarding both children and adults.

Internal audits together with SCR’s and SFO reviews offer assurances that these policies and procedures are embedded in practice and highlight areas for development.
Public protection, including safeguarding children, and reducing re-offending are core responsibilities of the CRC and this is reflected in our Business Plan and a multitude of policy, procedural and guidance documents.

Comprehensive risk assessments are undertaken, both in custody and in the community for all of our Service Users and are shared with key partners, together with risk management plans. Home visits enable us to observe Service Users interactions with their families in their home environment and identify and respond to signs of abuse. This could include breach, for those on Community Orders, and recall to custody for those on licence.

In all cases where there are identified risks to children or concerns in relation to potential risk, there is regular management oversight and any change in circumstances should be reviewed by the practitioner and their line manager.

Child Sexual Exploitation training is offered through the Local Safeguarding Children Boards on a regular basis and these events are recommended to all practitioners and managers. LSCB booking process is detailed in each Learning & Professional Development bulletin published by the CRC; line managers are also asked to encourage their staff to attend.

There are a number of tools available on the Intranet for practitioners including:
- Child sexual exploitation toolkit
- Safeguarding Children; Successful Practice
- Working together to Safeguard Children

KSS CRC staff attend child protection meetings including child protection conferences to ensure effective joint working with other agencies to prevent and disrupt child sexual exploitation.
CAFCASS

Cafcass (the Children and Family Court Advisory and Support Service) is a non-departmental public body sponsored by the Ministry of Justice. The role of Cafcass within the family courts is: to safeguard and promote the welfare of children; provide advice to the court; make provision for children to be represented; and provide information and support to children and their families.

Cafcass’ statutory function, as set out in the Criminal Justice and Court Services Act 2000, is to “safeguard and promote the welfare of children”. Safeguarding is therefore a priority in all of the work we undertake within the family courts and the training and guidance we provide to staff reflects this.

Effectiveness of Safeguarding Arrangements

A key focus during 2014/15 was continued improvement following our “good” Ofsted judgement in April 2014. Ofsted summarised that Cafcass consistently worked well with families to ensure children are safe and that the court makes decisions that are in the children’s best interests. The report also highlighted areas where Cafcass should make improvements, and these areas formed a dedicated action plan which we implemented throughout the remainder of the year. An audit in November 2014 assessed that all of the following actions had been met:

- To improve the minority of safeguarding letters which are not yet fit for purpose: this has been met;
- Improve effectiveness of efforts to contact parties. Where sufficient efforts have been made these should be better recorded: this has been met;
- Ensure that in all private law work casework begins as early as possible once a Family Court Adviser (FCA) has been allocated: this has been met;
- Improve the percentage of “good” work in private law work after first hearing (WAFH) in London: this has been met;
- Improve further the analysis in the report to the court and ensure that all relevant information is pulled through in to the report based on research: this has been met.

We are continuing efforts with one further action, to eliminate poor grammar and typographical errors; the percentage of “good” and “met” work in this respect has improved considerably, and we aim to increase this.

Cafcass has a robust programme of internal audits to assure the effectiveness of safeguarding in both public and private law. We provide tools for practitioners to use in self-assessment in order to benchmark the quality of their own work, and these tools are also used by managers and auditors as an evidence base for assessment. Throughout all the tools there is a consistent focus on assessing risk and whether appropriate actions have been taken after the assessment of risk.

Practitioners are supported extensively and scrutinised routinely to ensure the effectiveness of their safeguarding practices. FCAs are encouraged to take responsibility for their own performance, and are provided with the resources to do so via MyWork, an online platform containing performance and workload data. Learning and assessments are consolidated in quarterly Performance Learning Reviews (PLRs), allowing FCAs, with their line managers, to formally assess safeguarding practice and evidence whether service objectives have been met along with effective adherence to policies.
Reports to court are routinely quality assured and practice observations are undertaken, as set out in our Quality Improvement and Assurance Framework. Managers are further assisted by the Performance Management System by strengthening their ability to identify areas requiring improvement, as well as helping to meet the development needs of staff. Actions by practitioners and managers are further scrutinised by senior operational managers via a monthly sample of closed files and the observation of one PLR per manager, per annum.

Further assurance is provided through yearly national audits and our Key Performance Indicators (KPIs). A national audit of practice was undertaken in November 2014 with the objective of providing a snapshot assessment of the standard of casework. The audit measured the progress of work since the audit in September 2013 and the Ofsted inspection of April 2014. The conclusions were positive, reporting the percentage of work graded as “good” at 65%. This represents a significant improvement of 16% from the previous year’s audit.

Our KPIs, set by our sponsor department the Ministry of Justice, measure the proportion of open public law care cases allocated to an appointed children’s guardian, and private law cases allocated to an FCA. Other KPIs measure the timeliness of allocation in care applications and the proportion of private law Section 7 reports that meet their agreed filing times. All of our KPIs are consistently met.

We will undertake three thematic audits in 2015/16, focusing on further improvements required. These will look at the extent of the improvement in the joint working between the Independent Reviewing Officer (IRO) and the Guardian; the Guardian’s involvement and agreement to any position statement filed in proceedings; and evidence in WAFH of the improvement in analysis of assessment and increased use of research and tools.

Alongside our internal methods of quality assurance, we record and disseminate learning identified within service user correspondence, including correspondence received from children and young people. The learning points are fed back to the National Improvement Service (NIS) which maintains a national learning log, updated and disseminated throughout the organisation on a quarterly basis. The learning log sets out clear action plans designed to improve safeguarding practice and systems across the organisation.

Further scrutiny is given to our safeguarding practice and processes by the Family Justice Young People’s Board (FJYPB) comprising young people with direct experience of the family court. The FJYPB contribute to our publications, review our resources for direct work with children, and are involved in the recruitment of frontline staff. Board members also review the complaints we receive from children and young people.

**Number of serious incidents involving children & young people and outcomes from reviewing them**

Cafcass has contributed to 26 Individual Management Reviews (IMRs), requiring a variety of methodological approaches. Of all the child deaths Cafcass has been made aware of from April 2014 – March 2015, in 52% of cases, maltreatment was suspected. This information is collated and managed nationally.
The learning from IMRs is collated and reported in an annual paper, which is disseminated nationally within Cafcass. We also publish externally a redacted version of the report, with a focus on wider learning points within the family justice system.

**Responding to emerging issues**

We continue to respond to, and facilitate, developments within the family justice system and in particular the move, in private law towards supporting parents, where possible, to make safe decisions outside of court proceedings. We are currently piloting a programme announced by the MoJ, to provide advice and to encourage out of court pathways for separating parents, where it is safe to do so. The supporting separating parents in dispute (SSPID) helpline was launched in November 2014. Callers are put through to a Cafcass practitioner who can talk through the difficulties of separation, offering support, guidance, and information. We also ran a six month pilot of a safeguarding advisory support service for mediators, aimed at providing support in cases featuring child protection concerns.

Cafcass is also working on the Parents in Dispute pilot, in partnership with the Tavistock Centre for Couple Counselling. The chief aim of the project is to support separating parents involved in high conflict disputes in the family courts. FCAs in London have been able to recommend that separating parents attend the course in order to help parents to reconsider their behaviour in order to better focus on their children and create positive outcomes for them.

A significant emerging issue in recent years has been child sexual exploitation (CSE). We are implementing a CSE strategy which involves consolidating systems to capture data on CSE in cases known to us; providing mandatory training on CSE to our staff, running workshops to increase awareness; reviewing policy guidance to staff; creating dedicated management time to support the delivery of the strategy at a national level; and creating CSE ambassadors within each service area.

**Partnership working**

Cafcass is committed to joint working, as demonstrated in some of our work recorded above. We continue to work with partners such as the Association of Directors Children's Services (ADCS), the FYJPB and the National Family Justice Board. With ADCS in particular we will continue to work in partnership to identify and share good practice.

Cafcass also plays a strong leadership role at a local level, actively participating in Local Family Justice Boards. Cafcass chairs 10 out of 42 local Family Justice Boards and has a strong leadership role on all others.

**Workforce Development**

The work of our FCAs in family proceedings is challenging, and the family justice system rightly has a high expectation of our staff. This is supported by a robust recruitment process. All FCAs have a minimum of three years post qualifying experience, although most of our staff have many more. FCAs must also maintain their HCPC registration as a condition of employment. When recruiting staff we look for social workers with proven experience in safeguarding, child engagement, inter-agency working, case analysis, planning and recording.
To ensure that our staff are able to safeguard children as best as possible, Cafcass has an extensive workforce development strategy. To begin with, new practitioners attend a core training induction programme comprising four separate days that require completion prior to confirmation in post. This four modules are: the legal basis of Cafcass' work and court skills; casework skills such as planning, recording, assessing and reporting, interview skills when working with conflict and talking to children; and risk and harm in Cafcass.

Thereafter training is delivered by NIS, which is also responsible for supporting operational services through audits and commissioned activities such as 1:1 coaching and mentoring. The national training programme is approved annually by the Corporate Management Team, and senior operational managers can commission from NIS specific training or coaching to meet local need in their service areas.

