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DATE: 22 January 2015

To: Members of the
HEALTH AND WELLBEING BOARD

Councillor Peter Fortune (Chairman)
Councillor David Jefferys (Vice-Chairman) and Councillor Diane Smith (Vice-Chairman)
Councillors Ruth Bennett, Mary Cooke, Ian Dunn, Judi Ellis, Robert Evans, William Huntington-Thresher, Terence Nathan and Angela Page

London Borough of Bromley Officers:

Dr Nada Lemic	Director of Public Health
Terry Parkin	Executive Director: Education, Care & Health Services (Statutory DASS and DCS)

Clinical Commissioning Group:

Dr Angela Bhan	Chief Officer - Consultant in Public Health
Dr Andrew Parson	Clinical Chairman

NHS England:

Mark Edginton	Head of Assurance - NHS England

Bromley Safeguarding Children Board:

Helen Davies	Independent Chair - Bromley Safeguarding Children Board

Bromley Voluntary Sector:

Ian Dallaway	Chairman, Community Links Bromley
Linda Gabriel	Healthwatch Bromley

A meeting of the Health and Wellbeing Board will be held at Bromley Civic Centre on **THURSDAY 29 JANUARY 2015 AT 1.30 PM**

MARK BOWEN
Director of Corporate Services

Copies of the documents referred to below can be obtained from http://cds.bromley.gov.uk/

AGENDA

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

3 COMMUNITY SERVICES INTEGRATION

This report will be discussed jointly with the Care Services PDS Committee.

This report is to follow.

4 MINUTES OF LAST MEETING (Pages 1 - 12)

5 QUESTIONS FROM COUNCILLORS AND MEMBERS OF THE PUBLIC ATTENDING THE MEETING

In accordance with the Council's Constitution, questions to this Committee must be received in writing 4 working days before the date of the meeting. Therefore please ensure questions are received by the Democratic Services Team by 5.00pm on 23rd January 2015.

6 QUESTIONS ON THE HWB INFORMATION BRIEFINGS

The briefings comprise of:

Bromley Pharmaceutical Needs Assessment-Final Draft January 2015.

The Child Death Overview Panel Annual Report 2013/14.

Members and co-opted members have been provided with advance copies of the briefings via email. The briefings are also available on the Council's Website at the flowing link:

http://cds.bromley.gov.uk/ieListDocuments.aspx?CId=559&MId=5241&Ver=4

Printed copies of the briefings are available upon request by contacting Steve Wood on 0208 313 4316, or via email at stephen.wood@bromley.gov.uk.

7 BROMLEY SAFEGUARDING CHILDREN BOARD (BSCB) ANNUAL REPORT 2013/2014 (Pages 13 - 64)

8 PROGRESS ON THE PNA ASSESSMENT 2015-2018 (Pages 65 - 68)

The full report has been disseminated by email as an Information Briefing.

9 OVERVIEW OF PRIMARY CARE DEVELOPMENTS (Pages 69 - 98)

10 UPDATE ON HEALTH & WELLBEING PRIORITY TASK & FINISH GROUPS (Pages 99 - 104)

11 WORK PROGRAMME & MATTERS ARISING (Pages 105 - 116)

12 ANY OTHER BUSINESS

13 DATE OF NEXT MEETING

HEALTH AND WELLBEING BOARD

Minutes of the meeting held at 1.30 pm on 16 October 2014

Present:

Councillor Peter Fortune (Chairman)
Councillor Diane Smith (Vice-Chairman)
Councillors Ruth Bennett, Mary Cooke, Ian Dunn, Judi Ellis, Robert Evans, Terence Nathan and Angela Page

Dr Nada Lemic (Director of Public Health) and Terry Parkin (Executive Director: Education, Care & Health Services (Statutory DASS and DCS))
Dr Andrew Parson (Clinical Chairman)
Linda Gabriel (Healthwatch Bromley) and Sue Southon (Chairman, Community Links Bromley)

Also Present:

Dr Agnes Marossy (Bromley Health Authority), Councillor Pauline Tunnicliffe and Clive Uren (Bromley Primary Care Trust)

1 APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor William Huntingdon Thresher, and from Councillor David Jefferys. Apologies were also received from Dr Angela Bhan, and Mr Clive Uren attended as her substitute.

2 DECLARATIONS OF INTEREST

There were no declarations of interest.

3 MINUTES OF LAST MEETING

The minutes of the meeting held on 24th July 2014 were agreed subject to an amendment suggested by Sue Southon (Chair, Community Links Bromley).

Referencing Section 5 of the minutes, (South East London Commissioning Strategy 2014-2019) the following amendment was suggested:

The sentence, "*The HWB was made aware that the Chief Executive of NHS England had sent out a letter with respect to the possibility of commissioning"* be changed to:

*"*The HWB was made aware that the Chief Executive of NHS England had sent out a letter with respect to the possibility of CCG co-commissioning primary care".

A Member referred to items 6 and 7 on the previous minutes. It was noted that

there were 5 JSNA (Joint Strategic Needs Assessment) priorities, and only four HWB strategy priorities. The comment was that it seemed disjointed to have two different sets of priorities, and this point was noted by the Board.

The Director for Education Care and Health Services explained that there existed an intrinsic difference between the two sets of priorities. The JSNA priorities would eventually become statutory after consultation and sign off, but the HWB priorities were non statutory and were the priorities that the Board had decided to focus on in Bromley, taking into account the findings of the JSNA.

RESOLVED that the minutes were agreed subject to the amendment suggested by Sue Southon.

4 NON VOTING CO-OPTED MEMBERS REPORT

Members discussed the proposal to appoint non-voting Co-opted Members to the Health and Wellbeing Board. Although the proposed nominees would have no voting rights, their expertise in particular fields would be of great value to the Board. Members were informed that it was currently proposed to appoint the following three nominees:

I. the independent chairman of the Bromley Safeguarding Children and Safeguarding Adults Boards
II. a non – executive member of the Bromley Clinical Commissioning Group
III. an NHS England representative.

The report clarified that the independent chairman of the Bromley Safeguarding Children and Safeguarding Adults Boards, was currently the same individual.

A Member expressed disappointment that the following three organisations had not been suggested for co-opted membership on the report:

- Bromley Health Care
- Kings Foundation Trust
- Oxleas

These organisations had generally been recognised as being the three key providers of services in their respective areas of expertise.

The Director of Education, Health and Care Services cautioned that the Board should give careful consideration to the size and proposed nature of the Board before inviting new co-opted members to join. Consideration should be applied to how large Members wanted the Board to grow to. It was a complicated issue, compounded by providers competing against themselves.

A Member expressed confusion in that she had anticipated that Kings would have been invited to join as a co-opted member, and also in that she was under the impression that the CCG was already a member of the Board.

A Member expressed concern that having too many providers on the Board would

skew the Board's direction, and could not see the benefit of doing so.

The Director of Education, Care and Health Services stated that the guidance from the Department of Health in this matter was not clear, and that at the moment the situation was that Health and Wellbeing Boards were responsible for their own direction and composition.

It was agreed that reference would be made back to Board Members before any future action was taken in appointing co-opted members.

There was a general consensus among Board members that currently the emphasis should be on "Task and Finish" groups.

RESOLVED:

I. that the Non-Voting Co-opted Members report be noted

II. that Board Members consider the size and proposed composition of the Board before any new appointment of co-opted members is made

III. that before any additional nominees are proposed for co-opted membership, Members would be consulted

IV. that the following non-voting appointments be made for 2014-2016

i. the independent chairman of the Bromley Safeguarding Children and Safeguarding Adults Boards

ii. a non-executive Member of the Bromley Clinical Commissioning Group

iii. an NHS England representative.

5 HEALTHWATCH BROMLEY ANNUAL REPORT 2013/14

A presentation on the Healthwatch Bromley Annual Report 2013/14 was given by Linda Gabriel, the Chair of Healthwatch Bromley.

Members were informed that Healthwatch Bromley was a company limited by guarantee, but that it had recently applied for charity status.

The presentation commenced with an overview of Bromley's "Health at a Glance", and then progressed to give an overview of the work undertaken by Healthwatch Bromley. The Board heard about the origins of the organisation, the various health and social care services that it monitored, and the various bodies that it reported to. An overview of the Board Members was provided, together with an exposition of statutory activities.

Linda Gabriel explained that it was the vision of Healthwatch Bromley to work towards a society in which people's health and social care needs were heard, understood and met.

It was explained to the Board that the core statutory functions of Healthwatch Bromley were set out in section 221 of the Local Government and Public Involvement Act of 2007, and updated by the Social Care Act of 2012.

The Board heard that a statutory power conveyed to Healthwatch was the power to carry out "Enter and View" visits to publicly funded health and social care organisations. Subsequent to these visits, reports were drafted and sent to the appropriate providers, who would read the report and respond. These reports were published on the website of Bromley Healthwatch. The Board was advised "Enter and View" visits in 2014 had so far included visits to accident and emergency departments, and also to maternity services. Future visits for 2014 were planned to Day Surgery and Outpatients departments. This would be followed by visits to Care Homes.

Linda Gabriel informed the Board that one of the statutory duties of Healthwatch was to obtain the views of local people about their experiences of local health and social care services and making these views known.

Other statutory duties included:

- making reports and recommendations
- providing advice and information
- reaching views on various matters and reporting them to Healthwatch England
- making recommendations to the Care Quality Commission
- making recommendations to Healthwatch England to publish reports
- giving Healthwatch England such assistance as it may require to enable it to carry out its functions effectively, efficiently and economically.

An explanation was provided of the "feedback system". In this context the key issue was to look for trends that required action; once this was established, intelligence would be sent to the relevant bodies for their action and response.

It was noted that much feedback had been received regarding GP practices and hospitals, and that a key problem had been identified as staff attitudes.

The Chairman asked for an explanation of what occurred during and after an "Enter and View" exercise, and an explanation of this was given. The Chairman also asked what would trigger an unannounced visit; the response was that there would normally be two main factors. The first one was negative intelligence, and the other was when the service was being un-cooperative.

A Member asked for clarification of what was meant by "negative issues". It was explained that this could be a range of issues, including allegations of mis-

treatment, mal practice and staff attitudes.

A Member enquired if the review of phlebotomy services had influenced future outcomes. The response to this was that the matter was being reviewed by the CCG.

A Member stated that during her surgeries, clients did not tend to reference health and social care very often, and that there seemed to be a lack of awareness from the public about the services provided by Healthwatch. It was suggested that perhaps a marketing exercise be undertaken to the public and Resident's Associations.

Dr Nada Lemic (Director of Public Health) thanked Healthwatch for the contributions made to Public Health and to the JSNA.

A Member stated that he was interested in the matter of "signposting" as the NHS was complex and difficult to navigate. The Member asked if Healthwatch could help the CCG to shape signposting. Folake Segun (Director of Healthwatch Bromley) answered that a report had been delivered to a CCG subcommittee and was being considered.

The Chairman and the Director of Education Care and Health Services thanked Healthwatch for all of their excellent work.

The presentation concluded with a summary of Healthwatch Bromley's impact so far, and matters that Healthwatch had influenced, these included:

- the appearance of the wards in the PRUH-Maternity
- the navigation of various health and social care websites
- communication with patients
- review of phlebotomy services
- Beckenham Beacon Urgent Care Centre Procurement
- gluten free prescribing

Healthwatch Bromley could be contacted in several ways:

In writing at:

Healthwatch Bromley, Community House, South Street, Bromley, BR1 1RH.

By telephone on 0208 315 1916, and by email at:

admin@healthwatchbromley.co.uk

The website address is www.healthwatchbromley.co.uk

RESOLVED that the Healthwatch Bromley Annual Report 2013/14 be noted.

6 QUESTIONS ON THE INFORMATION BRIEFINGS

It was agreed at the commencement of the meeting, that any questions arising from the information briefings be addressed at the appropriate point in the meeting when the matter arose on the agenda.

7 APPROVAL OF THE 2014 JOINT STRATEGIC NEEDS ASSESSMENT

Dr Agnes Marossy (Consultant in Public Health) gave a summary of her report concerning the approval of the 2014 Joint Strategic Needs Assessment. Dr Marossy explained that it was the purpose of the JSNA to deliver an understanding of the current and future health and well-being needs of the population of Bromley in the long and short term, to inform strategic planning commissioning services. The hope was that this would achieve better health and well-being outcomes and also reduce inequalities.

It was explained that the JSNA was a statutory requirement under the Health and Social Care Act 2012, and that it was a document that highlighted need; it would inform the Health and Wellbeing strategy. The purpose of the report going to this meeting was that the Health and Wellbeing Board was being asked to approve the 2014 JSNA for publication.

Dr Marossy reminded the Board that the 2014 JSNA had previously been circulated as an information briefing. The Board were now being asked to approve the document for publication on the Bromley MyLife website. An easy to read version of the full briefing document had been attached as an appendix to the report which was appreciated by Members.

