Brighton & Hove Fairness Commission

EVIDENCE PACK

6.00PM, THURSDAY, 10 DECEMBER 2015

THE LONG ROOM
SUSSEX COUNTY CRICKET GROUND - HOVE

Dear Commissioners

Please find enclosed the evidence pack for **Children & Young People: Improving Life Chances** meeting which will take place on 10th December, 6-9 pm in the Long Room, Sussex County Cricket Ground, Hove BN3 3AN.

This month's evidence pack contains:

- **Closing the Gap (in educational achievements for vulnerable groups in the city)** 2013-2015
- **Outliers: BME Communities in Brighton & Hove** (2015)
- **Briefing from Joseph Roundtree Foundation:** money and educational outcomes
- **Youth Work Review** (2015) & evidence from young people
- **Draft Commissioning Strategy: Health & Wellbeing of Children, Young People & Families** 2015-2020
- **Children's Centre Review** (2015) Brighton & Hove
- **Children' Centre Review: Appendix** – Supporting information October 2015
- **Children and Adolescent Mental Health Services in Brighton & Hove** (extract from draft Children & Young People's mental health needs assessment)
- Referral Flow Chart for **Brighton & Hove Child and Adolescent Mental Health Service (CAMHS)/Community CAMHS**
- CAMHS/Community CAMHS: **Guidance for Referrers**
- **Summary of the Family Nurse Partnership Programme** for the Fairness Commission
- **Family Nurse Partnership Annual Report** (2014/15)
- **Data briefing on Looked After Children** (year end March 2015)
- 'Call for Evidence' response from an organisation: **Children in Care**
- **Health of Looked After Children** (2013/14)
- **VFM - Looked After Children – Public Sector Audit Appointments**
- **Special Educational Needs and Learning Disability (SEND – LD) Strategy** – Next Step proposals (November 2015)
- **Partnership Outreach Pilot to Parents of Disabled People** – Evaluation report
- 'Call for Evidence' response from an organisation **– Learning disabilities**
- Statement for the Fairness Commission: **Young carers**
- **Trust for Developing Communities** presentation to the Children & Young People's Committee (June 2014)
- **Beating the Odds Pilot:** Presentation by Robin Banerjee et al (May – December 2014) on evaluation of Troubled Families Programme
- **Briefing on key issues for UK Youth Parliament**

I look forward to meeting with you all next week.

Kind regards

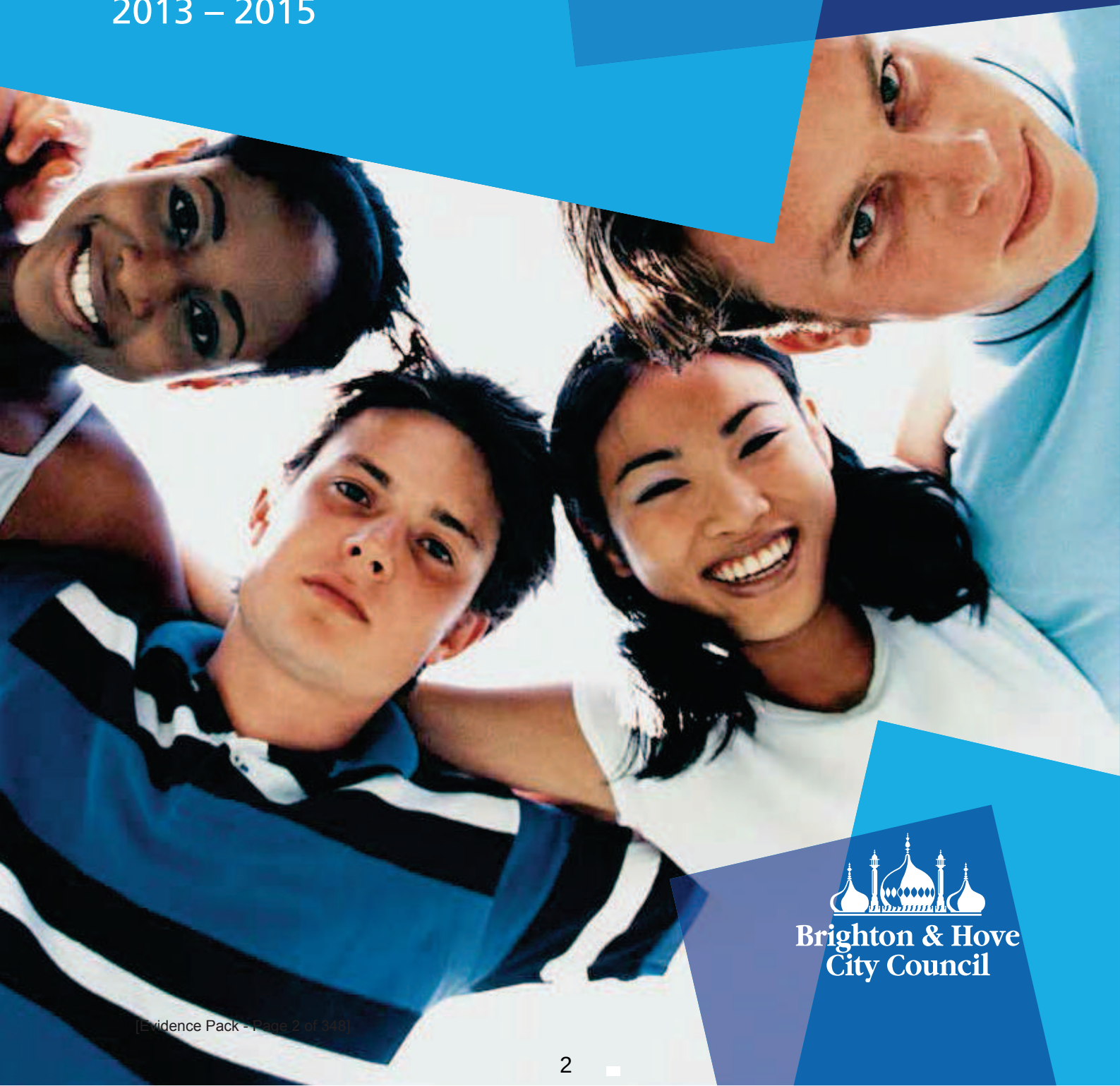
Julia Reddaway
Policy Team

Education and Inclusion

Closing the Gap

in Educational Achievement for Vulnerable Groups in the City

2013 – 2015



Brighton & Hove City Council

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1. Introduction

This strategy outlines Brighton & Hove's vision, priorities and expectations in relation to closing the gap in educational achievement for vulnerable children and young people in the city. It builds upon the success of schools in raising attainment and progress and is ambitious for the future. We are beginning to see the gap closing as the strategy elements are put in place.

Closing the Gap in educational achievement is a moral imperative. We believe that through educational success, vulnerable children and young people will maximise their life chances and secure their future economic well being. We are committed to partnership working and believe that everyone has a part to play in addressing this most serious issue.

2. Where does this strategy fit in? Links to the Corporate Plan

This strategy links to the theme of Tackling Inequality in the City Corporate Plan 2011-2015.

'We want to make sure that all of our children and young people have the best possible start in life, so that everyone has the opportunity to fulfil their potential, whatever that might be, and to be happy, healthy and safe'. This means making sure that all children and young people in the city have access to high quality education that will provide them with the knowledge and skills to secure employment and be active and responsible citizens. We will focus on raising overall attainment and narrowing the gap between the lowest and highest performing pupils.' (Brighton and Hove Corporate Plan 2011-2015.) Closing the achievement gap between vulnerable groups of children and young people in the City and their peers is a priority in a range of strategies and policies including: the Special Educational Needs Partnership Strategy, School Improvement Strategy and Early Help Strategy. This strategy outlines a consistent, city wide approach that we will take to 'closing the gap'.

3. Vision for Education

Our vision was devised by the Learning Partnership with contributions from learning organisations across the city. It is shared by all and interpreted by each phase and school to meet the needs of the learners. It underpins everything we do.

A 21st Century Vision for Learning in Brighton & Hove

Our provision will ensure a coherent and inclusive experience that makes learning personalised, irresistible, engaging and enjoyable. To maximise the potential of every learner, each must thrive from relevant, motivating and exciting experiences that draw upon the uniqueness of our vibrant city by the sea.

We will encourage all to become confident, flexible, resilient and capable life-long learners and critical and reflective thinkers, empowered with essential knowledge, life skills, dispositions and technological capability necessary to participate as responsible citizens in the 21st century.

4. Rationale for 'Closing the Gap'

Each year the Standards and Achievement Team carries out an extensive data analysis and examines the performance of the different groups of pupils in the City. The data analysis shows that the most significant gaps in performance are those between the performance of children and young people eligible for Free School Meals (FSM) and their more advantaged peers, between those children and young people identified as having special educational needs or disability (SEND) and their peers and for children in care (LAC/ CiC). These gaps widen as the young people move through our school system. The impact of large numbers of pupils, particularly pupils with FSM not achieving 5 GCSE's A* to C with English and Maths at the end of Key Stage 4, not only has implications for the economy of the city, but also has an impact on the quality of opportunity for young people in the city. However, there are overlaps in these groups.

In 2012:

- 11% of children in the city were both in receipt of FSM and identified as having special educational needs.
- 31% of pupils with SEN were also in receipt of FSM.
- 47% of pupils registered for FSM were also identified as having SEN.

5. Partnership working and the role of the LA

Brighton and Hove is committed to working in partnership to 'Close the Gap' in educational achievement for vulnerable groups.

Although schools are being given increased levels of autonomy, it is still the responsibility of the LA to ensure that there is robust self evaluation by the management of the school, particularly in relation to pupil progress. A key task for this LA is to further develop our work to ensure schools are effectively addressing the needs of their vulnerable groups of pupils, and that good progress is made towards 'Closing the Gap' in educational achievement in all schools. We would want to support schools to find their own solutions that will work effectively in the different contexts of the schools.

The Ofsted Chief Inspector, Sir Michael Wilshaw, has recently made it clear that Local Authorities still retain a direct responsibility for the standards achieved in all of the schools in their area, including academies; this responsibility is particularly in relation to the progress made by vulnerable groups. He also told Headteachers, that increasing attention will be given, during the course of school inspections, to the impact schools are making through the use of the Pupil Premium on the issue of 'Closing the Gap' for the disadvantaged. It has also been indicated by Her Majesty's Inspectors (HMI) that there will be an increasing focus on this issue, not just at a school level, but when considering the relative performance of local authorities in addressing the issue of the progress of disadvantaged pupils in their area.

In its role as champion of children and families, the LA can facilitate, broker and commission support. We have a small intervention team with a focus on closing the achievement gap and they offer support and challenge for schools in this area.

6. The Provision of Pupil Premium and SEN funding

Pupil Premium is intended to assist schools with addressing the gap in achievement between disadvantaged pupils and their peers; for the purposes of identification, disadvantage is identified with registration for Free School Meals (FSM). Although an imprecise indicator, FSM registration remains the most accessible way to identify disadvantage in schools.

From April 2014 the premium will stand at £1300 for each FSM pupil, registered during the last six school years, and this is likely to rise again by the final year of this parliament. Additionally, there is funding available of £500 for each FSM pupil to support Year 6/7 Summer School Transition Programmes, and a further £500 'catch-up' payment, paid for Year 7 pupils who did not achieve Level 4 at the end of the Primary phase; this produces a potential £1900 for each underachieving FSM pupil at the key point of the Primary / Secondary school transition.

Through the formula the LA has delegated directly into school budgets a notional amount to support children with SEN. In 2013 / 14 this was £12.7m across mainstream schools and academies. In addition there is 'top up' funding for pupils with high needs and in 2013 / 14 this in the region of £2.04m (adjustable over the year), giving an overall total approaching £15m.

7. Best Practice: What makes the difference?

Where schools have been most effective in raising the progress of vulnerable pupils, and have closed the gap, there are factors which are frequently observed:

- the deliberate and systematic involvement of pupils, at all stages, with taking responsibility for their own progress and learning;
- appropriate management structures, quality assurance and data collection;
- Quality First Teaching in the classroom, setting intervention into a context in which the progress secured can be developed and sustained;
- effective leadership on the issue of intervention from the school's senior management team;
- the identification of strategies that are right for the particular setting and needs of the pupils - all of the selected interventions being subject to a rigorous process of cost/benefit analysis;
- the careful selection, training and support of intervention staff, recognising that intervention requires a different range of skills to that of class teaching;
- integration of intervention staff into the work of the whole school - particularly that of the class/subject teacher;
- suitable assessment processes that fully and adequately inform intervention, enabling progress to be monitored across a range of learning need.

We have also seen the gap narrow in a number of schools across the city. Discussion with leaders of those schools also identified the following key points:

What do schools think makes the difference?

'We have high expectations from the top down and the bottom up'

'We make sure we do it well for every child – and there are no excuses'

'We make sure that teachers are aware of their responsibility and accountability for every pupil '

'There is a focus on tracking and assessment – making sure no one veers off track '

'We ensure high quality teaching and learning for all '

'ECAR and ECC are very valuable and have a positive impact '

Some special initiatives and projects local and national had lifted aspirations for all and accelerated progress e.g. (MfL) project

Case Study: Rudyard Kipling Primary School

Rudyard Kipling Primary School was judged to be 'good' in May 2013. The school RAISEonline shows that educational achievement gaps are closing.

The inspector wrote:

'Funding for the pupil premium is effectively used, primarily to provide non-class based teachers and additional adults to deliver tailored support in both English and mathematics. The impact of the funding has been clearly shown in improved achievement.'

Some of the features of the school are:

- The headteacher, ably assisted by the deputy headteacher, is very clear about what she wants the school to achieve.
- The School's approach to improvement is incredibly detailed and consists of very accurate school self-evaluation, improvement plans and detailed termly plans. All staff are fully aware of these realistic and achievable plans.
- There is an effective programme to monitor and improve the quality of teaching. Leaders ensure that all teachers meet the 'Teachers' Standards'. All staff, including support staff, have targets to help them improve their performance to make them accountable for accelerating pupils' progress. The school has produced detailed documentation to ensure that teachers fully understand how progression through the pay scales can be achieved and is inextricably linked to pupils' progress.
- The quality of the school's assessment information, detailing pupil progress, is exemplary. Personalised plans are made for each pupil, after looking at their books, their work in lessons and their progress information. Decisions about how to maximise progress and use carefully targeted interventions include the teachers and senior leaders as well as governors.
- Middle leaders are involved in all aspects of monitoring, including lesson observations. They have a good understanding of school performance and often trial innovative practice, as demonstrated in Year 5.
- Governors know the school well and are therefore able to offer effective support and challenge.

8. How our strategy will work

What we will do

- Form a group of school leaders and LA officers to drive the strategy
- Further evaluate and disseminate national research: (e.g. Sutton Trust)
- Evaluate and disseminate the national evidence into the most effective interventions
- Evaluate and disseminate the local evidence: e.g. Schools data and the Schools

Supporting Schools projects – what is working well?

- Provide a universal offer of data analysis, advice and guidance (e.g. Intervention health check / governor support and training)
- Support partnership / cluster data analysis – so that every school knows its pupils
- Identify, through the data analysis of schools where practice is strong and schools where the gap is particularly wide.
- Link schools with similar profiles together to share practice
- Investigate different evidence based programmes such as: 'Achievement for All' or 'Success for All', 'Working with Others' 'Talkboost', and 'School Start', to see if they would be the right support for schools in the city
- Continue to promote and facilitate the Every Child a Reader and the Every Child Counts programmes with schools along with their associated initiatives
- Extend the 'Every Child a Reader' programme, in a number of target schools, to encompass a broader strategy for addressing achievement in literacy, particularly in writing.
- Promote virtual learning opportunities where these have been shown to make a successful contribution to learning

9. What success will look like

Year on year, pupil achievement for all groups in the city will improve and the gaps between pupils in vulnerable groups and their peers will close.

We will identify key milestones and targets to support and challenge schools to accelerate achievement of the most vulnerable. The milestones seek to raise aspiration and ensure that the gaps in educational achievement are in line with and then below the national average at all key assessment points.

In Brighton and Hove we are committed to the success of every pupil and the achievement of these vulnerable groups must be our priority.

Appendices

Appendix 1

Brighton & Hove LA: Summary of the Comparative Achievement Data: Free School Meals/Non Free School Meals Pupils

Key Stage 1

Overall performance at the end of KS1 for 'all pupils' is greater than that of pupils nationally. However there is a gap between those pupils who are in receipt of FSM and their peers in all subjects. The gap is widest in writing.

KS1 writing L2+

Results	2008	2009	2010	2011	2012
B&H FSM	62.0%	61.0%	62.0%	64.3%	59.9%
B&H Non FSM	85.0%	85.0%	84.0%	84.6%	86.2%
B&H Gap	23.0%	24.0%	22.0%	20.3%	26.3%

There were six schools where the FSM pupils did as well, or better than the non Free school meals pupils in all three areas of the curriculum and had, therefore, closed the gap;

There were many schools where the FSM pupils had done as well or better than non FSM pupils in one or more of these areas of the curriculum;

69.5% of FSM pupils reach the benchmark in reading. National 64%

59.9% of FSM pupils reach the benchmark in writing. National 56%

79.6% of FSM pupils reach the benchmark in mathematics. National 68%

Key Stage 2

There is an overall fall in the achievement of the city's disadvantaged pupils (FSM) from the end of Key Stage 1 to the end of Key Stage 2

60% of Brighton & Hove non FSM pupils reached the Level 4 benchmark at the end of KS2 compared to 58% nationally, but only 37% of all FSM pupils achieved Level 4 SATS at the end of Key Stage 2

17.4% of pupils in Brighton and Hove at the end of Key Stage 2 were eligible for Free School Meals nationally;

- There were twenty four schools where the FSM pupils reached or exceeded the national end of Key Stage floor standard (60% of pupils achieving Level 4 in English and Mathematics);
- There were eight schools where the FSM pupils equalled or exceeded the percentage of all pupils achieving Level 4;

KS2 pupils achieving L4+ in English and maths 2007 – 2012

Results	2007	2008	2009	2010*	2011	2012
B&H FSM	46%	55%	52%	63%	51%	60%
B&H Non FSM	76%	79%	76%	82%	78%	83%
B&H Gap	30%	24%	24%	19%	27%	23%

Key Stage 4

The gap at the end of Key Stage 4 (Secondary 2011/12, achieving 5 GCSEs A* - C with English and mathematics) had widened to -34.5% from -23% at the end of Key Stage 2 (Year 6).

Nationally the gap at the end of Key Stage 4 was 36.4% giving a gap of – 8.1% between Brighton and Hove's FSM pupils and their FSM peers nationally.

27.1% of FSM pupils reach the GCSE benchmark at the end of Key Stage 4 36.4% nationally 61.6 % of all non FSM pupils achieved the benchmark in Brighton and Hove compared to 62.8 nationally

14.7% of pupils at the end of Key Stage 4 were eligible for Free School Meals;

- there were two schools where the FSM pupils reached or exceeded the national end of Key Stage 4 benchmark (40% of pupils achieving 5 GCSEs A* - C with English and mathematics);
- there were no schools where the FSM pupils equalled or exceeded the percentage of all pupils achieving 5 GCSEs A* - C with English and mathematics;

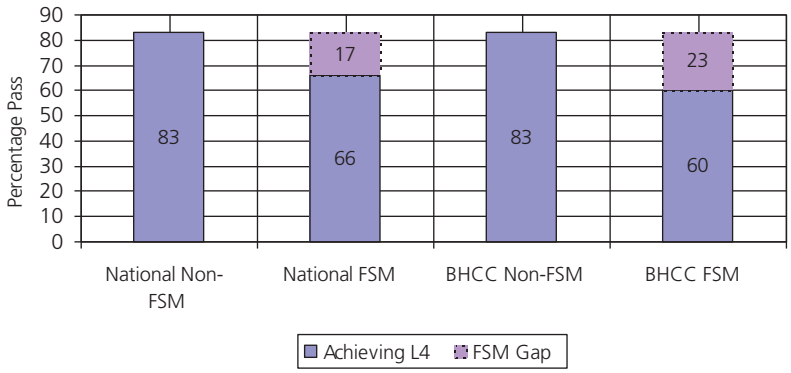
Pupils eligible for Free School Meals Gap % 5+ A*-C GCSE including English & Maths 2007 – 2012

Results	2007	2008	2009	2010*	2011	2012
B&H FSM	20%	19%	22%	22%	26%	27%
B&H non FSM	47%	49%	48%	53%	57%	62%
B&H FSM cohort	306	330	334	337	337	332
B&H non FSM cohort	1998	2008	1955	2032	1987	1881

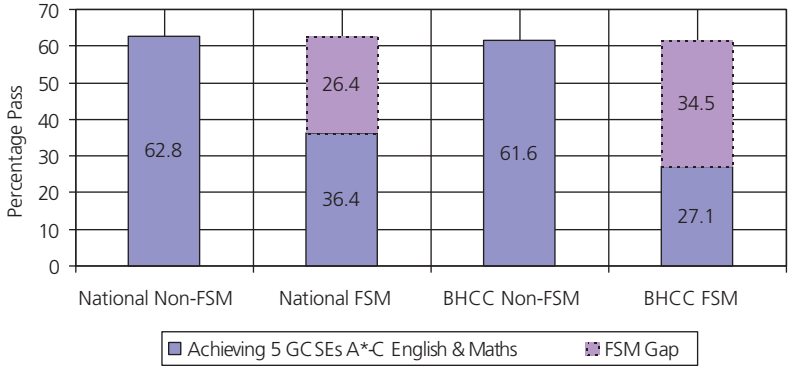
Appendix 2

Brighton & Hove LA comparisons with national Comparative Graphs of Achievement Data: Free School Meals/Non Free School Meals Pupils 2011 – 2012

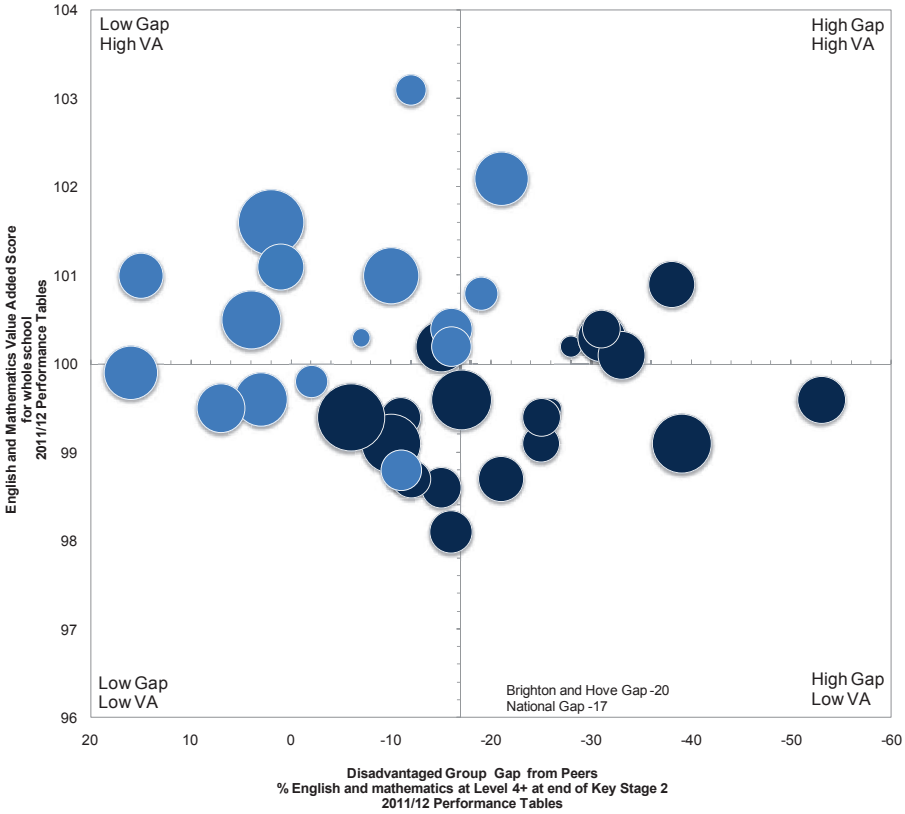
End of Key Stage 2 (Junior) National Benchmark: Level 4 English & Maths



End of Key Stage 4 (Year 11) National Benchmark: 5 GCSEs A*-C English & Maths



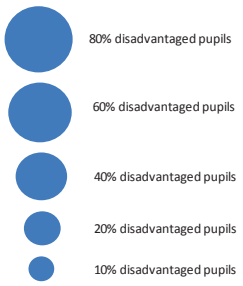
Disadvantaged Pupil Group Gaps in % English and mathematics at Level 4+, and English and mathematics Value Added Score



Key:

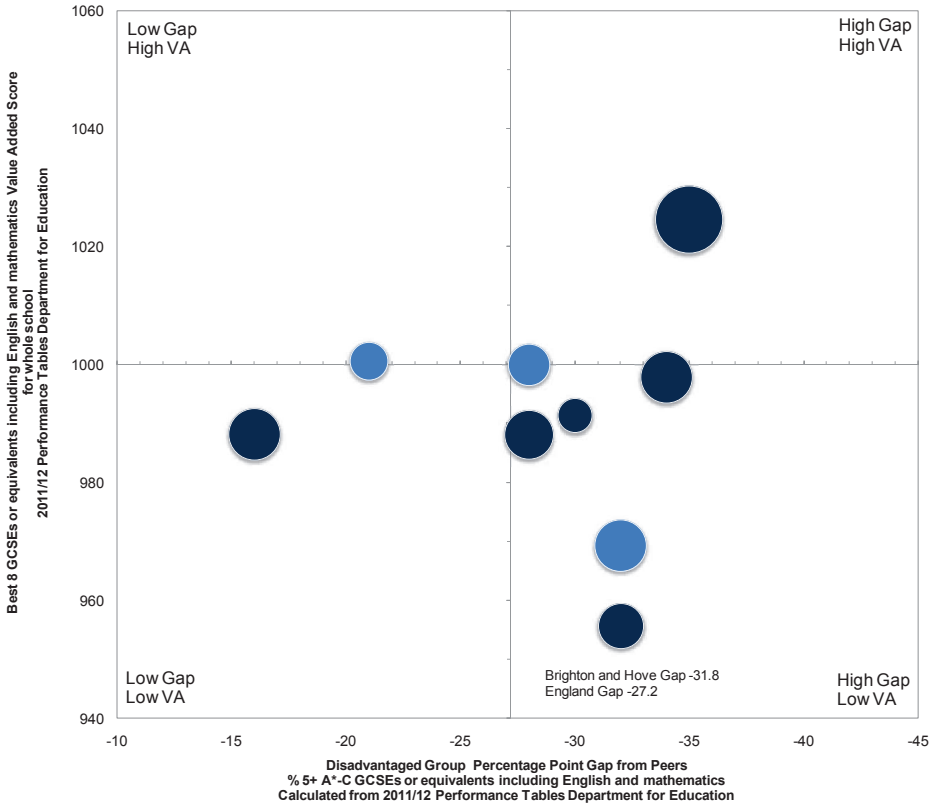
Seven schools are not shown as small numbers mean individuals could be identified.

The area of the circles are proportional to the % of disadvantaged pupils in the cohort.



The light circles indicate where the disadvantaged group % achieving English and mathematics at level 4+ was in line or above England, the dark blue below.

Disadvantaged Pupil Group Gaps in % 5+ A*-C GCSE or equivalents including English and mathematics , and 8 best GCSEs or equivalent including English and mathematics Value Added Score



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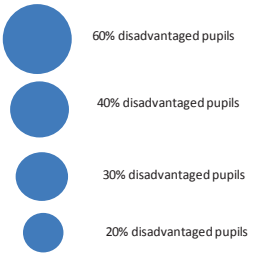
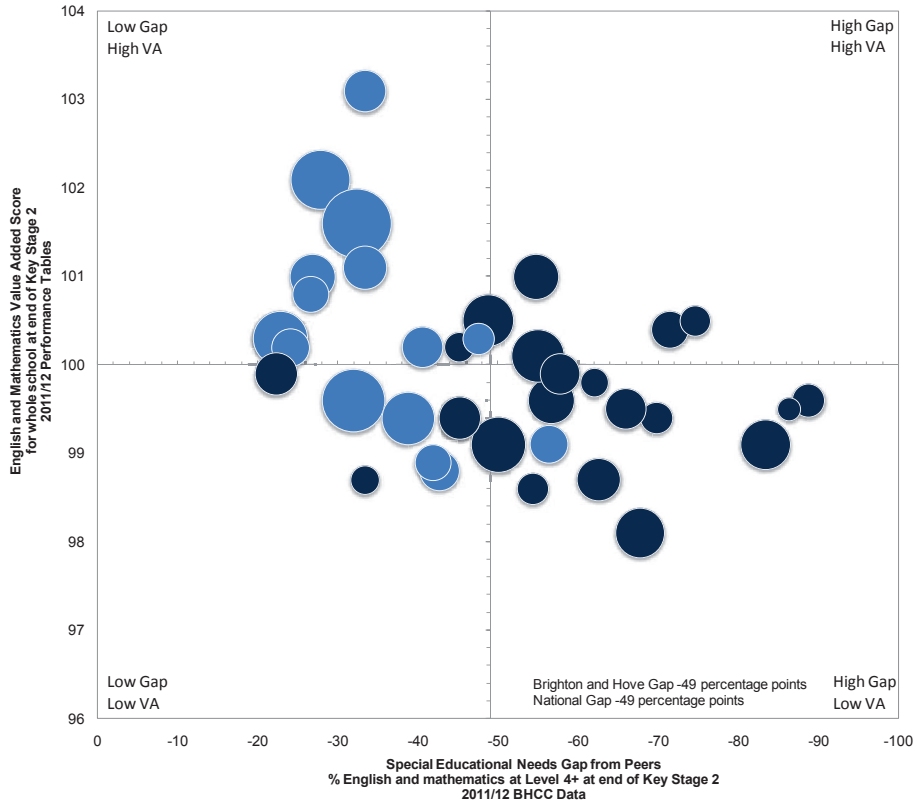


Lighter circles indicate schools where the disadvantaged group % achieving 5+A*-C GCSE including English and mathematics was above England, the darker circle below England.

Special Educational Needs Gap in % English and mathematics at Level 4+, and mathematics Value Added Score



Key:

Five schools were not shown as small numbers mean individuals could be identified.

The area of the circles are proportional to the % of disadvantaged pupils in the cohort.

60% Pupils with Special Educational Needs

50% Pupils with Special Educational Needs

40% Pupils with Special Educational Needs

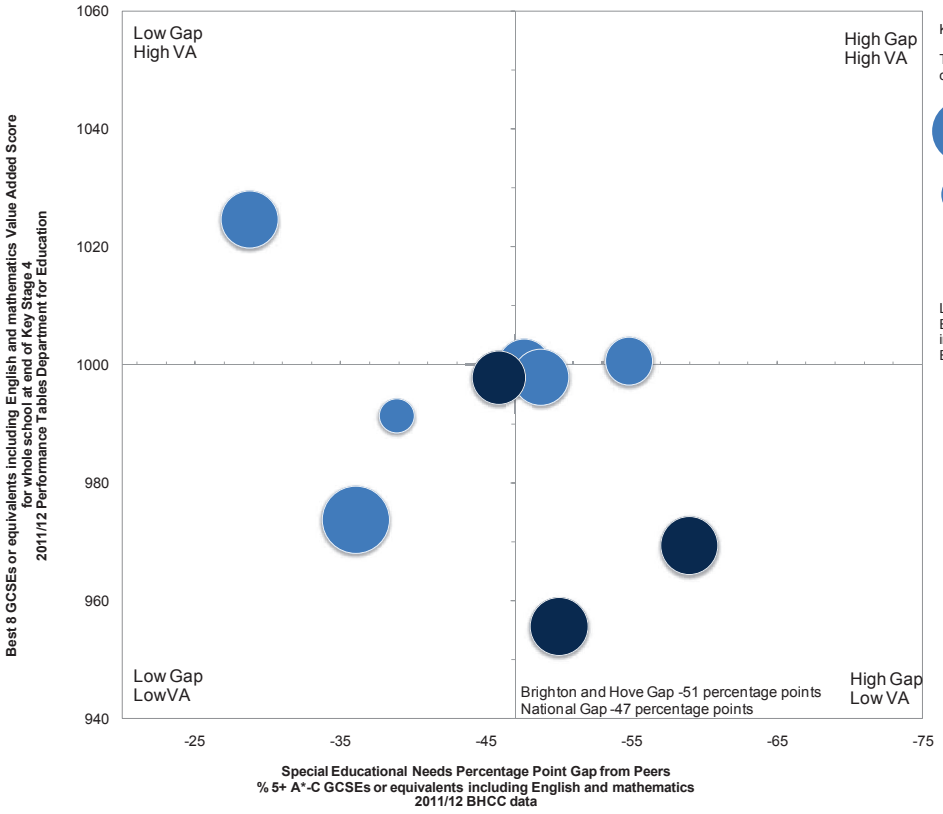
30% Pupils with Special Educational Needs

20% Pupils with Special Educational Needs

10% Pupils with Special Educational Needs

The light circles indicate where the Special Educational needs group % achieving English and mathematics at level 4+ was in line or above England, the dark blue below.

Special Educational Need Pupil Group Gaps in % 5+ A*-C GCSE or equivalents including English and mathematics , and 8 best GCSEs or equivalent including English and mathematics Value Added Score



Key:

The area of the circles are proportional to the percentage of Special Educational Needs pupils in the cohort.

30% Pupils with Special Educational Needs

20% Pupils with Special Educational Needs

10% Pupils with Special Educational Needs

Lighter circles indicate schools where the Special Educational Need pupil group % achieving 5+A*-C GCSE including English and mathematics was above England, the darker circles below England.

Issues outlined in the Black and Minority Ethnic Communities in Brighton and Hove 2015 report
(Version 2: 15 April 2015)

This document summarises data on key issues where there are notable differences in outcomes for, or perceptions of, people of different ethnicities. All the data is drawn from the *Black and Minority Ethnic Communities in Brighton and Hove 2015* report. The different section headings in this document relate to the chapter headings of that report.

Notes:

In some cases, data has not been updated since the snapshot report was released in December 2013 as the source data has not been updated. For example, Health Counts and Census data have not been updated. To show where data has not been updated relevant "Source" cells are shaded grey.

Where results remain within 1% of the data previously reported it has been noted in the third column, highlighted yellow.

Children and Young People issues highlighted in snapshot report	Comparator	Notable differences in outcomes or perceptions	Source
Early years foundation stage attainment gap for EAL children	9% (12% England)		2014 Good level of development ratings
Key Stage 1 attainment gap for EAL children	9% Writing in B&H (4% Writing in Eng) 5% Maths (4% Maths in Eng) 4% Reading (3% Reading in Eng)		KS1 attainment data 2014
Key Stage 2 attainment gap for EAL children	5% gap (2% Eng)		KS2 attainment data 2014
Key Stage 1 attainment- % meeting expected standard in Writing	81% LA average Writing	The results below are all consistent with the previous assessment Lowest performing groups:	KS1 attainment data 2014

Children and Young People issues highlighted in snapshot report	Comparator	Notable differences in outcomes or perceptions	Source
		59% Sudanese 60% Bangladeshi 70% Mixed White and Black Caribbean Highest performing groups: 93% Indian 93% Irish 93% Mixed White and Asian	
Key Stage 1 attainment- % meeting expected standard in Reading	86% LA average Reading	The results below are all consistent with the previous assessment Lowest performing groups: 67% Bangladeshi 76% Mixed White and Black Caribbean 77% Sudanese 77% Any other Asian background Highest performing groups: 96% Mixed White and Asian 96% Other Black African 93% Indian 93% Irish	KS1 attainment data 2014
Key Stage 1 attainment - % meeting expected standard in Maths	92% LA average Maths	The results below are all consistent with the previous assessment Lowest performing groups:	KS1 attainment data 2014

Children and Young People issues highlighted in snapshot report	Comparator	Notable differences in outcomes or perceptions	Source
		73% Bangladeshi 82% Sudanese 85% Mixed White and Black Caribbean <u>Highest performing groups:</u> 100% Indian 100% Irish	
Key Stage 2 attainment - % meeting expected standard in Reading, Writing and Maths	80% LA average	<u>Lowest performing groups:</u> 67% Mixed White and Black Caribbean 71% Other Asian Background <u>Highest performing groups:</u> 88% Mixed White and Asian 88% White Irish 87% Any other mixed background	KS2 attainment data 2014
Key Stage 2 attainment - % of those eligible for free school meals meeting expected standard in English and Maths	85% LA average for those not eligible for free school meals 59%LA average for those eligible for free school meals	33% Other Asian background eligible for free school meals / 76% Other Asian background not eligible for free school meals 44% Mixed White and Asian eligible for free school meals / 94% Mixed White and Asian background not eligible for free school meals 46% White and Black Caribbean eligible for free school meals / 79% White and Black Caribbean not eligible for free school meals	KS2 attainment data and FSM 2014
Key Stage 4 (GCSE) attainment - % achieving 5 GCSEs (grade A-C) including English and Maths	53% LA average	<u>Lowest performing groups:</u> 31% Mixed White and Black Caribbean	KS4 attainment data 2014

Children and Young People issues highlighted in snapshot report	Comparator	Notable differences in outcomes or perceptions	Source
		40% Mixed White and Black African NB Black Caribbean and Black African results are suppressed due to small numbers Highest performing groups: 82% Chinese 80% Pakistani	
Key Stage 4 attainment - % of those eligible for free school meals achieving 5 GCSEs (grade A-C) including English and Maths	58% LA average for those not eligible for free school meals 21% LA average for those eligible for free school meals	18% Mixed White and Black African eligible for free school meals / 47% Mixed White and Black African not eligible for free school meals (29 gap) 33% Mixed White and Asian eligible for free school meals / 71% Mixed White and Asian not eligible for free school meals (38 gap) 25% Other Mixed eligible for free school meals / 59% Other Mixed not eligible for free school meals (34 gap)	KS4 attainment data and FSM 2014
Obesity - % of Year 6 (10-11 year olds) who are obese	14% White UK/British	The results below are all consistent with the previous assessment 29% Black or Black British 21% Asian or Asian British	National Child Measurement Programme results 2013/14
Vulnerabilities identified through Safe and Well at School results		Students of Any other ethnic background or not giving an ethnicity were: More likely to report having been bullied (primary age): 20% (ethnicity not specified), 19% (other ethnic background) compared to 15 per cent overall More likely to report having been bullied (secondary age): 22% (other ethnic background), compared to 16% cent overall	Safe & Well at School 2014

Children and Young People issues highlighted in snapshot report	Comparator	Notable differences in outcomes or perceptions	Source
		Less likely to be physically active outside of school: -Secondary: 14% did 5 or more hours of exercise outside of school per week compared to 23% overall More likely to report feeling lonely or isolated; 31% compared to 25% overall Less likely to feel confident about using a condom correctly; 78% compared to 87% overall Chinese students were: Less likely to be physically active outside of school: -Primary: 10% of Chinese pupils did 5 or more hours of exercise outside of school per week compared to 22% overall -Secondary: 13% of Chinese pupils did 5 or more hours of exercise outside of school per week compared to 23% overall Less likely to say they felt safe at school- -Primary: 88%, all other ethnicities over 90% -Secondary: 80%, 91% overall More likely to report having been bullied that term (secondary): 22% compared to 12% overall More likely to report feeling lonely or isolated: 36% compared to 25% overall More likely to not have at least one good friend at school: 83% compared to 98% The least likely to say that they had never tried smoking; 73% compared to 77% overall More likely to feel unconfident about using a condom correctly;	

Children and Young People issues highlighted in snapshot report	Comparator	Notable differences in outcomes or perceptions	Source
		16% compared to 13% overall More likely to have tried alcohol; 53% compared to 45% overall More likely to have been drunk; 61% compared to 51% of all pupils who have ever had alcohol	
Not in employment, education or training (NEET)- % young people who are NEET compared to city profile	NA	14% NEET (61) are BME – lower representation than might expect as 17% of 16-19 year olds are BME	National Client Caseload Information System return April 2014

Families issues highlighted in snapshot report	Comparator	Notable differences in outcomes or perceptions	Source
People supported through Stronger Families, Stronger Communities - % compared to city profile		The results below are all consistent with the previous assessment 5% more White UK/British than city profile 7% less BME than city profile 6% fewer Other White than city profile	Stronger Families, Stronger Communities, Performance statistics April 2014

Neighbourhood issues highlighted in snapshot report	Comparator	Notable differences in outcomes or perceptions	Source
Believe local area has “got better” in last two years	23% White UK/British	36% BME	City Tracker 2014 results
Satisfaction with street cleaning - % very/fairly satisfied	46% White UK/British	51% BME	City Tracker 2014 results
Satisfaction with road maintenance- % very/fairly satisfied	27% White UK/British	43% BME	City Tracker 2014 results

Satisfaction with pavement maintenance- % very/fairly satisfied	29% White UK/British	42% BME	City Tracker 2014 results

Housing issues highlighted in snapshot report	Comparator	Notable differences in outcomes or perceptions	Source
Home ownership-% living in owned or part-owned accommodation	59% White UK/ British	40% BME Most likely: -56% White and Asian -54% White Irish -50% Indian -49% Pakistani -46% Bangladeshi Least likely: -21% Black African 25% Gypsy or Irish Traveller 29% Arab	Census 2011
Social rented homes- % living in social housing	15% White UK/British	12% BME Most likely: -23% Black/Black British (high level category) -33% Bangladeshi -32% Gypsy & Irish Traveller Least likely: -5% Indian -6% Other White	Census 2011

		-6% Chinese	
Private rented homes - % living in private rented accommodation	24% White UK/British	45% BME Most likely: -56% Other White -48% Black/Black British (high level category) -47% Chinese Less likely: -17% Bangladeshi -24% White UK/British	Census 2011
Approaches to Housing Options team for assistance to prevent homelessness		The results below are consistent with the previous assessment 3.4% Black/Black British (1.5% of population)	Housing Options data 2013/14
Homelessness prevention - % casework outcomes where homelessness was prevented	62% overall	60% BME -38% Black Caribbean -38% Mixed White and Black African -48% Black African -50% Black Other	Housing Options data 2013/14
Homeless applications		8%- Black/Black British (1.5% of population) (2012/13 figure was 6% for Black/Black British)	Housing Options data 2013/14
Homeless acceptances		7% - Black/Black British (1.5% of population) (2012/13 figure was 5% for Black/Black British)	Housing Options data 2013/14
Homelessness - % homeless applications accepted	38% overall	37% BME 34% - Black/Black British	Housing Options data 2013/14
Waiting for social housing - % on Housing		The results below are consistent with the previous assessment	Housing Options data

Register compared to city profile		5% Black/Black British (1.5% of population)	2013/14

Health and wellbeing issues highlighted in snapshot report	Comparator	Notable differences in outcomes or perceptions	Source
Good health- % saying in good or better health	84% all respondents	88% BME -95% Asian/Asian British -62% White Irish	Health Counts Survey 2012
Long term health problems /disability -% reporting long term health problem or disability	17% White UK/British	11% Black ethnic groups 9% Asian ethnic groups 9% Mixed/dual heritage groups	Census 2011
Overweight and obese - % overweight or obese	53% all respondents	57% White Irish 54% Black/Black British 33% Mixed/dual heritage 32% Other White	Health Counts Survey 2012
Breastfeeding initiation - % mothers breastfeeding on birth of child	86% White UK/British	97% Other White 97% Black/Black British 92% Asian/Asian British	Public Health directorate 2014
Hospital admission rates – rate of admissions per 100,000 population	19,763 all residents	30,716 Chinese or other ethnic background	Hospital episode statistics 2011/12
Hospital admission for circulatory disease – rate of admissions per 100,000 population -	1,271 all residents	1,931 Chinese or other ethnic background	Hospital episode statistics 2011/12
Hospital admission for respiratory disease– rate of admissions per 100,000 population	1,133 all residents	2,306 Chinese or other ethnic background	Hospital episode statistics 2011/12
Satisfaction with GP - % very/fairly satisfied	78% White	69% BME	City Tracker 2014

	UK/British		results
Satisfaction with NHS dentist - % very/fairly satisfied	63% White UK/British	56% BME	City Tracker 2014 results

Culture and leisure issues highlighted in snapshot report	Comparator	Notable differences in outcomes or perceptions	Source
Attended a creative, artistic, theatrical or musical event in last 12 months	63%	53% BME	City Tracker 2014 results
Visited museum or gallery in last 12 months	59% White UK/British	54% BME	City Tracker 2014 results
Library users - % completing library survey as proxy for library users compared to city profile		6.7% more BME than city profile -3.5% more Other White users than city profile -2.8% more Gypsy/Traveller	Brighton and Hove libraries user survey 2013/14
Frequent library users – visit daily	6% White UK/British	18% BME	Brighton and Hove libraries user

Community safety issues highlighted in snapshot report	Comparator	Notable differences in outcomes or perceptions	Source
Male victims of crime – rate per 1,000 members of male population reporting being victims of crime	36.9 White	45.7 non-White ethnicity	Sussex Police 2013/14
Female victims of crime – rate per 1,000 members of female population reporting being victims of crime	34.5 White	23.1 non- White ethnicity	Sussex Police 2013/14
Male charges (offending rate)- rate per 1,000 population	38.8 White UK/British	51.6 BME	Sussex Police 2013/14
Female charges (offending rate) –rate per 1,000 population	11.4 White UK/British	6.5 BME	Sussex Police 2013/14

Feelings of safety - % saying they feel safe in the city after dark	46% White UK/British	57% BME	City Tracker 2014 results
Feelings of safety - % saying they feel safe in own area after dark	70% White UK/British	67% BME	City Tracker 2014 results

Employment and skills issues highlighted in snapshot report	**Comparator**	**Notable differences in outcomes or perceptions**	**Source**
Students - % adults (16+) who are students	12% White UK/British 25% BME adults	Most likely: -56% Chinese -37% Asian/Asian British -35% Black/ Black British Least likely: 12% White UK/British	Census 2011
Economically active - % economically active	66% White UK/British 67% BME	Most likely: 76% Other White 74% Black Caribbean Least likely: 47% Arab 39% Chinese	Census 2011
Female economic activity -% economically active	61% White UK/ British 64% BME	Most likely: 74% Other White 73% Black Caribbean Least likely: 41% Bangladeshi	Census 2011

		40% Chinese	
Male economic activity - % economically active	71% White UK/ British 70% BME	Most likely: 78% Bangladeshi 78% Other White 75% Black Caribbean Least likely: 56% Arab 37% Chinese	Census 2011
Employment rate - % employed	62% White UK/ British 61% BME	Most likely: 71% Other White 64% Black African 64% Black Other Least likely: 35% Chinese 41% Arabs	Census 2011
Female employment rate - % employed	58% White UK/ British 58% BME	Most likely: 69% Other White 65% Black Caribbean Least likely: 33% Chinese 33% Bangladeshi 26% Arab	Census 2011
Male employment rate - % employed	65% White	Most likely:	Census 2011

	UK/British 64% BME	77% Other Black 73% Other White 70% Bangladeshi Least likely: 41% Arab 35% Chinese	
Unemployment rate - % unemployed	7.3% overall	Most likely: 18.7% Black African 16.9% Mixed White and Black African 15.9% Mixed White and Black Caribbean 15.3% Gypsy or Irish Traveller	Census 2011
Female unemployment rate - % unemployed	6% White UK/British	Most likely: 22% Arab 21% Bangladeshi 19% Black African	Census 2011
Male unemployment rate - % unemployed	8% White UK/British	Most likely: 23% Gypsy or Irish Traveller 18% Mixed White and Black African 17% Mixed White and Black Caribbean 16% Black Caribbean	Census 2011
Females economically inactive - % economically inactive	39% White UK/British 36% BME	Most likely: 66% Arab 60% Chinese	Census 2011

		59% Bangladeshi	
Males economically inactive - % economically inactive	29% White UK/British 30% BME	Most likely: 63% Chinese 44% Arab Least likely: 17% Other Black 22% Other White 22% Bangladeshi	Census 2011

DOES MONEY AFFECT CHILDREN'S OUTCOMES?

Evidence abounds that children in lower-income households do less well than their peers on many outcomes, including in health and education. But is money itself important, or do these associations reflect other household differences, such as parental education levels or attitudes toward parenting? This study reviewed the evidence, focusing on research investigating whether money is the cause of these differences in children's outcomes.

Key points

- This review identified 34 studies with strong evidence about whether money affects children's outcomes. Children in lower-income families have worse cognitive, social-behavioural and health outcomes in part *because they are poorer*, not just because low income is correlated with other household and parental characteristics.
- The evidence was strongest for cognitive development and school achievement, followed by social-behavioural development. Income also affects outcomes indirectly impacting on children, including maternal mental health, parenting and home environment.
- The impact of increases in income on cognitive development appears roughly comparable with that of spending similar amounts on school or early education programmes. Increasing household income could substantially reduce differences in schooling outcomes, while also improving wider aspects of children's well-being.
- A given sum of money makes significantly more difference to children in low-income than better-off households (but still helps better-off children).
- Money in early childhood makes most difference to cognitive outcomes, while in later childhood and adolescence it makes more difference to social and behavioural outcomes.
- Longer-term poverty affects children's outcomes more severely than short-term poverty.
- Although many studies were from the US, the mechanisms through which money appears to affect children's outcomes, including parental stress, anxiety and material deprivation, are equally relevant in the UK.

The research

By Kerris Cooper and Kitty Stewart, Centre for Analysis of Social Exclusion, LSE

OCTOBER 2013

BACKGROUND

Children in lower-income households tend to fare less well in school and to have worse health than their better-off peers. However, it is not clear how far this is due to differences in financial resources and how far to other household factors (e.g. levels of parental education or parenting approaches). Such uncertainty leaves room for considerable difference of opinion about policy solutions. Would raising household income make a difference to children's outcomes, or would it be better to focus on investing in schools or improving parenting skills?

This review examined studies which used particular research techniques to separate the effect of money from other correlated factors, to isolate whether money was a direct cause of differences in outcomes. It identified 34 relevant, high-quality studies from OECD and European Union countries examining children's health, social, behavioural and cognitive outcomes, as well as intermediate outcomes affecting children, such as maternal mental health, parenting and the home environment.

Does money matter, and how much?

The studies indicated clearly that money makes a difference to children's outcomes. Less well-off children have worse cognitive, social-behavioural and health outcomes in part because they are poorer, not just because low income is correlated with other household and parental characteristics. Low income affects direct measures of children's well-being and development, including their cognitive ability, achievement and engagement in school, anxiety levels and behaviour. The evidence on cognitive development and school achievement was the clearest and most common, followed by that on social and behavioural development. Of the 34 studies, only five found no evidence of a money effect on any of the outcomes examined, with methodological reasons for this in at least four cases. The studies also found effects of low income on outcomes that indirectly affect children, including parenting, the home environment, maternal depression, and smoking during pregnancy.

The effect of low income on cognitive and schooling outcomes appears to correlate broadly with the effects of spending corresponding amounts on school or early education programmes. Rough calculations suggest that increases in household income would not eliminate differences in schooling outcomes between low-income children and others, but could contribute to substantially reducing these differences. For example, increasing household income for children in receipt of free school meals (FSM) by £7,000, which would raise them to the average income for the rest of the population, might be expected to eradicate around half the gap in Key Stage 2 outcomes between FSM and non-FSM children.

What else is known about income effects?

The review found strong evidence that income effects are non-linear: an additional dollar or pound makes most difference to children in households on lower incomes than for those in better-off households. All thirteen of the 34 studies which asked this question reached the same conclusion. So does additional income cease to have any effect beyond a certain point? The evidence for this was mixed. Some studies found no impact of additional income on families above the poverty line (mostly taken as the official US poverty line), but others found that income continues to affect some health and schooling outcomes much higher up the income distribution scale, albeit a smaller effect than in less well-off households.

Evidence on whether money matters more at some stages of childhood than others was inconclusive, and seemed to depend partly on the type of outcome. Just five of the 34 studies considered this issue. They mostly focused on cognitive outcomes, and most indicated that financial resources in early childhood matter most. For behavioural outcomes, in contrast, the one relevant study found that income in later childhood is more important. As evidence in this area was so limited, the review

explored a broader set of studies that did not qualify for inclusion in the main evidence base. These were less clear in relation to the hypothesis that income in early childhood is more important for cognitive outcomes than income later on. However, they supported the idea that income in later childhood and adolescence is more important for behavioural outcomes than income earlier on.

Longer-term experience of poverty seems to affect children's outcomes more severely than short-term periods of low income. This was a common finding in observational studies, but was difficult to interpret because income is more accurately measured over a longer time period. Nonetheless, some evidence suggests that at least part of this association is causal.

None of the studies directly tested whether the source of income matters for children's outcomes, and nothing in their findings suggested that the source is relevant. Many studies examined increases in income as a result of benefit changes and found positive effects on a range of children's outcomes, similar to the smaller number of studies examining other sources of income change.

Just one study examined the importance of who within the household received additional income. It found that children's educational outcomes improved if mothers received additional money, but not if fathers did. This finding is consistent with wider evidence and with 'purse versus wallet' theories which predict that mothers are more likely to spend income on children than fathers are.

Assessing the size of money effects

Of the 34 studies, six used evidence from randomised controlled trials, 13 evidence from natural experiments or other external variation in financial resources (e.g. an oil shock affecting a particular region in Norway, or variation in benefit entitlement across US states), while 15 used 'fixed-effect' techniques on longitudinal household survey data, focusing on within-household changes in income and outcomes over time. Both the size and significance of identified effects were sensitive to the methods used, with fixed-effect studies identifying considerably smaller effects than those using other approaches. This is likely to be because of measurement error in household survey data on income, which is difficult to capture accurately at any given point because of its volatility and complexity. Measures of income change over time can therefore be particularly inaccurate. Other techniques are less subject to this problem as they frequently use a known quantifiable change in income, such as an alteration to the benefit system. Fixed-effect results seem to significantly underestimate the true size of money effects, and researchers using these techniques need to be aware of this issue.

Conclusion

There is strong evidence that households' financial resources are important for children's outcomes, and that this relationship is one of cause and effect. Protecting households from low income is unlikely to provide a complete solution to less well-off children's worse outcomes, but ought to be a central part of Government efforts to promote children's opportunities and life chances. The impact of increases in income on cognitive outcomes appears to be comparable with the effects identified for spending on early childhood programmes or education. However, income influences many different outcomes at the same time, including maternal mental health and children's anxiety levels and behaviour. Few other policies are likely to affect such a range of outcomes at once.

The downside of this picture, particularly in the current economic climate, is that reductions in household income are likely to have wide-ranging negative effects. Part of the Government's deficit reduction strategy is to reduce welfare budgets in order to limit spending cuts to essential public services, including education, with a view to protecting children's life chances. However well intentioned, the evidence from this review suggests that such a strategy is likely to be self-defeating, especially in a context of high unemployment. Reductions in financial resources in low-income households will damage the broader home environment in ways that will make it harder for public services to deliver for children.

Although most of the studies reviewed were from the US, the mechanisms through which income appears to affect children's outcomes are likely to apply equally in the UK. The studies found

supporting evidence for two central theoretical models regarding *how* income affects children's outcomes, one relating to the stress and anxiety caused by low income – the 'family stress' model – and the other to parents' ability to invest in goods and services that further child development – the investment model. However, this review focused on quantitative evidence, which is not always effective in answering 'why?' questions. Qualitative research would offer further insight.

About the project

This research was by Kerris Cooper and Kitty Stewart, Centre for Analysis of Social Exclusion, London School of Economics and Political Science.

The review used systematic review techniques to identify relevant research studies from 1988 to 2012. Studies were only included if they used randomised controlled trials, natural experiments, instrumental variable techniques or fixed-effect approaches on longitudinal data. In all, 46,668 studies were screened; 34 met the full criteria and a further 58 were included in additional discussion. The majority of these studies were from the US, with some from the UK, Canada, Norway and Mexico.

FOR FURTHER INFORMATION

This summary is part of JRF's research and development programme. The views are those of the authors and not necessarily those of JRF.

The full report, **Does money affect children's outcomes? A systematic review** by Kerris Cooper and Kitty Stewart, is available as a free download at www.jrf.org.uk

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ISSN 0958–3084

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Youth Work Review 2015 Brighton & Hove

Version 3 Final Committee

Brighton & Hove City Council

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1. Aim of report

This report sets out proposals for a city-wide partnership vision for the commissioning and provision of open access and targeted Youth Work services across Brighton & Hove.

The report describes a co-production review process during which commissioners, providers and young people together explored future delivery arrangements through a Review Group chaired by the Director of Children's Services. This report contains the findings and recommendations from the Review Group.

2. Executive summary

The Youth Service Review Board is recommending a model for youth work based on evidence based youth work practice. It proposes a 'flexible continuum' of joined up services from open access provision for disadvantaged neighbourhoods and communities, to targeted interventions for the most vulnerable young people and opportunities for all young people to have fun in spaces welcoming to them.

The Review Group recognises the severe financial pressure faced by the council including the likelihood of significant reductions in funding. Preliminary discussions have taken place about innovative thinking including new delivery models to attract and develop alternative revenue streams that could sustain the provision of youth services.

The Youth Review Board recommends that:

1. The council adopts the model of youth work set out in paragraph 8.1 and the outcomes framework and principles set out in paragraphs 6 and 7.

2. Council officers complete a Business Plan based on this report including:
   - Arrangements to explore new delivery models for services for vulnerable and disadvantaged children, young people and their families
   - Confirmation of the budget available for the proposed model of youth work
   - A service specification and commissioning process for open access and targeted youth work
   - Any necessary transitional funding and delivery arrangements between 2015/16 and 2016/17

3. Introduction and background

In 2011 the House of Commons Education Committee published 'Services for Young People' which succinctly describes the context for youth work:

'Local authorities have a duty to provide sufficient educational and recreational leisure-time activities for young people aged 13-19, and those aged 20-25 with learning disabilities. Provision has typically taken the form of open-access services, including a range of leisure, cultural and sporting activities often based around youth centres. Local authorities also provide targeted services for vulnerable young people, such as teenage pregnancy advice, youth justice teams, drug and alcohol misuse services and homelessness support. Whilst some authorities provide services directly, many are contracted out to voluntary, community or private organisations.' (House of Commons June 2011).

In August 2014 the National Youth Agency defined youth work as:

'Youth work is an educational process that engages with young people in a curriculum built from their lived experience and their personal beliefs and aspirations. This process extends and deepens a young person's understanding of themselves, their community and the world in which they live and supports them to proactively bring about positive changes. The youth worker builds positive relationships with young people based on mutual respect', (National Youth Agency Vision for Youth Work in England to 2020 – August 2014)

The Children's Service Directorate Plan sets out that long term vision for children and young people:
"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."

The Children, Young People and Skills Committee have agreed the following 4 priorities:

- Ensure that the most vulnerable and disadvantaged children receive the council's support, consolidating services where possible, and targeting resources at those most in need
- Take the council on an improvement journey to achieve excellent services for children and young people by 2019, as rated by Ofsted
- Provide greater challenge and support to council maintained schools to close the disadvantage and educational attainment gaps, including a focus on STEM subjects (Science, Technology, Engineering and Mathematics)
- Eliminate long-term youth unemployment (18-25 years old) and boost apprenticeships in the city by 2019

In common with other councils across England, Brighton & Hove City Council has to make savings across all service areas as a result of reductions in Government funding and pressures on services.

Nationally children's services are dealing with a growing number of child protection cases and children at risk of neglect. Reduced funding and rising demand mean councils need to change the way services for children and families are delivered. This includes work to strengthen early help services and "turn around" families just below social work thresholds as part of the Troubled Families initiative (known locally as Stronger Families Stronger Communities). Learning from this programme includes the importance of having one worker who works with the whole family to make sustainable changes.

A Fairness Commission has been set up to make sure that everyone has a share in the city's economic success, and an opportunity to lead healthy and productive lives. It was set up by the council, but is an independent body.

Brighton & Hove City Council plans to move to a co-operative model of service delivery. The City Neighbourhoods programme plans to establish hubs in the heart of communities, bringing appropriate services closer to those who need them by forging stronger links with local people. The neighbourhood hubs will host a variety of services, based on the specific needs and context of the local area; they will be delivered by council staff alongside a range of partners, including third sector organisations, and supported by volunteers. The aim is to save money, improve outcomes and reduce inequality.

The council published a joint commissioning strategy for services for young people in 2012. Based on a comprehensive needs analysis and extensive consultation with partners and young people, the strategy facilitated the development of an informal consortium of eight local voluntary sector providers - the Youth Collective - which successfully bid for a council contract to deliver open access youth work across the city.

In 2015/16 the Council will spend £1.6m on youth work. The Council's in house provision has been mostly targeted at vulnerable young people. Services commissioned from the Youth Collective have been mainly for open access provision.

£'000	Youth work spend
445	Contract/Equalities – Community & Voluntary Sector, youth and equalities groups
180	Administration/Management – Brighton & Hove City Council (BHCC)
410	Targeted Youth Work Interventions - BHCC
270	Participation & Youth Advocacy - BHCC
196	Open Access - BHCC
99	Targeted teenage pregnancy- BHCC (Public Health)
1600	**Total**

Significant reductions in youth work funding were proposed in February 2015 for the 2015/16 financial year. The council's Policy and Resources Committee subsequently agreed a Notice of Motion to extend existing contracts for a further 6 months to allow time for a review of the council's arrangements for the commissioning and provision of youth work to take place. The review was tasked with redesigning the delivery of youth work in the city focusing on the proportion of spend between targeted work (mostly delivered by Council staff) and open access activities (mostly delivered by the Youth Collective).

The remit of this review is to consider how the council provides and commissions services founded on a Youth Work curriculum. Youth work is integral to the early help interventions and preventive services provided or commissioned by the council and its partners to promote wellbeing, attainment and transition to employment and to avoid more costly social work intervention. The Review Group fully recognises that youth work is an integral part of this provision for young people and their families including: schools and colleges; statutory social work and youth offending services; public health programmes; and Child and Adolescent Mental Health Services.

From the beginning of its work the review has sought to respond to the following statement: 'Young people repeatedly tell us that they don't want to have to negotiate complex systems to access services – they need services that understand what it is like to be young, services which can either give them help directly, or to refer them to a service that can. Among all of this, young people want to have trusted sources of information and impartial advice'.
(Improving Young People's Health and Wellbeing: A framework for Public Health 2014)

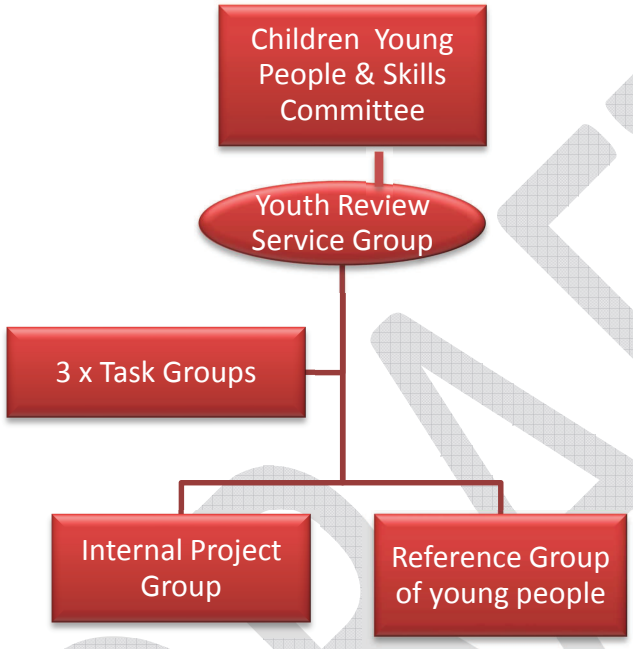
This report describes a model for the commissioning, delivery, support and co-ordination of youth work services to achieve the council's vision and priorities for children, young people and their families as set out above.

4. Youth Review 2015

4.1 Youth Service Review Group

A Review Group was established to manage, coordinate and oversee the review process. Membership has included young people, representatives of Community Works, Allsorts and Council officers.

Appendix 1 sets out the Terms of Reference for the Review Group and Appendix 2 lists membership, including the Task Groups. Governance arrangements for the review are set out in the following diagram:



The Review Group has agreed this report which will be presented to the Children Young People & Skills Committee on the 16 November 2015. The Committee will be asked to accept the report as the findings from the review and to agree the next phase of commissioning and service redesign.

The Review Group's first action was to set out that the purpose of youth work in the city is to:

- enable young people to develop holistically
- work with young people to facilitate their personal, social, educational development and good health
- support young people to develop their voice and influence and contribute to the common good
- help build a place for young people in the life of the city so as to reach their full potential, promoting inclusion and reducing inequality especially for young people with protected characteristics or who live in disadvantaged communities
- make sure young people have fun and enjoyment in spaces welcoming to them, recognising that adolescence is a time for exploration, new experiences and creative opportunities

The Review Group considered three broad options:

Option 1- do nothing – carry on with current spending and provision. This is not a realistic option as the council's budget is reducing significantly over the next 4 years.

Option 2 – end all council funding of youth work 2016/17. This was not considered to be viable because of the significant negative impact on the wellbeing and outcomes for young people.

Option 3 – a redesigned model that allows for significant savings whilst building sustainable, resilient provision for young people. This is the preferred option of the Review Group.

4.2 How were young people involved in the review?

Young people played a vital role in this review:

- Four members of the Review Group came from the Youth Council, Allsorts and the Hangleton & Knoll Project
- These four members also Co- Chaired the Task & Finish Groups
- Young people currently using youth services were invited to join the Reference Group

The reference group met three times during the review:

- In May when they provided general feedback on the review and their thoughts on youth services
- In July when members of the main Review Group, including the Director of Children's Services, were invited to hear their challenges and ideas
- In October they considered the outcomes framework and communication

Wednesday Croft from the Youth Council said ***"The Youth Review has been a brilliantly inclusive and absorbing experience - the financial drive for conducting the review was difficult and needed to be handled delicately, as sadly cuts to budget and services generally don't mean improvements. However I think we tried our best to mitigate the damage, and I feel that the ideas we came up with, and our method of practice was as successful as it could have been in the circumstance. It was great to work within the steering group itself, and also the young people's reference group. Both groups were equally rewarding, and it's fantastic to be so immersed in such a large project that will affect so many people, and know that the input I have is genuinely being listened to and my opinion respected. I think it's fantastic how eager the group were to have young people so involved - we each co-chaired a task group, and we were supported amazingly."***

James Holmes from the Youth Council said ***"Being involved with this report has been a very positive experience and it has given me an insight into how local government works. I understand much better how decisions are made and how they can be influenced. I feel that everyone involved has respected me and I never felt patronised, and everyone was genuinely interested in our opinions. Sometimes I felt I didn't have the expertise and experience to be able to contribute, but most of the time I felt I had a useful role".***

Sophie Murphy, one of the young participants, said the experience of being on the Review Group and the Co-Chair of the Model of Delivery Task & Finish Group was ***"an interesting, brilliant and positive learning experience working alongside Chris and had been involved in so much and learned a lot about the service"***

Reuben Davidson, Allsorts, young participant- ***"inviting young people to take part in the Youth Review empowers them to have their opinions, especially on such a significant topic, heard by the people making recommendations around their services. I felt privileged to represent the growing community of LGBT young people in Brighton and Hove during a time where economic limitations can have a profound impact on our futures."***

4.3 Task & Finish Groups

The Review Group agreed to establish three Task and Finish groups to consider:

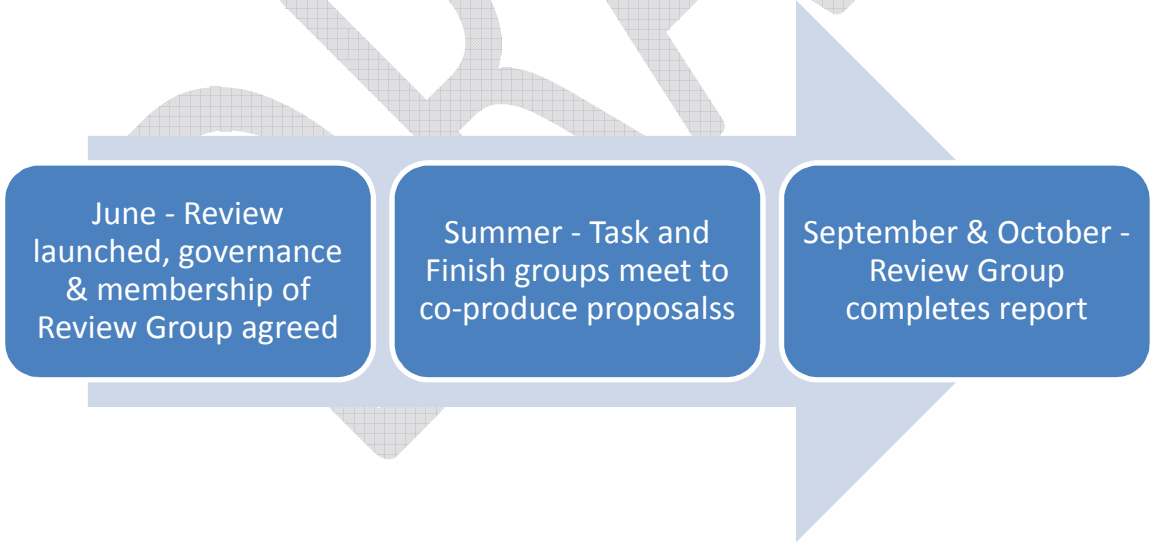
- **Buildings** - the use and feasibility of current youth centres in the future delivery of youth work and the resources required to support their use
- **Model of Delivery** - benchmarking other models of delivery to develop a proposal for Brighton & Hove to address the needs of young people within available resources
- **Outcomes** - the principles and outcomes for all youth work services provided or commissioned by the Council.

The Task & Finish Groups reported their findings to the Review Group as the work progressed.

4.4 Internal Support Project Board

An Internal Support Project Board was established to coordinate support for the review from across the council including finance, human resources, procurement, estates and legal advice.

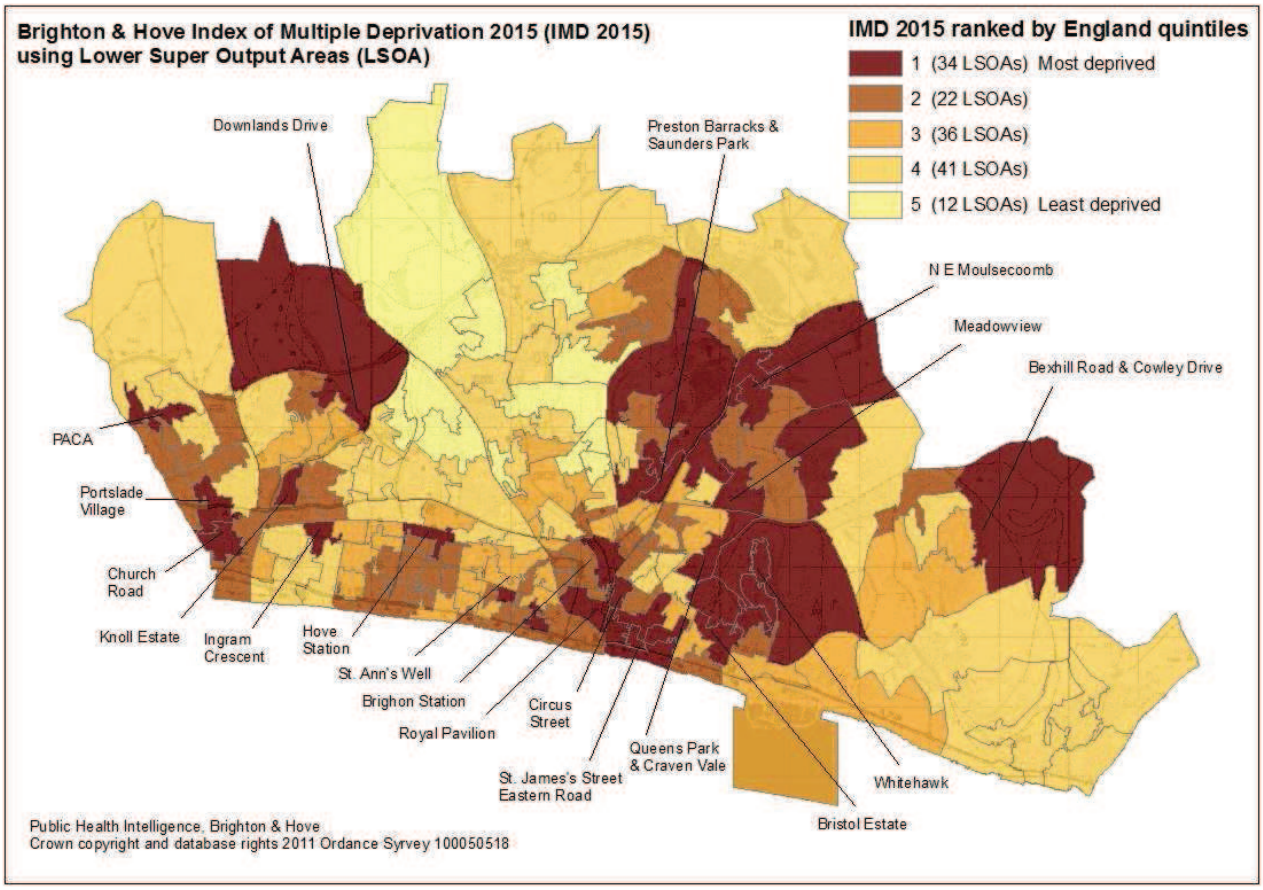
4.5 Timeline of the review



5. What we already know about young people in our city

5.1 Brighton & Hove Index of Multiple Deprivation 2015

The Table below evidences the highest proportion of children aged 0-15 year's old living in income deprivation. This only represents 4 years of young people within the remit of this review; which is 11-19 and up to 25 years. This shows us the pockets of deepest deprivation across the city and therefore helps us to see where the most help/support is needed.



5.2 Young People's Needs Assessment

The Youth Review Group's second action was to put together a young people's needs analysis. Closely linked to the city's Joint Strategic Needs Analysis, the data has underpinned the Group's work and the work of the Task and Finish Groups.

This summary sets out the context and issues which shaped the outcomes, principles and strategy proposed by the Review Group.

Young people's local profile

Locally

- Brighton & Hove has an estimated 18,000 young people aged 13-18 years and 1,573 aged 19-25 with special educational needs (SEN)
- Detailed local census information is available at the City Snapshot of Statistics (2014)
- As of May 2015, 674 young people were referred to the Early Help Weekly Allocation

Meeting due to concerns about their emotional wellbeing

- Overall there has been a rise in 5+ A*-C including English and Maths, to be above national and in the top quarter of local authorities in England. The Free School Meals attainment percentage point gap has closed to 36.4 percentage points from 37.1 percentage points as the free school meal group rise in results has been greater than the rise in the non-free school meal results. This attainment gap was wider than the 2013/14 national gap of 27.0, and the 2013/14 statistical neighbour average gap of 33.6
- In July 2015, Brighton & Hove reported that 5.1% of young people were not in education, employment or training (NEET), with 90% of 16 and 17 year olds participating in education and training
- There are currently 572 children aged 11 or over who are Children in Need and 109 who are subject to a Child Protection Plan.

Nationally

- Young people aged 16 and 17 are most at risk of abuse and neglect
- Anxiety disorders are among the most prevalent mental health problems affecting adolescents

Key documents

NEET Scorecard – Narrative 2015
SAWSS Briefing 2014
Youth Service Needs Assessment 2011

Young people – Disability

Locally

- The Disabled Young People's Council say inclusive provision is still lacking locally and nationally
- Significant numbers of referrals for sexual health support and concerns around sexual exploitation for young women with SEN
- Young people with SEN are more likely to report that they have experienced bullying as well as being more likely to bully others

Young people – Ethnicity

Locally

- There are 5,218 Mixed Ethnic background 0-19 year olds in Brighton & Hove, making this the largest ethnic group of young people in the city aside from White UK/British
- Black and Minority Ethnic (BME) young people report their main issues are education, employment, racism and racial discrimination and mental health and well-being
- More BME young people report being bullied than white British young people
- More BME young people are accessing Youth Work provision than last year
- More than expected BME young people are subject to a Child Protection Plan

Young people – Gender

Locally

- Youth work engages more with boys (60%) than with girls (40%)
- Boys are more physically active than girls
- Girls are more likely to experience bullying than boys
- Girls are more likely to smoke and drink alcohol than boys, however, boys are more likely to have tried prescription drugs
- White British boys in receipt of Free School Meals are most likely to underachieve at school

Nationally

- Physical activity declines across adolescence, particularly for young women
- Girls are more likely to self-harm. Mental health and risk of suicide is more prevalent in boys

Young people – Gender Reassignment

Locally

- The Trans Needs Assessment states that 55 young trans people are in contact with local specialist youth provision
- Transgender young people leave school earlier than any other group
- Transgender young people report bullying and harassment at school

Nationally

- Isolation, unemployment, mental health and hate crimes are almost a daily part of the life for many transgender people
- Discrimination and stigma can lead to an increased risk of depression and suicide

Young people –Neighbourhoods and Poverty

Locally

- 22.2% of young people live in families on less than 60% of median national income
- 3,333 young people aged 13-18 years were identified as living in one of the 20% most deprived Lower Super Output Areas in England
- Schools in East Brighton report more bullying than the rest of the city
- Carers in vulnerable communities or families with low income will have reduced options for their children to be involved in positive activities
- The rate of family homelessness is worse than the England average

Nationally

- There are strong links between income inequality and general health among young people
- Young people in the poorest households are three times more likely to have poor mental health than those in wealthier homes

Young people – Sexual Health/Pregnancy

Locally

- Lower percentage of births to teenage girls compared with national average
- Level of need for sexual health support in the city is high and often includes concerns around sexual exploitation. Referrals are mainly for young women – a significant number of which are for SEN young women

Nationally

- Pregnancy rates are falling
- Young people with unplanned pregnancy and teenage parents are at risk of poor educational achievement, poor physical and mental health, social isolation and poverty

Young people – Sexual Orientation

Locally

- 3,200 young people aged 13-24 years are a part of the LGBT community in Brighton & Hove
- LGBT young people are 'very likely' to experience bullying

Nationally

- Lesbian, gay, bi-sexual and transgender (LGBT) young people are more likely to be homeless than their non-LGBT peers

Young people – Risky behaviours

Locally

- Criminal behaviour – In 2011, 200 young people were recorded as being First Time Entrants (FTE) into the Youth Justice System
- Smoking – Smoking increases with age with 4% of students aged 14-16 saying that they smoke regularly (2014). Smoking is more common amongst the following groups of young people – LGBT young people, those who say they are not happy, those who have truanted or been excluded from school and those who have tried alcohol, drugs or had sex
- Sex and relationships – In 2014, the proportion of under 16s who have had sex (18%) is lower than the national figure (28%). Those who are sexually active generally know how to access free contraception (75%), get tested for chlamydia (45%) and are aware of emergency hormone contraception (57%)
- Alcohol and substance misuse – The number of young people reporting trying alcohol has decreased over the last three years (52% in 2014, 62% in 2011). Only 4% of 11-14 year olds have taken non-prescribed drugs – this figure rises to 21% for 14-16 year olds
- Domestic violence – In 2013, 52% of children who were subject to a Child Protection Plan had domestic violence/abuse recorded as a contributory factor for becoming subject to a CPP. The police reported that 29% of domestic violence cases had a victim aged between 16-25

- Radicalisation – Activities designed to engage and support young people at risk of radicalisation has increased over the last two years. The vast majority of young people (94%) thought that schools were the best environment in which to discuss terrorism
- Sexual exploitation – The Brighton & Hove LSCB confirmed child sexual exploitation as a priority area in 2013. In 2014, 6% of Single Assessments identified child sexual exploitation as a factor at the end of the assessment. The WiSE Project in Brighton & Hove worked with 86 young people in 2013-14 who were experiencing sexual exploitation or were at risk of experiencing it

6. An Outcomes Framework for Youth Work: how will we measure impact?

The Review Group established a Task and Finish Group to identify the outcomes we expect youth work to achieve.

An outcomes framework for Youth Work in the city has to be seen in the context of a whole system approach to children's services. A key principle of that approach is that additional needs are identified as early as possible and addressed through effective preventive services and, where necessary, early help interventions that focus on working with children, young people and their families to reduce the need for costly specialist services.

The purpose of an outcomes framework is to empower frontline staff to improve the quality of their services and demonstrate the impact of their work; to enable commissioners and investors to gather evidence and analyse the difference that services make to young people, and to offer a common language to support ongoing discussion and development of approaches to measuring and demonstrating the impact of services on the personal and social development of young people. See link below.

https://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/Outcomes_Framework_draft_final_for_publication.pdf

Rather than import a ready-made outcomes framework, the Task and Finish Group used external sources (especially the Cabinet Office report: 'Outcomes Frameworks: a guide for providers and commissioners of youth services' [December 2014]) to create a set of the short term, medium and long term outcomes we should expect from youth work provision. The proposed outcomes framework will underpin future service specification, service redesign and contract and performance management.

The Review Group recommends that youth services funded by the city council regardless of provider should be working to achieve the following short term outcomes which support the delivery of medium and longer term outcomes.