All staff have access to an online learning environment (MySkills) which hosts information and skills-based courses (core and optional) as appropriate to their roles and identified needs. MySkills is both a source of all training materials and a database for monitoring the take up of training across Cafcass.

Workforce development is also assisted by several other mechanisms. Cafcass commissions at least four pieces of research a year as part of its research programme, as well as subscribing to Research in Practice. The findings from this are disseminated throughout the organisation and incorporated into training. Staff also make extensive use of our in-house Library, with 5722 items provided to staff in 2014/15, and all operational staff can access the professional network as part of our corporate membership of the College of Social Work.
East Sussex Fire & Rescue Service

What have we done
ESFRS has undertaken training specifically covering Child Sexual Exploitation, and the Care Act 2014 for supervisory managers and for key roles. We have also promulgated communications on these topics and Neglect to all ESFRS staff via the Intranet and our Service Brief newsletter. There is ongoing access to Safeguarding Children E-learning packages which are compulsory for all staff and completion is monitored and audited. Two staff within Human Resources have undertaken Safer Recruitment training. “Prevent” training has been rolled out to City Fire crews. Crews have also received Suicide Prevention training conducted by Grassroots Suicide Prevention.

ESFRS continues to make child safeguarding referrals when appropriate which are monitored and audited. Internal scrutiny is provided via an internal panel which meets every 6 months. We continue to work with partners both to increase ESFRS awareness of child safeguarding and to support work in this field via our Home Safety Visits which are aimed at increasing safety in the home. We have appointed a Partnership and Inclusion Coordinator specifically for Brighton and Hove to attend relevant partnership meetings and to increase support.

How well have we done it?
In 2014-5 we made 9 safeguarding referrals for children, 7 in East Sussex and 2 in Brighton and Hove. We have worked with a variety of agencies to promote our Home Safety Visits and ensure we receive appropriate referrals to reduce risk in the home. “Children and Young Families” are a targeted group under our Care Providers Scheme. Our Partnership and Inclusion Coordinator attends the Early Help Hub meetings, Domestic Abuse MARACs, Modern Slavery meetings and the Suicide Prevention Group. We also attended the Community Works Summer Conference themed on safeguarding children and held a stall to increase awareness of ESFRS work within this area. An ESFRS Home Safety Visit is now considered for all families referred into the Integrated Team for Families as part of the referral pathway.

37 supervisory managers and specialist roles undertook centrally run training on Child Sexual Exploitation.

What difference did it make?
ESFRS continues to make safeguarding referrals in a timely manner ensuring these are referred to the correct agency. We have reviewed our internal guidance responding to feedback and changes in legislation to ensure staff have up-to-date knowledge. Referrals for Home Safety Visits received under our Care Providers Scheme relating to Children and Young Families are prioritised for attendance by our trained Community Safety Advisors.
What my agency has done to tackle child sexual exploitation

The ESFRS Safeguarding Children training available to all staff includes training on the identification of different types of Child Sexual Abuse, Child Sexual Exploitation and Neglect. Guidance is issued to staff covering all of these areas. Our education team (of 3 people), who undertake a programme of regular school visits and who also deal with young fire setters, has also undergone more specific training regarding these areas.

We have promulgated communications on Child Sexual Abuse, Child Sexual Exploitation and Neglect to all ESFRS staff via the Intranet and our Service Brief newsletter.

Key staff have received specific training focussing on Child Sexual Exploitation. Some staff have also attended WiSE training at the Moulsecomb safeguarding hub. This included input about online safety.

All staff have been briefed on Modern Slavery including where this may relate to sexual exploitation. ESFRS Fire Safety department now works closely with Sussex Police including undertaking joint operations aimed at tackling modern slavery, and a referral mechanism is in place for ESFRS to report intelligence on Modern Slavery directly.

What my agency has done to tackle child neglect

The ESFRS Safeguarding Children training available to all staff includes training on the identification of different types of Child Sexual Abuse, Child Sexual Exploitation and Neglect. Guidance is issued to staff covering all of these areas. Our education team (of 3 people), who undertake a programme of regular school visits and who also deal with young fire setters, has also undergone more specific training regarding these areas.

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We have promulgated communications on Child Sexual Abuse, Child Sexual Exploitation and Neglect to all ESFRS staff via the Intranet and our Service Brief newsletter.
Conclusion and Challenges for 2015-16

2014-15 has been a busy year for the LSCB and it is hoped that this report has provided readers with an assessment of the effectiveness of local arrangements to safeguard and promote the welfare of children. The report demonstrates safeguarding activity is progressing well in the area and that Brighton & Hove LSCB has a clear consensus on the strategic priorities achieved and what actions need to be taken forward over the coming year. The LSCB is aware of, and working to fulfil, its statutory functions under the revised Working Together to Safeguard Children (2015). Detail in agencies reports, starting on page 68, demonstrates that statutory and non-statutory members are consistently participating towards the same goals in partnership and within their individual agencies.

You will have read within the report that whilst the Board has no service delivery functions it has informed (through its co-ordination and effectiveness responsibilities) the commissioning intentions of partner agencies and has, throughout the year, monitored, quality assured and evaluated the quality and effectiveness of the services commissioned and delivered in the City.

Embedding and sustaining best practice at the front line 24/7 and 365 days each year, across the agencies, presents considerable on-going challenge and commitment, particularly in the current financial and organisational context. This requires a high degree of multi-agency collaboration at every level.
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Appendix 2: Local Safeguarding Children Board Members as of March 2014

Statutory Members:
Graham Bartlett, Independent Chair of LSCB

Brighton & Hove City Council (BHCC):
Pinaki Ghoshal, Director of Children’s Services
Helen Gulvin, Acting Assistant Director Children’s Services: Children’s Health, Safeguarding & Care
Jo Lyons (Dr), Assistant Director Children’s Services: Education & Inclusion
Linda Beanlands, Head of Community Safety

Sussex Police
Paul Furnell (D/Supt)

National Probation Trust
Andrea Saunders, Director of Public Protection

Kent Surrey & Sussex Community Rehabilitation Company
Nicola Maxwell, Resettlement Director

Youth Offending Service
Anna Gianfrancesco, Head of Service

CAFCASS
Nigel Nash, Service Manager

East Sussex Fire & Rescue Service
Andy Reynolds, Director of Prevention & Protection

NHS England
Katrina Lake (Dr)

Brighton & Hove Clinical Commissioning Group (CCG):
Soline Jerram, Director of Clinical Quality and Primary Care
Jamie Carter (Dr), Designated Doctor
June Hopkins, Designated Nurse
Mary Flynn (Dr), Named Doctor (GP representative)

NHS Trusts
Sherree Fagge, Chief Nurse, Brighton & Sussex University Hospitals (BSUH)
Susan Marshall, Chief Nurse, Sussex Community Trust (SCT)
Helen Greatorex, Executive Director of Nursing & Quality, Sussex Partnership Foundation Trust (SPFT)
Jane Mitchell, South East Coast Ambulance Service Safeguarding

Schools
Wendy Harkness, Head Teacher, West Hove Infants
Haydn Stride, Head Teacher, Longhill Secondary
Wendy King, Head Teacher, Bevendean Primary School

Domestic Violence Forum
Gail Gray, Chair, Brighton & Hove Domestic Violence Forum

Community & Voluntary Sector
Terri Fletcher, Director, Safety Net

Lay Members
Andrew Melrose (Professor)
Ella Richardson
Lorna Miller-Cooper
Signe Gosman
Stephen Terry (Rev).
Advisors:
- Ann White (Dr) Named Doctor, SCT/BHCC
- Carwyn Hughes (DCI) Protecting Vulnerable People Branch, Sussex Police
- Deb Austin Head of Safeguarding, BHCC
- Debi Fillery Named Nurse, BSUH, NHS Trust
- Eddie Hick Child Protection and Safeguarding Manager, Sussex Police
- Helen Davies Independent Safeguarding Consultant, Chair LSCB Monitoring & Evaluation Sub Committee
- Leonie Perera (Dr) Named Doctor, BSUH, NHS Trust
- Mia Brown Brighton & Hove LSCB Business Manager
- Natasha Watson Managing Principal Lawyer, BHCC
- Rebecca Conroy Principal, City College
- Sue Shanks (Cllr) Lead Member, BHCC Children’s Services
- Tom Scanlon Director of Public Health
- Yvette Queffurus Named Nurse – Safeguarding, SCT/BHCC

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<th>Representation at LSCB Meetings 2013-14&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Representation at LSCB Meetings 2014-15</th>
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</thead>
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<tr>
<td>Brighton &amp; Hove City Council</td>
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<tr>
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<tr>
<td>CAFCASS</td>
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<sup>a</sup> Average of statutory members from the agency attending or sending an appropriate delegate to all six LSCB meetings during 2014-15
Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. **Primary Care in Brighton and Hove**

1.1 This paper can be seen by the general public.

1.2 20th October 2015


2. **Summary**

2.1 The attached paper describes the configuration of primary care services in the City, in particular it outlines:

- The number of practices within the city:
- The emerging model for General Practice to work under a more collaborative city-wide structure from 6 sub-locality based clusters;
- The range of contractual agreements NHS England have with local practices;
- Findings from national surveys on satisfaction levels with local services and working conditions within General Practice;
- Look back at the recent closure of two practices: Goodwood Court and Eaton Place, factors leading up to these closures, the subsequent action taken by NHSE and the CCG and lessons learned;
- Other vulnerable practices in the City and ongoing action;
- The strategic direction for primary care services as set out nationally in the “Five Year Forward View”:
• How we are transforming primary care locally through a new collaborative model of clustering and investment in Locally Commissioned Services;
• How our practices currently fare against national outcome domains ie: preventing people from dying prematurely, enhancing the quality of life for people with long term conditions and ensuring people have a positive experience of care.