The JSNA recommended the following as priorities:

1. Diabetes
2. Obesity (Adults)
3. Smoking
4. Drinking
5. Dementia
6. HIV
7. Mental Health for young people
8. Homelessness
9. Childhood Obesity
10. Teenage Pregnancy
11. Suicide
12. Illegal Drugs
13. Life expectancy
14. Heart disease and Strokes
15. Cancer
16. High blood pressure

RESOLVED that the 2014 JSNA be approved for publication

8 CARE ACT IMPACT

An explanation of the impact of the Care Act was given by report author Chris Curran. It was noted that the report was being presented for the attention of the Board as it was important for the Board to have a full awareness of the impact of the Act, and the changes that it would bring to Adult Social Care. The report focused on the anticipated costs to LBB in delivering compliance to the Act.

It was noted that the non-financial provisions of the Act would come into force on 1 April 2015, whilst the financial reforms would largely take effect from 1 April 2016.

The Board were advised that Council Executive had previously authorised £266k to fund pre 1 April 2015 implementation costs, and that the Council's ECHS (Education, Care and Health Services) Department had already set up a Care Act Program to make the required preparations.

The Board were informed that the Bromley financial model had identified cost pressures from four main areas:

- Cared for Assessments
- Carer Assessments
- Carer Support/Services
- The Care Cap

It was explained to the Board that the "Care Cap" would be set at £72.000.00 commencing from 1 April 2016. This meant that anyone paying for eligible care costs would not pay any more towards their eligible care costs if they had already paid £72.000.00. There will be a number of important exceptions and rules, including that all 'care accounts' recording accrued expenditure will start from £0 in April 2016.

Mr Curran felt that there would be four key results deriving from the four areas listed above, these were:

- an additional assessment workforce would be required
- an improved service offer would be required for carers
- there would be a loss of income as a result of changes to the charging rules
- there would also be a number of smaller scale system changes required

A Member referred to section 4.9.5 of the report that alluded to a consultation paper due for publication in the autumn; this was in respect to the allocation of funding for 2016/17. The Member asked if there was any current knowledge of the anticipated contents; the answer to this was that there was not. Mr Curran felt that due to the complexities involved it may be possible that timescales may slip backwards.

A Member expressed the fear that once a person in care had moved passed the

care cap; the council may begin to experience financial burdens that would be difficult to bear, particularly for individuals who had chosen more expensive providers of care than the council's usual rate. Mr Curran explained that there would be a typical rate that a council would pay; these rates would be rational and common, except in exceptional circumstances. A member suggested that there may be problems later on down the line with people in expensive accommodation that had exceeded their cap. Mr Curran pointed out that it was anticipated that the council may have the power to move such persons into more cost effective accommodation at that point, if such accommodation was available and suitable.

The Director for Education, Health and Care Services pointed out that there would be many people in care that would not exceed the care cap; this was because individuals were fitter and living longer out of care. It was also the case that it was very difficult for central government to correctly assess the correct figure for the care cap. More information was expected to come to light after the autumn statement.

A Member queried how long a person would have to reside in Bromley to benefit from the care account/cap. Mr Curran explained that the care accounts were portable, meaning that any client moving between local authority areas would retain their progress towards the cap.

A Member asked what sort of information would be available to the public concerning these things as the issues seemed complicated. Mr Curran explained that there would be a national campaign, but that local councils would also have to engage in information dissemination, and council staff would need to be conversant.

Mr Curran explained the current financial model that had been used. It was noted that based on current estimates, there would be a deficit of funding in 2015/16 of approximately £192.000.00. It was possible that in around four to five years' time, the increased gross costs to LBB could be in the region of £12M. Mr Curran apprized the Board that any estimates of funding had to be treated with extreme caution until final allocations had been confirmed in December 2015; the report highlighted broad costings and funding which had to be treated with extreme caution at this stage

RESOLVED that the Care Act Impact Report and the initial financial model be noted.

9 PROGRESS ON THE PHARMACEUTICAL NEEDS ASSESSMENT 2015-2018

An update on the progress of the Pharmaceutical Needs Assessment 2015-18 was provided by the report author Dr Agnes Marossy.

It was explained to the Board that the Health and Wellbeing Board had a statutory responsibility to develop and publish the PNA by 1st April 2015. The Board were on target to meet the deadline. The PNA was a key commissioning tool that ensured that local areas had high quality pharmaceutical services that met local

needs. The completed PNA would inform commissioning decisions by NHS England.

Dr Marossy explained that the PNA Steering Group, together with the commissioned provider (PCC) had prepared a draft PNA ready for statutory consultation. This would be published on the My Life Website.

Dr Marossy explained to the Board that she was seeking approval to submit the PNA Assessment for the period of consultation; it was anticipated that the consultation period commence from October 17th 2014 to December 22nd 2014.

RESOLVED that the draft PNA be approved for statutory consultation.

10 Better Care Fund and Work Programme

The update on the Better Care Fund report was given by Mr Clive Uren, who was currently the Interim Director of Commissioning at Bromley CCG.

Members were reminded that the BCF submission was agreed by the Executive and signed off by the HWB Chairman on September 19th 2014. The revised guidance required that the BCF submission ensured that provision for social care was protected and that emergency hospital admissions be reduced by 3.5%

Mr Uren reminded the Committee that to achieve these primary objectives, eight specific schemes were developed with partners. Three of these schemes would look to reduce emergency admissions by 2.8% directly in 2015/16, and the other schemes would act as “enablers”. The “enablers” were in essence longer term initiatives.

The Committee were informed that the Bromley BCF Plan was currently being assessed by the Better Care Fund Programme Team at NHS England, and the expectation was that the Bromley plan would be approved with support. The next stage would be to look into specific project details, some of which may be procured. To this end, project management support would be brought in, and JICE (Joint Integrated Care Executive) would oversee the process.

Mr Uren reminded the Board that the report had identified several risk factors to the BCF work programme. It was estimated that the financial risk that would result from failing to achieve the reduced admissions targets would be in the region of £1.35m, and that this would be borne by the CCG as Commissioner. Mr Uren advised the Board that the CCG had set aside £4.5m to protect social care services.

Mr Uren informed the Board that the work programme had been agreed by LBB and Kings, and that a 2.8% reduction in admission targets had been agreed. It was also the case that another BCF plan had to be submitted by 21st November to release £45m from the BCF.

The Board endorsed the contents of the report.

RESOLVED that:

I. the contents of the report be noted

II. the Board endorse the Chairman's action in approving the Bromley BCF plan

III. updates on the development and implementation of the BCF plan be brought to future Board meetings

IV. the Board acknowledged the key role of the JICE in overseeing and delivering the BCF schemes

11 WINTERBOURNE VIEW PERFORMANCE POSITION STATEMENT

This was a report written by Mr Peter Davis from the Community Learning Disability Team. The report was a bi-monthly update that came to the Board to provide assurances that people with learning disabilities were safeguarded in the context of issues that previously arose from the Serious Case Review of Winterbourne Hospital in 2012.

The Executive Director of Education, Health and Care Services provided an overview of the report to the Board. It was noted that as far as possible, placements would be provided close to home; however this was not always feasible. It was always the case that the objective would be to facilitate the effective integration of care and medical treatment.

RESOLVED that

I. the contents of the report be noted

II. the Board agreed that all necessary measures were currently in place to safeguard adults with Learning Disabilities in Assessment and Treatment Units

12 HEALTH & WELLBEING PRIORITIES AND WORKING GROUPS

This report was being brought to the Board as the Bromley Health and Wellbeing Strategy was a key responsibility of the HWB; it outlined how the HWB would meet the needs identified in the JSNA. These needs would be met through a number of locally determined priorities. Nine priorities were identified in 2012.

The Board was now being asked to endorse the proposed approach to managing the four key health and well-being priorities that had subsequently been agreed upon.

The four key HWB Priorities were:

- Obesity
- Mental Health
- Diabetes
- Dementia

A Member stated that he strongly supported the creation of "Task and Finish" groups, and was anxious that the work pertaining to Dementia proceed with speed and vigour.

RESOLVED that

I. the Board endorses the proposed approach to managing the four HWB priorities through to May 2015

II. the Board endorses the draft Terms of Reference for "Task & Finish" working groups

13 WORK PROGRAMME & MATTERS ARISING

The purpose of the report was for Board Members to review the Board's work programme, and to consider matters arising from previous meetings.

RESOLVED

I. the Board noted matters arising from previous meetings, and also noted the Work Programme.

II. that the frequency of Board meetings be reduced to allow for the establishment of Task and Finish Groups

III. that the Board be kept informed of the progress of matters pertaining to the Better Care Fund by adding regular BCF update reports to the work programme

IV. **that the Board endorse the revised procedure for dealing with questions**

14 ANY OTHER BUSINESS

It was noted that Sue Southon was stepping down from her position as Chair of Community Links Bromley.

15 DATE OF NEXT MEETING

The board were informed that the date of the next meeting would be 29th January 2015

The Meeting ended at 3.00 pm

Chairman

Report No.

London Borough of Bromley

HEALTH AND WELLBEING BOARD

Date: **Thursday 29th January 2015**

Report Title: **BROMLEY SAFEGUARDING CHILDREN BOARD (BSCB) ANNUAL REPORT 2013-14**

Report Author: Helen Davies
Independent Chair
Bromley Safeguarding Children Board
bscb@bromley.gov.uk

1. SUMMARY

This annual report covers the period from April 2013 to March 2014. It is the seventh annual report of the Bromley Safeguarding Children Board (BSCB) which builds upon the previous annual reports. The report highlights a number of identified achievements and other areas where further improvement is needed.

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

2.1 Working Together to Safeguard Children (2013) requires Local Safeguarding Children Boards (LSCBs) to publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area.

2.2 This report presents to the Health and Wellbeing Board details of activity from 1 April 2013 to 31 March 2014 and an assessment of the effectiveness of local services in keeping children safe. The report provides evidence of commitment and determination among professionals and volunteers resulting in real improvement for children. The report also examines where there are weaknesses in the system and how the LSCB holds partners to account to ensure improvement. The Annual Report was approved by the Bromley Safeguarding Children Board at its meeting on 18 November 2014.

3. SPECIFIC ACTION REQUIRED BY HEALTH & WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

The Health and Wellbeing Board is asked to:

- Consider and comment upon the annual report and the effectiveness of local services in keeping children safe

Health & Wellbeing Strategy

1. Related priority: Children with Complex Needs and Disabilities, Children with Mental & Emotional Health Problems, Children Referred to Children's Social Care

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Financial

1. Cost of proposal: No cost

2. Ongoing costs: N/A

3. Total savings (if applicable): N/A

4. Budget host organisation:

5. Source of funding:

6. Beneficiary/beneficiaries of any savings:

Supporting Public Health Outcome Indicator(s)

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4. COMMENTARY

4.1 This annual report covers the period from April 2013 to March 2014. It is the seventh annual report of the Bromley Safeguarding Children Board (BSCB) which builds upon the previous annual reports. The report highlights a number of identified achievements and other areas where further improvement is needed.

4.2 An effective LSCB is one where all partner agencies feel able to fully participate and engage in the business of the BSCB. BSCB continues to achieve a high level of attendance at meetings which has enabled BSCB to deliver against the business plan and key priorities.

4.3 This year has seen a significant number of organisational changes since the last annual report. The responsibility for commissioning local health services changed from the Primary Care Trust (PCT) to the Clinical Commissioning Group (CCG) at the beginning of the year. The Metropolitan Police have implemented the Local Policing Model. The Princess Royal University Hospital (PRUH) has transferred from the South London Healthcare Trust (SLHT) to Kings College Hospital Trust and there are changes to the Probation Service which will take hold in 2014-15. In addition, all public bodies have faced significant resource pressures throughout the year. The challenge for BSCB has been to remain focused on achieving good outcomes for children in spite of these pressures. Through its scrutiny arrangements this year, BSCB is confident that agencies are compliant with their duties under Section 11 of the Children Act 2004 and in fact striving to enhance their services and practices through improvements. Where concerns or challenges have been raised through the year, these have been closely monitored to ensure improvements take place.

4.4 LSCB's now have the responsibility to scrutinise the availability of early help for children and their parents. BSCB believes that early support for families in Bromley is good. The re-launch of a more simplified Common Assessment Framework (CAF) for practitioners leading to record numbers of CAF completions, record levels of attendance at Children and Family Centres and the success of the Tackling Troubled Families programme are all good examples of this. BSCB will continue to monitor early support through 2014-15.

4.5 During this year BSCB has commissioned one Serious Case Review (SCR). The SCR was commissioned at the end of March 2014 and so will continue into 2014-15. Addressing the findings of this review will be a major part of the work during the next year.