Short Term Outcomes:

Greater self-awareness, agency and confidence:

- Confidence about their own identity in all its aspects (protected characteristics, socio-economic background, educational and/or vocational abilities, character)
- High self-esteem and sense of self-worth, respect and ability

- Aspirational and motivation to achieve for themselves to be ambitious
- Greater self-awareness and emotional intelligence
- Greater self-agency and resilience
- Strong interpersonal skills
- Advocate positively and constructively for self with peers, family, adults, services
- Participate and respond to conflict, change and challenge appropriately and positively and able to minimise negative impact for themselves and others
- Make and maintain positive relationships (family/carers, peers, partners, other adults) and leave negative ones positively maintaining sense of self and self-esteem
- Better relationship with their family and peers, school community and local community
- An understanding of risk and impact of risky behaviour and able to make informed decisions about risk-taking and opportunities for support to stay safe
- An understanding of the importance of a healthy lifestyle and take action to reduce unhealthy habits and increase healthy one

<u>Greater understanding of community, cohesion and civic society:</u>

- Individuals' rights and responsibilities
- Politics and democratic decision making locally and nationally
- Voluntary action as individual or group of individuals
- Community participation
- Equality
- Diversity and community cohesion and tolerance – respecting diversity and feeling connected to and a member of a community including for example, in respect of Government Policy concerning British Values
- Respect for your community – who you live with, where you live and how you behave
- Sustainability and environmental awareness

Medium Term Outcomes:

<u>Raised and positive aspirations and ambitions</u>**:**

- Positive outlook towards education and training and possible future opportunities in employment, education or training and to improve school attendance
- Better school attainment including educational attainment and readiness for work/training/further education and life skills
- Proactively reducing or avoiding risky behaviour and unhealthy habits and choosing healthier lifestyle activities/options
- Continual increase in their ability to positively respond and be resilient to change and challenges be these at school, in employment/training/further education, at home in the family, with peers, with partners and move towards independent living
- Continual increase in self-agency and advocacy
- Active and responsible citizens

Long term outcomes:

- Sustainable, fulfilling employment/training/further education with good future prospectus
- Active and responsible citizens
- Independent living skills and knowledge – practical and emotional
- A healthy lifestyle – physical, emotional and mental wellbeing
- Strong positive social network

As well as the outcomes framework proposed by the Task and Finish Group, the Review Group also recommends the following outcomes presented by the Young People Reference Group. The group felt the proposed outcomes were not easily accessible to young people. The outcomes they would like to see included are:

- Being able to have a say in how things are done - if you want to do something you can
- Learning how to make decisions
- Being listened to
- Somewhere for social mixing – breaking down barriers between groups or friends ie. if there's tension between two groups at school it can worked out in a youth club
- Communication skills
- Informal education
- Being able to take a break from life
- Feeling safe
- Being able to take your time to gain perspective on problems
- More wise
- Able to express your true emotions in a safe way with appropriate support
- Somewhere for social interaction – welcome and comfortable
- Advice that young people need, not that youth workers need to give
- Activities – freedom to explore new experiences and the support to do it safely
- Comfort zone – should be stretched and challenged
- Humanity Humility – showing your experience/honesty
- Professional and Informal
- A place TO BE

7. Principles for Youth Work

As well as creating an outcomes framework, the Task and Finish Group also drafted a set of principles for youth work in Brighton & Hove which have been amended and agreed by the Review Group and the Young People's Reference Group. Therefore it is proposed that all Youth Services funded by the city council should work to the following principles:

- They will work with young people aged 11 – 19 years (up to 25 years for young people with Special Educational Needs or a disability)
- Services are young person centred – young people have the opportunity to be fully involved in their individual care plans
- Engagement is voluntary and empowering for young people
- Young people participate in and drive service review, design and delivery at operational and strategic level
- Robust and up to date safeguarding practices and policies
- Prevention and early intervention to avoid escalation
- Equality and diversity embedded as well as targeted
- Open access youth work in targeted communities including geographical and/or identity: areas of multiple deprivation and young people with the following protected characteristics: BME, disability, LGBT, Gender
- The most vulnerable and disadvantage children are prioritised, but delivery promotes contact and cohesion across different cohorts of young people
- Young people have a creative role in the city's 'youth services system' which provides a continuum of interactions that deliver short, medium and long term outcomes and relates to

young peoples' experiences, and the 'offer' in other settings, for example, schools, further education, apprenticeships
- Youth work that provides information and guidance, and curriculum based informal educational leisure activities that generate short term outcomes and which relate and complement tailored targeted youth work and young people' offer in schools and further education
- Youth work contributes to closing the disadvantage and educational attainment gap

8. New Vision and Model for Youth Work:

8.1. Model of Delivery

The Review Group set up the Model of Delivery Task and Finish Group to explore different ways in which youth services could be delivered across the city within the context of shrinking budgets and growing demand.

The proposed model does not include any specific budget information and does not discuss in detail at this stage how the new model will be implemented. Those discussions will take place if the model is accepted at committee in November 2015.

Our driving ambition is to deliver youth work that is easy to access, joined up and reaches the young people we are most concerned about. The Review Group discussed the idea of a 'continuum of support' for young people, their younger siblings and their families – from universal and preventive services, through early help to specialist, sometimes statutory services.

The Young People's Reference Group pointed out that life is more complex than a straight line, that their lives often go through cycles; there are periods when everything is fine and other times when there are challenges and problems.

The Review Group is therefore proposing a model which responds flexibly as a young person's need emerges or changes. We have illustrated what we think a 'flexible continuum' of youth work support can offer with case studies (see Appendices 4 to 9).

Youth work provided or commissioned by the council must, and will, build upon the city's assets, the dedicated buildings, the skilled staff and existing networks and relationships in order to maximise opportunities to bring new resources to support young people in the future.

The Review Group is therefore proposing a model that has three parts based on established youth work practice and management accountability:
- Community based open access youth work: using a youth work curriculum to promote inclusion and the voice of young people, support engagement with community networks and involvement with preventive services and public health programmes
- Targeted youth work: closely connected to open access provision, using relationships with youth workers to engage vulnerable young people and respond to the issues and challenges they face including, where possible, working with their families and the professionals who know them
- Central support and strategic planning: recognising that the Local Authority will have a coordinating and oversight role as the commissioner or provider of youth work services

including quality assurance, performance management, ensuring value for money and the strategic development of new delivery models for the city

The Review Group recommends both open access and targeted youth work services should:

- Benefit young people aged 11-19, up to 25 if they have special educational needs, who may be from local communities (such as an estate or neighbourhood), from communities of identity (such as being LGBT) or communities of interest (such as playing sport or involvement in art or theatre work)
- Target geographic communities of high need and communities of identify with particular emphasis on where those two communities intersect
- Be organised around the city's most disadvantaged neighbourhoods, linked to other areas in a cluster arrangement

That the city's open access youth work offer:

- Is at its best when understood as a process of informal education and engagement, providing activities which build relationships and develop peer support to promote equality and inclusion and improve outcomes for young people who may be facing multiple deprivation as a result of poor housing, health issues, low attainment at school or family poverty
- Is delivered through dedicated youth buildings, recognising in the future these are likely only to be buildings currently owned or run by voluntary sector organisations, or street based work or other community venues
- Supports, advocates and amplifies the voice of young people, developing the work of existing initiatives such as the Youth Council, schools' councils, the Children in Care Council and representation at the UK Youth Parliament
- Ensures youth volunteering is part of the youth work offer, building young people's skills and capacity and, critically, supporting transition from school to employment opportunities such as the council's Youth Employability Service, the Duke of Edinburg Award and the Prince's Trust
- Is part of the city's community development and adult learning programme, supporting accredited progression routes for young people and adults willing to volunteer to lead community action to provide activities for young people, and to engage them in locally representative governance structures

That the city's targeted youth work offer:

- Is at the heart of the city's early help and safeguarding pathway: supporting open access youth work to identify vulnerable young people and provide additional support; working closely with some young people and, where possible, with their families; and ensuring timely referral to specialist social work, youth justice or health services when necessary
- Supports the city's Stronger Families Stronger Communities programme working with young people and families facing multiple deprivation
- Uses street based interventions to identify the most vulnerable young people who may not be engaged with other services
- Works in close partnership with schools, health providers and public health programmes to create tailored interventions which engage young people, individually or in groups, in a consent driven process to provide a needs led, time bound package of support to prevent problems from escalating

That the city council has a central support function in respect of open access and targeted youth work that:

- Leads and coordinates a strategic approach to the future funding, commissioning and provision of youth work, prioritising the exploration and development of an alternative delivery model for the city such as a foundation or trust
- Works closely with other council departments, schools, colleges and community and voluntary sector organisations to ensure the provision of youth work is fully connected to the development and delivery of other services for young people
- Establishes a single outcomes framework and a consistent performance , contract management and quality assurance processes for the delivery of in house and externally commissioned services
- Ensures an effective, cross sector workforce development strategy is in place for youth work

At the *'Youth review and beyond'* event on the 28th October 2015 young people explored options for how youth services could be run, including models where the young people as beneficiaries are also the majority stakeholder. Young people expressed the importance of the support from youth workers and youth work to their lives and Brighton & Hove.

9. Conclusions and recommendations:

The Youth Service Review Board is recommending a model for youth work based on evidence based youth work practice. It proposes a 'flexible continuum' of joined up services from open access provision for disadvantaged neighbourhoods and communities, to targeted interventions for the most vulnerable young people and opportunities for all young people to have fun in spaces welcoming to them.

The Review Group recognises the severe financial pressure faced by the council including the likelihood of significant reductions in funding. Preliminary discussions have taken place about innovative thinking including new delivery models to attract and develop alternative revenue streams that could sustain the provision of youth services.

The Youth Review Board recommends that:

1. The council adopts the model of youth work set out in paragraph 8.1 and the outcomes framework and principles set out in paragraphs 6 and 7.

2. Council officers complete a Business Plan based on this report including:

    - Arrangements to explore new delivery models for services for vulnerable and disadvantaged children, young people and their families
    - Confirmation of the budget available for the proposed model of youth work
    - A service specification and commissioning process for open access and targeted youth work
    - Any necessary transitional funding and delivery arrangements between 2015/16 and 2016/17

Next steps and key contacts

This report will be presented to the Children, Young People and Skills Committee in November 2015 with recommendations.

Key Contacts:

Council Youth Service
Chris Parfitt – Service Manager Youth
01273 294252
chris.parfitt@brighton-hove.gcsx.gov.uk

Youth Collective
01273 230130
hello@brightonandhoveyouthcollective.org.uk

Appendices

Appendix 1: Terms of Reference of the Youth Service Review Group

Role and Function of the Youth Review Group

The function of the group is to take responsibility for the strategic direction and management of the review.

The key roles and responsibilities are to:

1. Develop a vision and Business Plan for the commissioning and provision of sustainable Youth Work services for Brighton & Hove, making the most effective and efficient use of all our resources.
2. Focus on the council's current provision and commissioning arrangements i.e.

Current BHCC in-house service (including interventions commissioned by the council's Public Health Directorate)
Youth Centres
Mobile & detached work
Targeted Youth Work
Participation
Youth Advocacy
Duke of Edinburgh award
Youth Arts
Outdoor education
Workforce training
Quality assurance
Public Health commissioned Youth Work
Buildings and accommodation

Collective Contract (currently commissioned by BHCC Children and Public Health Directorates)
Brighton Youth Centre
Crew Club
Deans Youth Project
Hangleton & Knoll project
Impact Initiatives – Young People's Centre
Sussex Central YMCA
Tarner Community Project
Trust for Developing Communities
Equalities (currently commissioned by BHCC Children's Directorate)
Allsorts
BMEYPP
Extra time

3. To identify options for short term and long term financial savings (current council spend is £1.6m on youth services. There will be a significant reduction to the overall budget; this will

be included in the wider budget proposals to be considered by the Policy & Resources Committee and Full Council).

4. Take into account any relevant resources, buildings or funding opportunities which partners may wish to take into consideration in light of the review process and their individual or collective strategic planning processes
5. Listen to the voice of young people ensuring that this informs and shapes how the council and its partners invest in youth work and related services
6. To consolidate pathways between community and universal services, and early help and specialist services, providing practical options for early help to meet the needs of vulnerable young people. Outcomes and impacts of interventions will need to be evaluated to ensure they meet identified needs
7. Take responsibility for the Business Plan and achievement of outcomes
8. Ensure the scope aligns with the requirements of the stakeholder groups, including, for example: the Young people Health outcomes; Joint Strategic Needs Assessment; Housing Options and Mental Health Services
9. Address any issue that has major implications for the programme
10. Reconcile differences in opinion and resolve disputes
11. Identify and manage risks through the Risk Register
12. Be committed to, and actively involved in, pursuing the programme or project's outcomes
13. Nominate a proxy to attend a meeting if they unable to attend

Process and Scope of the Review:

Through a process of collaboration and co-production, the Group will review current activity and set out options for the future commissioning and provision of youth work services by the council and its partners, including providers in the community and voluntary sector. This will include:

- Identification and evidence of need: including aspirations and priorities of young people of secondary age
- Baseline analysis: current activity and investment including: council revenue and capital; relevant partner revenue and capital; use of community/related assets; current delivery models and programmes
- Benchmark/gap analysis: using examples of good practice alongside statement of intent, evidence of need and baseline analysis to complete a gaps analysis and identify priorities
- Options appraisal: to take to stakeholders, decision makers and commissioners
- Business planning/implementation: commissioning and/or service redesign

Membership

The Project group shall be comprised of:

Name	Job Title	Organisation	Role
Pinaki Ghoshal	Director of Children's Services	BHCC	Chair
Steve Barton	Assistant Director Children's Services	BHCC	Deputy Chair
Chris Parfitt	Service Manager Youth and Communities	BHCC	Senior Responsible Officer
Emma McDermott	Head of Communities and Equalities	BHCC	Advisory role
Jess Wood	CEO Allsorts	Allsorts	Equalities

			representative from Community Works
Ben Glazebrook	Development Co-ordinator B&HYC	Impact Initiatives	Youth Work representative from Community Works
Jo Martindale	Chief Executive Officer	Hangleton & Knoll Project	Community representative from Community works
Kerry Clarke	Strategic Commissioner – Public Health	BHCC	Public Health Commissioner
Reuben Davidson **Wednesday Croft** **Maram Takriti** **Sophie Murphy**	Young people	Allsorts Youth Council Youth Council Hangleton & Knoll Youth Manifesto	Service users
Sharmini Williams	Project Manager	BHCC	Project support
David Ellis	Principal Accountant	BHCC	Financial advice

The Youth Review group will be attended by Sharmini Williams, Project Manager, who will present the monthly project reports and update the members on current progress and risks. The Youth Review group shall meet 6/8 weekly on the dates shown in the Meeting Schedule.

Chair

The Chair shall be responsible for convening project meetings, although may delegate organisation to the Project Manager or other support staff. If the usual Chair is not available, the Deputy Chair will chair the meeting.

Agenda Items

All Youth Review group agenda items must be forwarded to Sharmini Williams at least five working days prior to the meeting. The Youth Review group Agenda, with attached meeting papers will be distributed at least three working days prior to the meeting.

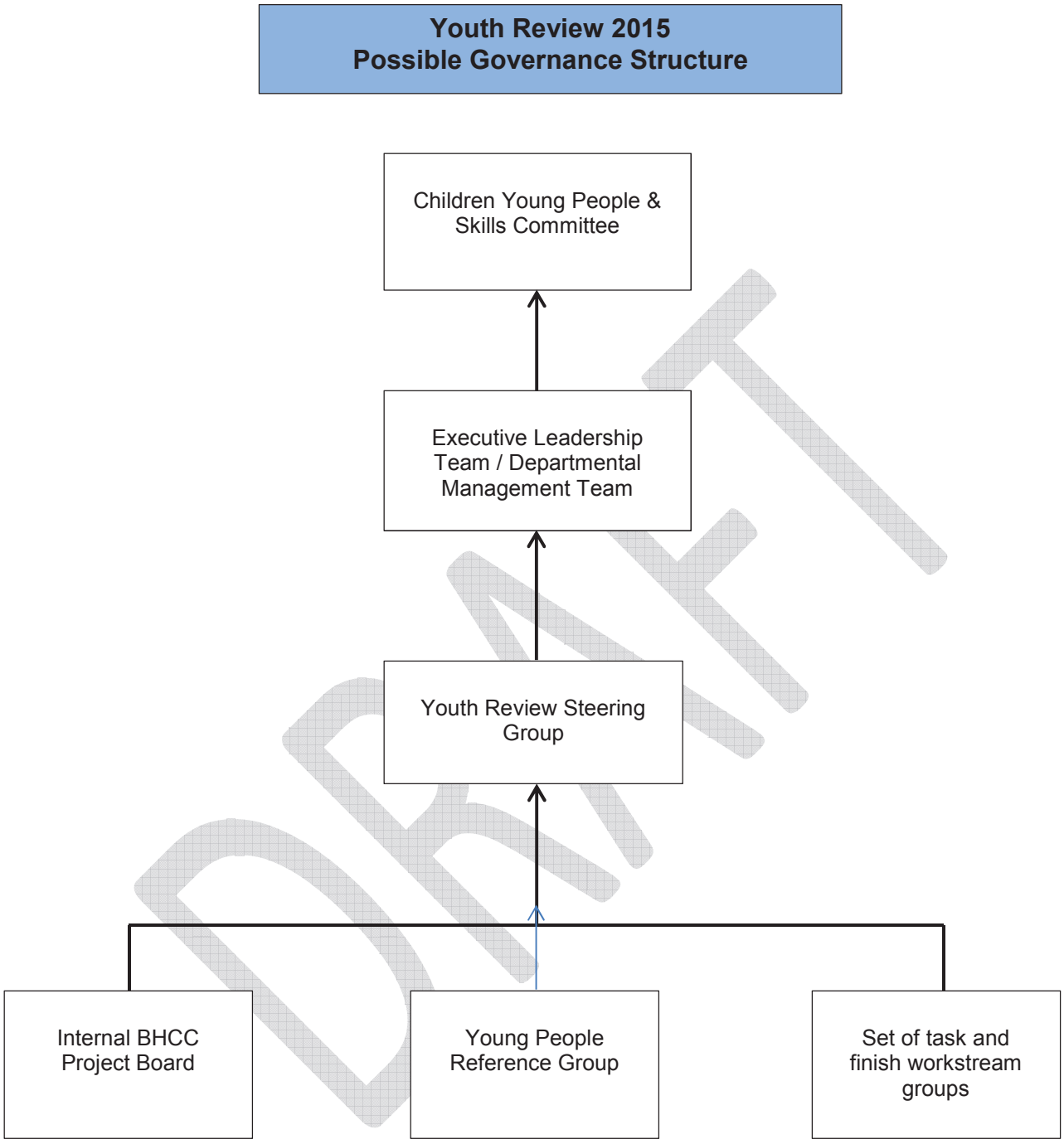
Minutes & Meeting Papers

The format of the group minutes shall be as previously circulated. The minutes of each group meeting will be recorded and distributed by Sharmini Williams.
Full copies of the minutes, including attachments, shall be provided to all group members no later than five working days following each meeting.

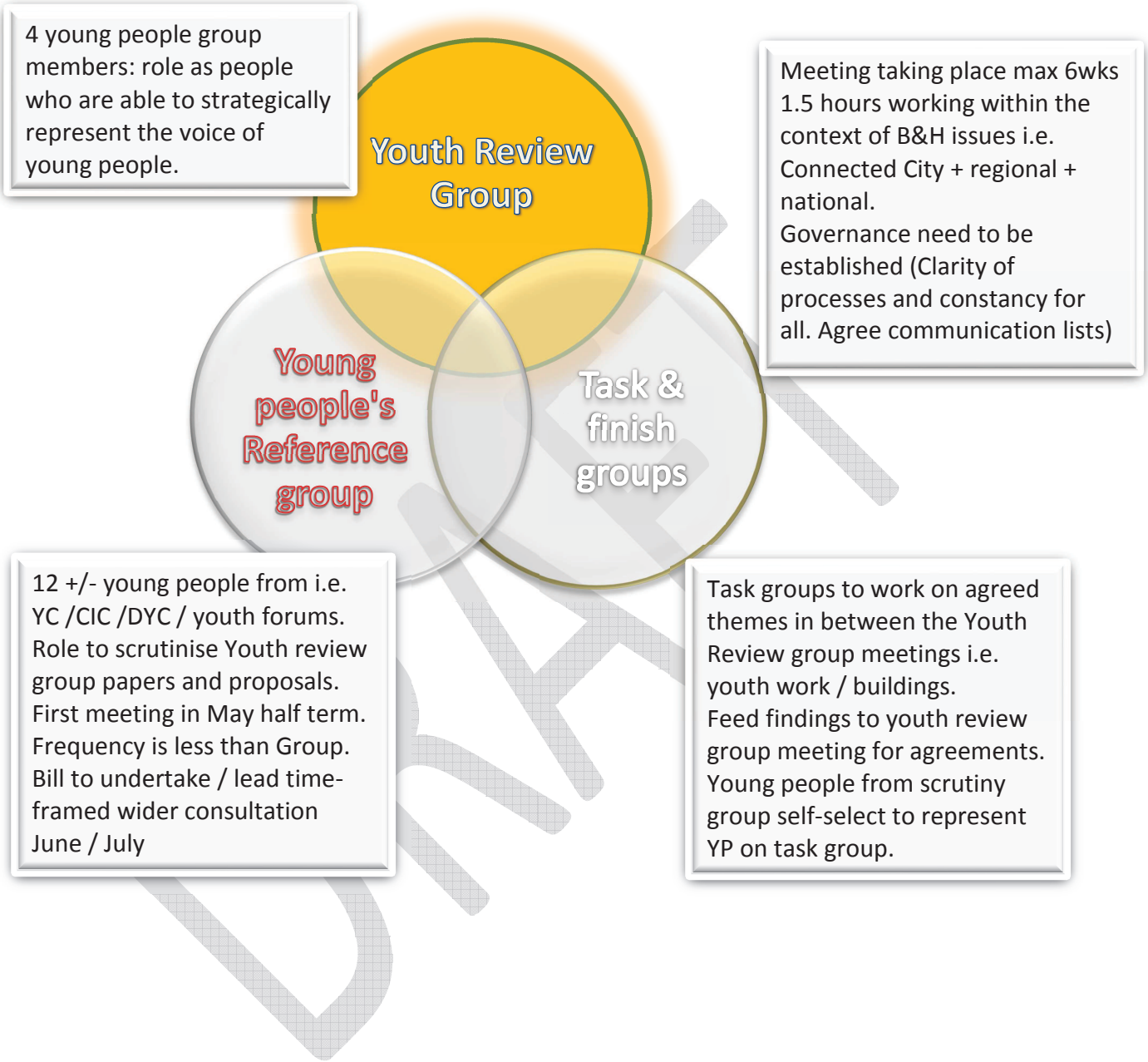
Normal operational management

Please note that there may be occasion when decisions have to be made outside of this programme in order to ensure that business as usual can continue in the Youth Service e.g. filling vacant posts.

Governance arrangements



Young people Involvement



Meeting Schedule

Date of Meeting	Time	Location	Key Meeting Topics
28-4-15	4.30 to 6 p.m.	Committee Room 2, Brighton Town Hall	Agree scope of review, TOR and key task and finish group areas
8-6-15	4.30 to 6 p.m.	2nd Floor Conference Room, Bartholomew House	Finalise TOR and key Task and Finish group areas. Agree timeline.
24-7-15	4.30 to 6 p.m.	Committee Room 1, Brighton Town Hall	Feedback from the Buildings, Delivery of Service and Outcomes Task & Finish groups and benchmarking.
1-9-15	4.30 to 6 p.m.	Committee Room 1, Brighton Town Hall	Agree recommendations from the Task and Finish groups and draft report.
7-10-15	4.30 to 6 p.m.	Committee Room 1, Brighton Town Hall	Agree first draft of the report.
12-10-15	4.30 to 6 p.m.	1st Floor Conference Room, Bartholomew House	Approve final draft of the report

Appendix 2: Summary Information of Task and Finish Groups

Summary of Task & Finish Group for the Youth Service Review

1. Buildings:

Chairs: Ben Glazebrook and Reuben Davidson

Group outline: To consider the use and feasibility of using buildings in the future delivery of youth work, and by association the resources that may be required to support their use

Summary includes:

1. Acknowledge the assets that we have
2. Consolidate and support the buildings that are viable to secure for future delivery
3. Identify co-location opportunities
4. Start addressing integration of youth services locally managed within community buildings
5. Invest in culture change to bring about well integrated services
6. Clearer understanding about the costs of BHCC premises and budget implications

Group members: Ben Glazebrook and Rueben Davidson (chairing), Linda Saltwell TDC, Vanessa Crawford BMEYPP, Tracie James BHCC YS, Clare King BHCC YS, and contributions from Mike Roe, Darren Snow, Jo Martindale, Adam Muirhead, Emma Jacquest through the B&HYC Quarterly Meeting

Emailed: City Gate, City Coast Trust, Downs Baptist, One Church, Scouts, Guides, Boys Brigade and Air Cadets

Meeting dates: 15 & 20 July 2015

2. Model of Delivery:

Chairs: Chris Parfitt and Sophie Murphy

Groups outline: To scope out models of delivery that attend to the need of young people in Brighton & Hove to the potential resources available

Summary includes:

1. Targeted around the needs of young people
2. Empowering communities to work with young people
3. Engagement of Uniform (eg, Brownies/Scouts) and faith groups
4. Structured city wide youth volunteering and accredited programmes. The need to develop young people as youth workers and partners and links to adults in the community
5. Pooling resources and consolidating impact and outcomes
6. Keep focus on youth work and recognise the difference between youth work and working with young people
7. Need to fund 16-19 work: big gap in funding - Trans up to 25 along with SEN
8. Key to youth work model of delivery is the developmental process and it should be part of a continuum of support provided by the right services at the right time for the young person
9. Duplication identified as a concern and a waste of resources

10. An overview of quality assurance is required
11. Use the Needs Assessment to form the questions to ask young people
12. Be mindful of other city strategic directions (Youth Information and Advice Counselling Service model YIACS / Housing)

Group members: Jess Wood – CEO Allsorts, Kerry Clarke - Strategic Commissioner, Children's services (BHCC), Adam Muirhead - Youth Worker Co-ordinator Trust for Developing Communities, Kemi Oluyemi - Youth Worker - Youth Services (BHCC), Vanessa Crawford - BMEYPP, Rachel Brett - Sussex Central YMCA, Mike Roe - Brighton Youth Centre, Sue Feighery - Practice Manager, Detached Youth Work Project (BHCC) and Dr. Mark Price - Assistant Head of School, University of Brighton.

Other members contacted: David Wright and Mark Price.
Meeting dates: 7 & 28 July, 3, 17 & 21 August 2015.

3. Outcomes:

Chairs: Emma McDermott - Head of Communities, Equality and Third Sector (BHCC) and James Holmes - Youth Council

Groups Outcomes: The proposal is that all Youth Services funded by the city council, regardless of model or provider, should include the following principles:

- 11 – 19 (up to 25 year olds with SEN)
- Young person centred
- Voluntary and empowering for young people
- Young people participate in and drive service review, design and delivery at operational and strategic level
- Robust and up to date safeguarding practices and policies

Summary includes:

Short term outcomes to include:

1. Greater self-awareness, agency and confidence
2. Greater understanding of community, cohesion and civic society

Medium term outcomes to include:

1. Raised and positive aspirations and ambitions
2. Proactively reducing or avoiding risky behaviour and unhealthy habits and choosing healthier lifestyle activities/options
3. Continual increase in their ability to positively respond and be resilient to change and challenges

Long term outcomes

1. Sustainable, fulfilling employment/training/further education with good future prospectus
2. Active and responsible citizens
3. Independent living skills and knowledge – practical and emotional
4. A healthy lifestyle – physical, emotional and mental wellbeing
5. Strong positive social network

Group members: Debbie Garret – Youth worker (BHCC), Adam Muirhead – Youth worker (Trust for Developing Communities), Joanna Martindale – Community rep (Community Work),

Michelle Pooley - Third Sector Commissioner (BHCC), Kerry Clarke – Young People's Health Commissioner (PH), Kim Wells – Practice Manager (BHCC)

Meetings: 23 July & 24 August 2015.

Appendix 3

Youth Service 2012 to 2015

The following briefing aims to give a summary of the key service developments and achievements from 2012-15

Service Developments 2012-13

- Introduction of the 1:1 Support Programme provided targeted support to referred young people across Brighton & Hove
- Group work programmes offered to schools, e.g. relationships, substance misuse, self-esteem
- Engagement delivery model of 'universal work in targeted areas' developed
- New Youth Mayor programme introduced working alongside the Mayor's office
- Partnership work with the Collective embedded into delivery and joint delivery plans written

Service Developments 2013-14

- Outcomes measurement tool developed to show the impact of one to one work – tool then verified by University of Brighton
- Youth Early Help pilot took place which later formed the foundation of the BHCC Early Help Hub
- New Young Ambassadors programme introduced involving care leavers in the recruitment/selection of social care staff
- Joint training event on equalities offered to all Youth Service and Collective staff

Service Developments 2014-15

- Move from an 'area' management model to a 'work group' management model
- Regular Youth Seminars held to bring together Youth Service/Collective teams
- Service restructure to reflect 80% targeted and 20% universal delivery
- Youth workers concentrate on caseload/group work delivery with Workers in Charge/ Youth Support Workers leading youth centre delivery
- Duke of Edinburgh's Award scheme redesigned to reach as many young people as possible

April 2012 — March 2015

Some facts and figures 2012/2013...

1:1 Work
- 151 referrals, 73 from Social Care
- 40% of cases evidencing positive improvement

Group Work
- 15 group work programmes delivered with 117 attendees

Engagement
- 2050 attendees and 928 participants (attendance 4+ times) with 65% achieving recorded outcomes
- 53% of participants were male, 86% were aged between 15-19 years, 12% were from an ethnic background other than White British and 16% had a form of SEN status

Participation
- Young people take part in Children in Care Council, the Youth Council, the Disabled Youth Council, and Young Assessors
- Active participation in the City's Young People's Strategy and the selection of the Collective as a joint provider of youth provision across the city

Some facts and figures 2013/2014...

1:1 Work
- 195 referrals, 81 from Social Care
- 65% of cases evidencing positive improvement

Group Work
- 21 group work programmes delivered with 194 attendees

Engagement
- 1916 attendees with 697 participants (attendance 4+ times) with 92% achieving recorded outcomes
- 56% of participants were male, 72% were aged between 15-19 years, 12% were from an ethnic background other than White British and 16% had a form of SEN status

Participation
- Youth council's form Brighton and Hove Youth Voice Executive Leadership host BHCC Takeover Day with city's secondary schools
- Member of Youth Parliament opened the debate at the House of Commons for the first time

Brighton & Hove City Council

1:1 Work

The Youth Service is part of the BHCC Early Help Strategy and receives referrals for young people and families from schools, Social Care and other agencies. The Youth Service provides targeted support for young people with low to vulnerable to complex needs. The youth workers work in partnership with the young person and/or family to produce an Early Help Assessment Plan to identify needs and appropriate early interventions. Progress is assessed by a distance travelled measure. Referrals also go to the Young Person's Health & Relationship Adviser and the Young Women's Health Worker who sit within the Youth Service.

****The Youth Service ran a pilot in 2014/15 to offer 1:1 support to young people in year 7 and 8****

474 young people received 1:1 support
63% evidenced positive improvement

Participation

The Participation Team enable young people to have a voice to influence local and national decision making. Current projects include: the Children in Care Council, Takeover Day, Young Assessors, the Disabled Youth Council, Young Ambassadors, the Youth Mayor, Youth Council and UKYP representation on Council and other Board Meetings.

825 attendees

100% have gained a recorded learning outcome

Engagement

Activities for young people are provide at four youth centres in targeted areas of Brighton & Hove.

The Mobile Information Bus meets young people in their space in different areas across the city.

731 participants (young people who have attended 4+ times)

74% have gained a recorded learning outcome

Accreditation

Duke of Edinburgh's Award	**353 Duke of Edinburgh's awards achieved** **73 young people currently attending the two open award centres that the Youth Service runs**
Youth Arts Award	**20 young people have passed their Youth Arts Award, including 12 young people with a statement of learning disabilities**
Brighton & Hove Youth Award	**198 Brighton & Hove Youth Awards achieved**

Group Work

The Youth Service offers schools a comprehensive group work offer to meet the needs of young people, who have been identified as being at risk of not reaching their full potential, and are at risk of becoming NEET. The programmes cover issues such as relationships, sexual health and anger management.

15 group work programmes run
150 young people attended

Key Documents

Youth Service Delivery Model // Youth Service Overview PPT
Youth Service Structure PPT // Youth Service Quality Assurance
Youth Service Curriculum Framework

+

The Youth Employability Service, Play Service and Youth Advocacy Project also sit within the BHCC Youth Team.

Appendix 4

Brighton and Hove Youth Collective

'Year 3' Report, October 2015

Throughout the year we have provided youth clubs, street outreach work, specific group work sessions, sports activities, arts opportunities, the B.Fest youth arts festival, the Big Lottery Fund's Chances 4 Change programme on young people's mental health, support to vulnerable and at risk young people, school lunchtime health drop ins in the city's secondary schools, support for young people to have their voice heard through participation work, holiday programmes, intergenerational events and co-ordinated training for volunteers across the city.

Service developments.

- Co-ordinated delivery of the Big Lottery Fund's Chances 4 Change – providing interventions for young people in schools through Right Here, Life Coaching to address individuals' issues and training for staff around mental health, suicide and self-harm
- Development of the Youth Collective web-site, building on the single brand and point of information
- Established School Health Drop Ins in 6 secondary schools providing a range of health support and better links into youth provision
- Continued development of the B.fest youth arts festival including a live music showcase at The Level and 57 arts events across the city
- Supported the White Ribbon Campaign addressing violence against women with workshops for young people for the first time
- Development of health Mentor roles to bring about greater consistency of delivery across Youth Collective projects
- Delivered alternative education provision for the Pupil Referral Unit
- Engaged with Social Media Think Tank event to address emerging concerns around the use of social media, mental health and self-harm
- Facilitated young people's participation in the Youth Review through the Young People's Reference Group
- Co-ordinated training for volunteers across the Youth Collective
- Development of the Wild Park Youth festival
- Facilitating voluntary contribution - our work is assisted by an amazing team of volunteers contributing around 300 hours per week, totalling 15,000 hours per year, the equivalent of over £142,500 of service delivery annually.

Activity and Performance

The reporting year for the Youth Collective has been aligned with the standard BHCC financial year reporting period and Interplan submissions – the following figures are for the reporting year April 14 - March 15 and the period April 15 – Oct 15 of the current reporting year.

Apr 14 – Mar 15

The Youth Collective were in contact with 2842 young people, of which 1512 were participants (attending 4 or more times, as per the youth curriculum). In total young people attended our provision 21,800 times during the year.
80% of the young people who are 'participants' achieved outcomes through their involvement – such as greater skills in art and design, improved emotional well-being, volunteering activity and making a contribution to their local community. We exceeded the targets for the year on recorded outcomes for Community Contribution and Increased skill in Arts and Culture and Sport by 17%, 3% and 20% respectively and were on target for the number of young people involved in volunteering at 10%

40% of young people using the service were female, 60% were male.

The majority of ethnic groups (as per the 2011 census) were represented in the young people who accessed our services, the total representation of BAME groups was 11.4%

Ethnicity Breakdown/Comparison April 2014 - March2015		
Ethnic Groups From 2011 census briefing (taken from bhconnected.org.uk)	Brighton and Hove 2011 census briefing	Youth Collective 2014-15
White English/welsh/Scottish/NI/British	80.5%	87.7%
White Irish	1.4%	0.75%
White Gypsy or Irish traveller	0.1%	-
Other white	7.1%	1.69%
Mixed/Multiple ethnic group	3.8%	5.36%
Asian/Asian British	4.1%	1.41%
Black/African/Caribbean/Black British	1.5%	1.6%
Arab	0.8%	-
Any other ethnic group	0.7%	0.56%
Total BME	19.5%	11.4%
		no info 0.9%

Apr 14 – Oct 15

So far, in this reporting year, 1328 young people have been in contact with the service, 881 were participants (attending 4 or more times, as per the youth curriculum), this is 119% of our target for this point of the year. 80% of the young people who are 'participants' achieved outcomes through their involvement and we are exceeding our targets for Community Contribution, Arts and Culture, Sports Activity, Volunteering and Accreditation.

Service improvement recommendations

Over the coming six months we will look to improve the numbers of young people involved in designing and planning activities as we were 1% below our target for participation in the last full reporting year and we will look to address the numbers of young people gaining accreditation as this figure was 3% below target.

Appendix 5 – Case Study 1 - Universal - BMEYPP

R is a 19 year old young woman who attends the BMEYPP regularly. She has been a member for over a year. R moved to the UK 4 years ago with her family. Moving to the UK she faced separation from her father and her close friends. At home R is responsible for taking care of her siblings as well as major house chores. She must balance this with her studies, future planning and part time job, which she finds stressful. This was enhanced by her mother giving birth last year, resulting in more chores for her to keep up with. She also faces high educational expectations from her mother who insists she should become a doctor.

The relationship between R and her mother has worsened since the mother found out she was sexually active and dating a young man who is from different culture. This resulted in R being beaten by her mother and locked in for several weeks which led to R self-harming. R feels that she cannot be honest with her mother about her relationship and it is unsafe for her to be out in public with her boyfriend as any member of the community can see them and inform her mother, as has happened in the past. At one point the young woman ended her relationship with her boyfriend out of 'guilt towards her mother for disobeying her', but they are now together. The mother has threatened R to send her back to Africa and marry her off. R is not allowed to attend social gatherings or be with friends because her mother fears the negative effect of western friends may have on her. R used to take part in dance lessons and performances with her college, however her mother forced her to stop, because she wants R to be at home.

In attending the BMEYPP Drop Ins, R has received support in many ways. During sessions she takes an active volunteering role, she enjoys cooking as well as meeting new young people and taking the time to relax away from her home situation. She also has access to healthy meals which are vital for R, particularly after developing negative eating habits. R has stated that attending BMEYPP 'is a necessary escape'. R is currently involved in planning BMEYPP events and will receive a certificate for her volunteering at the volunteers' celebration event. She receives continuous encouragement and praise from staff.
R receives support and advice on many issues. In the past she has received support on sexual health. She has had one-to-one support about education, university application as well as employment and help building a CV. She has also received advice on staying healthy, dealing with stress and maintaining overall healthy wellbeing.

R told the BMEYPP that her family were going to Africa for the summer, and we had shared concerns regarding forced marriage. Before she left, we researched support that she could access whilst in Africa and gave her advice to protect herself, if at any time she felt unsafe.

Appendix 6 – Case Study 2- Universal – Disability

J is 17 years old – he has severe learning disabilities, autism, sensory processing difficulties and physical disabilities, he has no verbal communication and limited understanding of alternative communication methods. His favourite thing is to be out and about.
J started attending Extratime's youth club in September this year. Since J left school in 2014 he has had very limited opportunities to socialise with his peers as he cannot attend after-school club now that he is at college. Although he has been able to go out with PAs and his parents he has only mixed with other young people at college.
At the club J has taken part in art and cooking activities, trips out in the local community, group games and chill-out time.

His parents were concerned that the club would be too tiring for J but in fact he is enjoying the sessions and has adapted well with the change in his routine. Extratime's staff were well briefed on J's needs, his likes and dislikes, and have been able to support him to take part in the activities on offer.
J's mum says, "I was keen for J to try the club as I have been concerned that he was getting isolated and not spending enough time with other young people, but I thought it might be too busy for him as he often seems tired in the evening. But we have found that he loves it – it is a great addition to his life and I really hope that it can continue after these pilot sessions."

Appendix 7 – Case Study 3 - Targeted

Terry is a young man aged 15, living with both parents, plus older & younger sisters aged 18 and 3.

Terry was referred by school to take part in Reflect (substance misuse programme in school). It became apparent he needed further support during pre- and post- course 1:1 meetings. Terry attendance at school was very sporadic; Terry was at risk of getting involved in ASB and had substance misuse issues. He responded better in a 1:1 situation than in a group, so he was happy to engage with the referral. Using interventions such as

- Reflect group work programme
- Weekly 1:1 meetings providing a space to reflect on issues & progress
- Substance misuse interventions e.g. harm minimisation triangle
- Food/mood tracking
- C card issued (access to sexual health information and condoms)
- Sex Relationship education and substance misuse screenings completed

The youth worker was able to help Terry to:

- Cut down alcohol/substance use
- Establish more regular eating and sleep routines
- Develop different friendship networks
- Spend more time with family

It was helpful that a positive relationship was already established through the group work engagement. By the post - Reflect 1:1 meeting Terry, was able to see the need for change and the benefits of a continued 1:1 engagement with the service.

- Terry is now reporting that he is happier at school
- Has reduced substance use (though not stopped altogether)
- Has realised how his substance use affected his relationships with family and his communication skills, and is now getting on much better with parents
- Has begun spending time with a more positive peer group in his local area; not involved in ASB
- Has started boxing classes
- *Where Are You Now* evaluation score increased from 20 to 32 points

Appendix 8 - Case Study 4 - Targeted

Jenny was a 16 young woman who was referred for support from Abbey (youth worker) with family issues, including physical and emotional abuse within the family. When Abbey first met Jenny she was being assessed by a social worker, but this support ended with no further action.

Jenny had issues with anxiety, low moods, poor socialisation skills with peers, daily cannabis use (and other substances) and some risky behaviour. She was generally lonely but found it difficult to reach out to people.

Jenny was at school and had to travel from Brighton every day and she was also holding down a part time job in a café in Brighton to ensure she had money for school

- Jenny had weekly meetings with Abbey in cafes in town after school and explored moods and anxiety, drug use and managing time
- They looked at change and motivation for making change in areas that Jenny was able to, and reflected on positive personal qualities
- Jenny was referred to a Journey of a Lifetime Project and although she wasn't successful, this enabled her to think about a potential life outside Brighton and what that might give her. She also considered options
- Abbey gave her a diary to write down a daily to do list and for appointments. Abbey linked Jenny to a young women's group so she could meet other young women and was referred to RUOK? for support around her cannabis use, engaging for a few sessions
- Abbey and Jenny set SMART goals when it was GCSE exam time and completed worksheets Abbey set and followed up information given
- Abbey kept in regular contact with Jenny to check in how she was doing with revision as Jenny said it helped to know that someone was interested in how she was getting on and wanted someone to keep her motivated
- Abbey gave Jenny time to explore other options such as apprenticeships when she was questioning her options and signposted her to services that could support

After Jenny realised she had passed her GCSE exams she decided to do A levels. Jenny keeps in touch to say that it is going well and she is enjoying it. She has friends and works hard. She now intends to go to university.

Jenny has significantly reduced her cannabis use and now presents as happy and confident about her future.

Jenny has not rebuilt her relationship with her family although there is contact and she does continue to have a relationship with her sister.

Jenny said that she had really valued the support Abbey had given her and had enjoyed the sessions she had.

Appendix 9 – Case Study 5 - Open Access

Kate is a 15 years old female of white British heritage. Kate had been a participant of the young women's group since it first started 3 years ago. Kate appeared to be very quiet and withdrawn, often crying throughout sessions. Kate seemed to find it difficult to express what was going on with her emotionally, and when asked she would whisper so quietly that it was impossible to understand what she was trying to say.

It wasn't until the beginning of the young women's art project that Kate really began to express what was upsetting her. Through her drawing and painting Kate found her voice. Her work was expressing her issues at home. Kate's mum suffers from depression, her dad and brother are autistic and she feels responsible for taking care of her younger siblings. Kate felt that nobody at school understood her difficulties, and explained that she was getting bulled at school. Kate said "I think people bullied me because I was always crying and walking out of class." This resulted in her feeling isolated and alone.

By the end of the project Kate's progress was shown in her ability to take part in group discussions. She had gained her bronze arts award. Kate carried this new found confidence through to the next young women's fashion and body image project singing, comparing and modelling outfits she had made to an audience of 50 local residents and other young women from groups city wide. Kate is passionate about mental health issues, and was articulate in expressing them to the young women's group.

Kate has now become an assistant youth worker. She attends meetings to help plan and evaluate the project. Kate has recently remarked: "Being part of the young women's project has helped me find my voice. It's helped me find see all the things I'm good at."

Hangleton and knoll project presentation to Neighbourhoods, Communities & Equalities Committee on Monday 23rd November

(Transcript of presenyation)

Sophie Murphy and Jack Stanford Hangleton and Knoll youth manifesto group,

Helen Bartlet, Hangleton and Knoll Project Youth Worker

Helen Bartlet: 'I am a youth worker at the Hangleton and Knoll project. It's really great to be here and to have an opportunity to talk about the youth work that we do and the community that we're in. Some of you obviously have a very in-depth knowledge of this community but for those who don't just to locate our work a little bit; we're a ward of 11,500 people, we stretch from Hangleton park up at the north down to the train line north of Portland road on the South, Hangleton way on the west and Holmes Avenue on the east. It's a relatively big ward, we do detach work, which means we walk out and about in the area, and it's about a one hour walk from the bottom right to the top and back again. It's interesting in terms of the demographic with quite a lot of people within it. There are areas through the middle around the schools- particularly around Blatchington Mill- of affluence. There are also areas of quite high levels of deprivation and poverty and those tend to be the areas in which we situate our work; around the park, around the children's centre up in Hangleton, where we're situated now on the Knoll estate and also in the housing estate area of Laburnum. So we try to work across the whole area but obviously responding to need those are where we do the most of our work.

To give an idea of some of the needs that we face both statistically and personally for the young people that we work with. So as I said there's quite high levels of deprivation we have especially high levels of child poverty which again is even more relevant because in our ward population we have really high numbers of older people and really high numbers of younger people and so that's a real focus of our work working in a community area, bring the different generations together. We also have high numbers of young people leaving school with no or low quality qualifications and correspondingly relatively high numbers of youth unemployment. So those are the context in which we do our youth work. Statistics also show that we are situated in an area with high levels of mental health needs both for our adult population and

for our children and younger people and obviously as you'll know they are linked. If you have high levels of mental health needs as children they tend to progress into the adult population. We've got a lot going on as that suggest but personally we've got a lot going on for the young people that we work with. So often the young people that we come in contact with through one-to-one work through group work are often facing issues at home that might include for example parental mental health, caring responsibilities. We work with a high number of looked after children both those who are in the care system but also maybe even more those children who are looked after by a family member who isn't a parent. We work with a lot of young people for whom drugs and substances is an issue with in the family. Young people who also experience poverty, poor or over-crowded housing and then high levels of parental of familial involvement with the criminal justice system. Both linked to this and also separate a lot of the young people we work with are struggling at school. I've said already they leave with low or no qualifications. We have young people who are really not engaging well with the school system. That's to do with a whole load of things; we worked with one young person who was caring for all of their younger siblings and so would have to take their siblings to school before they went to school which meant they got to school late, which meant they got into trouble for getting into school late. They didn't always want to have to face that and so would then non-attend themselves. These issues all kind of feed in and out of each other, you know they link. We think those issues link and through experiencing them one of the consequences is negative and risk taking behaviour and often some of the issues we hear about young people experiencing so whether those risk taking behaviours are things they do to themselves. There's a much higher rate of young people who are self-harming, who are causing damage to themselves. Risky behaviours around alcohol or substance misuse, risky sexual behaviours and then negative behaviours that impact badly upon the community as well that might manifest in anti-social behaviour, vandalism.

Through all of that and through behaviour that can be difficult to deal with the main thing that we see for our young people that we work with is a lack of self-esteem and it often doesn't look like that. You'll all be familiar with that notion of a group of young people that are difficult to engage with, they look scary. There's a group that hang around the community centre at the moment and to

be honest with you they're not great. They're not brilliant with members of the community, they aren't always polite, they can cause a real mess around the area. All of those are behaviours are things that we try to deal with, things that we look at. But what's really interesting is that for those young people who look brash, look a bit scary and all of that. They actually have no belief in themselves and if you ask them about their future they don't think they're going to make anything out of themselves and that's really the main core level on which we think we need to work and we need to going in an implement change.

(…)

For us we are situated in the community so we're part of the wider networks which forms young people's lives. So we're in a perfect position to work with them with and through those other structures. We can feed into family networks, we can feed into peer networks, and we can feed in and out of community meetings and so on. For us it's about making young people feel better about themselves through altering their relation and their input into where they live so from a community development perspective young people become a resource in terms of what you're doing. You involve young people in making a change in the area and through making that change you can make them feel better both about where they live and about themselves. Just to give an example we worked to develop a sports court. It was a really big project and we worked with a group of young people for three years to fund raise to get a new sports court in their local park it was something that had been wanted by community members for years and years and they managed. They fund raised £50,000, they developed a new sports court which was great in and of its self. Then we spoke to a young man afterwards about why he'd been involved and what he'd got out of it and he said 'you know actually it's really changed and I feel really differently about the park now. Before I'd see all these things going on but now that I've been involved this way I tell people to pick up the rubbish around because I don't want to see my area going back to the way it was because I've been in this and I've seen that we can make this change'. And I think through that you see all the level on which we can make a change which has benefit to the young people. I the time we worked in that group we had about a group of eight and we had four irregular or non-school attenders. We

were really working with young people who weren't engaging elsewhere. You see the benefit to the young person who gains their own skills and experience and you see the benefit to the community. You kind of work on multiple levels and that idea is what is so critical and what's so unique about youth work from a community perceptive.'

14:45

Jack Stanford: 'I started involved with the project when I was aged 11 I'm 21 now, so I've been involved with the project for a long time. I probably met Helen on detached in the park. I guess I instantly enjoyed the project, I started off as a participant in various activities. It basically allowed me to do things I wouldn't have been able to without the project; swimming and all the activities that as a young person I wanted to get involved with. As I had a positive experience almost straight away I stayed carry on. I eventually got too old to participate so I ended up carry on volunteering, the incentives are great. I should add that if you ever want to get young people to volunteer, food is a great incentive. That was really good but also activities in return for our opinion and our involvement. I also think it has a lot to do with having really good youth workers and building really good relationships, without our youth workers the project wouldn't be half as good. As I got more involved with the project and started to volunteer I guess it's fair to say I got more responsibilities and offered more responsibility. I'm involved with Hangleton and Knoll youth manifesto and also the Hangleton and Knoll youth bank which is the first youth bank in the country that we are aware of and we hold and fund raise money for other youth groups. After I joined the manifesto group and the bank I got asked to get involved with the board which is quite a big deal as I think I am the youngest member on the trustee on the Hangleton and Knoll board, which obviously fills me with joy and is quite a big deal for me it's quite self-satisfying. As I've been given more responsibility I've carried on from there and it's become a big part of my childhood as I grow as a person. It's given me more life skills and more confidence, probably a few years ago if you asked me to do what I'm doing now I probably would have said 'no', there's no way I would have done it. It's been lovely to give something back to the community. I grown-up and lived in Hangleton since I was two so for the project to offer you the choice to try to make a change in your local area is a

real nice achievement, it's positive. Instead of kicking the bin, replacing it and make it bigger and better changes that potential negative idea into a good one. I think it's important for all communities to have a youth service as good as ours. I think it's really important because it gives young people an opportunity. I've got lots of friends who didn't have the money or the time or support of parents to do such positive things but the project gives young people the opportunity to do that.'

Sophie Murphy: 'I'm vice chair for the Hangleton and Knoll project and my involvement first started when I was 14. So roughly where I live which is in the top part of Hangleton there's an area with a big green around it and I used to hang about a lot there with my friends and then one day Helen and another youth worker –Michelle- just doing their normal detached come up to us and have a bit of a chat and told us about a new group starting the next week which was group called heath and mind and that was mainly based around bringing a bit more awareness to young people in our area about health and general wellbeing. They handed out some leaflets and got chatting about it and I think my first response was 'well I'm on holiday next week'. Following on from that I then went the following week and from then I never really left the project for more than a couple of weeks at a time. From Health and Mind we then began a group of about 4 young women who got involved and fund raised and held events during the summer based around health and wellbeing and from there I joined the youth forum and from there I moved on to manifesto which is basically an online document and it consists of six sub-groups which are; negative perceptions, facilities, events and activities, health, opportunities and environment. These six sub-groups were chosen out of the consultation that was done with over 300 young people within this area about what they thought was most important and wanted they wanted changed in the area. So those sub-groups have each then got things we want changed and also things that they feel about it already. So on from that that's helped develop how the youth manifesto and the youth bank then work alongside each other. The manifesto fund raised some money to do some activities and that was done by another group called 'minifesto'. The youth bank held that money, the manifesto raised it and then younger young people then organised and held the events so it was very young people lead in the sense of summer activities and so on. Carrying on from that within manifesto I was then offered, like Jack,

a chance to join the board, I was then part of the board for about a year and half before becoming vice chair of the board of trustees. For me personally having youth work in my area that has provided me with so many opportunities that I wouldn't have been able to do without the support, guidance and general boost of self-esteem and that is what I think is key for young people now. I think its key to show young people this is what you can do rather than telling them what they can't do and I think that's one thing that I think youth work specifically does very well and I think we do it very well in this area. I am currently at university studying to be a youth worker. There so many things for me and for my area that I love doing and that's from holding events to helping young people have a voice and that's one thing the manifesto does it gives young people a voice and a chance to actually see change. We've done things from holding events to repainting things in the park to give them a bit more self-worth to it and since that's been repainted – it's a little youth shelter in Hangleton park- there's actually been no vandalism to it. So when you give something to the young people to do and to put a bit of their own self into I think it becomes a lot more special to them.'

DRAFT Commissioning Strategy: Health & Wellbeing of Children, Young People & Families

2015 - 2020

NHS
Brighton and Hove Clinical Commissioning Group

Brighton & Hove City Council

Health & Wellbeing

Foreword and welcome

Joint Chairs of the Children's Strategy Group …. Signal of working together……

Brighton & Hove is a city of aspiration, creativity and diversity. But it is also a city where the life opportunities of our children and young people and their families are uneven, with some families requiring high levels of support. In the context of diminishing financial resources nationally it is important that public services work closely to develop a joint strategy which ensures that the Clinical Commissioning Group, Children's Services and Public Health work together to help our children and young people to prepare for a good life, ensuring a city for all ages, inclusive of everyone and protecting the most vulnerable.

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.

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 it seeks to ensure that there is a balance of support across universal, early help and specialist services.

Through this strategy the following joint commissioning plans are being developed:

- Special educational needs and disabilities
- Emotional and mental health and wellbeing
- Support for the health of children in care and care leavers
- Public Health
- Stronger families and communities

Signed

Pinaki Ghoshal - Executive Director of Children's Services, Brighton & Hove City Council

Geraldine Hoban - Chief Operating Officer, Brighton & Hove Clinical Commissioning Group

Tom Scanlon – Director of Public Health, Brighton & Hove City Council

1. Introduction

1.1 What is the purpose of this strategy?

The purpose of this strategy is to set out the shared ambition of commissioners in the council and the NHS for the children and young people of the city. The strategy also sets out at a high level the way we intend to work together to achieve that ambition by 2020.

The strategy is informed through engagement events with key stakeholders, families and young people on the 15, 16 September and 6 October 2015.

This strategy will direct our joint commissioning of services to meet the needs of the children and young people of the city over the next four years. By 'joint commissioning', we mean the joint purchasing of services to meet the identified needs of the children and young people of Brighton & Hove.

The strategy is not an attempt to list all the work that is being undertaken by all the services involved or to repeat actions contained in other more detailed service and agency plans. Its focus is on the key shared work that the council, the NHS and other partners do together to meet high level joint priorities for action.

In compiling this strategy, all the data we have and the feedback from service users has been collated to determine our shared priorities for further improvement by 2020. We have then decided on our priorities, our vision for 2020 and the best means to achieve that vision over the next four years.

1.2 The shared vision

Our vision is to ensure that all children and young people in a `Child Friendly` Brighton & Hove have the best start in life as part of stronger families and communities; are happy, healthy and safe; and achieve their potential. This means that we will work together as commissioners with parents, children and young people and partners to strive for the best possible opportunities, experiences and outcomes at all ages and to tackle inequalities wherever they occur. We will promote personalisation, choice and control and whole family approaches. Underpinning our work will be a constant commitment to achieve the best outcomes for our children and young people.

1.3 The principles underpinning the strategy

I. Children and families at the heart of all we do, fully involved in all stages of commissioning and delivery of services
II. Safeguarding measures will be in place throughout the commissioning process to reinforce the safeguarding of children and young people in Brighton and Hove.
III. High quality assessment of local needs, informed by the Joint Strategic Needs Assessment (JSNA), with local plans that drives evidence based and outcome focused commissioning plans.

IV. Shared values, including a commitment to inclusion, tackling inequalities and closing gaps in outcomes caused by social disadvantage.
V. Effective joint commissioning arrangements across organisations including collaboration and co-ordination with commissioners of adult services, ensuring key transition points across the life course and a focus on adults as parents.
VI. Joined up approaches that strengthen safeguarding and embed a professional responsibility to the whole family.
VII. Commitment to a drive for efficiency within a best value context: this is about making sure we get the biggest gain for the population from the budget available.
VIII. Commitment to a `Child Friendly` city.
IX. Strong commitment to workforce development.

1.4 Key challenges

I. All agencies are facing significant budget challenges alongside a rise in demand for services and all will have to make savings across the life of this strategy.
II. For the council particularly, a reduction in the government grant will mean a very significant saving of around £25 million will have to be made each financial year up to the end of 2019/2020.
III. In this context many services are experiencing substantial additional pressures from a rising population and national trends, particularly the national increase in children coming into the care of the Local Authority.
IV. New legislation and particularly the Care Act 2014 and the Children and Families Act 2014, are rightly increasing expectations of services. For example for children and young people with the most complex special needs, Children's Services are required to support them via Education, Health and Care Plans up to 25 years instead of 19 years as under previous legislation. However the new legislation does not come with a commensurate increase in budget.
V. The NHS faces the challenges of more people (including children and young people) living with more complex conditions, putting pressure on NHS systems across acute , community and primary care, while funding remains flat.
VI. The challenge for partners here is therefore to commission and re-design services jointly in the most efficient and streamlined way such that families continue to receive good services but that these services are more cost effective to run.

how the NHS can deliver better outcomes at lower cost.

2. What are the shared priorities in this strategy?

1. To give every child the best start in life and to reduce inequalities
2. To provide children with complex education, health and care needs from 0-25 years and their families with high quality integrated support
3. To improve the emotional health and mental health and wellbeing of children and young people
4. To provide effective 'Early Help' for families facing multiple disadvantage that reduces the need for specialist social care and health services
5. To ensure all our children and young people are safe

2.1 How did we determine the five key priorities for the strategy?

In order to determine the key priorities we looked at the population factors: profile and characteristics.

We examined the data held across agencies and via the Joint Strategic Needs Assessment to see where outcomes are better or worse for children and young people in the city than elsewhere.

We also reviewed all the feedback and other intelligence we had available to us from consultations with families and professionals both nationally and locally on the various areas covered by the strategy. We then consulted further with a reference group of parents and of young people.

The full data set is too large to include meaningfully in this document. For a full analysis see:

Latest Joint Strategic Needs Assessment 2013 (is currently being updated) http://www.bhconnected.org.uk/content/needs-assessments

The most recent report of the Director of Public Health *"Look inequality, Annual Report of the Director of Public Health Brighton & Hove 2014-15"* http://www.brighton-hove.gov.uk/content/health/public-health-brighton-hove/annual-report-director-public-health-2014-15.

A summary of the key data, feedback and other intelligence used in compiling this strategy is set out below:

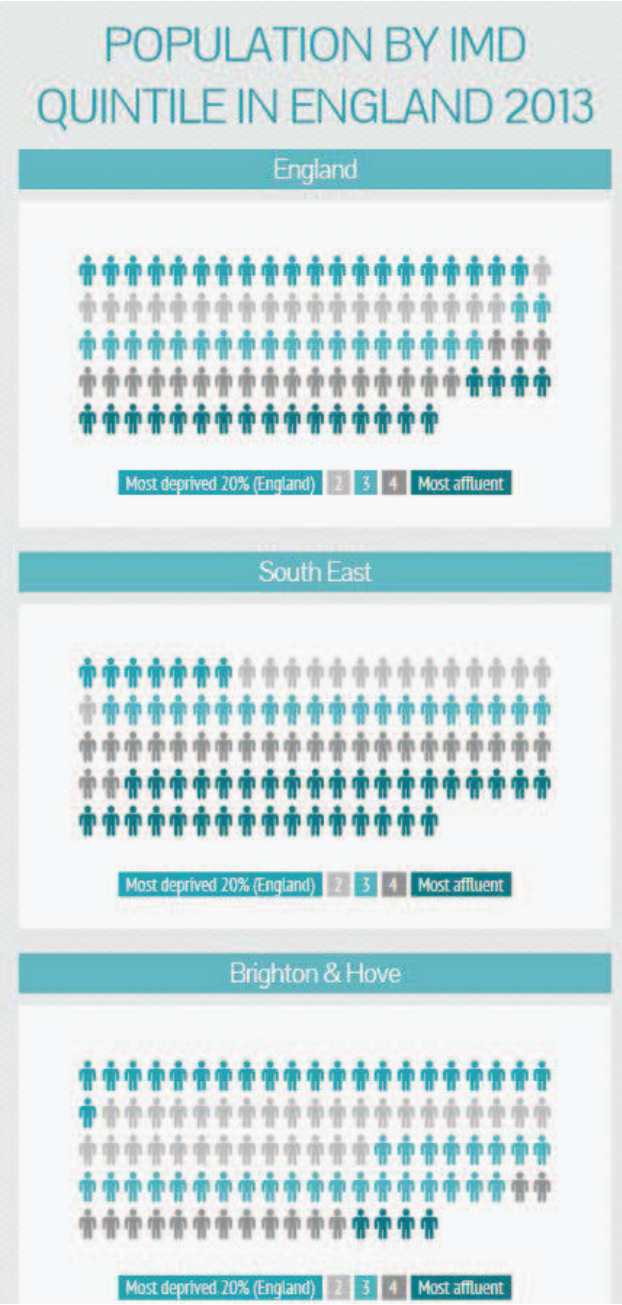
2.2 Overview of population profile and needs

The population of Brighton & Hove has been rising and continues to rise. In 2012 we had almost 59,000 children and young people aged 0-19 years living

in the city, around 6,000 more than in 2002. Over the next twenty years this is expected to increase to around 63,000. Since 2004 the number of primary school children needing a school place has grown by over 20% (550 children) and this growth is now reaching secondary schools; placing a strain on admissions in certain parts of the city.

The city's population is also a **diverse** one with around one in five (21%) school children from a black or minority ethnic group and 12% of school children have English as an additional language.

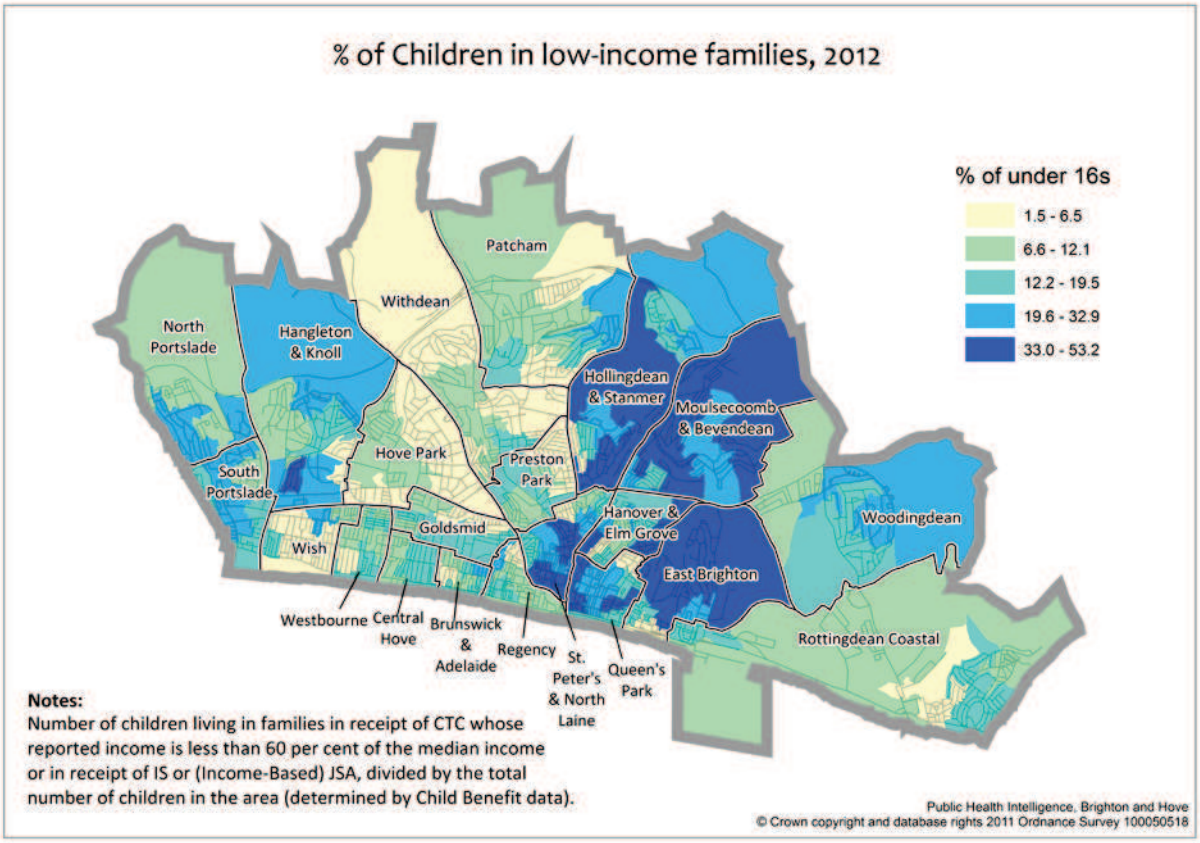
Index of Multiple Deprivation (IMD)



There are high levels of deprivation in the city: over half (56%) of the city's residents live in areas classed as the 40% most deprived in the country with only 4% living in areas within the 20% least deprived (See figure).

Affluence and social advantage varies widely across the city with wealthy areas but large pockets of significant poverty in Moulsecoomb, Whitehawk and parts of Queens Park and Portslade in particular.

Around 18% (7,735) children under 16 who live in poverty in the city (lower than across England at 19%). Child poverty varies widely; Moulsecoomb and Bevendean has 39% and Hove Park just 6% (see map).



2.3 Inequalities associated with poverty and deprivation

The outcomes for our children and young people are mixed and inequality of opportunity is a challenge for every age group from birth through the Early Years and into adulthood.

Issues identified in the Joint Strategic Needs Assessment as having the greatest impact on the health and wellbeing of children and young people in the city include: child poverty, education, youth unemployment, housing, alcohol and substance misuse, healthy weight and good nutrition, domestic and sexual violence, emotional health and wellbeing, smoking, as well as the wellbeing of children and young people with disabilities and complex needs.

In the **early years**, there are many positive indicators for Brighton, such as breastfeeding rates and good outcomes achieved in high quality nurseries and Early Years settings. In this strategy, there is a commitment to building on these strengths as a priority from the strong shared belief in early intervention and preventative working from a young age, both with parents and with their young children. Additionally there is recognition that the positive start many children receive in the city is not always sustained and that by the end of Key Stage 4 (16 years) educational outcomes are often lower than the national

average and particularly weak for children from vulnerable groups, such as those with SEND or eligible for free school meals.

In schools as many children are achieving a good level of development at the end of reception as the England average (both 60%), but this is lower for children with a free school meals status (42% for the city and 45% for England). Results in primary schools are similar to the national average; however, provisional results for secondary schools in 2013/14 suggest that just over half (53%) of GCSE students achieved 5 A*-C grades including English and maths, compared to the England average of 56%.

2.4 Key Health and Wellbeing issues for Children & Young People in Brighton & Hove

Data from the 2015 CHIMAT – Child Health Profile 2015 Brighton & Hove
http://www.chimat.org.uk/resource/view.aspx?RID=101746&REGION=146753

Child Health profile shows that the health and wellbeing of children in Brighton and Hove is mixed compared to the England average.

Infant and child mortality rates are similar to the England average.

Children in the city have better than average levels of obesity.

A higher percentage of mothers initiate breastfeeding compared to the England average. At 6-8 weeks a higher percentage of women continue to breasted compared to nationally.

Recent results from the Brighton & Hove Safe and Well at School Survey show that the overall trend of young people using drugs and alcohol is reducing, however our levels are higher than national levels and for those who are using substances they are using at a higher level and more regularly. Brighton & Hove
has higher rates of hospital admissions for alcohol for young people. In the period 2011/12 – 2013/14 admissions rates in the city was higher than the England average.

Brighton & Hove has significantly higher rates of hospital admissions for self-harm for young people. In the period 2011/12 – 2013/14 the admission rate was higher that the England average.

Teenage conception rate in the city is now comparable to the national average

Immunisation rates for Measles, Mumps and Rubella (MMR) are now comparable to the England average.

Hospital admissions for asthma for children under the age of 19 is significantly worse than the England average.

2.5 Children with Special Educational Needs and Disabilities (SEND)

Schools in Brighton & Hove identify more children as having SEND than the national average. Identification rates vary considerably across schools and there are issues of consistency and equity to address as a consequence.

For Brighton & Hove we currently have 20.9% of our pupils with special educational needs, 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%)

Spend in the city on SEND in our schools and in terms of disability services is generally above and sometimes well above the national average. However outcomes for young people with SEND are generally no better than the national average at the end of secondary education and in some schools are below the national average. Gaps in achievement are too wide.

2.5.1 Key Stage 4 outcomes for pupils with SEND

Only 1 in 5 pupils on SEND registers in the city achieved 5 or more good GCSEs in 2014. This compared to just under 7 out of 10 pupils who do not have SEND.

Nationally outcomes for pupils with SEND at the end of Key Stage 4 were similar to those in the City but Brighton and Hove has a higher percentage of young people on SEN registers than the national which makes it likely that a higher percentage of more able young people are included. This needs to be factored into comparisons against the national picture.

The 2014 the SEN attainment gap was 46.3 percentage points and 2012/13 was 50.7 percentage points. This narrowing of the gap was due to a larger drop in attainment in the non-SEN groups.

Progress rates for young people with SEND to the end of Key Stage 4 were slightly above the national average for English and slightly below the national average for mathematics.

2.5.2 The SEND Review

In the recent review of SEND across the city, a wide consultation process identified that 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. http://present.brighton-hove.gov.uk/mgconvert2pdf.aspx?id=80640

In terms of **transition to adulthood**, young people with SEND are significantly over-represented in the figures for young people not in education, employment or training (NEET) post 16.

Brighton and Hove NEET Figures

- NEET in the Learning Difficulties and Disability (LDD) population is comparatively low in the 16 to 18 population:
  - Age 16 (9.3%)
  - Age 17 (15.6%)
  - Age 18 (18.9%)
- NEET figures for Learning Difficulties and Disability (LDD) increase markedly at age 19 and beyond:
  - Age 19 (30.1%)
  - Age 20+ (42.8%)

Currently there are no specific council-led apprenticeships for young people with SEND.

The consultation to the SEND review indicated that parents and young people experienced considerable anxiety about the transition from children's to adult services. There were specific concerns about the transitions in terms of care and health services, with issues raised about both physical and mental health transition points.

Parents and young people have also reported a complex network of support that they find difficult to access and navigate across services, particularly in relation to mental health.

The SEND review has made a number of wide-reaching recommendations about integrated working to improve outcomes and reduce costs that will require significant changes to the way services are jointly commissioned over the next four years.

2.6 Safeguarding and Children in Care (or `Looked After`)

This Strategy is underpinned by a commitment to safeguard children and young people. As such

- Many looked after children have complex needs and high levels of mental health problems, frequently as a result of abuse, neglect, loss or attachment difficulties prior to coming into care. This makes CAMHS support vital but the wait for treatment is often too long.[1]
- At 31 March 2015, 1,479 children had been identified through assessment as being formally in need of a specialist children's service.

[1]Brighton & Hove Ofsted Inspection of services for children in need of help and protection, children looked after and care leavers, June 2015.

- At 31 March 2015, 309 children and young people were the subject of a Child Protection Plan. Children who have a Child Protection Plan are those considered to be in need of protection from either neglect, physical, sexual or emotional abuse, or a combination of these factors. Of the children made subject to a child protection plan from April 2014 to March 2015, 51.5% featured domestic abuse and 35.7% recorded parental mental ill-health. Parental drug and alcohol misuse were factors in 29.6% and 23.5%, respectively.

- High numbers of children are made the subject of repeat child protection plans. In a majority of cases, the reason for the need for repeat child protection plans is due to the recurrence of domestic abuse, parental mental ill-health or relapses in misuse of drugs or alcohol.

- At 31 March 2015, 481 children were being looked after by the local authority (a rate of 95.2 per 10,000 children). This is an increase from 465 (92 per 10,000 children) at 31 March 2014 and is higher than the national average.

3. What is happening already?

3.1 SEND Review & next Steps

The SEND review has made a range of recommendations predicated on the following key principles across education, health and care:

- Integrated commissioning
- Integrated provision
- Personalised approaches with children and families at the centre

http://present.brighton-hove.gov.uk/mgconvert2pdf.aspx?id=80640

All recommendations have been accepted by a joint meeting of the Health & Wellbeing Board and the Children's Committee (3.2.15) and the review is now producing detailed proposals for integrating education, health and care provision from 0-25 years, which will be presented again to board and committee late summer of 2016.

3.2 Mental Health and Wellbeing

Improving the mental health and wellbeing of children and young people in Brighton and Hove is a strategic commissioning 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 need.

The Joint Strategic Needs Assessment and whole system review in 2015 will support future commissioning intentions. The development of a local

Transformation Plan in response to the recommendations in *Future in Mind*[2] includes the following elements:

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.

3.3 Early Help – Developments

Following the launch of the Early Help Hub (September 2014) the city's Health & Wellbeing Board agreed a recommendation (December 2014) to proceed with the next stage of the Early Help Partnership Strategy to review, commission, de-commission or redesign early help services for children, young people and their families. As well as the consolidation and development of the Early Help Hub and pathway, for example developing a direct on-line referral process of GPs, a programme of work is underway to review:

- Youth Work provision
- Children's Centres
- Parenting Programmes
- Partnership arrangements to deliver the new expanded Stronger Families Stronger Communities Programme

3.4 Primary Care Transformation

Brighton & Hove 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 is underway to support collaborative approaches amongst practices in order to improve health outcomes for children and young people. A Locally Commissioned Services Outcomes Framework has been developed to resource local practices to identify the needs of children and families in their practice populations.

The aims are to enable general practice to play a stronger role at the heart of more integrated out-of-hospital services and to provide more personalised and proactive care. This will involve closer working relationships across health, Children's Services, Schools and Public Health.

[2]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413393/Childrens_Mental_Health.pdf

There is also a parallel programme of work to develop and invest in a model of children's community nurses across the city, supporting primary care, and interfacing with the acute hospital. This will be a key part of more integrated working in the future.

3.5 Children and Young People's Public Health Programmes

The new Public Health responsibility for Local Authorities includes the commissioning of the delivery of the Healthy Child Programme for children aged 0-5 years and for children and young people aged 5-19 years. In April 2013, Public Health in Brighton & Hove took responsibility for commissioning the school nursing service. In October 2015, the responsibility for commissioning the health visiting service (including the Family Nurse Partnership [FNP] service) will transfer from NHS England to Brighton & Hove City Council Public Health.

Our range of public health programmes, will have the advantage of being embedded in the Local Authority and will strengthen integration with education. They include:

- the Public Health Schools Programmes
- young people substance misuse service
- support for schools to deliver high quality PSHE and provide access to prevention interventions that build resilience and reduce the impact of risky behaviours for young people at risk of early pregnancy, sexual risk taking or substance misuse
- Support young people's emotional health and wellbeing, self-harm prevention and reduction and resilience building
- Domestic violence training.

3.6 Safeguarding Children and Young People

3.6.1 Multi Agency Safeguarding Hub

The Multi Agency Safeguarding Hub was established in September 2014 and this ensures 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. Ofsted (June 2015) has recognised that the MASH is effective and appropriate child protection thresholds are consistently applied.

3.6.2 Adolescents Strategy

An Adolescent Strategy is being developed that will identify an integrated pathway for our vulnerable adolescents. Part of this strategy is to provide a service that will work to those young people who are leading very unstable lives and are at high risk.

3.6.3 Children's Social Work: Model of Practice

Building on the work already undertaken with social workers about their vision of excellent social work and listening to the views of children and young people about what constitutes excellent practice, a relationship model of practice within social work has been established which prioritises the relationship between the social worker and the family as the main vehicle to facilitate change. Following extensive consultation the model of practice 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.

3.6.4 Care Planning Panel

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.

3.6.5 Support for families (domestic abuse, parental substance misuse and mental health)

A range of services are available to support families where domestic abuse, and/or drug and alcohol has an impact. These include services to support victims and children and statutory and non-statutory programmes for perpetrators of domestic abuse. Services to support parents who have mental ill-health but who are not eligible for an ongoing service from adult mental health services are limited. The majority of services are primarily available when risks to children are high. The local authority is in the process of reviewing its commissioning arrangements to ensure that services are effective in helping families to sustain improvements when high-level risks have reduced.

3.6.6 Kite Team (child sexual exploitation)

Working with partners we have established the Kite Team which is a specialist Missing and Child Sexual Exploitation (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.

4. What will we deliver?

In this strategy, we have identified a range of local and national statistics (and key policies), feedback, other intelligence that will drive actions forward and provide the framework for our key priorities for improvement. The priorities and actions described in Table 1 below link back to this. They are described at a high level and not intended to be a long list of all the health and wellbeing

issues or activities in Brighton & Hove. The final column in Table 1 below sets out what positive difference should be observed by 2020.

5. How will we work differently to deliver these priorities

This high level strategy will be supported by a joint commissioning action plan for each of the five priorities setting out timescales over the next four years to 2020.

Joint commissioning will be delivered through the bringing together of Public Health, Clinical Commissioning Group and Brighton & Hove City Council Commissioners and pooling together budgets and eliminating duplication.

6. How the Strategy will be monitored and evaluated

I. A strategic stakeholder group will be established to steer the strategy through the implementation phase, which will include parents/carers and young people
II. The action plans which will underpin the strategy will be subject to quarterly monitoring and evaluation by a joint commissioners' group
III. There will be an annual review of relevant data and intelligence followed by any amendments or updates needed
IV. A brief progress report will be produced annually for publication

Table 1 Key Priorities and Outcomes – 2015 - 2020

Priorities	What we will do	What will be different by 2020
1.To give every child the best start in life and to reduce inequalities	• Promote stronger emotional and physical wellbeing through pregnancy and in the early years • Support families at the earliest opportunity through quality integrated services • Enable all children to have access to quality childcare and nursery provision • Close the educational achievement gaps between disadvantaged children and their peers • Close the gaps in healthy lifestyle outcomes for children and young people in the areas of obesity, sexual health, smoking and substance misuse • Promote a `Child Friendly` city approach	• Fewer young children needing specialist health and social work services • Fewer babies and young children needing to come into care • Maximum take up of high quality childcare/ nursery place entitlement • Achievement gaps for disadvantaged children and young people have narrowed and are less than the national average • Inequalities in health outcomes for disadvantaged children and young people in the areas of obesity, sexual health, smoking and substance misuse have reduced • Children and young people know how & where to go to get help and report a positive experience of services
2.To provide children with complex education, health and care needs from 0-25 years and their families with high quality integrated support	• Ensure robust multi-disciplinary approach to the assessment and production of Education, Health and Care plans for children with complex SEND from 0-25 years • Develop integrated assessment and provision for children with the most complex SEND across education, health and care services • Empower parents through use of personal budgets	• High quality Education, Health and Care Plans with integrated direct payments for eligible children and young people • Three new integrated provisions for children and young people with SEND offering education, health and care on site • Fewer children with SEND need provision outside of the City • High quality 'Local Offer' of signposting services, including

	across education, health and care • Maximise opportunities for young people in terms of further education, supported internships and vocational opportunities • Provide quality, safe and sustainable models of care for children with acute short term illnesses and long term conditions and mental health issues, delivered closer to home • Empower children, young people and families that understand where and how they can get the best care when they need it	those across the transition to Adult Services • More young people with SEND accessing internships, apprenticeships and employment • Fewer children and young people in hospital attendances and in unplanned admissions • Increased recovery rates for sick children over shorter time periods • Fewer incidents of self-harm and suicide attempts
3.To improve emotional health and wellbeing and mental health and wellbeing of children and young people	• Transform mental health and wellbeing services by engaging children and young people especially vulnerable groups in their design • Support young people's emotional health and wellbeing and build resilience • Improve crisis and out of hours support for young people • Innovative communication of information and support about services and how to access them, by taking opportunities available in digital and social media • Collaborative and joint commissioning with Children's Services and Public Health to ensure efficient use of resources to meet need • All providers to adopt 'You're Welcome' standards to ensure they provide an environment that is young people-friendly	• Fewer incidents of self-harm ,eating disorder, anxiety and depression amongst young people • Fewer young people will need A&E attendance and hospital admission for mental health problems • Children, young people and their families will give much more positive feedback on their experiences of mental health services
4.To provide effective 'Early Help' for families facing multiple	• Signpost a clear pathway to available 'Early Help' services and targeted interventions	• Fewer children and young people coming into care

disadvantage that reduces the need for specialist social care and health services	• Provide multi-agency/professional support at the earliest opportunities to families facing multiple disadvantage • Improve the partnership between Children's Services, Adult Social Care and Health services to provide support to vulnerable parents/carers • Extend and strengthen the Troubled Families programme via our Stronger Families Stronger Communities team	• Reduction in substance misuse, domestic violence and mental health problems in parents/ carers • The Stronger Family Programme meets national targets for 'turning families around' • Further improvement to levels of school attendance and a reduction in exclusions from school
5.To ensure all our children and young people are safe	• Ensure all staff are aware of the importance of appropriate information sharing to safeguard children • Ensure responsive and effective identification of safeguarding issues via a high quality Multi-agency Safeguarding Hub (MASH) • Develop and implement the LSCB Child Sexual Exploitation & Other Groups of Vulnerable Children Strategy • Ensure that services commissioned to deliver adult services identify and respond to the needs of children and young people impacted by parental substance misuse, mental health, disability etc. and that this is evaluated through monitoring & compliance.	• Appropriate information is shared both within and across agencies in a timely manner to ensure children are safeguarded • Better safeguarding decision making for vulnerable children and families through the measurement of set criteria • Children and young people in Brighton & Hove will be protected from sexual exploitation • Children and young people will feel safe and protected and have improved life experiences • Children and young people living in the context of domestic abuse, parental substance misuse, mental health and disability are identified early and receive appropriate help and support.