3. **Decisions, recommendations and any options**

3.1 That the Health and Wellbeing Board note the content of the report.

4. **Relevant information**

4.1 NHS England holds contracts directly with General Practices in the City for the delivery of core general medical services.

4.2 NHS England, the CCG and City Council can “top up” core contracts with a range of Locally Commissioned Services over and above general medical services.

4.3 The CCGs as a membership organisation is required to support general practices around improving the quality of care. A quality report on General Practice in the City is produced for the CCG’s bi-monthly Governing Body.

5. **Important considerations and implications**

Legal

5.1 There are no legal implications arising from this report.

Finance

5.2 There are no financial implications arising from this report.

Equalities

5.3 There are no specific equality issues for consideration arising from this report.

Sustainability

5.4 There are no specific sustainability issues in relation to this report.
5.5 Promoting public health and wellbeing and addressing inequalities in health are specifically addressed in the attached document.

6 **Supporting documents and information**

6.1 A report entitled “Strengthening Primary Care Services in Brighton and Hove” is attached.
Strengthening Primary Care Services in Brighton and Hove
1 Executive summary

General practice is the bedrock of healthcare and local GP surgeries in Brighton and Hove and other parts of the country provide valuable services to their patients’ day in day out.

Yet these services face a number of challenges. We need to transform the way care is provided in order to address these issues, and to ensure the future delivery of good quality care to patients in a sustainable way.

Across the country, these challenges include:

- An ageing population and an increasing number of patients with complex care needs and multiple long-term conditions, who require more intensive support from GP services
- Increasing pressure on NHS financial resources
- Dissatisfaction amongst patients about the ability to access GP appointments and rising patient expectations about this.
- Variation in the quality and performance of local services and health inequalities
- Growing reports of workforce pressures, including recruitment and retention problems

A clear national strategy for the future of the NHS has been set-out in the NHS Five Year Forward View and this includes plans to address the principal challenges facing GP services. Action is being taken to address workforce and infrastructure issues and changes to the national GP contract have also been made in order to support improvements to patient care. Meanwhile, work is taking place across the country to test potential new models of care, so that services can be designed which will meet the needs of patients, both now and in the future.

In Brighton and Hove, NHS England and NHS Brighton and Hove Clinical Commissioning Group (CCG) are continuing to work together to address these challenges at a local level and to ensure the ongoing development of sustainable GP services for people in the community.

This paper provides an update on some of the recent challenges that have affected the provision of GP services in Brighton and Hove and how services are being developed for the benefit of local patients.
2 Overview of primary care services in Brighton and Hove

2.1 Number of GP practice contracts across Brighton and Hove

Across Brighton and Hove there are currently 46 GP practices, providing services to 308,847 registered patients across 52 surgery sites. Of these, all practices currently have ‘open’ patient lists and can register new patients.

The current Primary Care budget for general practice in Brighton & Hove is £34,678,045.

There are three different types of contract held by local GP practices. These are:

- **General Medical Services (GMS) contracts.** GMS contracts are nationally negotiated. These contracts run in-perpetuity and provide GP contractors with considerable flexibilities in terms of being able to take on new GPs as partners to the contract. This allows GMS contracts to be handed on from one GP or group of GPs to another, without this requiring the agreement of NHS England as the commissioner (subject to the individuals meeting certain conditions as set out in the national GMS regulations). GMS contracts can only be terminated by the commissioner should there grounds to do so (i.e. fundamental concerns regarding patient safety). GMS contracts cannot be held by public limited companies (PLCs). Across Brighton and Hove 41 GP practices hold GMS contracts.

- **Personal Medical Services (PMS) contracts.** These are locally negotiated contracts between NHS England and local GP practices which allow local flexibility compared to the nationally-negotiated GMS contract. PMS contracts allow the opportunity for variation in the range of services that may be provided by a GP practice, while also ensuring that the core services as required by the national GMS contract are also provided. A total of 130 practices across the South East hold a PMS contract. PMS contracts can be ended by NHS England as appropriate (for example if a GP practice is no longer able to provide the agreed additional services under the contract) and in such cases a standard period of notice would be given to the GP/GPs who held the contract. However, the GP contractor would then be entitled to revert back to holding a standard GMS contract in such circumstances, although this would not apply if the contract had been ended due to fundamental concerns about patient safety. PMS contracts cannot be held by PLCs.

- **Alternative Provider of Medical Services (APMS) contract.** APMS contracts vary from GMS and PMS contracts in two key ways. Firstly, they can be held by any form of entity (including PLCs, local GPs and GP consortiums and third sector organisations). Secondly they are for a fixed-term period. There is one GP practices in Brighton and Hove who currently holds an APMS contract. This is the contract for services at Brighton Station Health Centre, which covers both services for registered patients and walk-in services.
2.2 Patient satisfaction with local GP services

According to the latest GP survey results (published in July 2015):

- **85% of patients in Brighton and Hove rated their overall experience of using local GP services as good**, while **5% of patients rated services as poor**. This is in line with national findings from the survey.

- **88% of patients said the last time they wanted to speak to, or see, a GP or a nurse they had been able to get an appointment to see or speak to someone**. However, **9% of patients said they had not been able to do so**. This compared to **85% of patients nationally who said they had been able to get an appointment to see or speak to someone and 11% of patients nationally who hadn’t been able to do so**.

- **59% of patients in Brighton and Hove said they didn’t feel they normally had to wait too long for an appointment**, while **32% felt they did have to wait too long**. This compared to **58% of patients nationally who felt they didn’t have to wait too long for appointment and 35% who felt they did have to wait too long**.

- **73% of patients in Brighton and Hove were satisfied with the opening hours at their GP practice, while 11% weren’t satisfied**. Nationally, **75% of patients were satisfied and 10% weren’t**.

The findings above are based upon answers from 4,753 patients.

3 National Survey of General Practice

Another national survey of General Practitioner (GP) working conditions and attitudes to primary care reforms has been undertaken every three years by the University of Manchester since 1998. The most recent survey was undertaken in the summer of 2015 and the results have just become available. These surveys provide a consistent series over a long period on GP job satisfaction, stressors, hours of work and intentions to quit. Highlights from this year’s survey reveal:

**Job satisfaction**

The level of overall job satisfaction reported by GPs in 2015 was lower than in all surveys undertaken since 2001. On a seven-point scale (‘extremely dissatisfied’ (=1) to ‘extremely satisfied’ (=7)), average satisfaction had declined from 4.5 points in 2012 to 4.1 points in 2015 in the cross-sectional samples and by a similar magnitude in the longitudinal sample. The largest decreases in job satisfaction between 2012 and 2015 were in the domains relating to ‘hours of work’ and ‘remuneration’. Satisfaction with colleagues and fellow workers had improved relative to 2012.

**Hours of work**

Respondents to the 2015 survey reported working an average of 41.4 hours per week. This is a small (0.3 hours) decrease compared to the 2012 survey. Fewer GPs reported that their practice offered extended hours access at the weekend (31%
versus 32%) and on weekdays (72% versus 76%) than in 2012. The reported proportion of time (62%) devoted to direct patient care was the same as in 2012.

**Stressors and job attributes**

In 2015, GPs reported most stress due to ‘increasing workloads’ and ‘changes to meet requirements of external bodies’ and least stress due to ‘finding a locum’ and ‘interruptions from emergency calls during surgery’. Reported levels of stress increased between 2012 and 2015 on all 14 stressors. The increases were generally in the range 0.2 to 0.5 points on a five-point scale. Reported levels of stress are now at their highest since the beginning of the National GP Worklife Survey series in 1998.

Many attributes of GPs’ jobs had changed very little between 2012 and 2015. In 2015, the proportion of respondents reporting that they ‘have to work very intensively’ was 95%. Eight-nine percent of respondents reporting that they ‘have to work very fast’. Fewer than 10% of respondents thought that ‘recent changes to their job had led to better patient care’.

**Intentions to quit**

The proportion of GPs expecting to quit direct patient care in the next five years had increased from 8.9% in 2012 to 13.1% in 2015 amongst GPs under 50 years-old and from 54.1% in 2012 to 60.9% in 2015 amongst GPs aged 50 years and over.

**Conclusions**

The 2015 results continue the trends observed in recent waves of the National GP Worklife Survey. The 2015 respondents reported the lowest levels of job satisfaction amongst GPs since before the introduction of their new contract in 2004, the highest levels of stress since the start of the survey series, and an increase since three years ago in the proportion of GPs intending to quit direct patient care within the next five years.