4.6 Despite the challenges faced, BSCB remains confident that the foundations of good safeguarding practice are in place. The following is a summary of the key achievements of BSCB during 2013-14:

- Significant progress has been made in supporting a strategic and operational response to Child Sexual Exploitation (CSE) in Bromley with the development of a local protocol, multi-agency training and the establishment of Multi Agency Sexual Exploitation (MASE) and Multi Agency Planning (MAP) meetings;
- Annual Conference held in October 2013 focusing on Child Sexual Exploitation attended by over 100 delegates;
- An extensive multi-agency training programme delivered covering 17 courses attended by over 700 people;
- The completion of a gap analysis against the new Working Together 2013 which provided assurances that operational practice accords with the statutory guidance;

- Setting up a Safeguarding Network for front line staff to promote multi agency learning and engagement;
- The development of multi-agency protocols for children missing from home and care and children missing from education;
- Completion of the two year rolling programme of Section 11 Audits where each agency has completed a safeguarding self-assessment which has been scrutinised by the Quality Assurance & Performance Monitoring Committee;
- Undertaking three multi agency audits focusing on child protection arrangements, missing children and early intervention arrangements, sharing the learning and implementing action plans;
- Development of a Learning and Improvement Framework to support improvement in the quality of safeguarding practice;
- Setting up a new Education Safeguarding Advisory Committee (ESAC) and Safeguarding Education Forums to improve the involvement of the wider education sector alongside appointing Head teacher representatives to the Board.

5. LEGAL IMPLICATIONS

5.5 The production of an annual report for the Local Safeguarding Children Board (LSCB) is a statutory requirement as set out in Working Together to Safeguard Children, HM Government 2013.

Non-Applicable Sections:	Financial Implications Implications for other governance arrangements, Boards and Partnership arrangements, including any policy and financial changes, required to progress the item Comment from the director of author organisation
Background Documents: (Access via Contact Officer)	Bromley Safeguarding Children Board (BSCB) Annual Report 2013-14

BROMLEY SAFEGUARDING CHILDREN BOARD

Bromley Safeguarding Children Board (BSCB)

Annual Report 2013-2014

Contents

Chair's Foreword

I am pleased to present the Annual Report of the Bromley Local Safeguarding Children Board (LSCB) for 2013 – 14. This year has seen many new developments and positive changes in the organisation and delivery of the Board's work.

The purpose of this report is to assess the effectiveness of local services in keeping children safe. The key question is 'are we making a difference?' I would argue that we are, and this report will provide plenty of evidence of commitment and determination among professionals and volunteers resulting in real improvement for children. The report also examines where there are weaknesses in the system and how the LSCB holds partners to account to ensure improvement.

Key achievements in 2013-14 include:

- Multi agency audit to support continuous improvement
- Missing and Child Sexual Exploitation processes established
- Increase in number of children and families engaged in early help
- Delivery and impact of the BSCB training programme
- Setting up a new Education Safeguarding Advisory Committee to improve involvement of schools and other education settings
- Greater participation of young people

Our progress has been made possible through the commitment and enthusiasm for providing high quality services from a range of organisations. I would like to thank all those who have been involved in meeting our challenges this year. I hope you find this report of interest.

Helen Davies

Helen Davies
Chair
Bromley Safeguarding Children Board

Section 1: Executive Summary

1.1 This annual report covers the period from April 2013 to March 2014. It is the seventh annual report of the Bromley Safeguarding Children Board (BSCB) which builds upon the previous annual reports. The report highlights a number of identified achievements and other areas where further improvement is needed.

1.2 An effective LSCB is one where all partner agencies feel able to fully participate and engage in the business of the BSCB. BSCB continues to achieve a high level of attendance at meetings which has enabled BSCB to deliver against the business plan and key priorities.

1.3 This year has seen a significant number of organisational changes since the last annual report. The responsibility for commissioning local health services changed from the Primary Care Trust (PCT) to the Clinical Commissioning Group (CCG) at the beginning of the year. The Metropolitan Police have implemented the Local Policing Model. The Princess Royal University Hospital (PRUH) has transferred from the South London Healthcare Trust (SLHT) to Kings College Hospital Trust and there are changes to the Probation Service which will take hold in 2014-15. In addition, all public bodies have faced significant resource pressures throughout the year. The challenge for BSCB has been to remain focused on achieving good outcomes for children in spite of these pressures. Through its scrutiny arrangements this year, BSCB is confident that agencies are compliant with their duties under Section 11 of the Children Act 2004 and in fact striving to enhance their services and practices through improvements. Where concerns or challenges have been raised through the year, these have been closely monitored to ensure improvements take place.

1.4 LSCB's now have the responsibility to scrutinise the availability of early help for children and their parents. BSCB believes that early support for families in Bromley is good. The re-launch of a more simplified Common Assessment Framework (CAF) for practitioners leading to record numbers of CAF completions, record levels of attendance at Children and Family Centres and the success of the Tackling Troubled Families programme are all good examples of this. BSCB will continue to monitor early support through 2014-15.

1.5 During this year BSCB has commissioned one Serious Case Review (SCR). The SCR was commissioned at the end of March 2014 and so will continue into 2014-15. Addressing the findings of this review will be a major part of the work during the next year.

1.6 Despite the challenges faced, BSCB remains confident that the foundations of good safeguarding practice are in place. The following is a summary of the key achievements of BSCB during 2013-14:

- Significant progress has been made in supporting a strategic and operational response to Child Sexual Exploitation (CSE) in Bromley with the development of a local protocol, multi-agency training and the establishment of Multi Agency Sexual Exploitation (MASE) and Multi Agency Planning (MAP) meetings;
- Annual Conference held in October 2012 focusing on Child Sexual Exploitation attended by over 100 delegates;
- An extensive multi-agency training programme delivered covering 17 courses attended by over 700 people;
- The completion of a gap analysis against the new Working Together 2013 which provided assurances that operational practice accords with the statutory guidance;
- Setting up a Safeguarding Network for front line staff to promote multi agency learning and engagement;
- The development of multi agency protocols for children missing from home and care and children missing from education;
- Completion of the two year rolling programme of Section 11 Audits where each agency has completed a safeguarding self-assessment which has been scrutinised by the Quality Assurance & Performance Monitoring Committee;
- Undertaking three multi agency audits focusing on child protection arrangements, missing children and early intervention arrangements, sharing the learning and implementing action plans;
- Development of a Learning and Improvement Framework to support improvement in the quality of safeguarding practice;
- Setting up a new Education Safeguarding Advisory Committee (ESAC) and Safeguarding Education Forums to improve the involvement of the wider education sector alongside appointing Head teacher representatives to the Board.

Section 2: Governance and Accountability

2.1 Bromley Safeguarding Children Board (BSCB) has been set up under the requirements of the Children Act 2004. BSCB is the key statutory mechanism for agreeing how the relevant organisations in Bromley will co-operate to safeguard and promote the welfare of children in Bromley and for assuring the effectiveness of what they do.

2.2 Working Together to Safeguard Children (2013) clearly details the responsibilities of LSCB's which include:

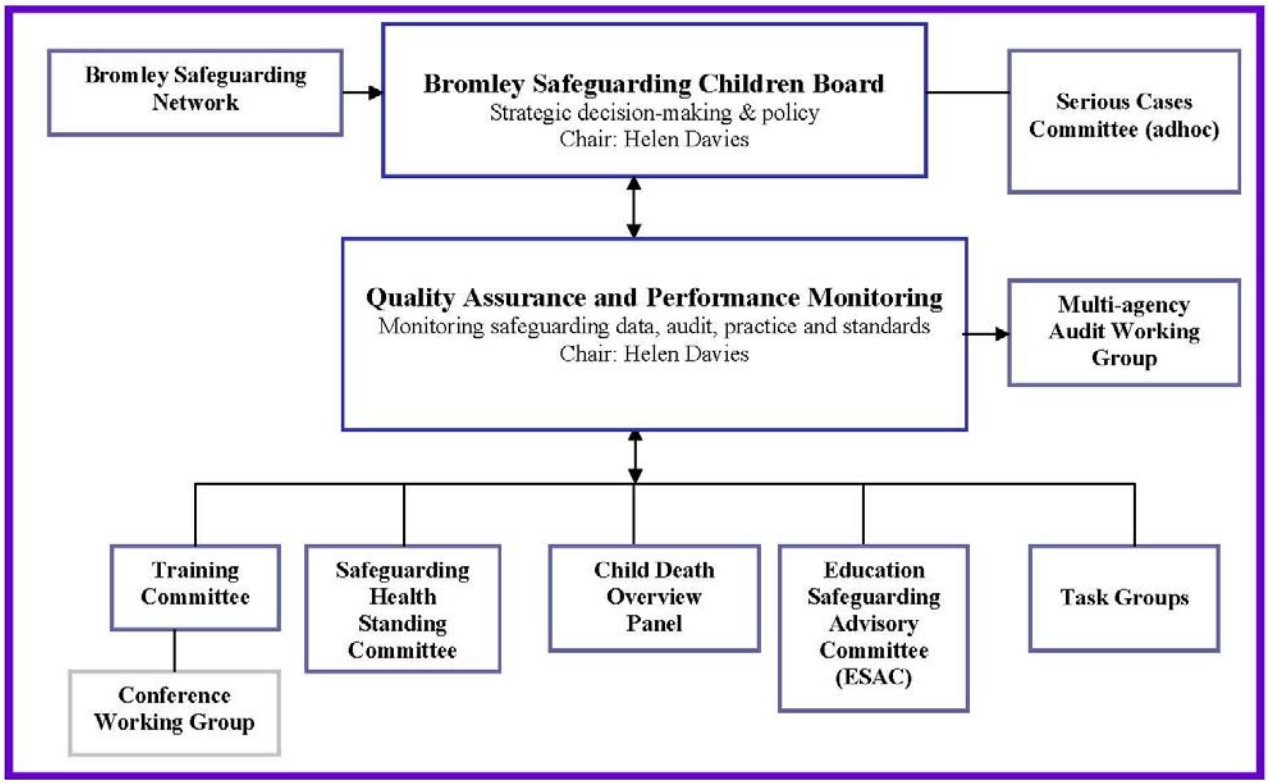
- developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures ;
- communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children ;
- monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve ;
- participating in the planning of services for children in the area of authority; and
- undertaking reviews of serious cases and advising the authority and their board partners on lessons to be learned.

2.3 The key organisational mechanism for delivering the statutory requirements of the BSCB are the meetings of the Board (four times a year) and the Quality Assurance and Performance Monitoring Sub Committee (six times a year). Further information about the Committees is available below.

Reporting

2.4 BSCB submits its annual report to the Joint Education and Care Services Policy Development and Scrutiny Committee and the Health and Wellbeing Board. In addition, in March 2014 the BSCB Chair presented to the Children and Young People Services Stakeholder Conference.

Figure 1—BSCB Committee Structure



Independent Chair

2.5 Helen Davies was appointed Chair of the BSCB and took up post in April 2012. She chairs both the Board and the Quality Assurance and Performance Monitoring Sub-Committee.

Committees

2.6 Following changes to the committee structure in January 2013, BSCB has maintained a similar structure throughout 2013-14 with the only change being that the Education Reference Group has been replaced by the Education Safeguarding Advisory Committee (ESAC).

Board

2.7 The Board is the key strategic decision making group with representation from agencies at Director and Assistant Director level. Designated professionals such as those from health and education now provide professional advice in the role of Professional Advisers. In addition, during 2013-14 the Board agreed to appoint two Head teacher representatives to the Board representing primary and secondary schools in Bromley. They will take up their roles during 2014-15. The Board met quarterly during 2013-14 to provide the strategic direction for the BSCB.

2.8 The Board agenda offers opportunities for information sharing and discussion, but also encourages questioning and challenge. The Board continues to have lay member representation which adds value to the BSCB. The two current lay members challenge thinking through active contribution at the Board meetings. The role and accountabilities of lay members will be reviewed in 2014-15. The Board also has representation from the Portfolio Holder for Care Services, a local Councillor.

2.9 In 2013-2014 the Board's work included:

- monitoring of and setting the BSCB budget for 2014-15;
- Development of the BSCB Business Plan for 2014-15;
- Delivery of an annual conference on Child Sexual Exploitation (CSE) and briefing sessions covering early intervention and the Common Assessment Framework (CAF);
- Setting up a Safeguarding Network for front line staff to promote multi-agency learning and engagement;
- Scrutiny of agency annual safeguarding reports;
- Agreement of multi-agency protocols for children missing from care and home, children missing education and children at risk of or experiencing sexual exploitation;
- Undertaking a gap analysis against the new Working Together to Safeguard Children 2013 which provided assurances that operational practice accords with the statutory guidance;
- Monitoring of the safeguarding arrangements in place for the takeover of the Princess Royal University Hospital (PRUH) by Kings College Hospital Trust from the South London Healthcare Trust (SLHT).

Quality Assurance and Performance Monitoring Sub- Committee (QAPM)

2.10 The Quality Assurance and Performance Monitoring Sub-Committee is central to the effective functioning of the BSCB. The sub-committee met six times during 2013-14. Since January 2013, the committee has been chaired by the Board's Independent Chair and takes responsibility for monitoring standards in safeguarding arrangements and other operational aspects of local safeguarding. It checks how well single-agency safeguarding arrangements are working and as it is chaired by the Board's Independent Chair it is able to provide robust challenge to improve practice and outcomes for children and young people.