8 Appendices - *in progress*

Appendix 1: List of Local and National Strategies & References

Joint Commissioning Strategy for Children's Services and Housing

List of National Strategies and Policies:

National

- Future in Mind; promoting, protecting and improving our children and young people's mental health and wellbeing (March 2015)
- National CAMHS Review (2008)
- CAMHS Tier 4 Report (2014)
- National Service Framework for children, young people and maternity services (2004)
- No health without mental health (2012)
- Five Year Forward View, NHS England (2014)
- Annual Report of the Chief Medical Officer (2013)
- You're Welcome – Quality criteria for young people friendly health services (2011)
- Promoting emotional wellbeing and positive mental health of children and young people, Public Health England (2013)
- Transforming Care and Commissioning Steering Group, Winterborne View; Time for Change (2014)
- Transforming Care for people with learning disabilities (2015)
- Schools Counselling Strategy DfE (2015)

Appendix 2 : Local linked strategies

	Name of Strategy	Status	Web link if completed
BHCC	SEN Partnership strategy:	Completed	http://present.brighton-hove.gov.uk/Published/C00000701/M00004024/AI00030994/$Item34tSENPartnershipStrategy.docA.ps.pdf
	SEND Review	Completed	http://present.brighton-hove.gov.uk/Published/C00000874/M00005597/AI00044015/$20150126165031_007091_0028782_finaldraftSENDreviewfullreport.docxA.ps.pdf
	Stronger Families Stronger Communities Outcomes Plan agreed by the Early Help Partnership	?	
	BHCC Corporate Parenting Policy & Strategy 2013-15	Completed	http://wave.brighton-hove.gov.uk/ourcouncil/Childrens%20Services/Pages/CorporateParenting.aspx
	Housing & Support for Young People aged 16-25	Completed	http://present.brighton-hove.gov.uk/Published/C00000709/M00004769/AI00036300/$20130916144749_004725_0018502_HousingandSupportforYoungPeopleJointCommissioningStrategyFinalSept.docA.ps.pdf
	Children's Services Directorate Plan 2015-16	Completed	http://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/Children's%20Services%20Directorate%20Plan%202015-16%20(PDF%20381KB).pdf
	A good, happy and healthy Life: Our plan for adults with learning disabilities in Brighton and Hove, 2015-2019	Completed	Due to be available on-line shortly
	Joint Strategic Plan: Winterbourne View, 2014-19	Completed	Due to be available on-line shortly
PH	Public Health Programmes: documents/action plans for Healthy Child Programme and Schools Programme - other?	?	
	Annual Report	Completed	http://www.brightonbusiness.co.uk/secure/assets/ni20140718.277692_53c8f07d4703.pdf
CCG	Childern & Young people's Mental Health and Wellbeing Transformation Plan	Not yet published	
	Brighton and Hove Joint Commissioning Statement / Agreement: Education, health and care provision for children and young people with Special Educational Needs and Disabilities (SEND) including social, emotional and mental health needs?	Not yet published	
LSCB	Brighton & Hove Local Safeguarding	Completed	http://www.brightonandhovelscb.org.uk/wp-

	Children Board (LSCB) Business Plan 2013-2016		content/uploads/NEW-LSCB-Business-Plan-2013-16-Year-1-3-Milestones-2015-v2.pdf
	Brighton & Hove LSCB, CSE and Vulnerable Children Strategy, draft v4 July 2015	Not yet published	

Local-

- Joint Health and Wellbeing Strategy
- Connected Cities and Council Corporate Plan
- CCG Commissioning Intentions
- Brighton & Hove City Council Skills and Employment Strategy
- Brighton & Hove Emotional Health and Mental wellbeing Strategy
- Brighton & Hove CCG Primary Care Strategy
- Health visitors and School Nurses transformation
- Early Help Strategy
- Acute model and capacity – reference Key Royal College Papers on Maternity & Paediatrics
- Child Friendly City

Children's Centre Consultation Briefing

Background - Children's Centres

- Statutory guidance from Government to improve early years outcomes and reduce inequalities between families in greatest needs and their peers.
- 12 designated children's centres (registered with the Department of Education and Ofsted). Services also provided in more linked sites and parents homes
- Government funding shift from children's centres to free childcare places for two year olds from low income families – high take up of over 85% in the city.
- Main children's centres include nurseries. No plans for changes as part of this consultation. The council is reviewing the nurseries and looking at different options to reduce the council subsidy. Considering the Government plans to offer 30 hours of free childcare and will express an interest in piloting from September 2016.
- Council management of health visiting ending but children's centres and health visiting will continue to provide integrated services for families.
- Funding reduction of £846,000: £670,000 was agreed in last year's budget with a proposal for a further saving of £176,000 for 2016/17.
- Listened to last year's consultation – parents value children's centres and groups
- Funding reductions mean we cannot provide the same level of service in the future.

Needs / Outcomes

- Inequalities across the city: eg. around 18% of children live in poverty but 37% in Moulsecoomb
- Roundabout (Whitehawk), Moulsecoomb, Tarner and Hangleton have the highest needs and poorest outcomes for education, health and need for social work services.
- 64.7% of all children achieve a good level of development at the end of their reception year (age 5) in the city compared to 66.3% in England;
- But only 52.8% in Moulsecoomb CC area and 51.6% of children from families on out of work benefits (eligible for Free School Meals)
- High numbers of children going into child protection and needing to be looked after: impact of issues such as substance misuse, adult mental health, domestic violence.

Consulting on proposals (deadline 20 December)

- Reduce from 12 to 7 designated (main) children's centres: Tarner, Moulsecoomb, Roundabout (Whitehawk), Hangleton, Hollingdean; Conway Court (Hove), Portslade – includes areas with highest needs and ensures a citywide spread
- Continuing to provide open access baby groups
- Reduced number of drop in stay and play groups but they will still be run across the city. Priority for families with identified needs and children under two.
- More parenting talks and discussion groups – fewer longer courses
- Promote volunteering and community / parent run groups
- Continue home visits for parents most in need
- Improved support for families facing multiple disadvantage from family coaches
- More focus on supporting parents into training and employment
- Develop children's centres as part of neighbourhood hubs.

Details of proposed early years services

Universal - available to all

- Health Visitors: five development reviews which are offered to all families: ante-natal, new birth, 6 weeks, one year and two years. Healthy child clinics.
- Open access baby groups – in the same venues as now
- Stay and Play Groups – one group per week in 11 venues across the city with priority for children under 2
- Advice and support for training / employment / volunteering
- Advice and information on parenting – talks and workshops open to all
- Access to free early education for 3 and 4 year olds – all children are entitled to 15 hours a week for 38 weeks or fewer hours for more week

Targeted services - aimed at particular groups or families with identified needs

- Access to free childcare places for two year olds living in low income families
- Parenting courses – Triple P Level 4 and 5 and Feeling Good Feeling Safe
- Post natal depression groups run by health visitors
- Bilingual families groups for families with English as an additional language (Tarner, Conway Court, Hangleton)
- Chatterbox groups for children identified with speech and language delay
- Now We Are Two – one term courses for families who will be entitled to free childcare for two year olds to help parents to support their child's early learning
- Home based interventions (for example covering developmental delay, parenting)
- Early Years Family Coaches for families with children under 5 facing multiple disadvantage
- Food banks (Tarner, Moulsecoomb, Roundabout)
- Specialist citywide groups eg. Rainbow Families (LGBT), MOSAIC , Little Wheels (disabled children), Dads' Group (Tarner)

Scenarios

Unemployed lone parent living in Patcham with an 18 month old

One year and two year development review by the health visitor, stay and play group at Hollingbury and Patcham Children's Centre, information and advice on how to volunteer or options for training and when to register for free childcare for two year olds.

Parents with two year old with SEND in a local nursery

Two year old review with the health visitor. Liaison between the health visitor, nursery and SEN Specialist about the support the child needs. Advice and training for the nursery and parents. Additional funding for the nursery to employ extra staff to support the child to access learning if needed.

Isolated family with English as an additional language with an 18 month old with speech delay

Development reviews at one year with the health visitor. Health Visitor agrees an action plan with the family. Early years visitor allocated to the family for home visiting to encouraged to attend the Bilingual Families Group in Hangleton CC to meet other parents. Supported to attend a Chatterbox group to help develop language. Speech and language referral if necessary. Parents encouraged to attend local parenting workshop.

Unemployed lone parent living in temporary housing with debts and concerns about parenting, difficult relationships and lack of stimulation of three year old and school attendance of an 8 year old

Identified by the health visitor as needing additional support and early help referral agreed with the family. Allocated an early year family coach to support with housing, debt and training options. Encouraged to attend the Feeling Good Feeling Safe course at children's centre, home visiting to support early learning and school routines.

Family in West Hove with new baby and no issues

Health visitor new birth and six week reviews. Advice on feeding and sleep. Attend the baby group at Conway Court CC.

Children's Centre Review 2015 Brighton & Hove

Final:

Brighton & Hove City Council

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1. Introduction

1.1 This report sets out proposals and options for a revised children's centre service across Brighton & Hove to take account of reductions in funding. The report will be submitted to the Children, Young People and Skills Committee as the basis for a public consultation on the future children's centre service in Brighton & Hove.

1.2 The report was completed following discussions with parents, voluntary sector representatives and officers from the council and Sussex Community NHS Trust who considered existing and future children's centre arrangements through a review board chaired by the Director of Children's Services. Appendix xiii on page 33 sets out the terms of reference for the review board.

1.3 In Brighton & Hove there is a citywide children's centre service integrated with health visiting. Midwives are based in the larger centres. All centres provide baby and stay and play groups for children and parents, healthy child clinics, parenting groups, volunteering opportunities and information about training or getting back to work. Some of the activities are drop-in sessions and available to all local families and others by appointment or referral. Children's centres also provide home visiting for families who need additional support. There are currently 12 statutory children's centres in Brighton & Hove serving a population of 14,745 children under five years old. Services are also provided from a number of linked sites.

1.4 When the first children's centres were developed they had to include 8am to 6pm childcare to support parents to work. Nurseries are located in four of our children's centres. All of the nurseries provide free early education places for two, three and four year olds funded by government as well as childcare paid for by parents. Council funding to subsidise the nurseries was reduced by £200,000 in 2015/16 and further savings will be agreed as part of the council budget for 2016/17.

1.5 The council's budget proposals for 2015/16 included a reduction in funding for children's centres. Following a public consultation the Budget Council agreed temporary funding of £670,000 to maintain services for 2015/16 only. There is a proposal for a further saving of £176,000 as part of the 2016/17 budget proposals. If agreed the total reduction will be £846,000 (35%) from the budget of £2,390,000.

2. Summary of factors influencing the review

2.1. In common with other councils across England Brighton & Hove city council has to make savings across all service areas as result of reductions in government funding and pressures on services.

2.2. It will not be possible to provide the same level of services through children's centres with the reduction in funding to children's centre budget. Nearly 80% of the budget is spent on staffing and so significant reductions in staff will be needed to achieve the savings.

2.3. The Labour administration's priority to ensure that the most vulnerable and disadvantaged children receive the council's support, consolidating services where possible, and targeting resources at those most in need.

2.4. The children's centres statutory guidance includes the requirement to reduce inequalities between families in greatest need and their peers. The government has announced plans to launch an open consultation this autumn about children's centres which will aim to make sure that they have the best impact on children's lives and maximise support to families. This will include working with Ofsted to reform inspections.

2.5. A public consultation on changes to children's centres in Brighton & Hove took place during the winter of 2014/15. Proposals included reducing the number of universal groups and merging children's centres. There was strong disagreement with the proposals. Key themes included: children's centres provide vital services and should not change, savings now will lead to greater costs and poorer outcomes in the future, universal services are key to reducing stigma and community cohesion and should be kept. There was agreement that families who have most needs should get priority. A summary of the findings of the consultation is on page 28.

2.6. Issues identified as having the greatest impact on the health and wellbeing of children and young people in the city include: child poverty, education, youth unemployment, housing, alcohol and substance misuse, healthy weight and good nutrition, domestic and sexual violence, emotional health and wellbeing, smoking, as well as the wellbeing of children and young people with disabilities and complex needs. (Joint Strategic Needs Assessment 2015).

2.7. National research evidence has shown that focussing on early years gives the best chance of transforming a child's life: "Giving every child the best start in life is reducing health inequalities across life… What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing." (Marmott 2010)

2.8. A needs analysis identified significant inequalities in outcomes across the city. Children living in Moulsecoomb, Roundabout, Tarner and Hangleton areas have some of the highest needs, and poorest outcomes in the city. However there are also pockets of deprivation across the city.

2.9. Nearly 20% of children in the city live in poverty and welfare reforms are having a further detrimental impact on families.

2.10. Nationally children's services are dealing with a growing number of child protection cases and children at risk of neglect. The council needs to strengthen early help services to "turn around" families just below social work thresholds.

2.11. There has also been a change in the council's relationship with Sussex Community NHS Trust. The Section 75 secondment agreement ended in March 2015 and temporary arrangements for the council continuing to manage the health visiting service will end in March 2016. Responsibility for commissioning health visiting transferred to the council's public health department in October 2015. Health visitors see and assess all children as part of the Healthy Child Programme during five mandated health and development assessments. Health visitors will continue to be based in and work from children's centres but there will be a clearer distinction between the roles of council and SCT staff in the future.

2.12. There has been a major shift in government policy on early years since the creation of children's centres with the introduction of free early education places for two year olds living in low income families. Eligible children include those in families on Income Support or Working Tax Credit with an income of less than £16,190 a year. Children are also eligible if they have an Education, Health and Care Plan or get Disability Living Allowance, adopted children and children looked after by the local authority. In Brighton & Hove around 30% of two year olds qualify for free places and the take up of more than 84% is one of the highest in England. Funding for early education places for two year olds is ring-fenced in the Dedicated Schools Grant and is worth £2.5 million in 2015/16.

2.13. The Special Education Need and Disabilities (SEND) Code of Practice (2014) covers the 0 to 25 age range. Health visitors support the early identification of young children who may have SEND, through the Healthy Child Programme. From September 2015 this includes an integrated review that covers the development areas in the Healthy Child Programme two year review and the Early Years Foundation Stage two year progress check for children attending early years provision. Children and young people with more complex needs have a co-ordinated assessment and an Education, Health and Care plan.

2.14. The council plans to move to a co-operative model of service delivery. The City Neighbourhoods programme plans to establish hubs in the heart of communities, bringing appropriate services closer to those who need them by forging stronger links with local people. The neighbourhood hubs will host a variety of services, based on the needs of the local area; they will be delivered by council staff alongside a range of partners, including voluntary organisations, and supported by volunteers. The aim is to save money, improve outcomes and reduce inequality. Children's centres will form part of this programme.

3. Consultation

3.1. Further consultation took place in the summer and autumn of 2015 to help identify options for future services. Face to face discussions were held with parents, staff and other stakeholders via the parents' reference group, staff meetings and children's centre advisory groups.

3.2. The key messages those we consulted wanted to get across were:

Children's centres are an early help service. Cutting provision will have negative consequences for child outcomes and for future budgets as problems are left to escalate.

In the context of wage freezes, rising living costs and cuts to benefits, tax credits and other support services, children's centre services will be needed more, not less.

Universal services like stay and play are key to reducing stigma, building social cohesion, reducing isolation and for attracting families into children's centres in the first place. Families have described these services as a 'lifeline'.

Reducing the number of universal drop-in services risks needs not being identified and met early on.

These groups are important for socialising children and preparing them for school and nursery. They offer a more structured learning environment and challenge children in ways that other community-led groups do not.

3.3. A more detailed summary of the consultation findings is on page 28.

4. Proposals for changes

Proposals for Children's Centres and Delivery Points

There is a considerable variation in the size of different children's centres across the city and the services that are delivered from them. The largest children's centres are stand-alone buildings based in the most disadvantaged areas of the city and deliver the most services. Other children's centres are much smaller, are generally small extensions to schools, and deliver fewer services.

Main Sites

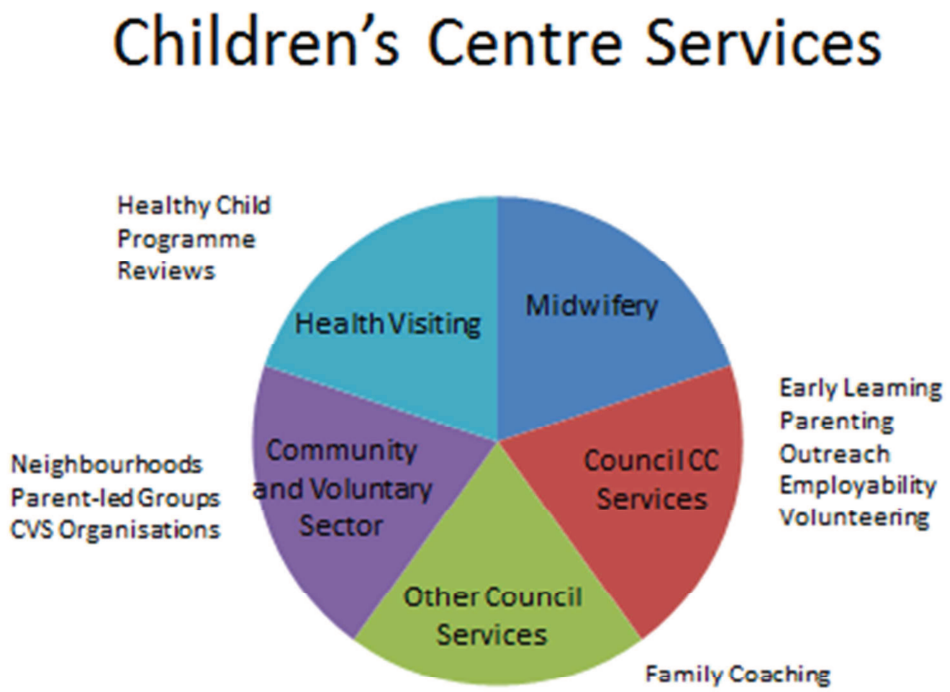
Proposals are to continue using the following seven children's centres as main sites and designated children's centres:

- Roundabout (Whitehawk)
- Moulsecoomb
- Tarner
- Hollingdean,
- Hangleton Park
- Conway Court
- Portslade (but with reduced opening hours)

This is because data shows that families have highest needs and poorest outcomes in these areas and also to ensure that there is a spread of main sites across the city. The main sites will offer a range of children's centre services and will be open from 9am to 5pm. North Portslade is a smaller centre and the proposal is to reduce the opening hours here.

The proposal is to develop these children's centres as part of neighbourhood hubs and explore whether they can host a variety of services, based on the needs of the local area. These services will be delivered by the council alongside a range of partners, including voluntary sector organisations, and supported by volunteers.

Future model for children's centres:



Delivery Points

The proposals are to merge the following children's centres and to continue to use them as delivery points for services:

- The Deans (Rudyard Kipling primary school) – merge with Roundabout
- West Hove (West Hove infant school) – merge with Conway Court
- Hollingbury and Patcham (Carden primary school) – merge with Hollingdean
- City View – merge with Tarner /Moulsecoomb

As part of these changes there will be a review of the City View catchment area to consider how it should be divided between the Tarner and Moulsecoomb catchment areas.

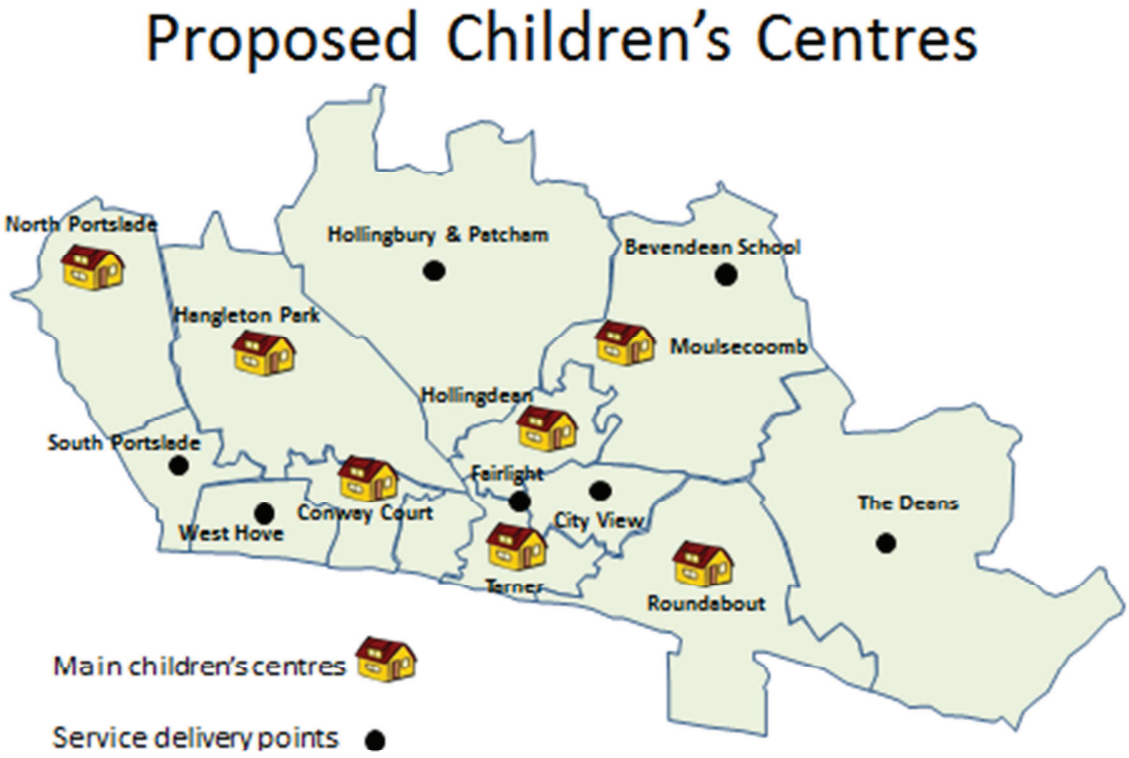
The proposal is that Cornerstone community centre will no longer be a children's centre. The community centre provides services including a baby group and hosts a pre-school that offers free early education places.

To minimise costs in running the buildings, service delivery points will only open for children's centre services when there is a service running. Services will vary from site to site and will be based on local need. A possible partnership with the library service is being explored for Hollingbury and Patcham.

The following venues will continue to be used as linked sites.

- South Portslade Library
- Bevendean primary school
- Fairlight primary school

In addition the proposal is to explore developing a citywide on-line children's centre providing access to information and advice via the council website and through social media for families with young children in Brighton & Hove. This would build on information already available from our Family Information Service, children's centre Facebook pages and national websites.



Children's Centre Services

Proposed citywide offer for children under five and their families across the city:

Universal - available to all

- Midwifery clinics
- Healthy Child Programme delivered by health visitors including development reviews and clinics
- Baby groups
- Stay and play group (one for each area) with priority for children under two
- Positive parenting talks and discussion groups
- Advice on training/employment/volunteering
- Access to free early education for three and four year olds

Targeted services - aimed at particular groups or families with identified needs

- Access to free early education for eligible two year olds
- Parenting courses
- Postnatal depression groups
- Bilingual families' groups

- Dads' groups
- Chatterbox (communication)
- Now We Are Two (supporting children's early learning)
- Home-based interventions (for example covering developmental delay, parenting)
- Food banks (Tarner, Moulsecoomb, Roundabout)

Baby groups

Last year there was a proposal to change baby groups to short courses. Parents said that these open access groups were vital, particularly for those parents who lack experience or who are socially isolated. The proposal is to continue to run on-going baby groups as this is a key transition time for new parents. There will not be any short courses in addition to the on-going groups. Health visitors and other professional will attend the groups to give advice and information to new parents and carers.

Proposed changes to stay and play drop-in groups

There are around 20 stay and play-type groups a week across the city including Toddler and You and Jump for Joy in some areas.

Because of reductions in funding there will not be enough staff to run this number of groups in the future.

Last year the proposal was to stop running on-going stay and play groups and to run time limited groups for children under two instead. Parents disagreed with this proposal and said that these drop-in groups are important for building friendships, reducing isolation, finding out about other services families need and for preparing children for nursery and school.

This proposal is to continue to offer **one** free, drop in stay and play session per week in the following eleven areas.

- Hollingbury and Patcham
- Hollingdean
- Tarner
- Moulsecoomb
- Bevendean
- Roundabout (in Whitehawk)
- Hangelton Park
- Conway Court
- The Deans
- North Portslade
- and City View

The proposal is not to provide a weekly stay and play drop in session at Meadowview where numbers are low.

Where there is high demand for a group priority will be given to families with needs identified by health visitors and children under two years old. This is because two year olds from families on the lowest incomes are entitled to free early education.

The proposal is to continue to support parents to volunteer and to encourage parents or community groups to use the space in children's centres to run other groups if there is a local demand.

Proposed changes to stories and play library groups

The Children's Centre budget has funded some Stories and Play sessions in libraries. Last year the proposal was to stop funding these groups but parents said that they valued them. The proposal this year is to continue to fund groups in the Moulsecoomb and Whitehawk libraries but to no longer fund other sessions in Coldean or Woodingdean. Data shows that the numbers of children doing well when they start school is lowest in Moulsecoomb and Whitehawk.

Proposed changes to parenting support

The proposal is to reduce the number of Triple P parenting courses and offer more help early on in Triple P weekly discussion groups and talks on parenting topics that will be open to all parents. Children's centres will continue to provide one to one parenting advice and Triple P tip sheets. The proposal is also to offer more online parenting support in the form of parenting advice and web-based courses.

Targeted support for families who need more help

Children's Centres will continue to run a range of groups targeted at families who need additional support. These include Bilingual Families Groups, Feeling Good Feeling Safe Groups, Chatterbox communications groups and Now we are two which supports parents with their child's early learning.

There will be an overall reduction in home visits and one to one contacts. Home visits and one to one contacts by council staff have been provided to a range of families with different levels of needs on issues including parenting, sleep, baby massage, and home learning. The proposal is to continue to encourage attendance at children's centres and only offer home visiting to those parents who need it most.

The proposal is also to improve support for families with young children facing multiple disadvantage as part of the city's Stronger Families Stronger Communities Programme. This programme includes Family Coaches who work with families and households on issues such as:

- School and education
- Offending and anti-social behaviour
- Housing
- Supporting adults and young adults into work and learning
- Advice about money
- Parenting skills
- Domestic violence and abuse,
- Alcohol and substance misuse
- Mental & physical health needs

Changes to children's centre advisory groups and support for volunteering, employment and training

There are 10 advisory groups which meet once a term to advise and help staff who run children's centres. The group makes sure that the centre knows parents' views and helps to challenge and improve the performance of the centre.

The proposal is to focus more on helping parents to volunteer and to access training and work with a living wage. We recognise that nearly 20% of children in the city live in poverty and that the range of benefit reductions are having an impact on our parents and will continue to do so with ongoing changes to tax credits.

This means there will be less time to support the advisory groups. The proposal is to reduce the number of advisory groups and consult them on ways to ensure that parents have a say in how children's centres are run. The proposal is to support five advisory groups in the future:

- Tarner /City View,
- Hollingdean/Hollingbury and Patcham,
- Moulsecoomb,
- Roundabout/The Deans,
- and Hangleton/Portslade/ Conway Court.

Appendices to the report

I. Information Considered by the Review Board

i. Importance of the Early Years

There have been a number of studies that have shown that focussing on the early years gives the best chance of transforming a child's life:

- "Giving every child the best start in life is reducing health inequalities across life… What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing." (Marmott 2010)

- "The early years is a time of dramatic growth and development: a child's brain doubles in size in the first year and by age three it will have reached 80% of its adult volume. At age two or three, the brain has up to twice as many synapses than in adulthood. Because the early years are a time when children are learning rapidly, how well they are taught, whether that is at home or outside of the home, is very important." (Ofsted 2015)

ii. Statutory Guidance and Ofsted

The core purpose of children's centres, as set out in the government's Sure Start Children's Centre Statutory Guidance (https://www.gov.uk/sure-start-childrens-centres-local-authorities-duties), is to improve outcomes for young children and their families and reduce inequalities between families in greatest need and their peers in:

- child development and school readiness;
- parenting aspirations and parenting skills; and
- child and family health and life chances.

Local authorities have a statutory duty to:

- Improve the well-being of young children in the following areas:
    - physical and mental health and emotional well-being
    - protection from harm and neglect;
    - education, training and recreation:
    - the contribution made by them to society; and
    - social and economic well-being.
- Reduce inequalities between young children in those areas; and

- Make arrangements to secure that early childhood services in their area are provided in an integrated manner which is calculated to:
    - facilitate access to those services; and
    - maximise the benefit of those services to parents, prospective parents and young children.

A Sure Start children's centre is defined in legislation as a place or a group of places which make available integrated universal and targeted early childhood services including:

- Early education and childcare
- Social services
- Health services
- Training and employment
- Information and advice

Children's centres must provide some activities for young children on site.

The guidance states that children's centres are as much about making appropriate and integrated services available, as about providing premises in particular geographical areas.

The government has announced that it plans to launch an open consultation this autumn about children's centres which will aim to make sure that children's centres have the best impact on children's lives and maximise support to families. This will include working with Ofsted to reform inspections.
The government has announced plans to increase free early education for three and four year olds with working parents from 15 to 30 hours a week.

iii. Council Vision and Priorities

The city's vision is for Brighton & Hove to be the connected city. Creative, dynamic, inclusive and caring. A fantastic place to live, work and visit. (Corporate Plan)

The service priority for children is that children and young people should have the best possible start in life, growing up happy, healthy and safe with the opportunity to reach their potential. (Corporate Plan 2015)

The Children, Young People and Skills Committee has agreed the following four priorities:

- Ensure that the most vulnerable and disadvantaged children receive the council's support, consolidating services where possible, and targeting resources at those most in need

- Take the council on an improvement journey to achieve excellent services for children and young people by 2019, as rated by Ofsted

- Provide greater challenge and support to council maintained schools to close the disadvantage and educational attainment gaps, including a focus on STEM subjects (Science, Technology, Engineering and Mathematics)

- Eliminate long-term youth unemployment (18-24 years old) and boost apprenticeships in the city by 2019

iv. Early Help Outcomes Framework

This early help outcomes framework indicates the expectations that we have for all children, young people and families living in Brighton & Hove. Performance indicators for each early help service sit behind the outcomes.

Children and young people are ready for and thrive in school and leave able to participate in the social and economic life of the city

- **Develop secure attachments**
- **Healthy and well**
- **Safe and protected from harm**
- **Stimulating home learning environment**
- **Attending nursery or school**
- **Reaching academic potential**
- **Resilient & able to make effective transitions**
- **Increased skills and qualifications**
- **Improved readiness for work**

Parents have the support, skills and resilience needed to bring up their children

- **Responsive positive parenting**
- **Good physical & mental health**
- **Free from domestic abuse**
- **Free from substance misuse**
- **Good levels of literacy & numeracy**
- **Good aspirations for selves and children**

Communities have inclusive, active networks which support & involve children, young people and families

- **Improved use of community assets**
- **Improved support networks**
- **Improved home & living conditions**
- **Parents and young people are law abiding and responsible in their community.**

v. Current Children's Centres and Services

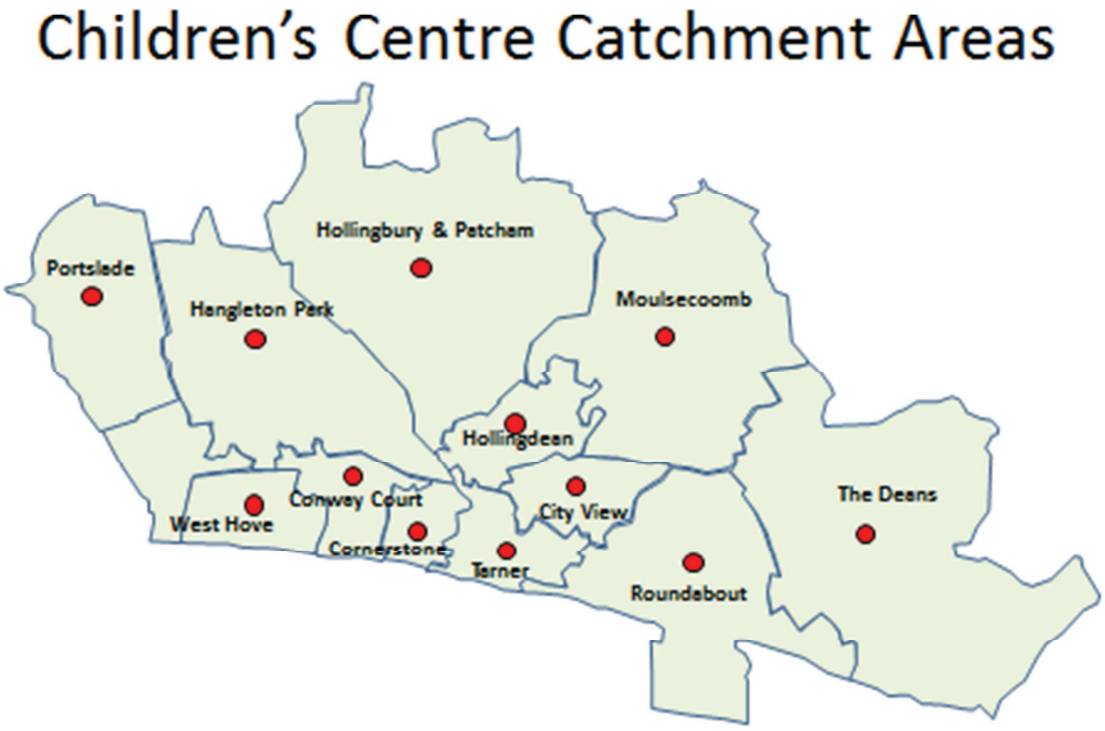
In Brighton &Hove there is citywide children's centre service with council children's services staff and health visitors working together.

There are 12 statutory children's centres serving a population of 14,745 children under five years old. Each statutory children's centre covers a defined catchment area with an average of 1,217 children under five.

Services are also provided from a number of linked sites and in family homes. All the children's centres were inspected by Ofsted in 2011/12 and judged as good or outstanding.

Most services are provided by the integrated children's centre teams with some additional services commissioned from the voluntary sector. The larger children's centres also include nurseries.

Health visitors are employed by Sussex Community NHS Trust (SCT) and are commissioned (from October 2015) by public health in the council.
Midwives are based in the larger centres and are employed by Brighton and Sussex Hospitals Trust and commissioned by the Clinical Commissioning Group (CCG).



Designated Children's Centres	Description
Moulsecoomb Children's Centre	Designated - main hub. High need area. Large building including council staff, health visiting, midwifery and Jump Start nursery
Roundabout Children`s Centre	Designated - main hub. High need area. Large building including council staff, health visiting, midwifery, Family Nurse Partnership with the Roundabout nursery next door. Outreach to the Deans
Hangleton Gateway Centre	Designated - main hub. High need area. Large building including council staff, health visiting, midwifery. Next to the community centre.
Hollingdean Children's Centre	Designated - main hub. Mixed needs in the catchment area. Large building including café, council staff, midwives and health visiting services, Cherry Tree nursery. Piloting community use at weekends. Health visitors and some council staff based in Shenfield Way
Tarner Children's Centre	Designated - main hub. Large building including council staff, health visiting, midwives, Family Information Service, café. Link to Friends Centre upstairs and Tarnerland nursery school (separate building).
North Portslade Children's Centre	Smaller building with Acorn nursery in the upper part of building. Most of the staff team based in a GP surgery but deliver services from the children's centre. Midwives. Services also delivered from South Portslade Library
Conway Court Children's Centre (Sussex Community NHS Trust)	Sussex Community Trust building which also includes other adult health services, midwifery, health visiting and council staff. Low need but very large catchment area and higher than average BME population.
West Hove Children's Centre (in West Hove infant school (Portland Road)	Extension to West Hove infant school (Portland Road). No staff based there. Used for small groups
Hollingbury & Patcham Children`s Centre	Part of Carden primary school with a separate entrance. Includes health visiting team.
Cornerstone Community Centre	Community centre with rooms rented for healthy child clinics only. Community centre now running baby groups themselves.
City View Children's Centre Sussex Community Trust	Sussex Community Trust building. Includes a health visiting team and service delivery for the Early Parenting Assessment Programme. Services also delivered from

	Fairlight primary school (see below).
The Deans Children's Centre (in Rudyard Kipling primary school)	Extension to the school. Outreach from Roundabout children's centre.
Linked sites	
Preston Park Children's Centre (Fiveways Playgroup)	Voluntary early years provider which runs groups. Health visiting outreach. Community use.
Fairlight Children's Centre (in Fairlight primary School)	Room in the school and outreach from City View
South Portslade (in South Portslade Library)	Rooms in the library. No staff. Midwifery and healthy child clinic
Bevendean Children's Centre (in Bevendean primary school)	Room in the school. Outreach from Moulsecoomb

Summary of Services

Universal (available to all)

- Midwifery clinics
- Healthy child clinics
- Health visitor reviews
- Baby groups
- Stay and play, Jump for Joy, library groups
- Toy libraries
- Book Start (free books)
- Advice on training/employment/volunteering
- Access to free early education for three and four year olds

Universal Plus / Partnership Plus (aimed at particular groups or families with identified needs)

- Access to free early education for eligible two year olds
- Bilingual families' groups
- Dads' groups
- Positive parenting programme groups (Triple P)
- Feeling Good Feeling Safe groups
- Postnatal depression group

- Crèches for children to allow parents to attend groups
- Chatterbox (communication)
- Now We Are Two (new group supporting the Early Years Foundation Stage)
- Home-based interventions (usually block of visits for six weeks covering neglect, developmental delay, parenting,
- Food banks (Tarner, Moulsecoomb, Roundabout)
- Supported childcare places for children under three with child protection and early help plans

The average number of groups run each week across the city is:

- Healthy child clinics– 22 *(led by health visitors)*
- Universal groups– 37 (including baby groups and stay and play type groups)
- Targeted groups– 23

Total number of groups and clinics per week (average) = 82

Council staff also provide home-based interventions for families, some of whom are reluctant to attend children's centres.

Children's centres host and provide administrative support for midwifery clinics.

vi. Children's Centre Advisory Groups

There are 10 children's centre advisory groups with members including parents, children's centre staff, voluntary organisations, schools and other local services. The advisory groups advise and help the staff who run children's centres. The groups makes sure that the centre knows parents' views and helps to challenge and improve the performance of the centre.

vii. Integrated Service with Health Visiting

Children's centres are part of an integrated, citywide service led by health visitors. Health visitors register parents at the new birth visit. They see and assess all children as part of the Healthy Child Programme during five mandated health and development assessments. The assessments form the basis preventative and early intervention services to meet need. They include:

- Antenatal health promotion visit
- New baby review
- Six to eight weeks assessment
- One year assessment
- Two to two-and-a-half year review – integrated with nursery progress check

Children's centres use the nationally defined health visiting levels of service which also match the Brighton & Hove threshold document:

- Community – understanding community needs and local resources to meet them
- Universal (level 1) – health child programme reviews, information about parenting and immunisation, universal groups, early education
- Universal plus (early help – low level 2) – targeted packages of care to meet identified needs eg. maternal mental health, breast-feeding, nutrition, parenting support.
- Universal partnership plus (high level 2 up including targeted early help, child protection, , looked after children) – contributing or leading packages of care for those identified as having complex needs or being at risk including troubled families and child protection.

Health visitors act as lead professionals for families and supervise council children's centre staff (such as early years visitors) to ensure that there is no duplication of assessment or support for families. A key strength has been complete information sharing between council staff and health visiting. Lack of information sharing has been identified by Ofsted as a major weakness in other areas.

viii. Proposed Changes to Children's Centre Services

Proposed Changes to Stay & Play

	STAY AND PLAY *(including Crawlers & Todlers and Jump for Joy)*		
	Current Services	**Future Services**	**Proposed Changes**
Hollingbury & Patcham	1	1	No change
Hollingdean	1	1	No change
Preston Park			No change
Tarner	2	1	-1
Cornerstone			No change
Moulsecoomb	3	1	-1
Bevendean	2	1	-1
Coldean			No change
Roundabout	2	1	-1
Hangelton Park	1	1	No change
Conway Court	2	1	-1

West Hove			No change
Woodingdean	2	1	-1
Rottingdean			No change
Saltdean			No change
North Portslade	3	1	-2
South Portslade			No change
City View	1	1	No change
Fairlight			No change
TOTAL	**20**	**11**	**-9**

Proposed Changes to Stories & Play

	STORIES AND PLAY (Libraries)		
	Current Services	**Future Services**	**Proposed Changes**
Moulsecoomb	1	1	No change
Coldean	1		-1
Roundabout	1	1	No change
Woodingdean	0.5		-0.5
Rottingdean	0.5		-0.5
TOTAL	**4**	**2**	**-2**

Proposed Changes to Baby Groups

	BABY GROUPS		
	Current Services	**Future Services**	**Proposed Changes**
Hollingbury & Patcham	1	1	No change
Hollingdean	1	1	No change
Preston Park			No change
Tarner	1	1	No change
Cornerstone			No change
Moulsecoomb	1	1	No change
Bevendean			No change
Coldean			No change
Roundabout	1	1	No change
Hangelton Park	1	1	No change
Conway Court	2	1	-1
West Hove			No change
Woodingdean			No change
Rottingdean	1	1	No change
Saltdean			No change
North Portslade	1	1	No change
South Portslade			No change
City View			No change
Fairlight	2	1	-1
TOTAL	**12**	**10**	**-2**

ix. Children's Centre Nurseries

Phase one children's centres had to include childcare provision open from 8 am to 6 pm to support parents to work. The children's centres with nurseries are:

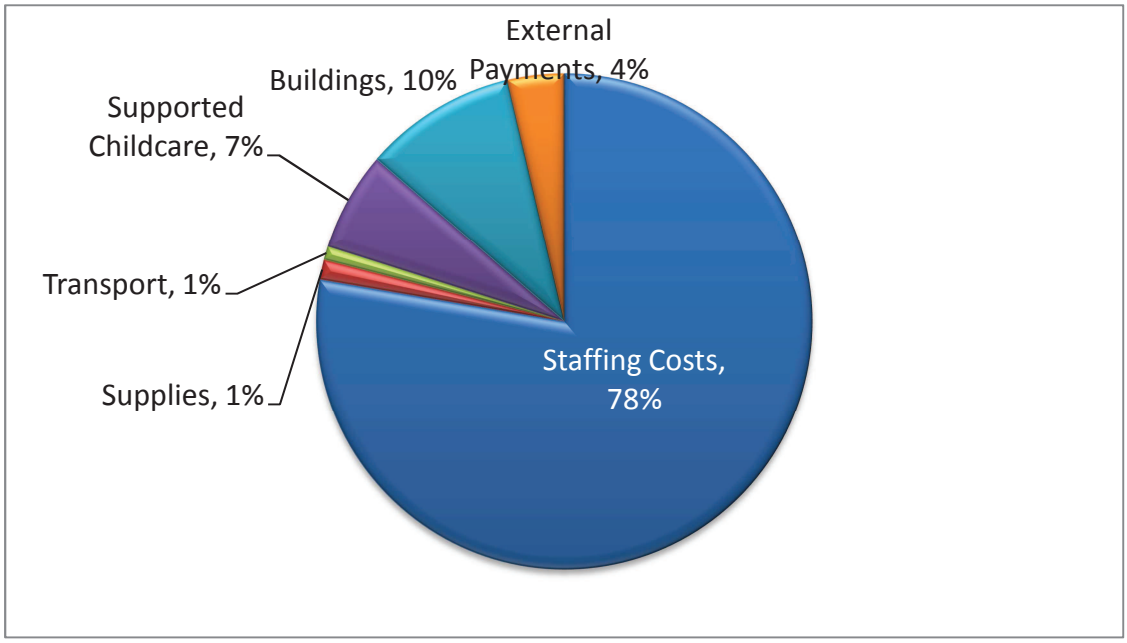
- Roundabout (Whitehawk): Roundabout Nursery and Sun Valley Nursery
- Moulsecoomb: Jump Start
- Hollingdean: Cherry Tree,
- North Portslade: Acorn,
- Tarner – in partnership with Tarnerland Nursery School

All the nurseries provide free early education places for two, three and four year olds funded by government and childcare which parents pay for.

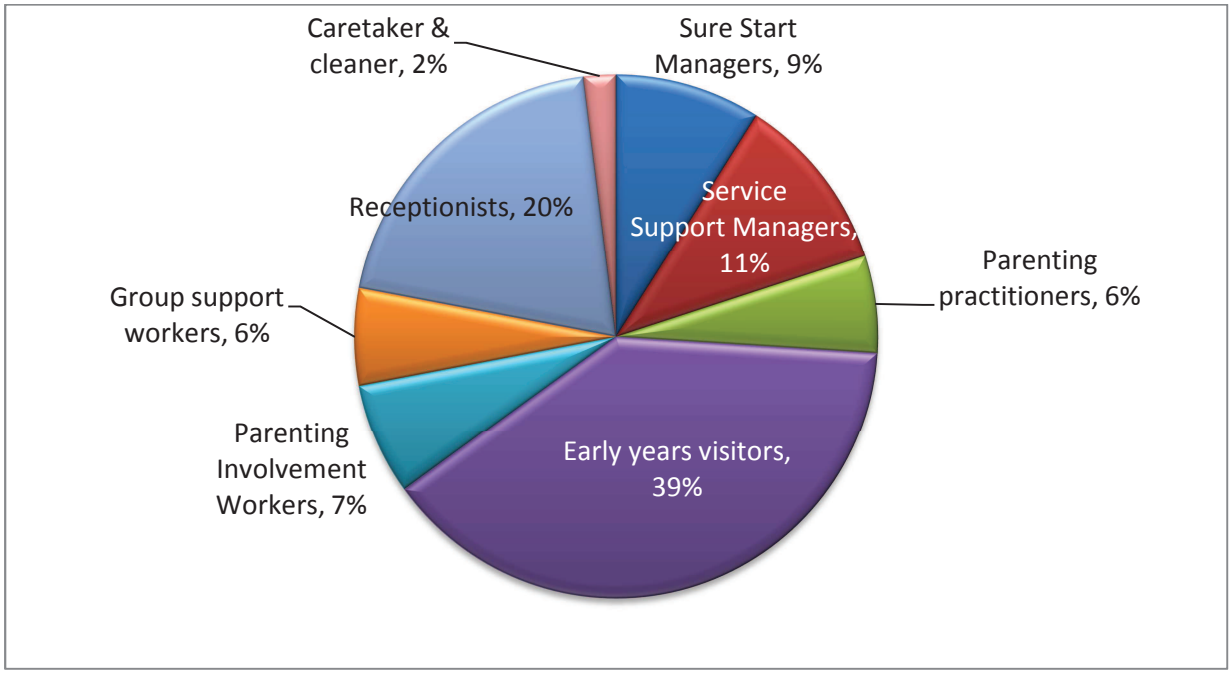
The children's centre budget has also paid for supported childcare places for children on child protection and early help plans. The need for this funding has reduced because of the increase in government funding for free early education places for low income two year olds.

x. Council Funding for Children's Centres

The council children's services budget for 2015/16 is £2.39 million and this includes one-off funding of £670,000 agreed in the 2015 budget. The majority of the funding is spent on staffing. Buildings costs make up a small proportion with the largest buildings costing the most.



The largest group of staff is early years visitors following by reception staff. Early years visitors run universal and targeted groups, support healthy child clinics and deliver home-based interventions.



xi. Summary of the Children's Centre Needs Analysis 2015

In order to help consider the population, needs and outcomes from children's centres and to inform the review, a small working group looked at evidence from five areas:

- Population
- Children with identified additional needs
- Deprivation
- Health and wellbeing
- Education

The full report is attached at appendix 4. Key points have been summarised here.

When we talk about needs and outcomes in the context of children's centres we mean:

- **Needs:** the things that might mean that some children (and families) require more support to help them develop
- **Outcomes:** the difference made to a child (and their family) at age five – this could for example be improved physical or mental health or being at a good level of development at school age, or having a job

Brighton & Hove context:

- Rising population of children and young people but the number of under five year olds projected to remain around 15,300 for the next decade
- Recent births figures have fallen below 3,000 for the first time
- The city's population is more ethnically diverse than in the past, with 21% of school children from a Black or Minority Ethnic Group and 26% of births to mothers born outside the UK

The outcomes for our children and young people in the city are mixed.
Issues identified in the Joint Strategic Needs Assessment as having the greatest impact on the health and wellbeing of children and young people in the city include: child poverty, education, youth unemployment, housing, alcohol and substance misuse, healthy weight and good nutrition, domestic and sexual violence, emotional health and wellbeing, smoking, as well as the wellbeing of children and young people with disabilities and complex needs.

Many outcomes are related with high levels of deprivation in the city (page 4 of the JSNA)

- Over half (56%) of the city's residents live in areas classed as the 40% most deprived in the country with only 4% living in areas within the 20% least deprived (See figure what?)
- Around 18% (7,735) of children under16 live in poverty (lower than across England at 19%)
- Child poverty varies widely; In Moulsecoomb and Bevendean 39% of children live in poverty, compared with 6% in Hove Park.

Population by children's centre

- Hollingbury and Patcham has the largest number of children of any centre

- City View and Conway Court have higher numbers aged under one year where more intensive support is required
- In Tarner almost one in five children is under one year old
- The percentage of BME children is high in the Cornerstone, Tarner and Conway Court catchment areas with Other White Children the largest group.

Identified additional needs

- Moulsecoomb, Roundabout, Tarner and Hangleton Park have significantly higher levels of children with additional identified needs (page 8)

Income deprivation

- Roundabout, Moulsecoomb, Hollingdean and Tarner have significantly higher levels of children living in the most income deprived areas in England.

Health and wellbeing

- Moulsecoomb, Roundabout, Hangleton Park, Portslade and the Deans have significantly poorer health and wellbeing indicators (page 10). However, it is worth noting that breastfeeding rates (2014/15) in all areas of Brighton & Hove are better than England (page 11)

Educational achievement at the end of the reception year in school.

- Moulsecoomb and Tarner have significantly poorer achievement at the end of reception year in school.

Combined ratings

- Looking at the ratings across each of the four domains shows that children living in Moulsecoomb, Roundabout, Tarner and Hangleton Park children's centre areas have some of the highest needs, and poorest outcomes in the city
- In each of these four areas more than 70% of the children resident attend their local centre rather than an alternative centre
- Other areas, like Cornerstone and West Hove, have consistent low need/better outcomes.

Children's Centre	Overall rating for population	Overall rating children with identified needs	Overall rating for deprivation	Overall rating for health and wellbeing	Overall rating for education
City View	SIMILAR	LOW	SIMILAR	SIMILAR	SIMILAR
Conway Court	HIGH	LOW	LOW	BETTER	SIMILAR
Cornerstone	HIGH	SIMILAR	LOW	BETTER	SIMILAR
Hangleton Park	SIMILAR	HIGH	SIMILAR	WORSE	WORSE
Hollingbury & Patcham	LOW	LOW	LOW	SIMILAR	SIMILAR
Hollingdean	LOW	SIMILAR	HIGH	SIMILAR	BETTER
Moulsecoomb	SIMILAR	HIGH	HIGH	WORSE	WORSE
Portslade	SIMILAR	SIMILAR	SIMILAR	WORSE	SIMILAR
Roundabout	SIMILAR	HIGH	HIGH	WORSE	SIMILAR
Tarner	HIGH	HIGH	HIGH	SIMILAR	WORSE

The Deans	LOW	SIMILAR	SIMILAR	WORSE	SIMILAR
West Hove	SIMILAR	LOW	LOW	SIMILAR	BETTER

xii. Consultation

The council consulted on proposed changes to children's centres in the winter of 2014/15 to take account of reductions in funding. The proposals for changes were to:

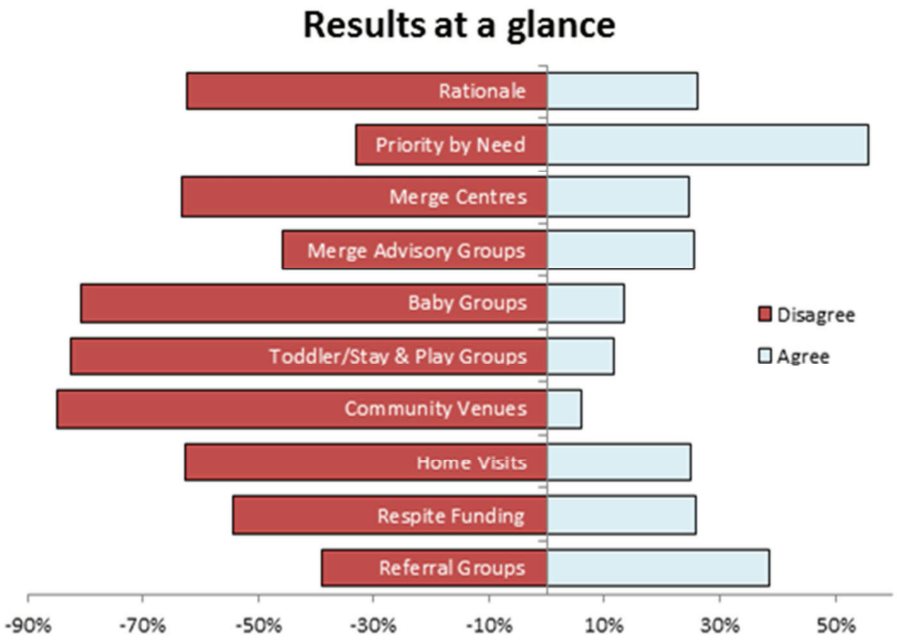
- Reduce the number of designated children's centres from 12 to eight. The following children's centres would no longer be designated as statutory: West Hove, Cornerstone, City View and Hollingbury and Patcham. These venues would continue to be used for health visiting. Explore whether other children and family services including those provided by voluntary organisations could be delivered from children's centres.

- Provide a revised core offer in the context of the early help strategy to focus council resources on those families in the greatest need of support and to use interventions which have the best evidence for improving outcomes. Reduce universal groups, encourage community and family capacity by supporting volunteering. Reduce council funding for voluntary sector partners in line with the revised core offer and reduce funding for respite childcare funding.

- Detailed proposals consulted on were to merge the following advisory groups: City View with Tarner and Cornerstone and Hollingbury and Patcham with Hollingdean; reduce universal groups by replacing on-going baby groups with an eight week course and to replace on-going toddler, stay and play and jump for joy groups with a one term long group aimed at children under two. The proposals included running additional groups in high need areas and supporting parent-led groups. The proposals also included no longer funding open access groups in libraries run by the Early Childhood Project. There were also proposals to reduce funding for childcare places for children under the age of three in need and reduce home visiting by council staff.

There was strong opposition to the proposals with more than 800 responses to the questionnaire.

The graph below shows the percentage of respondents who disagreed or agreed with each proposal in the consultation. A detailed analysis of the response to each proposal is provided in consultation report.



The table below includes a summary of the comments made in response to the consultation. Full details are in the consultation report.

Question	Response	Top three comments plus those with over 50 responses
Rationale for proposals to reduce children's centre services	62% disagreed 26% agreed	Children's centres provide vital services and should not change Savings now will lead to greater costs/problems in the future Universal services are more effective and should be kept Comments on national government/council should oppose cuts
Families who need most help should have priority	56% agreed 33% disagreed	All children and families need support regardless of income. How do you define need? (*Many responders assumed that need was based on whether a family was claiming benefits and disagreed with this approach)* Will increase the risk of post natal depression/mental health problems and isolation.
Proposals to merge children's centres	63% disagreed 25% agreed	Difficult and expensive for families to travel further Children's centres and services should be local Do not close children's centres or specific groups in children's centres
Proposal to merge advisory groups	45% disagreed 26% agreed 22% neither agreed nor disagreed	Children's Centres and services should be local. The questionnaire was hard to understand/don't understand the specific question Difficult and expensive for families to travel further *[Note – some responders did not know what an advisory group was and assumed this question was about closing children's centres or groups within them]*
Change baby	81%	Universal services more effective and should be kept

groups to an eight week course	disagreed 13% agreed	How do you define need? Group was a lifeline/invaluable Should be drop-in/flexible Will mean all potentially vulnerable families will not be identified Course too short/inflexible Will increase the risk of post natal depression/mental health problems and isolation.
Change on going stay and play groups to groups lasting one term	83% disagreed 11% agreed	All families need support regardless of income Course too short/too inflexible Children's centres provide vital services and should not change Should be drop-in/flexible
No longer run drop ins in libraries and community venues	85% disagreed 6% agreed	Don't close universal groups in community venues These groups support children with reading and access to books Services should be local
Reduce home visits	63% disagreed 25% agreed	Do not stop home visits Less home visiting will increase risks for vulnerable families Important for families who do not attend children's centres Remaining children's centres/groups will be over subscribed *[Some responders thought that this question was about health visitors. It refers to home visits from council staff].*
Reduce funding for childcare for children with high levels of need	54% disagreed 26% agreed	Will mean worse outcomes for children How do you define need? *Some responders assumed the question was about childcare for working parents/free early education.*
Proposal to review referral and target groups	39% disagreed 38% agreed	More information needed about the purpose of the review Children's centres provide vital services and should not change Agree with the proposals
Other comments		Children's services should be protected/cut other areas Heart-breaking/appalled/disastrous for future generations Do not close children's centres/groups in children's centres

Summary of what staff told us

- Home visiting gets families to come to groups in children's centres
- Reduction in early intervention will have impact on child outcomes resulting in more pressure on specialist services
- Need to avoid stigmatising target families
- Needs vary according to catchment area
- Concerned that universal provision may vary across the city
- Difficult to measure all preventative work
- Community-led groups will need support
- Look at income generation to offset cuts
- Increase usage/opening hours of centres
- Reorganise sessions to reduce costs
- Review groups in terms of investment and outcomes
- Rationalise the management and administration of centres

Initial Consultation in Autumn 2015

During September and October 2015 face to face discussions were held with parents, staff and other stakeholders to get their views on options for change. These discussions took place at the parents reference group, children's centre advisory groups, and staff team meetings.
The results of the initial consultation are summarised as follows:

How do we balance targeted and universal services?

- Universal services like stay and play are valued by families. They are seen as key to reducing stigma, building social cohesion and for getting families into centres where they can be referred to the right support services.
- Universal groups and drop-ins are also seen as vital for building social networks and reducing isolation, particularly for first time parents or those new to the city. Families have described these services as a 'lifeline'.
- Universal groups like stay and play are important for preparing children for school and nursery. They offer a more structured learning environment and challenge children in ways that other community groups do not.
- Targeted groups should follow on from universal groups to capture parents already in the centres. Health visitors and other early years professionals should be available at drop-in groups so that parents who have specific questions or concerns can get advice.
- More could be done to prioritise places for those most in need, for example not letting childminders occupy spaces intended for parents and to find ways to discourage parents from booking on to groups but not then turning up.
- Baby groups are particularly important and valued, particularly by first time parents who lack confidence and experience.
- Parents and carers prefer drop-in groups and activities than time-limited courses as they are more flexible and families may need help at different times.
- All families need support, regardless of income. Focussing resources on areas of high need within the city could disadvantage those living in more affluent areas who need help.

- Reducing prevention and early intervention services for children under five are likely to have consequences for child outcomes and for future budgets as problems are left to escalate. This is particularly key given cuts to tax credits, the high cost of living and cuts to other services
- Consider charging for some services but in a way that does not disadvantage those who cannot afford to pay
- Limiting targeted services or places for those on benefits are divisive and will exclude those in work but are poor/in need due to the high cost of living.

Home Visiting

- Nursery places are not enough. Parents need interventions in the home to help them play with their children, facilitate learning, develop parenting skills and care for their child effectively
- Reducing home visiting will increase risks for vulnerable families who do not come into children's centres for various reasons.

Volunteering

- Parent and community-led groups will need lots of support and resources to ensure they are safe, accessible and meet the needs of users.
- Must ensure community-led groups have the structure and training to aid child development and ensure the needs of the families are met. There will also need to be some way of referring and signposting families to the right support services.
- Need to look more widely than parents and consider who else in the community can volunteer.

Service locations

- Consider merging or de-designating the smaller centres but ensure there are services families can access in their locality, for example by providing mobile or pop-up services or running services from other community buildings or schools.

- Getting across the city can be expensive for families and there are other barriers to travelling such as restricted car parking and being far from home if children are ill or if other children need to be collected from school.

xiii. Children's Centre Review Board

Role and Function of the Board

The function of the board is to take responsibility for the strategic direction and management of the children's centre review.
The role of the board is to oversee a review of children's centres and make recommendations to the Children, Young People and Skills Committee for a redesigned service.

The board will:

- Provide effective leadership and promote a creative approach to service redesign
- Ensure the review is conducted fairly and with integrity and full attention is paid to equalities issues in conducting the review
- Reconcile differences in opinion and resolve disputes
- Take on responsibility for any corporate issues associated with the project.
- Identify and manage risks through the Risk Register
- Have a broad understanding of programme and project management issues and approaches
- Nominate a proxy to attend a meeting if they unable to attend.

xiv. Objectives of the Review

To review the children's centre service by:

- Considering the needs of young children and identifying the needs of adults which impact on their ability to parent in Brighton & Hove
- Taking account of the views of parents, young children, and staff
- Having regard to the council's statutory duties to improve outcomes for young children and reduce inequalities, provide integrated services and ensure there are sufficient children's centres
- Completing a baseline analysis of current activity and investment by the council and partners including assessing the strengths and weaknesses of the current model against the Ofsted framework and national evidence on what works in early years
- Benchmarking against other local authority approaches and input from a local authority peer challenge
- Taking account of the reviews of and changes to other children's services including Stronger Families Stronger Communities, the Youth and Parenting Reviews, Social Work and Special Needs and Disabilities.
- Scenario planning for future levels of funding over the next three years
- Taking account of equalities impacts.

To make recommendations for a redesigned service which will be sustainable for the future, addressing:

- redefining priorities linked to local and national developments and future resources
- strategy for involving and raising the aspirations of parents including the role of volunteers and/or parent run groups and future of advisory groups

- a revised core offer of universal and early help services as part of city's early help offer/pathway
- the model of integration with the health visiting including performance reporting
- working arrangements with other council services for both early years and older children
- relationships with other external partners including Job Centre Plus, midwifery and voluntary sector providers
- the future use of children's centre buildings including the number of designated children's centres, opening hours, possible role as local service centres, use by the community and opportunities for income generation
- a revised council staffing and management structure
- completing an Equalities Impact Assessment.

Appendix to the Children's Centre Review Report

Children's centre review – supporting information (October 2015)

Introduction

In order to help consider both the population and needs of Children's Centre area populations, to inform the review, a small working group defined and populated a minimum dataset of indicators at children's centre area level into these five domains:

- Population
- Children with identified additional needs
- Deprivation
- Health and wellbeing
- Educational outcomes

This report gives the detail of these indicators for children's centre areas.

Activity by children's centre is also included here, as is information on evaluations of improvement on activities city-wide.

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Brighton & Hove context

This section is taken from the Brighton & Hove Joint Strategic Needs Assessment – more information is available at http://www.bhconnected.org.uk/content/needs-assessments

The population of children and young people in the city has been rising and continues to rise. In 2012 we had almost 59,000 children and young people aged 0-19 years living in the city, around 6,000 more than in 2002. Over the next twenty years this is expected to increase to around 63,000. For under fives however, the population projections are more stable with 15,300 children under 5 in 2013 and this is project to be 15,400 in 2024 by the Office for National Statistics.

In Brighton & Hove, the number of live births was 3,291 in 2011, an increase of 8% (3,035 births) from 2005. In 2013 the number of births fell to below 3,000 (2,967). The number of births per year in the city is projected to increase by 11% from 2013 to 2024 – to around 3,300 births per year. This compares with a projected increase of 4% in England and 3% in the South East. However, this is not yet adjusted for recent lower numbers of births seen in the city.

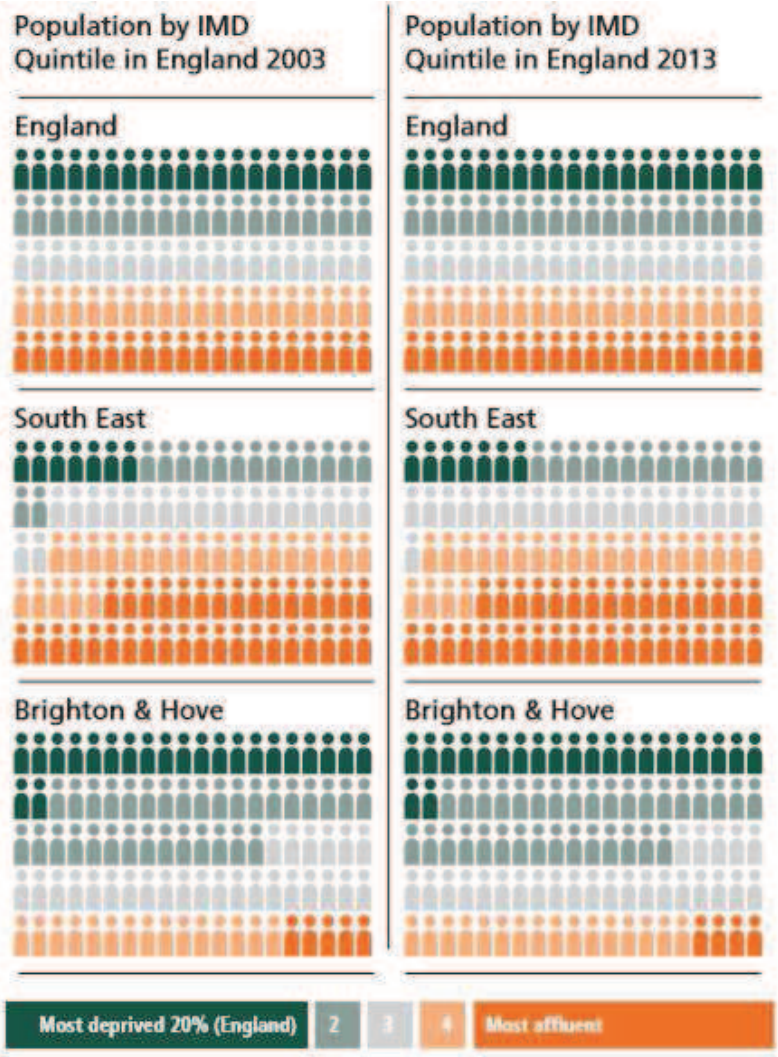
The city's population is also a diverse one with around one in five (21%) school children from a black or minority ethnic group and 12% of school children have English as an additional language. Likewise this is seen in new births, in Brighton & Hove in 1998 14% of births were to mothers born outside the UK, rising to 26% of births in 2011 and remaining at this level in 2013. The greatest proportion in 2013 was to mothers born in Europe (18%), Middle East and Asia (6%) and Africa (5%). Until 2003 the most common country of birth outside of the UK was Bangladesh, but in more recent years those born in Poland have a greater number of births.

The outcomes for our children and young people are mixed. Issues identified in the Joint Strategic Needs Assessment as having the greatest impact on the health and wellbeing of children and young people in the City include: child poverty, education, youth unemployment, housing, alcohol and substance misuse, healthy weight and good nutrition, domestic and sexual violence, emotional health and wellbeing, smoking, as well as the wellbeing of children and young people with disabilities and complex needs.

In schools slightly fewer children are achieving a good level of development at the end of reception in Brighton and Hove at 64.7% as the England average (both 66.3%) in 2015. Results in primary schools are similar to the national average, and provisional results for 2013/14 suggest that just over half (53%) of GCSE students achieved 5 A*-C grades including English and maths, across England this was 56%.

Many of these outcomes are related with high levels of deprivation in the City: over half (56%) of the city's residents live in areas classed as the 40% most deprived in the country with only 4% living in areas within the 20% least deprived (See figure).

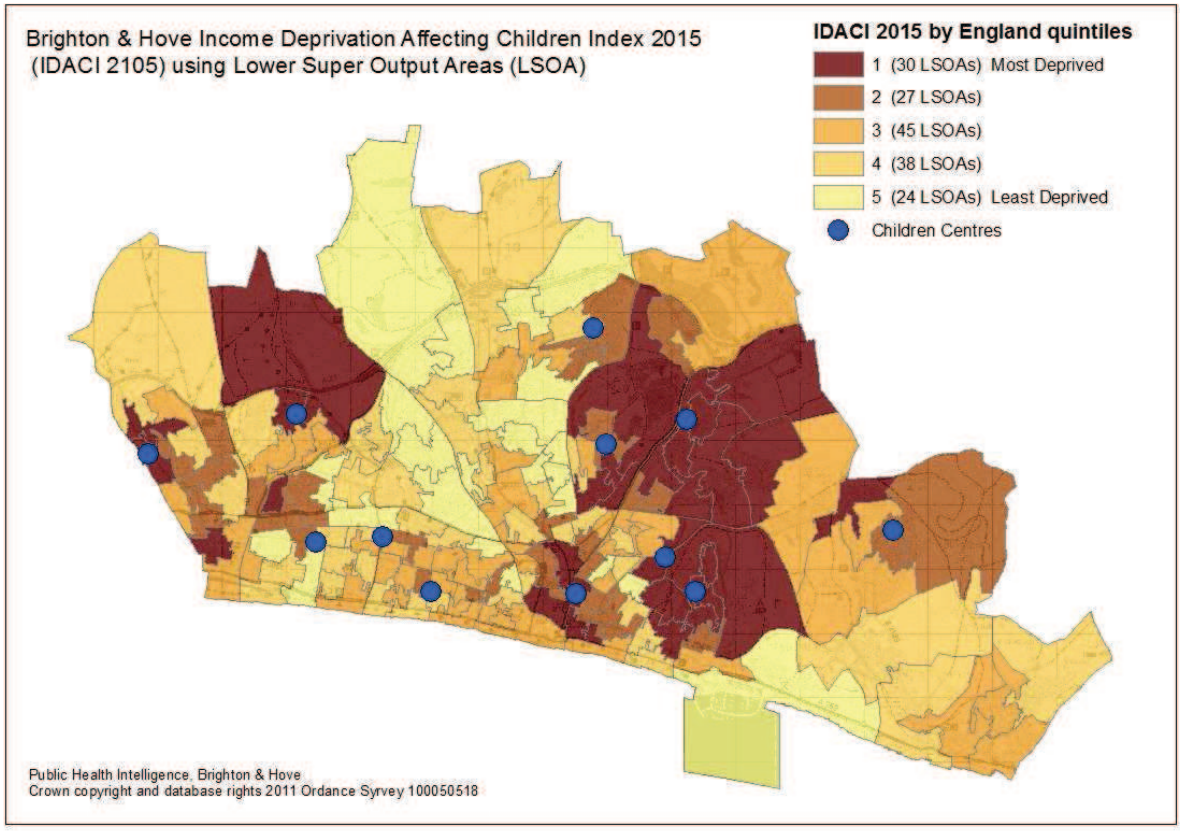
Proportion of people living in each deprivation quintile in England, for England, the South East and Brighton & Hove, IMD 2010 and Mid Year Population Estimate 2013, compared with 2003 population



Affluence and social advantage varies widely across the City with wealthy areas but large pockets of significant poverty in Moulsecoomb, Whitehawk and parts of Queens Park and Portslade in particular. Around 18% (7,735) of children under 16 live in poverty (lower than across England at 19%). Child poverty varies widely; Moulsecoomb children's centre has 37% and West Hove and Hollingbury & Patcham has 10%.

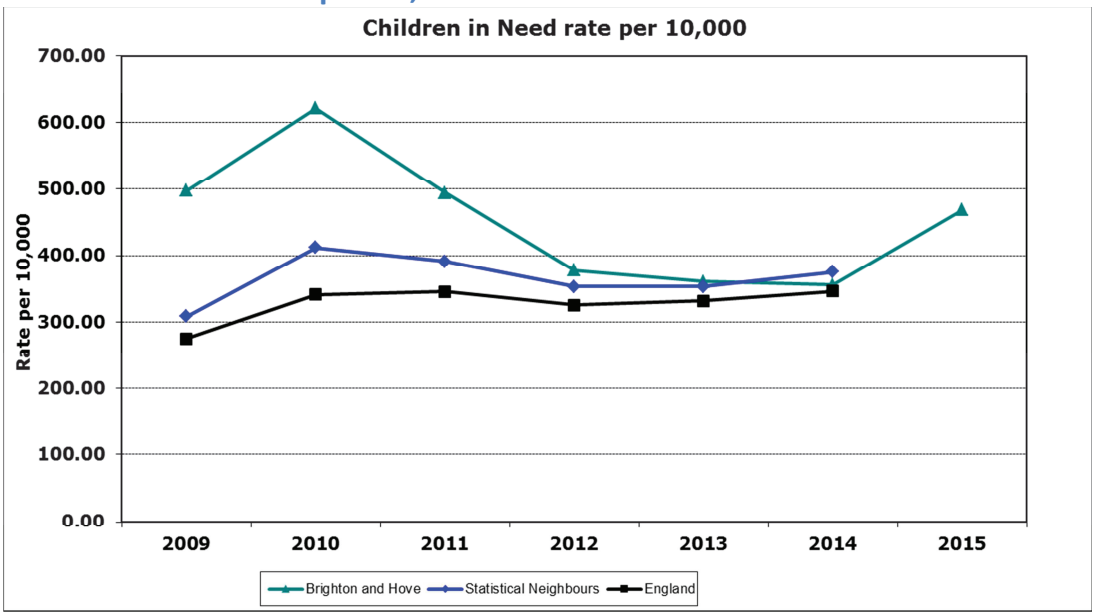
The city also has higher rates of children in care: for every ten thousand children in the City, 88 are in care compared with 60 in every ten thousand children across England. There has been a recent increase in children in need rates (see figure overleaf).

Income deprivation affecting children



Source: Index of Multiple Deprivation 2015, Communities and Local Government

Children in Need rate per 10,000



Source: LAIT for 2009 to 2014. CareFirst for B&H 2015 data. National publication due October 2015.

Population by children's centre

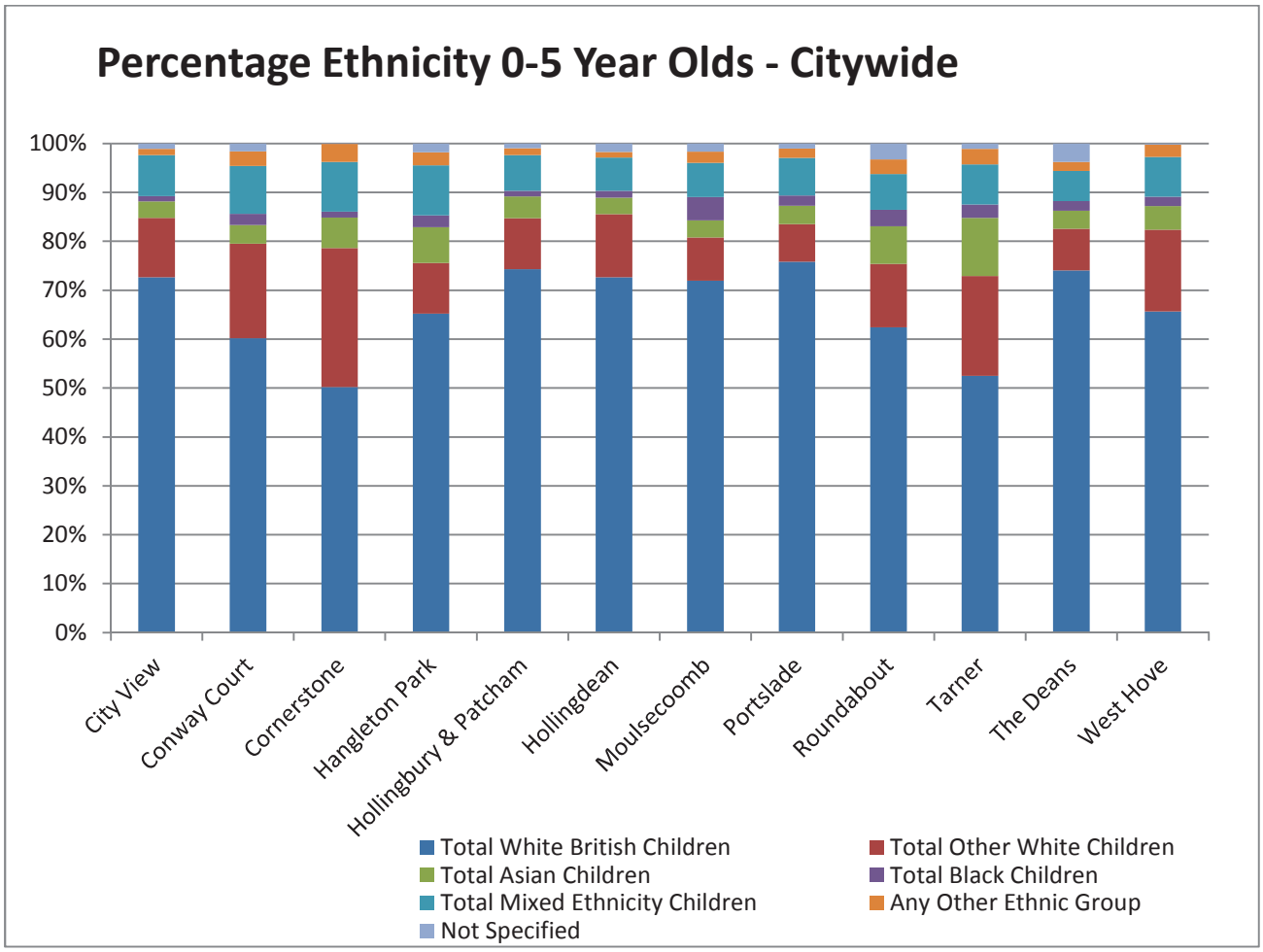
Population figures for under 5s by Children's Centre (split as under 1 years and 1 to 4 years) snapshot at Q1 2015/16

Children's Centre	Total under 5s	Number of children age under 1 year	Percentage of children aged under 1 year	Number of BME children aged 0-5 years	Percentage of BME children aged 0-5 years	Overall rating for population
City View	1396	295	21.1%	367	26.3%	SIMILAR
Conway Court	1455	321	22.1%	556	38.2%	HIGH
Cornerstone	926	199	21.5%	460	49.7%	HIGH
Hangleton Park	1245	206	16.5%	411	33.0%	SIMILAR
Hollingbury & Patcham	1698	278	16.4%	419	24.7%	LOW
Hollingdean	1320	211	16.0%	338	25.6%	LOW
Moulsecoomb	956	196	20.5%	252	26.3%	SIMILAR
Portslade	1393	278	20.0%	323	23.2%	SIMILAR
Roundabout	1106	223	20.2%	380	34.4%	SIMILAR
Tarner	1089	257	23.6%	509	46.4%	HIGH
The Deans	1002	176	17.6%	222	22.2%	LOW
West Hove	1010	188	18.6%	345	34.2%	SIMILAR
Unknown	0	0	-	0	0.0%	
Brighton & Hove Total	14596	2828	19.4%	4582	31.4%	
Brighton & Hove Average	1216.33	235.67	19.4%	382	32.0%	
Brighton & Hove Upper (+20%)	1459.60	282.80	23.3%	390	32.1%	
Brighton & Hove Lower (-20%)	973.07	188.53	15.5%	372	30.6%	

Hollingbury and Patcham has the largest number of children of any centre though City View and Conway Court have higher numbers aged under one year where more intensive support is required. In Tarner almost one in five children are under 1 year. The percentage of BME children is high in the Cornerstone, Tarner and Conway Court catchment areas with Other White Children the largest group.

Source: PIMS

Snapshot of population as at 30th June 2015


Percentage Ethnicity 0-5 Year Olds - Citywide
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
City View
Conway Court
Cornerstone
Hangleton Park
Hollingbury & Patcham
Hollingdean
Moulsecoomb
Portslade
Roundabout
Tarner
The Deans
West Hove
Total White British Children
Total Other White Children
Total Asian Children
Total Black Children
Total Mixed Ethnicity Children
Any Other Ethnic Group
Not Specified

Attendance - Unique attendance across the city CCs for Q1 2015/16

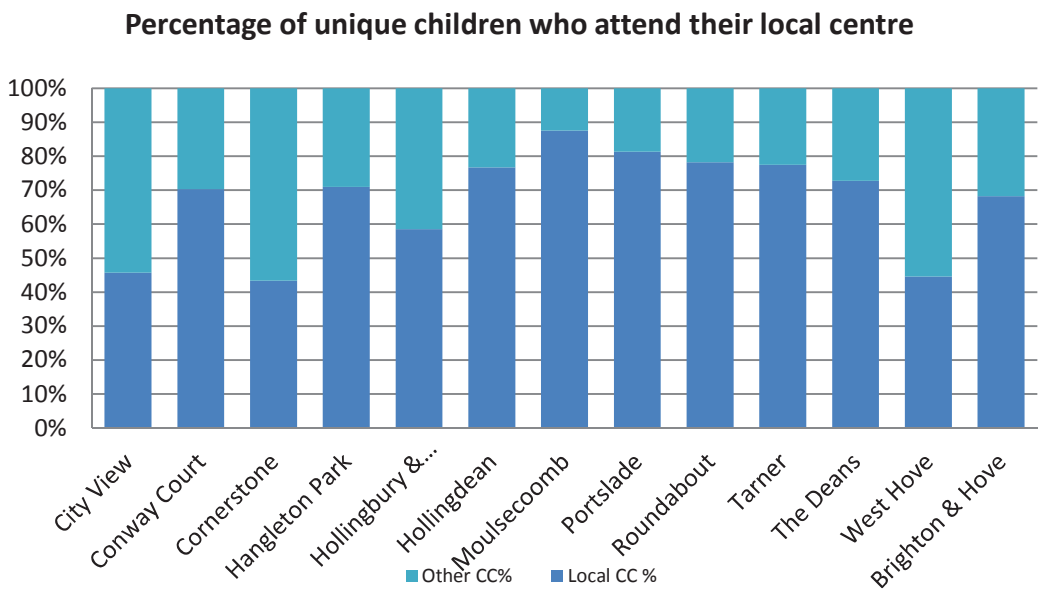
CC Residence	Total number attending CC	Number attending at local CC	% Attending at local CC	Number attending at other CCs	% Attending at other CCs	% of significant attendances at other CCs
City View	282	129	46%	153	54%	Tarner-27% Moulsecoomb-11% Hollingdean-8%
Conway Court	344	242	70%	102	30%	West Hove-13%
Cornerstone	173	75	43%	98	57%	Tarner-34% Conway Court-9%
Hangleton Park	200	142	71%	58	29%	Conway Court-12%
Hollingbury and Patcham	212	124	58%	88	42%	Hollingdean-18%
Hollingdean	236	181	77%	55	23%	
Moulsecoomb	208	182	88%	26	13%	
Portslade	284	231	81%	53	19%	
Roundabout	230	180	78%	50	22%	Tarner-13%
Tarner	288	223	77%	65	23%	Cornerstone-8%
The Deans	187	136	73%	51	27%	Roundabout-14%
West Hove	175	78	45%	97	55%	Conway Court-43%

High number of local children and families attending their reach area centre		High number of children and families attending other centres for services	

This table shows the number of individual children attending children's centres in the first quarter of 2015/16. It includes all attendances.