4 Closure of Eaton Place Surgery and Goodwood Court GP practice

Over the last nine months there have been two GP practice closures in Brighton and Hove, both for different reasons outside the control of NHS England and which required a swift response to ensure patients continued to have access to care.

4.1 Eaton Place Surgery

Colleagues will remember that Eaton Place Surgery closed in February 2015, after the retirement of the practice’s two GP partners.

Following notification by the GP partners of their intention to resign from the contract NHS England undertook an options appraisal.

This involved looking at the following:

- Availability of the surgery premises
• Capacity within the local area amongst other local GP practices
• Availability of patient choice

The options appraisal identified that there was sufficient capacity across other GP practices in the local area to register all affected patients. It was also determined that there were no suitable premises available from which patients could be treated from following the end of the contract with the GP partners at Eaton Place Surgery. Without surgery premises available it was not possible to issue a new contract to another provider to deliver patient care within the required timescales.

The unavoidable decision was therefore taken to ask affected patients to register with other local GP practices, in order to guarantee their ongoing access to GP services once the Eaton Place Surgery practice contract ended.

4.2 Goodwood Court Medical Centre GP practice

Colleagues will be aware that the Goodwood Court Medical Centre GP practice closed in June 2015, after the Care Quality Commission (CQC) took unprecedented action to remove the practice’s registration with the regulator. This was in order to protect the safety and welfare of patients following the findings of a CQC inspection at the practice.

NHS England shared concerns with the CQC that Goodwood Court Medical Centre was failing to provide essential services to its patients, so that the CQC could investigate this as the independent regulator of health services.

The CQC’s investigations confirmed the concerns that the practice was not providing an acceptable service to patients. The extent of the concerns were significant enough that it was felt by the Care Quality Commission (CQC) and NHS England that immediate action was required in order to protect patient safety.

The CQC’s findings were published at the end of August 2015 and are available on the CQC’s website at http://www.cqc.org.uk/location/1-614976812.

NHS England subsequently agreed an interim contract with doctors from the Charter Medical Centre to ensure ongoing care could be provided to affected patients following the closure of the Goodwood Court practice.

The need to secure immediate access to alternative care for patients meant that there was unfortunately limited scope to engage with patients and other stakeholders in determining the nature of these short-term arrangements.

There is now the opportunity for further work to take place to determine how best to meet the needs of these patients in the longer term.

The current arrangements with Charter Medical Centre, for the care of former Goodwood Court patients, are due to come to an end on 31 March 2016. NHS England will be seeking the views of patients and other local stakeholders as part of a review to determine longer term options for the care of these patients.
Our priority continues to be to ensure that all affected patients have continued access to local GP services and letters will be sent to patients and local stakeholders about this shortly.

4.3 Lessons learned

In both the case of Eaton Place Surgery and the Goodwood Court GP practice, NHS England secured alternative care arrangements for patients, to ensure they were not left without access to services.

We have however drawn a number of lessons from managing these issues, which we will take into account in any future work regarding the development of local GP services. These lessons include:

- **Contract reviews:** NHS England have instigated more thorough contractual review processes for practices where concerns about the provision of services have been highlighted, so that we can work with local partners to ensure these issues are addressed by practices.

- **Communication:** It is essential that our communication with stakeholders and patients is timely, consistent and provides reassurance to patients about any concerns they have regarding access to services. We have identified that the early establishment of frequently asked questions and answers for patients can help ensure they have consistent and practical advice available to them if significant changes are occurring at a local GP practice.

- **Engagement:** One of the key lessons learnt has been the need to improve our engagement process with both patients and stakeholders. Where NHS England needs to make any significant commissioning decisions about changes to the way local GP services are provided (for example in response to a single-handed GP retiring from their practice) we will give both patients and local stakeholders the opportunity to feed into the decision making process, so that we can take their feedback into account before any final decision is made about how to provide future patient care. This will ensure the best possible understanding of all local issues and concerns. In cases where urgent action is required to put in place changes to local services (for example where action is needed on the grounds of patient safety) we will seek patient views where this is possible.

- **Improved joint working:** Ongoing close working with a range of partner organisations is key to ensuring the best outcome for patients. This includes close working with other local GP practices to ensure consistent help and advice is provided to local patients. Following the closure of the Goodwood Court GP practice, other local GP practices supported Charter Medical Centre in their application to secure the interim contract to provide care for Goodwood Court patients.
5 Current issues regarding the provision of GP services in Brighton and Hove

5.1 Burwash Road Surgery

The Benfield Valley Healthcare Hub had to temporarily close their Burwash Road Branch Surgery in Hove during the summer, due to concerns regarding rodents entering the surgery premises. During this time, patients were offered appointments at the practice’s County Clinic surgery in Portslade.

These issues at the Burwash Road Surgery have since been resolved and the branch surgery has been reopened. We are however aware that the practice has experienced some recent problems with securing locum GP cover at the branch surgery and that this has had some impact on services.

It is the responsible of individual GP practices to ensure they have sufficient staff available to meet the needs of their patients, but NHS England will continue to monitor the situation to make sure patients are being provided with appropriate care.

5.2 The Practice Willow House

We are aware that The Practice Group Plc, which manages services at The Practice Willow House in Lower Bevendean, has been in discussions with the landlord of the surgery premises about his plans to develop the site. The landlord has been seeking to do this for a number of years, intending to replace the current building with another GP surgery and residential accommodation. The Council has given planning permission for the proposals, on the basis that a ‘surgery’ is still at the site. However, the planning permission does not specifically state whether this refers to having a GP surgery.

The practice is in ongoing discussions with the landlord about the level of rent that would apply to the use of the new surgery space that he is proposing. Any increase in rent would mean an increased financial commitment by the NHS to fund the use of the building. If the practice were to approach NHS England for any additional funding for the premises this would therefore need to be subject to formal consideration, in order to ensure value for money and to make sure patient needs are met.

We have asked The Practice Group Plc to keep us updated about discussions with their landlord, so that we can ensure the needs of their patients continue to be met. In addition to this the practice have worked with NHS England on a Business Continuity Plan to ensure that services can and will continue should the premises become unavailable.
6 Developing sustainable local GP services

6.1 The NHS Five Year Forward View

We need to change the way we deliver care to patients, in order to ensure sustainable services that will meet their needs – both now and in the future.

The NHS Five Year Forward View, published on 23 October 2014 by NHS England, sets out a vision for the future of the NHS, including how we can build a firm foundation for the future of local GP services. It was developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

The purpose of the Five Year Forward View is to articulate why change in the NHS is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. Everyone will need to play their part to realise the potential benefits, including system leaders, NHS staff, patients and the public.

The Five Year Forward View highlights that the traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need. Increasingly we need to manage systems – networks of care – not just organisations.

As such, the NHS of the future needs to be characterised by:

- Out-of-hospital care that is a much larger part of what the NHS does.
- Services which are integrated around the needs of patients. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.
- Applying rapid learning from the best examples, not just from within the UK but internationally.
- Evaluation of new care models to establish which produces the best experience for patients and the best value for money.

With specific reference to general practice, the Five Year Forward View sets out a number of steps to help achieve sustainable services. Some of these key steps are listed below.
NHS will continue to work with NHS Brighton and Hove Clinical Commissioning Group (CCG), GP practices and other partners to determine how local GP services can be developed and shaped to best meet the needs of local patients.

Most change will be led and shaped locally by GP practices themselves, in conjunction the CCG and in dialogue with partners in the local community. NHS England will play a key role in shaping and enabling this change to take place, but sustainable change will need to be clinical led and locally owned.

6.2 Stabilising core funding for GP services

The NHS Five Year Forward view confirms that NHS England will work with partners to seek to stabilise core funding for general practice nationally over the next two years, while an independent review is undertaken of how resources are fairly made available to support primary care in different areas.

6.2.1 Review of Personal Medical Services (PMS) contracts

Work has also been taking place across the country, including in Brighton and Hove, to review the use of Personal Medical Services (PMS) contracts for the provision of local GP services. This is in order to ensure equitable funding for all local practices for the provision of core services.

PMS contracts were formalised in 2004 and provide a range of mandated services, as well as services which can go beyond standard requirements (for example this might include the provision of diagnostic testing or specialist clinics by GP practices). These additional services can attract extra funding for GP practices, which is negotiated locally, but across the country this extra investment has historically not always been clearly linked to extra or higher quality patient services.

The aim of the PMS contract review is to ensure any extra funding above and beyond what an equivalent practice on a General Medical Services (GMS) contract would receive is linked to providing extra services.

This is part of work to ensure that every GP practice in the country should receive the same core funding for undertaking core work, and that any additional funding for additional services is agreed with local commissioners, against a set of consistent principles and criteria.

National guidance confirms that where local reviews identify that additional PMS funding is failing to deliver better care to patients, then this funding should be made available for reinvestment in general practice services within the immediate local area. Any changes to funding should be paced over a minimum of four years to ensure local services have time to adapt and develop.