2.11 This year the work of the Quality Assurance and Performance Monitoring sub-committee included:

- Development of a Learning and Improvement Framework to support improvement in the quality of safeguarding practice;
- Completing three multi-agency audits focusing on child protection arrangements, missing children and early intervention arrangements and learning from the audits has been shared and action plans implemented;
- Completion of the two year rolling programme of Section 11 audits;
- Review of the BSCB safeguarding dataset;
- Monitoring of safeguarding arrangements in place in a mental health hospital for children and young people in Bromley through requesting the completion of a Section 11 audit.

Bromley Safeguarding Network

2.12 The Bromley Safeguarding Network is not formally constituted. The focus of the Safeguarding Network is to share key messages through the facilitation of seminars, briefings and forums. BSCB held its first forum for the Bromley Safeguarding Network in March 2014 and will continue to provide opportunities to promote multi-agency learning and encourage engagement between practitioners and BSCB.

Training Sub-Committee

2.13 The BSCB Training Sub-Committee meets twice a year to evaluate the BSCB training provided in the previous six months and to agree the training programme for the following year. This year it achieved the following:

- Multi-agency training attended by over 700

people, a 20% increase from 2012-13;

- Agreeing the training programme for 2014-15 which will include 17 separate courses run over 46 sessions and the addition of new training on supervision;
- Increased the number of people completing Group 1 and Group 2 E-learning courses;
- Organised briefings on the Common Assessment Framework (CAF) attended by over 150 people;
- Development of a more rigorous evaluation framework for multi-agency training to include a three month follow up evaluation to monitor impact.

Child Death Overview Panel

2.14 This statutory multi-agency panel has a core membership of police, social care, and health professionals. The panel meets at least four times a year to discuss the circumstances of all child deaths in Bromley and to identify any issues or trends. The Child Death Overview Panel Annual Report is presented annually to the BSCB Board.

Serious Case Review Committee

2.15 This committee meets ad hoc to consider cases where a serious child protection incident has occurred. The committee may determine that either an Individual Management Review (IMR) is obtained from an agency or, in a case involving several agencies and that meet the criteria in Working Together, that a Serious Case Review (SCR) is commissioned. The committee did not meet in the previous year, however, in March 2014, the committee met twice to consider two separate cases. The committee determined one case should be subject to a root cause analysis review. In respect of the other case the committee commissioned a SCR which will be completed during 2014-15.

2.16 Membership of the Serious Case Review Committee during 2013-14 includes:

Independent Chair	Independent
Designated Dr	Bromley CCG
Assistant Director	Legal & Support Services, London Borough of Bromley
Assistant Director	Children's Social Care, London Borough of Bromley
Head of Service	Quality Assurance, London Borough of Bromley
Lead Officer Education Safeguarding	London Borough of Bromley
Consultant Public Health Medicine	Public Health
DCI Child Abuse Investigation Team	Metropolitan Police Service
Designated Nurse	Bromley CCG

Education Safeguarding Advisory Committee (ESAC)

2.17 In February 2014 the Education Safeguarding Advisory Committee (ESAC) was set up to replace the Safeguarding Education Reference Group. The overall aim of ESAC is to ensure that all children and young people are safeguarded in their place of learning. The Education Safeguarding Advisory Committee is chaired by the Assistant Director, Education, LB Bromley. The Vice Chair is the Lead Officer for Education Safeguarding, LB Bromley. The Committee meets quarterly in advance of BSCB Board meetings.

2.18 During this year ESAC has also set up termly Safeguarding Education Forums attended by safeguarding leads for the different educational settings to facilitate the effective dissemination of key safeguarding messages and learning.

Safeguarding Health Standing Committee

2.19 The overall aim of the Health Committee is

to ensure consistent and robust safeguarding practice across the health agencies in Bromley. The committee meets quarterly and is chaired by the Designated Doctor for Child Protection, the Vice Chair is the Designated Nurse for Safeguarding Children. The forum is made up of the safeguarding leads from all health agencies across Bromley.

BSCB attendance at meetings

2.20 Key to the effectiveness of BSCB is regular attendance by members. The BSCB membership in terms of agencies represented has remained stable this year although there have been some personnel changes, which has sometimes led to non-attendance as people started new in role. The Board monitors attendance at meetings and organisations with poor or no attendance are challenged by the Chair to ensure improved attendance.

Section 3: Achievements and Challenges

3.1 A summary of the Board's achievements against priorities are set out in Section 1, but this section provides further information about the achievements of BSCB over the last year and key challenges looking forward to next year.

DEVELOPMENT OF LEARNING AND IMPROVEMENT FRAMEWORK

3.2 The statutory guidance on safeguarding, Working Together to Safeguard Children published March 2013, set out an expectation for LSCBs and its partners to foster a culture of continuous learning and improvement. It required LSCBs to have a Learning and Improvement Framework in place. Prior to the publication of Working Together 2013 BSCB already had in place a Performance & Improvement Framework. During 2013-14, BSCB has updated the Framework to develop it into a Learning and Improvement Framework in line with statutory guidance. The Learning and Improvement Framework was approved by the Board in February 2014.

3.3 The framework supports BSCB and its partners to:

- Conduct regular reviews/audits of cases, both statutory reviews and cases that can provide insight and understanding into the way organisations are working together to safeguard and protect the welfare of children in order to enhance practice.
- Review cases rigorously and in detail showing what happened, how things went wrong, or well and why, accompanied by actions that show the learning from the review.
- Ensure lasting improvements to services to safeguard children and families result from the actions from reviews and audits
- Foster transparency about issues and actions arising from reviews and audits.

3.4 The purpose is to identify improvements which are needed and to consolidate good practice.

3.5 The different types of reviews covered by the framework are:

- Serious Case Reviews
- Child Death review

- Review of a child protection incident which falls below the threshold for an SCR
- A review or audit of practice in one or more agencies.

3.6 The Framework is not dependent on the learning from reviews alone. Other data and information also usefully informs practice:

- Performance data on safeguarding and child protection
- Agency inspection reports
- Agency annual safeguarding reports
- Single agency audits and Section11 Safeguarding Self-Assessment
- Feedback on services from children and young people

IMPROVING SAFEGUARDING THROUGH EFFECTIVE COMMUNICATION

BSCB Annual Conference

3.7 BSCB hosts an annual conference, bringing together staff at all levels to raise awareness about a current safeguarding theme. The Annual Conference 2013 titled "I thought I was the only one, the only one in the world" was held on 23 October 2013 and focused on Child Sexual Exploitation.

3.8 The Annual Conference focused on tackling some of the key issues around Child Sexual Exploitation and provided an opportunity to discuss key national themes and find out about the multi-agency approach in Bromley to tackle Child Sexual Exploitation. The conference was attended by over 100 people.

Listening to Front Line Practitioners - Network Forum

3.9 In March 2014, BSCB held its first Safeguarding Network Forum. BSCB will continue to hold Network Forums during 2014-15 and the aim of the Forums is to share key safeguarding messages, promote multi-agency learning and to encourage engagement between practitioners and BSCB.

3.10 The half day forum in March 2014 was attended by over 75 practitioners from a wide range of agencies. Interest in the Forum was very high and there was a waiting list for places. Feedback from the Forum was very positive. The first half of the Forum included a number of short presentations covering:

- Safeguarding Children Missing from Care and Home
- Safeguarding Children Missing from Education
- Children who Self Harm
- Lessons learnt from recent multi-agency audits undertaken
- Key Learning from three recent high profile Serious Case Reviews (SCRs) – Daniel Pelka (Coventry LSCB), Keanu Williams (Birmingham LSCB) and Hamzah Khan (Bradford LSCB)

3.11 The second half of the Forum enabled practitioners to engage in group discussions focusing on embedding the key learning from audits and SCRs and thinking about BSCB priorities for 2014-15. The feedback was fed back to the Board and incorporated into the BSCB Business Plan 2014-15.

The Voice of Children & Young People

3.12 BSCB recognises the importance of listening to and responding to the voice of the child in undertaking its work in relation to safeguarding. During 2013-14, the BSCB has developed links with the Bromley Youth Council and the Living in Care Council (LinCC). The Youth Council considered the BSCB priorities in the Business Plan and young people identified areas they would like BSCB to focus on in 2014-15. Young people felt there was a need to extend the BSCB priority around safeguarding young people living with parental mental health to include Safeguarding Children and young people dealing with personal mental health issues and as a result this will be the subject of the 2014 BSCB Annual Conference.

3.13 In addition, throughout the year evidence was provided on the voice of the child being heard across agencies in terms of consultation through Section 11 audits.

3.14 BSCB recognises that there is room for improvement with regards to listening to and responding to the voice of the child. This area is crucial for BSCB to operate effectively and has been identified as a priority for 2014-15.

TRAINING

3.15 During 2013-14 BSCB provided local multi-agency training through 17 courses and 46 sessions attended by 733 people. The number of people attending BSCB training has increased by nearly 20% from 617 in 2012-13. A table showing the training courses is provided below. BSCB aims to have a multi-agency mix of professionals at every training course and a breakdown of agencies attending training for the year is below.

3.16 In addition, two BSCB Briefing sessions were held on Early help for vulnerable children: The CAF and beyond. These half day briefing sessions focused on the launch of the new shortened Common Assessment Framework (CAF) Form; Children Social Care thresholds and the role of the Multi-Agency Support Hub (MASH). 155 people attended the briefings over the two days on 2 July and 11 July.

3.17 The BSCB consistently provides training of a high standard, with course participants agreeing that courses are useful and relevant to their needs. Each course is subject to **user evaluation**. Overall feedback across all courses showed that 70% of the attendees judged the courses to be Excellent, 27% Good and just 2% Satisfactory.

3.18 From early 2014, attendees at the Group 3 training courses have been asked to complete a pre-assessment form to be used as a benchmark for the participants' knowledge before attending the training. In addition, attendees of the Group 3 training were asked to complete an evaluation 3

Figure 2 – Agency attendance at BSCB Training

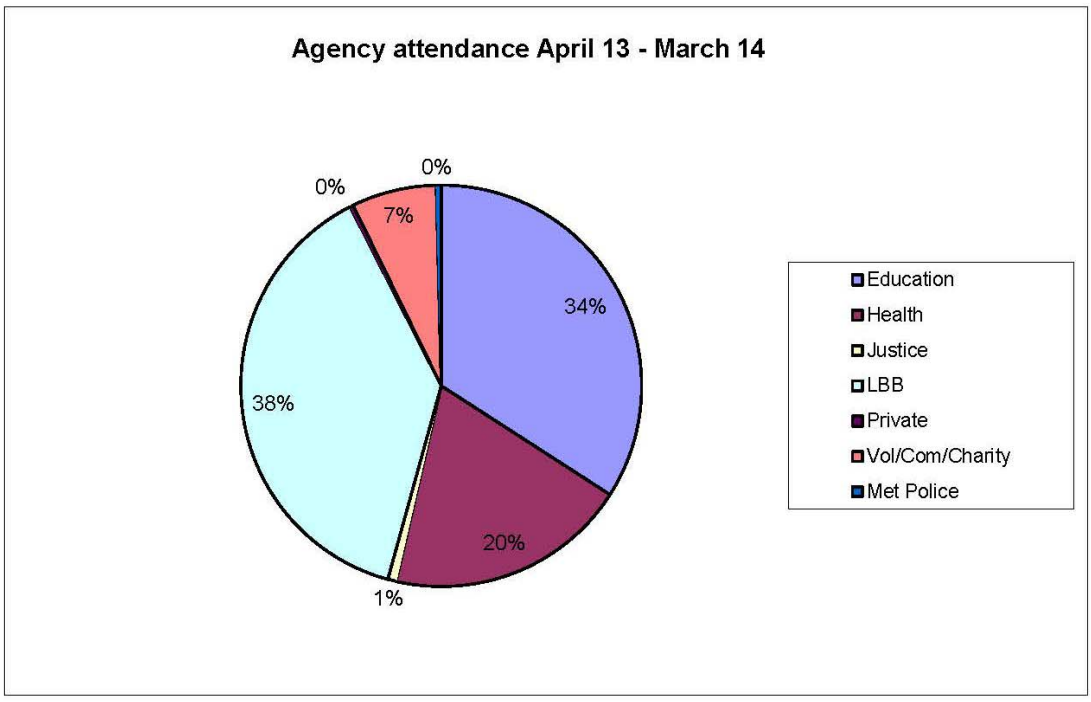


Figure 3 – Breakdown of attendance at BSCB multi-agency training courses from April 2013 – March 2014

Course Title	No. of courses run	TOTAL
Group 4 & 5 Safeguarding	5	82
Group 4 & 5 Refresher	5	66
Group 3	7	107
Group 3 Refresher	2	31
CAF	5	67
CAF Refresher	2	29
CAF–How to Chair Effective TAC Meet	2	15
Impact Parental Substance Misuse	2	30
Domestic Abuse & Safeguarding Children	2	28
Safeguarding Disabled Children	2	19
Safeguarding Neglected Children	3	45
Safeguarding and Parental Mental Health	1	25
Child Sexual Exploitation	3	46
Using A Child History to Analyse Risk	2	36
Signs of Safety	1	18
BME Families & CP	1	17
Basic Child Protection	1	72
TOTAL	**46**	**733**

months after attending the training. The purpose of this level of evaluation is to identify the impact of the training and whether it has led to changes in practice.