West Hove, City View and Cornerstone have a high proportion of children attending other children's centres.

Percentage of unique children who attend their local centre



Children with identified additional needs

Population of under 5s need (U, UP and UPP) and Children In Need rate per 1,000 snapshot at Q1 2015/16

Children's Centre	Total under 5s	Universal (U) %	Universal Plus (UP) %	Universal Partnership Plus (UPP) %	Significance based on UP+UPP	Children in Need (rate per 1,000)*	Significance on Children In Need	Overall rating for the domain
City View	1396	85%	10%	3%	LOW	32.2	LOW	LOW
Conway Court	1455	83%	14%	2%	LOW	20.6	LOW	LOW
Cornerstone	926	80%	17%	0%	SIMILAR	38.9	SIMILAR	SIMILAR
Hangleton Park	1245	73%	21%	3%	HIGH	43.4	SIMILAR	HIGH
Hollingbury & Patcham	1698	85%	11%	2%	LOW	21.2	LOW	LOW
Hollingdean	1320	80%	13%	4%	SIMILAR	39.4	SIMILAR	SIMILAR
Moulsecoomb	956	57%	29%	7%	HIGH	116.1	HIGH	HIGH
Portslade	1393	75%	19%	2%	SIMILAR	38.8	SIMILAR	SIMILAR
Roundabout	1106	63%	27%	4%	HIGH	103.1	HIGH	HIGH
Tarner	1089	70%	25%	3%	HIGH	66.1	HIGH	HIGH
The Deans	1002	80%	15%	1%	LOW	47.9	SIMILAR	SIMILAR
West Hove	1010	84%	13%	2%	LOW	24.8	LOW	LOW
Brighton & Hove Total	**14596**	**77.1%**	**17.2%**	**2.8%**		**46.4**		

Moulsecoomb, Roundabout, Tarner and Hangleton Park have significantly higher levels of children with additional identified needs.

Source: PIMS. *CIN from CareFirst

Children in need figures includes CIN, CPP and LAC

Deprivation

Income deprivation affecting children index (2015)

Children's Centre	DEPRIVATION	Income Deprivation Affecting Children Index (% of children 10% most deprived areas in England)	Income Deprivation Affecting Children Index (% of children 10%-30% most deprived areas in England)	Income Deprivation Affecting Children Index (% of children 30%-70% most deprived areas in England)	Income Deprivation Affecting Children Index (% of children 70%-100% most deprived areas in England)	Overall change since 2010
City View	SIMILAR	12%	12%	43%	33%	Relatively less deprived
Conway Court	LOW	0%	0%	92%	8%	Relatively less deprived
Cornerstone	LOW	0%	11%	74%	15%	Relatively less deprived
Hangleton Park	SIMILAR	7%	18%	37%	38%	Relatively less deprived
Hollingbury & Patcham	LOW	0%	7%	47%	47%	No change
Hollingdean	HIGH	8%	22%	34%	36%	No change
Moulsecoomb	HIGH	47%	20%	33%	0%	No change
Portslade	SIMILAR	0%	28%	59%	12%	No change
Roundabout	HIGH	35%	19%	36%	10%	Relatively less deprived
Tarner	HIGH	9%	35%	48%	8%	Relatively less deprived
The Deans	SIMILAR	0%	19%	76%	5%	No change
West Hove	LOW	0%	8%	59%	34%	Relatively less deprived
Brighton & Hove Total		**9%**	**16%**	**53%**	**22%**	**Less deprived (relative to national LSOAs)**

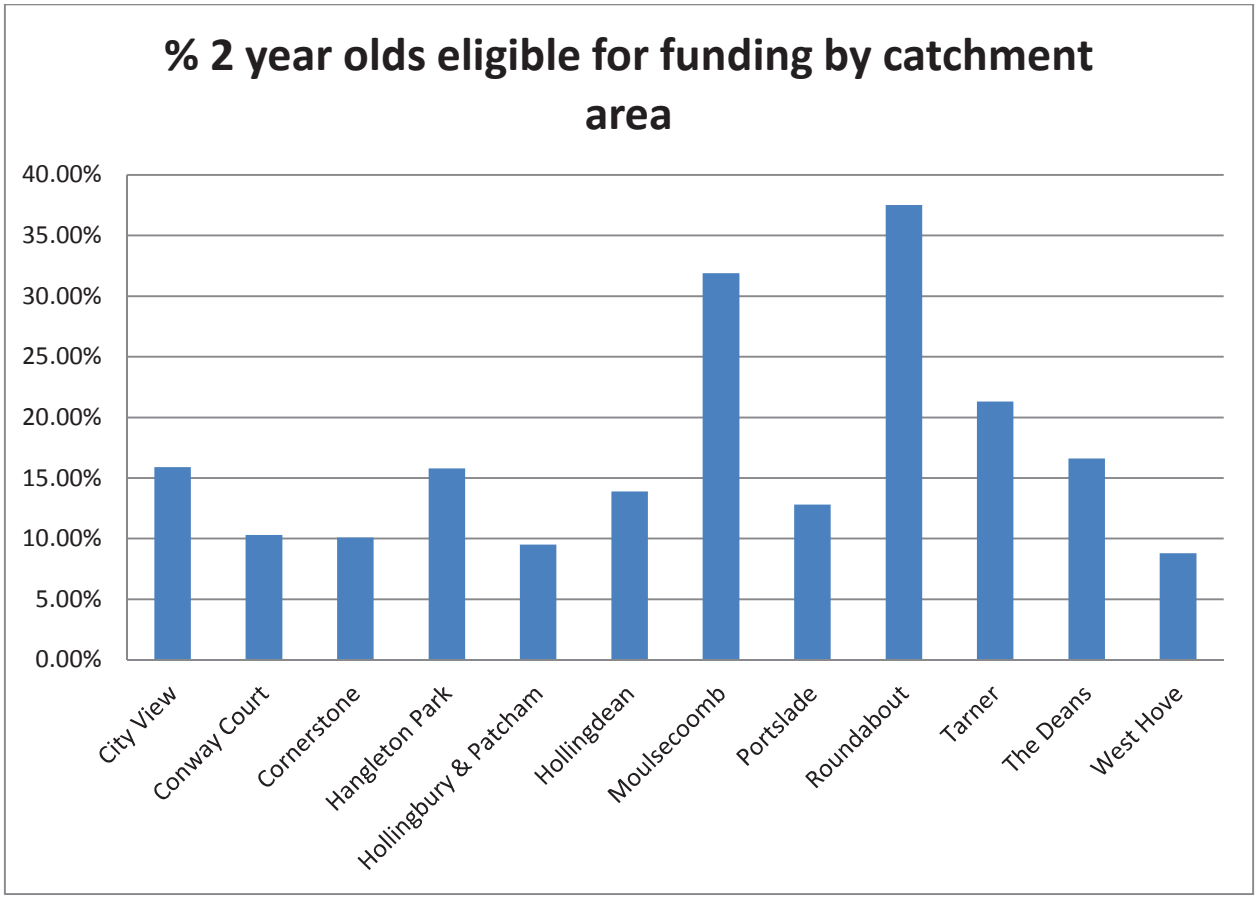
Note: Based on the updated index of multiple deprivation published on 30th September 2015: IDACI measures the proportion of all children aged 0 to 15 living in income deprived families (based on people that are out-of-work, and those that are in work but who have low earnings).

Roundabout, Moulsecoomb, Hollingdean and Tarner have significantly higher levels of children living in the most income deprived areas in England.

Percentage of 2 Year Olds Eligible for Funding, split by FSM and WTC (from the DWP)

The highest proportions are in Moulsecoomb and Roundabout. The lowest in Conway Court, West Hove and Hollingbury & Patcham

Children's Centre	Total 2 Year Olds in Catchment Area	Percentage of 2 Year Olds Eligible for Funding (FSM)	Percentage of 2 Year Olds Eligible for Funding (WTC)
City View	258	15.9%	9.7%
Conway Court	302	10.3%	12.6%
Cornerstone	189	10.1%	12.2%
Hangleton Park	247	15.8%	13.0%
Hollingbury & Patcham	357	9.5%	9.5%
Hollingdean	251	13.9%	9.2%
Moulsecoomb	182	31.9%	21.4%
Portslade	266	12.8%	13.9%
Roundabout	232	37.5%	22.8%
Tarner	244	21.3%	12.7%
The Deans	199	16.6%	17.6%
West Hove	193	8.8%	10.9%
Brighton & Hove Total	**2920**	**16.4%**	**13.4%**


% 2 year olds eligible for funding by catchment area
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
City View
Conway Court
Cornerstone
Hangleton Park
Hollingbury & Patcham
Hollingdean
Moulsecoomb
Portslade
Roundabout
Tarner
The Deans
West Hove

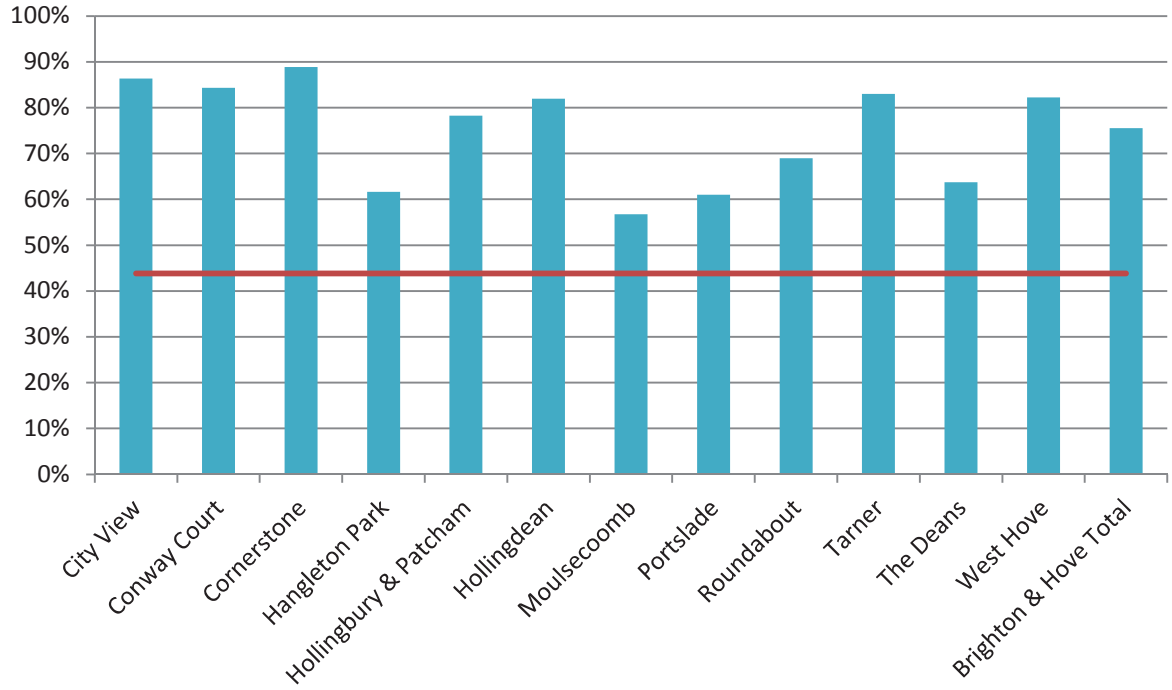
Health and wellbeing

Children's Centre	Overall rating	Maternal smoking at booking (2014/15)	Maternal smoking at delivery (2014/15)	Breastfeeding initiation (2014/15)	Breastfeeding 6-8 weeks (2014/15)	Healthy weight (2013/14 – 2014/15)
City View	SIMILAR	7%	4%	91%	86%	82%
Conway Court	BETTER	7%	4%	96%	84%	83%
Cornerstone	BETTER	6%	3%	98%	89%	84%
Hangleton Park	WORSE	10%	9%	86%	62%	76%
Hollingbury & Patcham	SIMILAR	9%	6%	90%	78%	84%
Hollingdean	SIMILAR	8%	4%	90%	82%	87%
Moulsecoomb	WORSE	18%	13%	78%	57%	78%
Portslade	WORSE	9%	9%	85%	61%	80%
Roundabout	WORSE	18%	12%	82%	69%	77%
Tarner	SIMILAR	8%	6%	93%	83%	81%
The Deans	WORSE	7%	5%	82%	64%	81%
West Hove	SIMILAR	6%	3%	91%	82%	83%
Brighton & Hove Total		**9%**	**6%**	**89%**	**76%**	**81%**
England					**44%**	

Note: Low birthweight excluded as rates are very low (6%) and there is no children's centre with significantly better/worse rates.

Roundabout, Moulsecoomb, Hollingdean and Tarner have significantly higher levels of children living in the most income deprived areas in England.

Breastfeeding - Prevalence data 6-8 weeks – 2014/15 compared to England



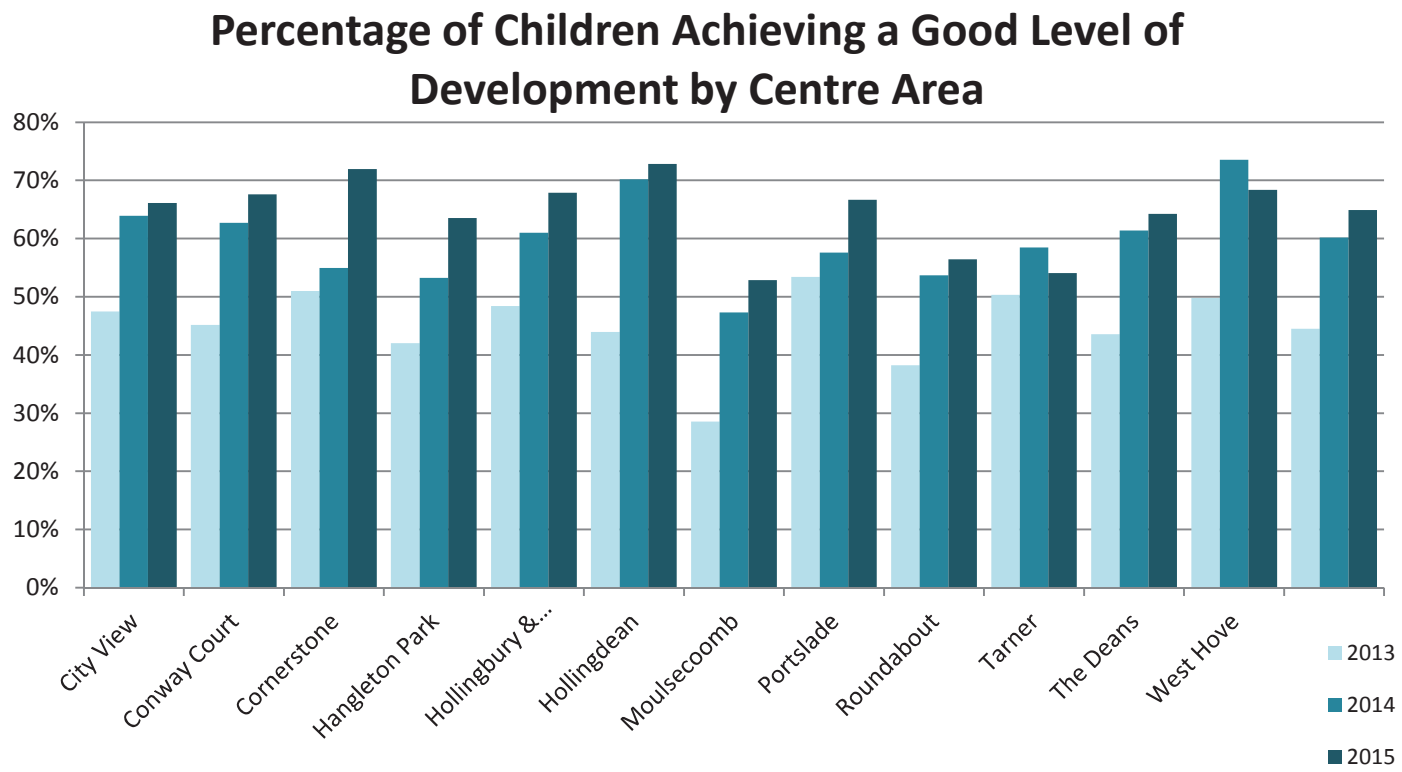
Educational outcomes

Early years foundation stage (EYFPS) and improvement since 2014

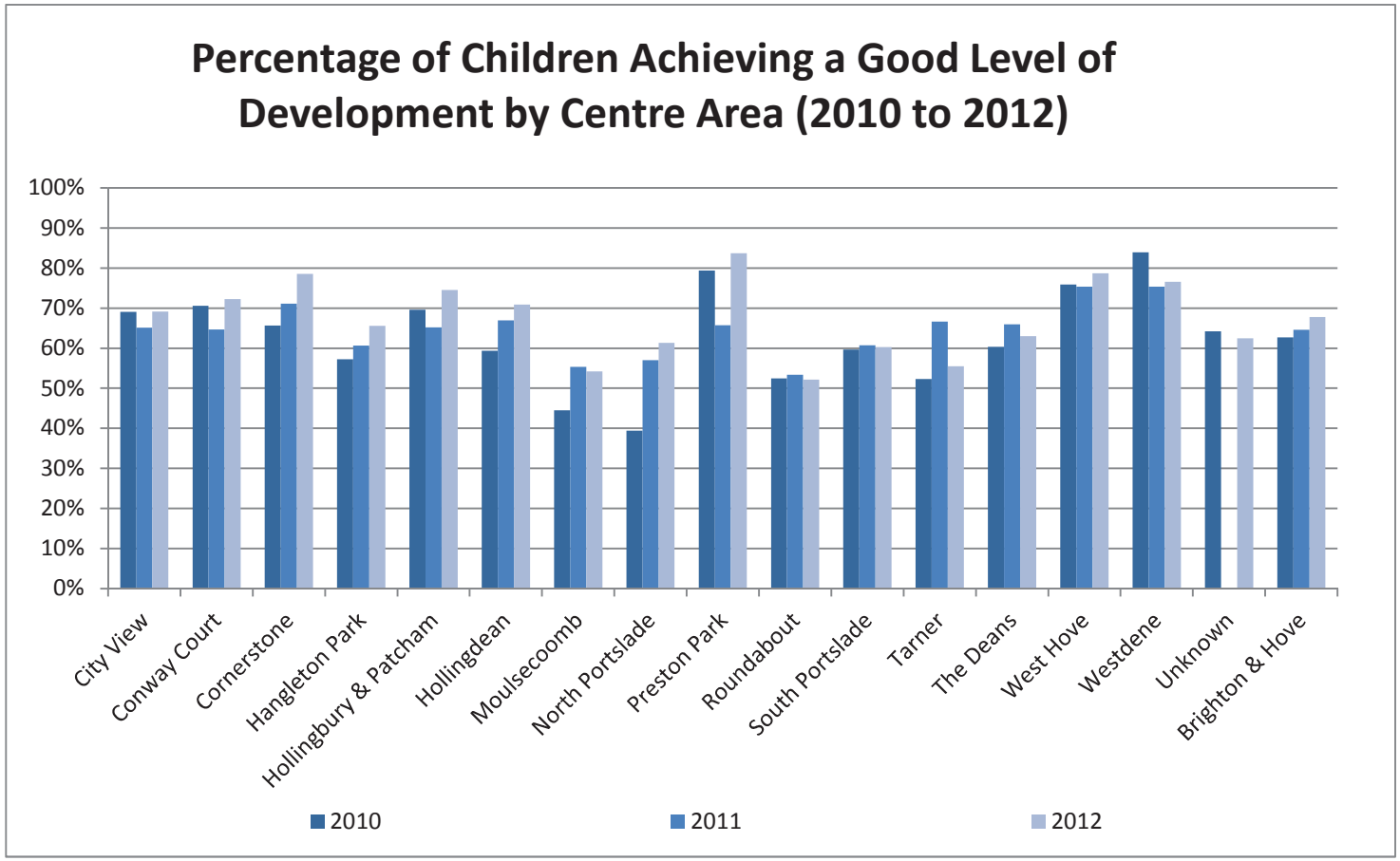
		2014		2015		
Children's Centre	Overall domain rating	% Pupils Achieving 'Good' FPS Standard	% FSM Pupils Achieving 'Good' FPS Standard	% Pupils Achieving 'Good' FPS Standard	% FSM Pupils Achieving 'Good' FPS Standard	Percentage points Difference in GAP 2014 v 2015
City View	WORSE	63.9%	27.6%	66.1%	42.4%	12.6%
Conway Court	BETTER	62.7%	66.7%	67.6%	61.3%	-10.3%
Cornerstone	SIMILAR	55.0%	45.0%	71.9%	68.4%	6.4%
Hangleton Park	SIMILAR	53.3%	30.6%	63.5%	50.0%	9.1%
Hollingbury & Patcham	SIMILAR	61.0%	39.1%	67.9%	58.1%	12.1%
Hollingdean	BETTER	70.2%	48.6%	72.8%	61.8%	10.5%
Moulsecoomb	WORSE	47.3%	36.4%	52.8%	42.4%	0.5%
Portslade	SIMILAR	57.6%	40.5%	66.7%	45.2%	-4.4%
Roundabout	SIMILAR	53.7%	45.1%	56.5%	51.7%	3.9%
Tarner	SIMILAR	58.5%	44.0%	54.1%	48.3%	8.7%
The Deans	SIMILAR	61.4%	46.2%	64.2%	51.5%	2.4%
West Hove	BETTER	73.5%	55.6%	68.4%	71.4%	21.0%
Brighton & Hove Total		**60.1%**	**41.8%**	**64.7%**	**51.6%**	**5.1%**
England Average		**60.0%**	**45.0%**	**66.3%**		

Moulsecoomb and Tarner have significantly poorer achievement at early years foundation stage.

EYFPS trend 2013 to 2015 – Percentage of Children Achieving a Good Level of Development by Centre Area



EYFPS trend pre 2013 – Percentage of Children Achieving a Good Level of Development by Centre Area



Note: Measure of development was changed after 2012

Combined ratings

Children's Centre	Overall rating for population	Overall rating children with identified needs	Overall rating for deprivation	Overall rating for health and wellbeing	Overall rating for education
City View	SIMILAR	LOW	SIMILAR	SIMILAR	SIMILAR
Conway Court	HIGH	LOW	LOW	BETTER	SIMILAR
Cornerstone	HIGH	SIMILAR	LOW	BETTER	SIMILAR
Hangleton Park	SIMILAR	HIGH	SIMILAR	WORSE	SIMILAR
Hollingbury & Patcham	LOW	LOW	LOW	SIMILAR	SIMILAR
Hollingdean	LOW	SIMILAR	HIGH	SIMILAR	BETTER
Moulsecoomb	SIMILAR	HIGH	HIGH	WORSE	WORSE
Portslade	SIMILAR	SIMILAR	SIMILAR	WORSE	SIMILAR
Roundabout	SIMILAR	HIGH	HIGH	WORSE	SIMILAR
Tarner	HIGH	HIGH	HIGH	SIMILAR	WORSE
The Deans	LOW	SIMILAR	SIMILAR	WORSE	SIMILAR
West Hove	SIMILAR	LOW	LOW	SIMILAR	BETTER

Looking at the ratings across each of the four domains shows that children living in Moulsecoomb, Roundabout and Tarner children's centre areas have some of the highest needs and poorest outcomes in the city.
In each of these three areas over 70% of the children resident attend their local centre rather than an alternate centre.
Other areas, like Cornerstone and West Hove have consistent low need/better outcomes.

Attendance

City-wide unique attendances per activities (grouped) for Q1 2015/16

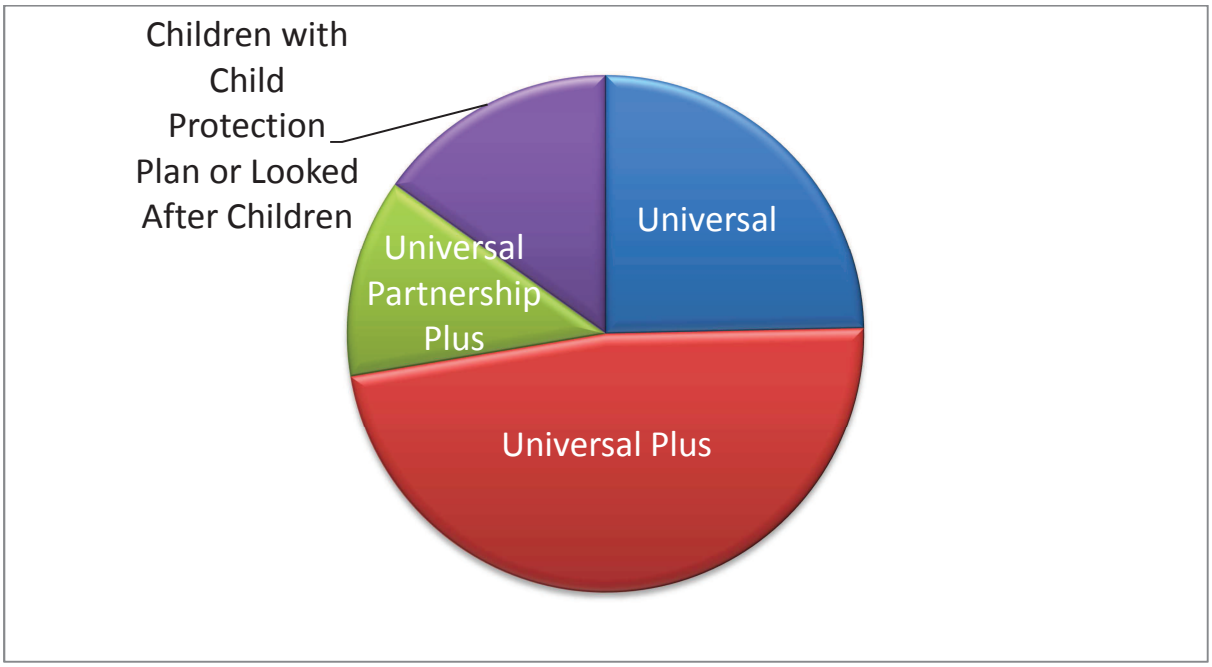
Attendance activity	Number of unique attendances	Number of all attendances	Average number of attendances
Healthy Child Clinic	1516	2317	1.53
Jump for Joy and Stay & Play and Toddler & You	1053	3686	3.50
Baby & You	306	770	2.52
Bilingual Families	189	622	3.29
Toy Library	182	464	2.55
Healthy Eating Group and Healthy Lifestyle	150	250	1.67
Positive Parenting Programme and Protective Behaviours	129	375	2.91
Breastfeeding Drop-in	124	198	1.60
Food Bank	94	376	4.00
Childminder Drop-in	67	353	5.27
Communication Group/Chatterbox	63	198	3.14
Post Natal Depression Group	46	162	3.52
All other activities	119	264	2.22
Total	**4038**	**10035**	**2.49**

Source: ChildView

Attendances between 1st April and 30th June 2015

Visits - Early years visitors and parenting practitioner home visits or 1 to 1 contacts by need for Q1 2015/16

	Level of need					
	Universal	**Universal Plus**	**Universal Partnership Plus**	**Children with a Child Protection Plan or LAC**	**Unknown**	**Total**
All visits	181	475	155	198	22	1031
Children visited	91	176	46	56	8	377
Average visits	2.0	2.7	3.4	3.5	2.8	2.7
Population	11256	2516	409	354	-	14535
Percentage children visited by need	24.1%	46.7%	12.2%	14.9%	2.1%	2.6%



Source: PIMS

Home visits by named staff during 1st April to 30th June 2015

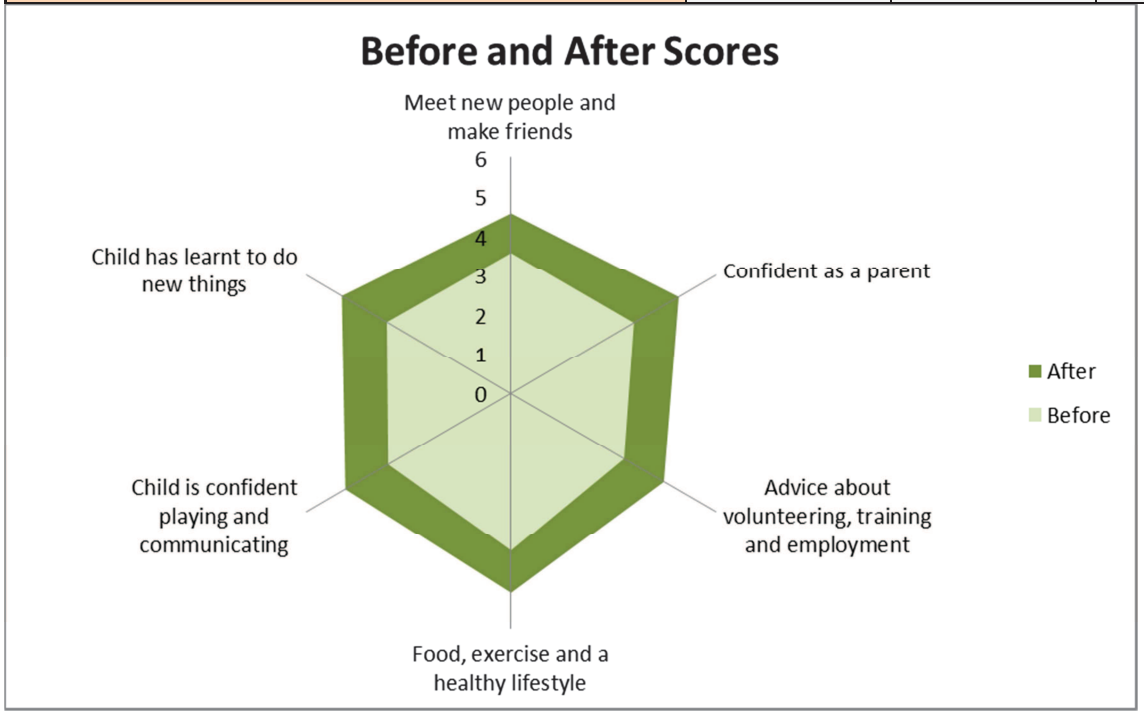
Appointments coded against 'Counsel, Advice or Support – Client' and 'General Child Care'

Evaluations of improvement on activities City-wide

Data: Consultation Portal. Evaluations entered between 1st April and 7th August 2015. Comparing before and after scores.

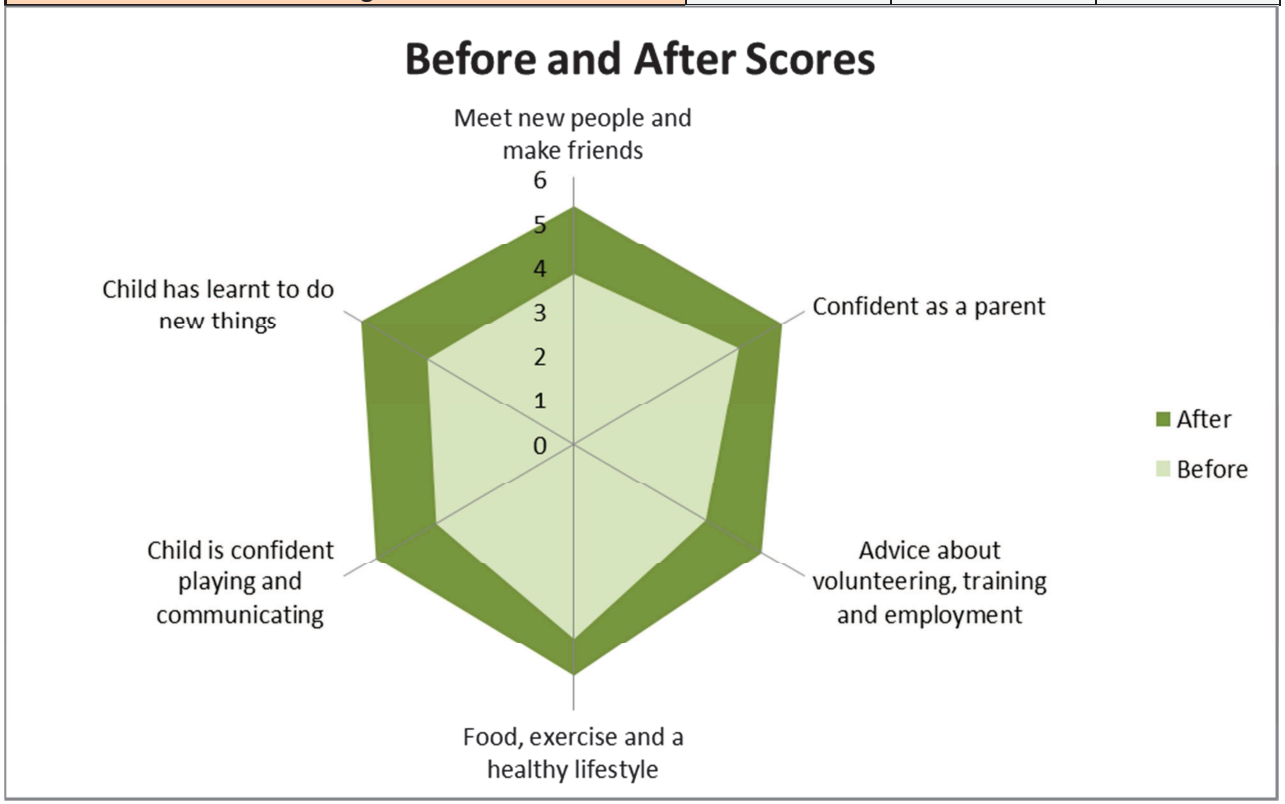
Universal Group: Baby & You (113 evaluations)

	Average Before	Average After	Average Improvement
Meet new people and make friends	3.59	4.58	1.00
Confident as a parent	3.60	4.92	1.31
Advice about volunteering, training and employment	3.31	4.48	1.17
Food, exercise and a healthy lifestyle	3.99	5.06	1.06
Child is confident playing and communicating	3.60	4.86	1.26
Child has learnt to do new things	3.64	4.96	1.32



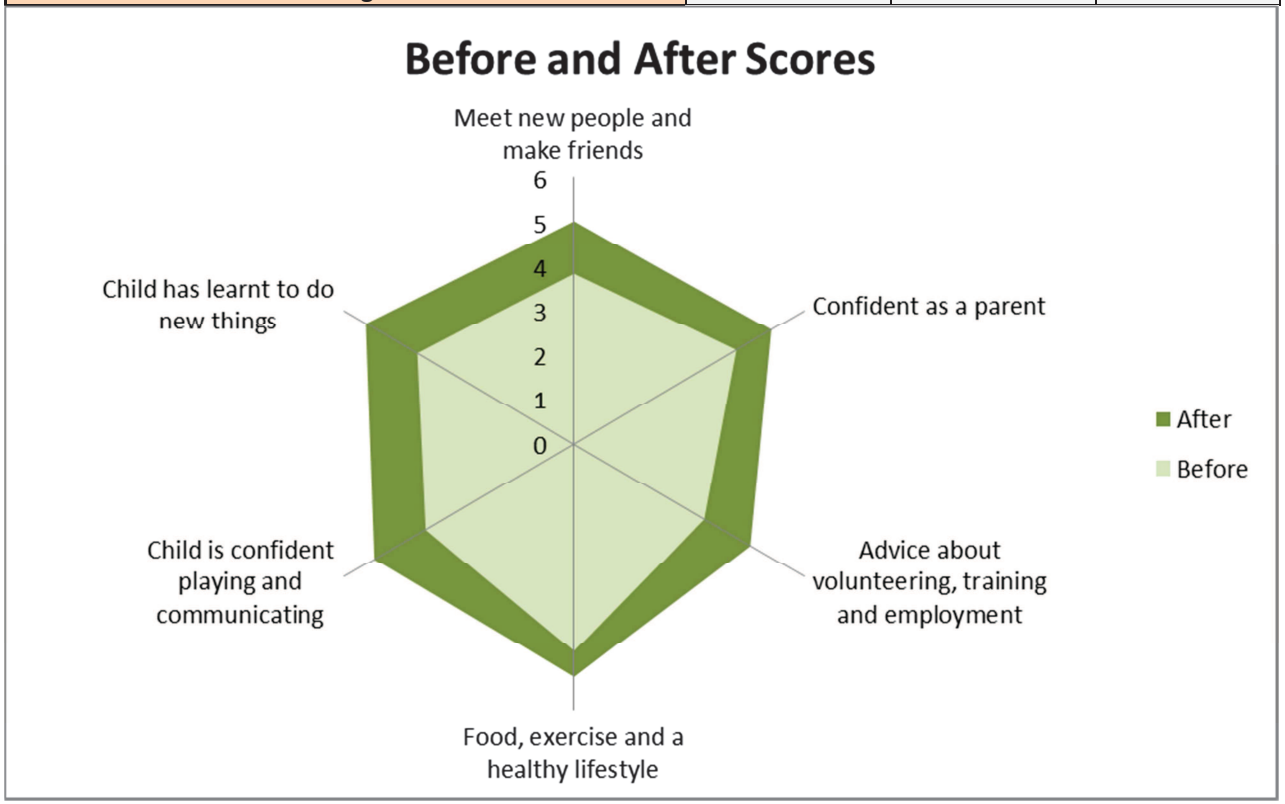
Universal Group: Bilingual Families (50 evaluations)

	Average Before	Average After	Average Improvement
Meet new people and make friends	3.84	5.38	1.54
Confident as a parent	4.30	5.43	1.13
Advice about volunteering, training and employment	3.43	4.89	1.45
Food, exercise and a healthy lifestyle	4.40	5.24	0.85
Child is confident playing and communicating	3.59	5.16	1.57
Child has learnt to do new things	3.82	5.55	1.73



Universal Group: Stay & Play (150 evaluations)

	Average Before	Average After	Average Improvement
Meet new people and make friends	3.84	5.04	1.20
Confident as a parent	4.23	5.14	0.91
Advice about volunteering, training and employment	3.39	4.59	1.20
Food, exercise and a healthy lifestyle	4.68	5.27	0.58
Child is confident playing and communicating	3.87	5.21	1.34
Child has learnt to do new things	4.09	5.43	1.34

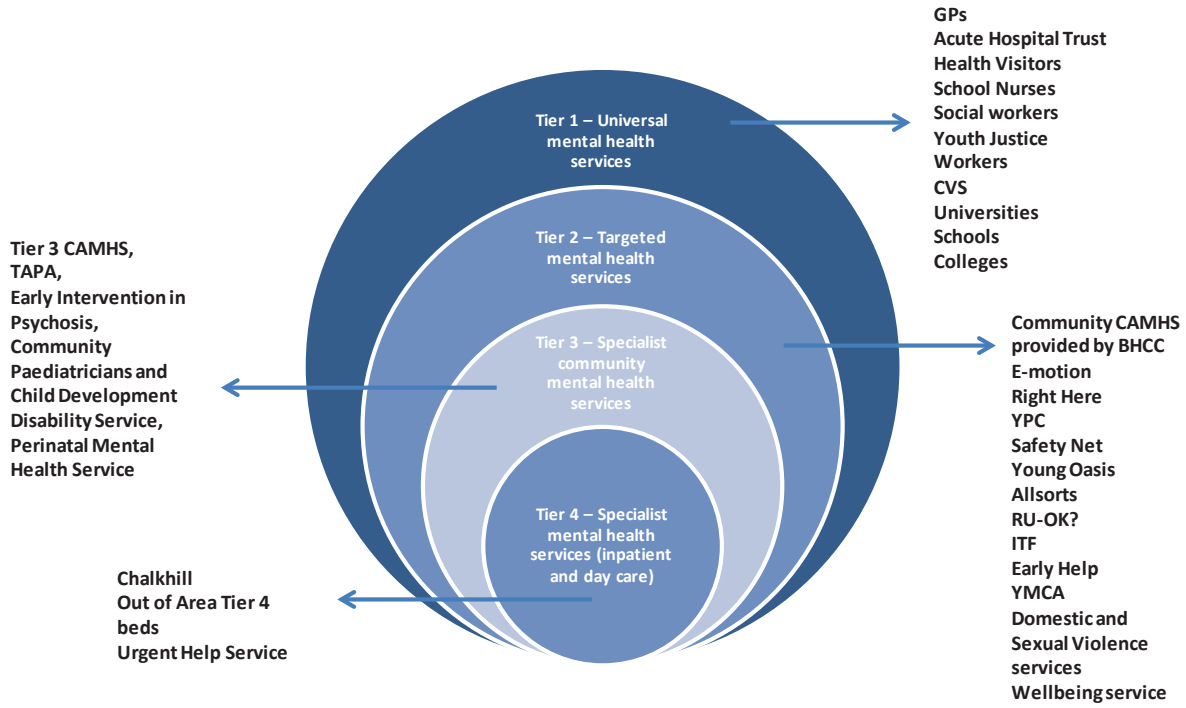


This information is taken from the draft Children and Young People's Mental health needs assessment to be published later in 2015

1.1 Children and Adolescent Mental Health Services in Brighton & Hove

Child and Adolescent Mental Health Services (CAMHS) in England are delivered through a four-tiered system which spans health promotion and primary prevention, through to specialist, inpatient care. Figure 2 below shows examples of services at each tier.

Figure 1: CAMHS Tiers with examples of services in each tier



1.1.1 Tier 1 Universal Services

Tier 1 services are universal services provided by professionals whose main role is not in mental health, such as GPs, health visitors, school nurses, social workers, youth justice workers, and voluntary agencies. They offer general advice and treatment for less severe problems, contributing towards mental health promotion, identifying problems early in a child or young person's development and referring to more specialist services where necessary.

1.1.1.1 Admissions to the Royal Alexandra Children's Hospital

Between June 2012 and June 2014, 127 children were admitted The Royal Alexandra Children's Hospital with psychiatric issues as the primary reason for admission. This excludes those who have been admitted due to deliberate self-harm.

Almost two-thirds (63%) of these admissions over this time period were for psychiatric disorders, and 37% were for behavioural disturbances from either alcohol or drugs.

Of those admitted for psychiatric disorders, 50% (40 admissions over a two year period) were for anorexia, 13% were for unspecified disorders, 11% were for depressive or psychotic disorders, 9% were for anxiety/panic disorders and Autistic Spectrum Disorders/ Attention Deficit Hyperactivity Disorders respectively, 8% were for conversion/ somatoform disorders. 1% were for manic episodes.

"Staff would benefit from knowing key psychologists and psychiatrists. More joint working, meetings, joint clinics, onsite presence- benefits from mutual training and knowledge sharing. Hospital clinicians need to know what CAMHS can and can't do."

1.1.1.2 University Support Services

University of Sussex

The University of Sussex provides a counselling service for all students – both undergraduate and postgraduate. This includes a daily single session bookable up to 24 hours in advance for urgent issues, in addition to a six session counselling core service. There are also therapeutic groups which deal with eating disorders and addictive behaviours.

Workshops are also offered on a variety of subjects, including procrastination, insomnia, stress, mindfulness, homesickness throughout the year.

Data from the University of Sussex counselling service is not currently available for inclusion within this needs assessment.

University of Brighton

In the academic year 2013-14, therapeutic support was accessed by 1,449 University of Brighton students, with approximately 5,300 individual sessions provided. There was a 10% increase in the number of students seeking therapeutic support compared with academic year 2012-13.

- 84% of clients were undergraduates
- 65% were female, 31% were male
- 80% were new clients, and 18% were returning clients.
- The average number of sessions was 3.6 per client. 83% of clients had six sessions or less
- 53% of clients were seen within five working days of approaching the service, and a total of 78% within ten working days. The average time between contact and 'Assessment' was six days.
- A total of 151 students (10%) made appointments but did not attend, and were never seen by the service.
- 27 clients contacted the service and were put on the waiting list, but were never seen by the service.
- 57% of clients self-referred, with 21% being referred by tutors and 4% by a G.P. or Nurse, 6% were referred by other services within Student Services.
- 9% of clients were referred on to other agencies or further help, with 4.5% of the total being referred to agencies outside of the University.
- For both specific, and general presenting problems, clients suffering from depression or anxiety made up the largest group (34%), followed by those with academic difficulties (19%), and self-esteem problems (14%).
- 13% of clients were assessed to be suffering 'Mild-to-Moderate' difficulties when first seen by a counsellor, with 72% categorised as 'Moderate', and 11% 'Severe'. These figures improved to 31%, 51% and 1% respectively at the end of counselling.
- A total of 53 clients (3.6%) were recorded to be at risk of self-harming – including eight who were also believed to be at risk regarding their use of drugs and/or alcohol, and seven also at risk of 'violence against women'.

- The drugs/alcohol risk and 'violence against women' were recorded in 41 (2.8%) and 31 (2.1%)of cases respectively, with 13 (0.9%) clients being in both categories.[i]

1.1.1.3 The Carers Centre

The Young Carers Team at The Carers Centre aim to support children and young people who care for a family member who has a physical or mental health support need, substance misuse issue or sensory or learning disability. The team supports children and young people whose social, emotional or educational development is negatively affected by their caring role.

In 2014/15:

- Casework was offered to 89 young carers (aged 8-17) who were assessed, as well as those who were reviewed over the year.
- Advice/ information was given to 55 families of young carers in accessing key support services.
- 1-2-1 support was offered to 79 young people on the caseload around illness/ disability of cared for person.
- Of 55 new cases of young carers in this time period:
    - 60% were female and 40% male
    - 85% of cases allocated in 2014/15 had a young carer who was White British, 15% were from Black and Minority ethnic backgrounds
    - 58% of young carers worked with in 2014/15 were caring for a parent, 42% were caring for a sibling – however there is some cross over between these groups as some young people will care for both a parent and a sibling.

1.1.2 Tier 2 Targeted Services

Tier 2 consists of targeted provision for children and young people who have identified needs and/ or are considered 'at risk'. This is provided by mental health professionals delivering primary mental health work, for example, psychologists and counsellors in GP practices, paediatric clinics, schools and youth services. Tier 2 also includes practitioners and services from community CAMHS who provide initial contact, assessments and treatment for children and young people.

Service mapping of Tier 1 and 2 provision already undertaken for the 'Where to go for' website is included in Appendix XXXXX

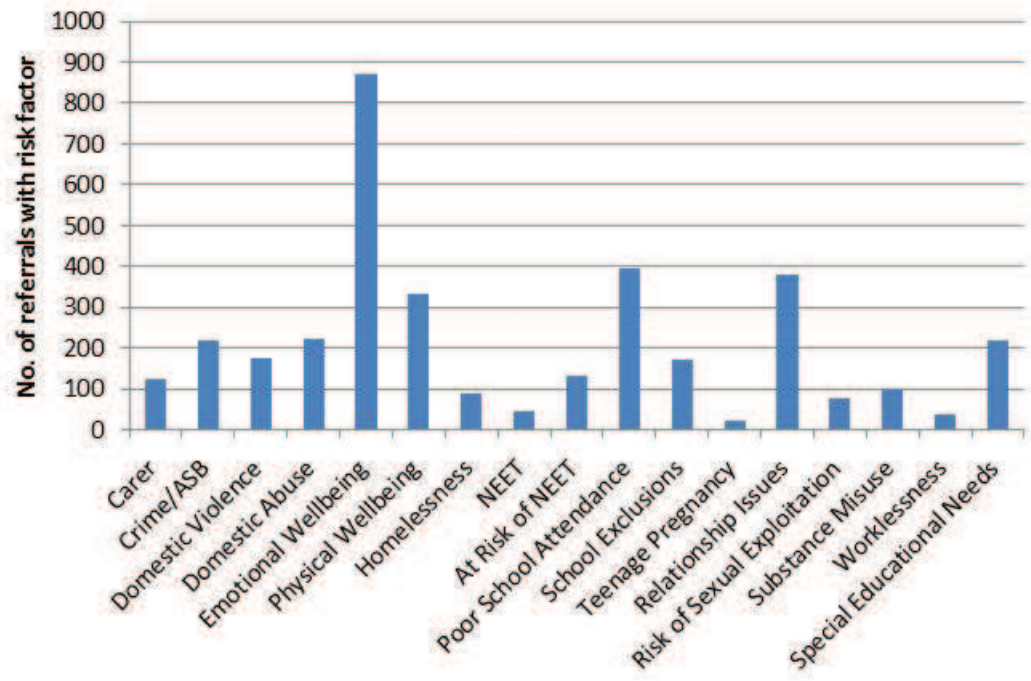
1.1.2.1 Early Help Hub

Ofsted's definition of Early Help is intervention aimed at "those children and young people at risk of harm (but who have not yet reached the "significant harm" threshold and for whom a preventative service would reduce the likelihood of that risk or harm escalating) identified by local authorities youth offending teams, probation trusts, police, adult social care, schools, primary, mental and acute health services, children's centres and all Local safeguarding Children Board partners including the voluntary sector where services are provided or commissioned".

In Brighton and Hove Early Help is expressed in the joined-up work carried out by a wide body of professionals. Registration of Early Help Activity (Early Help Assessments and Team around the Family Plans), and referrals for additional services are managed through the Early Help Hub. Each week a body of professional managers meet to discuss referrals and allocate to supporting services.

In the 11 months between September 2014 and July 2015, The Early Help Hub received 1,538 referred clients, from 676 households. Of those referrals, 63% were for children aged 11-18, 26% were for children aged 5-10 and 11% were for children under 5. 53% of referrals were for males, and 47% were for females.

Figure 2: Risk indicators for Early Help referrals, September 2014 – July 2015, Brighton & Hove



Source: Early Help Hub Performance Report July 2015

Note: Clients can have more than one risk indicator. Risk indicators are completed and risk is assessed by the referrer.

- 57% of referrals to the Early Help Hub between September 2014 and July 2015 were identified as having a risk indicator for emotional wellbeing, making up the largest risk factor for all early help referrals. Further information around the types of issues experienced by children and young people with this recorded risk indicator is not currently available. However, in the next year of operation the Early Help Hub is migrating the referral process to a more sophisticated ICT system that will allow much more detailed information around risk indicators to be captured. However, we can look at comorbid needs. So for example, in the first year of operation 892 12-18 year olds were referred to EHH, 566 of these were identified as having poor emotional wellbeing. Of these, 42% also had school attendance issues, 34% had physical health issues, 27% had needs around domestic violence and abuse, 25% had needs around anti-social behaviour or crime, 20% around school exclusions, 19% around SEN, 16% were at risk of NEET and 14% had needs around substance misuse.
- 26% of overall referrals had risk indicators for poor school attendance, and 25% had risk indicators for relationship issues.
- 26% of overall referrals had risk indicators for either domestic violence or abuse (recorded separately), and 8% were seen as at risk of sexual exploitation.

1.1.2.2 Integrated Team for Families

The Integrated Team for Families (ITF) is the delivery arm of the Stronger Families, Stronger Communities (SFSC) programme. The programme is Brighton & Hove's response to the national 'Troubled Families' initiative, which aims to turn around the lives of families with multiple complex issues.

The team works with partner agencies to deliver interventions to households and families who meet the national eligibility criteria. The team uses assertive outreach, coaching and intensive family intervention, working with families to reduce anti-social behaviour and youth offending, improve school attendance and reduce school exclusions, address worklessness, and address underlying problems including emotional and mental health problems, drug and alcohol misuse, long-term health issues and domestic violence.

The team is made up of Family Coaches and specialist advisors from a range of partners including Adult Social Care, Children's social care, Probation, Housing, and the Youth Offending Service. It also works closely with schools and colleges, community and voluntary sector organisations, and health service commissioners and providers.

Between April 2012 and September 2015:

Adults and families

- Of all adults worked with by the Integrated Team for Families during this period, 36% (n=104) had a mental health issue identified, of which 70% (n=73) were getting support from mental health services.
- 7% (n=21) of all adults worked with had an alcohol issue identified, of which 24% (n=5) were accessing support, 10% (n=28) had a substance misuse issue identified, of which 50% (n=14) were receiving support.
- 9% (n=20) of families worked with in this period were affected by current domestic violence and abuse and 54% (n=116) of families have been affected by historic domestic violence and abuse.

Children and young people

- 12% (n=53) of children aged 5-17 worked with by the team were identified as being engaged with CAMHS due to mental health issues.
- 5% of children and young people aged 11-17 with an ASPIRE record[1] were engaged with RU-OK for substance misuse or alcohol misuse issues at the intervention start date or within the following three months.

Benchmarking

The following benchmarking information is taken from Family Monitoring Data which uses a cohort of 75 families worked with in Brighton & Hove and compared against a range of indicators to England and South East figures. Data was extracted at the end of 2014:

- 19% of children in the Brighton & Hove cohort were suffering from mental health problems with a clinical diagnosis, compared with 21% in the South East and 19% in England.

[1] ASPIRE is a database used by the Youth Service, Youth Employability Service, Youth Crime Prevention service, and RU-OK young persons' drug and alcohol service. Young people have an ASPIRE record once they transition to secondary school. However it will not include those who are independently educated or those educated out of area.

- 32% of children in the Brighton & Hove cohort were identified as having a mental health problem in a key worker assessment, compared with 30% in the South East and 26% in England.
- 17% of young people (under 18) in the Brighton & Hove cohort had substance misuse issues that reach a threshold for structured treatment, compared with 16% in the South East, and 14% in England.

1.1.2.3 Virtual School

Brighton & Hove's Virtual School was established in 2011 and aims to track the educational progress of over 300 children in care in areas such as attainment, attendance and exclusion, as if they were on one school roll. The Virtual School aims to proactively disseminate good practice by supporting schools, carers and social workers to encourage children in care to have high aspirations during their school career and in progression to further and higher education.

The Virtual School review and self-evaluation for academic year 2013/14 highlighted the following[ii]:

- 65% of statutory school age children in care in Brighton & Hove have some form of SEN, including 21% who have a statement. Brighton & Hove have less statemented children compared to national, statistical neighbours and the South East.
- The mean value of the Strengths and Difficulties Questionnaire (SDQ) scores (a brief measure of psychological wellbeing)for each child or young person aged 4 to 16 who has been in care for a year has improved from 15.2 in 2013 to 14.8 in 2014[2]. However, this remains above the national average of 13.9 and is ranked 105th out of 152 Local Authorities in England (where 1 is best).

1.1.2.4 Psychotherapy in schools

Decisions on counselling provision are made individually by each school depending on the school assessment of priorities; however the majority of schools in the city do have counselling which is paid for from their own budget. YMCA Downs Link Group provides the majority of this, with counsellors in 40 primary schools, five secondary schools, two private schools and BHASVIC.

Dorothy Stringer and Varndean School directly employ school counsellors. Hove Park is moving to a different model using pastoral support staff.

Information is not available across schools to give a full picture of how many children and young people access counselling within schools and colleges in the city.

1.1.2.5 Brighton & Hove Wellbeing Service

The Brighton & Hove Wellbeing Service is a Primary Care based mental health service for all people over 18 who are residing and registered with a GP in Brighton and Hove. The service offers a range of mental health support for mental health problems such as low mood, stress, anxiety and depression in clinics across the city. The service also offers therapy over the phone, and a wide range of courses service users can access.

[2] A score of under 14 is considered normal, 14-16 is borderline cause for concern and 17 or over is a cause for concern. 43% of those with submitted SDQ scores in 2013-14 were considered 'normal' compared to 50% nationally, 15% were considered 'borderline' compared to 13% nationally and 41% were considered 'concern' compared to 37% nationally.

In 2014/15, the Brighton & Hove Wellbeing Service received 2,200 referrals from young people aged 19-25. However, one individual can have more than one referral to the service, as there are three parts to the Wellbeing Service, each requiring a separate referral. There were 1,535 individuals aged 19-25 who accessed services in 2014/15 –accounting for 19% of all patients accessing the service.

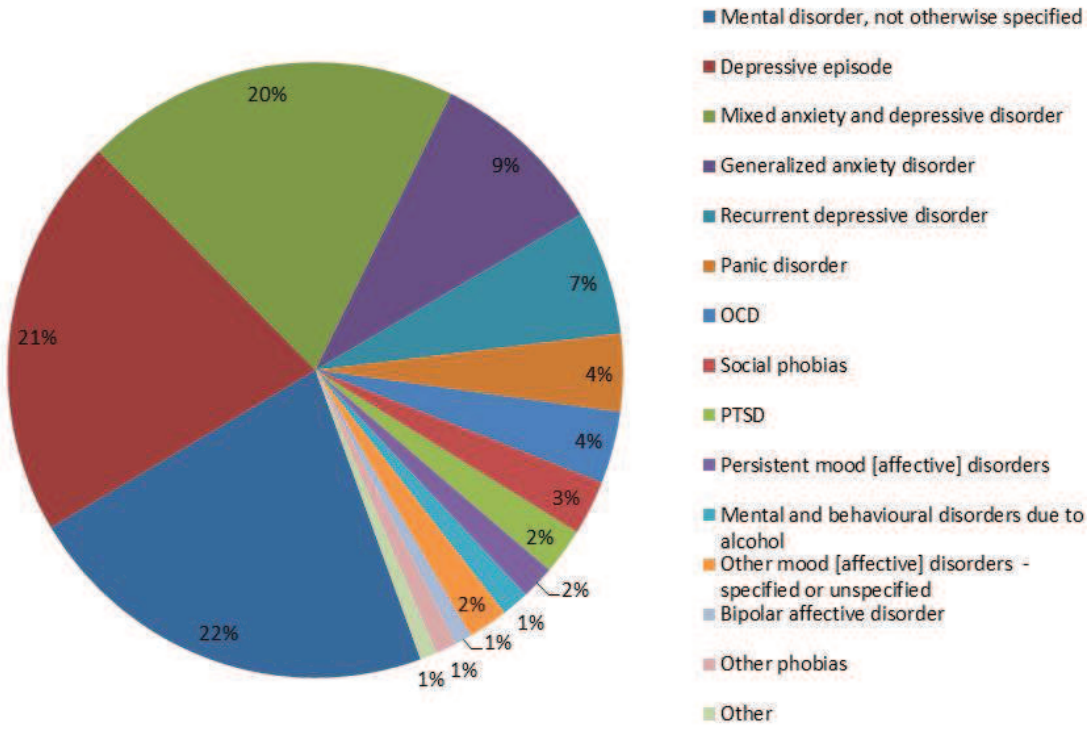
Of the 1,535 individuals referred to the service, 1,419 had at least one finished appointment, 116 patients did not get seen. Some were sent back to GP for more information or the referrer may have been given information about a more suitable option.

For 40% of referrals, talking therapy was offered, 36% a Primary Care Mental Health Worker, 21% a Psychological Wellbeing Practitioner, and 3% the Community Team. Individuals may be offered more than one service.

There were 581 referrals with a finished appointment for talking therapies, 524 referrals with a finished appointment with a Primary Care Mental Health Worker, and 314 referrals with a finished appointment with a Psychological Wellbeing Practitioner in 2014/15.

The highest proportion of those referred to the Wellbeing Service had a provisional diagnosis of 'mental disorder – not otherwise specified' (22%), followed by those with a provisional diagnosis of a depressive episode (21%) and those with mixed anxiety and depressive disorder (20%). Recording of provisional diagnosis has only been mandatory since November 2014 and data is from January – June 2015.

Figure 3: Provisional diagnosis for referrals to the Wellbeing Service, Jan – June 2015 (n=904), Brighton & Hove



Source: Brighton and Hove Wellbeing Service

BME Psychotherapeutic Counselling Service – access by refugees and asylum seekers

There is very limited data collected regarding refugees, asylum seekers and migrants across services in the city. However, the Wellbeing Service has a BME Psychotherapeutic Counsellor, who between October 2014 and September 2015, provided counselling to six asylum seekers aged 18-25, from countries including Afghanistan, Morocco, Sri Lanka and Iran. In previous years young asylum seekers from Balkan as well as other African countries such as Sierra Leone, Angola and the Cameroon have also accessed the service. Clients are worked with for up to six sessions on a weekly basis.

The main presenting mental health issue amongst this group is Post Traumatic Stress Disorder (PTSD). Patients have often witnessed death or have lost close relatives to arrest, imprisonment and presumed torture and death, and often do not know the fate of their relatives. As well as traumatic experiences in their country of origin, they have also often had long and traumatic journeys to the UK. Guilt surrounding their survival, as well as concentration, memory and academic problems are all common presenting issues amongst this group.

1.1.2.6 YMCA Community Counselling Services

YMCA Community Counselling Services are delivered at Dialogue @ 65 Blatchington Road, and the East Brighton Young Person's Counselling Service which operates from Whitehawk Library. The service currently offers 27 hours a week of counselling for young people aged 13-25.

There were a total of 172 referrals into the service in 2014/15, which resulted in 769 counselling sessions being offered, and 633 sessions being attended (136 were cancelled by young people). A total of 101 young people were seen in 2014/15, and 175 young people are currently on the list for community counselling. The average wait for counselling is 51 days.

Around a third (32%) of referrals came from GPs, 23% came from YMCA staff, 16% were self-referrals, 15% came from parents, 7% came from other sources, 6% came from CAMHS and 1% were unknown.

A third (33.5%) of referrals were for males, 66.5% were for females. The average age of young people referred for YMCA counselling services was 18 years of age.

"There's a disjoint between YMCA provision and early help. There's no interface with Weekly Allocation Meetings, more provision could be done here."

1.1.2.7 YMCA Downslink Group Safeguarding Alerts

In 2014/15, there were 50 safeguarding alerts across YMCA Downslink services regarding suicidal ideation from under 26 year olds in the city. Of these, 29 were for females, and 21 were for males. The highest number of presentations during this period (n=19) were made to the schools counselling service, followed by the Youth Advice Centre (YAC) (n=11). Between 1st April 2015 and 8th July 2015 there were 22 safeguarding alerts across YMCA Downslink services regarding suicidal ideation from under 25s – nearly half as many as in the whole previous year in just over 3 months. Of these, 9 were or males, 13 for females, and the highest number of presentations (eight) were made at the YAC.

In 2014/15, there were 15 safeguarding alerts for self-harm, the majority of which were from females. Seven of the 15 presentations were at the YAC. Between 1st April and 8th July 2015, there were 14 safeguarding alerts for self-harm, evenly split between males and females under the age of 25. Ten of these 14 presentations were at the YAC. As this data has only been collected since 2014/15, the increase in safeguarding alerts seen is likely to be as a result of better recording practices and greater awareness from staff.

1.1.2.8 E-motion

E-motion is a free online counselling project for young people aged 13-25 years who live in Brighton and Hove. The project is the result of partnership work between the Young People's Centre and the Youth Advice Centre.

In 2014/15, E-motion had a total of 117 referrals to the service. Of these, 84 (72%) were provided with assessments, 25 (21%) didn't reply to an initial response and request for further details, and eight (7%) were enquiries or further information was given.

Of those referrals where gender was known, 87% were female, 12% were male, and less than 1% were transgender. Of those referrals where age was known, 46% were aged 13-16, 25% were aged 17-19, and 29% were aged 20-25. 48% came from the BN1 area, 31% from the BN2 area, 14% from the BN3 area and 4% from BN41. 3% were from out of area.

Of those provided with assessments 59 (70%) were allocated for counselling. Of those not allocated counselling, 15 (18%) were deemed unsuitable or referred on. Reasons included clients being out of area, over the age limit, too high risk, or in need of more support to access face to face counselling. 7% (six) were assessed as suitable but did respond to the safe email set up, and 2% were assessed but decided not to continue with the service. 11% of assessments carried out were for clients assessed as at either serious or medium risk of suicide.

All clients in 2014/15 had a response to an initial enquiry within two working days, and all waited less than a week for assessment. 86% had counselling within a week, and 14% waited two weeks for counselling. At the end of 2014/15 there was no waiting list for counselling. A total of 65 clients were provided with counselling in 2014/15 (including 6 assessed in the previous year).

The main presenting issues to E-motion were: anxiety (75%) and depression (54%), followed by suicidal thoughts (33%), self harm (30%), hearing voices (10%), abuse (9%) and bereavement (7%).

The source of 32% of referrals to E-motion was unknown. 22% of referrals came from schools, 16% were self-referrals, 12% were from college, 10% were from GPs, 5% were from parents and 3% were from Universities.

The most commonly cited reason for accessing the service were: preferring writing as a way of expressing themselves (58% of clients), finding the online format more convenient (48%) and being socially anxious/ or not liking face to face counselling (42% of clients).

Outcome measures

100% of young people worked with had an outcome of improved emotional wellbeing or reduced anxiety. 86% developed better coping skills, 70% had improved self-esteem and confidence, 66%

were better able to regulate their behaviour, 40% were able to go on to access face to face support or groups and 40% had improved life circumstances (in relation to jobs/ college/ uni/ leaving home etc). 34% were able to return to work or education. 26% no longer needed mental health services.

E-motion provides an out of hours service – 55% of enquiries were received at weekends and evenings.

1.1.2.9 Safety Net

Safety Net's Children's and Young People's Services are designed to support the mental, physical and emotional well-being of children and young people aged 8 – 13 across Brighton & Hove. This work includes a playground buddies scheme in primary schools, SNAP (Safety Net Assertiveness Project) in Primary and Secondary schools, whole class Protective Behaviours and personal safety sessions, transition sessions for year 6 children, online safety sessions to 8-11 year olds and their parents and anti-bullying week activities. Safety Net uses the evidence-based programme, Protective Behaviours, to underpin their work.

The following information comes from the Safety Net Project Report, July 2014 – June 2015[iii]:

Safer Transition to Secondary School

644 children took part in transition sessions between July 2014 and June 2015 to explore how they feel about moving on to secondary school. Children were seen to have an improved ability to deal with the transition from primary to secondary school through increased life skills and better coping strategies and knowledge around who to go to for help, following sessions.

Personal Safety Sessions

250 year 6 children took part in Personal Safety courses between July 2014 and June 2015. Personal Safety sessions cover the basic principles of Protective Behaviours and how to apply personal safety strategies to keeping safe in the community and on the way to and from school.

Safety Net Assertiveness Project (SNAP)

- In a survey carried out with 62 children who had received a four week programme of SNAP sessions from Safety Net, 68% of children increased their score for the statement "I can find different ways to help myself in difficult situations."
- Initially 62% of children and young people referred to SNAP scored low on a nationally benchmarked wellbeing survey. Post intervention, 38% scored low indicating an increase in overall wellbeing.

1.1.2.10 Young People's Centre Counselling

The Young People's Centre provides a safe young people friendly environment for vulnerable young people aged between 13-25 years old, where they can access a range of wrap-around support services for often complex and multiple emotional and mental health needs. The Young People's Centre Counselling Service provides up to twenty five clients per week with free confidential counselling sessions and is complimented by drop-in services.

In 2013-14, 202 counselling assessments were provided, an increase of 38% compared with 2012-13. The service reported a significant increase in demand for counselling services, with many more young people presenting with mental health issues, and issues linked to the economic downturn,

especially in terms of accommodation, employment, anxiety and depression, and in relation to concern about their own, or family's future prospects.

The average waiting time for assessment in 2013-14 was 2-4 weeks, with the waiting list closed several times during the year due to over-demand. Young people were referred to other services or encouraged to apply at a later date. 65% of clients attended their assessment session, a similar pattern seen in the previous year.

Of those who had counselling assessments in 2013/14:

- 80% went on to waiting lists for counselling services, 18% were referred to in-house or other more appropriate services (such as Teen to Adult Personal Advisors, Young People's Centre life coaching/ mindfulness meditation, 1-2-1 drop in, low cost and private counselling services and the Early Intervention Psychosis team) and 2% did not progress to counselling due to issues being addressed at their assessment session, or as they decided they did wish to have counselling.
- 30% of clients were referred from Mental Health Services such as CAMHS or the Wellbeing Service, comprising the largest proportion of referrals to the service. 21% were referred by GP's.

Referrals from mental health services have increased over the past five years, particularly in severity and complexity. In 2009/10 referrals from the Community Mental Health Team/ CAMHS/ Wellbeing Service accounted for 12% of referrals, increasing to 30% in 2013/14.

In 2013/14:

- 75% of counselling clients were female, 25% male.
- 20% of clients were aged 13-16, 31% were aged 17-20 and 49% were aged 21-25.
- 86% of counselling clients were white British.
- 14% were LGBT
- 11% of clients had disabilities
- 30% had physical health issues
- 38% of young people were in education, 32% were neither in education or employment, and 30% were employed.

Issues presented with:

- 72% of clients presented with mental health issues, of which anxiety and depression account for the largest proportion of issues presented with at the counselling service.
- The service reported that in 2013/14, most clients attending the counselling service presented with a combination of issues and multiple needs. The service has noticed a marked increase in young people with various forms of anxiety and depression, personality and mood disorders but especially self-harm and suicidal clients who are considerably at risk. The service also saw an increase in more complex combinations of mental health issues, such as anxiety and depression alongside substance misuse, or domestic violence.
- 75% of clients presented with relationship issues, predominantly around relationships with parents. 56% of young people had parents whose issues were affecting them, often as a result of multiple issues, the most prevalent of which were parental breakdown, domestic violence, and parental mental health issues.

- 28% of young people experienced difficulty attending education or work.
- 28% of clients were experiencing some form of transition, for example from child to adolescent mental health services, preparing to leave home for university, transferring from school to college or returning from university and seeking employment, or around transgender issues.
- 20% of clients had on-going bereavement issues, 8% of whom had close family members or friends who had recently committed suicide.

Outcomes
87% of counselling clients in 2013/14 recorded successful outcomes.

- 8% of clients with anger management issues had needed police intervention at the start of treatment, and no longer needed police intervention at the end of treatment
- 24% of clients with mental health issues no longer needed treatment from the mental health services CAMHS, CMHT or the Wellbeing Service.
- 5% avoided their situation escalating into crises.
- 85% of young people who self-harmed were able to reduce or change their behaviour to develop more healthy coping strategies

42% of clients were significantly able to change their life circumstances as follows:

- 28% changed or secured accommodation. Able to move out of home
- 34% found a job or changed their employment
- 12% were able to have the confidence to apply for and become accepted onto university or college courses
- 6% were able to leave abusive relationships
- 5% were able to pursue and secure an apprenticeship
- 4% decided to plan travelling trips, some to volunteer, travel or work abroad

In 2014/15 the counselling service provided 181 assessment sessions to young people. Of these 118 young people went on to be provided with counselling sessions. In 2014/15, the counselling service provided 1,386 hours of assessment and client counselling sessions. 2014/15 has continued to see high levels of referrals from GP's and statutory Mental Health services. Further data for 2014/15 is not yet available.

"Young people don't feel they're at the centre of what's happening, being done to rather than done with. They talk to them about dealing with these situations. It's about how they communicate. They need to contribute to the conversation. YPC advocates for them."

1.1.2.11 Ru-ok?

Ru-ok? provides advice and support for under 18s in Brighton & Hove whose lives are affected by substance misuse.

A snapshot of cases in September 2014 showed that 22% of young people open to the team were in contact with tier 2 or tier 3 CAMHS and a further 19% were open to the Specialist CAMHS Nurse within the service at this time (therefore 41% of the total RU-OK caseload were accessing a mental health service).

The specialist CAMHS Nurse generally holds a caseload of 7-15 young people at any one time and presenting issues are mainly anxiety (including paranoia and PTSD) and low mood/ depression (often with self harm). The ratio of males to females is approximately 1:3, and the caseload is predominantly White British and between the ages of 14 and 17.

In 2014/15, 13% of the Ru-ok? caseload were reported as having wider vulnerabilities around mental health. This compared with 17% nationally. 13% were also recorded as having additional vulnerabilities around self-harm, compared to 17% nationally[iv].

"*RU-ok gets few referrals from Tier 2 or 3, have got to question why? If they are not seeing young people from here they're missing a group of young people or may be they're being contained by CAMHS or they may be the ones that don't attend as they are hard to engage."*

1.1.2.12 Oasis Project

Oasis Project is a substance misuse service for women and their families in Brighton & Hove. Oasis provide services for children and young people who have been affected by problematic drug or alcohol use in their family, including a crèche for pre school infants and children which can be used whilst a parent/ carers accesses treatment or support, and individual therapeutic support for children and young people referred to the Young Oasis Therapy Service.

The therapy service has seen a need for increased provision over the last six years, expanding from offering 10 therapy sessions a week in 2009 to 25 sessions currently and finding a new location in April 2013, separating the housing of the young oasis therapy service from the women's drug and alcohol project so that a more child centred service could be delivered.

There has also been a shift to a higher number of children with complex needs, with an upward trend in the proportion of children in care being referred to therapy (16% of referrals were from children in care in 2009/10, rising to 40% in 2014/15. There has also been an upward trend of the number of children on a child protection plan (from 20% in 2011/12 to 75% in 2014/15), a reflection of the increased number of referrals from social services. In 2014/15, half of children referred to the service were experiencing domestic violence, a figure which has remained consistent over the last three years.

In the 24 months of the Young Women's Alcohol Project, 60 young women engaged in casework, with the average engagement moving from 3 months in year 1 to 5 months in year 2. Between year 1 and year 2 of the project there was a 20% increase in the number of young women accessing casework. In Year 2, 52% of young women accessing casework experienced parental substance misuse as a child. On average, 48% of young women were care leavers

1.1.2.13 Allsorts

Allsorts Youth Project aims to support and empower young people under 26 who identify as lesbian, gay, bisexual, trans or unsure (LGBTU) of their sexual orientation and/or gender identity.

In 2013/14, mental health issues formed the largest proportion of issues raised by young people during one-to-one support sessions (129 out of a total of 699 sessions, 18%). Self-harm was raised as an issue in 59 sessions, and suicide in 23 sessions.

Of 299 brief interventions that took place in drop in sessions over the same time period, mental health was raised as an issue in 42 (14%). Self-harming was raised in 11 interventions (4%), and suicide in seven (2%).[v]

Of 32 LBGTU 16-25 year olds surveyed between October 2014 and March 2015, 28 had experienced mental health problems such as depression or anxiety in the last three months that had left them feeling unable to cope. Eleven had done something to injure or harm themselves, 13 had contemplated suicide, and five had attempted suicide.[vi]

Of 13 LGBTU under 16s surveyed in the same time period, all reported experiencing mental health problems such as depression or anxiety in the last three months that had left them feeling unable to cope. Eight had done something to injure or harm themselves, five had contemplated suicide, and fewer than five had attempted suicide.[vii]

1.1.2.14 Specialist domestic and sexual violence services

RISE

- In 2014/15, 21% (n=116) of referrals engaged by RISE Domestic Abuse Prevention and Recovery Service were for those aged 25 or under. Of these, the largest proportion (55%) of clients were aged 19-25. This age group accounted for 12% of total referrals engaged by the service in 2014/15.
- 74% of adult clients in 2014/15 reported a better understanding of the impact of domestic violence and abuse on their family, 79% reported a better understanding of the impact it has on their children and 88% report a better understanding of the impact on their role as parents following engagement with the service.
- In 2014/15, RISE worked with 37 individuals who had children with a Child Protection Plan
- The Counselling and Therapeutic team engaged with 25 children aged under 13 in 2014/15. There were a total of 41 children on the waiting list for therapeutic support at the end of March 2015.
- In 2014/15, 31 Rising Stars sessions were carried out, working with 21 children. Rising Stars is a six week group for children aged 6-11, focusing on 'Protective Behaviours', teaching children how to keep safe through a variety of fun activities.
- The Independent Domestic Violence Advisor (IDVA) service worked with 83 17-25 year olds in 2014/15 who were themselves in abusive relationships.
- In 2014/15 nearly half of all adults (n=17 out of 35) who were provided with refuge accommodation in 2013/14 had children.

Survivors Network

- From April to December 2014, Survivors Network Independent Sexual Violence Advisor (ISVA) service supported 16 under 18 year olds, and 40 18-25 year olds. Trend data is not yet available.
- In 2014/15 a total of 105 referrals were made to the service for survivors of sexual violence and abuse aged 14-26. Of these, 56 (53%) were identified as having vulnerabilities around mental health, 26 (25%) were identified as having vulnerabilities for self-injury, and 20 (19%) were identified as being at risk of suicide.

WiSE

WiSE is a YMCA DownsLink group project developed in 2009 for 13- 25 year olds who are experiencing, or are at risk of experiencing sexual exploitation. WiSE has a capacity of up to 17 one to one cases at any one time, dependent upon complexity of cases and levels of engagement. All referrals taken are now very high risk, and therefore need longer, more complex support plans. WiSE has on a number of occasions needed to operate a waiting list for direct one-to-one case work due to an improved awareness and response to child sexual exploitation (CSE) locally.

In 2014/15:

- WiSE conducted case-work with 28 young people experiencing or at risk of experiencing sexual exploitation.
- 23 young people received a joint intervention
- 12 drop in/ outreach sessions were conducted[viii]

Clermont Therapeutic Service

The CCG commissions a therapeutic service at the Clermont Centre for children who are the victims of sexual assault. It aims to provide therapeutic support to children under 14 and the safe care giver, where sexual abuse is being disclosed or where serious concerns about child sexual abuse from the professional network have been raised. It also aims to strengthen the pathway and signposting between support services for children under 14 and their safe care givers and to ensure the Clermont Centre signposts to other sources of support. E.g. Survivors Network and Mankind for young people (15-18) and young adults (19-25) who are disclosing historic sexual abuse.

1.1.2.15 Single Point of Access Triage data

The tier 3 CAMHS team and the tier 2 Community CAMHS team work closely together to support children and young people with emotional and mental health needs through one single point of access. When a referral is received, a decision is made on what would be the most appropriate service using the information given on the referral form. All referrals for mental health support in Brighton & Hove go to a central weekly triage meeting that is attended by both tier 3 and tier 2 staff.

In financial year 2014/15 there were 1,767 cases triaged by the single point of access for CAMHS. Of those, 24% were referred to Tier 2 CAMHS, 35% were referred to Tier 3 CAMHS, 13% were signposted to external agencies, 1% were signposted at pre-referral consultations and 9% went back to the referrer asking for further information. 20% were closed or deemed inappropriate. 3% of these cases had an open Common Assessment Framework (CAF).

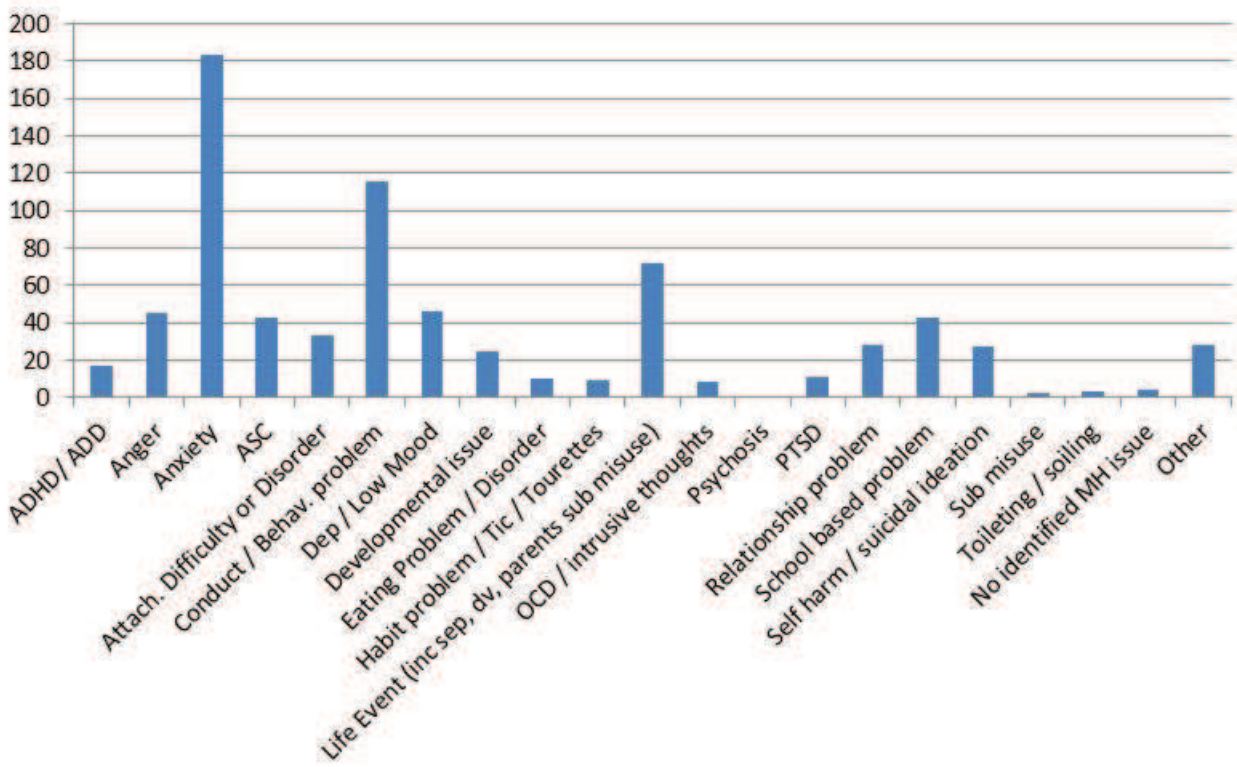
Further data for Tier 3 CAMHS can be found in section 7.2.3

1.1.2.16 Tier 2 Community CAMHS data

Tier 2 Community CAMHS provide a targeted response to mental health and emotional wellbeing for issues such as ADHD, stress, anxiety, phobias, ASC, eating disorder, family difficulties, school refusal, mood changes, and bereavement and grief.