We want to ensure that PMS funding in Brighton and Hove is aligned to services for patients and local strategies to improve patient care. Where this isn't the case, we need to ensure funding is reinvested to where it is needed to help transform local general practice services.
We will work closely with NHS Brighton and Hove Clinical Commissioning Group (CCG) in regards to this, with the CCG able to reinvest any funding in accordance with the needs of local GP services.

There are five practices in Brighton and Hove who hold a PMS contract. We will ensure no local practice is unfairly disadvantaged and we recognise the need to balance any reinvestment of funding with the need to manage this in a way that doesn't adversely impact on practices and patients.

We have recently written to these local GP practices about the process for the review and will continue to work with the CCG throughout this process.

### 6.3 Give local clinical commissioning groups more influence

It is intended to give GP-led clinical commissioning groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute care to primary and community services.

The introduction of co-commissioning is an essential step towards expanding and strengthening primary medical care services, helping to drive up quality, reduce health inequalities and put the NHS on a sustainable path for the future.

Co-commissioning recognises that CCGs are harnessing clinical insight and energy to drive changes in their local health systems that have not been achievable before now, but that they are also hindered from taking a holistic and integrated approach to improving healthcare for their local populations, due to their lack of say over the commissioning of primary care services. Co-commissioning will be a key enabler in developing integrated out-of-hospital services based around the needs of local communities. It will also drive the development of new models of care.

In May 2014, NHS England invited clinical commissioning groups (CCGs) to come forward with expressions of interest to take on an increased role in the commissioning of GP services.

Across the South East area, two of the 20 CCGs (Eastbourne, Hailsham and Seaford CCG and High Weald, Lewes Havens CCG) were subsequently granted delegated responsibility for the commissioning of GP services.

The remaining CCGs have been invited to submit their proposals for either entering into joint commissioning arrangements, or taking on delegated responsibility for commissioning GP services, by early October 2015. Should their applications be supported then these arrangements would take effect from 1st April 2016.

Any CCGs that do not submit proposals to change their status, or whose proposals are not supported, will retain their existing advisory role with regards to the commissioning of local GP services.
During August 2015, NHS Brighton and Hove CCG consulted its member practices, patients and the public about their view as to what the CCG’s approach to co-commissioning should be locally, ahead of a formal vote by the CCG’s member practices at a meeting on Tuesday 29 September. Member Practices voted on 29th September for no change to existing arrangements.

6.4 Funding to support new ways of working and to improve access to services

6.4.1 Brighton and Hove Primary Integrated Care Scheme

Funding, through schemes such as the Prime Minister’s Challenge Fund, is also being used across the country to support new ways of working and to improve patient access to services. The scheme has supported over 50 schemes to date across the country, testing a variety of ideas to offer better access to services and appointments for patients, including through offering evening and weekend opening hours and the use of new technology such as Skype to support patient consultations.

In Brighton and Hove, the Prime Minister’s Challenge Fund supported the introduction of a ‘community navigator’ scheme for patients who may be isolated and require health guidance rather than medical care. This has been part of the Extended Primary Integrated Care (EPIC) scheme delivered by the Brighton Integrated Care Service (BICS).

Working with voluntary care organisations, Age UK and Impetus, trained community navigators provide support for people with complex needs in community setting, particularly those living on their own. They are helping to signpost individuals to third and voluntary sector organisations, and other local resources, to meet their needs.

Sixteen GP practices working with local pharmacies also established four ‘primary care clusters’ (covering over 125,000 patients) in order to give patients a more responsive and flexible service. Under the scheme, appointments are available from 8am to 8pm Monday to Friday and from 8am to 2pm at the weekends, taking place either at a GP practice, in a pharmacy, or at a patient’s home. Pharmacists have access to the patient’s medical record, to ensure they can carry out effective consultations.

6.4.2 New branch surgery in Whitehawk

NHS England has also approved funding to support Ardingly Court Surgery to open a new branch surgery at Wellsbourne Health Centre on Whitehawk Road.

The new branch surgery at Wellsbourne Health Centre, which opened in September, is initially providing appointments four mornings a week. The practice has said that they will keep opening hours under review as more patients register with them.

This new service will help increase the capacity of local GP services in this area of Brighton and Hove, where there are health inequalities.
6.5 Addressing workforce challenges

Across the country, including in Brighton and Hove, local GP services face workforce challenges.

The Five Year Forward View sets out the need to expand as fast as possible the number of GPs in training, while also training more community nurses and other primary care staff. There is also a need for increased investment in new roles, and in returner and retention schemes, ensuring that current rules are not inflexible and putting off those health professionals considering a potential return to general practice.

At a national level, NHS England, Health Education England (HEE), The Royal College of General Practice, and the British Medical Association’s GP Committee are all working together to ensure that we have a skilled, trained and motivated workforce in general practice.

6.5.1 The New Deal for General Practice

All four organisations have jointly developed a new GP workforce action plan called ‘Building the Workforce – The New Deal for General Practice’. This is a 10-point action plan, with three broad areas of action around recruitment, retention and returning to general practice. Initiatives set out in the plan to expand the general practice workforce across the country include:

- **To recruit newly trained doctors into general practice** in areas that are struggling to recruit. They will be incentivised to become GPs by offering a further year of training in a related clinical specialty of interest such as paediatrics, psychiatry, dermatology, emergency medicine and public health. This work will be underpinned by a national marketing campaign aimed at graduate doctors to highlight the opportunities and benefits of a career in general practice. Alongside this, pilot training hubs based in GP practices will be established in areas with the greatest workforce needs to encourage doctors to train as GPs in these areas. They will also enable nurses and other primary care staff to gain new skills.

- **To retain GPs** the national plan includes establishing a new scheme to encourage GPs who may be considering a career break or retirement, to remain working on a part-time basis. It will enable practices to offer GPs the opportunity to work with a modified workload and will be piloted in areas which have found it more difficult to recruit. There will also be a wider review of existing ‘retainee’ schemes.

- **To encourage doctors to return to general practice** Health Education England and NHS England will publish a new induction and returner scheme, recognising the different needs of those returning from work overseas or from a career break. There will also be targeted investment to encourage GPs to return to work in areas of greatest need, which will help with the costs of returning to work and the cost of employing these staff.
NHS England is investing £10 million of funding to kick start the initiatives in the plan, which will complement work that is already underway to strengthen the GP workforce and will ultimately benefit all areas, including Brighton and Hove.

6.5.2 Engaging clinical pharmacists in the delivery of GP services

As part of work to deliver the 10-point workforce plan for general practice, NHS England also launched a new £15 million national programme on 7 July 2015, designed to engage clinical pharmacists in the delivery of GP services.

Many GP practices already have clinical pharmacists in patient facing roles and the intention is to invest at least £15 million over the next three years to test out extending the responsibilities of their jobs, beyond any current ways of working. GP practices have suggested that this extended role could include the management of care for people with self-limiting illnesses and those with long term conditions and have asked that the new team members have the ability to independently prescribe.

It is anticipated that around 250 clinical pharmacists will be involved in testing these new ways of working over the three-year period, with the ambition of supporting over 1 million patients. The pilot will be evaluated so that successes and learning can be shared and the expectation is that GP practices would continue to support the role of clinical pharmacists after the three-year period of national funding has ended.

Practices, including those in Brighton and Hove, are being invited to bid to take part in the pilot scheme and are strongly encouraged to work together on joint bids, involving pharmacists across a number of surgery sites.

5.3.3 Local Community Education Provider Networks (CEPN)

Across the South East, Community Education Providers Networks (CEPNs) have been also established in each of the 20 local clinical commissioning group (CCG) areas, including in Brighton and Hove.

The purpose of the CEPN is to facilitate educational networks between GP practices, with GP and primary care workforce tutors offering support in education, training and workforce planning. This provides an important local foundation through which to address the workforce challenges facing general practice, with partnerships involving Health Education England, NHS England, CCGs, GP practices and various professions.

6.6 Use of funding to improve primary care infrastructure

6.6.1 National GP Infrastructure Fund

NHS England will be investing an extra £1 billion into general practice infrastructure over a four year period commencing 2015/16, in order to support patient care. The national GP Infrastructure Fund will see £250 million a year, every year, invested over a four year period.
The first tranche of £250m is being used to improve premises, help GP practices to harness technology and give practices the space to offer more appointments and improved care for frail, elderly patients – which is essential in supporting the reduction of hospital admissions. It will also lay the foundations for more integrated care to be delivered in community settings.

For the first year of funding, GP practices were invited to submit bids in relation to making improvements to existing surgery buildings or the creation of new ones. In the first year it is anticipated that the money will predominantly accelerate schemes that were already in the pipeline, bringing benefits to patients more quickly. Practices were asked to set out proposals that would provide them with more capacity to do more; provide value for money; and improve access and services for the frail and elderly.

5.6.2 New premises for Wish Park Surgery in Hove

Patients of Wish Park Surgery in Hove will now be able to benefit from a better, more modern environment after the GP practice moved into new purpose-built premises at the end of August 2015. The practice, which was previously located in a converted residential property on New Church Road, is now providing services to patients from their new surgery just a short walk away at 191 Portland Road.

The new GP surgery premises are part of a wider development on the site of the former Gala Bingo Hall, with a local pharmacy also set to provide services to patients there alongside Wish Park Surgery. Due to the extra space at the new surgery there is also the potential for the practice to deliver additional services for patients in the longer term.