3.19 All of the respondents reported that since the training they felt **very** confident about how they can help to ensure children are safeguarded. One respondent reported the following:

> "...Very soon after the training I came across a situation of a child at risk of harm, and because of the training I think I recognised that there was a potential problem sooner, and was therefore in contact with supervisor/safeguarding professional for advice straight away..."

3.20 The BSCB Training Committee has updated its evaluation forms for attendees of the training and in June 2014 will be introducing a much more comprehensive evaluation process which will include pre and post training evaluation as well as a three month follow up evaluation with attendees for all courses to identify the impact of training BSCB provides.

3.21 In September 2012 the BSCB Training Committee introduced free e-learning courses for Groups 1 and 2. The e-learning includes fourteen courses which make up the Group 1 and 2 courses. The advantage of online training is that delegates can learn at a time and pace that suits them. A breakdown of the number of people taking the BSCB e-learning courses between April 2013 and March 2014 is below. In total 466 people have completed the Group 1 course and 45 the Group 2 courses. Evaluation sheets to enable BSCB to evaluate the effectiveness of the E-learning courses will be introduced when the system is upgraded in 2014-15.

Figure 4 – Breakdown of number of people who have completed the Children's Safeguarding Group 1 & 2 courses April 2013 – March 2014

No. who completed	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	TOTAL
Group 1	17	13	19	25	5	25	77	33	21	36	37	158	466
Group 2	3	2	7	3	1	1	6	0	0	5	6	11	45

TACKLING CHILD SEXUAL EXPLOITATION

3.22 Following the development of a BSCB multi-agency task group on Child Sexual Exploitation (CSE) in 2011, this year BSCB signed up to the Pan London CSE Protocol and developed a local multi-agency protocol. The BSCB protocol for safeguarding children who are abused or at risk of abuse through child sexual exploitation follows on from Bromley's Strategy to Safeguard Children & Young People at Risk of or Experiencing Sexual Exploitation which was published in March 2012.

3.23 The CSE protocol outlines the local procedures for safeguarding children and young people who are at risk of or experiencing child sexual exploitation in the London Borough of Bromley.

3.24 The procedures aim to prevent and protect children and young people in Bromley from sexual exploitation and wherever possible prosecute those who are perpetrators of child sexual exploitation.

3.25 BSCB has ensured that all trainers currently facilitating multi-agency safeguarding training programmes are notified of the need to integrate the signs and symptoms of CSE and how to respond to it into their existing courses. These training programmes include basic, intermediate and advanced levels of safeguarding training as well as training around working with specific groups where the young people would be deemed particularly vulnerable to CSE such as Domestic Abuse, Mental Ill Health and Parental Substance Misuse.

3.26 BSCB has commissioned a series of one day training programmes around child sexual exploitation to be delivered over the next two years by specialist trainers from Barnardo's. This multi-agency training has been designed specifically for those professionals who will be working with children and young people who are at a low, medium or high risk of child sexual exploitation.

3.27 Specialist CSE intervention can be of enormous benefit in helping those young people who as victims of CSE have suffered emotional, psychological or physical harm. With the aim of achieving the best possible long-term outcomes for the victims of CSE in Bromley, Children's Social Care has commissioned the specialist sexual exploitation service provided by Barnardo's. This specialist recovery service will provide victims aged 11 to 18 years with an intensive 6 month programme of one to one support and intervention.

3.28 During the year the task group considered the seven essential principles, eight recommendations and the See me, Hear me framework recommended in the Office of the Children's Commissioner's (OCC) final report on CSE. BSCB is confident that the protocol and processes in place address these recommendations.

3.29 Multi Agency Sexual Exploitation (MASE)

and Multi Agency Planning (MAP) meetings have been established in Bromley and Bromley was one of the first boroughs to set up MASE meetings. The MASE meetings are monthly and they have had 12 referrals since Christmas, approximately 25 in total. All relevant agencies attend and play their part in MASE and in February 2014 the Board agreed that the CSE Task Group had completed its work and that the strategic role would be undertaken by the MASE Panel which will report regularly back to the Board. The MASE meetings:

- identify new cases
- monitor progress and agency participation
- identify and set actions against trends/ locations
- address cross border issues
- monitor children placed outside borough
- ensure CSE is integrated with other child protection procedures

CHILDREN MISSING FROM CARE AND HOME

3.30 Children running away and going missing from care and home is a key safeguarding issue for BSCB. An audit of arrangements for safeguarding children who are missing from home or care for more than 24 hours was undertaken in May 2013.

3.31 The audit was particularly concerned with use of procedures, quality of assessment and whether the needs of young people were being identified, and the quality of partnership work including impact on outcomes and challenge to other professionals. It also considered management and supervision of cases; views of children and young people being taken into account; and that timely and appropriate interventions were made. The audit highlighted areas of concern which were acted on immediately by BSCB and a multi-agency action plan was developed to implement the recommendations. The following actions were taken immediately:

- Staff reminded to follow the procedure for missing children, including use of the indicators to identify vulnerabilities and use of risk assessment forms;
- Agencies continue to raise awareness among staff and managers on the identification of sexual exploitation risk indicators such as the importance of a focus on welfare concerns; and that boys are as much at risk of sexual exploitation as girls;
- A working group was set up to review and simplify the procedure for the Board to sign off;
- Updated risk assessment form to be included within foster carer handbook, and shared with other agencies for inclusion in their electronic records, to be distributed at BSCB conference;
- Behaviour service completed a review of cases to determine the appropriateness of alternative school provision, home tuition and set clear plans for some of the young people audited.

3.32 Following the audit in May 2013, BSCB set up a Working Group on Missing Children to review and update the Multi-agency protocol. The BSCB Multi-agency protocol for children missing from home and care was approved by the BSCB Board at its meeting on 12 November 2013. The protocol is designed to support an effective collaborative safeguarding response from all agencies involved when a child goes missing. Since the approval of the protocol, DfE published their Statutory Guidance on 'Children who run away or go missing from home or care' and BSCB responded by reissuing the protocol to take account of the changes in the statutory guidance. BSCB used its annual conference to raise awareness of the needs of missing children and the Network Forum in March 2014 to brief practitioners on the vulnerability of missing children and the revised referral pathways.

3.33 From January 2014, children who have gone missing more than once are considered for review at the Multi Agency Sexual Exploitation (MASE) Panel. The role

of the panel is primarily a strategic one and helps to identify trends and patterns of missing children in Bromley, for example whether children are going missing in a particular part of the borough. It will consider whether the support put in place to prevent the child going missing in the future and prevent any risk of sexual exploitation is adequate. Plans are also in place to ensure return home interviews are carried out. During 2014-15 BSCB will scrutinise regular reports from the local authority analysing data on children missing from home and care. Data on missing children from home and care will be included in the BSCB quarterly dataset reviewed by the BSCB Quality Assurance & Performance Monitoring Committee. This will include reviewing analysis of return interviews. BSCB will also review annual reports from children's homes used by the local authority or within the local authority area on the effectiveness of their measures to prevent children from going missing.

SAFEGUARDING IN EDUCATION

3.34 In February 2014 the Education Safeguarding Advisory Committee (ESAC) was set up to replace the Safeguarding Education Reference Group. In addition agreement was made to appoint two head teacher representatives to the Board.

3.35 The changes were introduced as a way to improve the involvement of the wider education sector engaging all education settings. The previous Safeguarding Reference Group, although representative of different sectors, did not have a role sharing and feeding back information to the different educational settings. The changes have also led to a more clearly defined relationship between ESAC and the Board, enabling the Board to question, challenge and hold ESAC to account.

3.36 The Safeguarding Education Forums will help to engage education settings and ensure effective dissemination of key safeguarding messages to education settings. As a forum attended by safeguarding leads from the different educational settings, it will enable learning from colleagues and peers and joint problem solving as well as training delivered by specialists. The Safeguarding in Bromley Schools Section 11 undertaken in 2013 identified that different methods of informing schools of information should be explored and the Safeguarding Education Forums have been set up to help to address this.

3.37 The first meeting of ESAC in 2014 focused on establishing a clear brief for the committee. Previously the Education Reference Group discussed and considered relevant issues but members were not able to disseminate information and advice to the groups that they were there to represent. ESAC exists to continue to raise key strategic issues as well as report any concerns or issues. In terms of getting information and advice out to stakeholder groups there are to be a number of forums each year, hosted by the education safeguarding lead and existing for the purpose of ensuring that safeguarding leads from all educational settings are kept up to date with any local or national changes. ESAC will also:

- update policies and identify gaps in training;
- identify items for future forum agendas;
- take a regular report from the educational welfare team on children missing from education (CME) and those on elective home education (EHE);
- Include raising awareness of private fostering arrangements and their implications with schools and other settings via the education safeguarding forum.

3.38 During 2013-14 BSCB scrutinised the arrangements for children missing from education and those being home educated. As part of this work, in early 2014 the Board approved the BSCB Children Missing from Education Policy and Procedure. This multi-agency Policy sets out the responsibilities of agencies for identifying children missing

from education and outlines Bromley Local Authority's (LA) systems for identifying and maintaining contact with children missing education and current procedures for identifying those at risk of going missing from education. The Policy and Procedure was launched at the BSCB Safeguarding Network Forum in March 2014.

3.39 Key challenges for ESAC moving in to 2014-15 include ensuring that all settings attend the forums and implement policies effectively and addressing the high number of children on EHE.

SAFEGUARDING IN HEALTH

3.40 There has been an unprecedented level of organisational change across the local health economy during 2013-14 including the establishment of the Clinical Commissioning Group (CCG) and the transfer of responsibility of acute service provision from South London Healthcare Trust (SLHT) to King's College Hospital Foundation Trust. The CCG which was established in April 2013 has achieved significant improvements in embedding safeguarding children within commissioning over the past year.

3.41 Safeguarding arrangements are in place in all local NHS organisations, both commissioning and provider. Assurance data from providers is monitored via the CCG's Safeguarding Children Commissioning Group, which is chaired by the CCG executive lead for safeguarding children. In addition designated professionals meet regularly with named professionals and executive leads for safeguarding children within provider organisations and attend the safeguarding committees of the main NHS providers, to provide challenge and support development.

3.42 Health organisations from within the NHS and private sector, working within Bromley, meet quarterly at the Safeguarding Health Committee. The committee is jointly chaired by the designated doctor and the designated nurse for Safeguarding Children in Bromley and brings together work and developments in safeguarding children across the Borough. The committee reports to the Safeguarding Children Commissioning Group of the CCG as well as the Quality Assurance and Performance Monitoring group of the BSCB.

3.43 Strategic links to the BSCB are well developed with executive leads, designated and named professionals for safeguarding children regularly forming part of development and audit groups, as well as sitting on relevant committees. Health organisations are also represented within multi-agency forums across the borough including MARAC and MAPPA, domestic abuse forum and steering group, MASH steering and operational groups, CSE strategic group and multi-agency panel.

3.44 The Francis Inquiry into the failures in care at Mid Staffs Hospital (published 2013) and subsequent government responses has placed a renewed and strengthened emphasis on the importance of listening to patients and carers and seeking their views and feedback on services. The CCG is working with providers to ensure that patient voices are heard and responded to, as well as ensuring that there is engagement at all stages of service redesign.

3.45 King's College Hospital Foundation Trust took over the management of the Princess Royal University Hospital (PRUH) in October 2013. Level 2 safeguarding training sessions are being offered to nurses and midwives when they join the Trust during their induction and training sessions for established staff are available every week. The Trust has been attending BSCB board meetings and sub-committees. Good progress had been made in establishing positive working relationships, however, there have been a number of changes in the safeguarding teams in Bromley so

establishing strong relationships will be a priority for 2015.

3.46 During this year Oxleas NHS Foundation Trust has continued to make excellent progress in the provision of learning and development opportunities to enable staff compliance with mandatory training and updating expectations, which are aligned to the requirements of the Intercollegiate Document (2014). An audit of the effectiveness of Oxleas level 3 training found very good retention of knowledge gained at training and there has been excellent evaluation feedback from attenders. The year also saw an increase in case file audit activity together with an ongoing commitment by Oxleas to the BSCB multi-agency audit programme. In addition, further work in Oxleas has led to a growth in the number of safeguarding children champions embedded within clinical teams. Champions have been supported and gained knowledge through regular local borough based forums and an annual Trust wide forum.

3.47 Bromley Healthcare continues to work closely with BSCB to deliver high quality and effective safeguarding of children and young people living in Bromley. This has been achieved by developing good working relationships, attendance at relevant meetings, supporting with recruitment for key personnel for BSCB and participation in joint training events and audits.