Of those cases closed in 2014/15 the following mental health presentations were reasons for referral to the Tier 2 Community CAMHS service:

Figure 4: Needs identified in cases closed, Community CAMHS, April 2014 – March 2015 (n=754), Brighton & Hove

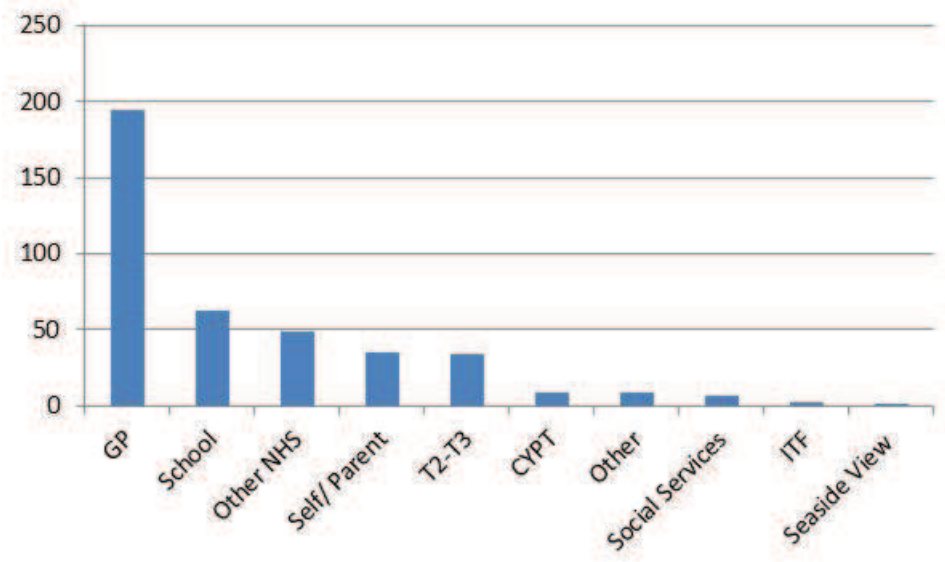


Source: Tier 2 Community CAMHS Closing Data

Anxiety was the most common need identified amongst children and young people worked with whose cases were closed in 2014/15, with 24% of referrals listing this as one of their identified needs (children and young people can have more than one need identified). This was followed by conduct/ behavioural problems (15%), and life events such as separation, domestic violence or parental substance misuse (10% of referrals).

The most common referral source was GPs (49%), 16% of referrals came from schools, and 12% from other NHS departments.

Figure 5: Referral sources for cases closed in 2014-15, Community CAMHS (n=399), Brighton & Hove



Source: Tier 2 Community CAMHS Closing Data

Of those cases closed in 2014/15:

- 76 of 407 (19%) were recorded as having a parent with a mental health issue.
- 43 (11%) were recorded as having experienced domestic violence.
- 43 (11%) were recorded as having poor health.
- 19 of 407 (5%) children and young people referred were recorded as having a caring role.
- 20 out of 407 (5%) children were on a Child In Need plan
- 9 out of 407 (2%) children were on a child protection plan.
- Less than 5 children were children in care, adopted or on a special guardianship order or residence order respectively.
- Of 43 young people asked about substance misuse, 9 identified substance misuse, and 12 alcohol use (of which 5 were identified as 'problem use').

Feedback and outcome measures

The service collects feedback following treatment via Strength and Difficulties Questionnaire scores and on the user experience via feedback forms.

- Feedback forms on the user experience stated that 89% would recommend the Tier 2 Community CAMHS service to others.
- SDQ scores measuring mental health on children and young people referred to Tier 2 Community CAMHS showed significant improvement in 83% of cases in 2013 and 90% of cases in 2014.[ix]

1.1.3 Tier 3 Specialist Community CAMHS services

CAMHS tier 3 is the specialist, community-based mental health team in Brighton & Hove (non-inpatient service), with an aim to provide expert case management and expertise to help children and young people (0-18 years) to achieve good mental health. Tier 3 aims to develop children and young people as individuals and maximise their life chances through an integrated, multi-disciplinary

approach to mental healthcare, for a full range of mental health disorders. The response to mental health need is based in a community setting, and close to home.

1.1.3.1 Referrals

There has been an upwards trend in the total number of referrals in 2014/15. In the last 6 months of 2014-15, there was a 10.9% increase in the number of referrals compared with the same time period the previous year (Oct 13 – Mar 14). Referral data is currently only available from July 2013 onwards, as such full year comparisons are not possible. The number of referrals in 2014/15 peaked in February 2015 with 178 referrals in a month, compared with 130 in the same month the previous year. Data from March 2015 shows a drop to 151 referrals in the month, lower than a peak of 188 referrals seen in March 2014.

Figure 6: CAMHS referrals July 2013 – March 2015, Brighton & Hove

Source: CSU performance data

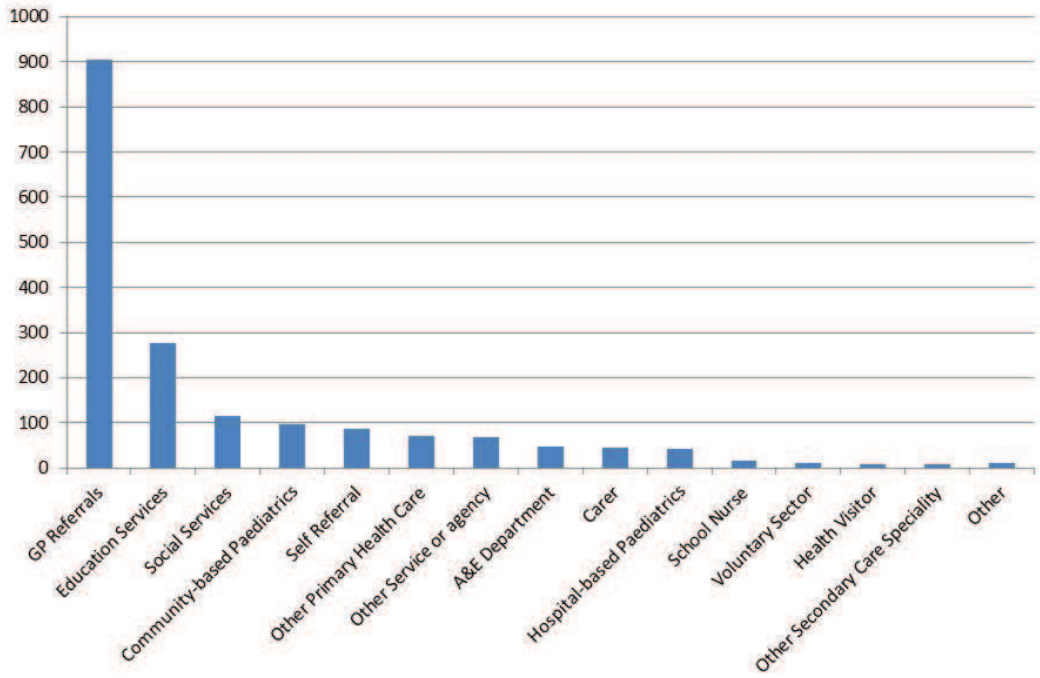
The percentage of referrals accepted by CAMHS has also increased in the last six months of 2014/15 compared with the previous year. Between October 2014 and March 2015, 67.3% of referrals to CAMHS were accepted, compared with 51.8% in the same six months the previous year.

The percentage of referrals not accepted, or signposted, decreased in this period from 48.2% between October 2013 and March 2014, to 32.7% between October 2014 and March 2015.

1.1.3.2 Sources of new referrals to CAMHS

In 2014/15, the largest proportion of referrals came from GPs (50%), followed by education services (15%) and social services (6%). Other referral sources include police, probation, court liaison and diversion service, drugs misuse agencies, out of area agencies, other independent sector mental health services and transfers from other mental health trusts.

Figure 7: CAMHS referral sources 2014/15 (n=1,809), Brighton & Hove



Source: CSU performance data

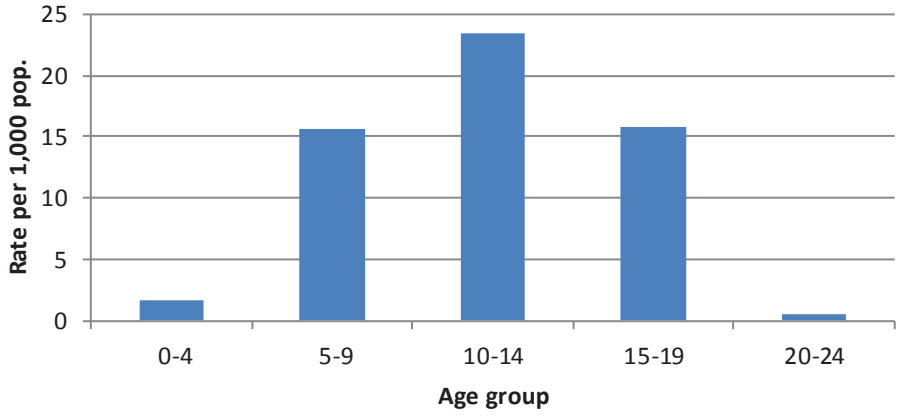
1.1.3.3 Caseload

At the end of March 2015, Brighton & Hove CAMHS had 910 cases open. 164 new cases were opened up in March 2015, and 133 cases were closed.

The following analysis is based on the CAMHS caseload during March 2015 – this profile is for patients whose case was open at any point in March 2015:

- 44% of CAMHS patients were female, and 56% were male. Less than 1% described themselves as 'both'.
- Those in the 10-14 age group made up the highest in both number and rate amongst the CAMHS caseload, with a rate of 23.4 patients per 1,000 population (n=308). This is followed by those in the 15-19 age group, with a rate of 15.8 patients per 1,000 population (n=260) and those in the 5-9 age group with a rate of 15.6 per 1,000 pop (n=220).

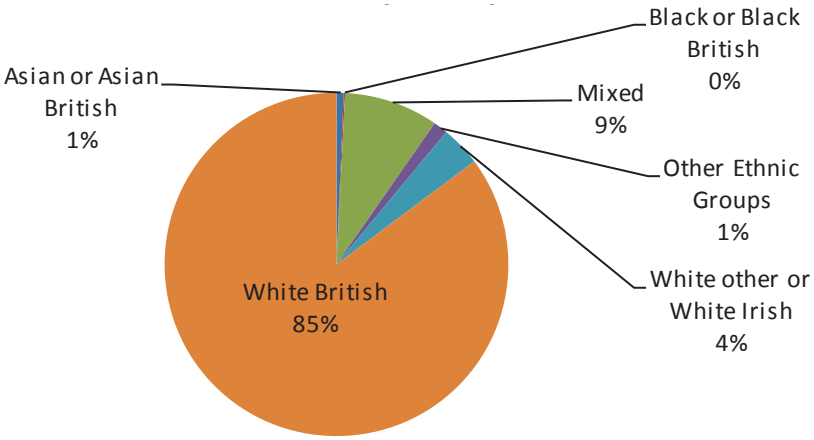
Figure 8: CAMHS caseload, rate per 1,000 population by age group, March 2015, Brighton & Hove



Source: CSU performance data

- 85% of patients on the CAMHS caseload in March 2015, where ethnicity was known or recorded, were White British. 15% were BME, the highest proportion of which were of Mixed ethnicity (9%).

Figure 9: CAMHS caseload, by ethnic group (%), March 2015, Brighton & Hove



Source: CSU performance data

- As at March 31st 2015, there were 32 Children in Care in the CAMHS caseload, and an additional five who were Children in Care out of area.
- The average length of stay in the service for those patients in the CAMHS caseload on March 31st 2015 was 622 days.

1.1.3.4 Waiting times

- 99.7% of referrals in 2014/15 had a waiting time of 0-4 weeks between referral and assessment.
- 91.2% (n=498) of referrals had a waiting time of 0-4 weeks between referral and first treatment, 7.9% (n=43) had a waiting time of 5-13 weeks between assessment and first treatment, 0.9% (n=5) had a waiting time of 14-18 weeks between assessment and first treatment.

1.1.3.5 Benchmarking

Across Tiers 1-3 of Sussex CAMHS in 2014/15, the maximum waiting time for routine appointments was 12 weeks, below the mean nationally of 21 weeks, and also than the average for the CAMHS benchmarking group[3], which was 34 weeks.

Across Tiers 1-3 of Sussex CAMHS in 2014/15, the maximum waiting time for emergency appointments was one day, compared to an average nationally of 11 days, and amongst the CAMHS benchmarking group of seven days. The DNA rate was 6% across Sussex CAMHS, compared with 11% nationally and 7% amongst those in the benchmarking group[x].

[3] Other areas in the benchmarking group include: Berkshire, the Isle of Wight, Oxford, and Surrey and borders.

1.1.3.6 16-17 year olds in transition

Numbers of transitioning patients from the CAMHS caseload to adult mental health services are low, with only eight transitioning patients between December 2013 and August 2015. Prior to this, data was not recorded for this measure.

1.1.3.7 CAMHS service users by Lower Super Output Area (LSOA)

Figure 10: Brighton & Hove CAMHS caseload as of 31st March 2015 by Lower Super Output Area

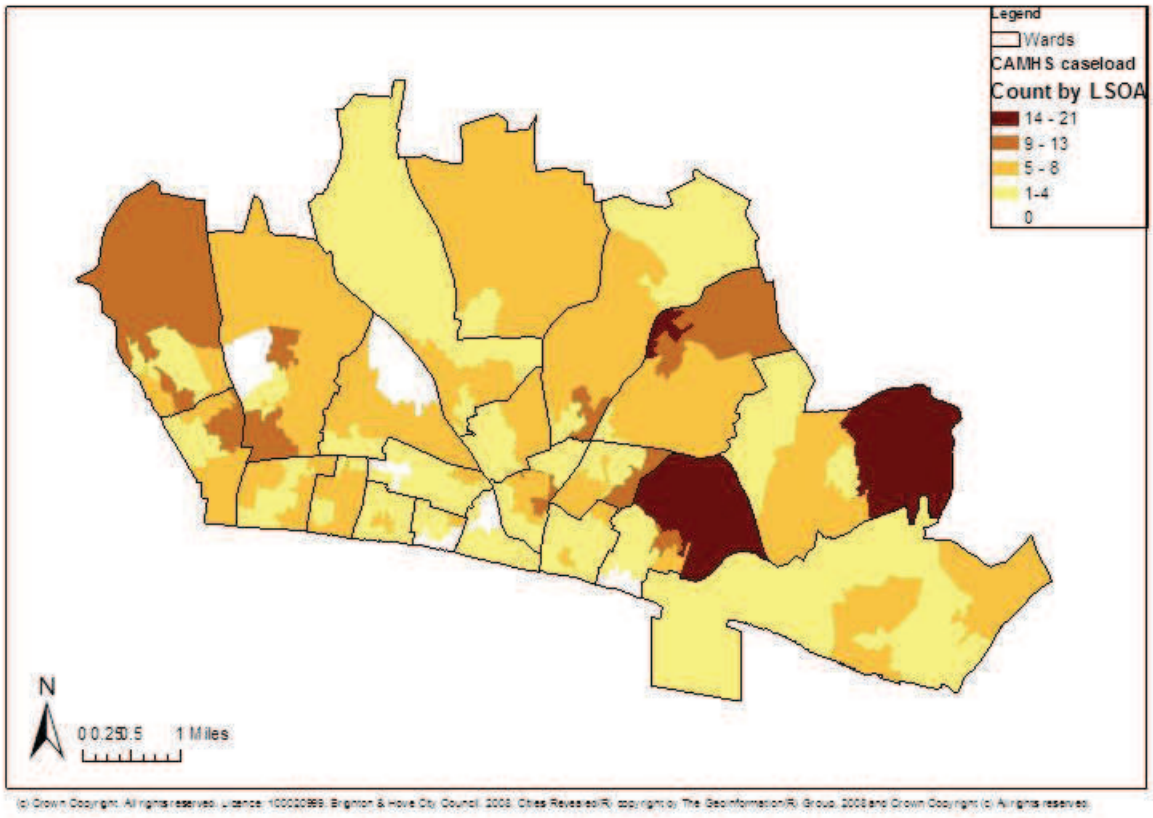


Figure 12 shows young people from all areas of the city are accessing CAMHS. 79 records are excluded from the above map where Brighton & Hove CAMHS patients live outside of the city boundary.

Postcode data for those on the CAMHS caseload as of 31st March 2015 has been used to analyse the relationship between treatment by Tier 3 CAMHS and deprivation in Brighton & Hove, according to the newly updated Index of Multiple Deprivation 2015.

There is some relationship between treatment by Tier 3 CAMHS and deprivation in the city, however this is not a strong relationship: in the most deprived 20% of areas in the city there are 113 children and young people on the CAMHS caseload for every 10,000 children and young people resident there, compared with 77 per 10,000 in the least deprived 20% of areas – an absolute range of 36 children and young people treated by Tier 3 CAMHS per 10,000. This means that children and young people living in the most deprived 20% of areas are 1.5 times more likely to be treated by Tier 3 CAMHS than those in the least 20% deprived areas.

1.1.3.8 Teen to Adult Personal Advisors (TAPA)

TAPA workers provide direct mental health work to young people and young adults aged 14-25 and advice, consultation and training to professionals and young people. TAPA workers attend a number of drop-in sessions in different locations in the city, such as at All Sorts, YPC and the YAC.

In 2014-15, the TAPA service accepted 142 referrals from young people in Brighton & Hove, a 7% increase compared with 2013/14, and a 29% increase compared with 2012/13. However, whilst accepted referrals have increased between 2013/14 and 2014/15, the number of young people discharged from the service dropped in the same period from 146 in 2013/14 to 122 young people in 2014/15, a decrease of 16%.

"TAPA follows up DNAs assertively and generally text people or ring, sometimes send a letter. They keep trying to engage people, linking with the referrer at the hostel, Devi8te etc. They try to get the bigger picture and work with other agencies to engage with people. They don't discharge people because they don't make 3 appointments. They make sure that complex cases are part of the TAF/CAF meetings."

1.1.3.9 Access to CAMHS for children and young people with Learning Disabilities

The CAMHS learning disability service is based at the Seaside View Child Development Centre and the team consists of a family & systemic psychotherapist, a senior assistant psychologist, and a part-time clinical psychologist and consultant child and adolescent psychiatrist.

The service works with children and young people from birth to age 18. In August 2015, the team had approximately 75 children and their families open to the team who were being worked with. Where a case is open, the service will also undertake joint transition work with adult Community Learning Disability Team colleagues, during young people's 19th year if necessary. The service report seeing increasingly more complex children with moderate learning difficulties and attachment trauma.

Referrals to the service are mainly for:-

- Detailed assessment and guidance re the management of children and young people's challenging behaviour at home/school/community
- Concerns around children and young people's mental health presentation i.e. anxiety, depression, ADHD etc.
- Concerns re. family dynamics and family coping
- Psychiatric overview and assessment including requests for medication
- Consultation & psychological overview/ work up regarding complex cases - from social work colleagues, paediatricians, OT's etc.
- Pre- referral consultations
- Re-referrals to the service are common due to the enduring nature of young people's difficulties and challenges that families experience across the lifecycle, particularly at key transition times.

Training and Consultation

In addition, the CAMHS learning disability service provide monthly consultation support to the two council residential respite units, Tudor House and Drove Road. This input will be in relation to open CAMHS LD cases, and other young people who may not be open cases but are receiving a respite

service. Input is given regarding behaviour support plans, developing a psychological perspective on understanding young people's behaviour and group dynamics. Drove Road currently accommodate 11 young people, and Tudor House 14 young people.

The outreach service for children and young people with learning disabilities in Brighton also offer half-termly consultation clinics for staff and parents at Downs Park. Approximately 30-40 families a year benefit from this service, which can lead to a recommended referral into the service, or signposting on to other services. The team also provide consultation support to staff at the Cedar Centre school, as well as joint consultation clinics with health occupational therapy colleagues to staff at Downs View and Hillside schools.

The team also recently set up a group for parents, jointly with colleagues from education, providing a 10 week course on Positive Behaviour Support, which was available to both families open to the service and to others. This 10 week course was attended by 12 parents. A second course is planned for November/ December 2015.

" CAMHS LD works best when services are integrated but this is under threat from cuts. Complex clients need integrated working, it will save money in the long term. The consultation model helps them get their knowledge out there but they also need the capacity to do direct work with children and young people."

1.1.3.10 Early Intervention in Psychosis Service

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. The service works with 14 – 35 year olds.

In 2014/15, the Early Intervention in Psychosis Service in Brighton & Hove received 123 referrals, of which 39 were accepted. The waiting time from referral to assessment was a median of nine days.

1.1.3.11 Paediatric Psychology Support Service (PPSS)

The Paediatric Psychology Support Service is provided at the Royal Alexandra Children's Hospital and aims to look after the mental and emotional wellbeing of children with long-term physical health conditions. The team provides monthly parent drop-in information and advice sessions, a therapy group for young people living with chronic illness (funded by Rocking Horse) as well as a 10 week group for young people living with chronic pain, and relaxation workshops for primary age children.

Of a total of 232 referrals to the Paediatric Psychology Support Service were received between January and December 2014. Of these, 116 were for Brighton & Hove patients. 92 of these referrals were accepted, and an additional 24 referrals for Brighton & Hove patients were not accepted. These were signposted on to other services such as ACAS, CAMHS or health visitors. The remaining referrals were for East or West Sussex or out of area.

Of those referrals accepted, 76 (83%) were outpatient referrals, and 16 (17%) were inpatient referrals. The largest proportion of referrals came from general, gastro, oncology and diabetes clinics. The largest proportion of referrals in this time period were for anxiety (22%), followed by adaption, adjustment or loss issues (17%) pain management, (15%) and Medically Unexplained Physical Symptoms (13%).

Between January 1st 2015 and July 1st 2015 there were an additional 34 referrals to the Paediatric Psychology Support Service for Brighton & Hove Patients, 28 of which were accepted, and 6 which were not accepted and signposted to other services. In July 2015 there were 8 active Brighton & Hove cases, and 16 patients on the waiting list.

1.1.3.12 Parent Infant Psychotherapy (PIP)

Parent Infant Psychotherapy is grounded in attachment theory and the neuroscience of infant development. It utilizes the expanding evidence base regarding the severe long-term effects of disturbed early relationships, placing an emphasis on the first two years of a child's life, and the need for a strong foundation in mental health from the very beginning of a child's life. The service works with the parent-infant relationship (while holding the baby in mind as the index of concern), aiming to strengthen sensitive caregiving behaviour and promote infant security.

Between May 2014 and October 2015, there were 18 referrals into the service. The average number of sessions (of those who had completed treatment in this time period) was 11 sessions.

Of those referred, eight received Parent Infant Psychotherapy, and three received Video Interactive Guidance, and three received other referrals, signposting or other forms of psychotherapy (some clients received more than one intervention).

The most frequent presenting issue amongst those referred in this time period was post-natal depression, with eight presentations, followed by trauma (six presentations) and attachment or bonding issues (five presentations). Some clients will have more than one presenting issue.

1.1.4 Tier 4 CAMHS services

Child and adolescent mental health services tier 4 (CAMHS tier 4) have been commissioned by NHS England since April 2013 in order to provide consistent standards across the country. CAMHS tier 4 is made up of day and inpatient services and includes; intensive care units, low secure inpatient units, eating disorder services, and inpatient learning disability services. There are approximately 1,264 CAMHS tier 4 beds available across the country, and following a review of CAMHS tier 4 in 2014, and due to recognised pressure in the system to locate suitable beds for children and young people's needs as close to home as possible, a further 50 beds were made available nationally.

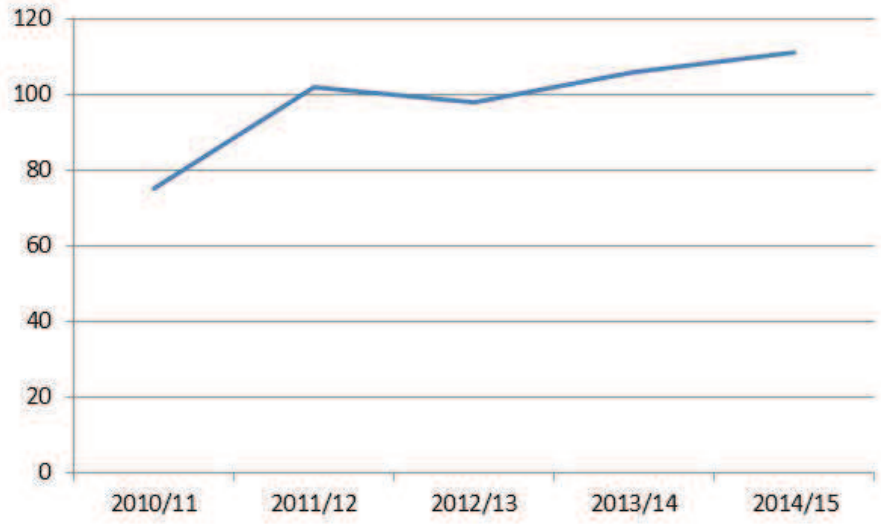
The nearest NHS England CAMHS tier 4 unit to Brighton & Hove is located in Haywards Heath – Chalkhill. It is a 16-bedded acute mental health unit, which provides multi-disciplinary care and treatment within a least restrictive environment (open acute), which is both safe and therapeutic. The inpatient setting is dedicated to those aged between 12 and 18; based upon age appropriate assessment. On rare occasions, it may be necessary to admit a young person under the age of 12 years or over the age of 18 years. Chalkhill operates at 95% occupancy.

1.1.4.1 Urgent help

The Urgent Help Service is a link between CAMHS tier 4 beds and CAMHS tier 3 community teams, allowing children and young people to remain at home supported by local services, as well as supporting admission to a Tier 4 service if required. As such, the service is partly funded by both the CCG as well as NHSE. It aims to add to existing packages of care for children and young people with acute mental health needs in an intensive way by providing 3-5 contacts per week over a time limited period of 4-8 weeks in order to maximise the coping resources of the child or young person

and the their support networks. The service operates 09:00-20:00 weekdays, with a Chalkhill-based weekend service in order to meet crisis and home treatment needs during this period, and where possible to prevent hospital admission (CAMHS tier 4).

Figure 11: No. of referrals to Urgent Help Service 2010/11 – 2014/15 (n=492), Brighton & Hove

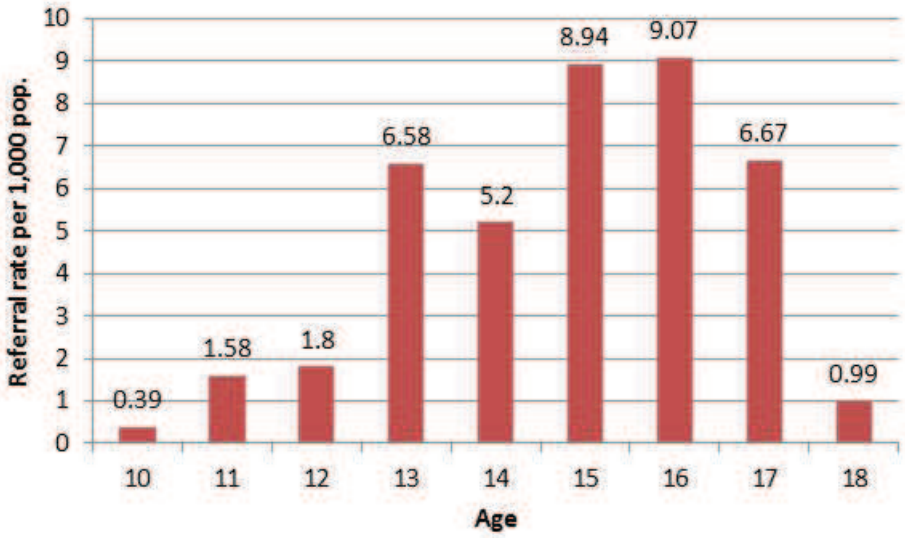


In 2014/15, there were 111 referrals to the Urgent Help Service of children and young people from Brighton & Hove. This is a 48% increase compared with 2010/11, and a 4.7% increase since 2013/14. However, at least part of this increase is likely to be due to a push internally to improve the recording of referrals, ensuring that all consultations are recorded as referrals.

In 2014/15, 58% of referrals to the Urgent Help Service came from the CAMHS Community mental Health Team, a further 16% came from A&E, and 10% came from hospital based paediatrics. Other referrals sources included other secondary care specialities, other services or agencies, social services, GPs, and self-referrals.

68% of referrals to the service in 2014/15 were female, 32% were male.

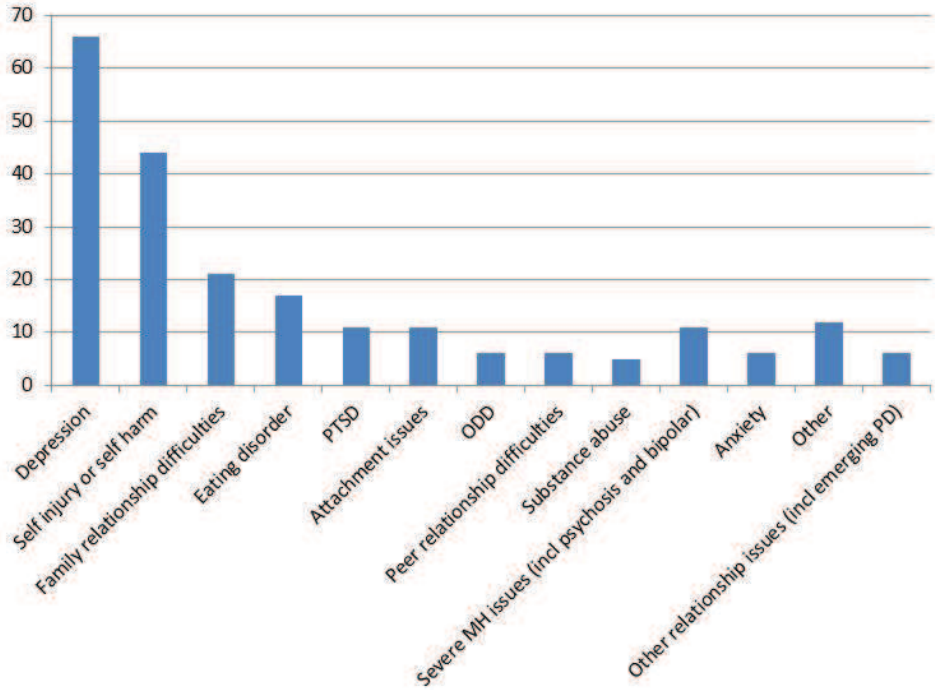
Figure 12: Age of Urgent Help referrals, 2014-15, rate per 1,000 pop. Brighton & Hove



The rate of referrals to the Urgent Help service was highest amongst 16 year olds, with 9.07 referrals per 1,000 population, followed by 15 year olds, with 8.94 referrals per 1,000 population.

80% of referrals to the service in 2014/15 were White British, and 20% of referrals were from BME backgrounds. This is in proportion to both the BME population of Brighton & Hove, which was 19.5% in the 2011 census, and the BME population of 0-24 year olds specifically, which was 23% at the last census.

Figure 13: Presenting issues for referrals to the Urgent Help Service 2014/15 (n=222), Brighton & Hove



59% of those referred to the Urgent Help Service in 2014/15 recorded a presenting issue of depression (patients will often present with more than one recorded issue). 40% of those referred to the service recorded a presenting issue of self-harm or self-injury. 19% recorded a presenting issue as family relationship difficulties. An additional 5% of referral s respectively presented with either peer relationship difficulties or other relationship issues. 15% of referrals had eating disorder as a presenting issue, and 10% respectively had PTSD , attachment issues, or severe mental health difficulties including psychosis or bipolar.

The average length of stay in the Urgent Help Service for those referrals opened between 1st April 2014 and 31st March 2015 was 68.9 days.

"People who get the Urgent Help service get a good service. It's an intensive service and flexible, can see people at home and at school."

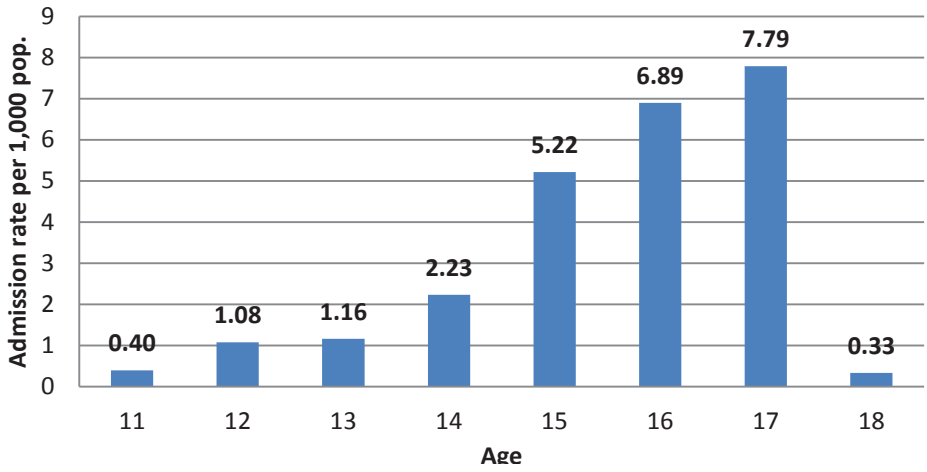
1.1.4.2 Crisis Admissions to Chalkhill

In 2014/15, there were 14 admissions of young people from Brighton & Hove to Chalkhill. This number has remained largely similar in the last five years, with between 12 and 15 admissions per year.

In the five year period between April 2010 and March 2015 there were 68 separate admissions, and 50 unique patients. There were 18 readmissions in this period.

The admission rate for children and young people increases with age, from 0.40 per 1,000 population for 11 year olds, to 7.79 per 1,000 population for those aged 17. Between the ages of 14 and 15, the admission rate rises from 2.23 per 1,000 population, to 5.22 per 1,000 population (Figure 15). It should be noted that as this data is for admissions over a five year period, this data will contain some multiple admissions for the same patient.

Figure 14: Admissions for Brighton & Hove young people to Chalkhill by age, rate per 1,000, April 2010 to March 2015



- 76% of the individuals from Brighton & Hove admitted into Chalkhill in the five year period between April 2010 and March 2015 were female, 24% were male.
- 16% of Brighton & Hove individuals admitted to Chalkhill between April 2010 and March 2015 were from BME backgrounds – this compares to 19% of children and young people aged 10-18 in the 2011 Census.

- 36% of the individuals admitted to Chalkhill in this five year period were from the BN3 postcode area, 28% were from the BN2 postcode area, and 26% were from the BN1 postcode area. 10% were from other postcode areas.
- 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%).
- 56% of admissions to Chalkhill in this period were referred from other Sussex Partnership Teams, 38% were from the Community Mental Health Team, and 6% were emergency admissions.
- The average total ward length of stay (including Home Leave) was 55 days. Not including Home Leave, the average total ward length of stay was 33 days.
- 84% of patients in this 5 year period were discharged when their treatment was complete, in 12% of cases the discharge reason wasn't specified, in 3% of cases no treatment was required, and 1% of cases the discharge reason was recorded as 'not applicable'.
- 87% of patients were discharged to their 'usual place of residence', 7% of cases were discharged to Local Authority foster care. The remaining 6% of cases were discharged to secure units, temporary places of residence or other NHS facilities for mental health or learning disability.

1.1.4.3 Tier 4 admissions out of area

In 2014/15 there were eight admissions for Brighton & Hove young people to Tier 4 out of area, relating to fewer than five individuals (some patients had multiple admissions). In each of the four years previously there were fewer than five admissions out of area.

Data from the last two financial years 2013/14 and 2014/15 (n=11 admissions) shows that the average length of stay for out of area Tier 4 admissions was 116 days. Eight of these 11 admissions were re-admissions.

Reasons for admissions included eating disorder, psychosis, attachment disorder, PTSD, ADHD, and Dissociative Identity Disorder. Seven of 11 discharges were to the young person's home. The average age for patients admitted out of area over this two year period was 15, and patients were predominantly female.

[i] University of Brighton, 'Student Services, Counselling and Wellbeing Annual Report 2013-14'
[ii] BHCC, 'Virtual School for Children in Care: Annual Self-evaluation' 2014
[iii] Safety Net, 'Safety Net Project Report; Emotional Wellbeing for 8-13 year old children and young people in Brighton & Hove', July 2015.
[iv] Public Health England, 'YP Specialist Substance Misuse Interventions – Executive Summary', Q4 2014-15
[v] Allsorts Youth Project, '*Allsorts Annual Report, Year Ending March 2014'*
[vi] Allsorts Youth Project, '*Allsorts Survey Report, Q3 & Q4'*, 2015
[vii] Allsorts youth Project, '*TAG LBGT Trans Survey Report 2014-15 Q3-Q4'* 2015
[viii] YMCA DownsLink Group, 'The WiSE Project Annual Report', 2014-15
[ix] INSERT REFERENCE
[x] NHS Benchmarking Network, Presentation to the South East MH CEO Group '*Mental Health Benchmarking'*, July 2015.

Family or Carers decide to ask for help with a Child or Adolescent Mental Health or Emotional Wellbeing concern.

Professional considers making a referral. Discusses this with the family or young person.

Direct Self Referral

Pre Referral Consultations # from Community CAMHS (T2)
Tel: 01273 294411

Urgent Referral or Duty Call to CAMHS (Tier 3)
Tel: 01273 718680

Key to abreviations
TAPA = Teen to Adult Personal Advisers
YOS = Youth Offending Service
RUOK = Young people's substance misuse Service
YAC Youth Advice Centre
YPC Young Peoples Centre
EPS = Educational Psychology
FCAF = Family Common Assessment Framework
TAF = Team Around the Family Mtg

No Further Action from CAMHS/CCAMHS

All Referral received for CAMHS/Com CAMHS by T3 Admin

Signpost or redirect to appropriate service(s) e.g. *YAC, YPC, School Counselling, Health Visitor, Seaside View, Social Services, EPS, Parenting Team.

T3 Duty Worker Involvement

URGENT/ HIGH RISK Referrals

T3 duty assess whether can wait for Triage

T3 allocate immediately

T4 Services

Weekly Referrals Meeting between T2/T3

Request further info

Com CAMHS

CAMHS

TAPA
Clients who have not engaged with T2/3

RUOK

Y.O.S.
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Pre Referral consultations are offered by Com CAMHS staff, initially this would be by a telephone consultation. This is offered to parents, carers and professionals, for them to discuss concerns about young people's emotional wellbeing and mental health. If needed a Primary Mental Health Worker (PMHW) / Family Support Worker (FSW) could attend a Team Around the Family meeting (TAF) or other meeting to discuss/consult on most appropriate emotional wellbeing or mental health intervention for a young person and their family.

NHS Brighton & Hove City Council Sussex Partnership NHS

NHS Brighton & Hove City Council

Sussex Partnership NHS
NHS Foundation Trust

Brighton and Hove CAMHS (Child and Adolescent Mental Health Service) and Brighton and Hove Community CAMHS (Com CAMHS) GUIDANCE FOR REFERRERS

For **urgent** referrals contact the CAMHS duty worker on
Tel: 01273 718680 (08.30 – 17.00) *Fax: 01273 738407*
For non-urgent advice or to book a ***pre referral consultation*** *contact Com CAMHS Tel: 01273 29 4411/ 3481*
Send ALL referrals to: Specialist CAMHS, The Aldrington Centre 35 New Church Road, Hove, BN3 4AG
Please state if a Looked after Child (LAC) or Adopted Child is being referred

Problem	What information is required		Referral Pathway
ADHD	Child should have marked difficulties in concentration, hyperactivity and impulsivity, with evidence of this occurring in both school and home environment with a detrimental impact on functioning.	Consider Early Help Hub referral first.	Parenting intervention such as PPP should have been tried prior to referral to CAMHS/Com CAMHS.
Anxiety / Phobias	**Mild** - Some difficulties in a single area but generally functioning well. Consistent minor difficulties with school work, mood changes of brief duration, fears and anxieties that do not lead to gross avoidant behaviours. **Moderate / Severe** – If affecting the child's development or level of functioning or dramatic deterioration in mood which is out of proportion to the family situation and impacting on the child and parents relationship.		**Mild** • School based pastoral care • School Counsellor • YAC or YPC (13+) • E-Motion online counselling **Moderate / Sever** Refer to CAMHS/Com CAMHS
Autistic Spectrum condition	Children with impaired social functioning, poor communication, rigidity in thinking, need for structure.	Consider getting advice from school EP or requesting pre-referral consultation from Com CAMHS	Primary School up to 11 year old – refer to Seaside View Secondary School Over 11 years old – refer to CAMHS

Problem	What information is required		Referral Pathway
Behavioural problems	**Early intervention** Families with children with developmental and behavioural problems should have already received significant advice and intervention from other named professionals such as health visitors, early intervention services such as Parenting Team and education support services. **More Severe:** • Significant impact on daily living • Significant delay in acquiring appropriate social skills • Significant difficulties with the child's peer relationships • Unusual or very fixed interests and bizarre or unusual behaviours • Marked preference for routine and difficulties in adapting to change • Hyperactivity, impulsivity, inattention in more than one setting ***For under 5s, refer to specialist visitor in first instance***	An Early Help Referral and interventions should have been tried before contacting CAMHS or Com CAMHS	**Early Help Hub** can be contacted on **01273 292632** Parenting team can be contacted to find out about PPP groups and workshops **01273 294471** Referral to CAMHS/CCAMHS only if interventions from other services have not had desired impact. Prior to a referral Com CAMHS can attend TAF to advise whether referral to mental services would be appropriate.
Bereavement/Grief	Children's response to grief can be varied and age-dependent. **Mild to moderate**, where children are experiencing difficulty in coping with issues of separation, loss, or significant changes in parental figures. --- **Moderate to severe** – extreme impact on child's functioning • Significant distress following traumatic loss or extreme circumstances • Where traumatic incident impacts upon the school group	For families with complex needs sometimes an Early Help referral is helpful .	**Prolonged grief** • Pastoral case – school counsellor • CRUSE • Winston's Wish • YPC or YAC (13+) • Contact Com CAMHS for consultation --- **Traumatic grief/Complex Bereavement** Refer to CAMHS/Com CAMHS

Problem	What information is required		Referral Pathway
Eating disorders	• Anorexia • Bulimia Should be referred via GP, so a doctor can make an assessment (blood tests, height, weight, BMI) to rule out physical complications.		Refer to CAMHS/Com CAMHS Please include height and weight of person being referred and any recent changes in weight.
Enuresis / Complex Soiling	Initial screening by GP and if appropriate paediatrician. Treatment should be overseen by School Nurses and Health Visitors.		Referral only if other interventions have failed. A pre-referral consultation with Com CAMHS can be helpful prior to referral being sent.
Family difficulties	Emotional discord in relation to family stresses/parental separation or divorce; including access issues	We believe it would be good practice to have a TAF in place with parent's agreement if multiple services are involved.	Consider mediation service such as Dialogue / Relate. Only refer to CAMHS/Com CAMHS if the issue is severe, complex and significantly impacting on a child's emotional wellbeing or mental health. We need evidence that other interventions have not been successful. An Early Help Hub referral should be considered.
	Where there are serious concerns about welfare safety of the child that need immediate investigation	Contact Social Services Advice Contact and Assessment Service (ACAS)	**Refer to Social Services** Safeguarding Team by contacting **MASH** on **01273 290400** if you have concerns about child's safety. Then consider a Com CAMHS/CAMHS referral or consultation if appropriate.
	If difficulties are associated with parental mental illness – GP to refer to Adult Services, who can contact CAMHS for joint working. Parental Substance misuse, refer to adult services.	We would advise that a Early Help Plan is considered if adult MH services are involved.	Refer to Adult Mental Health Services via GP.
	Legal issues / reports		**<u>Do not</u>** refer to CAMHS/Com CAMHS. Solicitors should commission these independently.

Problem	What information is required		Referral Pathway
Mood changes	Beyond age-appropriate mood variation, if this is considered to be a change from previous behaviour and if there is a significant impact on daily living e.g. sleeping, irritability, decrease in energy, social isolation, school performance and expressed thoughts of self-harm.	Dependent on level of need. If no TAF in place a we may recommend that an TAF be instigated	Refer to CAMHS/CCAMHS
Obsessive compulsive disorder	Please include description of obsessions (intrusive repetitive thoughts) and compulsions (repetitive, ritualistic unwanted action), as well as level of distress and impact on functioning.		Refer to CAMHS/CCAMHS
Psychosis	Please state symptoms, onset and impact. Immediate advice can be sought from Headspace (Early Intervention in Psychosis team) on 01273 764500 or Duty CAMHS worker on 01273 718680		Refer to Headspace or CAMHS/CCAMHS
School refusal or emotional problems in school	This is normally the responsibility of the school pastoral care professionals. These professionals can at any time discuss cases with practitioners from the Community Mental Health and Wellbeing Team and it is usual that they would make a referral into CAMHS/CCAMHS when the following conditions apply: • Severe difficulties in attending school resulting in prolonged absences • Severe emotional upset such as extreme fearful or anxiety	Early Help Plan is **essential** prior to referral.	Refer to CAMHS/CCAMHS only after involvement from school and only in cases where there is evidence of emotional distress.
Self harm	Describe self harm, duration of problem, method of self harm and last incident. Where there is concern about self harm in the context of other difficulties, referrers can contact CAMHS duty worker to discuss and determine priority before making a referral.		Refer to CAMHS. Can contact CAMHS duty worker on 01273 718680 to discuss. If urgent medical treatment needed take young person to A & E or call 999

Problem	What information is required		Referral Pathway
Selective Mutism	Where young person is able to speak in an age appropriate manner but is only speaking to certain people. This needs to have been happening for an extended period of time before referral i.e. 3-9 months	If child is involved with other services TAF is needed.	Refer to CAMHS/CCAMHS A pre referral consultation is advised.
Substance misuse	Where young person's main problems appear to be with substance misuse in the absence of a significant mental health problem, then the young person should be referred or self refer to RuOK?	N/A	Refer or give young person information from RuOK? http:/www.areyouok.org.uk 01273 293966
Trauma	Single event, we would expect normal support services to offer initial support. People who are known to child are often the people best place to offer support needed. CCAMHS able to offer consultation to support this. We need details of trauma and how it is impacting on young person Multiple events or significant traumatic experience. We need details of trauma and how it is impacting on young person. If trauma connected to DV consider ref to RISE. If trauma connected to Parental substance misuse consider a Young Oasis referral.	Dependent on level of need, If no TAF in place a we may recommend that an TAF be instigated As other services are likely to be involved we would expect Early Help Plan to be instigated prior to referral.	If normal support services do not effect change then a referral to CAMHS /CCAMHS. Refer to CAMHS/CCAMHS
Tourettes / Tic	Child has complex tics evident in both school and home environments which are impairing functioning. Please outline difficulties, describing tics and situations where more evident.		Refer to CAMHS/CCAMHS

Other Brighton and Hove services to consider for emotional wellbeing / mental health support of young people

- Allsorts (LGBT advice for young people) Tel: 01273 721211 Web: http://www.allsortsyouth.org.uk/
- Amaze (support for parents of children with speical needs) Tel: 01273 772289 Web: http://www.amazebrighton.org.uk/
- ACAS - Childrens Social Services Tel: 01273 295920 Fax: 01273 295910
- Dialogue (Counselling Service) Tel: 01273 320500 Web: http://www.dialoguecentre.org.uk/
- Early Intervention in Psychosis Service (EIP) Tel: 01273 764500 Fax: 01273 758789
- Educational Psychology Service Tel: 01273 290545 Web: http://www.brighton-hove.gov.uk/ (enter "Educational Psychology" into search box)
- MOSAIC (BME family support) Tel:01273 234017 Web: http://www.mosaicequalities.org.uk/
- NHS Direct Tel: 111 Web: http://www.nhsdirect.nhs.uk/
- Parenting Team Tel: 01273 294471 Web: http://www.brighton-hove.gov.uk/ (please enter "Parenting Team" into search box)
- Parentline Plus Tel: 0808 800 2222 Web: http://familylives.org.uk/
- Right Here (mental health for 0ver 16) Tel: 01273 222562 Web: http://right-here-brightonandhove.org.uk/
- RISE (Domestic Violence) Tel: 01273 622822 Web: http://www.riseuk.org.uk/
- RUOK (Young Peolple Substance Misuse) Tel: 01273 293966 Web: http://www.ruokservice.co.uk/
- Safe and Sorted (Young People's Drop in Service) Tel: 07734791200 Web: http://www.sussexcentralymca.org.uk/safe+sorted
- School and College Counselling Services Discuss with school or college attended
- Sussex Mental Health Line (5pm to 9am Mon to Fri - 24 hours weekend and bank holidays) Tel: 0300 500 101
- Young Oasis (Young People affected by substance misuse) Tel: 01273 696970 Web: http://www.oasisproject.org.uk/yp-services.html
- Where to go for (directory of B&H emotional wellbeing & mental health services for young people) Web: http://www.wheretogofor.co.uk/
- YAC (Youth Advice Service) Tel: 01273 889292 Web: http://www.hoveymca.org.uk/yac
- YPC (Youth Advice Service) Tel: 01273 887886 Web: http://ypc.ebabel.org.uk/

Useful national web resources

- Anxiety UK Web: http://www.anxietyuk.org.uk/
- Get Self Help(Cognitive Behaviour Therapy Self-help Resources) Web: http://www.getselfhelp.co.uk/
- Mindfulness Web: www.bemindful.co.uk or www.mindfulnet.org
- OCD UK Web: http://www.ocduk.org/
- Winston's Wish (Bereavement) Web: http://www.winstonswish.org.uk/
- Young minds (mental health) Web: http://www.youngminds.org.uk/

Summary of the Family Nurse Partnership Programme

Fairness Commission meeting on 10th December 2015

Date: **27th November 2015**

Author: **Lydie Dalton, Public Health Programme Lead for children and young people, Brighton & Hove City Council**

Background

The Family Nurse Partnership (FNP) is a voluntary, preventive programme offered to first time young mothers age 19 and under at conception. The programme offers intensive support in the form of structured home visits from early pregnancy until the child is 2 years old. The FNP is delivered by a team of trained Family Nurses, led by the FNP Supervisor. The FNP programme is a nationally licensed programme and must be delivered with fidelity to the FNP model in order to meet the licensing requirements. This includes a maximum caseload of 25 families per FNP nurse at any one time.

Funding and Delivery

The FNP programme in Brighton and Hove started in 2012/2013. The provider of the service is Sussex Community Trust (SCT). The programme was initially funded by Brighton & Hove City Council Children Services, with a contribution from Public Health, under the Children Services Value for Money programme. The objective of the Value for Money programme was a reduction in the number of children coming into care. In 2014, Children Services asked the Public Health Directorate to fund it wholly and following an internal Public Health review the service was fully funded by Public Health. The cost of the FNP programme in Brighton and Hove is £290,000 per annum.

FNP is now part of 0-5 services, which transferred from NHS England to Brighton & Hove City Council Public Health Directorate on 1st October 2015. The FNP programme reports to an Advisory Board - chaired by Public Health since October 2015, and is subject to an annual evaluation review. The next annual review will be in February 2016.

Evidence base

The following documents are attached to this report:

- The Brighton & Hove Family Nurse Partnership Annual review 2014/2015;
- The *Building Blocks* Randomised Controlled Trial (RCT), published in the Lancet in October 2015

The FNP was established on evidence from a similar programme in the United States and adapted for use in England using young age (19 and under) as enrolment criteria. Hence it hasn't been possible to compare like for like the programmes in England and in America. The first RCT of the FNP in this country was recently published in The Lancet. The *Building Blocks* RCT began six years ago and followed over 1,600 young mothers-to-be until their baby reached two years old. It focused on four primary outcomes and a range of secondary outcomes.

The trial showed that there were some positive effects on early child development and that FNP may prevent children slipping through the net by identifying safeguarding risks early. It also found that young mothers engaged well with FNP and especially valued the close and trusting relationship that they had with their family nurses. However, its effects on the main outcome measures were disappointing. The RCT did not find that the FNP service lowered the rates of subsequent pregnancy within two years. There were no differences between the intervention (FNP) group and control group (usual services) on the four primary outcomes (smoking in late pregnancy, birth weight, child A&E attendances/hospital admissions, subsequent pregnancy) overall or for key sub-groups.

The study also found that the FNP was not cost effective to the NHS by the child's second birthday on the basis of maternal health outcomes as measured by Quality Adjusted Life Years (QALYs). Cost effectiveness in relation to child outcomes was not assessed.

Following the trial some commentators have stated that part of the reason that the FNP was not found to be significantly better than health visiting services in this country, was that in

the UK, routine health visiting services are much stronger than equivalent routine care in the USA.

The 2014/15 Brighton & Hove FNP Annual Report shows that the FNP programme has some good short term outcomes including for breastfeeding initiation and continuation at 6 weeks and 6 months; clients' use of long acting reversible contraceptives (LARC), smoking intake in late pregnancy and early infancy, and low birth weight. Data on subsequent pregnancies within the two-year intervention will be collated by Public Health and the potential differences in outcomes between the FNP and health visiting case loads will be examined. Due to the programme being relatively recent and the two-year period of intensive support, longer-term outcomes in Brighton and Hove are not available.

Future of the FNP in Brighton and Hove

The programme is experiencing challenges of long-term staff sickness, which has meant that a significant number of cases are receiving a service from the mainstream health visiting services. This will also affect the evaluation of the programme.

There are also challenges due to the need to balance delivering the FNP programme and safeguarding concerns, for example the FNP team has to produce court reports, which are time consuming and have to meet strict court deadlines.

As is the case in all local authorities, the financial pressures due to the national reduction in the Public Health grant, as well as the wider financial pressures within councils' budgets mean that Public Health Directorates across the country are reviewing all their Public Health contracts.

In light of this, Public Health are exploring a range of options including moving from the licensed FNP, but retaining some of the strengths of the programme, into an enhanced vulnerable teenage parent pathway approach delivered through the main health visiting service. Health visitors would work to a more intensive delivery model for this cohort working closely with the Stronger Families programme. The pathway would also be developed in the context of services such as the Early Parenting Assessment Programme

(EPAP) to ensure complementary and avoid duplication. The timeframe for such a shift is likely to follow the review of Public Health nursing services with a view to a new model for all these services being in place by April 2017.

Link to the article in the Lancet about the Randomised Controlled Trial recently published

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00392-X/abstract

FNP Site	**Brighton and Hove**
Date of Annual Review	**22nd January 2015**

Local Authority(s)	**Brighton and Hove City Council**
NHS England Area Team	**Surrey & Sussex Area Team**
Chair of Advisory Board	**Jenni Thomas – Public Health Programme Manager / Trudy Mills – Public Health Commissioning Manager – Surrey & Sussex Area Team, NHS England**

Future Advisory Board Dates	**18th May 2015**
	21st September 2015
	7th December 2015
Date of next Annual Review	**To be confirmed**

Please describe any characteristics of Local Authority/Area (using information such as level of deprivation, child health profile, JSNA etc.)
Tell us "What is it like being a young parent (and their baby) growing up in Brighton and Hove today?"

In 2012 we had almost 59 thousand children and young people aged 0-19 years in the city, around six thousand more than in 2002. Over the next twenty years this is expected to increase to around 63 thousand. *[Office for National Statistics. 2013 Mid-year Population Estimates. London: Office for National Statistics; 2014.]*

Around one in five (21%) school children are from a black or minority ethnic group. *[Office for National Statistics. 2013 Mid-year Population Estimates. London: Office for National Statistics; 2014.]*

Around 20% (8,600) children live in poverty (lower than across England). Child poverty varies widely; East Brighton has 47% and Withdean just 7%. *[Brighton & Hove City Council. Joint Strategic Needs Assessment 2013. Brighton & Hove: Brighton & Hove City Council; 2013.]*

The rate of family homelessness is worse than England, with 302 statutory homeless households with dependent children/pregnant women (2012/13). *[Public Health England. Child Health Profiles. London: Public Health England; 2014.]*

For every ten thousand children in the city, 92 are in care compared with 60 in every ten thousand children across England. *[Public Health England. Child Health Profiles. London: Public Health England; 2014.]*

As many children are achieving a good level of development at the end of reception as the England average (both 60%), although this is lower for children with a free school meals status (42% for the city and 45% for England). (EYFSP 2014)

Achievement results in primary schools are similar to the national average, and provisional results for 2013/14 suggest that over half (53%) of GCSE students achieved 5 A*-C grades, the same as England. *[Department for Education. Provisional GCSE and equivalent results in England: 2013 to 2014. London: Department for Education; 2014.]*

More young people aged 16-18 years are not in education, training or employment (NEET) than the England average (7% in Brighton & Hove compared with 5%). *[Brighton & Hove City Council. Joint Strategic Needs Assessment 2013. Brighton & Hove: Brighton & Hove City Council; 2013.]*

The majority of pupils are often or sometimes happy, 92% of 15-16 year olds, but being anxious (often or sometimes) rises from 45% in 11-12 year olds to 57% in 15-16 year olds. The following groups were less likely say they were often happy: girls, young carers, LGB and unsure pupils, those who need extra help, had truanted, been bullied, and those who have tried alcohol, taken drugs. *[Brighton & Hove City Council. Safe and Well at School Survey 2013. Brighton & Hove: Brighton & Hove City Council; 2014.]*

The majority of 11-14 year olds (69%) and the minority of 14-16 year olds (24%) have never tried alcohol - significant improvements from 2011. *[Brighton & Hove City Council. Safe and Well at School Survey 2013. Brighton & Hove: Brighton & Hove City Council; 2014.]*

The majority of 14-16 year olds have never taken drugs (77%), this has changed little since 2010. Of 14-16 year olds, 51% of reported being given alcohol and 5% drugs, by a family member or family friend. *[Brighton & Hove City Council. Safe and Well at School Survey 2013. Brighton & Hove: Brighton & Hove City Council; 2014.]*

Almost two thirds (65%) of 14-16 year olds have ever been in a relationship where they have had a boyfriend or girlfriend. Of these 22% had experienced any of the following: been yelled at; put down and/or humiliated; been hit, kicked, pushed or slapped; exchanged sexualised/naked pictures or photos; threatened if they didn't want to do something their partner wanted or been constantly checked up on. *[Brighton & Hove City Council. Safe and Well at School Survey 2013. Brighton & Hove: Brighton & Hove City Council; 2014.]*

There are significantly higher rates of hospital admissions for both self-harm and alcohol for young people in Brighton & Hove. *[Public Health England. Child Health Profiles. London: Public Health England; 2014.]*

Team 1	Name	WTE
Supervisor	**Terry Ragbourne**	1.00
Family Nurses	**Amanda Tamlyn**	1.00
	Debbie Lees	0.93
	Lisa Cosgrove	1.00
	Kit Francis	1.00
	Stephanie Hardy	0.80
Quality Support	**Post Vacant**	

Team 2*	Name	WTE
Supervisor		
Family Nurses		
Quality Support		

*** If applicable**

FNP Advisory Board Membership		
Name	Role	Attendance
Brenda Davis	**Consultant Clinical Specialist – Sussex CMHS**	0 of 3
Caroline Parker	**Head of Sure Start – BHCC**	3 of 3
Cas Short	**Practice Manager – EPAP – BHCC**	1 of 3
Chris Parfitt	**Service Manager – Youth and Communities – BHCC**	0 of 1
Dulcie McBride	**FNP Service Development Lead (South East)**	0 of 3
Emma Cockerell	**Head of Service for MASH and Assessment – BHCC**	2 of 3
Fran Boulter	**Service Manager – Mental Health Care – Sussex Partnership**	0 of 3
Gillian Luckock	**Practice Manager – EPAP – BHCC**	0 of 3
Jane Griffiths	**Senior Practitioner – Prevention and Recovery Service – RISE**	1 of 1
Jenni Thomas	**Public Health Programme Manager – Surrey and Sussex Area Team – NHS England**	3 of 3
Joanna Sharp	**Commissioning Officer – Housing – BHCC**	2 of 3
Joe Harding	**Housing Options Manager – Housing – BHCC**	0 of 3
Kerry Clarke	**Strategic Commissioner – Children's Services – Public Health Commissioning – BHCC**	1 of 1
Lydie Lawrence	**Public Health Programme Manager – Public Health Commissioning – BHCC**	1 of 2
Marion Wilyman	**Manager – Community Midwives – BSUH**	0 of 3
Mary Flynn	**Name Doctor for NHS and B&H - NHS**	0 of 3
Matthew Stone	**Specialist CAMHS Service Manager – Sussex Partnership**	1 of 1
Mitch Denny	**Teenage Parent Midwife – BSUH**	0 of 3
Peter Joyce	**CAMHS General Manager for East Sussex – Sussex Partnership**	0 of 1
Siobhan Hier	**Sure Start Service Manager / Professional Lead for Health Visiting – BHCC**	3 of 3
Terry Ragbourne	**Family Nurse Supervisor - BHCC**	3 of 3
Trudy Mills	**Public Health Commissioning Manager – Surrey & Sussex Area Team – NHS England**	0 of 3

1 – Vision & Aspirations: *(to be completed by the FNP Advisory Board and presented by the Chair)*

- **What kind of future do you want for the young parents and their babies living in Brighton and Hove?**
- **What are your aspirations for them and how do you want to see progress and make changes?**

Brighton & Hove: The Connected City – our Sustainable Community Strategy

"It is vitally important that young people get the absolute best start in life and enjoy a stable, healthy childhood, a good education, fun new experiences and the confidence, ability and opportunity to obtain meaningful employment….. A good start provides the bedrock for a happy and fulfilling life."

The FNP Programme in Brighton and Hove, working with partner agencies in health and social care, aims to help young families and children to have the best possible start in life. The aspiration is to build strong foundations that support young people to fulfil their potential and achieve the best possible health and social outcomes.

The three aims of FNP to improve pregnancy outcomes, improve child health and development and improve parents' economic self-sufficiency fit well with those of the East Sussex Early Help Strategy which aims to work together in partnership with parents, children and communities to '*make sure that all of our children and young people have the best possible start in life, so that everyone has the opportunity to fulfil their potential, whatever that might be, and to be happy, healthy and safe*.' Corporate Plan 2011-2015

Some of the key principles underpinning the vision and approach to Early Help within Brighton and Hove resonate strongly with those of FNP namely that:

- Early Help requires a collaborative approach and will be best tackled in partnership with all those supporting and working with children, young people and families across the city
- Adult and children's services across the city should work together to put processes in place for the effective assessment of the needs of children, young people and their families.
- For services to be effective they should be based on a clear understanding of the needs and views of children: a child-centred approach
- To recognise and utilise the strengths and expertise within parents, families and communities
- There should be an integrated and evidence based approach to services and support.

There is a firm commitment to Early Help in Brighton and Hove to achieve better outcomes for children and young people and an increasing recognition that a focus on early intervention and in particular the application of evidence based programmes can make a significant contribution to better outcomes for children and families. Therefore the results of the UK randomised controlled trial for FNP are keenly awaited with the expectation for similar outcomes as those seen from the implementation of FNP in the US.

2 – Strategy: *(to be completed by the FNP Advisory Board and presented by the FNP Chair)*

Please describe the three or four keys steps to support your aspirations for young parents over the last 12 months and also your plans for the next 12 months:

- How does FNP relate to the wider universal and targeted services offer?
- How is that supported strategically?
    - (e.g. Strategic Partnerships; FNP within local strategies, plans and policies)
- How will you grow FNP?

Describe your current strategy for FNP and recent actions to promote the programme across your local system
The key priority over the last 12 months has been to consolidate the strength of the programme within the city. The programme has been funded jointly by both public health and the council to date, recently it has been confirmed that Public Health will assume full responsibility for the funding of the programme. The commissioning of the programme, ensuring its quality and delivery of the fidelity goals under the license remains the responsibility of NHS England until October 2015 when this passes across to the Local Authority as part of the transfer of the 0-5 Healthy Child Programme. The Family Nurse Partnership contributes to the city's Early Help strategy to contribute to the Council's Corporate Plan priority of reducing inequalities and making sure that "all of our young people have the best possible start in life, so that everyone has the opportunity to fulfil their potential, whatever that might be, and to be happy, healthy and safe". The Early Help strategy aims to provide a range of evidenced based programmes and to shift investment towards prevention, early intervention and community provision. FNP has been highlighted in the strategy as an example of this approach. FNP also contributes to the city's Health Visitor Implementation Plan and is contributing both to the increase in health visitor posts and the HCP levels of service. FNP is based and managed as part of the city's integrated health visitor led Children's Centre service and is therefore well placed to influence future developments. FNP is covered by the 0-19 Healthy Child Programme Transition Board. This includes representatives from the local authority including the Director of Public Health, Sussex Community NHS Trust and NHS England. The Board will consider how FNP will be developed in the future.
Describe actions for developing/implementing your strategy over the next 12 months (three/four key steps/stages)
The area team have set up the Brighton and Hove 0-19 Transition Board bi- monthly, membership includes representation from Public Health, the local service Provider for HV and FNP and the Head of Sure Start and the Associate Director for Children Services. Further work is needed now in preparation for Transition in 2015 to ensure safe transfer of commissioning responsibilities. Transition plans have been developed and monitored through the transition board meetings. These plans will ensure preparedness for the transfer of commissioning responsibilities for FNP.

3 – FNP Advisory Board: *(to be completed by the FNP Advisory Board and presented by the Chair)*

Please describe the FNP Advisory Board (FAB) taking into account the following key points:

- How does the Advisory Board lead, promote and support the integrating and embedding of FNP both strategically and operationally?
- How does the Advisory Board promote Programme quality?
- How does the Advisory Board fulfil its governance and accountabilities (including clinical guidance)?
- How does the Advisory Board engage FNP with the broader strategic agenda for children, young people and family support?
- Please describe the frequency of meetings, membership/attendance including client involvement and participation

Describe progress over the last 12 months (including progress from previous Annual Report)
The FNP board has met quarterly at one of the local children's centres. At each meeting the Supervisor reports key performance data and on a quarterly basis an update against the fidelity measures. The supervisor will also raise any issues or areas of concern are brought to the attention of the Board to provide guidance and support to address/resolve. During the course of the year client involvement in the Board was addressed and the agenda organised so that the end part would provide a chance for Board members to meet clients and hear first-hand what participation in FNP is like for them and those close to them. Board members have reported that this has helped them to appreciate the impact that the programme has on the clients' self-esteem, confidence and skill as parents and their plans for future education and/or employment. The Area Team have continued to Chair Board meetings but it is anticipated that from early in 2015 Public Health colleagues will assume this role in preparation for the transfer of commissioning of the 0-5 HCP in October 2015. The Advisory Board reports into the 0-19 Transition Board which provides the governance arrangements to oversee the performance and quality of the programme being delivered. The Board have closely monitored caseload data and regularly discuss the capacity of the teams and levels of safeguarding that they are managing. The Board also provides supports to the FNP Team responding to any necessary challenges the team have, for example staffing, caseload, capacity, housing and safeguarding concerns.

Areas for Action (Plans for the next 12 months)	Outcome (Where do we want to get to?)	Actions (How will we get there?)	Owner(s) and Timescales
Preparation for Transfer of Commissioning to LA in October 2015	To ensure the safe transfer of commissioning responsibilities and stability for the FNP programme and the FNP team in Brighton and Hove.	Transition plans have been developed and are monitored through the regular transition board meetings. These plans will ensure preparedness for the transfer of commissioning responsibilities for FNP.	NHS England and Brighton and Hove CC Public Health Team
		Transfer of FNP Board chair to Brighton and Hove CC Public Health Team in early 2015 to assist smooth transition	NHS England and Brighton and Hove CC Public Health Team

4 – Provider Leadership: *(to be completed and presented by the Provider Lead)*

As a provider organisation:

- How are you supporting the operational delivery of FNP (including clinical governance)?
- How are you supporting FNP strategically?
- How is the Supervisor (and team) being supported within the organisation (e.g. supervision for the supervisor, clinical supervision, management)?

Describe progress over the last 12 months (Analysis and Narrative)
There is high level commitment to this programme from Brighton and Hove Children's Services. Over the past year our Public Health agreed to fund the whole programme. It has a strong evidence base and the nurses are trained to a high standard, they are gaining more skills and competencies as the programme in Brighton and Hove develops. The FNP board have met regularly and achieved the actions identified at the last annual review. There is good engagement with partners on the board. Despite challenges with sickness and maternity leave in the team the programme has progressed significantly though the leadership of the supervisor and the commitment of the nurses. The administrator vacancy has disrupted the team functioning to some degree and created more work for the supervisor. We have tried to ensure that temporary cover is available with some success. This post has been advertised again. We provide accommodation at one of largest Children's Centre in the east of the city where most of the young parents live. This is a children's centre with school nurses and midwives also based there. This venue reduces travel time for the nurses and being in a large children's centre team provides a dynamic and professional base from which to work. There are some pressures on space for the team but this needs to be seen in the context of the pressures on space on the other teams in the centre. The team have moved into a better space out of the large open plan office they were in last year which is much better. The team are likely now to be at their 'peak' in terms of resources they need storage for as they are near their capacity Provider Lead manages and supervises the FN supervisor monthly and has regular ad hoc conversation as required. FNP is represented through FNP supervisor on the Quality and Standards Group and she is part of the management team which meets monthly. Training needs are identified and agreed where appropriate. The supervisor is contributing to the HV roll out of the Ages and Stages tool for 2-21/2 year old review at a presentation to all HVs on 11th February.

Describe progress over the last 12 months (Analysis and Narrative)
Computer issues have continued to be a problem but a solution has been agreed and should be resolved. SystmOne plan for the rollout of electronic records and mobile working is likely to be in early Autumn 2015 Three of the nurses have requested to reduce from fulltime to 4 days. This will be considered and another post may be recruited to. This will help the sustainability of the team.

Areas for Action (Plans for the next 12 months)	Outcome (Where do we want to get to?)	Actions (How will we get there?)	Owner(s) and Timescales
Improve IT Performance for the Team	The team will have efficient access to IT in the centre	Sussex HIS will work with Council IT to resolve	July 2015
Recruit another FN if current FNs Reduce their Hours	A more resilient FNP team	Reduce hours and recruit to another FN	When numbers of children each nurse is working with allow / when new FN is ready to take families.

5 – Safeguarding: *(to be completed and presented by the safeguarding representative)*

- Please describe your local FNP Safeguarding Model. How is this different from the recommended model in the FNP Management Manual?
- What are you doing to inform all relevant agencies of how FNP contributes to local safeguarding policies and practices?
- What are the local opportunities and challenges for the safeguarding of children and vulnerable adults on the FNP programme?
- What have you noticed about the ways FNP practice contributes to the safeguarding of children and vulnerable adults?
- What are the links with the Local Children's Safeguarding Board?
- What is the safeguarding representation on the FNP Advisory Board?

Describe progress over the last 12 months (Analysis and Narrative)

The model of safeguarding in Brighton and Hove follows the recommended model in the FNP management manual and DOH Working Together 2013.The key principles of this model are that: Safeguarding is everyone's responsibility and all those involved must play a full part in protecting children.

It is a child-centred approach: for services to be effective they should be based on a clear understanding of the needs and views of the children. The FNP programme is uniquely positioned to provide the kind of vigilance, support, trust, respect that the Working Together guidelines described by young people as essential qualities in the professionals who work with them.

The weekly /fortnightly visiting structure, the strengths based approach, observational skills and respectful curiosities that encompass the FNP programme are essential to ensure robust safeguarding practices

75% of the parents on the FNP programme are 18 or under, 53% are 17 or under. The team are mindful that both the children and their parents are subject to the Children Act 1989 and robust safeguarding practices require that the team are fully aware of their responsibilities

Since last year's Annual review tripartite supervision has commenced between the FN, Named Nurse Safeguarding Children and Supervisor. The Named Nurse also attends team meeting for group case discussion where the supervisor and named Nurse have revisited the ten Pitfalls of safeguarding. The Named Nurse also gives monthly individual and group supervision to the Supervisor and is available for ad hoc advice and also covers safeguarding issues in the Supervisor's absence.

The team is developing a relationship with a link SW who has attended one team meeting. The Supervisor is part of the Early assessment panel and FN are aware of recent safeguarding changes and the Early help hub and MASH. The team are forging positive links with Social care and FN intend to meet and revisit the FNP notification criteria and the role of a FN.

Describe progress over the last 12 months (Analysis and Narrative)

Of the clients enrolled onto the programme, 50% have either current or previous Social care involvement and 25% have been looked after children.

The FNs have had many compliments from Social care colleagues around the strength based working and positive relationships forged with clients.

A written quote from a recent conference report said:
"I chaired a conference yesterday attended by a FN and I thought the report was excellent (and that the model used by Family nurses is excellent) and that the FN's contribution to the conference was also excellent, asking really important and useful questions and being really clear about the strengths and the risks and contributing to the development of the plan." **Tom Stibbs, Safeguarding Manager, Quality Assurance and Safeguarding Unit**

The complexity of the caseloads continues to be a big issue within the team with clients who have been subject to neglect, emotional abuse, domestic abuse, mental health issues and child sexual exploitation.

The need to balance delivering the FNP programme and safeguarding concerns can be a challenge. The team have had to produce court reports which are time consuming and have to meet strict court deadlines.

The team has clients linked into WISE and are booked on to LSCB training around Child sexual exploitation. The FN will complete a DASH assessment when DA is of concern and link in with RISE and refer to MARAC. The team has had cases where clients have been threatened with knives, smothered with a pillow and has been stalked and harassed on social media sites.

The current Data reporting on DA at intake to the programme is as follows:
32.8% of clients have self reported that they have been abused by someone close to them
10% of clients are afraid of a current or previous partner
20% of clients have reported physical or sexual abuse in the last year

The FNP team have links with the LSCB via the Named Nurse who attends the LSCB Board and is an active member of the LSCB subgroups of Training, Monitoring & Evaluation and Child Protection Liaison Group. The FNP team records have recently been audited as part of a LSCB SCIE thematic audit looking at the quality of the antenatal assessments. The audit found that the quality of the FN records was good and outstanding with excellent interagency and partnership working. The recommendation following the Audit was for other agencies to adopt the FNP model of good practice.

Describe progress over the last 12 months (Analysis and Narrative)

2013 Data

CAF/TAF	14
LAC	2
Child in Need	14
Child Protection Plan	16

2014 Data

CAF/TAF	11
LAC	5
Child in Need	12
Child Protection Plan	12

The safe guarding figures vary throughout the programme. We currently have 4 clients who are having pre birth assessments and 8 who are no longer on CP plans and do not require Social work intervention. Two babies have step down plans from LAC, CP to CIN and 5 clients who have reduced from CP to CIN.

These figures are demonstrating that the FNP programme is reducing the need for Child Protection plans and that the FNP intervention is working to reduce risk and is safeguarding children.

All FN are up to date with their Level 3 Safeguarding Children Training.

Areas for Action (Plans for the next 12 months)	Outcome (Where do we want to get to?)	Actions (How will we get there?)	Owner(s) and Timescales
To Strengthen Further the Partnerships between FNP and Social Care	Good partnership working where there are safeguarding concerns.	The Supervisor will liaise with Emma Cockerell, Head of MASH, to highlight vulnerabilities and safeguarding requirements for the FNP Team.	Supervisor June 2015

6a – FNP Team: *(to be completed and presented by the FNP Supervisor)*

Describe what is working well in your area and where are the challenges and opportunities? Please include:

- Logistics (e.g. accommodation, IT, mobile working)
- Service user / client feedback
- Description of last 12 months (including any appointments, gaps in service etc.)
- Describe use of Supervisor Partnership Arrangements for observed practice
- Provision and use of psychological consultancy (include report if possible)

Describe progress over the last 12 months (Analysis and Narrative)
The FNP team are based at Roundabout Children's centre. The team has moved into an open plan office with the School Nurses. The team has forged good relationships with the teams which has contributed to positive multi-disciplinary working. The Children's centre is a friendly base to work from and allows the FN the opportunity of booking rooms to invite their clients into the Children's centre to meet with their Family Nurse and to use the facilities at the Children's centre. It is often more difficult to book rooms at other Children's centres in the community. **IT Mobile Working** One of the challenges to the team is poor and inconsistent IT connectivity which results in delayed data entry. The FN are covering a city wide area and returning to the office to collect, return and complete paper records and equipment can be time consuming and often requires duplication of information. The FN are currently visiting clients who are in LAC placements outside of the city and this is increasing travelling time. We were due to have SystmOne which would have reduced the need for storage of paper records. This is currently on hold. The Supervisor has met with the project lead for SystmOne who has acknowledged the issues experienced by the team and plans for the FN to pilot new mobile IT equipment. This will hopefully allow data entry to be inputted in the client's home in a timely manner and to reduce duplication of information as well as providing us with more efficient ways of working. **Lack of Storage Space** Another challenge is the lack of space for storage of resources and records. The Supervisor has liaised with the Service Support manager at the Children's centre re ordering cupboards and reorganising the office to create more space for resources and records.

Describe progress over the last 12 months (Analysis and Narrative)

Service Users' Feedback

Client feedback is asked for at set intervals during the FNP programme using the facilitator 'How's it going between us'. The feedback reflects the relationship that clients have with their FN and quotes are provided at the end of the end of the report.

The last 12 months has been a challenging time with one FN going on maternity leave and long term sickness in the team. The FN who was appointed to cover mat. Leave was unable to commence in the team until July 2014 and a secondment from the HV service was recruited in time to do her Pregnancy training (March 2014).

The FNP administrator left her post in March 2014 and the team to date have relied on Bank admin. The Admin post is currently advertised and has been successfully re-banded to a Band 4. When working in a small team, disruption such as sickness or vacant posts can impact adversely on a consistent, dedicated service. The remaining team have maintained their tenacious qualities taking on extra work of visiting vulnerable clients and reengaging them.

The current team consists of one Supervisor and five FN Family nurses. The original three Family nurses continue to work within the team and have embraced the new FN and have supported their learning. The new Family Nurses have brought a renewed enthusiasm to the team and are said to be enjoying their new roles. One FN has reduced her hours on a temporary basis and this will be reviewed in March 2015. A further FN has requested a reduction to her working week to 4 days. The two new FN are on a fixed term contract and a secondment basis from HVs.

The FN are currently working with 53% of their clients who are 17 and under. There are often safeguarding factors identified such as Sexual exploitation, domestic abuse and Mental health issues. To address these issues demands work over and above the delivery of the FNP programme. This is often complex and emotional work but despite this, FN are working to the fidelity requirements of the programme.

FNP Supervisor peer partnership arrangements are in place with neighbouring FNP teams and it is planned to buddy up with East borne in March 2015 for peer review and quality assurance of supervision. Psychological consultation takes place with the Supervisor monthly and monthly team meetings are held.

Please also see Appendix 1 – Psychology Report FNP 2014

Areas for Action (Plans for the next 12 months)	Outcome (Where do we want to get to?)	Actions (How will we get there?)	Owner(s) and Timescales
Recruit Quality Support Officer	Quality Support post filled	Recruit to vacancy	FNP Supervisor March 2015
Mobile Working	To have mobile devices	To work with SystmOne and FNs to pilot mobile working devices	IT services and FNP Supervisor, March 2015
Storage of Records and Equipment	To have safe storage of records which comply with information governance	To order new storage facilities	Service Support manager, February 2015

6b – FNP Team: *(to be completed and presented by the FNP Supervisor)*

Describe how the FNP team is delivering against the core model elements with a focus on practice that supports change.

- What have you noticed about the ways in which FNP learning has been integrated into practice?
- Describe your approach to team-based learning. What works well? What is new? What has been challenging?

Key points:

- FNP learning programme and competencies (include attendance at Supervisor Quality Improvement Days, Extended Practice Workshops and DANCE proficiency)
- One-to-one supervision, home visits with each family nurse and regular team meetings
- Use of the FNP Information System to accurately input data and use of reports to assess, manage and enhance programme quality
    - How are you using data clinically and in supervision?
- Dedicated administrative support for the team to quality assure data entered by Family Nurses (including timeliness) and providing general administrative support

Describe progress over the last 12 months (Analysis and Narrative)

The Core model elements of the programme have been maintained in accordance with the management manual.

Family Nurses

All the FN are registered with the NMC and meet the person Spec for a Family Nurse. The FN receive weekly supervision unless on leave, sickness or training.

The team have regular team learning days to aid reflection and consolidation of the programme. Having two new nurses in the team has endorsed the skills and knowledge that the existing team has acquired and revisiting the learning has been affirming. Specialists are invited to team meetings to share their expertise and to further support FN interventions with clients, to enhance partnership working and to work towards the outcomes of the FNP programme.

To date we have had representation from Domestic Abuse (DA) services, Mental Health, Contraception and Sexual Health (CASH) service, Midwifery, Youth Employment services, Parents involvement workers, Home Safety and Housing.

DANCE Proficiency

The Supervisor and four FN have recently attended DANCE training (December 2014) and are waiting to find out whether we are proficient in DANCE observations. The team have reflected on the DANCE training finding the training intensive but nevertheless they really enjoyed the training. The FN believe it has rounded off the developmental journey of FNP learning. We are looking forward to embedding DANCE into practice. It has already altered the way the Family Nurses look at the Dyad between a caregiver and her baby. One FN is to complete her DANCE training in the new year and two Family nurses are to complete Toddler training and Compassionate Minds training in February/March 2015.

Describe progress over the last 12 months (Analysis and Narrative)
The Supervisor has attended Supervisor Quality Improvement days and the annual conference. The FN input their own data on to Open Exeter and FN are reminded to complete overdue forms with their clients. Data entry has recently been problematic due to slow IT connectivity and this has affected data completeness as well as lost time and frustration to FN. Each nurse receives a monthly report on their actual activity levels measured against their expected level of visits and this is discussed in supervision. This helps to determine engagement of clients and further ways are explored to promote engagement. **Admin Support** The team are currently relying on Bank admin and, although the quality of admin has been good and has supported the team, the team are looking forward to having dedicated admin who can support the FN to deliver the FNP programme by setting up an organised and well-resourced office. The post is currently advertised and it is hopeful that we will recruit good quality and dedicated admin who can support the supervisor and FN with addressing fidelity goals.

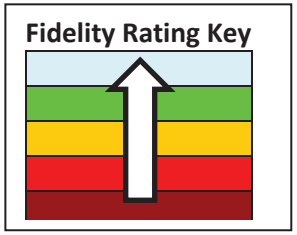
Areas for Action (Plans for the next 12 months)	Outcome (Where do we want to get to?)	Actions (How will we get there?)	Owner(s) and Timescales
To integrate DANCE into practice	All FNs proficient with DANCE training	Skill practice, joint visit with Supervisor and FNs to look at competencies in this field	FNs and Supervisor, June 2015

7 – Clinical Quality – Enrolment, Caseload and Attrition: *(to be completed and presented by the FNP Supervisor)*

- Please fill in progress for enrolment and attrition in the table below and describe any over or underperforming areas and plans for improvement.
- Describe caseload trajectories, intensity and distribution across the team (including Supervisor)

Key points:

- Sites enrol at least 60% of clients enrolled in the Programme by the 16th week of pregnancy and 100% no later than the 28th week;
- Each client enrolled is visited by the same family nurse throughout her pregnancy and the first two years of her child's life
- Percentage of clients offered the programme who are enrolled (please detail % uptake data and include analysis for previous 12 months)
- Eligibility criteria and client recruitment pathways



Describe progress over the last 12 months (Analysis and Narrative)
Recruitment: In the last 12 months 45% of clients have enrolled by 16 weeks of pregnancy. The team has received notification of late bookers of vulnerable clients and have had clients who have been initially difficult to engage. Looking at data on OE the majority of clients are enrolled by 17.5 weeks of pregnancy. Attrition within pregnancy and infancy has achieved fidelity with only 2.2% leavers in pregnancy and 13.9% leavers in infancy. These figures include three babies whom have been removed from their mothers' care and one client who moved out of Brighton /Hove. We have transferred 9 clients to other FNP sites and have had 3 transfers in. Some clients enrolled have been visited by 3 different Family nurses but this to date has not reflected on attrition.