In addition, the new surgery premises provides improved physical access for patients, including disabled patients, with services now located on a single level.

6.7 New models of care

There is a need to transform the way we provide services to patients, in order to ensure the NHS can continue to meet their needs in the future.

Although it is expected that many smaller GP practices will continue in their current form, it is recognised that primary care is entering the next stage of its evolution.

Primary care services of the future will build on the traditional strengths of GPs as ‘expert generalists’, proactively providing services for patients with complex ongoing needs, such as the frail elderly or those with chronic conditions, and working much more intensively with them. Future models of care will expand the leadership of primary care to include nurses, therapists and other community based professionals. It could also offer some care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients.
However, England is too diverse for a 'one size fits all' care model. Different local health communities will instead be supported to adopt the approach which will work best for their patients.

The NHS Five Year Forward View points towards two new models of primary care provision which local areas could consider adopting in order to develop sustainable local services which will allow them to provide a wider range of care to their patients 1) the multi-speciality community provider and 2) primary and acute care systems.

6.7.1 Multi-speciality Community Provider

This option will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care providers, to create a system of integrated out-of-hospital care for local patients. These Multispecialty Community Providers (MCPs) would become the focal point for the provision of a far wider range of care and early versions of this model are emerging in different parts of the country.

Three GP practices across Whitstable and Canterbury were successful in applying to become one of only 29 sites across the country to test this new model of care by forming a Multi-speciality Community Provider service.

The establishment of Multispecialty Community Providers could provide the following potential future opportunities to improve patient care:

- These providers could in future begin employing hospital consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff.

- GP practices working as part of these providers could transfer the majority of outpatient consultations and ambulatory care out of hospital settings.

- These providers could potentially take over the running of local community hospitals, which could substantially expand their diagnostic services for patients, as well as other services such as dialysis and chemotherapy.

- GPs and specialists in the group could be given authority in some cases to directly admit their patients into acute hospitals.

- In time, Multi-speciality Community Providers could take on delegated responsibility for managing the health service budget for the patients registered with their GP practices. Where funding is pooled with local authorities, a combined health and social care budget could be delegated to Multispeciality Community Providers, so that they could determine how best to meet the needs of their patients.
• These new models would also draw on the support of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours.

6.7.2 Primary and Acute Care Systems (PACs)

Another new model being explored nationally to support the delivery of more integrated care to patients is to combine GP practice and hospital services for the first time through the development of new Primary and Acute Care Systems. This will allow single organisations to provide NHS GP and hospital services, together with mental health and community care services.

The leadership to bring about these ‘vertically’ integrated Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies.

• In some circumstances – such as in deprived urban communities where local general practice is under strain and GP recruitment is proving hard – hospitals could be permitted to open their own GP surgeries with registered lists. This would allow the investment powers of NHS foundation trusts to kick start the expansion of new style primary care in areas with high health inequalities. Safeguards would be needed to ensure that they do this in ways that reinforce out-of-hospital care, rather than general practice simply becoming a feeder for hospitals still providing care in the traditional ways.

• In other circumstances, the next stage in the development of a mature Multi-specialty Community Provider (see section above) could be that it takes over the running of its main district general hospital.

• At their most radical, Primary and Acute Care Systems could take accountability for the whole health needs of a registered list of patients, under a delegated, capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.

Primary and Acute Care System models are complex in their nature and will take time and technical expertise to implement. As with any new model there are also potential unintended side effects that will need to be managed.

The intention therefore is to pilot these in a small number of areas across the country to test these approaches with the aim of developing prototypes that work, before promoting the most promising models for adoption by the wider NHS.

Learning from work that is taking place to test these new models of care nationally will be used to inform the ongoing development of services in Brighton and Hove.
6.8 Local Plans for More Resilient and Integrated Primary Care Services

Locally General Practices are being encouraged to work more collaboratively as a single entity across the City to ensure equity and to provide more resilience at local practice level.

Under a new Locally Commissioned Service offer to General Practice called “Proactive Care” – part of the Better Care Programme, the CCG is investing approx. £2.5m in supporting practices to form collaborate clusters – serving populations of approximately 50,000 and to:

- proactively identify patients who are frail or vulnerable via a new city wide risk stratification tool;
- meet regularly as part of a multi-disciplinary team to oversee and better co-ordinate care around patients;
- deliver a new model of care for frail people which addresses their needs more holistically and provides and enhanced level of personal support through care coaches and more formal engagement of the third sector;
- share resources more effectively within clusters – eg pharmacists based within each cluster to help patients better manage their medicines, care navigators who can signpost registered patients to more preventative care and social support;

Clusters of practices have developed Memorandums of Understanding detailing how they will work more formally together, share resources, ensure robust clinical governance arrangements etc and also how clusters will come together under a city-wide Steering Group.

Once the cluster working and proactive care LCS has bedded in we will be extending the LCS offer and investing more substantially in primary care. Our aim is to take a more preventative and population health approach and agree a contract which is more outcome focused and addresses the variations in health access and outcomes across the City. The CCG are working collaboratively with Public Health on this enhanced LCS offer to practices which we hope to roll out from 2016/17.

7. Ensuring the quality of local primary care services

NHS England’s vision is to see general practice play an even stronger role in supporting people to keep in good health, as part of a wider joined up system of local health services at the heart of local communities.

As such, it is vital that all GP practices provide the best possible care to all patients, to the highest standards.

Last year, the Care Quality Commission (CQC) began a programme of work to inspect and rate every GP practice in England. This helps ensure the appropriate
checks are in place for GP practices, enabling us to make sure patient care is of a high quality and so any issues can be identified and addressed where improvements are required.

To date, the CQC has published findings of its inspections of the following Brighton and Hove GP services:

<table>
<thead>
<tr>
<th>Name of surgery</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pavilion Surgery</td>
<td>Good</td>
</tr>
<tr>
<td>Sackville Medical Centre</td>
<td>Good</td>
</tr>
<tr>
<td>The Avenue Surgery</td>
<td>Good</td>
</tr>
<tr>
<td>New Larchwood Surgery</td>
<td>Good</td>
</tr>
<tr>
<td>Goodwood Court Medical Centre practice</td>
<td>Inadequate</td>
</tr>
<tr>
<td>Brighton Homeless Healthcare</td>
<td>Good</td>
</tr>
<tr>
<td>The Practice Whitehawk Road</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>The Practice Willow House</td>
<td>Good</td>
</tr>
</tbody>
</table>

In the case of the Goodwood Court Medical Centre GP practice, the CQC took urgent action to withdraw the practice’s registration with the regulator in the interests of patient safety.

However, where a GP practice is rated inadequate this does not mean that it has to close. Where a GP practice is rated inadequate and placed into special measures, NHS England will work with the local clinical commissioning group (CCG) to support the practice to make sure the necessary improvements are made to support the delivery of safe, high quality care to all patients.

**Sources of Quality-related Information**
The CCG and NHS England collate data and information on Practices from a range of sources, such as:

- Public Health data
- QOF
- Premature Mortality audits
- Annual patient surveys
- Friends and Family Test
- CQC reports
- Healthwatch ‘Enter and View’ visits and information received via their public helpline
- Attendance at education and training events
- ‘Soft intelligence’ from a range of local networks
- Sign up to providing locally commissioned services (LCS’s)
- Workforce information, such as staffing levels, use of locums etc

The CCG has started, and continues to develop, a database that captures all the quality-related information described above, in order to be able to analyse and assess levels of risk for individual practices, which are then escalated and shared with the following:
(i) Internally to the CCG’s Performance and Governance meeting and Quality Assurance Committee, which report directly to the Governing Body.
(ii) High level concerns are shared at the NHS England-led Quality Surveillance Group meetings, which are held monthly and attended by the CCG’s Director of Quality, as well as other key stakeholders such as CQC and Healthwatch.

**Joint Working with Stakeholders**

The CCG Quality team meets with CQC and Healthwatch on a quarterly basis. The purpose of these meetings is to share intelligence on GP Practices from all parties. Based on information shared, this may trigger an inspection visit by the CQC, or an Enter and View visit by Healthwatch. Any reports following CQC and Healthwatch visits are publicly available, and the Practices are required to respond with a written improvement plan within an agreed timeframe. The CCG will also use these reports to inform any additional supportive actions that may be taken. The actions taken by the CCG will depend on the issues identified. The CCG has the following personnel and resources to hand to support this as follows:

- A GP Clinical Lead for Quality
- A Lead Nurse and Director of Quality
- A Clinical Quality Manager (registered nurse and experienced practice nurse)
- A Primary Care Workforce Development Tutor
- An Infection Control Specialist Nurse
- A lead professional for Adult Safeguarding
- A Designated Nurse and Doctor for Childrens Safeguarding as well as a named GP
- Project Management support
- Local Member Group (LMG) GPs, Practice Nurses and Practice Managers
- Informatics Support
- Medicines Management support and advice

Interventions that may be undertaken by the CCG include:

- Practical support and advice, such as Practice visits from team members described above
- Training and education - either directly by CCG staff or enabling Practices to identify education and training requirements which are submitted to the CCGs Education and Training Committee.
- Also around training and education, the CCG coordinates a number of Protected Learning Scheme (PLS) events annually for Practices.