3.48 Bromley Healthcare Safeguarding Children training compliance between 2013-2014 has fluctuated for levels 2 and 3. The Named Nurse who was in post in 2013 left early in 2014 and the post was unfilled until August 2014. The gap in training has been addressed since the new Named Nurse came into post. More sessions are available and are in line with the Intercollegiate Document March 2014. Future plans have been made for regular joint workshops in the coming year; this will be educative but will also support better understanding and communication between health practitioners and social workers.

Priorities

3.49 The priorities for 2014-15 will be to ensure that safeguarding children remains a priority across all health agencies. Health agencies have identified the following specific priorities for the year:

3.50 Bromley CCG

- The CCG will ensure that new staff appointed to the safeguarding team are supported as required to develop competencies at the required level, including specific knowledge and skills such as safer recruitment.
- There have been a number of personnel changes within specialist safeguarding teams within Kings and Bromley Healthcare. CCG Designated professionals will continue to provide support to these staff and to ensure that they are able to effectively provide assurance on safeguarding arrangements.
- The CCG will review and strengthen engagement of commissioning staff within the safeguarding children commissioning engagement.
- The updated Intercollegiate Guidance, which informs safeguarding children training across health, was published in April 2014. The CCG will work with providers to review the implications of this.
- The CCG supports development within primary care and this includes safeguarding children training. In 2014-15 the CCG intends to increase training available to practice nurses above the requirement set out in the intercollegiate Document (Level 2). Practice nurses will be invited to participate in the annual academic half day provided to GPs during January 2015 (Level 3 training). This will support the development of additional skills and competencies within primary care teams.
- The CCG will review data collection for safeguarding and work with providers to provide additional data as required. This includes new quality schedule monitoring

for Kings, new providers using the safeguarding scorecard.

3.51 King's College Hospital Trust Foundation

- Recruitment to ensure the safeguarding team was staffed to appropriate levels.
- Training to ensure that the safeguarding training provided to staff was of a high standard and that sufficient training sessions were available to achieve an 80% compliance rate.
- Introducing and embedding the Trusts safeguarding policies and procedures at the Princess Royal.
- Establishing relationships with the Bromley board and safeguarding professionals across the Bromley health economy.

3.52 Oxleas NHS Foundation Trust

- Increasing awareness and understanding of domestic abuse, MARAC and increasing referrals to MARAC
- Increasing identification, support and referrals for Young Carers
- The progress against and embedding of action plans arising from audits and continue to embed the outcomes of previous audits and reviews
- The need for staff to engage, together with partners, with the Early Help agenda including the Common Assessment Framework (CAF) process

3.53 Bromley Healthcare

- To actively participate in a joint audit on Neglect, looking at learning from case studies and improving outcomes for children living in long term neglect.
- To actively participate in a joint audit of selected cases that have been referred to the MASE Panel to ensure services are being directed and offered to vulnerable exploited young people
- To deliver Level 3 training to BHC staff on FGM, CSE, Honour Based Violence and Witchcraft, the MASH, MARAC and MASE
- To ensure all BHC staff are compliant with identified training needs
- To offer a weekday 9-5pm consultation service for all BHC staff on all safeguarding children matters
- To undertake an audit on supervision of staff, to identify any gaps in record keeping and practice and also to access the quality of the supervision from the supervisees perspective

POLICING

3.52 The Local Policing Model has now been established since September 2013. This saw an increase in the number of staff in the missing person unit by two detective constables. In addition a review will be undertaken in 2014-15 into how safeguarding for children is managed looking at the borough based systems and the centrally based child protection teams.

3.53 In June 2013, the Sapphire Command (SCO2) and the child Abuse Investigation merged to form the Sexual offences, Exploitation and Child Abuse Command (SOECA). This does not affect the investigation on child abuse allegations but has resulted in police officers joining the command from Sapphire and Homicide (SCO1).

3.54 During 2013-14, the Chair of BSCB requested a report from LB Bromley regarding the appropriate adult service, emergency accommodation for young people who have been arrested and detained overnight and the recording of overnight detention. BSCB is satisfied that the arrangements for the appropriate adult service are effective but the Board has requested a multi agency audit of the safeguarding implications of the current arrangements for detaining young people overnight in Bromley. The audit will be scrutinised by BSCB in 2014-15.

CHILDREN'S SOCIAL CARE

Audits

3.55 Bromley Children's Social Care carried out a full programme of audits in 2013-14 which were reported to the BSCB QA& PM Committee and helped to identify a number of key areas where the service could make improvements. The majority of these recommendations have been put in place and those which remain to be actioned have been added to the appropriate work plan. The 2013-14 programme included:

- Child Protection thresholds for children with disabilities;
- Leaving Care Team;
- Children in Need/Teenage and Parent Support Service (TAPSS);
- Step up/step down in safeguarding; and
- Child Protection strengthening families

Continuous assessment

3.56 The 2014-15 programme for audits is ongoing and future areas for development have been identified.

Multi Agency Support Hub (MASH)

3.57 MASH is now fully implemented within the Referral and Assessment Service and the continuous assessment framework (Social Work Assessment) will be used for all cases starting in July 2014. Police and Health are co-located within the MASH team. Bespoke software, MASH Protects, has been purchased and implemented to support the management of data. Performance data is being collected and will be regularly recorded within the Performance Digest.

3.58 The recent co-location of agencies in Bromley is at an early stage and it is too early to tell the impact on numbers of referrals to Children's Social Care. There does however appear to be anecdotal evidence of closer working relationships. For instance in cases involving children where there is a health visitor involved and issues have been raised that do not meet the criteria for Children's Social Care, discussions with the MASH health colleague has meant a greater focus or extra visits by the health visitor.

Early Help

3.59 The Early Intervention Performance Digest has been fully developed and is able to provide data on vulnerable families, facilitating future service improvement recommendations. It specifically shows step up and step down data to enable Children's Social Care to measure how well it is targeting children in need. It clearly shows there is a year on year increase in the take up of Children's Centres activities. Health visitors have also been co-located to two Children's Centres.

3.60 The Tackling Troubled Families Programme has hit its targets for payments by results and achieved full funding drawdown. The funding is used to employ a team of eight Family Practitioners who work closely with families to achieve outcomes. A plan is currently being developed to employ a further four practitioners to specialise in working specifically with Children in Need and subject to a plan. Specific links are being made with Bromley's behaviour units and Tackling Troubled Families support workers as part of targeting vulnerable children's groups.

Children in Care

3.61 BSCB continues to monitor the safeguarding arrangements for children in care. The Board scrutinises the Annual Report of the Independent Reviewing Officer (IRO) Service and the QA&PM Committee regularly reviews data on children in care through the safeguarding dataset.

3.62 The Living In Care Council (LinCC) website was successfully launched at the celebration of achievement awards ceremony in November 2013 and is a useful resource for Bromley looked after

children. A Film workshop is being held in August 2014 as part of the Children in Care summer programmes and will provide participants with the opportunity to make a series of short films for the publication on this website. During 2013, the LinCC supported the development of training and recruitment DVDs for foster carers. In July/ August 2013 the 'welcome packs' for children in care were updated and distributed by social workers. These packs include the DVD produced by LinCC members. These will be regularly updated and are provided to all children and young people.

3.63 Children in Care were also offered the opportunity to be involved with the recruitment process for members of staff. Training sessions were held in October 2013 and also in February 2014 and have been attended by a small group of young people who have actively participated in interviews.

3.64 The Foster Carers Handbook has been fully updated and was re-launched this year. This online resource which is available for all Bromley Foster Carers offers advice, guidance and access to relevant information. The feedback received back from foster carers has been very positive.

3.65 The training programme for foster carers has been reviewed and updated and an annual foster carer conference was introduced in 2013 attended by foster carers , social workers and supervising social workers.

3.66 The Independent Reviewing Service (IRO) carried out a stakeholder consultation in March 2014. The response rates varied between stakeholder groups, 40% for foster carers, 21% for social workers and 12% for children's guardians. In all groups, the majority of recipients rated the service they received as either excellent or good. The IRO service have been developed during 2013-14 to strengthen their role and function in driving up the quality of care plans. Mid way monitoring of care plans has also been introduced.

3.67 Independent advocates have been engaged to undertake return home interviews for looked after children who go missing and feedback will be included in contract monitoring meetings from July 2014.

Care Proceedings and Court Pilot

3.68 The Bromley and Bexley Court Pilot concluded on 31 March 2014. The Pilot ran for 14 months with a Case Manager tracking and monitoring all court work and outcomes for cases in care proceedings across both boroughs and reported to the Chair of the Court Pilot Project Board. The Project Board had representation from each borough, the Judiciary, CAFCASS, Lawyers and other stakeholders. The focus was to support partners to work together to implement the new Public Law Outline in time for the introduction of the Children and Families Act 2014, which has made the conclusion of care proceedings within 26 weeks a legal requirement. Under the Pilot Bromley issued **53** sets of proceedings which concerned **91** Children. Bromley's average number of weeks for concluding care proceedings at the start of the pilot was 42 weeks against a national average of 45 weeks and by the end of the Pilot Bromley's average for concluding care proceedings was **24** weeks. In September 2013 CAFCASS, in its Second Quarter Heat Map reported Bromley as being ahead of the curve for London and was scored as Green alongside only two other London Boroughs, which was an excellent achievement.

Private Fostering

3.69 BSCB monitors the arrangements in place for privately fostered children in Bromley. The Quality Assurance & Performance Monitoring Committee (QA&PM) considers the quarterly data on private fostering and BSCB receives the local authority annual report to scrutinise the arrangements the local authority has in place to discharge its

duties in relation to private fostering. At the beginning of 2013-14, Bromley already had 3 children subject to Private Fostering arrangements. During the 12 month reporting period, the Local Authority was notified of 10 new children subject to Private Fostering arrangements; 8 of which were deemed to be long-term arrangements for on-going monitoring and support and the remaining two cases were monitored and ceased as both young people became sixteen in July and September 2013. Two other private fostering arrangements were ended in April and July 2013.

3.70 All private fostering notifications have been acted in accordance with the local authorities policies and procedures. The local authority has a Lead Officer for Private Fostering who has been working with partner agencies such as language school and other professionals to raise awareness and to ensure the safety and well-being of privately fostered children. Robust oversight and monitoring of performance is being undertaken by Children's Social Care Senior Management Team. Bromley is now a member of the Private Fostering Specialist interest Group (PFSIG) run by BAAF and this has been helpful to determine areas Bromley can improve its performance regarding Private Fostering.

3.71 Statutory visits were completed within the timescale except where some of the foreign language students were out of the country due to school half term or summer school holiday.

3.72 Awareness raising activities has made no differences in increasing notifications during the reporting year. Research and good practice suggest the most effective awareness campaign should focus primarily on the local authorities own staff, GP's, School admissions and language colleges. As a result, the private fostering communication strategies have been reviewed in line with the existing evidence of good practice.

3.73 The Private Fostering policies and procedures are currently being reviewed. The Bromley Council and BSCB websites will be updated with private fostering information and new leaflets will be developed for privately fostered children, their parents and carers as well as professionals and members of the public. The leaflets will be available both online and hard copy by the end of November 2014.

CHALLENGES

Embedding the Learning and Improvement Framework

3.74 Now that the BSCB Learning and Improvement Framework is in place, the challenge is to ensure that agencies learn from the findings and take appropriate action to improve outcomes for children and young people in Bromley. The QA&PM committee has put measures in place for 2014-15 to ensure that there is regular follow up and monitoring of actions arising from audits and case reviews.

3.75 In addition, the revised BSCB quarterly dataset will be available in 2014-15, supporting members in identifying changes in the key areas of safeguarding children and promoting an ethos of continuous improvement. The challenge will be to ensure that the dataset is fully embedded.

Domestic Abuse

3.76 Domestic abuse is a consistent feature of child protection cases and serious case reviews nationally. In February 2014, CAADA (Co-ordinated action against domestic abuse) published its second national policy report 'In Plain Sight: Effective help for children exposed to domestic abuse' highlighting the harm experienced by children exposed to domestic abuse. Domestic abuse continues to be a priority for BSCB and following a multi-agency case review carried out in February 2014, BSCB is proposing to set up a Domestic Abuse Task and Finish Group. The BSCB Domestic Abuse Task and Finish Group will work with

the Bromley Domestic Abuse and VAWG Forum and focus specifically on the impact of domestic abuse on children and young people.

3.77 The overall aims of the Domestic Abuse Task and Finish Group are:

- To make recommendations to the BSCB Board to ensure that children living with domestic abuse are safeguarded;
- To raise awareness of the impact of domestic abuse on children and young people.

Voice of Children & Young People

3.78 A key theme in the BSCB Business Plan 2014-15 is to listen to children, young people and their families to enable BSCB to understand the impact of safeguarding work and ensure their views are reflected in the work of BSCB. In addition, all agencies will continue to develop work to ensure that young people's views are evidenced and it can be seen how they contribute to decisions being made about them. Throughout the next year BSCB will look to build on the work undertaken in 2013-14.