Enrolment and Attrition (also refer to dashboard)		
Data for last 12 months	**Performance**	**Fidelity Goal**
Recruitment by 16 weeks	**45%**	60%
% enrolled who are offered FNP	**78%**	75%
Attrition (Programme Completers)	**N/A**	40%
Attrition (pregnancy)	**2.2%**	10%
Attrition (infancy)	**13.9%**	20%
Attrition (toddlerhood)	**0%**	10%

Team Capacity (places)	**Expected Caseload** (based on current team position)	**Actual Caseload**
112	**112**	**103**

Areas for Action (Plans for the next 12 months)	**Outcome (Where do we want to get to?)**	**Actions (How will we get there?)**	**Owner(s) and Timescales**
Recruitment by 16 weeks	To increase recruitment by 16 weeks to 60%	To look at engagement of clients	FNP Advisory Board, FNP Lead, Supervisor & nurses – 6 months
To revisit the notification pathway	To recruit the most vulnerable clients who will benefit most from the FNP.	To discuss notification criteria with the FNP Board	Supervisor and Sure Start Service Manager – 12 months

8 – Clinical Quality – Visit Dosage: *(to be completed and presented by the FNP Supervisor)*

Please fill in progress for visit dosage and average length of visit in the tables below and describe any over or underperforming areas and plans for improvement (include reference to fidelity stretch goals)

Describe progress over the last 12 months (Analysis and Narrative)
Dosage describes the number of visits offered to clients in each stage of the programme. The stretch goal for FNP is that 100% clients are offered at least 80% visits in pregnancy, 65% visits in infancy and 60% visits In infancy. Dosage within the pregnancy phase has reduced since last year's annual review this has been mainly due to staffing issues and clients who have not wanted later pregnancy visits. The work that the FN is doing to engage clients prior to enrolment is not captured in this data. More clients now sit within the infancy phase of the programme and it is reassuring to see that dosage is above the expected rate for those clients in this phase. The figure in toddlerhood is based on two programme completers. Average length of visit is slightly longer than the fidelity stretch goal, reflecting higher levels of programme delivery.

Visit Dosage (also refer to dashboard)		
Data for last 12 months	**Performance (Stage Completers)**	
Pregnancy	**55%**	% receiving ≥80% of expected visits*
Infancy	**76%**	% receiving ≥65% of expected visits*
Toddlerhood	**50%**	% receiving ≥60% of expected visits*
*N.B. fidelity stretch goal states that all clients receive the expected % of visits		

Average length of visit (also refer to dashboard)		
Data for last 12 months	**Performance**	**Fidelity Stretch Goal**
Pregnancy	**76**	≥60 mins
Infancy	**70.3**	≥60 mins
Toddlerhood	**63.3**	≥60 mins

Areas for Action (Plans for the next 12 months)	Outcome (Where do we want to get to?)	Actions (How will we get there?)	Owner(s) and Timescales
To Increase Pregnancy Dosage	To increase by at least 10%	To look at dosage in supervision and team meetings and to discuss ways to increase engagement. To make use of individual dashboards when available.	Supervisor Family nurses – On-going March 2015

9 – Clinical Quality – Programme Content: *(to be completed and presented by the FNP Supervisor)*

- Please fill in progress for programme content in the tables below and describe any over or underperforming areas and plans for improvement.

Key points:

- (Core Model Element) Follow the FNP Home Visit Guidelines and adapted programme guidelines, which specify the desired structure and content of each visit;
- (Core Model Elements) Apportion home visit time among content domains within the ranges specified.

Describe progress over the last 12 months (Analysis and Narrative)
The FNP team is delivering the programme content to the fidelity stretch goals which could account for low attrition. Similar to the national picture, environmental health domain continues to be above programme in toddlerhood but within normal domains in pregnancy and infancy There are challenges for suitable housing options for young parents in Brighton and Hove .The FNP have good relationships with housing support workers who will support the young person with housing difficulties. Personal health for clients can sometimes become the focus of visits as it is recognised that if a mother is in good personal health this will allow her to be emotionally available for her baby. The Psychology consultation supports management of clients with emotional regulation and mental health conditions. Life course development is slightly lower than the goal .The majority of the FNP clients remain in infancy phase and this will be revisited in supervision and team meetings. The performance on maternal role domain in pregnancy is higher than programme goal .On discussion with the FN this is often due to supporting clients to develop a nurturing a relationship with her unborn.

Programme content (also refer to dashboard)		
Last 12 months	**Performance**	**Goal**
Pregnancy		
Personal health	**38.8%**	35-40%
Environmental health	**7.1%**	5-7%
Life course development	**13.1%**	10-15%
Maternal role	**26.9%**	23-25%
Family & friends	**14.7%**	10-15%
Infancy		
Personal health	**21.1%**	14-20%
Environmental health	**9.9%**	7-10%
Life course development	**10.6%**	10-15%
Maternal role	**46.4%**	45-50%
Family & friends	**12.2%**	10-15%
Toddlerhood		
Personal health	**14.2%**	10-15%
Environmental health	**10.6%**	7-10%
Life course development	**13.3%**	18-20%
Maternal role	**45.1%**	40-45%
Family & friends	**12.7%**	10-15%

Areas for Action (Plans for the next 12 months)	Outcome (Where do we want to get to?)	Actions (How will we get there?)	Owner(s) and Timescales
Life Course Development	To work to the programme content.	To discuss in supervision and team meetings. To look at individual dashboards. To review programme material and ways to increase this domain. To link in Youth employment services.	Family Nurse / Family Nurse Supervisor April 2015.

10 – Demonstrating Impact: *(to be completed by the FNP Advisory Board and presented by the FNP Supervisor)*

Given the challenges identified locally, how is the Programme impacting on outcomes (health, social, emotional) for young parents and their babies?

- Please include some examples using client quotes/feedback, case studies, other evidence
- You may want to refer to the programme short term outcome data, other sources of information, observation, challenges and opportunities.

The FNs in Brighton and Hove are enrolling some of the most vulnerable clients that research suggests will benefit most from the positive outcomes of the FNP programme.

In Brighton and Hove 53 % of the clients enrolled on to the FNP programme are 17 and under and are data suggests that 36% of the FNP clients have no GCSE at any grade.62.2 % are NEET and 63.3%are living entirely on benefits. .
Lack of affordable and suitable housing for all living in Brighton is an issue.

The team currently have 10 clients living in emergency accommodation, two clients who have been sofa surfing and 12 clients in supported housing .The FNP data is suggesting that 43.6% of client have lived away from their Parents for 3 months or more under the age of 18. The majority of the FNP clients are in LA or other rented accommodation.
The team have improved links with housing support workers and have had a positive influence in rehousing pregnant clients.

The FNP team have received feedback from clients that they would like to attend groups for young parents. The FN have also recognised that a lot of clients are socially isolated. In response to this request the team have linked in with HVs and EYV at children's centres to set up groups that are run on a one Stop shops basis with relevant professionals supporting . The themes have been around attachment, home safety, Contraception, sexual health, healthy eating, youth employment services, and community learning. The groups have been well attended and have allowed clients the opportunity to meet with other young parents and services. The groups will support clients' transition from the FN service to universal services and increase their knowledge about services and opportunities.
Many clients have overcome much adversity and the FNs are supporting clients with their aspirations for the future. For some clients coming into a group has been a huge step and the Xmas party hosted by the FNP team was very well attended. It was great to observe positive interactions from clients with their children and the increasing confidence that the clients have gained.

The first two FNP clients have recently graduated and both have returned to college and have aspirations to go to university. Tom Scanlon, Public health consultant, spent the morning with the FNP team in June 2014. FNP clients were willing to meet and be visited by Tom and shared their experiences with him.

Given the challenges identified locally, how is the Programme impacting on outcomes (health, social, emotional) for young parents and their babies?

- Please include some examples using client quotes/feedback, case studies, other evidence
- You may want to refer to the programme short term outcome data, other sources of information, observation, challenges and opportunities.

FNP Quotes

"I enjoy the FN visits. She is none judgemental and has increased my confidence in being a Mum".

"The FN is friendly, if you need advice she is there for you".

"I would not be where I am now without Mandy. I love the FN programme and have learned a lot".

The FN at an enrolment visit when a client stated she definitely wanted the FNP programme as her friend had informed her "it was the best thing she has ever done".

"The FN has really helped me to be a great Mum. I am really glad that I have been able to be a different Mum from my own. I was in care as a child. I really believe I have changed the Cycle. I love my Son".

Comments from Grandmas:

"I like it when the FN comes around, I have learned a lot and it helps me to support my daughter".

"The programme makes her think for herself and it has increased her confidence".

"The FN has been the only professional who has included my son and has supported him to be a Dad".

From a Dad:

"My parent as a child was the TV. I was not good at school. I have learned a lot in the FNP programme about being a Dad .It has made me think about the starving children in Africa .I am really interested in my son's development and how I can help my child to be a brainy boy and do well at school".

From a Granddad:

"The FN is always positive, she always finds good things about my daughter and her parenting. I have seen my daughter increasing in confidence. She practises the games she has learned and enjoys singing and reading to her daughter".

Given the challenges identified locally, how is the Programme impacting on outcomes (health, social, emotional) for young parents and their babies?

- Please include some examples using client quotes/feedback, case studies, other evidence
- You may want to refer to the programme short term outcome data, other sources of information, observation, challenges and opportunities.

The following is evidence taken from Open Exeter and will look at short term outcome data since the start of the programme in October 2012:

Birth Statistics[Comparison with national average in brackets]

Birth Statistics [comparison with national average in brackets]	2013/2014	2012/2013
Percentage of Full Term Infants with a low birth weight	2.6% [4.1%]	2.8% [4.5]
Percentage of infants, including twins, that were premature (i.e. before 37 weeks gestation)	5.1% [11.4%]	7.8% [10.8%]
Percentage of infants who have spent any time in SCBU at birth	2.3% [7.4%]	7.4% [7.5%]
Median Time in Special Care Baby Unit (Days) at birth (of those infants who have spent any time in SCBU)	2 [5]	14 [5]

Comments:
Low birth weight is closely associated with disability and mortality in infants and children, with additional long-term health consequences in adulthood. Low birth weight is directly linked to the health and health behaviours of the mother before and during pregnancy (Bakeo and Clarke, 2006; Bradshaw, 2011; Chomitz et al, 1995). Brighton and Hove has a low percentage of low birth weight full-term infants and reflects clients making positive lifestyle choices in pregnancy and being mindful of their baby's health. The importance of a health pregnancy is paramount to gain positive outcomes for mother and baby.

The percentages of babies being born prematurely in 2013/2014 is lower than the national picture with fewer babies spending time in TMBU. In 2012 /.2013 the team had 2 premature births at 25wks and 28wks. I am pleased to say that both babies are developing well.

Given the challenges identified locally, how is the Programme impacting on outcomes (health, social, emotional) for young parents and their babies?

- Please include some examples using client quotes/feedback, case studies, other evidence
- You may want to refer to the programme short term outcome data, other sources of information, observation, challenges and opportunities.

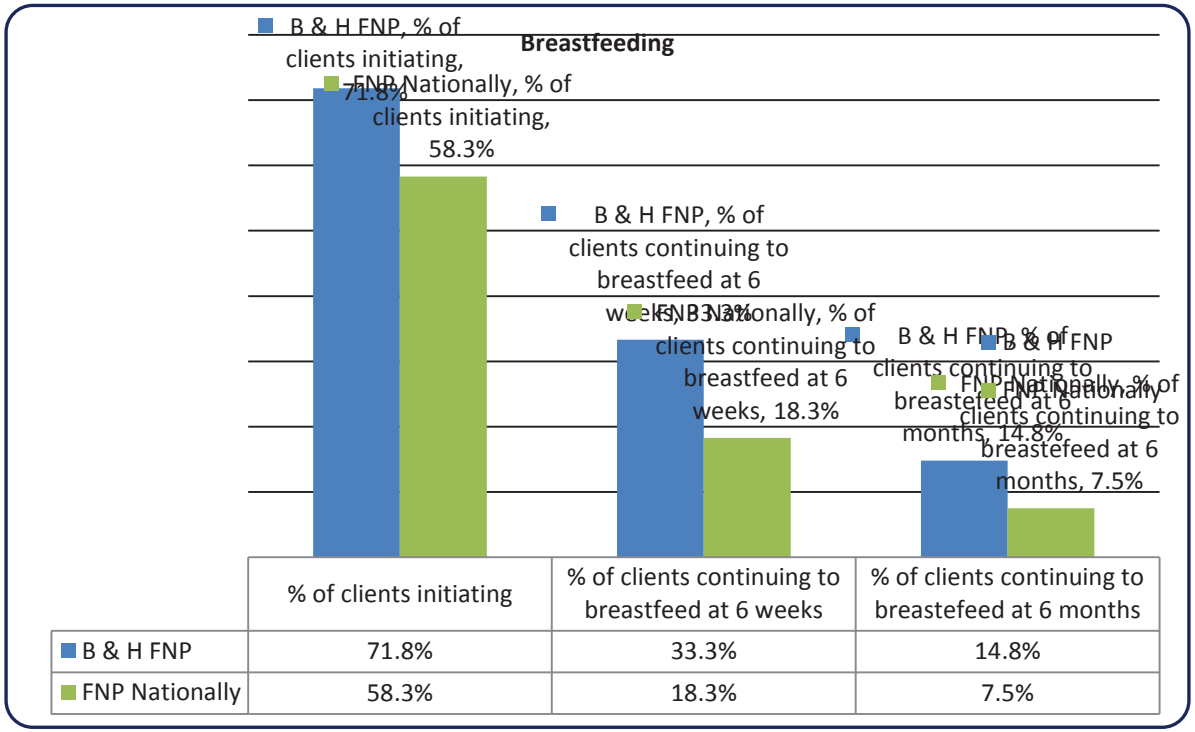
Smoking in Pregnancy / Early Infancy	2013/2014	2012 / 2013
Clients smoking at intake	54.5% [56.3% nationally]	69.2% [57.3% nationally]
Clients smoking at 36 weeks gestation	47.4% [53% nationally]	57.8% [53.8% nationally]
Clients smoking fewer cigarettes at 36 weeks gestation	57.7% [58.8% nationally]	55.6% [59.3% nationally]
Clients smoking at 6 weeks infancy	33.3 % [38.4% nationally)	46% [37.8% nationally]

Comments:
The amount of young women smoking at the beginning of the programme has fallen from last year and 57.7% of pregnant women are smoking fewer cigarettes at 36 weeks gestation. The nurses have utilised the many facilitators within the programme as to explore the benefits and drawbacks of smoking and skills of motivational interviewing to elicit change talk.

Carbon Monoxide Monitors are sometimes used to demonstrate levels of carbon monoxide and to discuss the effects of passive smoking. The family Nurses will direct clients to Smoking Cessation services and use positive affirmations when clients have reduced smoking and created smoke free zones. Many nurses have noticed improvements to the family home environment in previously smoke filled homes, with extended family members also taking on board advice. This practice remains following the birth of the baby.

Given the challenges identified locally, how is the Programme impacting on outcomes (health, social, emotional) for young parents and their babies?

- Please include some examples using client quotes/feedback, case studies, other evidence
- You may want to refer to the programme short term outcome data, other sources of information, observation, challenges and opportunities.



	% of clients initiating	% of clients continuing to breastfeed at 6 weeks	% of clients continuing to breastefeed at 6 months
B & H FNP	71.8%	33.3%	14.8%
FNP Nationally	58.3%	18.3%	7.5%

Comments:

One of the Brighton and Hove FNP Actions from the last review was to increase breastfeeding rates at 6 weeks .At the Annual review last year the breast feeding figures were reported to be 12.2% 2012/ 2013) The continuation of breastfeeding at 6 weeks 2013/2014 is 33.3% .The FNs aim to visit early in the post natal period to support breastfeeding. This is often the time that mothers will face challenges and switch to formula feeding. The FN will text clients with words of encouragement and affirmations for each day that they have continued. The Breast Feeding Support team will also support as needed. The FN have attended in house training.

Given the challenges identified locally, how is the Programme impacting on outcomes (health, social, emotional) for young parents and their babies?

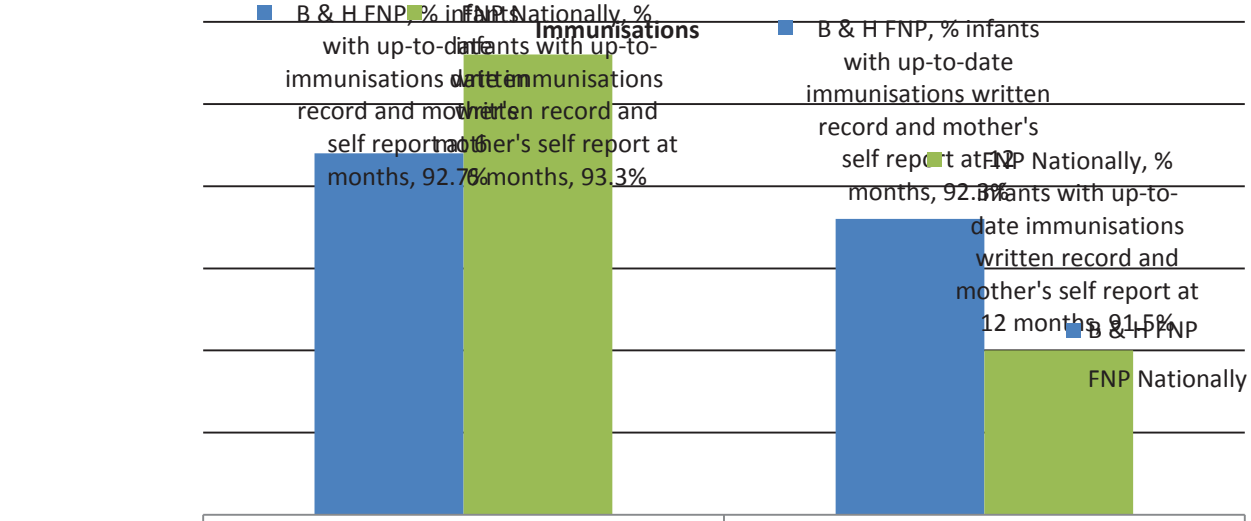
- Please include some examples using client quotes/feedback, case studies, other evidence
- You may want to refer to the programme short term outcome data, other sources of information, observation, challenges and opportunities.

A & E Attendance / Hospitalisation	2013/2014	2012/2013
A & E Attendances – clients with at least 1 visit to A & E with ingestation or injury between birth and 6 months	**2.1% [5.5% nationally)**	**1.7% (5.5% nationally)**
A & E Attendances – clients with at least 1 visit to A & E with ingestation or injury between birth and 12 months	**14.8% [11.0% nationally]**	**14.3% (11%nationally)**
Hospitalisations – clients with at least 1 admission to hospital due to ingestation or injury between birth and 6 months	**0.0% [0.9% nationally]**	**0%(1.2% nationally)**
Hospitalisations – clients with at least 1 admission to hospital due to ingestation or injury between birth and 12 months	**0.0% [1.2% nationally]**	**0% (1.2%)**

Comments:
We have an increased figure of A & E attendance between birth and 12 months. Following discussions with FN the following accidents have occurred to babies in Brighton and Hove: 2 minor injuries to forehead as a result of using a coffee table to walk around and losing balance and bumping head. Coffee tables are a feature of many homes. The supervisor has liaised with the liaison HV at the hospital .Receiving information that sustaining injuries from coffee tables is a common occurrence. The FN do a lot of work on home safety and anticipatory guidance is given re stages of development and prevention of accidents. We have a good links with safety net who will supply most home safety equipment. Including Cots and Highchairs. The numbers of babies having accidents is of concern but it equates to small numbers A&E attendance data should be treated cautiously, national comparisons would increase its meaningfulness and having local data would be helpful.

Given the challenges identified locally, how is the Programme impacting on outcomes (health, social, emotional) for young parents and their babies?

- Please include some examples using client quotes/feedback, case studies, other evidence
- You may want to refer to the programme short term outcome data, other sources of information, observation, challenges and opportunities.



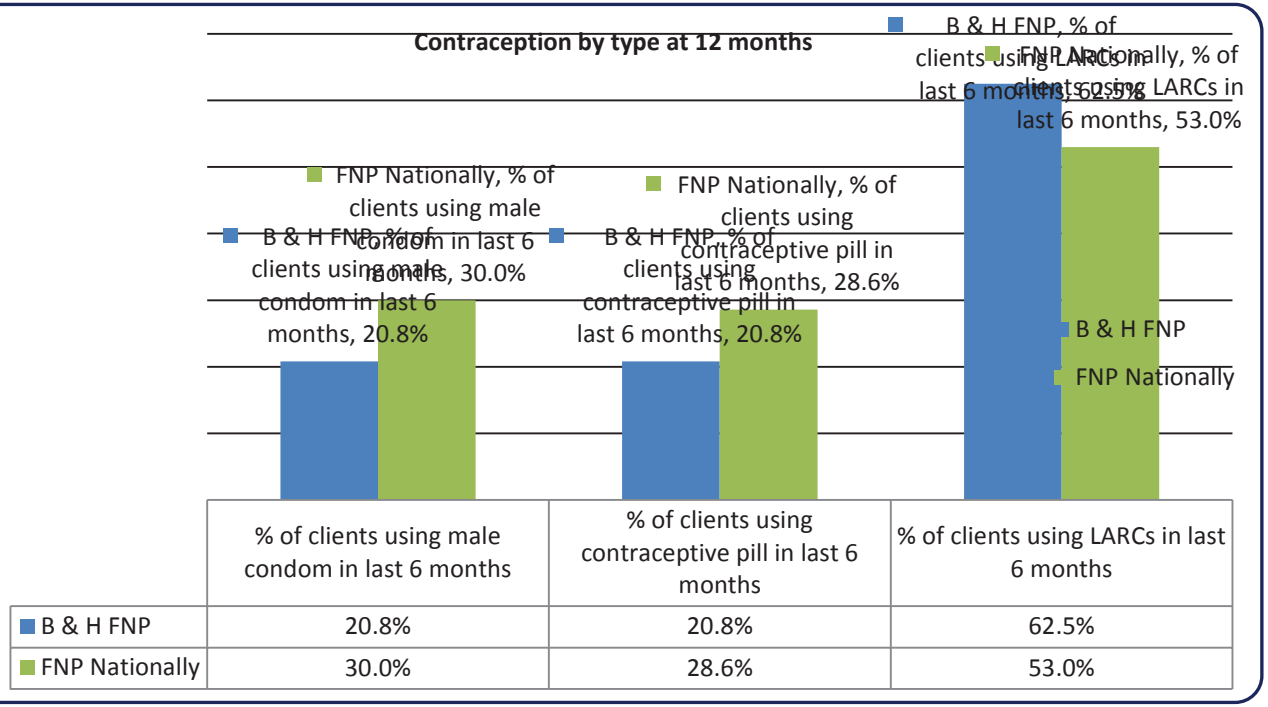
	% infants with up-to-date immunisations written record and mother's self report at 6 months	% infants with up-to-date immunisations written record and mother's self report at 12 months
B & H FNP	92.7%	92.3%
FNP Nationally	93.3%	91.5%

Comments:

FNP families are protecting their children from infectious diseases through immunisations. The FN are proactive in supporting and reminding clients to attend for immunisations.

Given the challenges identified locally, how is the Programme impacting on outcomes (health, social, emotional) for young parents and their babies?

- Please include some examples using client quotes/feedback, case studies, other evidence
- You may want to refer to the programme short term outcome data, other sources of information, observation, challenges and opportunities.



	% of clients using male condom in last 6 months	% of clients using contraceptive pill in last 6 months	% of clients using LARCs in last 6 months
B & H FNP	20.8%	20.8%	62.5%
FNP Nationally	30.0%	28.6%	53.0%

Comments:

For FNP clients who choose to use contraception 62.5% are using LARCs.This reflects the work FN and Contraception and sexual health services are doing with easy access to services.

Given the challenges identified locally, how is the Programme impacting on outcomes (health, social, emotional) for young parents and their babies?

- Please include some examples using client quotes/feedback, case studies, other evidence
- You may want to refer to the programme short term outcome data, other sources of information, observation, challenges and opportunities.

Developmental Assessment Progress

Ages and Stages are completed 6 monthly during the FNP programme and allow for early and accurante identification of any developmental concerns .The assessment enable the family nurse to identify areas of parenting that may require support. The use of PIPE and DANCE which is an FNP intervention used in pregnancy, infancy and toddlerhood allows the family nurse to identify problems early and to support the parents to make changes.

The high scores below reflect that babies in Brighton and Hove are achieving well and have to date not required referals to other services .The children who have shown delay in gross motor skills are monitored by the FN and to date have not needed refering to other services.

The FN team will support the Health visiting teams to intergrate Ages and stages into the 2 year review as part of the HCP and it will support the FNP to make comparisons with toddlers who have not been part of the FNP programme .

Ages and Stages	4 months		10 months	
	Mean Score	% Needing onward referral	Mean Score	% Needing onward referral
Communication	55.3	0%	55.6	0%
Fine Motor	51.9	0%	56.7	0%
Gross Motor	55.4	0%	51.9	12.5%
Personal – Social	56	0%	56.3	0%
Problem Solving	53.8	0%	56.3	0%

Areas for Action (Plans for the next 12 months)	Outcome (Where do we want to get to?)	Actions (How will we get there?)	Owner(s) and Timescales
To Reduce Child Accidents and Attendance at A/E	Lower accident rate to national average or below	To revisit FNP programme material and to link in with Safety Net	Family Nurses and Family Nurse Supervisor – On going
To Support the HV Teams to Integrate ASQs into the Healthy Child programme	Supervisor and FNs to be part of training schedule for Health Child Programme	Facilitate training in February 2015	Family Nurses and Family Nurse Supervisor – February 2015

11 – Successes and Achievements: *(to be completed by the FNP advisory board and presented by the FNP Supervisor)*

Please describe successes and achievements and any aspects of the team's work you are proud of over the last 12 months:
• Successfully retaining the majority of vulnerable clients during periods of staff absence. • Successfully rebuilding the team. • Increasing breastfeeding at 6 weeks. • Clients attending the Board. • Continuing to achieve fidelity within stretched goals. • Supporting clients to attend Children's Centres. • Forging good links with Children's centre staff and other services.
What is the ONE thing that you are most proud of and would be willing to share with other FNP sites and teams? Please describe and summarise below: (this might be an innovation, service improvement or way of working that might benefit other FNP teams)
Working within an integrated service and fostering positive relationships with Children's centre staff and other teams e.g. Mental Health, Housing ,Social care, Teenage pregnancy midwife, CASH: all have supported the team and have allowed it to be a smoother route making it easier for clients to access the services they require.

Appendix 1

PSYCHOLOGY REPORT for FNP - 2014

Dr Kate Alexander
Principal Clinical Psychologist,
Associate Parent-Infant Psychotherapist (AFC)

Clinical Supervision

Clinical supervision from a psychologist is an integral component of support for the FNP and is delivered within a structured format. This comprises:

- Group supervision on a monthly basis for the FNP team and FNP Supervisor together
- Individual supervision on a monthly basis for the FNP Supervisor alone.

The group supervision is primarily provided to encourage reflective practice among the Family Nurse team. Individual supervision to the FNP supervisor provides a forum for the wider issues of clinical oversight of the programme

Theoretical Focus

The supervision aims to replicate and mirror the strength based partnership model that underpins the FNP programme. The modality of delivery therefore draws upon Appreciative Inquiry, Solution Focused Therapy and Attachment. These frameworks allow for an analysis of safety and risk within the FNP therapeutic relationships which are often (though not always) situated within safeguarding or CP mandates.

Safety is defined as strengths demonstrated over time (**ref**). This is a key conceptual *psychological* focus for the delivery of a long-term therapeutic relationship outside the context of a formal psychotherapy setting.

Individual Supervision

General themes

Individual clinical supervision with the FNP supervisor is primarily a space to think through any issues that are particularly relevant or currently salient at that time. However there are recurrent themes which include: infant mental health and the inherent tensions of working within a parent-baby dyad, the systemic dynamics that accompany work with high-risk/complex families and the wider partnership issues related to safeguarding and CP.

These themes reflect, in part, that the FNP supervisor is responsible for potentially competing drivers. These are the need for adherence to a nationally licensed programme ***and*** the skilful embedding of the programme into a local and specific context. As a result, clinical supervision often provides a space simply to reflect upon the complex external ecological framework and relevant transactional partnerships.

Furthermore, over the last year, this FNP programme has developed beyond the ‘start-up’ phase and consequently many of the Nurses are up to their full quota of clients. This has resulted in an increasing focus on the caseloads of the Nurses,

particularly where they have had a high proportion of clients with particular vulnerabilities and/or child protection issues. In turn, this has led to a parallel processing of the role of FNP Supervisor, and reflection upon issues of caseload management, engagement/morale and team dynamics.

The on-going development of the programme needs a dynamic partnership between clinical supervisor and FNP supervisor. This offers a reflexive space to both parties in which to consider questions such as 'how are we working together? and 'what do we do well?' and 'what do we need to do next?'

Progress over the last twelve months

Infant mental health

Over the last twelve months, the FNP supervisor has skilfully and adeptly helped the team to keep a focus on the relationships between the parents and their babies while keeping the baby in the forefront of everyone's mind. Working within the dyadic relationship and holding a very large caseload is an exceptionally demanding task. Indeed, a workshop at the beginning of the year, attended by us all, highlighted the oscillating dynamic between 'break down and break through' - a dynamic which tends to characterize the stochastic development of infants ***and*** the affective experience of professionals working with them (Amanda Jones).

Most recently, DANCE training – a model of infant observation - has supported a more detailed focus on infant mental health within the FNP. Progress on in vivo infant observation i.e. attunement, mirroring and marking of the babies affective experience has therefore become a key area for development.

Areas for action

Infant observation training has now taken place. Early attachment patterns are provided by video examples, and the supervisor and clinical supervisor will now provide focused supervision on the components of interaction that constitute sensitive parenting (Tronick, 1975). Desired outcomes will include the psychologist supporting the training and practice in relation to infant observation and ensuring the team are provided with a safe space to build competencies in this area. Actions are likely to include individual supervisions that focus on the Nurses DANCE observations and bring them together with the wider experimental literature on IMH. This will include an analysis of early co-created (defensive) attachment patterns associated with later psychopathology (Beebe, 2012)

Risk and safeguarding

Individual supervision sessions about child protection and safeguarding are an essential component of the supervision package. While the FNP supervisor has special CP supervision, issues of risk/harm and strength/safety inevitably come into the clinical supervision with the psychologist. Where issues are particularly complex to weight or formulate, the supervision is used to explore in great detail the key psychological elements for consideration. This includes, though is not limited to, clinical exploration of adult psychopathology, MH, trauma and loss, and personality disorder. This has resulted in discussions about the boundaries of the Nurses therapeutic relationships and onward referrals to other mental health/perinatal practitioners.

Progress over the last twelve months

Over the last twelve months, the FNP supervisor and clinical supervisor have focused on formulations of safety and harm and begun to build a shared repertoire of cases to formulate these issues. The FNP supervisor has worked extremely hard to build and maintain relationships with the wider CP network and to evaluate at all times the relative needs of the babies and their parents. The clinical supervision has therefore been used, at times, to look at the dynamics of working in partnership with other agencies, and to maintain a reflexive stance within the different professional views present in each case.

The FNP supervisor is extremely skilled at managing CP liaison, and has been active in ensuring that the FNP has been integrated into formal CP procedures. However, the FNP does not have a mandate to investigate, only to report where relevant, and thus the FNP supervisor has to make frequent decisions on information/concerns reported to her from the Nurses team. These type of decisions carry a notoriously heavy psychological loading, and supervision provides an opportunity to take stock of this.

As a result, over the last year, there has been a noticeable increase in confidence and use of the reflective stance necessary for the calculus between over and under estimations of risk. This is a key competency for any professional working in CP, but it is particularly important where cases are taken from Universal services.

Areas for action

Individual supervision will continue to aim to provide a reflective forum designed to create possibilities for critical reflection. In this context, critical reflection includes and values *both* the explicit logical frames of thinking and intuitive reasoning including the contribution of emotions. This is because the emotional dimensions of working with babies and families play a significant part in how professionals reason and act, which '…if not explicitly discussed can be harmful…' (Munro Review of Child Protection. Interim report: The Childs Journey.ch.3, paras 6-10, p.35)

We will continue to think about complex cases with a view to deriving shared psychological case formulations i.e. what is really going on, rather than staying on the surface. This then guides future interventions by the Nurses and helps to avoid a fragmented symptom response pattern.

Group Supervision –progress over last year

General themes

Initially, Nurses appeared to be a little nervous about group supervision sessions with the Psychologist. However, over time, concerns seemed to dissipate. Over the last year in particular the Nurses have been an extremely active and engaged group, always willing to think through client issues, and comparing and contrasting different perspectives.

Often we have ensured that some time is dedicated in each group to focus on specific clients, particularly where there are critical clinical issues present (e.g. NAI, serious depression/anxiety, acute trauma). The group, therefore, provides a means to work through how best to approach client-specific issues and the clinical interface with programme implementation issues.

Thus, within group sessions, the Nurses have shared their learning and discussed the psychological issues inherent in their approach to delivering the programme materials with clients. At the beginning of the year, this seemed to be of particular importance as the group provided the opportunity for the team to observe programme materials being delivered by other Nurses in advance of delivering them themselves.

The group supervision also provides an opportunity for the Nurses think about how they are performing as a team. Specific groups have, at times, been dedicated to thinking through their challenges as a team and discussing how each of them as individuals have managed those challenges. We have looked at: stress and boundaries, compassionate minds, and taking care of ourselves, strategies to deal with anxiety

Specific groups

In the last 12 months, we have looked at: adult parental pathology, markers of psychopathology (e.g. passivity/avoidance) in babies, affect regulation, and intergeneration repetitions of trauma ('Ghosts in the Nursery'). We have also explored: the dynamics of the transference in perinatal work and how this relates to the stochastic learning of infants and early infantile switching between different states.

In the early part of the year, we considered anxiety, depression, PTSD and looked at how to use a strength-based approach with parents. This raised a key therapeutic dilemma about how to stay focused on 'what are you doing well' and 'what is making a difference?' and we explored the importance of attempting to remain in the 'here and now' of the therapeutic frame. However, since a key part of the early programme delivery necessitates taking a past history and family genogram, we also considered in depth matters such as: what difference does the past make, how do we weight past risk factors, how to manage reports of past trauma, when should we *not* ask questions.

At this time, we also looked in detail at anger and difficulties with affect regulation in young parents. More recently, I have presented a number of practice models in this area such as Danya Glazers model of Emotional Harm and some of the concepts from Mentalisation based treatment. Inevitably, this has led us on to discussions within group supervision about reflexivity and reflexive functioning, and the degree to which RF can constitute a safety factor in parenting.

Areas for action

As stated above, the team has now undertaken DANCE training, which is structured infant observation training on the micro 'serve and return' interactions that constitute sensitivity. Areas for action include a focused set of group sessions in which we investigate in detail the range of affective, cognitive and somatic categories that comprise the DANCE tool. This type of training can be very emotive as individual practitioners will be individually rated by the US license holders. We will therefore strive to ensure that the group supervision is experienced as a safe and supportive space to develop competencies in micro observation.

Areas for action might also include an on-going study of key IMH articles and the wider literature in this area.

Lastly, it will be important for the team to formulate collaborative outcomes for the next year of group supervisions and to consider where they wish to get to – this might include increased confidence in the CP arena, a focus now on the ending phases of their therapeutic relationships, i.e. strength-based endings and handover, and (possibly) an increasingly structured look at 'what are we proud of?' and 'what have we done well?'

Post Meeting – Summary and Improvement Plan (for completion by the Service Development Lead)

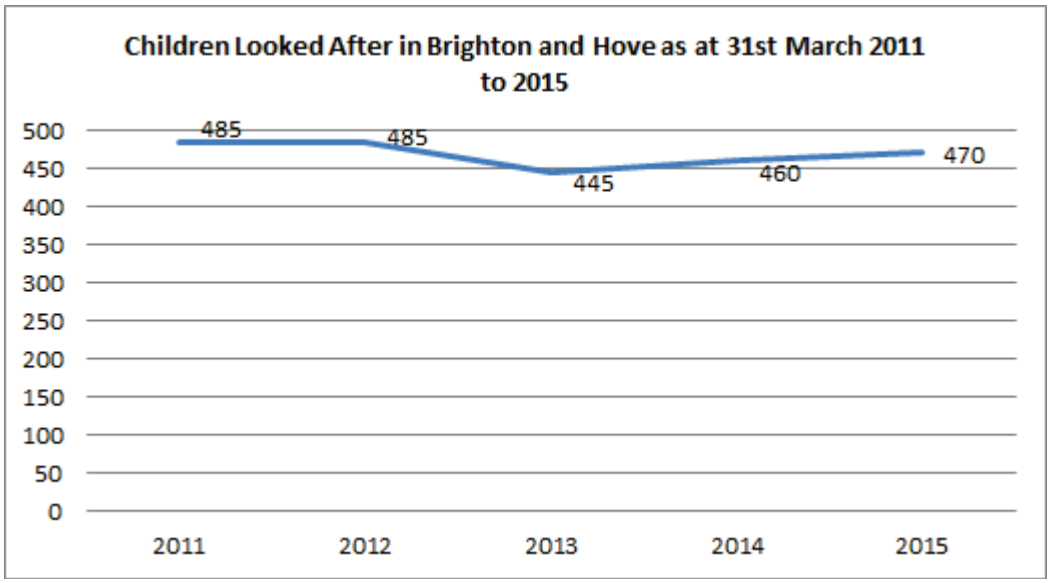
Themes from site
Narrative and Analysis

FNP Improvement Plan for "*INSERT NAME OF SITE*"			
Areas for Action (Plans for the next 12 months)	**Outcome (Where do we want to get to?)**	**Actions (How will we get there?)**	**Owner(s) and Timescales**

Children looked after year ending 31 March 2015

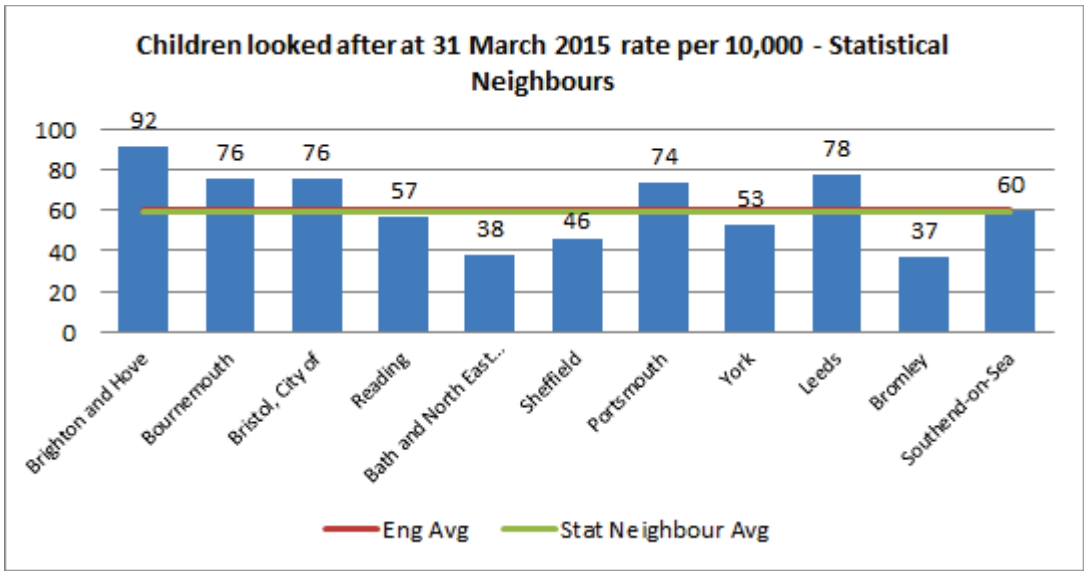
Please note that the source for the data in this briefing is the SSDA 903 Statistical First Release.

Figure 1: Children Looked After in Brighton and Hove as at 31st March 2011 to 2015



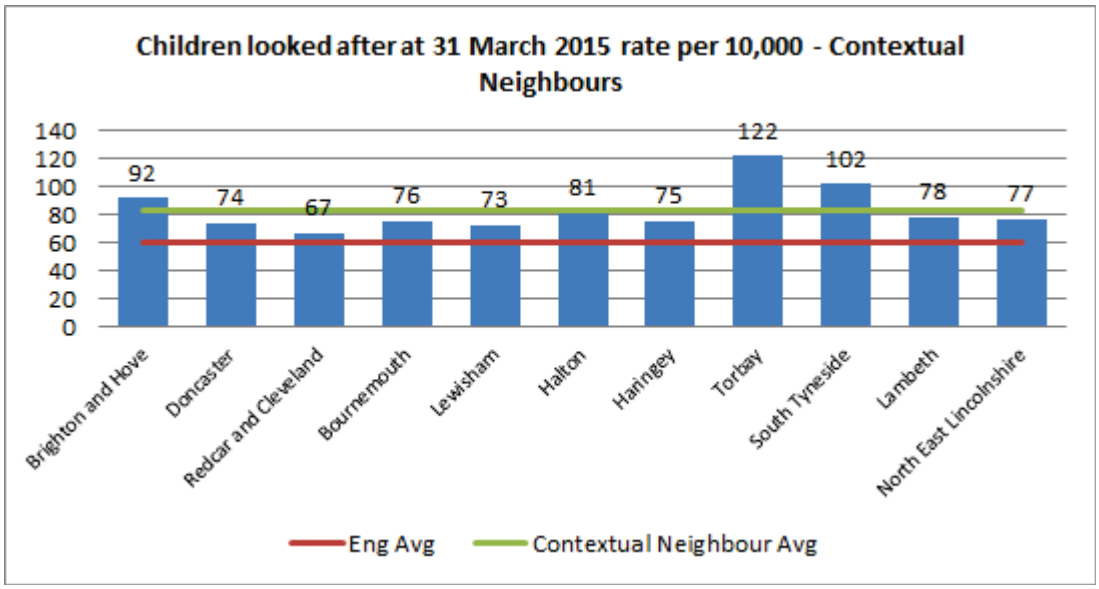
There were 470 children looked after as at 31st March 2015, an increase of 2% compared to 31st March 2014 and a decrease of 3% from 31st March 2011. Nationally, there were 69,540 looked after children at 31stMarch 2015, an increase of 1% compared to 31st March 2014 and an increase of 6% compared to 31st March 2011.

Figure 2: Children looked after at 31 March 2015 rate per 10,000 - Statistical Neighbours



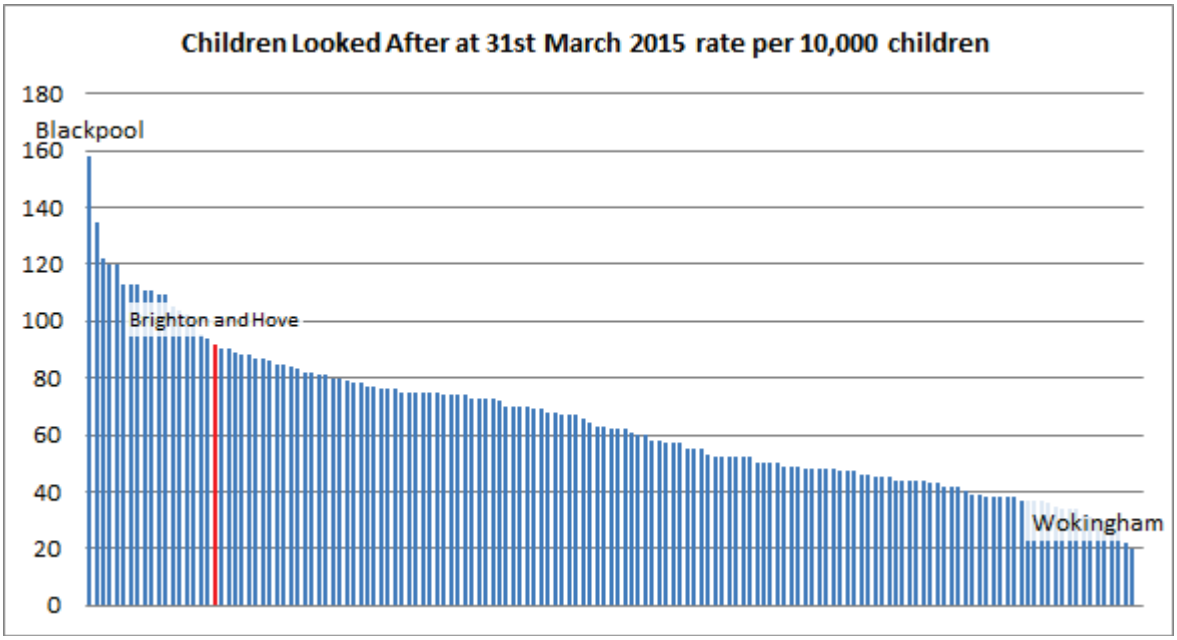
Brighton and Hove's rate of children looked after at 31st March 2015 per 10,000 children aged under 18 is 92, above the England average of 60 and statistical neighbour average of 59.5. The rate is highest in our statistical neighbour group, with Leeds second highest with a rate of 78.

Figure 3: Children looked after at 31 March 2015 rate per 10,000 - Contextual Neighbours



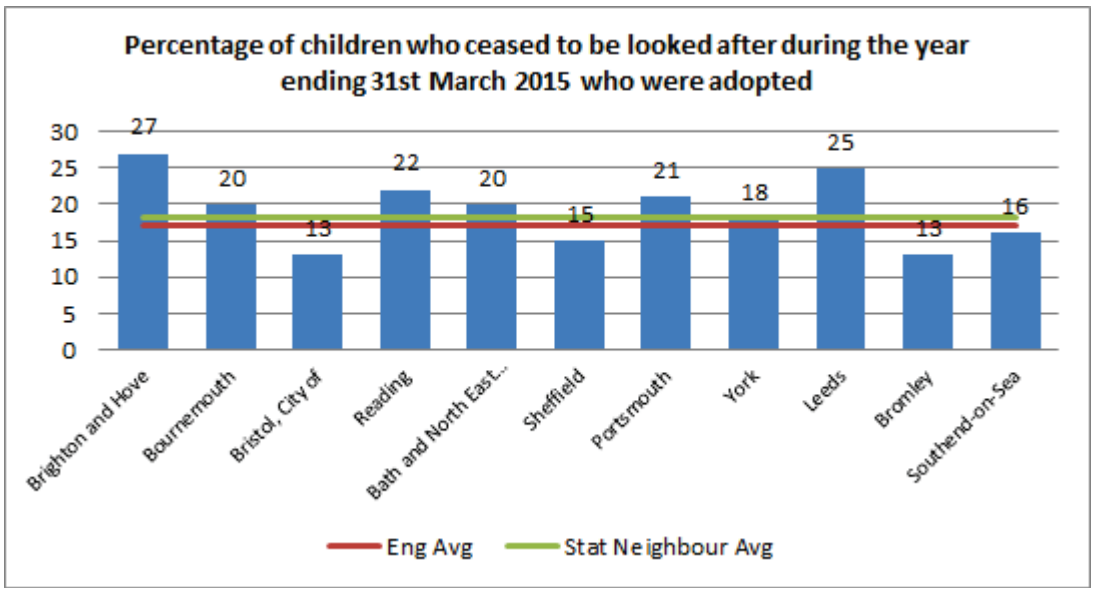
The rate of children looked after for our contextual neighbour group is 82.5, with Brighton and Hove third highest in our contextual neighbour group behind Torbay (122) and South Tyneside (102). Contextual neighbours are our 10 nearest authorities in terms of contextual factors based on Public Health analysis of deprivation, alcohol, drugs and mental health

Figure 4: Children looked after at 31st March 2015 rate per 10,000



Brighton and Hove's rate of children looked after is ranked 19th highest out of 152 Local Authorities in England, unchanged from last year. Blackpool is ranked highest nationally with a rate of 158 and Wokingham is ranked lowest with a rate of 20.

Figure 5: Percentage of children who ceased to be looked after during the year ending 31st March 2015 who were adopted



27% of children who ceased to be looked after during the year ending 31st March 2015 in Brighton and Hove were adopted, above the national average of 17% and statistical neighbour average of 18.3%. This is ranked joint 11th highest out of 149 Local Authorities in England with published figures.

Share your community group's views - FS750419

What does a fair city mean to you? : A fair city takes care of its most vulnerable residents. It creates opportunity for creative involvement in work and social life for all. Children and Young peoples rights are upheld and they are given the respect and resources they need to grow into healthy adults who have a stake in the city.

What is fair about life in Brighton & Hove at the moment?:

What is unfair about life in Brighton & Hove at the moment?: Children in care and careleavers are routinely discriminated against. They have the poorest life chances of all residents. They do not have access to the same opportunities as other young people. They are not able to exercise their rights properly in the city due to a lack of joined up work on corporate parenting.

What specific experience or evidence do you have about inequalities and fairness that may be of use to the Commission? : Children in care have the poorest outcomes. Careleavers are overrepresented in prisons, homeless etc. 37% of children in care return to their abusive birth family, yet no preparation or understanding of this is discussed at a strategic level. Careleavers have had to fight for priority housing, and were discriminated against by their own corporate parent. The city does not take collective responsiblity for children in care, the directorates of BHCC have yet to come together to embrace this, and the business community has never been galvanised to offer something to these children. Childrens services collects alot of data so all the evidence is there and has been for many years.

Based on your experience or evidence, what is your or your organisation's analysis of the causes of inequalities in Brighton & Hove? : These particular inequalities are perpetuated by a constant remodelling/reshaping of childrens social care, changes in DCS and administration. Not enough voice or influence given to childre in care and careleavers.

Are there any people or communities for whom life in Brighton & Hove is particularly unfair? : Our particular concern is about children in care and careleavers.

What do you or your organisation believe would be the best ways to tackle inequalities and increase fairness in the city? : Increase the voice and influence of children and young people. We talk about co-production etc, but I dont believe that we have really invested in getting this right. We need to have grass roots power to hold senior officer to account, not just sit in board meetings and bluff. Where is the childrens rights champion in the city? Who is championing the rights of children in care?

Your first fairness priority: Ensure a city-wide, cross directorate corporate parenting board that is accountable to children in care

Your second fairness priority: That all policies are measured against a Childrens Rights Impact assessment

Your third fairness priority: To ensure that BHCC and Schools are providing services that comply with childrens rights

Health of children who have been looked after continuously for at least twelve months 31st March 2014

Percentages derived from rounded numbers for other Local Authorities

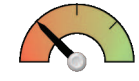
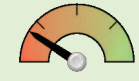
Local Authority	Number of children looked after at 31 March who had been looked after for at least twelve months	Percentage of children identified as having a substance misuse problem during the year	% whose immunisations were up to date	% of children who had their teeth checked by a dentist	% of children who had their annual health assessment	Average Health and Dental Checks	Number of children looked after for at least one year, and aged 5 or younger at 31 March 2013	% whose development assessments were up to date	Percentage of eligible children for whom an SDQ score was submitted	Average score per child	Normal (score under 14)	Borderline (score 14-16)	Concern (score 17 and over)	LAC for 12 months or more aged 10 or above convicted or subject to a final warning or reprimand during the year	Percentage convicted or subject to a final warning or reprimand during the year
Brighton and Hove	**325**	**0.3%**	**76.8%**	**84.5%**	**81.7%**	**83.1%**	48	100.0%	**77**	**14.8**	**43**	**15**	**41**	**14**	**6.2**
Bournemouth	180	x	97.2%	100.0%	97.2%	98.6%	35	100.0%	87	13.9	49	12	39	5	5.2
Bristol, City of	495	2.6%	78.8%	91.9%	89.9%	90.9%	55	x	73	14.3	48	12	40	25	6.3
Reading	160	x	93.8%	84.4%	87.5%	85.9%	35	71.4%	51	17.1	37	x	57	10	12.2
Bath and North East Somerset	100	x	95.0%	95.0%	90.0%	92.5%	15	33.3%	77	15.1	46	18	36	x	x
Sheffield	380	1.6%	81.6%	59.2%	80.3%	69.7%	70	85.7%	92	16	41	14	45	15	5.8
Portsmouth	215	6.5%	95.3%	90.7%	90.7%	90.7%	40	100.0%	69	13.8	51	17	32	15	12.7
York	185	4.4%	91.9%	83.8%	51.4%	67.6%	30	66.7%	89	14.4	49	13	38	x	x
Leeds	1025	x	98.0%	69.3%	98.0%	83.7%	260	100.0%	49	13.9	51	16	34	25	4.3
Bromley	180	4.4%	94.4%	83.3%	88.9%	86.1%	25	100.0%	92	14.6	49	11	39	10	9.6
Southend-on-Sea	165	4.2%	78.8%	93.9%	90.9%	92.4%	20	75.0%	52	13.6	59	13	29	5	5.5
England	**47,670**	**3.5%**	**87.1%**	**84.4%**	**88.4%**	**86.4%**	**8760**	**86.8%**	**68**	**14**	**50**	**13**	**37**	**1,710**	**6**
Stat Neighbour Average	308.5	N/A	90.5%	85.2%	86.5%	85.8%	59	N/A	73.1	14.7	48.0	14.0	38.9	N/A	N/A
East Sussex	425	3.5%	89.4%	96.5%	90.6%	93.5%	75	93.3%	83	15.1	46	12	42	x	x
West Sussex	420	8.4%	88.1%	92.9%	95.2%	94.0%	45	100.0%	0	.	.	.	.	20	5.5

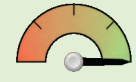
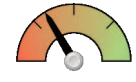
Source: SSDA 903

x = number less than or equal to 5 or percentage where the numerator is less than or equal to 5 or the denominator is less than or equal to 10.

Looked after children

Small numbers of looked after children with high unit costs can suggest better practice, as councils provide residential care only for those with high care needs. Large numbers of looked-after children may suggest issues with a council's effectiveness of care management and value for money of its provision. An increase in looked after children can occur when high-profile abuse cases are publicised.

Indicator	Period	Value	% change	DoT	Rank (Percentile)	Average
Total spend on children looked after (£s)	**2013/14**	£26,264,709	-3%		 In the highest 20%	£19,017,965
Spend on education of looked after children per looked after child	**2013/14**	£97.79 per LAC	22%		 Average	£223.33 per LAC
Number of looked after children per 10,000 children aged 0 to 17	**2013/14**	92 per 10,000	3%		 In the highest 20%	75 per 10,000
Spend on children leaving support care services per child leaving care	**2013/14**	£6,216.70 per head	-84%		 Average	£7,601.54 per head
The percentage of looked after children with a stable placement for at least 2 years	**2013/14**	64.0%	5%		 In the worst 25%	67.9%
The percentage of children looked after with three or more placements during the year	**2013/14**	15.0%	7%		 In the worst 20%	12.0%
Total spend on adoption services per child placed for adoption	**2013/14**	£66,796.57 per adopted child	55%		 In the highest 20%	£53,320.66 per adopted child
Number of looked after children placed for adoption	**2013/14**	35	-30%		 Average	39

Number of looked after children placed in foster care	**2013/14**	25	-93%		 Average	24
Total spend on own provision of foster care as a percentage of total foster care	**2013/14**	43.6%	3%		 In the lowest 25%	62.4%
Total spend on special guardianship support per looked after child	**2013/14**	£1,962.78 per LAC	34%		 In the highest 20%	£1,506.13 per LAC
Total spend on other looked after children services per looked after child	**2013/14**	£1,600.12 per LAC	95%		 Average	£2,664.82 per LAC
Total spend on short breaks (respite) for looked after disabled children per looked after child	**2013/14**	£2,899.15 per LAC	-5%		 In the highest 5%	£497.89 per LAC
Percentage of children looked after in year 11 achieving 5 GCSEs at grade A* to C	**Sep 2013 to Aug 2014**	26.3%	Unable to calculate	Unable to calculate	 In the best 5%	20.8%
Emotional and behavioural health of looked after children	**2013/14**	14.8	-3%		 In the worst third	14.4

1 Special Educational Needs and Learning Disability (SEND-LD) Strategy – Next Stage Proposals

1.1 This report is open to the general public.

1.2 This paper is for a joint meeting of the Health and Wellbeing Board and the Children, Young People and Skills Committee. The report spans both children with Special Educational Needs and Disabilities (SEND) and adults with Learning Disabilities (LD).

1.3 Joint Children, Young People and Skills Committee and the Health & Wellbeing Board meeting on the 10th November 2015

1.4 Regan Delf, Interim Assistant Director (Children's and Adult Services for SEND/LD), Telephone number: 01273 293504
regan.delf@brighton-hove.gov.uk

2 Summary

2.1 This report sets out proposals aimed at improving services for children and adults with special educational needs and learning disabilities within a very challenging financial context for the Local Authority.

2.2 Key themes in proposals are:

2.2.1 **Personalisation**
Every young person in specialist provision and every adult service user will have a personalised pathway and they and their families will have more control of spend to meet their needs via the option of a 'personal budget'

2.2.2 **Integration**
Children and Families will be able to access all education, health and care services in the new proposed integrated provision as part of a 'one-stop shop'

2.2.3 **Consolidation**
The aim is to bring together and consolidate specialist provision to provide an efficient and sustainable service into the future

2.3 This report sets out the rationale for two sets of recommendations relating to:

2.3.1 Proposed merger of related functions and services across Children's Services and Adult Social Care with an improved pathway from 0-25 years
2.3.2 Proposals to work up and consult on a re-organisation of special provision for children and young people with the most complex SEND

2.4 In relation to the proposals for children and young people, current specialist provision in the City is highly valued with Ofsted judgements that are at least 'good' and sometimes 'outstanding' in terms of quality but our vision is for further improvements in key areas, notably:

2.4.1 Further improved outcomes for young people in terms of health and wellbeing as well as academic achievement
2.4.2 Reduction in the very high percentages of young people with SEND who are 'not in education, employment and training' (NEET) as young adults by improving vocational pathways
2.4.3 Reduction in the number of costly out of City independent specialist placements through the creation of high quality local integrated provision
2.4.4 Reduction in the disruption and anxiety that families experience over the transition to adulthood by creating a better pathway across provision and services in education, health and care from 0-25 years
2.4.5 Provision of better and more coordinated support for our most vulnerable young people and particularly socially disadvantaged children in need or in care and those with complex and chronic medical and physical needs
2.4.6 All settings stronger and more financially sustainable into the future

2.5 Proposals stem from the review of Special Educational Needs and Disabilities (SEND) in Children's Services and the review of Learning Disabilities (LD) in Adult Social Care

2.6 The term 'SEN-LD Strategy' is used to describe the implementation phase of the two reviews, which were joined under the leadership of an interim Assistant Director in May 2015.

2.7 Both reviews/strategies with recommendations were presented to the Committee and Board on 3.2.15 with a further update report on the progress of the joint strategies presented to both Board and Committee meetings in July 2015.

2.8 **Rationale: Proposed merger of related functions and services across Children's Services and Adult Social Care**

2.9 New legislation has impacted on the work of Children's Services (Children and Families Act 2014) and Adult Social Care (Care Act 2014). Both Acts have introduced sweeping reforms and a need for cultural change with

considerable areas of synergy and overlap and potential for consolidation and consequent efficiencies. Specifically the Children and Families Act places responsibilities on Children's Services for the 0 - 25 years age range where young people are eligible for Education, Health and Care Plans. Young people from 18-25 are covered by both of the above Acts.

2.10 Key elements of both Acts overlap, notably:

2.10.1 A increased focus on ensuring that families and service users are at the core of all we do
2.10.2 An increased focus on transition and preparation for adulthood, with an extension of responsibility in Children's Services for young people with SEND up to 25 years of age if they meet eligibility criteria
2.10.3 A new focus on identifying and meeting the needs of carers
2.10.4 A requirement for joint commissioning approaches and closer partnerships with health in particular
2.10.5 Personalisation of approaches
2.10.6 Empowerment of parents and service users through extended personal budgets and direct payments
2.10.7 Requirement for much improved independent information, advice and guidance

2.11 The bringing together of the SEND and LD strategies has clarified that the two Directorates have many responsibilities and functions that could usefully be integrated in an efficient and cost effective manner. Managers of services working across the age-range have identified some key areas where there is currently synergy and overlap as areas for immediate consolidation and shared practice. These are set out in the recommendations below.

2.12 **Rationale: proposals to work up and consult on a re-organisation of special provision for children and young people with the most complex SEND**

2.13 **Vision:** the central vision is that our children and young people of all ages with the most complex needs will have special provision that is integrated across education, health and care

2.14 Although the city has some well integrated provision already, during the major consultation exercise that led to the publication of the SEND review report in February 2015, a central message from parents and carers was that provision and services across education, health and care can still seem fragmented and difficult to access.

2.15 The vision is that by 2020, parents, carers and children will be able to say the following:

Vision: by 2020 parents and carers will be able to say:

Every professional working with my child is working on the same goals and the same plan

We don't have to dash around the city to go to take our child to all the different appointments and clinics as everything is in one place – feels like a `one-stop shop` now

Professionals are working and planning together on a daily basis so we can just tell our story once – no need to start from the beginning with every new professional we meet

Staff visiting us at home has meant they have a greater understanding of some of the challenges we face as a family

Our child was up and down half the night and then wouldn't get up for school in the mornings – we were worn out but with the help of school and care staff supporting us in the home setting early morning and in the evening, that is all behind us now

Because we are eligible for a personal budget, we have been able to make some decisions about activities and respite which really support us as a family, including some beyond the school day, at the weekends and in school holidays

The new resource allocation system (RAS) makes us feel confident that resources are being shared fairly across those who need them

We are pleased that our child will have the opportunity to make friends in mainstream schools too and take part in mainstream classes and activities as this will improve his confidence and he will have more fun

Vision: by 2020 children and young people will be able to say:

I can spend some time in my local mainstream school and still get the special help I need in my other school – that means I can have friends in two places and some of them live near me

I am able to go to lots of different clubs and other activities after school and some nights I stay with a really nice foster family to give my parents a break

My teacher came home to talk to my parents about how to help me stop losing my temper when things go wrong and upsetting Mum – she showed Mum how she helps me to stay calm at school and that really helped - now I get special stickers at home too

Dad has learned Makaton at school with the teachers and now he is much better at talking to me about things

My teachers and my physiotherapist work together in the classroom every week to help me sit up so I can see what is happening and what I have to do in lessons

Everyone knows what to do now if I am ill and how best to take care of me and that has made Mum, Dad and me feel much safer

My school helped me get work experience in a local hotel and my boss is saying now I might get an apprenticeship with them – I know I will need support to manage everything but people there know I'm good at a lot of things too

I do get stressed by life and sometimes I can't face everyone but I've had really good support to manage my anxiety and I feel everyone understands now and is looking out for me

2.16 **Principles:** the proposals are predicated on the following principles:

Principles

2.16.1 The number of specialist places for children with Special Educational Needs and Disabilities (SEND)/Social, Emotional and Mental Health (SEMH) will not reduce but will show an overall small increase as a consequence of implementation

2.16.2 Provision will be integrated across education, health and care to provide a more holistic response to children's needs

2.16.3 The proposals will be phased in over four academic years from September 2016 to ensure minimum disruption for children in their current provision

2.16.4 Every child and family will have a personalised plan that will ensure their progress and wellbeing are paramount considerations if there are changes that affect them

2.16.5 Savings will be made from consolidation of provision and consequent reduced management and infrastructure costs

2.17 **Current specialist provision and budget pressures**

2.17.1 The city makes overall very good and valued provision for children with complex SEND in:

2.17.1.1 Six special schools
2.17.1.2 Two Pupil Referral Units
2.17.1.3 Six Special Facilities within mainstream schools
2.17.1.4 Two specialist part-time nurseries
2.17.1.5 The independent and non-maintained sector where local provision deemed insufficient to meet all needs

2.18 Overall costs are listed in appendix two, table two.

2.19 Research into the limited comparative national data suggests the city has more than the average number of special schools in similar LAs and our special schools are on average smaller.

2.20 As a consequence of a higher than average number of special schools, there are inevitable additional cost associated with infrastructure and leadership and management, which could be managed more efficiently by consolidation of provision.

2.21 While some special schools are consistently over-subscribed, others have struggled to admit enough pupils to be financially viable without LA additional support.

2.22 As a consequence of falling rolls for some special schools (appendix 2, table 3), the LA has had to find **£900K in 'transitional protection'** over the past five years to purchase empty places in these schools and enable them to balance their books. While we need our special provision to be financially viable, 'transitional protection' is in reality much needed money that could have been used to meet the needs of children with SEN elsewhere.

2.23 Under the most recent national funding formula for special schools, funding follows individual pupils in 'real time' and thus it is difficult for schools to be financially viable unless they can fill all their commissioned places and are of a sufficient size to withstand inevitable movements of pupils in and out of the school across the year.

Additional budget pressures

2.24 There are multiple demands and pressures on the budget for children and young people with SEND which mean we need to find more efficient ways of working if we are to meet the needs of all children and young people with SEND going forward

2.25 Additionally new legislation has extended the age range for the maintenance of Education, Health and Care Plans (formerly Statements of SEN) for our most complex young people from 2-16 years to 0-25 years. There is also a new requirement to create personal budgets for families and to improve the information, advice and guidance given to them.

2.26 The new duties above are welcomed by the LA. However there has been no corresponding uplift in SEN national funding to LAs and this is creating an increasing year on year pressure on SEN budgets here and across the country.

2.27 Additionally a national rise in emotional and mental health problems for young people, with associated problematic behaviours, is leading to increased pressure on the provision we run for 'social, emotional and mental health' (SEMH) needs (formerly known as BESD – behavioural, emotional and social difficulties)

Proposals

2.28 The recommendations are therefore to work up and consult on a means to:

- integrate special provision across education, health and care for all children with complex SEND

- include children and young people in the naming the new integrated provisions

- offer an improved and innovative curriculum

- make the system more efficient and financial viable into the future, by consolidation of the current six special schools and two PRUs to form three integrated special provisions across the city.

Relevant Background Reports

2.29 This report should also be considered in conjunction with the following papers:

2.29.1 Adult Social Care Direction of Travel 2016-2020 going to the Health and Wellbeing Board on 20.10.15

Direction of Travel ASC.pdf

2.29.2 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 – 21.07.15

2.29.3 Review of Provision and Services for: Special Educational Needs and Disabilities (SEND) including Behavioural, Emotional and Social Difficulties (BESD) – 03.02.15

2.29.4 The Outcome of the Learning Disability Review & "A Good, Happy & Healthy Life": A strategy for Adults with Learning Disabilities in Brighton & Hove – 03.02.15

3 Recommendations

In accordance with the governance arrangements relating to the report and recommendations below:

3.1 The Children, Young People and Skills Committee is asked to agree the following recommendations relating to the Children's Services SEND Strategy:

In relation to educational provision *(councillors and voting co-optees to vote)*

3.1.1 Upon the basis:-

(i) that there will be no overall reduction in the number of school places available to pupils in the city requiring specialist provision, and

(ii) the Board noting that before any final decisions can be taken regarding the proposed reorganisation of specialist provision it will be necessary to follow the statutory processes set out in the school organisation legislation, in particular the Education and Inspections Act 2006 and associated Regulations, these processes requiring periods of formal consultation with all interested parties, (which will include parents, governors and staff at the respective schools), and the publication of statutory notices,

It is agreed:

3.1.2 That approval be given to draw up detailed proposals in relation to each element of the restructuring of current specialist education provision described below, so as to offer integrated education, extended day activities, respite care and short breaks and integrated health and care teams within each new provision. The proposals being as follows:

(a) That the existing six special schools (Patcham House, Homewood College, Hillside Special School, Downs Park Special School, Downs View Special School and the Cedar Centre School) and two Pupil Referral Units (Brighton & Hove Pupil Referral Unit and the Connected Hub) be re-organised to form three extended and integrated specialist provisions with clear vocational pathways and strong support for preparation for adulthood.

(b) That two specialist provisions be created for children with learning difficulties as set out below:

(i) That Hillside Special School and Downs Park Special School amalgamate to form one **Integrated Provision West** for the full range of cognition and learning needs. The provision will cater for pupils aged 5 - 16 years i.e. Key Stages 1 – 4, and will operate from both of the current school sites but under one leadership team and governing body.

(ii) That Downs View Special School expand to create **Integrated Provision East** for the full range of cognition and learning needs. The provision will cater for pupils aged 5 - 19 years, i.e. Key Stages 1 – 5, and will be based on the current site of Downs View School which will be expanded as necessary.

(c) That Cedar Centre School, Patcham House School and Homewood College be re-organised as the city's school provision for children with social, emotional and mental health needs to form the **Integrated Specialist Provision Central (SEMH)** catering for pupils aged from 5-16 years ie from Key Stages 1 – 4. The provision will be based on the current Cedar Centre School site.

(d) That further provision for pupils with complex needs/moderate learning difficulties be made at the Integrated Special Provisions East and West (Cognition and Learning) so that no capacity is lost for these needs following the re-designation of Integrated Specialist Provision Central to cater for SEMH.

(e) That B&H Pupil Referral Unit (currently situated at Lynchet Close and Dyke Road) and The Connected Hub (situated at Tilbury House) merge to form a single B&H **Integrated Provision Central Pupil Referral Unit** for pupils with Social, Emotional and Mental Health needs. The Unit will cater for pupils aged 11 – 16 years i.e. Key stages 3 and 4 and will be based on the Lynchet Close and Tilbury House sites.

(f) That children who are currently attending full time at the primary Pupil Referral Unit (based at Lynchet Close) with statements of special educational needs or EHC Plans naming this provision, move onto the roll of the Integrated Provision Central (SEMH). Any part-time PRU places will convert to extensive additionally funded support in mainstream school.

3.1.3 That for each integrated specialist provision, a lead partner mainstream secondary and mainstream primary school be identified to champion the needs of young people with SEND/SEMH and facilitate shared and inclusive opportunities across mainstream and specialist provision.

3.2 In relation to other provision for young people *(councillors only to vote):*

3.2.1 That the Clinical Commissioning Group (CCG) and Children's Services shall jointly commission support from health providers to form an integrated team within each integrated special provision as required.

3.2.2 That it is noted that the current Jeanne Saunders nursery is sited in unsuitable premises at Penny Gobby House which does not provide disabled access for children with disabilities, which has necessitated the creation of the satellite site at Easthill Park for six of the children with the greatest mobility needs.

3.2.3 That an inclusive integrated nursery with specialist health and care facilities on a mainstream nursery site shall replace the current part-time specialist nursery provision at the Jeanne Saunders/Easthill Park nursery.

3.3 Recommendations relating to merged SEND/LD Strategy across the Children's Services and Adult Social Care Directorates *(councillors only to vote)*

3.3.1 That the Adult and Children's directorates of the city council shall support the Clinical Commissioning Group (CCG) to commission an all-age 'Wellbeing' Service that will respond to the emotional and mental health needs of

parents, children and families rather than the individuals within families.

3.3.2 That approval be given to identify, consider, and review social work structures and functions supporting children and adults with learning disabilities that are likely to be delivered more efficiently and create a better pathway for service users by one combined Children's Service and Adult Social Care response rather than via two Directorates

3.3.3 That specifically the following options be reviewed relating to a single approach to adult and children's provision:

(i) The adoption of the same Resource Allocation System (RAS) in Children's Services as well as in Adult Social Care for an equitable and fair allocation of resources and direct payments.
(ii) The combining the Autism strategies and plans across Children's and Adult Services to have one approach for autism across the age range.
(iii) Consolidating as far as possible transport arrangements across the full age range.
(iv) Consolidating the services relating to adults and young people involving deprivation of liberty
(v) A single service for emotional and mental health support.

3.3.4 That any service redesign should:

(i) facilitate the transition from Children's to Adult Services (0 - 25 years) by better preparation for adulthood and pathways to supported internships, apprenticeships and longer term employment.
(ii) encourage inclusive practice through universal and community services such that people with SEND and LD do not have to rely on scarce 'specialist' provision and can live and thrive within the wider community.
(iii) aim to prevent the need for high cost placements where children and adults have very complex needs and challenging behaviour by improving local services including mental health and behavioural support services.

3.3.5 That options for re-providing services at better value for money and to a good standard in the community and voluntary sector or the private sector be identified and explored.

3.3.6 That upon noting the recommendations of the Policy and Resources Committee of 4 November 2015 in respect of a review of the in house learning disability accommodation services, there shall be consideration given to whether joint work between the Housing Department and Learning Disability Services in both Children's and Adults' Services should take place to review the need for supported living arrangements within the city and develop proposals for supported living arrangements accordingly.

3.4 The Health and Wellbeing Board is asked to agree the following recommendations:

Recommendations relating to the Children's Services SEND Strategy

Item 1

3.4.1 That the Board notes the recommendations to be considered by the Children, Young People and Skills Committee (the Committee) in relation to specialist educational provision for children.

3.4.2 That an inclusive integrated nursery with specialist health and care facilities on a mainstream nursery site shall replace the current part-time specialist nursery provision at the Jeanne Saunders/Easthill Park nursery.

3.4.3 That the Board supports the joint commissioning by the Clinical Commissioning Group (CCG) and Children's Services of support from health providers to form an integrated team within each integrated special provision as required.

3.5 Recommendations relating to merged SEND/LD Strategy across the Children's Services and Adult Social Care Directorates

Item 2

3.5.1 That the Board supports the proposal by the Clinical Commissioning Group (CCG) to commission an all-age 'Wellbeing' Service that will respond to the emotional and mental health needs of parents, children and families rather than the individuals within families.

3.5.2 That approval be given to identify, consider, and review social work structures and functions supporting children and adults with learning disabilities that are likely to be delivered more efficiently and create a better pathway for service users by one combined Children's Service and Adult Social Care response rather than via two Directorates

3.5.3 That specifically the following options be reviewed relating to a single approach to adult and children's provision:

(i) The adoption of the Resource Allocation System (RAS) in Children's Services that is currently established in Adult Social Care for an equitable and fair allocation of resources and direct payments.
(ii) The combining the Autism strategies and plans across Children's and Adult Services to have one approach for autism across the age range.
(iii) Consolidating as far as possible transport arrangements across the full age range.
(iv) Consolidating the services relating to adults and young people involving deprivation of liberty.

(v) A single service for emotional and mental health support.

3.5.4 That any service redesign should:

(i) facilitate the transition from Children's to Adult Services (0 - 25 years) by better preparation for adulthood and pathways to supported internships, apprenticeships and longer term employment.
(ii) encourage inclusive practice through universal and community services such that people with SEND and LD do not have to rely on scarce 'specialist' provision and can live and thrive within the wider community.
(iii) aim to prevent the need for high cost placements where children and adults have very complex needs and challenging behaviour by improving local services including mental health and behavioural support services.

3.5.5 That options for re-providing services at better value for money and to a good standard in the community and voluntary sector or the private sector be identified and explored.

3.5.6 That upon noting the recommendations of the Policy and Resources Committee of 4 November 2015 in respect of a review of the in house learning disability accommodation services, there shall be joint work between the Housing Department and Learning Disability Services in both Children's and Adults' Services to review the need for supported living arrangements within the city and develop proposals for supported living arrangements accordingly.

4 Relevant background information

4.1 Other Options explored

4.2. **All Services and Provision** - One option is to leave current services across Adult Social Care and Children's Services unchanged. Many of the services and provision are of good quality and valued by professionals and service users alike. However current services need to adapt to meet the new legal framework with a drive to more integration of services, the empowerment of service users and their families and the promotion of personal budgets. The council is facing substantial budget pressures in the context of most services for vulnerable service users, including schools, costing more than the national average. There is an urgent need to ensure services are of good quality, are offered within the modern context based on feedback from service users and their families about improvements and are affordable within the available budget envelope.

4.3 **Merging functions across services for children and adults** - An alternative option to proposals to merge functions across Adult Social Care Learning Disabilities (LD) and Children's Services SEND provision is to leave them separate as now but improve partnership, co-operation and joint working. However parents and young people have given extensive feedback about the problems of transition to adulthood and multiple complications

associated with different age ranges and thresholds for adult and children's services. Additionally the number of young people with LD not in employment, education or training at age 19+ is over 40% and improvements are clearly needed in terms of preparation for adulthood. In this context, leaving the situation as it is would not address well-known problems around transition. Equally leaving things as they are would not enable efficiency savings that could be made from merging management and function.

4.4 **Special School and PRU provision** - Alternative proposals that would leave unchanged the current matrix of specialist provision, including special schools, PRUs and nurseries would not represent good value for money, with some provisions too small to offer a full curriculum and requiring annual financial protection from the council to sustain them while others are over-full with waiting lists. The council has spent 900K on 'transitional protection' over the past 5 years to support special provision with too few pupils to be financially viable.

4.5 **Inclusive nursery provision** – An option to creating an inclusive nursery would be to offer pre-school provision at the new integrated provisions for children with learning difficulties. This would be of high quality but would be a less inclusive option.

4.6 **Merging special schools catering for different levels of learning difficulty** - It would be possible to leave unchanged the current divisions between 'complex needs' schools (formerly schools for children with 'moderate learning difficulties') and schools for children with severe, profound and multiple learning difficulties, especially as all special provision in the city is either judged 'good' overall or 'outstanding' by Ofsted. However having five small schools for children with different levels of learning difficulty means that some struggle financially with fluctuations in pupil numbers while others are in high demand. Current arrangements also diminish opportunities for teachers to work and learn together to improve curriculum delivery and outcomes. The merging of schools to create a complete response to all children with complex learning needs has been an increasing trend nationally with both East and West Sussex having successfully reorganised their provision on this basis.

5 Adult Social Care Learning Difficulty Strategy

5.1 Brighton and Hove has seen an increase in demand for all services and it is estimated that there would be a 12% increase in the numbers of people with a severe or moderate learning disability by 2030. This should also be seen in the context of the continued year on year savings for Adult Social Care in Brighton and Hove and the acceptance that unit costs for people using Learning Disability services are more expensive than comparator councils (see CIPFA data).

5.2 Following an LD Review a strategic vision was developed and agreed at the Health and Wellbeing Board on 23rd February 2015. This strategy, "A Good, Happy & Healthy Life" is now the driving force to ensure good outcomes and personalised services for adults with learning disabilities in Brighton & Hove.

5.3 An Operational Group has been set up to develop and implement a delivery plan to deliver on the recommendations contained in the new strategy "A Good, Happy & Healthy Life" and achieve the necessary savings identified from the ASC budget. This group report into an LD Board, which meets fortnightly to review progress.

5.4 The programme is divided into 4 workstreams:

5.4.1 Personalisation and Independence
5.4.2 Community & Day Activities
5.4.3 Good Health
5.4.4 Respite & Short Breaks

5.5 Planning under the four workstreams is taking place within the context of a wider 'Direction of Travel' report for Adult Social Care being taken to the Health and Wellbeing Board in October 2015 which sets out how change and modernisation of quality services to meet need will take place within an affordable budget envelope.

5.6 Proposals for adults with LD are intended to empower service users through extended use of personal budgets and providing a menu of lower cost options to meet needs and promote best outcomes for people with learning disabilities.

5.7 In order to ensure stability and maintain the confidence of service users and their families, great care will be taken to review every situation and provide a personalised plan to ensure smooth and sustainable transition with ongoing support and guidance.

5.8 Extended use of personal budgets and greater choice in the system will reduce the need for council run services provided in static buildings and thus these provision for day activities, community care and supported living currently provided by the council will be outsourced over the next four years.

Children's Services Special Educational Needs and Disability Strategy

5.9 The Children and Families Act 2014 and the associated SEN Code of Practice 2014 place a duty of council and health services to commission services for children jointly in consultation with young people and families and also where appropriate to integrate provision across education, health and care.

*'3.13 Local authorities **must** work to integrate educational provision and training provision with health and social care provision where they think that this would promote the wellbeing of children and young people with SEN or disabilities, or improve the quality of special educational provision. Local partners **must** co-operate with the local authority in this. The NHS Mandate, NHS Act 2006 and Health and Social Care Act 2012 make clear that NHS*

*England, CCGs and Health and Wellbeing Boards **must** promote the integration of services.'*
SEN Code of Practice 2014

5.10 As a consequence the SEND review proposed a number of wide-ranging recommendations to a joint meeting of the Health and Wellbeing Board and the Children, Young People and Skills Committee in February 2015, all of which were accepted.

5.11 Central themes in recommendations were:

5.11.1 integration of services and provision across education, health and care across the 0-25 years age range;

5.11.2 reducing dependents on expensive out of city/independent specialist placements by providing integrated "wrap-around" provision in the city;

5.11.3 greater personalisation for families and extended use of personal budgets;

5.11.4 improved support to families where children have complex and challenging needs and behaviours;

5.11.5 more systematic identification of SEN and improved outcomes for identified young people;

5.11.6 A re-organisation of special schooling and specialist nursery provision, children's health and therapy provision, children's residential and respite provision and outreach/extended day activities in the areas of both learning difficulties and of behavioural, emotional and social difficulties;

5.12 These recommendations above will not reduce the number of specialist places available but by consolidating and integrating provision will enable a substantial reduction in costs.

5.13 How will the savings be made?

Savings will come from:

5.13.1 consolidation of buildings and infrastructure in the new model with part of capital receipts being used to fund adaptations and improvements to the new provisions (subject to a successful business case and approval from Policy and Resources Committee and any resultant capital receipts being considered in relation to the council's Medium Term Financial Strategy and capital investment programme);

5.13.2 streamlined leadership and management costs across the reorganised provision;

5.13.3 more effective pooling of budgets across the council general fund, the DSG High Needs Block and joint-commissioning arrangement with partners in health;

5.13.4 no longer needing to pay 'transitional protection' to smaller schools which have empty places and are not otherwise financially viable

5.14 Integrated Provision for Learning Difficulties and Disabilities

5.14.1 The proposal here is that special school provision for children with learning difficulties will be merged so that special schools cater for the entire range of learning difficulties within one establishment (not as currently divided to 'moderate learning difficulties/complex needs' and 'severe learning difficulties').