Following changes to the national GP contract, it is also now a requirement for each GP practice to have a patient participation group (PPG) and to make reasonable efforts for this to be representative of the practice population.
See Appendix 1 for an example report submitted to the CCG’s bi-monthly Governing Body.

8. Conclusion

This paper describes just some of the work that is taking place both locally and nationally to ensure the ongoing development of sustainable GP services in Brighton and Hove.

NHS England and NHS Brighton and Hove Clinical Commissioning Group (CCG) will continue to work with local partners, patients and the public in regards to the development of these services – to ensure that they meet the needs of the local community, both now and in the future.
Appendix 1:

Primary Care Quality and Patient Safety Exceptions Report

1. Executive summary
The CCG is responsible for quality and development of Primary Care. It is important that the assurance of quality is supported by data. This paper has used a suggested data set to support assessment and comparison of primary care providers. However there have been some amendments to ensure robustness and transparency of data consistently. The data requires on-going triangulation and analysis when the full data set is supplied.

The report presented to the Quality Assurance Committee focused on 3 Domains, Domain 1: Dying Prematurely, Domain 2: Quality of Life for LTC patients and Domain 4: Patient Experience. There is not new CQC data so this has been excluded, therefore the focus has been on QOF Points/available, Peer to Peer meetings, and Patient access and experience with analysis of the patient survey from September 2014 compared to March 2014, on-going review of primary care data will be used to support member practices and feed into education and training provision.

2. Background
A quarterly Quality and Performance report is produced by the CCG; this provides information and data on the quality of services for Brighton and Hove CCG 45 member practices (Eaton Place closed end of February 2015), but who are contractually managed by NHS England Area Team. Quantitative data and soft intelligence are analysed from a wide range of data sources, which includes national data as well as regional and local information, in order to create and triangulate sources of quality-related information.

8. Conclusion
This report provides a high level summary of quality and patient safety issues for the CCG in relation to Brighton and Hove CCG 45 member practices. This is evolving as a resource of primary care quality data practice in Brighton & Hove CCG. Next steps further discussion and guidance needs to be discussed to continue to agree reporting that is used to support and develop member practices in delivering are to triangulate and interrogate the data to start to create a narrative of quality variations and good practice across the CCG. This will inform the work that the LMG undertakes with practices in 2015/16 as well as being used to support education and training provision.

Recommendation
The Governing Body is recommended to note for information.

Primary Care Quality
This is a summary of the Primary Care Quality report that was presented and discussed at the Quality Assurance Committee in June 2015. It covers performance and quality issues within Primary Care in Brighton & Hove CCG’s 45 member
practices. The data was collected from either annual, quarterly or monthly sources to date, with the aim to always obtain the most up to date information.

This report reflects the formal performance reporting framework against the core responsibilities of Brighton & Hove CCG in line with the NHS Constitution and CCG assurance framework 2013-2014. Additionally, this report reviews how practices are performing within QOF and patient experience indicators, against National and the 17 ONS comparator CCGs as mentioned in previous report.

7 Introduction

This report covers performance and quality issues within Primary Care in Brighton & Hove CCG’s 45 member practices. The data has been collected from either annual, quarterly or monthly sources to date. The information has been collected from various sources but each section states the source and the period collected for. The aim is to always obtain the most up to date information.

This report reflects the formal performance reporting framework against the core responsibilities of Brighton & Hove CCG in line with the NHS Constitution and CCG assurance framework 2013-2014. Additionally, this report reviews how practices are performing within QOF and patient experience indicators.

7.1.1 Background Information

A Quality Dashboard has been produced in order to showing information for all 45 GP practices in 12 different categories:

1. Population
2. QOF: Clinical Quality Outcomes
3. QOF: Exception Reporting
4. QOF: prevalence
5. Public Health: Screening and Prevention
6. Prescribing
7. Patient Access
8. Patient Experience
9. Patient Safety
10. Patient Survey response rates
11. Enhanced/Commissioned Services
12. Information Governance

The Quality Dashboard was adapted from Hastings & Rother CCG. This has been further developed in order that it is consistently reproducible using the same data in the same way.

7.1.2 Structure of the report

Care Quality Commission reports have been moved to the beginning of the report as their overarching findings support the Five Domains below. Excluding Population, the 12 above categories have been sorted into sections based on whether they fall under the Five Domains.

<table>
<thead>
<tr>
<th>No</th>
<th>Indicator name (short name)</th>
<th>Indicator name (full name)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Dying prematurely</td>
<td>Preventing people from dying prematurely</td>
</tr>
<tr>
<td>2</td>
<td>Quality of Life for LTC patients</td>
<td>Enhancing quality of life for people with long term conditions</td>
</tr>
<tr>
<td>3</td>
<td>Recovery from ill health</td>
<td>Helping people to recover from episodes of ill health</td>
</tr>
</tbody>
</table>
This report has focused on 3 Domains, Domain 1: Dying Prematurely, Domain 2: Quality of Life for LTC patients and Domain 4: Patient Experience.

Data is analysed against National and Comparators - currently set as average of our 17 ONS comparator CCGs as below:
- NHS Newcastle North and East CCG
- NHS North Durham CCG
- NHS Greater Preston CCG
- NHS Lancashire North CCG
- NHS South Manchester CCG
- NHS Leeds West CCG
- NHS Sheffield CCG
- NHS Nottingham City CCG
- NHS Coventry and Rugby CCG
- NHS Norwich CCG
- NHS Brighton and Hove CCG
- NHS Canterbury and Coastal CCG
- NHS Portsmouth CCG
- NHS South Reading CCG
- NHS Southampton CCG
- NHS Bath and North East Somerset CCG
- NHS Bristol CCG
- NHS Liverpool CCG

7.1.3 Miscellaneous
Portslade County Clinic and Burwash Surgery merged in April 2014. They are listed in this report under the name “Benfield Valley Healthcare Hub”. Eaton Place Practice closed at the End of February 2014.
Any data for Brighton Station Walk-in-centre is not included. Only Brighton Station Health Centre is included.

It is worth noting that the demographic of practice population at the University of Sussex Health Centre is noticeably different than other practices with the majority of patients falling into the 20 – 29 age bracket (see graph). It is also worth noting that the demographic of the practice population at The Brighton Homeless Practice is significantly different to most general practice they are a specialist GP surgery which only registers homeless patients, this includes street homeless, sofa surfers, temporarily housed, gypsies and travellers.

8 Care Quality Commission (CQC)
No Brighton and Hove Practices have been visited by CQC since the last report.
9 Domain One: Preventing People from dying prematurely

9.1.1 1:1 QOF Points Total/available (%) 2013/14

Source(s): HSCIC Website
Collected Annually

The total QOF point’s data was analysed to understand QOF achievement for practices in Brighton and Hove CCG (BHCCG). BHCCG average shows a 92% achievement, which is equal to the National average; BHCCG comparators average is 94% achievement which is above the National and BHCCG average. 26 practices achieved equal to or above BHCCG comparators and the National average and 20 practices achieved below the National and BHCCG average.

6 practices, Ardingly Court, Preston Park Surgery, Beaconsfield, Regency, Saltdean and Rottingdean and Mile Oak achievement remained the same. 31 practices showed a small to significant decrease in achievement and 8 practices, The Haven, Brighton Health and Wellbeing, The Broadway, St Luke’s, New Larchwood, Hove Park Villa, Benfield Valley and Whitehawk showing a small increase in achievement.

However there are of the practices showing a fall, there are 5 practices of concern

- The Practice-Hangleton Manor achieved 59.6% with a fall of 22%
- Seven Dials Medical Centre achieved 74.7% with a fall of 11%
- Goodwood achieved 77% with a fall of 9%.
- The Practice-Willow achieved 78.7% with a fall of 18%
- Lewes Road achieved 83.7% with a fall of 13.3%

Further analysis of other data such as Locally Commissioned Services sign up and achievement as well as QOF achievement for 2014/15 should be carried out to understand the potential impact this is having on the practice and its population.

1:2 Peer to Peer Quality Meetings

9.1.2 Overview

The Peer to Peer Quality Meetings with BHCCG and member practices took place over January and February 2015. The process was led by the Local Member Group Team with support from the Primary Care Development Team (PCDT) and Public Health (PH). Practices were assigned a date and given a preparation pack, funding was allocated for 5 hours GP, PN and PM for pre and post work as well as their attendance. Discussions from the meetings were captured and shared with practices to support the completion of a practice development plan.

9.1.3 Post Meetings Review

9.1.4 Non-attendees

All 46 practices were invited; 45 practices were expected to attend as Eaton Place was closing. 44 practice confirmed attendance with Seven Dials declining. However 6 practices did not participate, these were:
- The Practice PLC-Whitehawk, Hangleton Manor, Boots and Morley Street, who had numerous opportunities to attend and at each failed opportunity they were followed up via email and in person by the LMG teams
- Goodwood Court, failed to respond to any email, telephone or other contact, despite actively being sort by the LMG teams
Wish Park and Brighton Station HC were due to attend the last dates of the meetings and both failed to attend. The lack of engagement from The Practice PLC (with the exception of Willow) has been escalated within the CCG with the view to a meeting between the Chair of the CCG, the Director of Quality and Patient Safety and the Directors of The Practice PLC. The lead GP for Goodwood Court and the Director of Quality and Patient Safety has met.