Listening to Frontline Practitioners – planned Survey

3.79 In February 2014, the Board agreed to introduce an annual survey for frontline practitioners. Evidence from the Munro review on child protection systems and practice in England informs us that a confident and involved workforce, who feel heard and responded to, and a workforce that believes it is suitably resourced to do its job, leads to effective safeguarding practice.

3.80 The view of staff is important to our understanding of how well local safeguarding practice is working. An on-line practitioner survey of the view of frontline staff has been developed and it is proposed that this is repeated on an annual basis. The first survey will be undertaken between July – September 2014.

3.81 In addition, BSCB will continue to host Safeguarding Network Forums to share key learning and encourage engagement between BSCB and practitioners.

Changes in Probation

3.82 The Board has received regular updates on the changes the Ministry of Justice are making to Probation including the creation of a new national Probation Service to manage the high risk offenders and undertake all initial assessments and the creation of 21 Competed Package Areas (CPAs) to manage all medium and low risk offenders. The Board will continue to monitor the safeguarding implications of the changes throughout 2014-15 and considers it a priority to ensure that Probation continues to be represented on the Board and other committees to ensure that the new probation Service and CPA are held to account.

Self harm in young people

3.83 Self harm appears to be an increasing issue for young people in Bromley, and there is some evidence that rates of presentation to services with self harm are higher in Bromley than in most London boroughs.

3.84 In Bromley, most of the attendees presented due to self-cutting as opposed to self-poisoning suggesting a possible shift in self-harming behaviours. Of particular note were the common 'triggers' of a new episode of self-harm that presented to A&E, which included family arguments, bullying and already being an inpatient on a mental health unit.

3.85 The evidence that self harm may be reduced by psychological well-being programmes for young people and gatekeeper training for those who they may present to is being taken forward in secondary schools, A&E at the PRUH and CAMHs services in the borough.

Section 4: Sufficiency of arrangements to safeguard children and young people in Bromley

4.1 BSCB monitors and evaluates the effectiveness of what is done by partner agencies individually and collectively to safeguard and promote the welfare of children. It does this through its business plan and evaluates the effectiveness and accountability of partners through Section 11 audits, multi-agency audits, a quarterly dataset and monitoring of action plans.

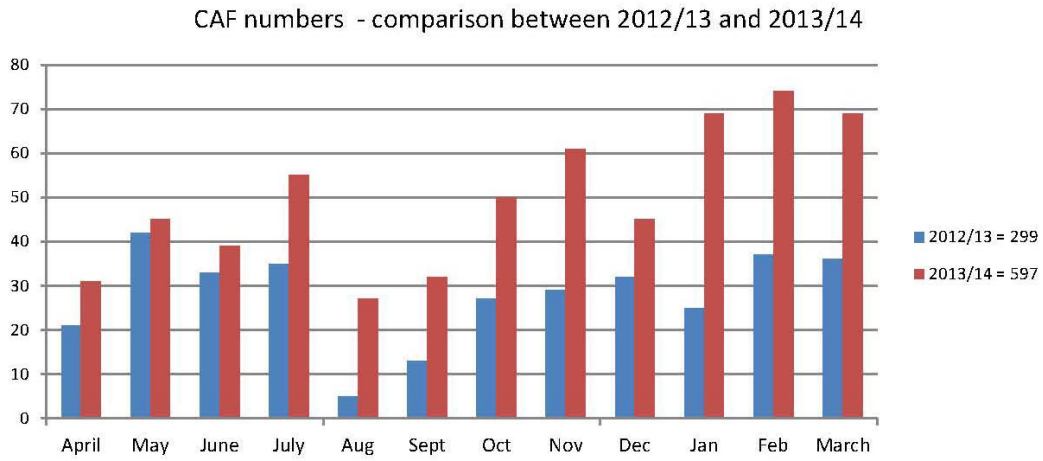
PERFORMANCE MONITORING

4.2 In Bromley, partners acknowledge the importance of regularly receiving multi-agency information on safeguarding as an essential element of holding agencies to account. A quarterly dataset is produced to support this role. It focuses on the core areas of child protection and the information can identify the need for improvements in service or enhanced joint work to minimise safeguarding risks. For the first time this year, the quarterly dataset has included data from a range of agencies including children's social care, health, the police and probation. The dataset has been widened to report on child sexual exploitation, children missing from home and care, and children missing from education. A summary of some of the key data is below.

Prevention and Early Intervention Services

4.3 Within Bromley the Common Assessment Framework (CAF) is used as a holistic assessment of need, leading to a co-ordinated provision of services, involving a Lead Professional and 'Team Around the Child/Family' approach where appropriate. The total number of CAFs for 2013/14 is **597.** This represents a significant increase compared to last year's total of 335 and is in fact the highest annual number since the CAF was launched in Bromley.

Figure 5 – Common Assessment Framework (CAF) numbers comparison between 2012-13 and 2013-14



4.4 There are several contributory reasons for the increase:-

- A targeted piece of work with schools
- The launch of a new CAF form
- A greater focus on stepping cases down from Social Care
- The offer of individual CAF training

4.5 Work with schools - Last year's CAF figures showed a significant drop from both primary and secondary schools compared to previous years. The CAF Team undertook a targeted piece of work focussing on schools that were completing a high number of CAFs but had reduced their output and schools who had completed few or no CAFs but are located in areas of deprivation. Individual meetings were set up with a number of these schools.

4.6 The launch of a new CAF form - the new CAF form was launched in July 2013 with two launch events hosted by BSCB attended by 160 participants. The form was devised to encourage greater use of the CAF process within Bromley. It has been simplified from the original version and can be used as a family CAF in that more than one child can be included in the assessment.

Figure 6 – Breakdown of CAF numbers from schools over the past 3 years

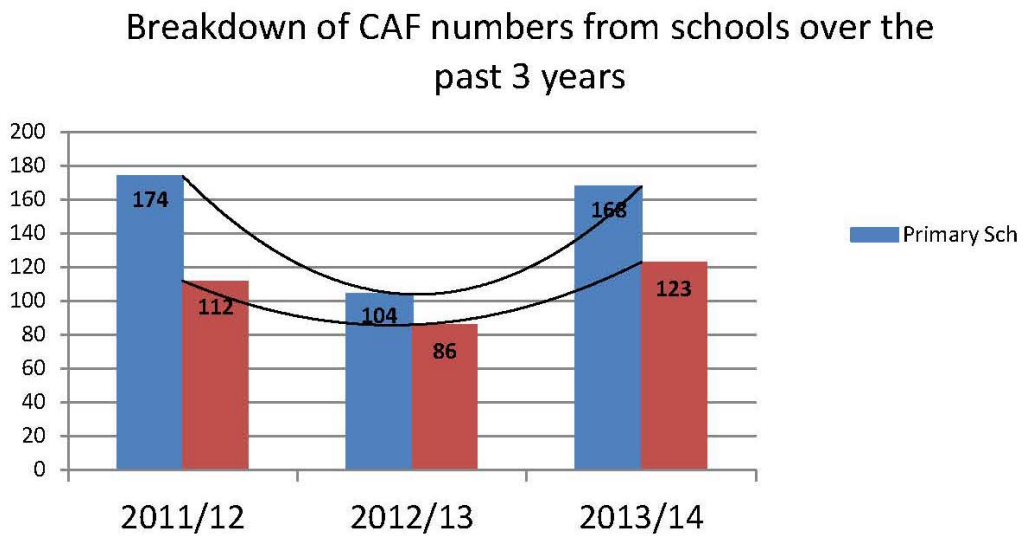
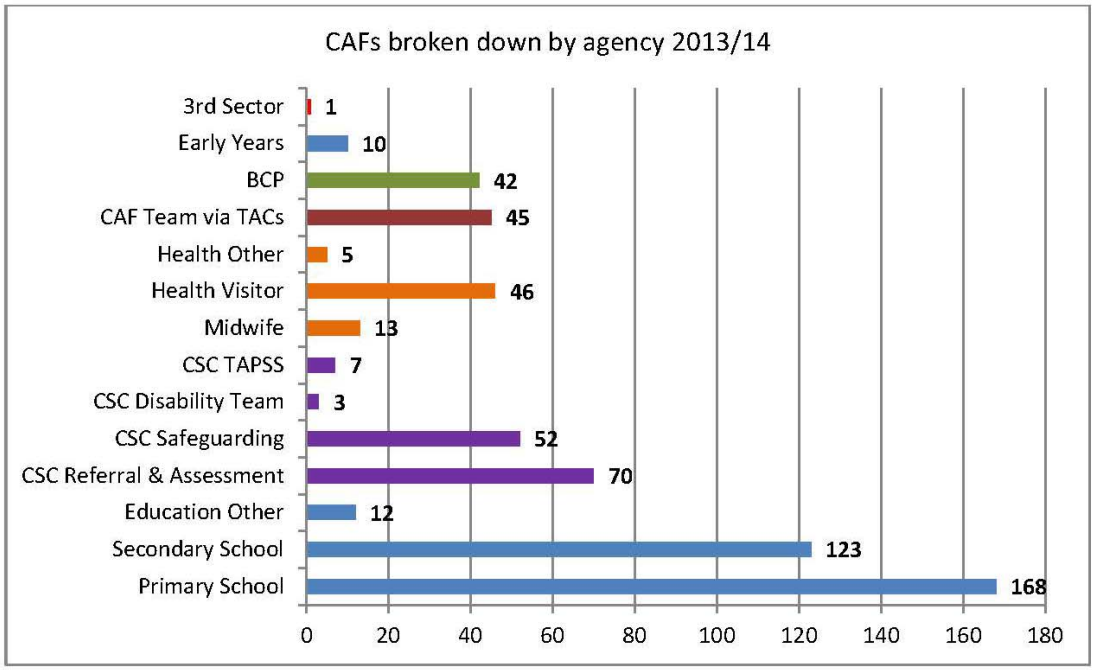


Figure 7 - Breakdown of CAF numbers completed by agencies/services during 2013-14



4.7 An increase in cases stepping down from Social care – there has continued to be an increase in cases stepping down from Social Care in line with Bromley Safeguarding Threshold Guidance (see Figure 7 for a breakdown of CAFs received via agency/service).

4.8 The offer of individual CAF training – over the past year the CAF Team have completed a number of request based training sessions in addition to the CAF Training facilitated via BSCB. These have included a number of schools and pre-school settings, Adult Mental Health, Portage, the Youth Policing Team, Childminders, Midwives, Health Visitors and School Nursing.

4.9 As can be seen from Figure 8 the main category for CAF completion has been parental issues impacting on the child for example, neglect, parental conflict, mental health issues, etc. This is in contrast to previous years when the child/young person displaying behavioural issues has consistently been the top category. For example, aggression, disruptive behaviour within school, drinking/drug use, etc.

Figure 8 - Primary reason for CAF completion during 2013-14

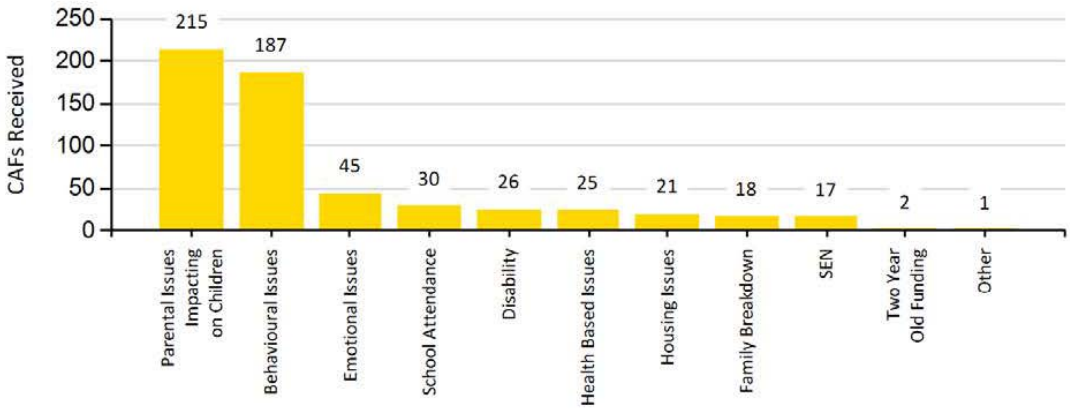
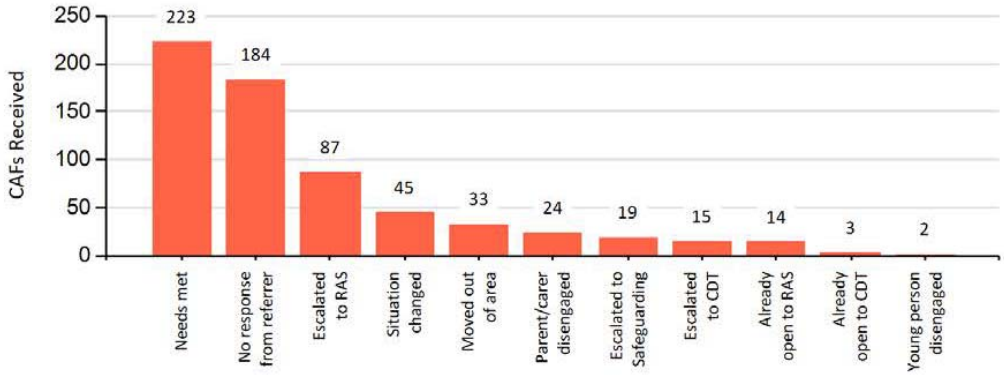


Figure 9 - Outcomes of CAFs completed during 2013-14



4.10 Figure 9 below shows the outcomes of CAFs completed during 2013-14. The CAF Team transferred from using Capita ONE to Synergy Connect for recording CAF data in April 2013. As part of that transfer the CAF Team completed a data cleanse. The 'no response from referrer' relates largely to that data cleanse. Many of the CAFs on ONE were very old. Some of the young people were over 18 or had left school. Some CAFs were closed due to a lack of response from the author/agencies despite a number of letters being sent out. Going forward the CAF Team plan to run requests for updates on a regular basis if there is a pattern of no response from individuals or agencies this will be taken up. It is important that where there is a CAF in place for a child/young person it is being actively progressed.