5.14.2 There will be two specialist provisions catering for children with learning difficulties:

5.14.2.1 in the East, based on the site of an extended Downs View School

5.14.2.2 in the West, based on a merger of the current Hillside and Downs Park Schools under one leadership but retaining both current buildings

5.14.3 An integrated health/therapy team comprising medical, nursing, mental health/Child and Adolescent Mental Health Service (CAMHS), Occupational Therapy (OT), Physiotherapy and Speech and Language Therapy will be jointly commissioned by the Clinical Commissioning Group (CCG) and the council to be based at each provision and provide support as part of an integrated team with school staff.

5.14.4 Each provision will provide direct support to families, including if needed support to parents/carers at home in managing complex physical/medical needs and challenging behaviours.

5.14.5 Social work, key working and disability care, including extended day activities, respite and outreach, will be also provided as part of the integrated learning difficulty provisions with relevant staff and activities forming part of an integrated team with school and health staff.

5.14.6 Each provision will work with a lead partner secondary and primary school to champion inclusive and shared opportunities.

5.14.7 Further choice at better value will be provided to families of 19+ young people with complex special needs by developing 19+ provision with students on the roll of further education (FE)/sixth form college, commissioning provision from

Downs View Link College of high quality and better value than independent sector alternatives.

5.15 **Social, Emotional and Mental Health Needs**

5.15.1 The current school and Pupil Referral Unit provision for Social, Emotional and Mental Health Needs (SEMH) would be reconfigured as follows:

5.15.2 The two Pupil Referral Units (Brighton and Hove PRU and The Connected Hub) merge to form one PRU catering for Key Stages 3 and 4 based at the current sites (Lynchet Close and Tilbury House).

5.15.3 A special school for SEMH taking pupils in Key Stages 2, 3 and 4 with the site of the current Cedar Centre School as the main hub.

5.15.4 Additional places will be provided at the Integrated Specialist Provisions East and West for children with complex needs/moderate learning difficulties.

5.15.5 There will be resourced provision for mainstream schools in the form of 28 'virtual places' attached to the PRU, where the PRU will offer much enhanced support to mainstream schools to commission support and alternative provision.

5.15.6 Integrated leadership for the SEMH school and PRU will come from an Executive Headteacher overseeing the full matrix of provision, including alternative provision and vocational pathways.

5.15.7 Integrated health, mental health, Youth Offending and social care provision will work as part of an integrated team with school staff to support eligible young people as needed and create a full service for adolescents with SEMH and challenging family circumstances.

5.16 Early Years Provision for Young Children with disabilities and complex special needs

5.16.1 A new full time integrated inclusive nursery will be created for young children with disabilities and complex special needs in a mainstream nursery setting.

5.16.2 This to provide one inclusive setting with specialist health and care facilities available on-site that will provide new premises for the Jeanne Saunders/Easthill Park nursery.

5.16.3 The current part-time Jeanne Saunders nursery based at Penny Goby House is sited in unsuitable premises which do not provide disabled access for children with disabilities, hence a satellite site being needed at Easthill Park taking six of the children with the greatest mobility needs.

5.16.4 The recommendation is therefore that this building is not used for a nursery for children with disabilities. It is in Trust and negotiations are taking place with the charity and Trustees as to usage going forward.

6 Important considerations and implications

Legal implications:

6.1 The presentation of this report to a joint Health and Wellbeing Board and Children, Young People and Skills Committee reflects the specific functions of each to oversee and make decisions concerning either Adult Social Care or Children's Services.

6.2 The Children and Families Act 2014 which came into force in September 2014 introduced a new single system from birth to 25 for all children and young people with special educational needs and their families. The Act requires Local Authorities to place children, young people, their parents and carers at the heart of the process in a more person centred manner. It also introduced a new requirement on local authorities and health services to jointly commission education, health and social care services for young people and families. The proposed re-structure and reorganisation of specialist educational provision in the city aims to enable the Council to further achieve this integration. The proposed arrangements for co-operation inter-departmentally and between the Local Authority and health partners in commissioning and delivering services reflect the requirements of the Care Act 2014.

6.3 In order to achieve the proposed education reorganisation it will be necessary to follow the statutory processes set out in the school organisation legislation, in particular the Education and Inspections Act 2006 and associated Regulations. These processes require periods of formal consultation with all interested parties, (which will include parents, governors and staff at the respective schools), the publication of statutory notices and further periods for the submission of representations before any final decisions can be taken.

6.4 At this stage the Committee are not being asked to approve the school reorganisation proposed to in the body of the report. As and when the proposals are developed in more detail they will return to CYP committee for consideration as to whether or not to proceed to consultation, the first stage in the statutory process for reorganisation.

6.5 Any future provision, arrangements and commissioning in respect of adults with care and support needs must ensure compliance with the requirements of the Care Act in addition to the wider duties including wellbeing, prevention, provision of information and advice and market shaping.

6.6 Any detailed proposals which may emerge as a result of the recommendations in this report must include full consideration of any need to

consult interested and potentially affected persons and implications arising under Equalities legislation and Human Rights Act 1998.

Lawyer Consulted: Natasha Watson Date: 02/11/15

Financial implications:

Children's Services

6.7 The recommendations included in this report have implications to both revenue and capital funding.

6.8 The proposals state that the intention is to retain at least the same number of specialist placements for children with SEN and disabilities but to re-structure and re-organise provision. This approach will safeguard Dedicated Schools Grant (DSG) high needs block funding levels whilst, at the same time, delivering greater economies of scale resulting in reduced unit costs.

6.9 In particular, the plan to integrate provision will facilitate savings in revenue budgets relating to management and administration, and premises. Analysis of special school budget plans for 2015/16 has identified approximately £2.9m is currently spent in these areas and the proposals in the report seek to save £900,000 over a 3 year period from 2017/18. The reduction in costs will mean that the unit values for top-up funding in special schools will be recalibrated. It is likely that the Local Authority will need to seek approval of Department for Education (DfE) to dis-apply the minimum funding guarantee that exists within the Schools and Early Years Finance Regulations.

6.10 The savings identified in 2016/17 associated with the SEND review relate to the cessation of transitional protection funding to special schools and other identified savings in the high needs block of the DSG, such as the re-organisation of the Learning Support Services.

6.11 The proposal to integrate provision for children and young people with an Education Health and Care plan will allow more effective use of resource across the Council's general fund, the DSG and joint-commissioning with partners in health. It will be necessary to ensure that the proposals are compliant with the relevant funding regulations, particularly where DSG funding is being extended to support provision currently being delivered through core council funding.

6.12 The disposal of any surplus assets identified under this review may potentially generate capital receipts. Those receipts, less any disposal costs, will be ring-fenced to support capital investment through the Council's Capital Investment programme to enable the adaptations and improvements to the new provisions. The balance of receipts after the initial ring-fencing will be used to support the Council's future corporate capital strategy.

Finance Officer Consulted: Steve Williams Date: 08/10/15

Adults Services

6.13 The proposals arising from the LD Review will be reflected in the four year integrated service and financial plans which will be considered by Policy and Resources Committee on 3 December 2015. The extended use of personal budgets and a review of how care and support needs are met is expected to result in a more cost effective model which will reduce unit costs. Unit costs for Learning Disability services are currently high compared with comparator authorities and there is significant pressure on the 2015/16 budget. There is a savings target of approximately £8m against Adult Learning Disability services over the next four years against which plans are being developed.

6.14 Detailed financial implications for the proposals when implementation plans are referred back to Committee.

Finance Officer Consulted: Anne Silley *Date: 13/10/15*

Equalities implications:

6.15 An Equality Impact Assessment will be drawn up in relation to all proposals for service redesign to be considered prior to the consideration of any recommendations relating to implementation.

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

6.16 Partners in Adult Social Care, Children's Services, Public Health, the Clinical Commissioning Group, Sussex Community Trust and Sussex Partnership Foundation Trust welcome the strengthening of the requirement for joint commissioning and integrated delivery of services in both the Children and Families Act 2014 and the Care Act 2014. Colleagues in health services and the council have worked together to draft Joint Health and Wellbeing Strategy and a Joint Children's Health and Wellbeing Commissioning Strategy to be presented to the Health and Wellbeing Board in December 2015. Specifically in the context of the new legislative framework, there is a commitment to joint commissioning of a smooth pathway for children and young adults from 0-25 years who are eligible for Education, Health and Care Plans and joint delivery of services for them where needed.

6.17 In this context, there has been close liaison and co-operation between the council and health partners throughout the period of the developing SEND and LD strategies in Adult Social Care and in Children's Services. Specifically in relation to the proposals for children and young people, all partners are committed to the principles of integrated education, health and care provision for children and young people with the most complex needs and to formulating specific proposals for joint commissioning of integrated services for the proposed new special provisions.

Appendix 1:

Summary of acronyms used in the report

ASC	Adult Social Care
BESD	Behaviour, Emotional and Social Difficulties
BHPRU	Brighton and Hove Pupil Referral Unit
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
DSG	Dedicated Schools Grant (DfE grant to provide funding for schools)
DOLS	Deprivation of Liberty assessment
DVLC	Downs View Link College
EIA	Equality Impact Assessment
HNB	High Needs Block (LA funding for pupils with 'high needs')
LA	Local Authority
LD	Learning Disabilities
MLD	Moderate Learning Difficulties
OT	Occupational Therapy
PRU	Pupil Referral Unit
RAS	Resource Allocation System
SEMH	Social Emotional and Mental health
SEND	Special Educational Needs and Disabilities

Appendix 2 – Table One:

Current provision in the City

Establishment	Caters for pupils with	Commissioned Numbers 2015/16
Hillside Special School (Portslade)	Severe and profound multiple learning difficulties	72
Downs Park School CDP Federation (Portslade)	Moderate learning difficulties and complex needs	90
Downs View Special School (Woodingdean) and Downs View Link College (Fiveways)	Severe and profound multiple learning difficulties	120
Cedar Centre CDP Federation (Hollingdean)	Moderate learning difficulties and complex needs	72
Patcham House School CDP Federation (Patcham)	Academically more able pupils with a range of additional complex needs	31
Homewood College (Moulsecoomb)	Social, Emotional and Mental health needs	45
The Connected Hub - Alternative Provision (Fiveways)	Social, Emotional and Mental health needs	34
B&H Pupil Referral Unit (Hollingdean and Dyke Road)	Social, Emotional and Mental health needs	54
Establishment – Post 19 Provision		**Commissioned Numbers**
Post 19 Provision in Independent Sector	Severe learning difficulties	26
Establishment – Early Years		**Commissioned Numbers**
Jeanne Saunders/Easthill Park (Hove and Portslade)	Complex needs, severe learning difficulties and disabilities	18

Table Two:

Current Costs and expected Savings

Current SEND Expenditure 2015/2016	Commissioned Numbers	£ cost
Special Schools (six)	430	£9.53m
The Connected Hub/PRU	88	£1.45m
Post 19 Provision	26	£1.04m
Early Years	18	£0.75m
Total	562	£12.77m

Please note the cost shown against Early Years represents both the on-site and off site (outreach) provision delivered by PRESENS, whereas the place numbers are attributable to the on-site service only. Further work is being undertaken to split the total service cost accurately between on and off site provision.
(Paragraph added 10.11.15 and republished)

Overall savings from the proposed reorganisation are £1,595,000 million over four years to 2019/20

Appendix 2 - Table Three

Special School Commissioned Numbers and Pupil Numbers 2011/12 to 2015/16

	Year 2011/12		Year 2012/13		Year 2013/14		Year 2014/15		Year 2015/16	
School	Place	Pupil	Place	Pupil	Place	Pupil	Place	Pupil	Place	*Pupil
	Nos	Nos	Nos	Nos	Nos	Nos	Nos	Nos	Nos	Nos
Homewood	60	47	60	43	45	42	45	40	45	38
Cedar Centre	85	78	80	78	80	78	76	75	72	72
Downs Park	73	76	77	82	84	85	86	89	90	93
Downs View	114	109	114	115	117	119	117	119	120	119
Hillside	66	60	66	58	60	66	70	70	72	73
Patcham House	50	46	48	36	40	40	36	38	31	32
	448	416	445	412	426	430	430	431	430	427
Alternative Provision										
Pupil Referral Unit					54	34	54	42	54	36
Connected Hub					32	34	34	36	34	36
					86	68	88	78	88	72

The Pupil Referral Unit and Connected Hub were established as stand alone establishments in 2013/14

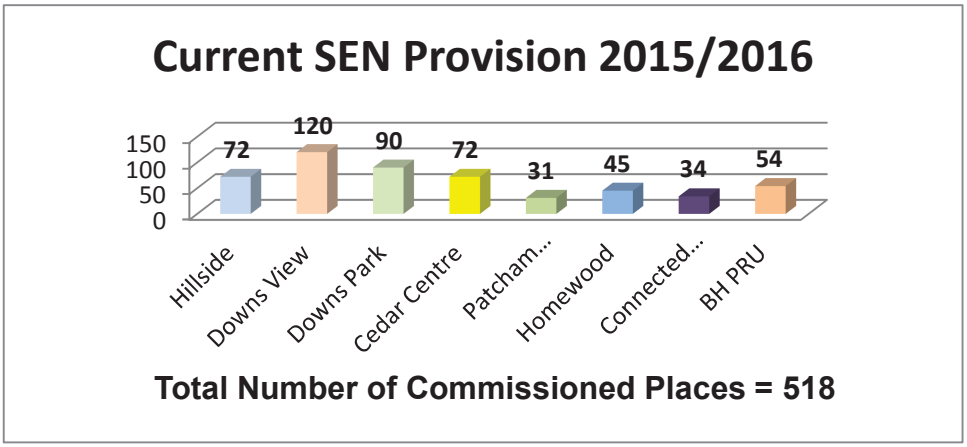
*Pupil numbers are as at January census with the exception of 2015/16 where the provisional October 2015 census data is shown. For all provisions, there is a turnover of pupils throughout the year so these figures are a snapshot.

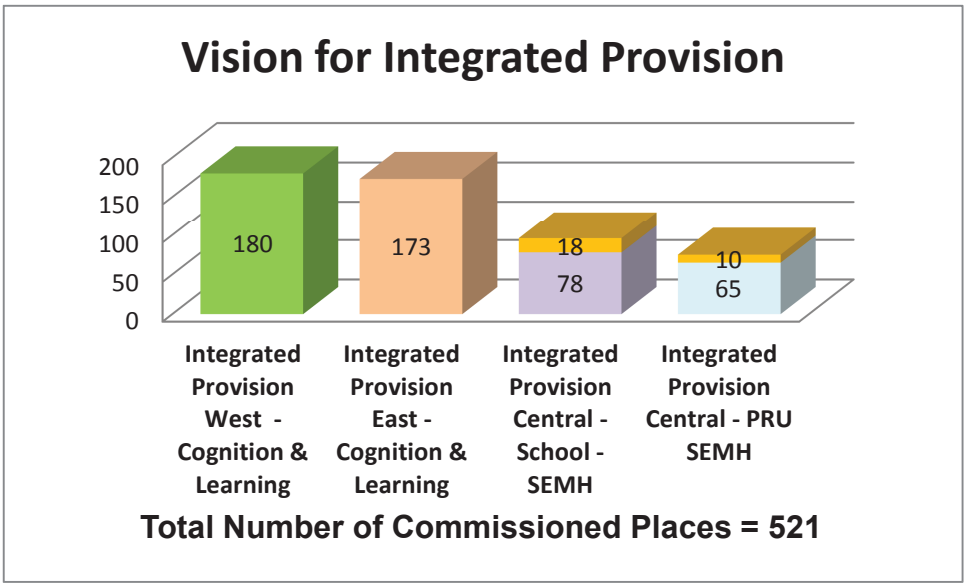
Analysis of special school data in the table shows that 4 special schools (Cedar Centre, Downs Park, Downs View and Hillside) have had very similar or increased pupil numbers over the 5-year period. This in contrast to Homewood College and Patcham House where pupil numbers have consistently reduced over the same timeframe, and this has been from a very low starting baseline in 2011/12. As a consequence of the low pupil numbers at Homewood and Patcham House, to ensure the schools have remained viable, the Local Authority has paid transitional protection funding in 4 of the last 5 years, and this has totalled almost £900k. This is not sustainable and does not represent value for money. Furthermore, guidance from the Department for Education now states that special schools should be funded on a place and pupil top-up funding basis and that the option to apply transitional protection is no longer included within funding regulations.

Appendix 3:

Projected figures for the implementation of integrated provision 2016-2020

Hillside Special School	INTEGRATED PROVISION WEST (C&L)
Downs Park Special School	
Downs View Special School	INTEGRATED PROVISION EAST (C&L)
Cedar Centre Special School	INTEGRATED PROVISION CENTRAL (SEMH) SCHOOL
Patcham House Special School	
Homewood College	
B&H PRU	INTEGRATED PROVISION CENTRAL (SEMH) PRU
The Connected Hub	





Partnership Outreach Pilot to Parents/Carers (POPP) of Disabled Children
Evaluation Report

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1. Introduction

Amaze is a city-wide charity working to support parents/carers of children with disabilities and special needs. The charity is subcontracted by Brighton and Hove City Council (BHCC) to manage the city's register of disabled children which they do with considerable success, compared to other local authority areas, as families trust their independence to hold their information confidentially. Families are provided with a discounted leisure (Compass) card and are then hooked into other Amaze services such as telephone helpline, education/benefits/transitions casework, resilience building and parenting skills workshops/training etc.

Despite this success, Amaze estimates it is in regular contact with only 54% of the total population of disabled children and their carers. In order to further understand its reach, sophisticated data analysis was carried out as part of the Databridge project (**see appendix D**) to try to pin point areas of under-representation. Despite Amaze data being able to evidence that it already had significantly higher contact with families in the more deprived wards in the city – namely Moulsecoomb, East Brighton, North Portslade and Hangleton and Knoll- the results indicated there were still many children with disabilities living in these more deprived areas whose parents/carers were not getting

"I want to look at other schools but I don't know who to phone."

any support from Amaze. Two of the highest 'undercounts' were the Moulsecoomb and Knoll estates. As a result of this new insight, Amaze approached the two community development organisations working in those neighbourhoods to see how they could develop a new partnership outreach model to identify new parents/carers, better understand the needs of their disabled children, and better signpost/support them to access the city-wide and local services which were set up to help them.

The Hangleton and Knoll Project is a resident-led Community Development, Youth work and Adult Education Charity operating in the ward of Hangleton and Knoll and has been established for 30 years. This area contains 15,000 people and is made up of two local authority Housing estates and a mix of social and private housing. Super output areas across the ward are identified as in the top 10% nationally when measured on the index of multiple deprivation (IMD). Hangleton and Knoll has high numbers of children living in single parent families and in poverty.

The Trust for Developing Communities (TDC) is a city-wide organisation delivering community development work across Brighton and Hove and Sussex. As well as delivering training, its aim is to support local community groups and develop them to flourish and represent their neighbourhoods in their own right. Moulsecoomb is one of the Trust's core areas for community development work. With a population of around 3,000 people Moulsecoomb is within the top 5% areas of multiple deprivation nationally, child poverty levels are almost 60% and disability living allowance claimants are double the City's average.

The approach we followed to deliver the Partnership Outreach Pilot for Parents/Carers (POPP) of disabled children is described in **appendix A-D** but, in brief, comprised door knocking and linking up with existing community groups followed by facilitated coffee mornings with the aim of establishing regular, local, peer support groups. We wanted parents to feel safe, be listened to and get the specialist advice/help they need and become more engaged with local and citywide services.

2. Project Aims

See Appendix E for full background and aims but in summary we hoped that the partnership of a city-wide community of interest/specialist advice/support organisation and the community development organisations with knowledge of the target neighbourhoods would lead to:

i. Increase in the use of Amaze services within the groups identified as currently out of reach.
ii. Parents feeling more confident and resilient to cope in their caring role.
iii. Increased Compass registrations - with associated financial savings (we estimate the leisure discount card saves the average family £650 per year) and other health and well-being benefits of undertaking more physical and leisure activities, and other benefits of being on the Amaze mailing list and included in our aggregated statistical reports/analysis for commissioners
iv. Support establishment of new, sustainable parent carer support group (if desirable)
v. Parents feel less isolated and more empowered in their neighbourhood (more informed about local services available for them and their children).
vi. Parents in group supported to feed into relevant consultations affecting them themselves or their views consolidated and presented by Amaze or PaCC representation at key strategic meetings e.g. views fed up to Link/Healthwatch, Disabled Children's Partnership Board etc
vii. Parents in group supported to be part of local decision making about local services or their views consolidated and presented by local community development organisation at key local meetings – encouraged to join the Local Action Teams (LATs) or local Patient Participation Group (PPG) etc

viii. We will ensure support group is sustainable and if required, can set up as own (finances, constitution etc.)

3. Summary of Outcomes and Outputs so far

The POPP clearly demonstrates the power of partnership to deliver value for money, effective outreach for Amaze. This ground-breaking project has enabled some specialist advice and help to be given directly to families in the heart of geographically isolated and economically deprived communities and is beginning to build knowledge and understanding in the partner community development organisations (staff and volunteers) of the needs of disabled children and their carers and what services are available to them.

This Project recognises that where parents/carers face multiple issues they are less likely to have a voice and receive the services that they require. Parenting a child with special needs is hugely challenging and can be completely overwhelming when coupled with other difficulties (such as financial, housing or mental health problems). The families identified by this project are some of the most vulnerable in our local area. This shared desire among partners to ensure equity of provision and enable the development of local support has driven this project and led to some very clear outcomes for parents and their families

The POPP found parents on the estates in Moulsecoomb and Hangleton & Knoll facing multiple deprivation with high levels of mental health needs and low levels of resilience and capacity to access the services they need. Parents feel both socially and geographically isolated and are often coping alone with their children, who have significant additional needs.

Door-knocking exposed a high density of parent carers in both areas. In Moulsecoomb we knocked on 1500 doors and spoke to 200 people of whom 52 had a child with special needs (25%) In Hangleton & Knoll, we knocked on a further 1800 doors and spoke to 300 people of whom 34 had a child with special needs (11%).

We found that parents were keen to meet and share their stories but we underestimated their need for specialist Amaze casework, information and advice. We also underestimated the time that it is going to take to establish sustainable, parent/carer-led, groups due to the high levels of vulnerability among the families who engaged with us during this pilot.

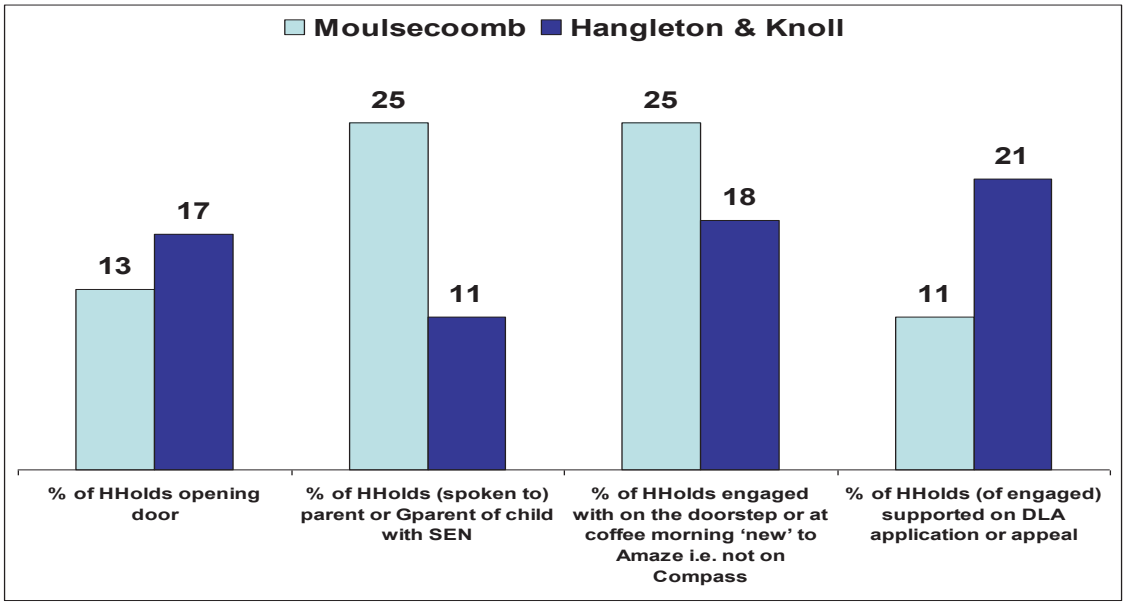
This project has enabled us to develop a model that is not only innovative but easily replicable with other city-wide 'community of interest' organisations looking to improve their reach in the City and a model that we will seek to develop and expand jointly. We also hope our findings can help inform the Health and Wellbeing Strategy on emotional and mental ill-health.

In the last 6 months, the POPP has already managed to deliver significant outputs, see below (for full table **see appendix C**). The Project in Moulsecoomb commenced in May 2012 and in Hangleton/Knoll in October 2012.

"We are very well supported by Amaze"

"Single parents need support. There's no time to rest and hand the ropes over…"

	Moulsecoomb	Hangleton & Knoll
No. households 'door knocked'	**1,500**	**1,800**
No. households opening door	**200**	**300**
No. households spoken to identifying with being the parent or grandparent of a child with SEN	**52 (25%)**	**34 (11%)**
Coffee Mornings held	4	2
No. parents/carers attending coffee mornings – helped so far	7	25
No. of those engaged with on the doorstep or at coffee morning 'new' to Amaze i.e. not on Compass	**13**	**7**
No. supported (or to be supported) to complete a DLA application or appeal against a decision on DLA	**6**	**8**
No. supported to join the Compass	**11**	**6**
No. new parent carer volunteers from the community supporting coffee morning.	1	4



We are also beginning to identify many positive outcomes for parents/carers who have been identified and are now getting involved with the POPP which, if sustained, will have a longer-lasting impact on these families including:

- Sense of belonging to community of other local families with disabled children.
- Reduced isolation, increased sense of support network.
- Access to local neighbourhood representation structures and activities.
- Increased self-confidence and resilience from having information/support to access right services for child.
- Improved outcomes for the CYP with disability:
  - Help sorting child's statement/education placements
  - Help accessing services e.g. CAMHS (Child And Adolescent Mental Health Services), housing officers, keyworking,
  - Improved school attendance levels

    - Support with assessment process ensuring that the CYP get the help they need and help to access appropriate community activities
    - Increased take up of leisure/sporting/cultural activities via Compass Card membership benefits
- Improved health and well-being of carers.
- Improved family finances - via access to DLA project. This may be through new claims, help appealing claims that have been turned down or increasing the rate of DLA e.g.: from middle to upper). Assuming we supported 15 new families to successfully access DLA benefit, this will bring in at least £450,000 to those families (average award £10k p.a. per family for average 3-year period). This may also involve signposting the family to other benefits advice (e.g. one family are thought to be eligible to a higher rate of working tax credits).
- Improved family finances - via access to Compass Card - average financial savings equivalent to £650 p.a. per family.
- As parents/carers become more resilient they will begin to feel more able to become engaged with service design/delivery and evaluation. Service user participation will lead to improved services, better allocation of scarce resources and fewer complaints. Through the project, we have also been able to signpost parent carers to the help they need.

We are keen to identify some additional capacity to allow us to evaluate more keenly these outcomes; including asking all parents attending the new groups to complete a baseline questionnaire about how they think they are coping, which can then be redone in 8-9 months time.

4. What we found out about families with disabled children in these neighbourhoods

So far we have found that families with disabled children living in Hangleton and Knoll and Moulsecoomb are:

4a. Families are Facing Multiple Deprivation

The majority of the 86 families we spoke to during this POPP relayed they were experiencing a number of difficulties often compounded by having a child with a disability or special need or directly connected to the huge challenges this brings. We have witnessed a real 'concentration of deprivation' in the two pilot areas. Grouped together these can be classified as 'multiple deprivation' factors and include factors like:

- More than one child with a disability
- Parent with disability/mental health problem/long term health condition
- Unemployment/living solely on benefits/low income
- Single parent
- Poor housing
- Experiencing domestic violence
- Lack of social support/inclusion

Most families have reported feeling very isolated as a result of having a child with a special need/disability coupled with financial pressures, transport and housing issues, mental health issues and family breakdown. Some described feeling that their whole family felt excluded, not just their child who has special needs, including siblings.

Families have expressed high levels of anxiety about the cuts and changes to welfare benefits, including Disability Living Allowance (DLA) eligibility, and "how they are going to cope". Mothers reported feeling under pressure to "do the right thing" and worried that they were in some way responsible for their child's difficulties. Dads were also widely affected: in one family, the father had given up work in order to support his son with his very challenging behaviour at school. Another

father had not applied for another job after being made redundant due to the pressures on the family of bringing up a daughter with a life limiting condition (he also has caring responsibilities for his wife who has been diagnosed with ME). Obviously, having two parents out of work, or the main income earner out of work, has long-term and far reaching impacts on the family's economic situation and emotional wellbeing.

The anecdotal findings from the POPP mirror other national and local evidence. National evidence shows it costs 3 times more[1] to bring up a disabled child and over 40% of disabled[2] children live in or on the margins of poverty. City-wide we know many disabled children live in the poorest parts of the city, in particular Moulsecoomb and Bevendean (12%), East Brighton (11%), Hangleton & Knoll (7%), North Portslade (7%) meaning their health outcomes are likely to be further reduced.

4b. Significant needs of parents/carers, which evolve over time (parent carer journey)

So far the POPP has brought Amaze into contact with some 20 new families. However, we have also been reconnected with families who have been in touch with Amaze in the past (and been on the Compass) but a long time ago for a one-off intervention, but have since not been in touch or 'forgot' that Amaze may be able to help. This is an indication of the level of vulnerability as many parents are presenting with complex and chaotic lives.

Parents have appreciated the face-to-face contact at the coffee mornings and talking to each other. Indeed, many of these families who were already known to Amaze had 'new' live issues concerning their child with a special need or disability or a sibling they were now concerned about. The coffee mornings provide a different 'forum', giving parent carers a space to consider and discuss issues they may not have explored when receiving an alternative Amaze service. Parents/carers have said it would be helpful if there could be a way for Amaze 'check in' on existing clientele – to prompt them to see if they have any emerging or new concerns. Clearly this would require additional helpline capacity as the service is hugely oversubscribed currently.

4c. Identifying needs and signposting to the right agency

In Moulsecoomb, community development workers linked families in with other sources of support (e.g. low-cost counselling at the Women's Centre in the city centre) and in HKP siblings were referred into youth team activities. This ability to signpost is really important. Educating neighbourhood workers about which issues are best picked up by Amaze and jointly thinking about the optimum referral routes for other issues is vital. This could be addressed by developing a short training course for neighbourhood workers who are working in partnership with Amaze through the outreach project.

In both areas, parents/carers had a high level of mental health needs. Going forward, it would be beneficial to link to mental health community organisations and examine how they work in specific communities and how we can link families into their services. Likewise, we uncovered a high level of housing issues. Parents complained about outstanding repairs on their council properties (and not being able to access the relevant help) and issues with housing. For example, in Moulsecoomb, one Mum and Grandma share the care of their son/grandson, aged 8. Mum lives in Moulsecoomb in a two-bedroom house, Grandma lives in Hove in a two-bedroom house. They want to live together but a solution has yet to be found.

[1] *Paying to Care: the costs of childhood disability* by Barbara Dobson and Sue Middleton in 1998.

[2] Children's Society report called *4 in Every 10* (Oct 11) states that 4 out of 10 disabled children now live in poverty. They estimate this to be 320,000 children nationally. Of those, 110,000 are experiencing extreme poverty.

4d. Parents/carers experience very low resilience levels

Many parents reported finding it hard to cope with multiple pressures in their lives. One parent said "It's just one thing after another and I don't know how I am going to keep going." This low level of resilience coupled with significant demands on their time and high levels of need has shown very few parents/carers are ready to engage yet in the setting up of a support group, let alone any further engagement with city-wide health service development etc.

4e. Parents/carers face difficulties accessing city-wide services

Some of these families feel very cut off from city-centre delivered statutory and other services. Parents reported that the cost of travelling to Brighton prevents them accessing services, training and events. The issue of dealing with their children on public transport was also raised and the fact that from Hangleton and Knoll it can take an hour to reach the town centre means that people feel unable to manage that journey. Travelling with a child with a special need or disability can be very challenging and many residents do not have a car. Geographical and social isolation were both raised in Hangleton and Knoll and Moulsecoomb.

Many stated that they find there are practical barriers to accessing Amaze e.g. phoning the helpline takes a lot of courage/energy (one parent in Moulsecoomb described 'building up' to the call). Due to limited resources, the helpline is only staffed 17.5 hours per week and callers are generally asked to leave a message and they are called back. Several parents reported that they did not leave a message and never found the time (or confidence) to call again.

4f. Many families with a child with SEN are fragmented

We met at least 10 single-parent families. One family in Moulsecoomb are seeking support from Relate due to relationship difficulties as a result of coping with their two children with special needs.

In addition, grandparents are presenting as main carers across both areas. Many more spoke to us on the door about their caring role in their children and grandchildren's lives.

In Hangleton and Knoll, one parent reported that her two daughters were living with her sister as they could not live with her due to her elder son's unpredictable and aggressive behaviour. At the second coffee morning one of the two grandparents that came was looking after her disabled grandchild as her adult child has tubular sclerosis and is in residential care. The issue of siblings and the lack of ability to meet their needs was a theme in Hangleton and Knoll. Several parents described the impact of dealing with a child with special needs leaves little time for their brothers and sisters. Better links are needed with The Carers Centre 'Young Carers Project' and youth activities in both communities.

We also met at least 2 adoptive parents/carers.

4g. Late diagnosis makes it difficult for families to access the right services/support

Having to wait for a diagnosis and 'navigate' the system was a recurring theme. Parents reported having to wait months and even years for a diagnosis and so a huge delay in early intervention and support which impacts on outcomes for a child or young person later in life (and impacts social care and education budgets). One family (in Moulsecoomb) described how her child had been flagged up by one teacher in year 1 but was only just being assessed in year 6. This was a sibling of a child with significant ASC (autistic spectrum condition) difficulties and the parent felt she was 'fobbed off'. Another mother reported that she had had to push for intervention for her 6-year-old son. Her 15-year-old daughter has a diagnosis of ASC and she has had concerns about her son for several years. The team at Seaside View child development centre were about to discharge her until she insisted on further intervention and he is now being seen as part of the 'autistic pathway' and will be subject to further assessments. There was a feeling from one parent carer (in Hangleton and Knoll)

that her background meant that instead of an ASC diagnosis she was accused of not being a good parent and that there were 'attachment issues' and that this judgement hampered and delayed the eventual diagnosis of her child.

Concerns about transition to adulthood and adult services were raised by two families at the event and one door-knocking in Hangleton and Knoll. One parent of a child living on the Knoll and attending a special school reported they had received no transitions advice, support or information despite her child being 16.

Many families felt their child's school was not able to cope with their needs/behaviour and their child had been sent home/given an informal exclusion as a short term solution to the lack of diagnosis and associated additional support.

Late diagnosis issues were compounded by a significant percentage of people attending the events who had children with health problems.

5. What we found out about outreach work in deprived communities

Our initial POPP project plan set out to pilot the provision of outreach in Moulsecoomb and Knoll estates with the assumption that 7-8 months would be sufficient to identify and support groups of families with disabled children, not previously known to Amaze, to come together, be supported to access the appropriate services and for their groups to become self-supporting in the longer term

A summary of what we have learnt is below:

5a. Need realistic budget for meaningful engagement

These are not 'hard to reach' communities – they are 'seldom heard from' as engagement is generally high-cost and labour intensive. If investment is not made in their engagement, they will not be engaged and their voices left unheard. Engagement with this group requires a pro-active approach, it is simply not enough to use traditional methods and it is pertinent that because of this the voices that probably most need to be listened to are hidden. These are the families that could benefit most from early intervention, yet because of complex barriers, they are not accessing the support they need and are eligible for.

This £9k POPP project budget (kindly provided by the BHCC and Link/CCG) has been insufficient to cover the costs of these two pilots in full. In reality the early stages of the pilot has cost more in the region of £15,000. In addition, we didn't factor in the need to provide on-going maintenance funding to continue to support the initial outreach advice and support needed by these families, nor the cost to provide on-going facilitation to ensure the continuation of the new support groups including the maintenance of family contacts and links to other local groups/networks. This gap in funding has been met to date by additional input from Amaze, TDC and HKP.

5b. Value for money achieved through city-wide specialist agency working in partnership with community-based organisation

Amaze has not previously been able to afford to carry out outreach work in targeted neighbourhoods. This work would have been far more expensive as a solo project as we would have needed to set up a lot of systems and, more importantly, the project would have taken much longer and required greater resources if we hadn't been able to link in to existing networks and trusted relationships in both communities.

The model of a specialist (city-wide) 'community of interest' organisation working in partnership with community development organisations has achieved real savings/synergies by using established links and relationships in the community keeping costs low and increasing our reach/impact.

The ability of partners to harness and support volunteers in the medium to long-term to support this work also makes for a very sustainable model.

5c. Partnership working needs trust and time

We also underestimated the amount of management time that the POPP would require. We took a very collaborative/partnership approach but have learnt that there needed to be one manager ultimately responsible for the project in each area. Our learning is that this should be the manager on-site in the local community and there should be regular project team meetings to ensure all partners communicate what's going well/not so well and plan ahead. All staff involved in the POPP need to have clearly defined roles/responsibilities.

We have had to acknowledge that working in partnership in new communities takes a high degree of trust and flexibility to change culture and working practices in order to best meet the needs of the project in hand. This clearly requires additional managerial capacity but also commitment and leadership and collaboration at all levels of the organisation.

5d. Door knocking/promotions processes

From the outset we were keen to incorporate time and resources to getting out in both areas to physically knock on doors and speak to residents as a proactive way to come into contact with families who may be completely isolated and not engaging with other services/school. This is the traditional approach within neighbourhoods and is the only way to reach the most isolated residents who will only respond to face-to-face contact. It's also a very good way of getting a message out into a community's networks. In each area we spent around 60 staff hours to speak to people and distribute flyers.

We identified the streets to door knock from the original data analysis work (see **appendix F**).

We believe door-knocking was very effective and the only way to reach some parents. In time we believe this will serve us well as families will remember that face-to-face interaction and we hope will be encouraged to get more involved over time. In Moulsecoomb in particular, most of the people we contacted didn't know each other and we were not building on existing contacts. This is perhaps evidence of how isolated residents are in the area and how little support residents draw from their neighbours. Face to face conversation is far more effective than just a flyer and was the best way to establish relationships. Both areas benefitted from attendance at events where the parent was already known to the CD worker

We found the door-knock also to be very successful in terms of relationship building on the 'door-step'. We met one family with a 5-year-old with a visual impairment claiming DLA but not on Amaze's Compass database. She did not come to the coffee morning but very positive engagement took place and we are confident of involving the mother at a future date. Another mother, who attended the fourth Moulsecoomb coffee morning, said that she had 'built up the confidence' to come. She was visibly moved when talking about her child as the family had just been told that he would 'not live independently'. She said that she appreciated the opportunity to talk to others 'in the same position' and discuss concerns about on-going support from Seaside View with the Amaze worker.

In Moulsecoomb we followed up practitioner contacts after the event and had a very positive meeting with Moulsecoomb Primary's Family Support Worker. She is directly targeting families who may benefit and through links with Moulsecoomb Primary School we will do a 'leaflet' drop outside the school gates prior to the next coffee morning. As projects in both areas develop, we will continue to target Schools and other practitioners working in the area to network their local contacts. This relationship building takes time and worked best when we were able to involve other practitioners at the planning stage building a feeling of 'ownership' of the project.

"We want to know what local activities are available for our children. There's nothing for them to do."

In Hangleton and Knoll we had more time to prepare (as the second pilot area) and were able to outreach to the Children's Centre staff and other community groups as well as being able to place an advert in the local newsletter prior to the first event.

Going forward, it is also important to consider targeting families with a preschool child with SEN. These are new to the system and may be at a very difficult stage post-diagnosis. There is a citywide focus on Early Intervention, coordinated by Seaside View child development centre. Amaze will explore how we can work in partnership with Seaside View as well as strengthening links with nurseries and PRESENS (Preschool Special Educational Needs Service) in order to identify families in these communities and encourage attendance and engagement.

5e. Staff/Volunteer training, increasing knowledge, capacity building

Without increased capacity/resources to allow Amaze helpline staff to attend POPP outreach sessions on an on-going basis, we have recognised the importance of the capacity building/training for the CDWs. This will enable them to better understand what services Amaze can provide to families and support them to access these (especially the helpline) and what other agencies/organisations may be able to assist with. With improved knowledge, CDWs on the ground will feel more confident/empowered to signpost families to the right agencies earlier in their relationship.

We are seeking funding to host a day's training for all staff and volunteers involved in the POPP to gain a better understanding of what services/support are available from a range of providers for disabled children and their carers. This staff training is something Amaze could provide and we could build in some basic training/knowledge on the principles of building resilience which they can use when working with families. If we can evidence the value of this, we would suggest this model could be used by other city-wide community of interest groups.

We recognise the importance of ensuring all staff involved are familiar with (and have attended training in) Child Protection and Vulnerable Adults policies and that these need to be aligned across partners to ensure a consistent approach is achieved.

5f. Service delivery is required before engagement can happen

It does appear that parents need a lot of support before they are able to run their own group and get more engaged. The first coffee morning event in each area was well funded and resourced to include 3-4 Amaze helpline/casework advisors specialising in benefits, education and transitions advice but there was no budget for on-going support which illustrates a real gap in our thinking/planning.

As such Amaze is hoping to identify some funding for an Amaze 'Outreach Parent Support Worker' to attend one coffee morning a month in each location until March'13 with the aim of continuing to advise/support parents with individual queries where possible, or support them to access support from the relevant Amaze/or other service, and to continue to support the local CDW on the ground to promote the on-going groups and provide information about Amaze services where necessary.

The hope is that once parents feel able to regularly attend their new local parent support group, they will feel more inclined/supported to engage with the development of services in their local area and then ultimately feel able to join the Parent Carers' Council (PaCC).

5g. New groups take time to 'storm/form/norm'

In Moulsecoomb, a clear evolution of the coffee morning has been seen since May. At the initial two coffee mornings, parents needed intensive advice, signposting and support. By the third, parents started to chat amongst themselves and 'share' stories, intelligence and tips. Families have shared that they are not able to go on holiday or access days out easily and so they are keen to explore

opportunities for day trips as a group. One mother said that her 12-year-old, who has emotional difficulties, has 'never been on holiday'. Parents/carers came up with their own ideas and unanimously agreed that they really needed a 'night out' for the mothers to have a 'break'. The mothers present at this coffee morning do not 'go out much' and there are financial barriers (childcare etc.) as well as emotional ones.

In Hangleton and Knoll, there have been two follow up coffee mornings post the event. Attendance is much higher in this area reflecting the much larger population and also wider mix of families attending. As well as families new to Amaze who are very vulnerable, the coffee mornings have attracted parents who currently access support from Amaze but who welcome the opportunity to get together with families who are in the same situation. At the follow up meeting the parents insisted on a December meeting (we had planned the next meeting for January) as they did not want to wait so long.

The Hangleton and Knoll community workers had more established links with parents/carers from existing work and these volunteers formed part of the planning group from the start of the project and door-knocking with Amaze and HKP staff. There are now 4 volunteer parent carers who are involved in all stages of the planning and delivery of coffee mornings. We hope that this core group might form the basis of a committee as we go into 2013 and therefore it is likely that we will achieve a constituted group in Hangleton and Knoll first.

A group is already established in Hangleton and Knoll called 'Hangleton Fun for Families' and HKP are working with them on developing their group to have the ability to offer more inclusive trips and increase the opportunities for low-cost days out for parent carers. The Chair of this group has an autistic son and is a volunteer on the HKP POPP.

In Hangleton and Knoll parents have already asked for a series of talks themed around issues such as communication and behaviour management. This is something that Amaze hopes to be able to offer in both areas as themes emerge in Moulsecoomb too.

On-going support groups need facilitating carefully, to ensure we keep up the momentum and engagement of these families. This requires on-going CDW time. For example, numbers attending the Hangleton and Knoll coffee mornings are significant (25) and it is already a challenge to keep case notes up to date. We will train CDW staff and volunteers to be able to take notes as it is vital we capture all the data to best support parents.

We are also keen to engage existing parent support groups (The Parent Carer Council (PaCC), the 'parent voice' work stream within Amaze has 'partnered' with several parent led groups such as Pebbles and Sweetpeas) that support children with SEN and disabilities about what has worked/not worked for them and how they started/barriers to development. We could also see if one of these groups would support the development of the new, local parent carer group in conjunction with the CDWs. This sort of peer to peer learning would be in valuable and very empowering.

We would like to link new parent support groups to PaCC so that at some point these new groups will become the PaCC partners of the future. Parents/carers may feel able to join PaCC and become more involved in at a city-wide level. Similarly we would like to link the new support groups to representative structures in their own neighbourhoods such as Local Action Teams, Community Forums and Patient Participation Groups. This would enable them to build relations with other community groups with complementary aims.

5h. BME involvement

Sadly no parents have yet attended the groups in either area, from BME backgrounds. This is disappointing as the Hangleton and Knoll team visited the Multi-Cultural Women's Group and the Moulsecoomb team visited the Bangladeshi Women's Group, both explaining the background to the

"Some health visitors are good, some aren't. There needs to be better consistency in their service."

POPP and publicising the new support groups. One member said she would bring two of her friends along who had children with Special Educational Needs (SEN) but they didn't come, but with further engagement opportunities she may. This is an area that needs further on-going work and it is likely to be a 'slow burner'.

We understand city-wide parent carer support groups (such as Sweet Peas and Pebbles) are having more success attracting BME families as they are often introduced through a health visitor or speech and language therapist (SALT). We need to do more work linking up with health visitors, SALTS and health visitors to build these relationships so that they can 'refer' families to the POPP groups. One barrier is often the need for an interpreter and this is an area that would benefit from discrete funding.

Our next step will be to ask the established groups (the Hangleton and Knoll Multi-Cultural Women's Steering Group and Moulsecoomb Bangladeshi Women's Group) for their advice on how to identify families with disabled children in their communities and offer to run a separate/subgroup coffee morning for families needing interpreters, which could then become part of the main support group once initial needs/concerns have been discussed. Feedback is that a face to face support group without offering interpreters will not succeed in attracting the most vulnerable BME parent carers.

5i. On-going roles for POPP

We have learnt that HKP, TDC and Amaze need to provide an on-going resource to attend the monthly coffee morning/support groups whilst they are still so new in formation and parents have so many pressing concerns/problems. **See 5g)** above.

One model would be to ask trained Amaze helpline staff to go on a POPP rota and attend these meetings in turn as part of their 'helpliner' role. But demand for Amaze's helpline is huge and at present we can't take these staff out to work on the POPP (**see 6e** below). We are seeking funding for an 'Amaze Parent Support Worker' to attend follow up groups, supporting the CDWs on the ground. They are needed in addition to the CDW as they can listen empathetically to the parental concerns from their own experience of being a parent carer and can suggest services/support to access and help signpost/refer the parents to these. We need to consider whether this person should be provided with an Amaze mobile phone so families can easily make contact with them for support.

To ensure sustainability of this work, we need to identify some resource to deploy our specialist Amaze caseworkers to provide training/awareness raising for the CDW staff (see e) above so they can be armed with information/leaflets about what services Amaze offers and refer appropriate families to us. It is important to build the capacity/knowledge about Children and Young People with SEN in the neighbourhoods and this is potentially a model that could be rolled out across the City and with different target populations.

5j. Promotions/building relationships locally

We need to continue to produce the flyers promoting the POPP support groups and ask that other agencies/groups/services use the leaflets and refer relevant families to us.

It has been vital to build links with local schools, helped in Moulsecoomb by locating the meetings in the local primary school and in Hangleton and Knoll by a parent volunteer who has links with Goldstone Primary. We need to ensure we have direct contact at the schools on a regular basis and have explained the project to the schools SENCO (Special Educational Needs Coordinator). We are trialling the effectiveness of school gate leafleting at Moulsecoomb Primary School although this has also revealed the stigma felt by parents as they feel judged by other parents at the gate. Leaflets were put in the book bags at special schools but the key is to capture the very large population of children with SEN who are at mainstream school. We are working with local

mainstream schools to add flyers to the book bags of children on their SEN register and to help us promote the coffee mornings.

We need to continue to promote the coffee mornings through other channels too for instance:

- Local fun days are very well attended and an Amaze stall at these events would reach a range of local families but we need resource for this.
- Neighbourhood practitioner groups build links between services and groups. Amaze workers could join these practitioners group in target areas if resourced (e.g. Coldean, Bevendean and Moulsecoomb) or present at local representative groups such as HK Community Action.
- In both areas the CDWs are making links with GP surgeries and this will prove helpful as a referral point when on board.

There are opportunities to learn from other services such as the Carers Centre who are launching a group aimed at carers from the LGBT and BME Populations. There are community engagement parallels and lessons that can be shared such as project planning and uptake as we start to disseminate our findings.

5k. Sharing information/data about families

Staff and volunteers working on the POPP have had to learn how to work best to gather, then share appropriately (and with permission), sensitive information about each family.

For some families, this may be the first time they have shared certain thoughts or problems and we have had to be very respectful of that, whilst needing to be clear that Amaze/TDC/HKP are working in partnership and checking if they are happy for their information to be shared.

Following the first Hangleton and Knoll coffee morning the team decided we needed to create a POPP Case Notes sheet – to prompt those speaking with families to capture the necessary data/information. These case notes are now being added to the Amaze database so if families subsequently ring/access Amaze services this will not need to be repeated. A consistent approach has now been created across both areas with 'template' forms for 'case notes' and spread sheets detailing parent carer details.

As facilitated group support sessions continue we need to clarify the system for recording any information shared in group work so this intelligence can be collated and reported upwards.

5l. Planning ahead

It's vital to spend enough time project planning and to book in dates for groups to meet (coffee mornings) as early as possible, to allow for staff/volunteers/venues to be booked. Publicity then needs to be arranged and we've learnt the importance of advertising in the local community newsletters. In hindsight, we probably rushed the first event in Moulsecoomb (our first pilot site) in order to get the project started before the school summer holidays and we missed the deadline for the Moulsecoomb Community newsletter.

An advert in the Knoll Scroll and Hangleton Harbinger did result in parents attending as well as raising general awareness in the community which builds momentum over the medium term.

5m. Working with / signposting to other agencies

As mentioned in **4c) above**, the POPP has been signposting/referring families to other agencies where appropriate. Going forward, it will be important for the CDW to consider how best to link this work with other colleagues e.g. housing officers, or MIND and the training mentioned in **4e)** above would help consolidate understanding about what other agencies offer.

6. Recommendations for funders & sector

6a. Investment needs to be made in engaging with 'seldom-heard' families

See 4a) above

6b. Recognise the highly-effective and value for money partnership approach between local neighbourhood organisation and city-wide community of interest organisation

The POPP has brought real benefits for all partners – with specialist knowledge being taken into the communities and geographical/community expertise being shared with a city-wide service provider. CDWs know the unique challenges of the area and have established and trusted networks and relationships and Amaze staff understand the particular challenges facing families who have a child with a special need or disability.

Synergies are created by offering a 'lure' in terms of a specialist service/advice/support session, in a locally accessible and trusted location, then leading to increased engagement/participation/voice.

6c. Recognise that significant outcomes have been delivered already

These can be evidenced in more detail with some additional funding to support monitoring.

6d. CCG, Public Health, Stronger Families/Stronger Communities to consider joint-commissioning future engagement

The POPP is already reaching families who are 'seldom heard from' (**see 4a** above) and is helping to reduce health inequalities and deliver positive impacts across health/well-being, education and social care. As such we would like strategic commissioners in these areas to consider jointly funding this work on an on-going basis.

This model could be replicated across other CCG Engagement Gateways to achieve benefits from a co-ordinated approach between community development support and city-wide engagement gateway organisations.

6e. Agreement to fund an extension to POPP during 2013 and beyond

This could be via the CCG Engagement Gateway, HealthWatch commission, or other joint commissioning opportunities, and would allow us to support the development of two self-sustaining groups in Moulsecoomb and Hangleton and Knoll. This would recognise that POPPs need a bit more initial/kick-start investment recognising that after 18-24 months these groups are likely to be self-sustaining. Investment for 2013 would allow all partners to employ staff for one day a month each – at Amaze this would be a part time Amaze Parent Support (outreach) worker and at HKP and TDC this would be a contribution to their CDWs.

It should be noted that project costs have been significantly reduced by the support matched via the Community Development Commission/Grants.

In 2014 we would like to begin working in partnership with local community development consultancy Serendipity to extend this work into Whitehawk and the Friends, Family and Travellers Project to test this approach with the traveller community.

6f. Need to increase capacity for Amaze helpline.

The pilot has highlighted the need for extra capacity on the Amaze helpline. Frequently parents have said they have tried calling but as the line is engaged and they are asked to leave a message they often don't bother/don't have the courage to. Amaze has seen an 86% increase in calls in the last 5 years with no uplift in funding. Commissioners could consider if they can help find some additional resource for a very over-subscribed service. Amaze is also keen to develop new, more accessible ways, for parents to contact the Helpline – for instance being able to text the Helpline to ask for someone to call them back.

6g. Identify funding for Amaze to deliver a resilience-building course for parents/carers in each local area.

Amaze's Insiders' Guide is an 8-week course designed to increase parent carer resilience and capacity to cope with caring for their disabled child.

An independent evaluation (April 2012) of this training showed for every £1 invested in the course there is social value created in the range of £24-38. The evaluation said parent/carers reported significant changes for themselves and their families as they became, equipped, informed and confident. The resilience elements were of particular importance for parent carers coming to understand the need to attend to their own health and wellbeing in order to continue caring for their children with additional needs in the long term. Parent carer improvements in: confidence, securing more help and support, willingness to ask for help, feelings of isolation versus connectedness to others, use of new ideas and strategies in everyday situations, more positive general outlook for the future, and greater interest in joining other learning situations in the future (evidenced by pre and post measure in each of these categories).

Families attending the groups in Moulsecoomb and Hangleton and Knoll have told us they struggle to access training (and other services) in city-centre locations so often miss out on the benefits this can bring – not just the learning but the social networking/inclusion aspect too.

We would like to offer an IG course for each group at a cost of £3,250 per course.

6h. Accept that early intervention/engagement with these families is essential and saves money in the longer-term.

We know that if a child with complex needs full-time residential care as their parent carer can no longer cope with them at home; this can cost the city up to £250k per annum. Also, new figures show that the average 'troubled family' costs around £75,000 a year to support and we anticipate many of these identified in the city may have children with SEN. If we can engage these families early, and help them to feel less isolated and better able to cope, this should generate savings in the longer term.

Appendix A:
Trust for Developing Communities
– full findings and case studies from Moulsecoomb

a. Process in Moulsecoomb

Our aim was to contact residents of the fifteen streets in Moulsecoomb that the Databridge analysis had identified as having 64 children on disability living allowance that were not in touch with Amaze services.

We set up a team of staff and volunteers from Amaze and the Trust to knock on the doors of 1,500 homes in the area. Volunteers were recruited from a pool of parent carers and two were involved in door knocking. Overall the 'door-knocking team' was made up of three staff and two volunteers and they worked in teams to ensure one person knew the neighbourhood well and one could answer queries about having a disabled child.

We visited all the homes over five days in July 2012. Most visits took place during the day and the team found that in the main there was someone in the household who answered the door and was keen to talk about their child. Many residents who didn't have a child with special needs knew of another family or friend who did.

From door knocking and leafleting over 1,500 houses, approximately 200 residents answered the door and from these 52 said they had or thought they may have a child with special needs. This was just over 25% of the households contacted self-identifying as having a child with special needs.

Contact details were taken from approximately 25 families who said they would be interested in attending the first coffee morning event. Some were already on Amaze's Compass database already. Eight were not and were new families to Amaze.

We wanted to bring families with disabled children together in a local, well known venue and chose the community room in Moulsecoomb Primary School as an accessible place that most families were familiar with.

In order to meet the most pressing needs we provided immediate outreach advice from Amaze staff with DLA and transition advisors from Amaze attending. We promoted the idea of forming a new parent support group and had unanimous agreement that it was a good idea to set a group up. We also provided free pampering, tea and cakes which encouraged parent/carers to stay, chat and share experiences.

The first coffee morning was booked for July 16th so that it fell in the last week of the summer term and seven parent/carers attended. Whist we managed to hold the event before the school holidays it fell in a busy week for the school and on a particularly wet and rainy day which meant parents were not in school for the cancelled sports day.

From this first meeting we established that many of the parents/carers attending had significant and multiple needs. We recognised that significant support would be needed to firstly meet their immediate concerns and needs and to then work with them to set up a regular support group.

b. Initial findings in Moulsecoomb

- **Grandmothers play a significant caring role.** Two grandmothers came in place of daughters who were struggling. These grandmothers were, in fact, caring for the children with special needs most of the time.
- **Parents have needs themselves.** One mother who rarely went out of the house managed to attend with support and encouragement from the door knocking team. The mother's mental health problems were significant.
- **Families are facing multiple challenges.** We found that these families have complex and multiple needs; for example many single parent households were struggling on benefits and were very concerned about forthcoming benefits changes.
- **There can be an educational impact.** Parent/carers reported that for various reasons their children were often missing a lot of their schooling. There were also concerns about their child(ren) being excluded.
- **Accessible low cost activities are needed.** Families wanted more inclusive activities and places to go for their child with special needs within the local area.

c. On-going work and findings in Moulsecoomb

Initially it was decided to try to hold a fortnightly coffee morning at the local Moulsecoomb Primary School and flyers were made and circulated to publicise the event. Three families attended the first three events and a further, new, family attended the 3rd coffee morning. Another new family attended the fourth coffee morning. The mother said she it had taken her several weeks to gain the confidence to come along. This mother was feeling upset as she had been told, at a recent appointment, that her son would "never live independently".

The families who have been attending regularly have distinct and complex needs and Amaze has had to consider carefully what on-going support it can offer them given there was no on-going budget to perform outreach work. However, one family has been able to access the DLA project and is being set up with a DLA volunteer to provide help completing the DLA application, which is a service provided in the family's home. One mother has been provided with the Amaze social work student to act as her informal support worker/advisor. The mother reports that she is finding this hugely effective and has said she feels better able to cope following this support being put in place.

The TDC team has also been able to provide information and links into other neighbourhood and city support services including the Bridge Community Education Centre and Mind.

Following these first two follow up meetings, and in order to avoid the half term break, we revisited initial contacts and also approached the school support team about referrals to the coffee mornings.

We also targeted those families living in the area who were already on the Amaze Compass with the intention of engaging families who may have been at a different stage of their caring journey, with possibly fewer immediate needs, and maybe more able to take a lead with group.

The second 'door knocking' went very well but we were unable to turn these contacts into attendance at the coffee morning, highlighting the levels of trust and confidence that need to be built for families to feel able to access services. One new family attended all three coffee mornings and this family is now able to tap in to the full range of Amaze's services. Two families had new concerns about a 'sibling' of a child already on Amaze's database and Amaze is able to help with assessment and possibly DLA in the future.

Given resourcing constraints, a monthly parent support group will be facilitated. In the New Year, when individual issues are more resolved, the group will start to look at locally accessible integrated

activities and ways of broadening engagement so that families with children who have special needs can access them.

d. Outputs/outcomes in Moulsecoomb

As a direct result of the pilot outreach project in Moulsecoomb we have achieved:

- **Three parent/carers supported to do a DLA application for their child**. There will be a likely financial output of £8-12k per annum if the applications are successful. Achieving DLA for a family has been evaluated as an important mental health intervention[3].
- **Improved health and wellbeing** reported through group sessions resulting from having space to share problems and peer support.
- **Three parent/carers supported to resolve SEN concerns** about their child with schools.
- **Two parent carers given support with forthcoming meetings**. Meetings with professionals can be stressful for parents and help with planning the meeting (and writing up notes) was reported to be very helpful.

e. Conclusions and learning from Moulsecoomb

- The families we contacted through the door knocking were isolated and not part of existing community groups. This makes it more difficult to build a parent/carer support group and the community development worker visited many generic groups and services to build up contacts. The school has been very effective in introducing families and once the autumn term started the newest two families both came via school contacts. Our learning is to build strong links with school support team early on in the project.

- Families with complex needs find it difficult to commit to regular activity. It has been an achievement to now have five 'regular' families in Moulsecoomb who are committed to the group. We have found that the sessions need to be informal and unpressured and that we needed to offer information by post and email as well as through attendance at group.

- Families with several children can find it difficult to get out of house for activity. We will need to support the group to strengthen if they want to eventually constitute and fundraise independently. We are looking into how supported activity can be funded for whole families.

- Those attending the group have very specific queries regarding the support they can access and so are using group as an advice surgery because they find accessing central services and the helpline difficult. We are looking at how to improve access into central services rather than duplicating them locally.

- The group will need a range of members to be sustainable so that there are members who can take on running the group. We are approaching families who are already on the Compass to bring more experience to the group.

- Four families have so far been referred on to appropriate other service including Mind, the GP, the Bridge Community Education Centre, the Amaze helpline and Social Services.

  There was significant confusion about role and remit of service providers from those families who went to the drop-in– pupil services, Seaside View, the school and the GP. One family reported that the SENCO at their son's primary school had failed to engage with Seaside View and the family had self-referred in the end. There is confusion over who can refer and

[3] University of Brighton's Independent Evaluation of the Amaze DLA Project, November 2012

the family spent months waiting before taking action themselves.

We are exploring how to get some basic referral route information out to families.

- There are significant issues around transition from junior to senior school and the late flagging of a child's needs. For example families whose children are about to apply to secondary admissions are not sure if should be at mainstream school. This transition was described by one parent as 'scary' and the whole idea of moving schools perplexed parents. One parent, whose son is very unhappy and not making progress at a local primary, said, "I want to look at other schools but I don't know who to phone."

  So that workers can support families we are providing them with clear timetables of this process and information about Amaze's transition work including copies of Through the Maze and Through the Next Maze - Amaze's comprehensive handbooks to services and the journey of having a child with special needs.

Appendix B:
HKP – full findings and case studies from the Knoll Estate

a **Process in Hangleton and Knoll**

In total 29 roads were 'door-knocked'/flyered over. Three teams of 2 workers worked a total of 15 hours between 23/10/12 and 05/11/12. We knocked on about 1,800 doors speaking to 300 people and 34 identified as having/knowing a child with special needs. We also identified 8 older people and gave information about older peoples groups and 5 people interested in IT learning. 18 said they would be interested in attending the initial coffee morning with 2 specifically unable to make it. There were 7 people in total involved in doing the door knock including 2 CD workers, Amaze worker, Hangleton Holistics and 3 local resident parent carer volunteers who were already involved in HK community groups.

The Project Team comprised of the 2 CD workers and Amaze worker plus Hangleton Holistics and 3 local parent carer volunteers. 6 planning meetings were held including one on the day.

Posters and flyers were distributed across the attached area to a very wide variety of venues to really raise awareness.

Hangleton Community Centre
St Richard's Church and Community Centre
Portage Children's Society
Little Ducklings Nursery (HCC)
BHIP
Hangleton Children's Centre
Sama (HCC)
Dance school (HCC)
Circus project (HCC)
Tiny Tims (HCC)
Hove Park School
Blatchington Mill School
Goldstone Infant and Primary School
Hangleton Infant and Junior School
West Blatchington Primary School
Little Lambs
Oasis Church
Hangleton GP Surgery
Burwash Road GP Surgery
Shops at Grenadier, Burwash Road, Margery Road and Boundary Road
Community Noticeboards
Hillside
Downs Park
Extra time
Drove Road
Swan Centre
Blakers
Sweet Peas parent and toddler group
Patcham House
PACC (Parent Carer Council)
Jeanne Saunders
Little Darlings
ACE

Tudor House
Link Plus
Seaside View (nursery nurse)
HK Community Groups -
Sunbeams
Fun for Kidz
Socca tots
Hangleton Fun for Families
Hangleton and Knoll Multi Cultural Women's Group
50+ Steering Group
LGBT Group

On the day of the event, one parent carer who was very anxious was collected and brought to the event with her son by the CDW. Before the event we telephoned all the parent carers that we had made contact with via door-knocking.

The kick off coffee morning in Hangleton and Knoll took place in St. Richards Church hall on 6th November, supported by a team of 4 from Amaze, 4 from HKP and 2 volunteers. **17 parents/carers** attended and were offered 1:1 advice from the Amaze advisors and HKP staff, as well as a Hangleton Holistic treatment and free tea and cakes.

b) Initial Findings in Hangleton and Knoll

- Benefits changes were mentioned frequently. One parent reported that she had her DLA stopped with no warning
- Compass forms were mentioned as difficult to fill in. Two parents had received Compass forms and had felt unable to complete them. Several parents had not renewed their child's Compass card, even though some had been sent the forms
- The complexity of applying for DLA was an issue
- Informal exclusions from school
- Lack of support from school leading to one father spending all of each and every day supporting their child in school leaving him unable to work
- Caring responsibilities for a wife as well as children
- Lack of advice and support at key transition points (junior to senior school and to adult services) raised by 3 parents
- Sibling issues and lack of local things to do
- Affordability of transport

c) **On-going work and findings in Hangleton and Knoll**

Parents voted at the initial event that they wished to meet again on a monthly basis and that they would like the meetings to be facilitated by the HKP and would be happy to contribute £1 to the cost of the venue hire.

The second coffee morning was held 27th Nov. CDW door-knocked the addresses of known parent carers again and utilised the school contact that emerged from previous door-knocking and circulated flyers as before.

The second event attracted **16 parent carers** of whom 8 had attended the first event. The team of parent carer volunteers all attended, helping with refreshments and making parents feel welcome. The group started to evolve as parents began to share stories with each other. The Amaze worker took all the notes which was tricky because of the numbers of parents there. In future HKP staff and volunteers need to be trained to write up case notes. Many parents expressed their feelings of isolation and of coping alone. We had drafted dates for monthly future meetings starting in January through till April but there was a unanimous demand for a December 18th meeting. This has been agreed along with the monthly dates for 2013.

We are not only picking up families with known needs who have felt unable to 'navigate' the DLA and compass forms but also new families with younger children (pre-school) who are new to the system. Also some families may be eligible for a higher rate of DLA that may then be the pathway to other benefits and support. One family in Hangleton and Knoll had had their DLA at the higher rate taken off them even though their child has a life limiting condition (as it was viewed that her difficulties are not as substantive currently). They lost their entitlement to Motability and therefore their car and their entitlement to Carers Allowance. They are fearful of appeal as they have been told that their daughter would have to appear in court. This family were able to be signposted to Amaze for further specific advice around the DLA process. Several families are very worried about the benefits changes and in losing their DLA and have questions about DLA post 16. Issues of late diagnosis were raised again with one Mum talking about her daughter who is in year 5 but is only now being assessed for having autism/ADHD. GP's were criticised by another parent for a very slow referral with Mum having to chase and wait a long time for referral to Seaside View. Another parent was not even aware of Seaside View and the role it could play with her child. There was feedback about difficulties with thresholds and access to CAMHS services and of the lack of services and support in general with mental health issues. A new parent attended, unknown to Amaze whose teenage daughter is only part time at Hove Park but whose violent behaviour is causing problems. Mum is worried and feels "there is more going on with her but the school just describes her as disruptive".

Liaison between services was raised as an issue by a family with disabled children aged 22 and 27 with special needs who have been told that their children need to move out but they are worried that Bed and Breakfast might be the only option. They are living as a family of 9 in a three bedroom house.

Parents identified behaviour management as a theme which could benefit from some additional input in future. They are really interested in having speakers. Parents also raised issues with GPs which we will ensure are fed into local PPGs and surgeries.

d) Outputs/outcomes in Hangleton and Knoll

As a direct result of the pilot Outreach project in Hangleton and Knoll and after only 2 coffee mornings we have identified

- 7 new families not in receipt of Amaze services
- 8 parent carers supported to do DLA
- 1 Compass card sign-up from a parent receiving DLA but no compass.
- 25 parents who have attended a coffee morning
- Carers Card information circulated
- 4 Parent Carers as active volunteers in Project
- Tailored advice given around issues ranging from behaviour management to bed wetting.

e) Conclusions and learning in Hangleton and Knoll

- This project was helped by existing HKP contacts and community group members with 4 parent carers who have become volunteers and have supported the door knocking and the coffee mornings.
- A couple of parents are so vulnerable that they have required collecting to have the confidence to attend.
- It's clear that this new parent group will not be ready quickly to constitute as independent, the level of need and vulnerability is just too high. However we continue to work to bring in better networked and less vulnerable parents who can both peer support but also perhaps together with our volunteers maybe form a committee. We will aim for constituting this group during 2013.
- On-going CDW facilitation and Amaze expertise is necessary in the medium term.
- There has been a demand for us to ensure we fully include Hangleton, there were not so many parents unknown to Amaze on the estate however it is felt by some parents that there is a high level of need for face to face contact.
- The issues around form filling, complexity of service provision, late diagnosis and lack of statements are indicative of the issues faced by parent carers living with multiple disadvantage. There is a clear need expressed for extra support for these parents especially when there are mental health issues on the part of the parent.
- Really reaching parents was time intensive and the project massively benefitted from having 2 CD workers and 3 volunteers supporting the outreach door-knock phase.
- The 'door-knock' following the first meeting brought in 8 new parents to the second meeting.
- To get the involvement of parents from BME communities we feel we need a separate session with interpreters. Perhaps a session where we get people to book onto as need will be very high and face to face on-going support might be better met through the existing BME mechanisms alongside the Parent Carer group.

Appendix C:
Partnership Outreach Pilot for Parent/Carers: - Outputs Table

	Moulsecoomb	Hangleton & Knoll
No. households 'door knocked'	1500	1800
No. households opening door	**200**	**300**
No. households spoken to identifying with SEN child	**52**	**34**
Of these no. dads presenting on doorstep or at coffee morning	4	2
No. parents/carers attending coffee mornings	**9**	**25**
No. of these 'new' to Amaze	**13**	**7**
Of which not pre-school	5	3
No. grandparent carer presenting	3	5
No. supported to join Compass – total New Renewals	**11** 7 4	**6** 4 2
No. with DLA not on Compass	1	0
No. helped with new DLA form	**6**	**8**
No. helped with SEN statement	**3**	**5**
No. helped with other forms	1	2
No. where Compass card expired (not renewed) or not joined despite invite	4	2
No. on Amaze Compass but not further engaged with Amaze: - For over 1 year - For over 2 years - For over 5 years - Ever	 3 2 2 3	 6 1 0 2
No. with one child on Compass but with new sibling identified	4	0
No. not attended coffee mornings yet but are 'hot leads' to follow up	9	3
No. new parent carer volunteers for the area	1	4
No. CYP excluded from school, according to what parents told us	1	1
No. CYP on part time timetable	1	3
No. CYP problems with school refusal	1	2

Special/difficult circumstances (leading to multiple-deprivation)
Amaze is able to gather more in-depth information for families who access our DLA project (delivered by volunteers meeting with families in their own home). We are entrusted with more details about special/additionally-difficult circumstances (SCs) e.g. experiencing domestic violence, disability/mental health problem of carer, living on benefits, foster carer etc.

Analysis from this shows: 79% families had at least one SC.
30% had 3+SCs (rising to 41% in the more deprived wards including Moulsecoomb and Hangleton & Knoll)
34% had 4+SCs (rising to 45% " ")

Appendix D:
Case Studies

Case study 1:

Family's situation (carer's needs etc.):
Parent with three children, a boy aged 15, at a local secondary school and waiting for a re-referral to CAMHS, and a girl aged 7, who is at a specialist school 'unit' and a girl aged 2.

Mum has significant mental health needs and is worried about on-going therapy (she has been doing a course of CB therapy that is about to end). She has anxiety disorder and goes through periods when she does not eat. She has not had a meeting with her health visitor for several months. Housing concerns are exacerbating Mum's mental health needs (she says her 'bathroom is falling apart' which she finds really stressful). Mum was taken in to care as a child herself and says she is 'wary' of social services. Mum says she has many days when she feels she can't get out of bed.

Details of the child with special needs and their diagnosis or needs:
Her 7-year-old daughter who has speech and language difficulties and also delayed fine motor skills. The mother reports that her daughter is passive and does not 'feel pain'. She is still in nappies. She is also worried about her 15-year-old son who has been under CAMHS (Child and Adolescent Mental Health Services) before due to anxiety issues and has been referred again. He is showing signs of OCD (constantly washing hands).

What help does the family need?
This family needs help across several areas. They need help with housing as mum needs help to get the right repairs that need to happen to her house. Mum needs support to access the right help for her little girl and 15-year-old son. Her 15-year-old is still awaiting an assessment with CAMHS. Mum describes him as 'very anxious' and 'paranoid' and 'emotionally immature'. Her little girl is well supported at a unit at the moment but is still awaiting blood test results from Seaside View. Mum will need help with the statementing process going forward. The family also needs financial help, support to get DLA for mum and for her little girl. The Compass Card will also allow them to access activities for free or at a reduced rate. The mum needs support from adult mental health services as she is worried her mental health could impact on her ability to care of her children. She is bordering on agoraphobia. She has just completed CBT with Mind but this is about to end. There seems to be a lack of a clear pathway for help and 'waiting lists are long' (mum's words).

What barriers are they facing?
This family is facing multiple barriers including financial pressures, mum's mental health problems, poor housing, difficulties parenting two children with special needs and relationship difficulties.

How did our outreach pilot help them?
Amaze was able to offer support through its student social worker (Mum did not feel wary of this as the placement was with Amaze, an organisation she trusts) and she will contact the family's health visitor. Mum reports feeling very well supported by this. Amaze's temporary 'Outreach Parent Support Worker' also enquired about a keyworker for the family (through the keyworking service at Seaside View) but the child needs to be receiving input from four different services to be eligible. Amaze is currently carrying out this 'keyworking' role in an unofficial way through the student social worker, helpline, DLA and IPS project.

What needs to happen next?

This is a family who are at risk of 'falling through the gap' without on-going support and intervention. Eventually this family could access the key working service at Seaside View as it is likely the little boy will have four health professionals involved (has two to three currently). Mum seems to really benefit from the on-going coffee mornings and is likely to engage with a support/outings group. As a result of intervention from Amaze's student social worker, mum seems visibly more able to cope.

Case study 2:

Family's situation (carer's needs etc.):
Mum and Grandma with an 8-year-old daughter with severe anxiety issues and possible ASC and a 2-year-old son with no apparent difficulties.

Details of the child with special needs and their diagnosis or needs:
Their little girl was having huge problems at home and school. She is being bullied at school, sleeps with her mother, as she is very anxious and has many 'phobias' (hair washing, scratchy clothes, loud noises). She will only eat certain foods and obsessive behaviours (she is obsessed with computer games). She has difficulties forming friendships and gets on better with children who have special educational needs.

What help does the family need:
Their concern was that they would get to the assessment (with a paediatrician and speech and language therapist) and would not be able to articulate their on-going concerns about their child, who exhibited anxiety, behavioural and social communication difficulties.

What barriers are they facing?
The family were also concerned about housing (mum and grandma provided a 'team' to support the child as Dad is not around) as they were not able to live together in a three bedroom house due to restrictions in the council's housing policy. Mum and grandma 'pool' their money (Mum works and Grandma has a pension) but struggle to get by. The little girl does not see her Dad. The little girl can be aggressive to the grandmother when stressed/anxious.

How did our outreach pilot help them?
Amaze was able to offer bespoke support to the family who were very worried about a forthcoming meeting at Seaside View, the child development centre in Brighton & Hove.
The temporary Amaze Outreach Parent Support Worker prepared a detailed history of parental thoughts. The family reported an increase in confidence about the meeting and were grateful for this specific support. This family do not currently get DLA. They believed that you had to wait for a 'diagnosis' but Amaze's DLA project lead was able to reassure them that they can still apply and this process is being undertaken.

What needs to happen next?
Nervousness about appointments and letter writing was reported by several parents and they really benefit from somebody capturing their thoughts for them. This family would benefit from counselling (mum and Grandma). The school appear to have lots of support in place. Housing is a particular issue for this family as they are living in two separate council houses (one in Moulsecoomb and one in Saltdean) and because of council red tape cannot live together (so two lots of bills and logistically very difficult). CD Project Manager to approach local councillor about writing a letter regarding this.

Case study 3:

Family's situation (parent carer's needs etc.).
Grandparent has been bringing up her grandson since birth. The child's mother has a genetic condition (as does her brother) so the grandparent also cares for both her adult children who have special needs/learning difficulties.

Barriers: This grandparent carer's physical mobility has deteriorated over recent years and she now walks with a stick. She is less able to attend city-centre (Amaze etc) events. She and her husband are worried about the future and what will happen to their grandson when they are no longer able to look after him. The family also worries about his DLA status and what will happen when he turns 16 as he is not able to manage this himself. The family are also concerned that the diagnostic process may not have been thorough enough. He has only had one of the available tests for the condition that affected his mother and uncle, for example. The family report that they have been discharged from local child development centre, Seaside View.

How Amaze has helped this family overcome those barriers: Amaze's DLA team was able to advise the grandmother on how to continue to claim the DLA on behalf of her grandson once he turns 16.

Outcomes: The grandparent reports feeling less isolated since attending the first two coffee mornings in Hangleton and Knoll and plans to attend on-going monthly coffee mornings. The key is that they are local and she can get to them. She takes great solace from listening to other families' experiences and she reports that the coffee mornings have boosted her wellbeing.

What needs to happen next: She would further benefit from a 'grandparent' focused event in her community. This family would benefit from on-going regular coffee mornings. There are other issues that Amaze can support her with such as signposting to help with 'will writing' and planning for the future. Amaze will support the grandmother to approach Seaside View regarding possible further testing.

Case Study 4:

Family's situation (carer's needs etc.):
Single-mum with significant mental health problems and agoraphobia. She has two sons and the youngest is not attending school currently.

Barriers:
Multiple-barriers. Mum has significant mental health needs. She is very worried about money and also she feels her housing is not appropriate (two bedroom house). Her son faces significant isolation. The CDW identified that this mum seemed particularly isolated and lacking in confidence so she gave them a lift to the event.

How Amaze has helped the family overcome these barriers? This family have been assigned the Amaze IPS co-ordinator to help identify what support they need. The Amaze DLA project also helped to assess that the family were getting the right level of DLA.

Outcomes: It was a huge achievement for mum to attend coffee mornings and feel 'safe' to return for a second time. Her confidence was visibly lifted. With IPS support the youngest child now has a statement of SEN. The IPS co-ordinator helped mum negotiate a package of home tuition and joint CBD in the home

What needs to happen next?
With on-going coffee mornings, we believe the POPP can make a real difference to this family. Mum trusts the team and sees us a source of support.

Appendix E:
Background and Pilot Methodology

a) Background

In 2011 the Oxford Consultants for Social Inclusion (OCSI) worked on a project called Databridge looking at how to maximise the potential and intelligence from data gathered and held at 5 Brighton based VCS organisations. Amaze participated in this project due to it hosting the City's register of disabled children – called the Compass - (a statutory duty) on behalf of the Local Authority. This Compass Database holds up to date records of approximately 1,500 children and young people with significant (in receipt of DLA or statutory assessment of SEN) disability or special need, approximately 50% of the total population.

The Databridge project supported Amaze to analyse its data against nationally available datasets, in this case the DWPs data on childhood DLA claims. It found that the Compass database held details of 55% children (under 16) of the total DLA claimants in the City – an undercount of 657 children. The analysis was able to then pin point exactly 24 Super Lower Output Areas (SLOA) – collections of streets – where the Compass undercount was greater than 10 children.

Areas in Moulsecoomb, Whitehawk and Hangleton and Knoll had the largest undercounts: 4 SLOA's in Moulsecoomb totalling 64 children on DLA not in touch with Amaze services, and 26 children in Hangleton and Knoll.

This study set out very clearly what we already knew: that whilst Amaze's management of the disability register (and subsequent membership) was frequently cited as one of the most successful in the country, we were still not reaching everyone – particularly in these more deprived neighbourhoods in the City.

This very powerful data showed our current strategies were not working for some sections of the community and Amaze decided it needed to work more closely with the community development organisations in these areas in order to change this pattern.

Amaze decided to trial a new way of outreach working in two pilot sites at opposite sides of the City and develop a partnership venture with the relevant community development teams in situ: Moulsecoomb – with the Trust for Developing Communities and Hangleton and Knoll with the Hangleton and Knoll Project.

b) Assumptions we wanted to test

We assumed that these families may be facing multiple deprivation factors alongside their child's disability e.g. parental mental health problem or own disability, poverty, adult illiteracy, English as second language etc. which may be preventing them from accessing Amaze and other services. We also assume it is unlikely these families will be engaged or participating with the city-wide Parent Carers Council (PaCC) or other engagement opportunities.

We assume that newly identified parent carers may be isolated and may need some support to cope with their own lives before they feel able to participate more fully in their community or with the PaCC.

c) Pilot aims

We know families with disabled children are high incident, high-cost users of health services[4] as well as other services, and we all have a duty to reach out to them to find out why they are not engaging with local services. At the outset we were hoping this pilot would lead to:

ix. Increase in the number and diversity of families with disabled children that are aware of services provided by Amaze.
x. Increase in the use of Amaze services within the groups identified as currently out of reach.
xi. Parents feeling more confident and resilient to cope in their caring role.
xii. Increased Compass registrations - with associated financial savings (we estimate the leisure discount card saves the average family £650 per year) and other health and well-being benefits of undertaking more physical and leisure activities.
xiii. To increase the number of young people with special needs attending and taking part in community based leisure and sporting activities (Compass Activities)
xiv. Increase in the representation on the PaCC by families from the targeted groups.
xv. Parents feel less isolated and more empowered in their neighbourhood (more informed about local services available for them and their children).
xvi. Parents in group can feed into relevant consultations affecting them themselves or their views consolidated and presented by Amaze or PaCC representation at key strategic meetings.
xvii. Parents in group can be part of local decision making about local services or their views consolidated and presented by local community development organisation at key local meetings.
xviii. We will ensure support group is sustainable and if required, can set up as own (finances, constitution etc.)
xix. Communication of successful engagement methodologies to local partner groups and the National Parent Partnership Network.
xx. Skilling up Community Development workers on the ground.