9.1.5 Summary:

An email has been sent to all practices thanking those who attended and encouraging those that missed the opportunity. A summary of the outcomes from the meetings was attached:

**COPD – highlighted from the PPMA**

**For Practices**

- Call COPD patients in for review in the summer months when they are well and give them a health plan including details of how to take their emergency medication so they can cope with their symptoms in the winter months.
- Audit patients on a COPD specific inhaler who do not have a diagnosis code of COPD.
- Consider doing FEV1 recording at flu clinics.
- Proactive case finding of COPD patients opportunistically or by more sophisticated reporting.
- More detailed information should be put on x-ray forms to help radiologists.

**Items for Commissioners:**

- Better process for discharge with COPD diagnosis without spirometry being done. Commissioners to look at referrals to pulmonary rehabilitation without spirometry post discharge.
- Smoking cessation service for the housebound

**CANCER AUDIT**

**For Practices**

- Practices could consider an internal system for checking where 2 week referrals were in the system.
- Practices to remind patients opportunistically about breast/bowel screening if patients have not attended (same as cervical screening).

**Items for Commissioners**

- Enable Radiologists to refer for CT scan if they have concerns about an x-ray.
- Continue to review issues with digestive disease service

**EXCEPTION REPORTING**

**For Practices**

- Share resources for recalls across clusters
- Practices to continue to use the ‘Tips for Exception Reporting’ provided by LMG Chairs
- Phone patients for QOF reviews – a lot can be done on the phone which would mean the patient may only have to come in for one short appointment at a time convenient to them.

**SIGNIFICANT EVENT REPORTING**

All participants agreed that a simple, electronic reporting system enabling the sharing of incidents across the City for learning purposes would be a good idea.

9.1.6 Future Peer to Peer Meetings

The planning for next round of peer to peer quality meetings has already started. The most ideal time for practices is felt to be September however for 2015/16 it was felt this would be too soon and so the aim is for November. There needs to be a mechanism of understanding the changes if any from
the previous peer to peer meetings and further work needs to be undertaken to be able to measure this. Consideration of other quality measures’/ indicators is needed, as well as ensuring participation by all practices. It is envisaged these meetings will support cluster working and facilitate practices undertaking peer to peer reviews both independent and with BHCCG.
10 Domain Two: Enhancing quality of life for people with Long Term Conditions

10.1.1 Prescribing and medicines management

Data source: Medicines Management Team

The aim is to ensure high quality and safe prescribing in primary care that takes into account existing national (QIPP) and local guidance ([Prescribing Incentive Scheme](http://example.com)) ([PIS]). The strategy for medicines optimisation includes using medicines management resources to support GP practices in improving diagnosis, addressing unmet pharmaceutical need, reducing unsafe prescribing and improving patient use of medicines (including reducing wastage). To this end practices should continue to receive regular feedback on their prescribing, enabling benchmarking and setting of performance indicators. The six medicines management indicators we will be monitoring in the quality report in 14/15 are noted below. These have been derived from the National QIPP work stream, including the Medicines and Prescribing Centre at NICE.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Ezetimibe %</th>
<th>Antibacterial items/STAR PU-13</th>
<th>Cephalosporins &amp; quinolones % Items</th>
<th>NSAIDs ADQ/STAR PU-13</th>
<th>NSAIDs: Ibuprofen &amp; Naproxen % Items</th>
<th>Benzodiazepine receptor drugs ADQ/STAR PU-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitored under Prescribing Incentive Scheme (PIS) or QIPP</td>
<td>PIS</td>
<td>QIPP</td>
<td>QIPP</td>
<td>QIPP</td>
<td>QIPP</td>
<td>PIS</td>
</tr>
</tbody>
</table>

Red, Amber and Green (RAG) ratings used in the scorecard are based on prescribing compared to national levels, where:

<table>
<thead>
<tr>
<th>RAG rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>Prescribing levels based on national top quartile of CCGs</td>
</tr>
<tr>
<td>Amber</td>
<td>Prescribing levels based on national levels in-between top and bottom quartiles of CCGs</td>
</tr>
<tr>
<td>Red</td>
<td>Prescribing levels based on national bottom quartile of CCGs</td>
</tr>
</tbody>
</table>

As only a selection of medicines management indicators have been selected, using an aggregate score would not give an accurate picture of the general performance for practices. Six separate graphs have therefore been used with the following key:

This current Medicines Management Quality Dashboard only looks at 6 prescribing indicators taken from Prescribing QIPP dashboard, details of which can be accessed via the NICE website [www.nice.org.uk/Contents/Item/Display/10363](http://example.com). Rationale and evidence base for these indicators can be accessed via [Key therapeutic topics - medicines management options for local implementation 2015](http://example.com), updated by the Medicines and Prescribing Centre at NICE.
The CCG performs well on antibacterial items and high risk antibiotics (cephalosporins and quinolones), as well as NSAID volume of prescribe and choice of drugs where half or more of the constituent practices are performing in the top quartile.

The CCG is not performing as well in the Benzodiazepine Receptor Drug Domain and this is and has been a longstanding problem with 37 practices performing to the level of the bottom quartile. However, much work has been done in this area such that we are not the worst performing CCG as we have been over the last few years. We continue to monitor and try and influence reducing the prescribing.

Practices with GREEN rated domains:
- 6 GREEN ratings – 1 practice (Stanford)
- 5 GREEN ratings - 5 practices (Portslade Health Centre, University, Hove Park Villas, New Larchwood)
- 4 GREEN ratings - 6 practices (The Practice North Street, Central Hove Surgery, Brighton Station Health Centre, Park Crescent New Surgery, Albion Street Surgery, The Haven)
- 3 GREEN ratings - 14 practices
- 2 GREEN ratings - 15 practices
- 1 GREEN ratings - 5 practices (Whitehawk, Matlock Road, North Laine, Broadway, Carden Avenue)
- 0 GREEN ratings - 1 practice - Ship St - this practice is a single handed practice inner city based with a high transient population along with a patient group that has specialist needs

Domains with RED rating
- 4 RED ratings - 6 practices (Ship St, Broadway, Carden Avenue, Pavilion, The Avenue, Morley Street)
- 3 RED ratings - 15 practices
- 2 RED ratings - 10 practices
- 1 RED ratings - 9 practices
- 0 RED ratings - 6 practices (Woodingdean, Hove Medical Centre, Mile Oak, Portslade Health Centre, University, Stanford)

The Medicines Management Team continue to monitor and feedback performance through the annual Prescribing Visit, in year regular reporting of QIPP and PIS to practices, with the aim of encouraging peer review, applying peer pressure and incentives to improve performance.
11Domain Four: Ensuring that people have a positive experience of care

**Patient Access and Experience**

The measures reviewed for Access and Experience are:

- Able to get an appointment
- Experience of making appointment (result from patient survey)
- Convenient appointment (result from patient survey)
- Preferred doctor (result from patient survey)
- Telephone access (Hours) / week (result from patient survey)
- Experience of the practice
- Helpfulness of the reception staff
- Waiting times

The analysis of the above 8 questions on Access and experience shows that overall 64% of Brighton & Hove CCG practices have witnessed a fall in scores between the latest results (September 2014) compared to previous (March 2014), this was compared against the National average, BHCCG average and BHCCG comparators. It is worth noting that the selections of questions asked and the actual number of questionnaires returned is probably tiny compared to the number of appointments and activity within general practice.

**Summary**

Analysis of the data for BHCCG 45 practices shows that there were 3 practices that were consistently high across the majority of the questions, above the National, BHCCG and BHCCG comparators averages, these are:

- Links Road 8/8 indicators
- St. Luke’s 5/8 indicators
- The Haven 5/8 indicators,

These are all relatively small practices with raw practice populations of 5,740, 2,237 and 3,051 respectively.

Of concern are 4 practices who were in the bottom 3 for 4 or more indicators, these are

- The Practice-Whitehawk-bottom 3 for 7/8 indicators and in the bottom 5 for all indicators, with ‘Telephone access’ being their worst results.
- Goodwood Court- bottom 3 for 6/8 indicators of these indicators they were the very bottom for 4, ‘able to get an appointment’-with a drop of >10%, ‘Making an appointment’-with a drop of >10%, ‘Preferred Doctor’-with a drop 40% and ‘Experience of the Practice’.
- Hove Medical Centre- bottom for ‘Helpfulness of the reception staff’ although they were in the top 3 of practices for ‘Waiting Times’.  
- University of Sussex- bottom 3 for 3/8 indicators with The University of Sussex being at the bottom for ‘Waiting Times’.

Whilst there is recognition of the small numbers used to process this analysis it gives a useful oversight of how practices are performing especially when added to other practice performance data and should be used to support practice development and improvement.