We were hopeful that following an initial 'launch event' (one coffee morning in each neighbourhood) a group of parent carers would decide to establish themselves as a parent support group – who could then be supported by the CDW to be self-sustaining. We knew that it was likely that these groups would then need to attract further funding to continue and to provide more support to meet the needs of the particular groups once these had bedded in e.g. we thought the parent support groups may identify that they needed additional support to increase their resilience as parent carers e.g. seek funding to deliver a community-based delivery of Triple P, Insider's Guide and Looking After you training, but that this was outside the scope of the project.

d) Pilot methodology

The pilot stages were designed as follows:

- Develop clear street and route maps using the SLOA data from the Databridge report
- Door knocking and flyering in those streets over a period of 2 weeks to ask local people if they had a child living in their home who had a 'disability, health problem or was having difficulties at school.
- If yes, they were provided with a flyers or verbal information advertising the coffee morning event to take place 1 week later.
- Collection of contact details so the carers could be phoned back by the Amaze helpline and reminded about the event by CDWs

[4] Amaze/PaCC's Talk Health Report, 2011

- Promotion of the coffee morning event via other local channels (GPs, schools, churches, women's groups, youth groups, LAT newsletters etc.)
- Initial coffee morning – with relevant Amaze and CDW staff, holistic therapy (nails, massage), tea and cakes – facilitated discussion about immediate needs of carers and signposting where appropriate
- Assess appetite for continuing parent support group (coffee morning) to then meet regularly after this

Appendix F:
Glossary of Terms

ASC - autistic spectrum condition
BHCC – Brighton and Hove City Council
CDWs – Community Development Worker
COMPASS – discounted leisure card for families with children who have a special need
CYP – Children and Young People
DLA – Disability Living Allowance
DWP – Department of Work and Pensions
HKP – Hangleton and Knoll Project
PaCC - Parent Carers Council
POPP - Partnership Outreach Pilot to Parents/Carers
SEN – Special Educational Needs
SENCO - Special Educational Needs Coordinator
TDC – The Trust for Developing Communities
VCS – Voluntary and Community Sector

Appendix G: Acknowledgements

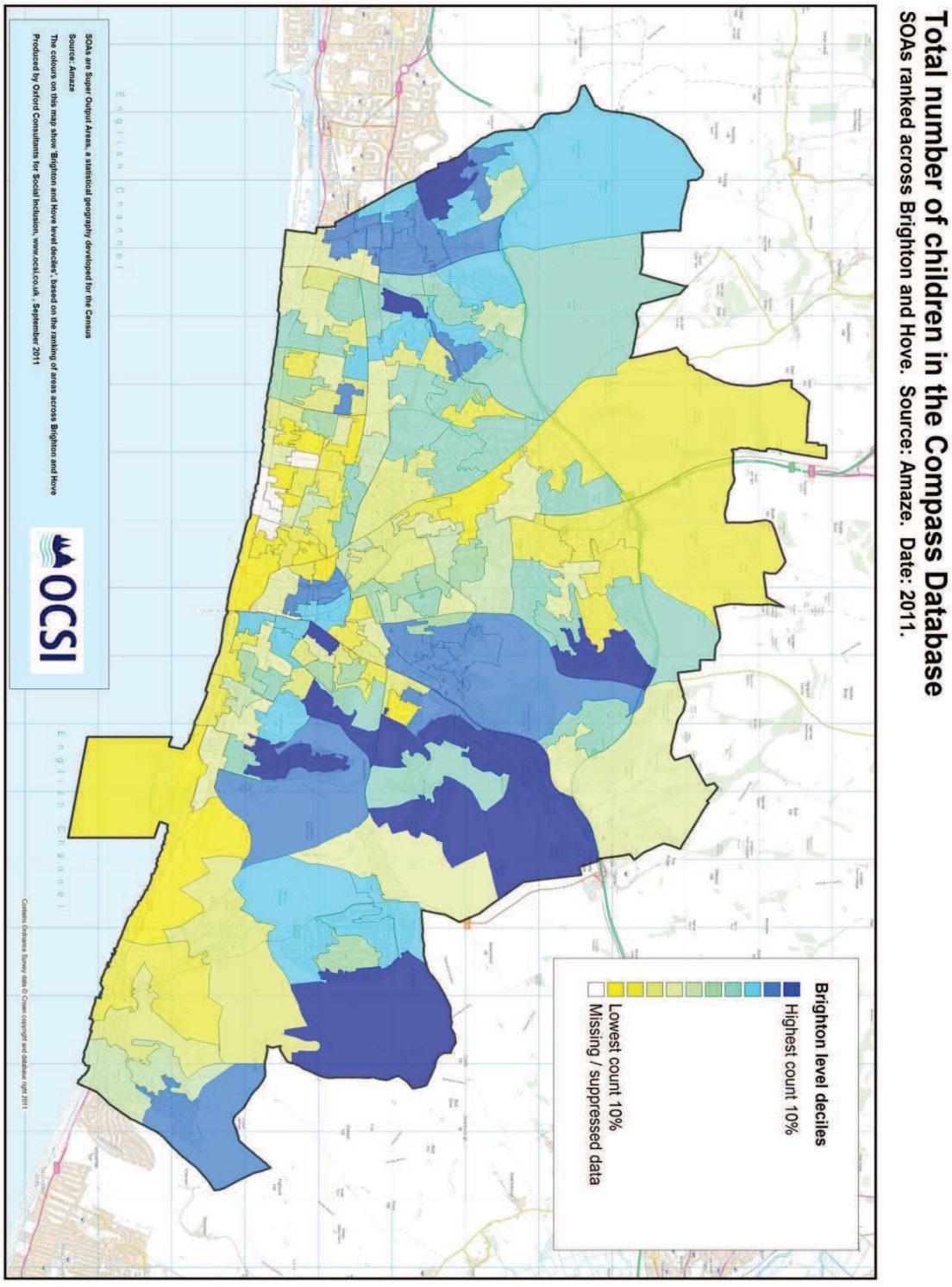
Thanks to the following staff and volunteers who have really pulled together to make this pilot project happen:

Amanda Mortensen
Claire Sillence
Kirsty Walker
Kalishia Le Coutre
Rhiannad Summerset
Angie Walker
Lyn Densley
Catherine How - Community Development Worker
Hangleton Holistics – Lizzie Beckett
Tracy Cox
Lucy Raynor - Moulsecoomb Primary School

We'd also like to thank the following for their financial contribution to date:

Brighton and Hove Link
NHS Brighton and Hove
Brighton and Hove City Council through Community Development Commission match funding.

Appendix H:
Databridge Report and Maps



Map 1. Neighbourhoods across the city with the highest *numbers* of children on the COMPASS register (areas shaded blue have the highest numbers, and those shaded yellow, the lowest)

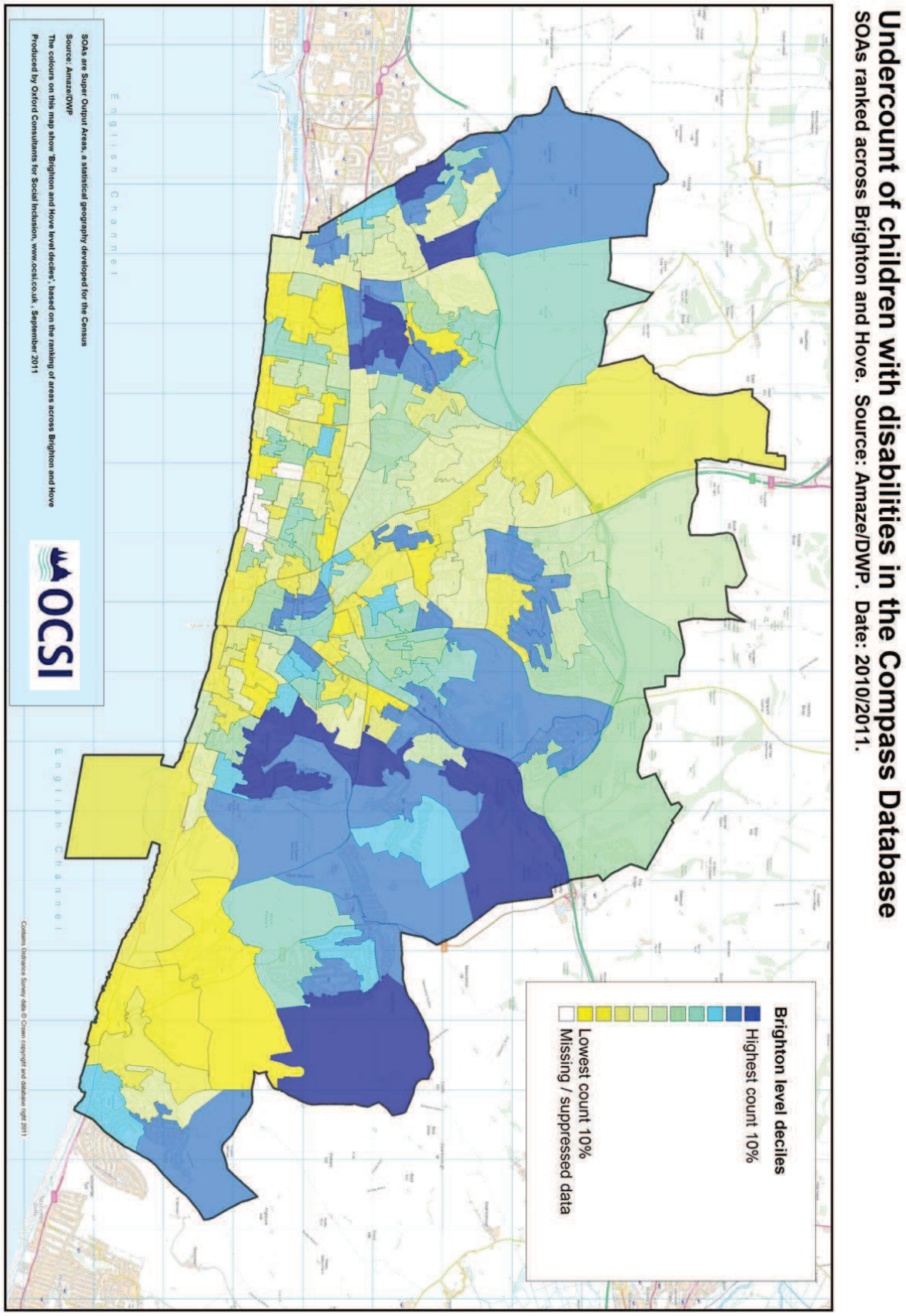
The table below shows the SOAs in Brighton and Hove with the largest undercount in children with disabilities. In this case we have shown the *number* of children missing from COMPASS database, not the *percentage*, as Amaze are interested in targeting the areas where the greatest number of people are missing from their information. Other questions might need analysis by percentage.

Area	COMPASS with DLA	Total with DLA	Undercount
Brighton and Hove total	**793**	**1,450**	**657**
East Brighton E01016866	15	40	25
Moulsecoomb and Bevendean E01016914	16	35	19
East Brighton E01016865	22	40	18
Moulsecoomb and Bevendean E01016910	7	25	18
East Brighton E01016868	15	30	15
Moulsecoomb and Bevendean E01016915	15	30	15
Hangleton and Knoll E01016879	16	30	14
Hanover and Elm Grove E01016895	6	20	14
East Brighton E01016867	2	15	13
Hangleton and Knoll E01016880	18	30	12
Moulsecoomb and Bevendean E01016908	13	25	12
North Portslade E01016919	18	30	12
North Portslade E01016921	13	25	12
Woodingdean E01017011	8	20	12

1.1.1 In 24 different SOAs across the city, the number of children with disabilities was undercounted by 10 or more (i.e. there were at least 10 more children with DLA than was recorded on the COMPASS database). Areas in Whitehawk and Moulsecoomb are the most underrepresented in absolute terms - In SOA E01016866 in East Brighton (Nuthurst area of Whitehawk) there were 40 children receiving DLA of whom only 15 are on the COMPASS database.

1.1.2 The map on the following page shows the areas with the largest undercounts across the city.

Map 3. Neighbourhoods across the city with the highest undercount on the COMPASS register (areas shaded blue have the highest number, and those shaded yellow, the lowest)



All Super Output Areas across Brighton and Hove

Which ethnic groups are over/under represented in among groups with disabilities in Brighton and Hove?

1.1.3 The COMPASS database provides details on the ethnic breakdown of children on the system. This is based on broad ethnic groups which broadly correspond with the standard ethnic groups included in the 2001 Census and ONS population estimates[5]. We can therefore compare the numbers of children on the COMPASS database in each broad ethnic group with the number of children in the city as a whole[6] in these groups to see if any ethnic groups are more likely to be in the COMPASS database (and consequently have a higher prevalence of disability). The age bands in census[7] ethnic group figures differ from COMPASS database, with children covered under the 0-15 age range rather than the 0-19 in COMPASS. So we needed to filter this age band from the COMPASS groups.

Findings

1.1.4 People in Black Caribbean groups were more likely to be on the COMPASS database than other groups, with 13% of Black Caribbean children aged 0-15 on the amaze database[8], compared with 2% of White British children. Other Asian were also significantly over-represented 9%. In absolute numbers terms, the highest number of children on the COMPASS database from a particular minority group was 'Other White' with 18 (which include children from EU countries such as Poland), followed by Bangladeshi with 16 children.

For further information on the Databridge project see www.databridge.org.uk.

OCSI, 21st October 2011

[5] The COMPASS register includes an additional category for the large local Coptic community.

[6] As Census data is available at small area level, it would in principle be possible to estimate the proportion of people with learning disabilities in each ward by ethnicity. However in practice, the numbers of children in each ethnic minority group is too small for robust analysis at neighbourhood level.

[7] We used census data rather than ONS data for ethnicity because the ONS figures are based on applying the national birth rates of people from different ethnic groups to the ethnic profile of child bearing age cohorts in each Local Authority. These cohorts tend to be less reliable in university towns, where a large proportion of people in their late teens and early 20s are less likely to remain in the area to have children.

[8] Albeit with low numbers.

Coffee Morning

Do you have a child with a disability, health problem or who is having difficulties at school?

All Sessions held at Moulsecoomb Primary School in the Island Room

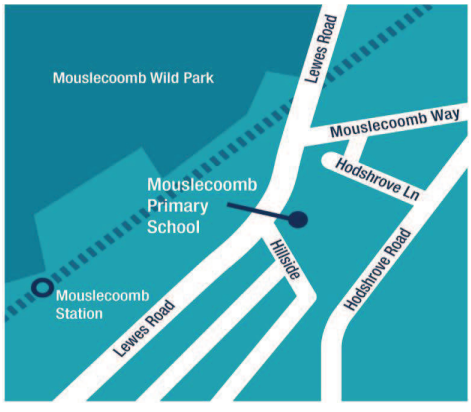
Dates & Time:

Mon 19th Nov 2012, 9am
Mon 3rd Dec 2012, 9am
Mon 17th Dec 2012, 9am
Mon 21st Jan 2013, 9am

- Check you're getting all the benefits and services you have the right to
- Come and find out what's out there to help you
- Chat to other mums, dads, grandparents and carers
- Bring any friends who also have a child with special needs
- Under 5s welcome
- Free tea and coffee

Amaze is a local charity supporting parents who have children with special needs and disabilities. For a confidential chat about your child call the Amaze Helpline on 01273 772289. Or look at our website: www.amazebrighton.org.uk

Or for more information contact your local community development worker Kalishia Le Coutre on tel: 01273 676416, mob: 07411 251969 (call or text) or Kirsty Walker on 01273 262220



Island Community Room
Moulsecoomb Primary School
The Highway
Moulsecoomb
Brighton, BN2 4PA

Supported by the Trust for Developing Communities and Amaze
Amaze Brighton and Hove, UK Company Limited by Guarantee No: 3818021 Registered Charity No: 1078094

Coffee Morning

Do you have a child with a disability, health problem or who is having difficulties at school?

Come along to this support network and meet other parents and carers in a similar situation

All Sessions held at Moulsecoomb Primary School in the Island Room
Dates & Time:
Monday 12th November 2012, 9am
Monday 3rd December 2012, 9am
Monday 17th December 2012, 9am
~~Monday 7th January 2013, 9am~~
Monday 21st January 2013, 9am

Supported by the Trust for Developing Communities and Amaze

- Check you're getting all the benefits and services you have a right to
- Come and find out what's out there to help you
- Chat to other mums, dads, grandparents and carers
- Bring any friends who also have a child with special needs
- Under 5s welcome
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Island Community Room
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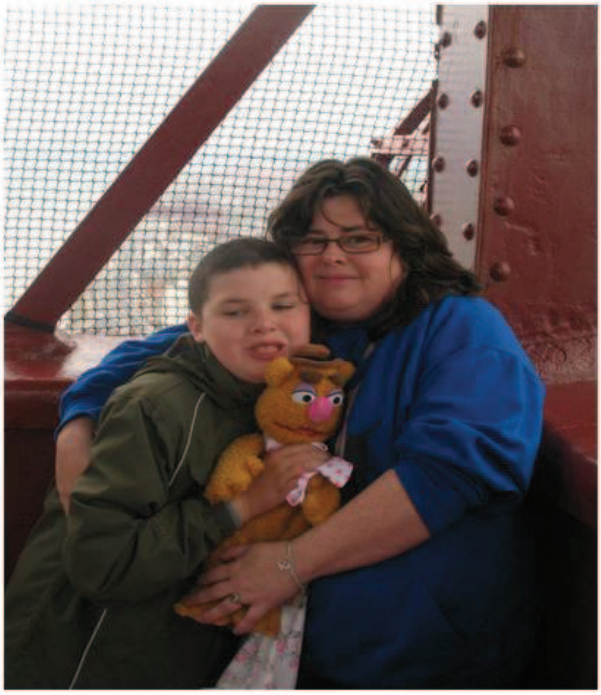
Or for more information contact your local community development worker Kalishia Le Coutre on tel: 01273 676416, mob: 07411 251969 (call or text) or Kirsty Walker on 01273 262220

Hangleton and Knoll Family Coffee Morning

Do you have a child with a disability, health problem or who is having difficulties at school?

The Hangleton & Knoll Project
Working for a better community

Is your child eligible for or receiving Disability Living Allowance?



Local Mum Rhianydd and her son Owen

Tuesday 6th November

9.15 - 11.15 am

At St Richards Church and Community Centre

Egmont Road Hove

Come along and meet other parents and carers in a similar situation.

Enjoy a free Neck and Shoulder Massage or Manicure.

Tea, Coffee and Homemade Cupcakes provided

Be part of our Facebook group search Hangleton and Knoll Family Coffee Morning and Join us!

The Hangleton and Knoll Project in partnership with Amaze.

For more information contact Claire Sillence at the Hangleton and Knoll Project on 01273 383805 Catherine on 01273 410858 or email claire.sillence@hkproject.org.uk

Brighton & Hove LINK MAKE IT HAPPEN!

The Hangleton and Knoll Project is a registered charity no 1139971 and a company limited by guarantee no 7260539. www.hkproject.org.uk . Amaze Brighton and Hove, UK company limited by guarantee no 3818021 and registered charity no

For more information about Amaze please visit www.amazebrighton.org.uk or call 01273 772289

Share your community group's views - FS794873

What does a fair city mean to you? : A place where all people are able to take part, contribute, be supported, travel and live their lives to the fullest.

What is fair about life in Brighton & Hove at the moment?: We have a strong voluntary sector, a diverse community, lots of assets in terms of geography, parks, arts & heritage opportunities and strong sense of place. Generally, statutory agencies want to work in partnership with their communities, and in some cases they do this well.
The council's Third Sector Strategy supports fairness, as does the CCG's commitment to Social Value in its commissioning.

What is unfair about life in Brighton & Hove at the moment?: We are making three separate submissions to put forward three issues that are unfair about life in Brighton & Hove.

Parents with Learning Disabilities
Our experience in working with parents with learning disabilities has revealed the unjust and unfair way in which they are treated by the local authority. Parents are repeatedly set up to fail by a system that does not adequately support them to be the parents they want to be, takes a siloed approach to working across Adult and Children's services and refuses to acknowledge its legal duties under the Human Rights Act, Equalities Act and Care Act. It also fails to adhere to Department of Health guidelines on supporting parents with a learning disability. The result is that our clients regularly have their children removed into care, which has a devastating emotional, social, financial and safeguarding impact on their lives.

There are numerous models from around the UK where Councils successfully support people to parent and save the local authority money in the process . We are using these to raise awareness of alternative models that BHCC could adopt in order to create better outcomes for both parents and children alongside evidence of their obligation to meet relevant legislative duties.

B&H would be a fairer place (and BHCC would save money) if we could adopt a more sensible way of supporting parents with LD.

What specific experience or evidence do you have about inequalities and fairness that may be of use to the Commission? : In Brighton and Hove there are an estimated 5,053 adults aged 18 or over with learning disabilities, of whom 1,065 are estimated to have moderate or severe learning disabilities.

On parents with learning disabilities - much of this is taken from Bristol University's Working Together with Parents Network, who are experts in this field. (http://www.bristol.ac.uk/sps/wtpn/policyessentials/)

The Working Together with Parents Network (WTPN) believes that if provided with earlier personalised support, many parents would not become involved with the child protection system and fewer children would be placed in care.

The foreword to the Department of Health Good Practice Guidance on Working with Parents with a Learning Disability (2007) states in England that:: 'People with learning disabilities have the right to be supported in their parenting role, just as their children have the right to live to live in a safe and supportive environment.'

The guidance recognises that parents with learning disabilities/difficulties can be good parents if provided with positive support. The five key features of good practice in working with parents with learning disabilities/difficulties:

Accessible information and communication
Clear and co-ordinated referral and assessment procedures and processes, eligibility criteria and care pathways
Support designed to meet the needs of parents and children based on assessments of their needs and strengths
Long-term support where necessary
Access to independent advocacy.

services and across health, social care, housing and non-statutory sector) of the need to provide early (page 45).'

Section 17 of the Children Act 1989 (children in need) states that local authorities have a duty to safeguard and promote the welfare of children within their area who are in need and, so far as it is consistent with that duty, 'to promote the upbringing of such children by their families by providing a range and level of services appropriate to those children's needs'.

Early preventative support clearly is essential to this statutory principle and to the principles set out in, for example, Children's Act 2004, Working Together 2013, Think Family 2009.

The Care Act specifically includes support for parenting in issues for which support and advocacy must be provided.

In addition, on people with a learning disability & Mental health:
• People with learning disabilities demonstrate the complete spectrum of mental health problems, with higher prevalence than found in those without learning disabilities
• Between 25 and 40% of people with learning disabilities also suffer from mental health problems
• The prevalence of dementia is much higher amongst older adults with learning disabilities compared to the general population (21.6% vs 5.7% aged 65+)
• Prevalence of anxiety and depression in people with learning disabilities is the same as the general population, yet for children and young people with a learning disability, the prevalence rate of a diagnosable psychiatric disorder is 36%, compared with 8% of those who do not have a learning disability.

We would like to ask the Fairness Commission to consider the above in conjunction with evidence from the Council itself about issues related to the fairness commission. For example we have been refused sight of the full Learning Disability Review and feel that the summary report lacks detail around the views on parents with a learning disability. The reason given for refusing to share this report is confidentiality but we feel that this issue can be surmounted and an open appraisal of the full content is important, including areas where service users were critical.

We want the full Learning Disability Review and the above evidence to be considered by the commission along with BHCC data on:
* numbers of parents with learning disability in child proceedings
* number of parents with learning disability who have had their child(ren) removed
* number of parents with learning disability who were offered a reasonable adjustment to the PPP course
* numbers of parents with learning disability who were offered any other kind of support to parent

Based on your experience or evidence, what is your or your organisation's analysis of the causes of inequalities in Brighton & Hove? : This is far too complex an issue to be summarised in a box!

However, as we have set out above, there are systemic issues which exacerbate inequalities - the way that adults and children's services operate, for example, make lives much less fair for parents with learning disabilities - and needlessly so.

Funding and finance issues - the current reduction in public services supporting certain groups means that that these groups don't have access to the kind of opportunities that others do. These are fundamental to our lives - being a parent, being able to access education, training or employment, being able to travel independently, take part in society, volunteer and contribute.

Are there any people or communities for whom life in Brighton & Hove is particularly unfair? : People with a learning disability, parents with a learning disability, adults with Asperger's, older people who are isolated, those with mental health support needs.

What do you or your organisation believe would be the best ways to tackle inequalities and increase fairness in the city? : Implement learning from other local authority areas on how models such as Shared Lives and adjusted parenting support programmes can enable parents with a learning disability care for their children. We are organising a round table discussion in this issue shortly, with colleagues from areas who are already working in

this way, and we would welcome Fairness Commissioners at that meeting. Details provided to Julia Reddaway.

Your first fairness priority: Enable parents with a learning disability to be able to care for their child by providing adjusted support

Your second fairness priority: Support community based activity which can prevent loneliness, isolation and the health impacts of these

Your third fairness priority: Providing services for adults with Asperger's to be able to engage in work, learning, volunteering.

Statement for the Fairness Commission about statistics/evidence/case studies on the impact of being a young carer in light of the December Panel Meeting; Children, young people and improving life chances

Children and young people (CYP) with caring roles experience significant social, financial and educational disadvantage and their families are more likely to experience poverty, relationship breakdown and poor health and wellbeing.

- Local data
  The Council's Annual Safe and Well School Survey data shows that young carers are a vulnerable group who are
  - Significantly more likely to receive in class support
  - Twice as likely to have been excluded from secondary school
  - Over twice as likely to have been bullied
  - Twice as likely to bully others
  - Significantly more likely to worry about problems with friends
  - Twice as likely to worry about their family
  - Significantly more likely to feel anxious/worried
  - Twice as likely to feel sad/depressed
  - More than twice as likely to feel angry

- Data we know regarding the education of Young Carers in Brighton & Hove

  - 77% Young Carers are entitled to FSM compared to 45%
  - 23% are absent more than 15% of school sessions compared to 6% for all children in Brighton and Hove
  - 54% have SEN compared to 20.9% for all children in Brighton and Hove

  Young carers are similar percentage ethnic breakdown to all children in Brighton and Hove

  - Young Carers achieve significantly below all children at all Key Stages (e.g at KS2 16% below in reading; 13% below in writing; 18% below in Maths)

- A cautious estimate suggests that there are over 500 young carers in Brighton and Hove, The Young Carers Team currently work with 150

- Young Carers Team data/case studies

Three case studies outlining the benefits of Young Carers Team support and advocacy- all three of these support roles are dependent on charitable funding and are due to run out in Spring 2016. (Please note, due to time constraints these case studies are historical and current cases will be provided for the December meeting. However, these cases reflect the nature and impact of our support.) Since April of this year the council have taken back responsibility for assessment and referral of young carers and this raises concerns in the light of imminent reduction in council capacity due to financial cuts.

1 . Case Study Scarlett

Scarlett cares for her mum who has Bechets Syndrome and partial hearing loss. Bechets is a rare condition that causes inflammation of the blood vessels. It causes problems in many parts of the body. The most common symptoms are, sores in the mouth, sores on the sex organs, other skin sores, swelling of parts of the eye, pain, swelling and stiffness of the joints which affects mobility and fatigue. Bechets has also caused mum to have mini fits, which have meant regular spells in hospital. Scarlett also has 2 younger siblings, one who is 14 and the other is 3.

Scarlett is currently attending college where she is doing a course in catering. Before going to college in the morning she gets up and makes sure that mum is alright and gets her breakfast, she also gets her younger brother ready and takes him to nursery. When she comes home she does all of the household chores and helps mum cook dinner, she gets her brother to bed and makes sure her sister has done any homework, before she gets a chance to do her own homework.

Due to the nature of mum's condition and how little is known about it in this country, there are concerns about whether mum's mental capacity could be affected by the strokes. The carers centre offers appointments with solicitors, where issues such as this can be discussed and help can be given to put things in place. Scarlett, her mum and her granddad attended one of these appointments to get some advice.

In her first year of study the catering equipment required for her course cost £300. Her mum was unable to afford to pay these costs. The Young Carers team case worker applied for and secured funds from the Frank Buttle charitable trust to cover these costs. Also the college were made aware of her caring role and a support worker was given to Scarlett for the first few months when she started.

The YC team worker made a referral for counseling for Scarlett, as a few months ago she felt that she may be suffering from depression, as she had low energy and was finding it difficult to motivate herself to do things. She has now had a few sessions with a counselor which she says is helping.

Money from the carers grant has also been given for driving lessons, so that when mum is too ill to drive, Scarlett can have access to the car for shopping, errands and running the younger children around. Support with housing as present housing unsuitable with mums mobility needs, along with support from other professionals involved with the family, via Team around the Family meetings. The family has now been moved to more suitable accommodation.

Scarlett has been out for meals and on an Ice-skating trip, as well as a trip to Thorpe Park. Where she has had the chance to meet other young people with shared experiences and make new friends.

2. **Case study – Sports Relief**

BL has been supported by the young carers project for 6 months and is 12 years old. He cares for a parent who has mental and physical health problems which means they are highly medicated and have limited mobility. The parent requires a large amount of practical and emotional care. There are also a large number of children in the family including two younger siblings which B helps to care for and an older sibling who also has severe mental health problems and frequently needs support and emotional care. B has a very significant

caring role which has a large emotional impact on him. The needs of his family also limit his ability to get out and do activities, although he is a very keen footballer and plays for a local team. He is also interested in boxing and sport in general. The family struggles financially and so access to activities is limited.

The Sports relief funding has enabled us to offer activities that nurture B's interest in sports whilst also giving him a much needed break from his caring role. B has attended a Trek Co adventure day as well as a weekend long residential at Hindleap Warren.

B seemed to genuinely love being outdoors and having the opportunity to just 'let loose' and be a child. This was evident when we were doing an activity called the forest adventure where we had to leap in to mud pools and generally get very dirty. B was fully involved and engaged and also took on a strong leadership role, helping other young people who were nervous and pulling people out of the mud and helping them to climb.

The activities have also improved B's emotional resilience. He had some anxieties around his ability to manage being away from home and his ability to accept his strengths and challenge his fears and find that they were manageable. B struggled a lot with a fear of heights but really pushed himself to try every activity and do his personal best. He was incredibly proud of his achievements and recognised these at the end of the weekend.

For B, the best thing about the sports activities have been getting out in the countryside, being able to have a break from his caring role and engage in age appropriate fun with children with shared experiences. It has also nurtured his interest in trying other sports and activities and has been in touch about funding for boxing lessons

3. **Case study – TC – Aged 11 Years**

T was referred to the young carers project by his primary school. The school recognised that T had a substantial caring role and this was also impacting on his anxiety levels and behaviour in school.

T cares for his mother who was diagnosed with breast cancer in 2009 when she had a double mastectomy. As a result of breast reconstruction she has considerable problems with her back and shoulder muscles for which she is taking medication. She also suffers from depression, anxiety and agoraphobia. The medication for her physical and mental health issues causes side effects including sleep deprivation and tiredness. T's Mum can't walk very far or drive. She is a single parent. The family manages on a very low income.

T's role, when he was assessed included a range of domestic tasks such as cooking, cleaning and caring for the family pets. He also assisted his Mum with her mobility – getting out of the bath, getting down stairs, moving around the house and getting dressed. He helped to sort and prepare her medication and massage her back to ease the pain. T also provided significant emotional care for his Mum – he worried about her frequently and often stayed off school to look after her.

This part of T's role had been reduced due to his referral in to the 8-12's group. After his assessment an Adult Social Care referral was made with a view to ensuring the statutory agencies were providing care hours for T's Mum and they now have 6 hours of time with a carer who has taken on some of the domestic tasks and the medication. Adaptations have

also been made to the house to give Mum more independence and most importantly to give T more time. He still has a very significant role however when he met with us he expressed that having a carer in the home has been 'life changing'. Accessing the project allowed us to be able to properly assess his needs and make the right referrals to get T and his Mum support.

T was and continues to be greatly impacted by his caring role. He experiences high levels of anxiety and suffers from panic attacks and migraines as a result of his worries about Mum. His attendance has dropped very low and he experiences anxiety and difficulties at school as a result.

However, since joining the project, we have been able to build up a strong and supportive relationship with T and his family. The family now have a family coach due to our referral to the early help service. He attends activities regularly that give him respite from his caring role, for example our recent trip to London to see Wicked. T has also been benefiting from focused group work and has been attending a boys group looking specifically at managing anxiety. He has made a group of good friends from the groups and likes that they are able to understand and empathise with his role, fears and anxieties. We have enabled T to access a carers grant to allow him to get a passport and go on his first ever holiday to France. We will continue to support T with groups, one to one support and respite activities and we liaise with school and the family coach to ensure his caring role is well supported.

- 14% of under 12 young carers on our books have a Child in need or Child Protection plan
- 9% of teenage young carers on our books have a Child in Need or Child Protection plan
- Nationally- 3.5 % of CYP have a CIN plan and O.45% have a CP plan

(based on 11million children – 391,000 CIN plan 49,700 CP plan)

- <u>National research and data</u>

"Councils and PCTs face immediate funding pressures, which may lead some to think that increasing spending on carers is not a realistic solution to the challenges they face. However, this report produces evidence that makes improving support for carers a vital element of any solution to the various challenges faced and key to meeting the QIPP challenge."-

The Case for Change report
http://www.carers.org/sites/default/files/supporting_carers_the_case_for_change.pdf

Young carers and young adult carers

- 13,000 of the UK's young carers care for over 50 hours a week.
- Following a survey in 2010, the BBC estimated that there are 700,000 young carers in the UK.
- Young adult carers aged between 16 and 18 years are twice as likely to be not in education, employment, or training (NEET).
- In total there are 290,369 carers in the UK who are aged 16–24.

Conclusions

Locally there is a significant need:

- To support young carers to prevent their needing a CIN or Child protection plan
- To identify and support hidden young carers
- To identify and support particularly isolated families in more deprived neighbourhoods/community where the family is likely to be facing multiple disadvantage.
- To build the well-being and resilience of young carers to ensure more successful futures
- To address family needs to significantly reduce the caring role of young carers

Area 3 (Moulsecoomb, Bevendean, Coldean)

presentation to CYP committee

Adam Muirhead 2nd June 2014

- The Trust for Developing Communities employs a community development model of work with young people. This means that we aim to co-produce youth provision, building on existing community infrastructure, including community groups, volunteers and the Council's Youth Service to promote an asset-based development of youth provision which, in turn, encourages increased sustainability and local ownership.

- To help make clear what that means on the ground I have come prepared to tell you a little about what we at the BHYC have achieved so far in Moulsecoomb and the rest of Area 3, and how we have achieved it.

- Our plan was never to parachute in youth provision with our commission. With Moulsecoomb as a mostly new area for our work it was an opportunity to see what was already happening, see how we could help, then try to plug any gaps.

- We conducted a scoping exercise and discovered that in addition to the Youth Service's work, which we were aware of, there were a good number of other organisation conducting work with young people:

    - 26th Brighton Boys Brigade and Girls Association
    - RAW Youth Group
    - MYClub (Moulsecoomb Youth Club)
    - 225 Squadron Air Cadets
    - Moulsecoomb Treasures
    - Moulsecoomb Amateur Boxing Club

- Whilst asking them what they do and when, we also asked them what they need and how might an organisation like our help them.

- We also met with the local representative community group – Moulsecoomb Local Action Team. As it turned out they have young people's issues as a permanent item on their agenda and a list of priorities surrounding their young people. We were able to sit with them and ask them how I could help to achieve their goals.

- Responding to the community's mandate has been an overwhelming success and has quickly established a positive presence for the Brighton & Hove Youth Collective in an area where we weren't delivering just two years ago.

- With this engagement with and guidance from the community, the Brighton & Hove Youth Collective have been able to build capacity of youth provision by catalysing infrastructure developments and communicating between a wide range of partners.

- We established regular area meetings with Collective partners and the Youth Service in order to strategize and plan provision in a co-ordinated manner as well as communicate issues that were coming up.

- For example we have helped to fund youth organisations by delivering a participatory budgeting project called the 'Big Dish Out' where 12 local projects shared £20,000 with the decisions about funding made by local young people.

- We supporting broader partnership work – summer planning meetings (resulting in website) and Wild Park Youth Festival (with Active for Life, Sussex Police, Adventure Unlimited and Albion in the Community) where over 130 teenagers were registered on the day.

- The Thursday night youth club run by Collective partners (in the YPC) sees between 20 and 40 young people each week.

- The Friday night sports hub, again in partnership, meets 40 young people each week.

- 3,149 Attendances and tasked with engaging 300 young people 4 or more times and we are up to 95% of our target.

- Next steps for Area 3 – increased participation from young people in local decision making processes.

Beating the Odds Pilot

Stronger Families, Stronger Communities Programme

May-December 2014

Robin Banerjee, Janet Boddy, and Fidelma Hanrahan

University of Sussex

F.Hanrahan@sussex.ac.uk

University of Sussex

artswork

Brighton & Hove City Council

What is Beating the Odds all about? Research focus

- Evaluating the Stronger Families Stronger Communities (SFSC) programme run by Brighton & Hove City Council's Integrated Team for Families

- Evaluating creative arts outreach work in Brighton
  - Brighton Dome ‘s 'Miss Represented‘ project
  - AudioActive’s projects with young offenders referred by YOS

- Developing an assessment protocol to be used with young people (13-18 years) working with professionals across Children’s Services to track their psycho-social development

What is Beating the Odds all about? Methods of the pilot work

- Using five different types of methods to achieve these goals:
  1. The setting up of two steering groups made up of practitioners, parents and young people, to guide our research questions and methods.
  2. Focus groups with practitioners working with young people i.e. family coaches and creative arts practitioners
  3. Face to face interviews with parents and children/young people working with family coaches, as well as with young people in creative outreach projects
  4. Short telephone interviews with parents working with ITF
  5. Survey study with young people on measures tapping into socio-motivational constructs

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  5. **Survey study with young people on measures tapping into socio-motivational constructs**

Thanks!

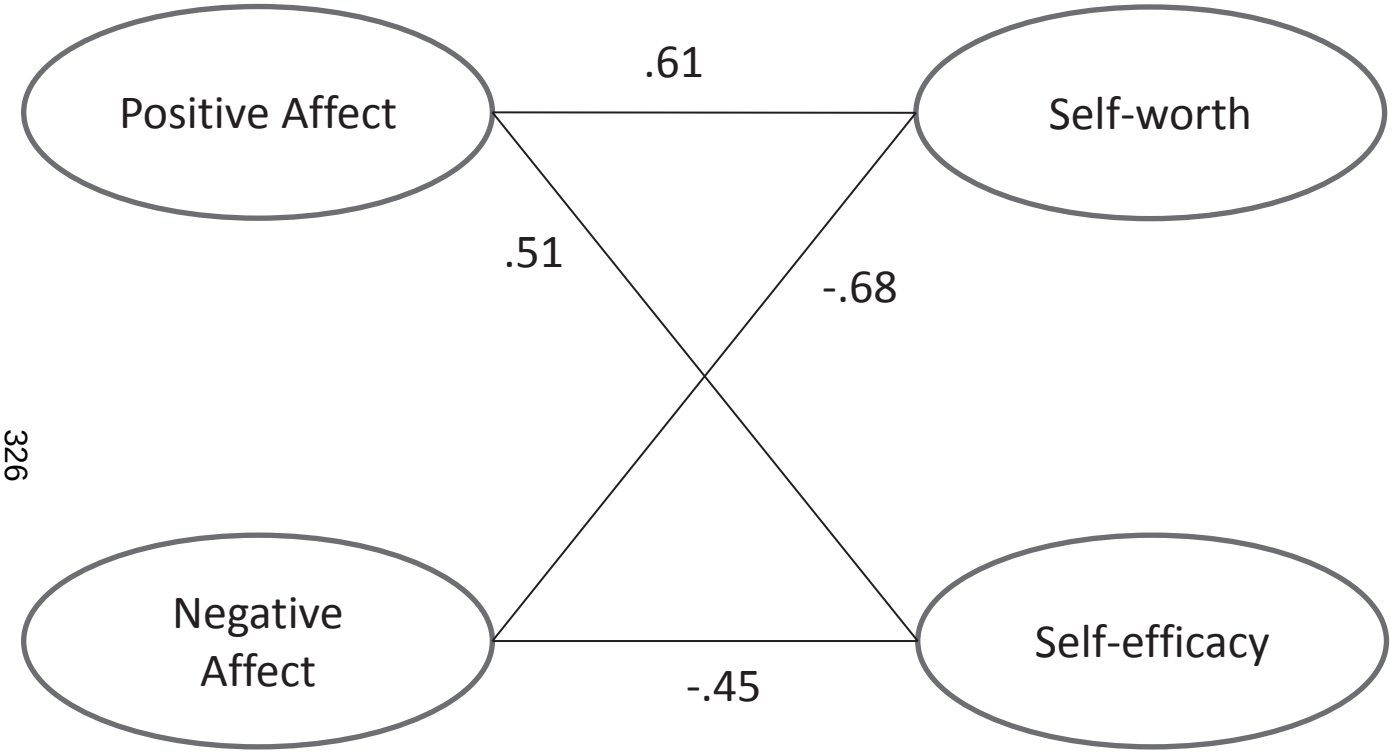
- excellent support from the whole SFSC team
- fantastic communication and organisational support
- insightful contributions from SFSC coaches at focus group and steering group meetings
- great efforts and commitment to support data collection

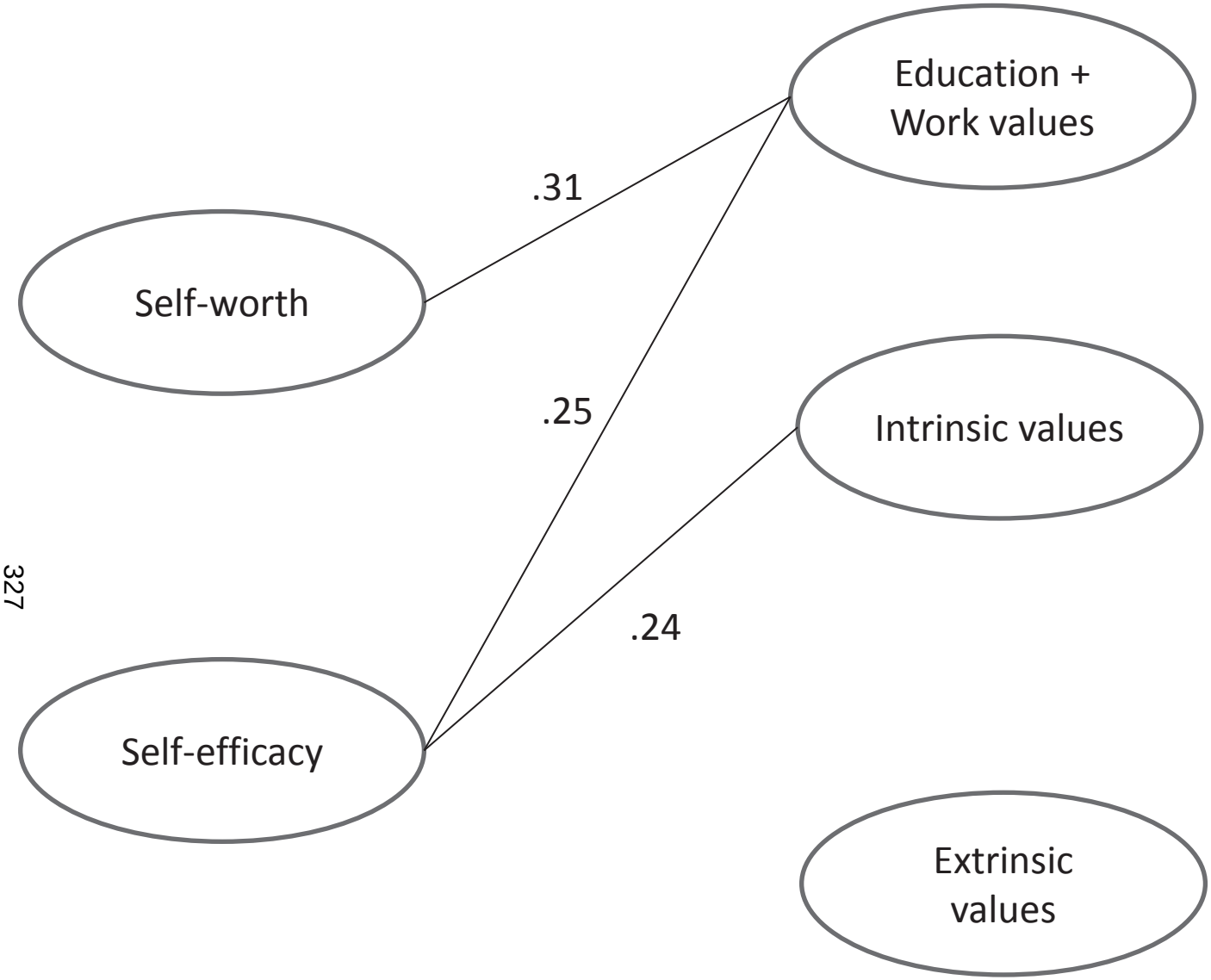
General patterns in pilot survey data

- 147 young people
  - 45 SFSC
  - 98 comparison

- Excellent internal consistency of scales

- Meaningful patterns of correlations between scales


Positive Affect
Self-worth
.61
.51
-.68
Negative Affect
Self-efficacy
-.45


Education +
Work values
.31
Self-worth
.25
Intrinsic values
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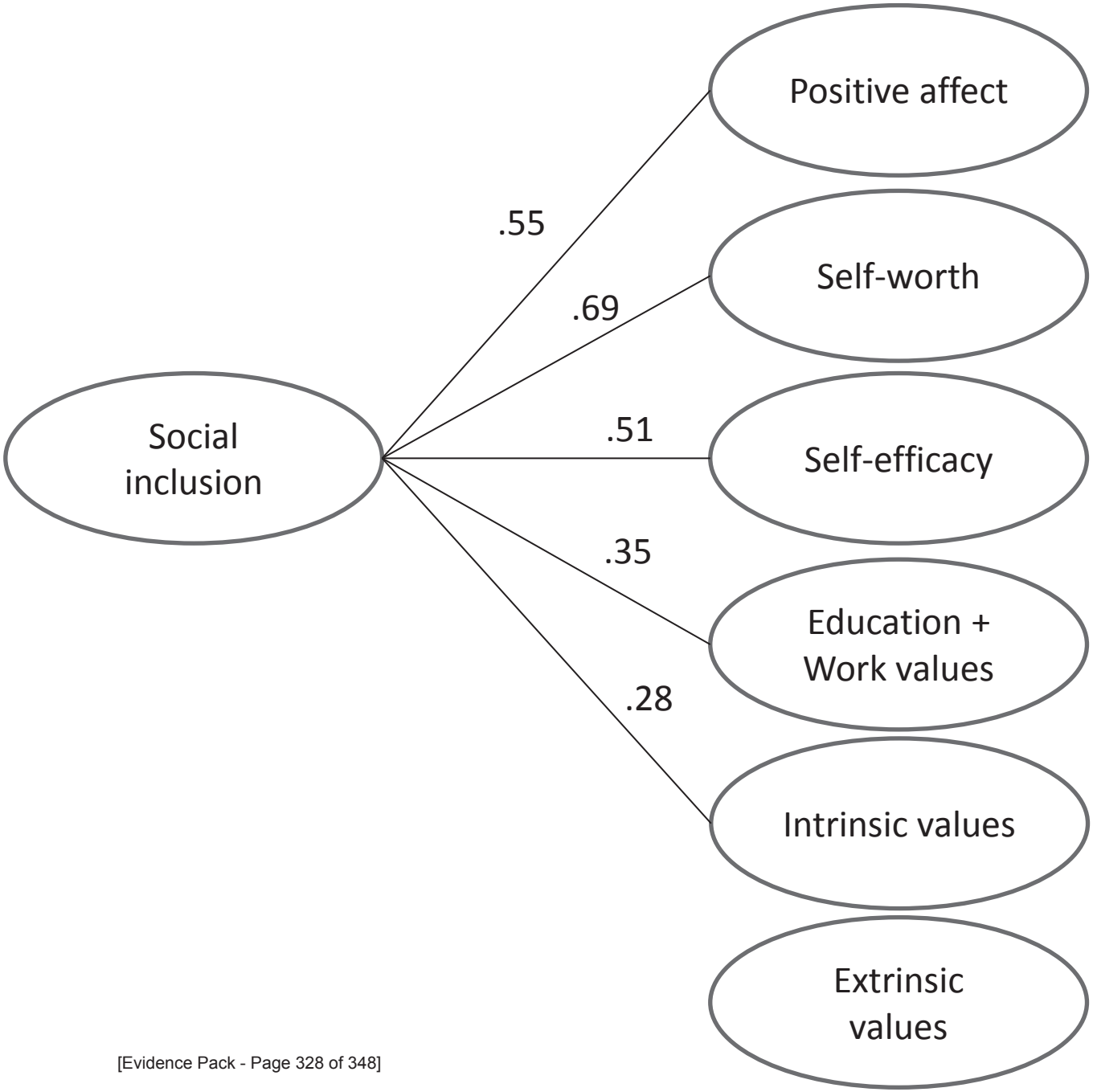
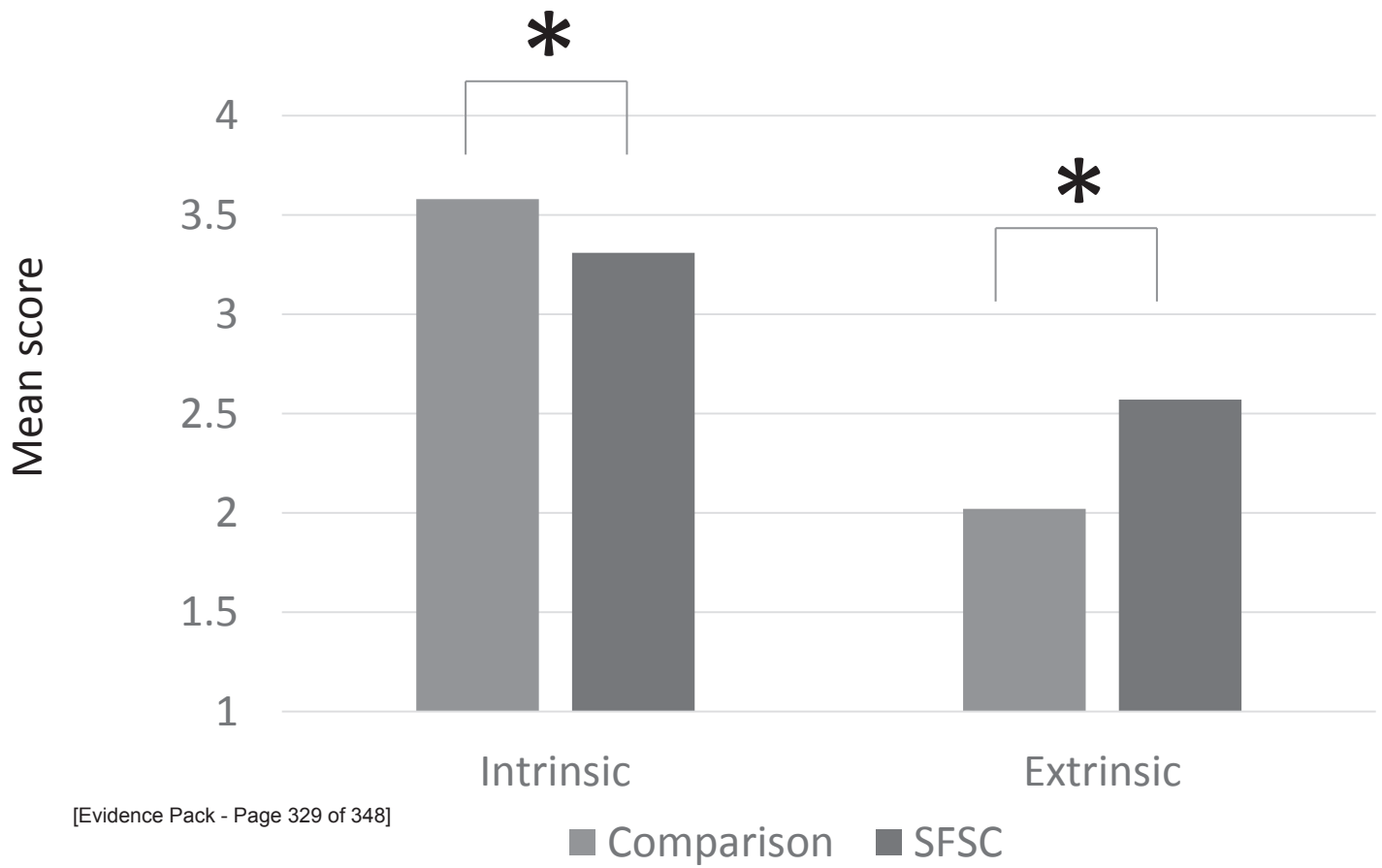
Self-efficacy
Extrinsic
values


Social inclusion
.55
.69
.51
.35
.28
Positive affect
Self-worth
Self-efficacy
Education + Work values
Intrinsic values
Extrinsic values

Group differences in values

- after controlling for age and gender



Unauthorised absence

- complex picture
  - different ways of recording absences
  - different time points for recording before and after intervention
  - missing data
- significant variability within SFSC group
  - some striking reductions
    - e.g., from 42% to 6%, from 29% to 9%
  - but also some increases
- longer time frame to capture trends
- monitor attendance and provide feedback
- understanding of individual family circumstances

Interview themes

- Overall experience is positive for families and young people

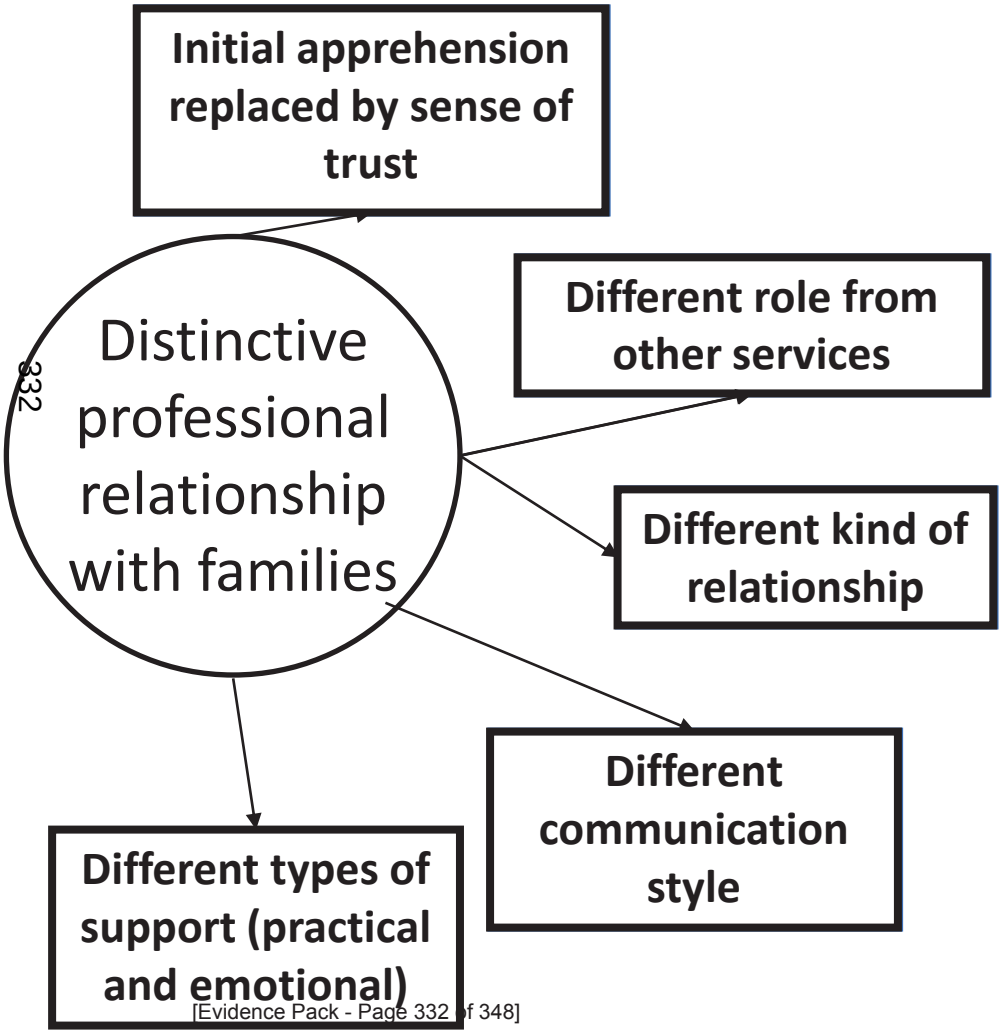
I think if we didn't have the Family Coach I think our family would have fallen apart and everything would have gone completely into crisis, to be honest. With [Family Coach] […] she knew how to help people and she didn't give up on us, and she saw the good in us, which is good, and you know, she didn't just come for me, she come for the whole family, which is good because she gets to see the whole family and see how everything is. (Parent, Family 6)

YP: [Family Coach] He's a really positive aspect of my life. I'd say, yeah.

Int: Great, yeah. So what's it been like…?

YP: […] He's always there for me. He's always helped me out. I think he's like the best youth services I've ever had. Yeah. (YP, Family 1)

Relationship with family coach



- family coaches have a very distinctive professional relationship with young people and parents

Initial apprehension replaced by sense of trust

Distinctive professional relationship with families

333

I didn't at first, feel open, I felt a bit nervous and a bit shy [*laughs*] and embarrassed because it was like someone you don't know coming to home, and you think, cos I've had bad experiences with Social Services in the past, and they seem to like judge you, you think that the Family Coach is, but they honestly don't. (Parent, Family 6)

When I first met him, I was so rude to him. […] I was like 'You're a freak mate, go away.' And then […] I see him like a week after at my house again […] I was just thinking, like, 'Who is he?', he keeps appearing and that. […] And then after a while when he started telling, the family needs to start doing this, the family needs to start doing that, we started doing it and it started working out all well and that. It was like, everything started getting better and better. Then I realised that he was helpful. Then I thought, 'Well, if he's helping my family then I'm gonna help, like… […] So I, so then I started speaking with him and that. (YP, Family 2)

Different role from other services

In our corner

Help on all issues anytime

Support for whole family

Different kind of relationship

Like a friend

Non-judgemental

Unconditional positive regard

I was frightened of ringing up to cancel this CAF appointment […] and [Family Coach] said, "Don't worry, I'll be at the meeting, I will fight the corner for you because I know what you've been going through because I've been seeing you during this time" (Parent, Family 3)

Having the Family Coach. I think that having them, not having them judge you, help you, they're more, I mean, they're like friends. I treat 'em as family now. You get to know them and, you know, they just help you, they understand you more as a family and they see that there is families there who just want people to help them, not to judge them. (Parent, Family 6)

She spoke to me a lot, and I could tell her and she didn't judge, even though I was really bad, she didn't judge (YP, Family 6)

The other services judged me, write reports on you like you're some bad person and stuff like that, which put me off the other services, but when [Family Coach] come in, she did tell you, she was honest. She is honest, you know, she tells you, "Right, this needs to be done. This needs to be done", but she's doing it for the right reasons – to make you realise that, you know, that there's these issues that you've gotta be able to cope and do yourself. (Parent, Family 10)

Different communication style

Direct and honest

Respect for parent/yp autonomy

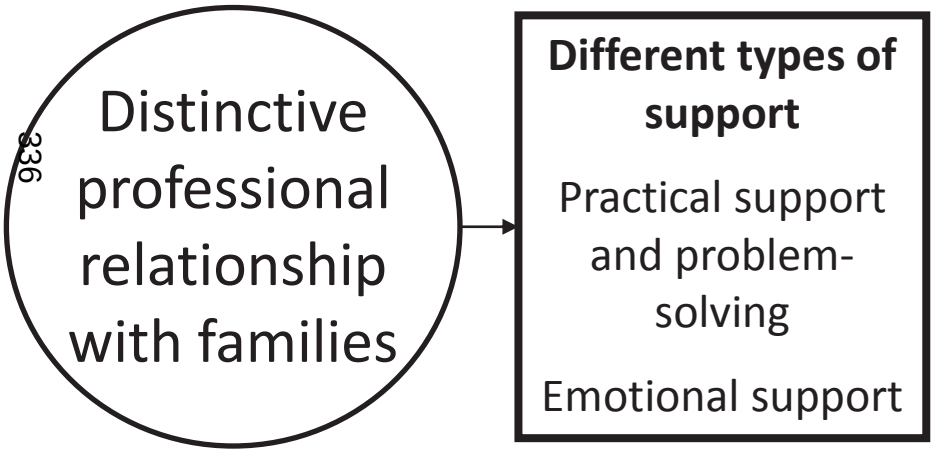
YP: He [Family Coach] used to always give me feedback, so say if I said something to him, and I asked him about something, he'd, he'd be honest, and he'd say what he reckons best. He wouldn't say, 'That *is* the best thing', he'd be like, 'I reckon' or this, this is a good thing. But […] he wouldn't say definitely that that's what you have to do […]

Int: And why is that a good thing?

YP: Cause it shows that he's not just always giving orders, he's letting us know, like, we have a choice. (YP, Family 2)

Now if I call her [Family Coach] up and say 'well this has happened', she'll be like 'OK, this is how we're gonna approach it, this is what we're gonna do', and she'll talk me through the situation and she'll help me and direct me if it's something I don't understand then she'll like explain it better and, or then she'll point me in the right direction, 'cos she's really good. (Parent, Family 5)

YP: The best things [about working with FC]… probably it's like she's getting me like a desk for my room so I can do homework and stuff, and I think that will be good because sometimes I do get in loads of trouble for not doing my homework and […] if I like have my own space to do my homework I'd be able to do it. (YP, Family 11)

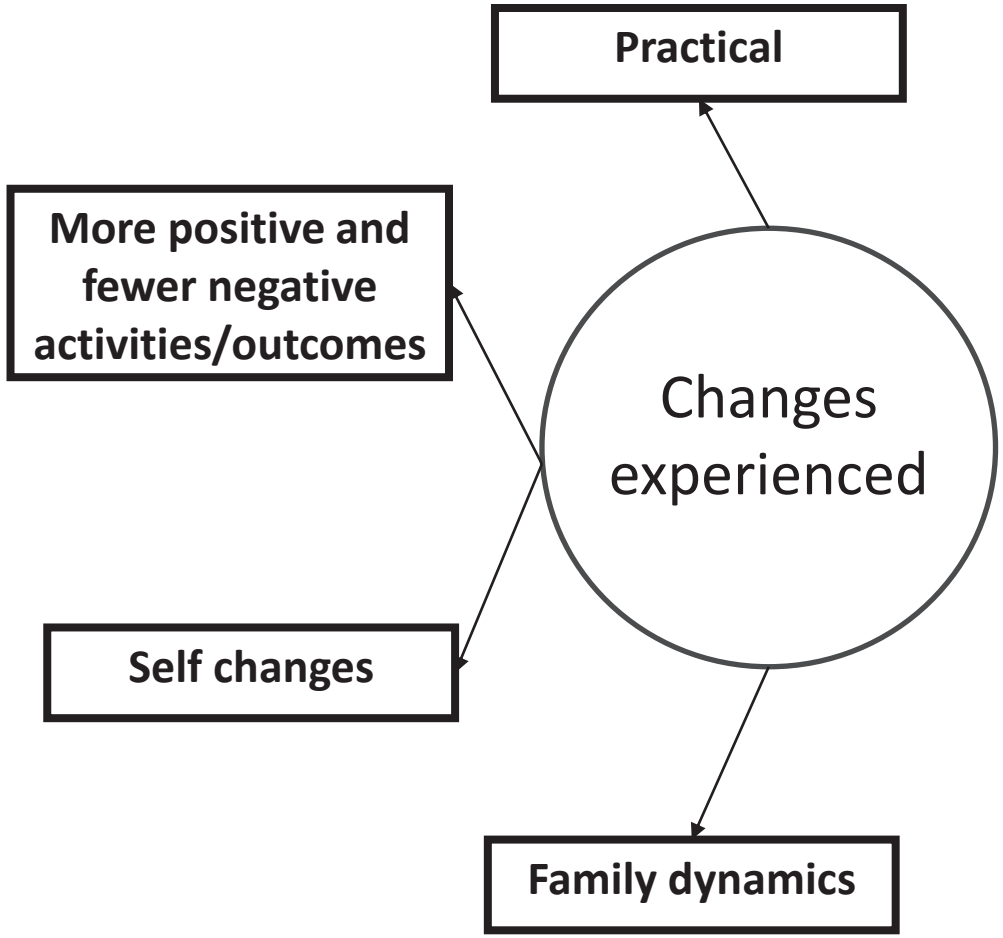


The weeks before [son] went into foster care he [Family Coach] was willing to talk to me whenever I wanted to about the difficulties of doing it, how I was feeling emotionally, the ups and downs […]. So I felt I had someone I could talk to because before there wasn't anyone. (Parent, Family 10)

Yeah, [Family Coach] is just always there, she's like that, the fact that she's like helping me with my anger and stuff like that, it's nice to have someone there, like if I can't talk to my mum or my sisters or anyone, I could go to her and talk to her and she'd like understand. (YP, Family 3)

Changes

- changes experienced
  - practical
  - more positive and fewer negative activities/outcomes
  - self, confidence, motivation, aspirations
  - family dynamics



Int: Are you getting other support [aside from home tutoring] for the nightmares and the anxiety?

YP: Yeah, quite a lot of things. […] a couple of CAMHS related things, […] TAPA […]. [TAPA] It's pretty good. […] [Family Coach] organised all of it, the tutors, TAPA, CAMHS before TAPA, yeah. (YP, Family 10)

Practical

[Family Coach] she's looking at days out for the kids, help with grants, best ways to get the kids to and from school… So she's helped out with quite a lot […] also like debts and everything, she helped me to resolve them and sort them out. (Parent, Family 11)

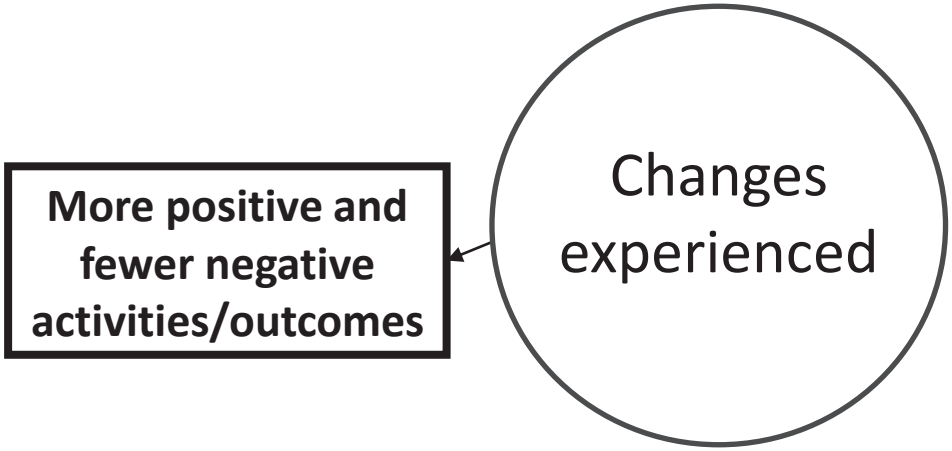
Changes experienced

[Family Coach] researched a lot of stuff [college courses] and she sort of presented it to me, that helped a lot, she also sort of told me what else to look into if I wanted to. […] If I didn't really have [Family Coach] there I suppose that I wouldn't have found [particular college course and desired career] because I would have relied on the school and they weren't really doing much anyway. (YP, Family 7)

Int: Do you feel like [son's] school attendance has changed [since involvement with Family Coach]?

Parent: Yeah, he hasn't had a day off since he's been […] back at school in September, and before we got [Family Coach]… 'Cause when we first got [Family Coach] we were changing [son's] schools because [son] wasn't really fitting in socially. (Parent, Family 5)

I struggled with alcohol over the years, however now I know why, and [Family Coach] helped with that. […] Because I'm not drinking I cope with things a million times better because it did affect my nervous system, I'm pretty sure about that, and I know that if I ever went back on it I wouldn't be able to deal with things. (Parent, Family 7)

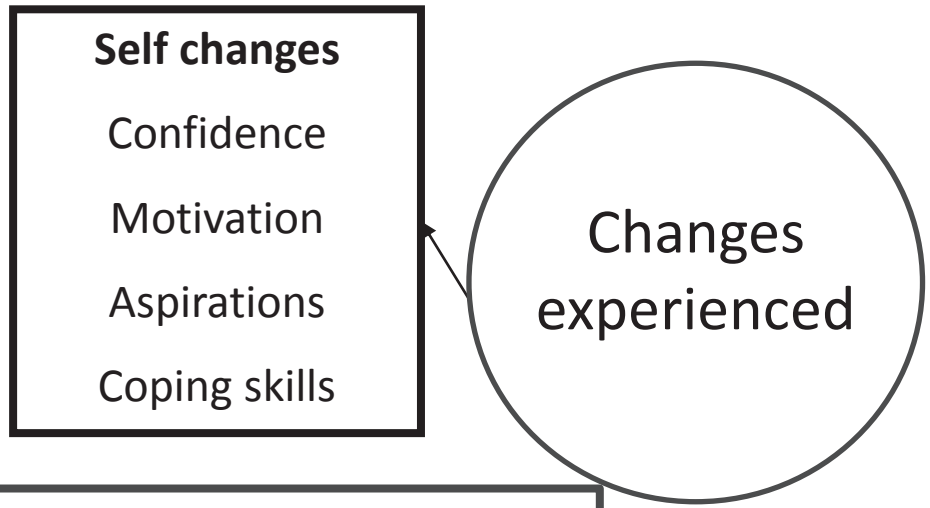


I was really bad. **[…]** I weren't going to school, like drinking and stuff. Like, I got arrested […] like taking stuff, like drugs and stuff. […] I think [Family Coach] she's helped me a lot, I don't think I would have changed if it weren't for her. I think I'd still be doing most of the stuff that I was doing. […] So she's really helped, and I'm a completely different person now. (YP, Family 6)

Everyone's more active [since involvement with Family Coach], definitely, mum's doing a drugs course […] so everyone's active. (YP, Family 7)

Before [involvement with Family Coach] I wouldn't have thought about going into work, you know, doing anything. Now I want to go into work, I want to be able to be something my kids can look up to more. I realise when I done my courses, that my kids were actually proud of me because I got certificates. They were, "Well done, mum, you've actually achieved…", you know, and it shows them as well that if I can do it, they can do it. So that's what I encourage with them. (Parent, Family 6)

Through [Family Coach] I did a group called Boost which was self-esteem group, absolutely fantastic, and it's doing that, not only has it built my self-esteem, it's also given me the confidence in certain ways of dealing with my children. (Parent, Family 3)



Before [Family Coach involvement] I thought I was just like a boy who had all this anger, and now I think I'm a boy who's gonna get a good job, who's gonna get good grades, who's gonna have a good life. (YP, Family 3)

Before [Family Coach involvement] […] I wanted to go and meet my mates […] I wanted to go rob someone for as much as they got. I wanted to go beat someone up. […] Now it's like […] I wanna go to school. I want to achieve good. And me, myself, like, I want to put the effort in. (YP, Family 2)

A lot of the time [son and daughter] they really clash, so it's trying to get them to sit down and talk about their frustrations rather than shouting and screaming and stuff like that. So [Family Coach] she's helped us to sort of make that better. You know, instead of if they get cross or angry, talk about why you're angry, talk about why you're upset, and not shout and scream and swear, you know, so […] that's, you know, our approach now so it's really good. Because it's not nice, it felt like we were living in a war zone. (Parent, Family 5)

We [Both parents] did [Triple P course with Family Coach] and we've both taken on board and we've both done things that were suggested in the videos and things, which has helped, it's helped a hell of a lot, [daughter] she's calmed down a lot towards us. (Parent, Family 9)

Changes experienced

Int: Has anything changed for the rest of your family do you think?

YP: Less shouting so they're a bit more happy. (YP, Family 5)

We're all really close now cos we've had her for ages, and she's like taught us how to like get on better and stuff. (YP, Family 6)

Family dynamics

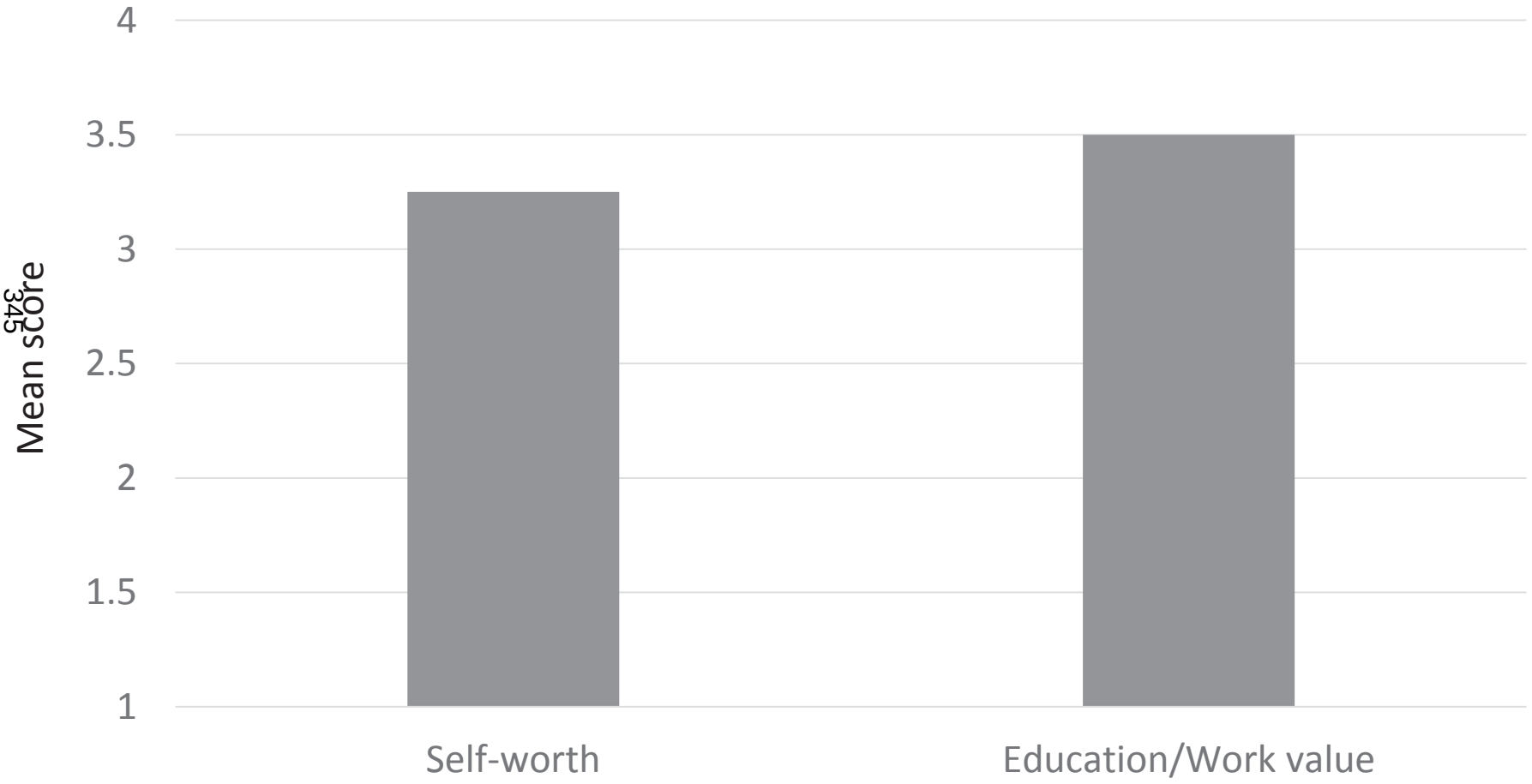
- directions for further enhancement
  - integration with other provisions in the community
  - issue of after-care and dependence on SFSC service: integrate parent pathway into other support networks/parent groups to work against over-reliance on family coach
  - staged approach to get the social context right before pushing for success criteria

Conclusions

- theoretical model mapped onto lived experiences of young people and families
  - affective characteristics
  - self-efficacy, self-worth, possible selves
  - values and aspirations
  - social inclusion
  - relationships
- highly informative and robust assessment protocol
  - reliable and valid quantitative data on overall patterns
  - rich and detailed qualitative data on family experiences

- Next steps
  - work with SFSC team on connecting our assessment data with existing ‘success criteria’ data
  - developing a longitudinal approach to tracking so the assessment can be used:
    - for predicting outcomes
    - for informing intervention approaches

Summer 2014 start, girl aged 17, intensive SFSC support



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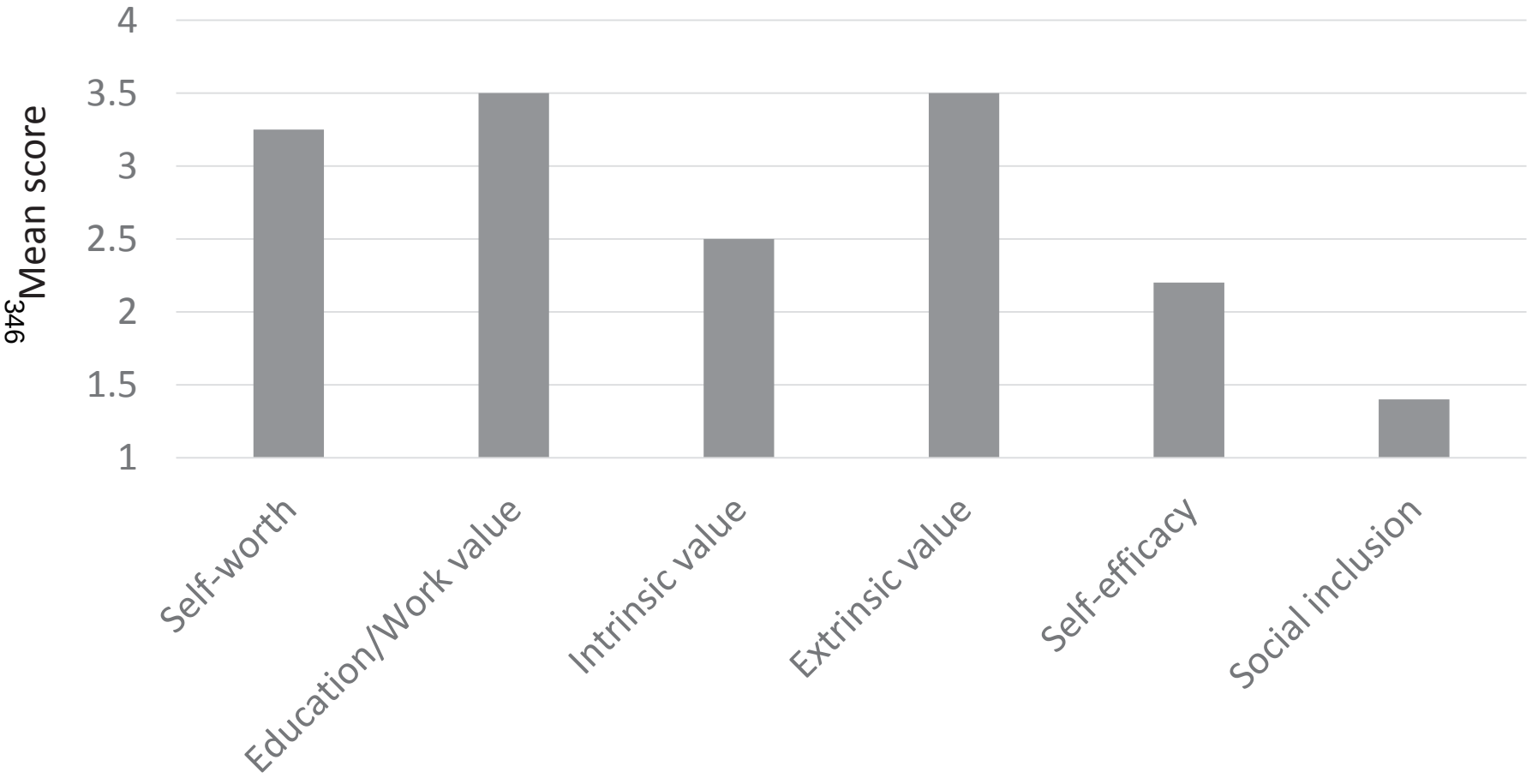

- expansion of assessment protocol to include Phase 2 domains
- parent survey
- dissemination event and opportunity for sharing practice, with wider group of policymakers and practitioners

Who and what is a Member of UK Youth Parliament (UKYP)?

Members of the UK Youth Parliament (MYPs) are elected annually by young people. The most important aspect of an MYP's role is to make sure they represent the views of the young people in their constituency.

The MYP for Brighton and Hove is Maram Takriti, who was elected from the Brighton & Hove Youth Council (BHYC).

What is Make Your Mark?

Now in its seventh year, the Make Your Mark campaign is the largest national consultation of young people. It includes the views of young people from England, Scotland, Wales, Northern Ireland and British Overseas Armed Forces.

Every year the MYP's from across the UK meet in the House of Commons (HoC) to debate the top five issues voted for in the Make Your Mark campaign. The result of the debate decides the UKYP campaign for the following year.

This year over 967,000 young people made their mark nationally, with over 4,000 of those votes coming from Brighton & Hove. This year's top issues for young people living in Brighton & Hove are:

1. **Living wage**
2. **A Curriculum to prepare us for life**
3. **Transport**
4. **Mental health**
5. **Tackling racism and religious discrimination, particularly against people who are Muslim or Jewish**

What will happen at the House of Commons?

On the 13th November the UK's MYPs will debate the top five issues voted for nationally in the Make Your Mark campaign. The top five issues are the same both locally and nationally, with only one difference; locally transport is the third top issue, nationally it is fourth.

Maram, the MYP for Brighton & Hove, will debate these issues with her peers from across the country before they follow parliamentary procedure and vote for their next annual campaign by walking through the 'Ayes' and 'Noes' doors.

The proceedings will be conducted by The Right Hon. John Bercow MP, Speaker for the House of Commons, recorded in Hansard and televised live on BBC Democracy Live.

Want to find out more?

If you would like further information about the UKYP Make Your Mark debate at the House of Commons contact the Participation Team on 01273 295504 or email paul.belluscio@brighton-hove.gcsx.gov.uk