4.11 The overall trend across all Early Intervention and Prevention Services is one of solidly increasing engagement. Bromley Children Project Children and Family Centres are enjoying record levels of attendance year-on-year with 2013/14's 69,355 total active unique service users besting 2012/13 (56,607), by 12,748.

Performance Patterns in Child Protection

4.12 All referrals to Children's Social Care are now made through the Multi Agency Support Hub (MASH) with colleagues from the police and health service co-located with local authority staff at the Civic Centre. This provides more cohesive decision making and sharing of appropriate information. Figure 11 shows the number of initial contacts made to children's social care. There were 9928 contacts made in 2013-14 which is slightly less than the

Figure 10 – All Children and Family Centres: Access to Services – All children and families including those in target groups most in need of support and intervention

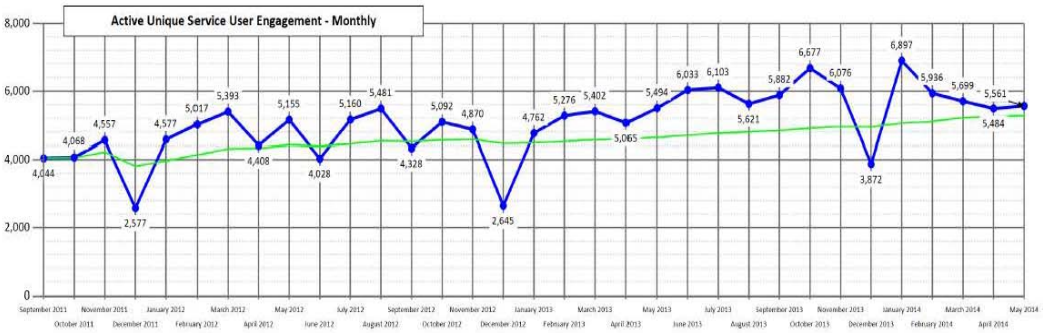


Figure 11 – MASH and Referral and Assessment Activity

Type	2013/14												Full EOY Figure	Target	2012/13 data
	Quarter 1			Quarter 2			Quarter 3			Quarter 4					
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
Local	Total workflow - all initial contacts (including MASH)														
	828	886	653	860	689	883	868	858	864	989	779	777	9928	-	10069
Local	Number of referrals														
	177	190	126	200	154	186	208	195	176	185	108	118	2023	-	2111
Local	Number of re-referrals and (%)														
	17 (10%)	19 (10%)	14 (11%)	26 (13%)	20 (13%)	18 (10%)	26 (13%)	11 (6%)	14 (8%)	16 (9%)	22 (21%)	19 (16%)	222 (12%)	15%	15%
Local	Number of referrals due to concerns of child sexual exploitation														
	1	2	1	3	2	1	5	6	2	2	2	3	30/1934 1.6%	-	
N9	Percentage of referrals going onto an initial assessment														
	21%	21%	19%	23%	22%	21%	22%	22%	22%	19%	14%	15%	20%	-	21%
N7	Rate of assessments per 10,000 of the CYP population (Cumulative)														
	44	90	119	163	200	243	296	340	378	420	449	477	477	-	464

10,069 in 2012-13.There was a small reduction in referrals made in 2013-14 compared to the previous year, however re-referrals remains consistent. Following a successful pilot all children's referral and assessment teams are now using a single assessment model instead of the previous initial and core assessment model. By using the Strengthening Families model this is consistent with that used in multi-agency child protection conferences and focuses on the experiences of the chid.

4.13 The number of children subject to a child protection plan in March 2014 was 262 compared with 184 at March 2013.

4.14 The number of children in care at the end of March 2014 was 268 compared with 277 in March 2013. Research evidence suggests that children who are looked after achieve much better outcomes if placed in a placement that can fully meet their needs and wherever possible is close to the geographical area that they are familiar with and enables them to have continued contact with significant people in their lives.

4.15 For all but a very small cohort, the most appropriate placement is with foster carers. The number of children placed with foster carers (including family and friends foster carers) in 2013/13 was 69%, down slightly on 2012/13 (71%). However, the number

Figure 12– Children subject to a Child Protection Plan

Type	2013/14												Full EOY Figure	Target	2012/13 data
	Quarter 1			Quarter 2			Quarter 3			Quarter 4					
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
Local	Total number of Children subject to a Child Protection Plan														
	177	190	204	185	198	193	189	197	204	229	269	262	262	-	184
N19	Rate of Children subject to a Child Protection Plan per 10,000 under 18 population														
	25.8	27.7	29.7	26.9	26.9	28.1	27.5	28.7	29.7	33.3	39.6	38.1	38.1	-	26.8
Local	Number and Percentage of Black and Minority ethnic (BME) (excluding unborn children)														
	57 (32%)	57 (30%)	62 (30%)	59 (32%)	63 (32%)	63 (33%)	65 (34%)	69 (35%)	64 (31%)	65 (28%)	78 (29%)	85 (32%)	85 (32%)	-	56 (30 %)
Local	Number of CP with disabilities														
	3	3	3	3	7	7	6	6	6	6	8	5	7	-	4

Figure 13 – Children becoming subject to a plan for physical emotional or sexual abuse or neglect (rate per 10,000 population)

Initial Category of Concern	Number	Percentage
Emotional abuse	96	37%
Neglect	66	25%
Neglect and Emotional abuse	4	2%
Physical abuse	15	6%
Physical abuse and Neglect	4	2%
Physical and Emotional abuse	44	17%
Sexual abuse	5	2%
Sexual abuse and Neglect	14	5%
Sexual and Emotional abuse	1	0%
Multiple (not listed above)	13	5%
Total	262	
Rate per 10,000	38.1	

of children and young people placed in residential accommodation fell from 16% in 2013/14 to 13% in 2013/14.

4.16 We continue to actively recruit local foster carers to meet our needs, and in particular those who are able to offer placement to disabled children, adolescents and sibling groups.

4.17 Figure 15 shows the school attainment levels for Children in Need (CIN) and Looked After Children (LAC). The percentage of Bromley Looked After Children achieving 5 GCSEs at A*-C (16%) was in line with the national figure for Looked After Children of 15.3% for academic year 2012/13. The KS4 reporting cohort for this academic year was the smallest for some years and, notably, 78% had recorded SEN.

4.18 Overall school attendance for Bromley Looked After Children is good. Persistent absence, however, is frequently a pre-existing feature of the lives of children who become looked after during adolescence and reluctance to engage with an education provider can be one of the biggest challenges of working with them. The figures for persistent absence also include children who are missing from placement and those whose medical conditions or disability means that they have prolonged periods when they are unable to access school

4.19 Bromley has had no reported permanent exclusions of looked after children since 2008 and the number of fixed term exclusions has decreased year on year over this period. This is the result of increased levels of support offered to both individual pupils and their schools by the Virtual

Figure 14 – Number of Children in Care

Type	2013/14												Full EOY Figure	Target	2012/13 data
	Quarter 1			Quarter 2			Quarter 3			Quarter 4					
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
Local	Number of Children in Care														
	287	279	280	282	287	291	289	291	283	279	277	277	268	-	277
Local	Number and Percentage of CiC with Special Educational Needs (SEN)														
	65 (23%)	63 (23%)	61 (22%)	61 (22%)	65 (23%)	68 (23%)	68 (24%)	68 (23%)	68 (24%)	65 (23%)	68 (25%)	68 (25%)	67 (25%)	-	65 23%
Local	Number and Percentage of CiC from black and ethnic minority groups (BME)														
	106 37%	101 36%	97 35%	101 36%	102 36%	102 35%	107 37%	109 37%	102 36%	102 37%	100 36%	101 36%	80 30%	-	81 29%

Figure 15 – Comparison of Children in Need (CIN) and Looked After Children (LAC) achievement data by contextual factors

2013/14 Attainment	Children in Need	Children Looked After	All Bromley Children	All National (2012/13)
Table N2 School aged children in need and looked after children attainment and contextual information *(Source: DFE)*				
Special Educational Needs (SEN)				
SEN (including all action, action plus and statemented pupils)	516 (71%)	80 (68%)	83%	19%
No SEN	207 (29%)	40 (32%)	17%	81%
Eligibility for Free School Meals (FSM)				
Eligible for FSM	322 (45%)	100%	12%	17%
Attainment at Key Stage 2 (KS2) (academic year 2012/13)				
Achieving level 4 or above in reading	27 (54%)	9 (64%)	89%	85%
Achieving level 4 or above in writing	21 (42%)	7 (50%)	85%	83%
Achieving level 4 or above in maths	24 (48%)	7 (50%)	88%	84%
Achieving level 4 or above in grammar, punctuation, and spelling	17 (34%)	*	79%	73%
Attainment at Key Stage 4 (KS4) (academic year 2012/13)				
Achieving any pass	53 (75%)		100%	100%
Achieving 5+ A*-G grades	33 (47%)	21%	98%	94%
Achieving 5+A*-G grades (including English and maths)	28 (39%)	-	97%	91%
Achieving 5+ A*-C grades	21 (30%)	21%	93%	82%
Achieving 5+ A*-C grades (including English and maths)	16 (23%)	3 (16%)	74%	59%
Absence from school				
Percentage of sessions missed through overall absence	10.7%	4.2%	4.8%	5.3%
Percentage of persistent absentees	14%	8.2%	3.9%	4.8%
Exclusions from school				
Permanent Exclusions	X	0%	0.07%	0.06%
Percentage of Fixed Term Exclusions	3.5%	9%	2.28%	3.52%

School and of improved collaborative working between the Service and colleagues in the Behaviour Service, SEN and Education Welfare and our local schools. Fixed term exclusions of looked after children have been reducing consistently since 2009. This represents a reduction both in the number of days and in the number of pupils experiencing exclusion. This trend is not borne out among our statistical neighbours, most of whom saw an increase in the numbers of fixed term exclusions in 2011.

SECTION 11 AUDITS

4.20 It is a statutory requirement for agencies to complete a Section 11 agency self-assessment on safeguarding children. In Bromley this runs as a two-year rolling programme - the 2011-13 programme was completed in January 2014. Submissions are made to the Quality Assurance & Performance Monitoring Committee (QAPM). This is a significant change to previous years when paper-based submissions would be made at the same time biennially. The change provides time for in depth discussion of each submission and a presentation by agency senior staff, where they can be held to account for their arrangements. In submitting self-assessments agencies reflect not only on their compliance with the section 11 Standards, but also must address this within the context of agency challenges, successes and Board priorities. This new approach facilitates improved understanding between agencies of operational and strategic contexts and challenges.

4.21 The changes have been a milestone in Section 11 reporting in Bromley. it raised the status and importance of this statutory duty and has provided opportunities for inter-agency challenge leading to change in practice. BSCB has kept abreast of these challenges through logging issues and actions raised in this process and reviewing them regularly at the QAPM committee.

4.22 BSCB uses an adapted version of the

Section 11 tool developed by the London Board. In doing so this relieves some burden on agencies reporting to several Boards.

4.23 Of the notable milestones in Section 11 reporting in Bromley, there were important firsts within the programme. One of which was a Section 11 for schools which was reported on in last year's annual report.

4.24 The London Borough of Bromley's Early Years Service also provided an audit for the first time. There are a significant number of private and voluntary providers of early years provision in Bromley and the team identified a plan to send a questionnaire to the range of providers and ask for information on their safeguarding arrangements.

4.25 Bromley is home to one of few secure mental health hospitals for children and young people, Oakview. Oakview provided a Section 11 audit and presented to the QA & PM Committee. This was the first opportunity for BSCB, in session, to challenge the agency.

4.26 London Borough of Bromley Adult Services also provided a comprehensive audit to the Board. The programme ensured that key services as outlined in Working Together 2013 made separate and comprehensive submissions. The Youth Service & Youth Offending Service also made a first separate submission.

4.27 The voluntary sector was audited via an on-line survey promoted through the Children and Families Forum and the Safe Network. Due to the limited response, an alternative audit approach for this sector is being considered for 2014-15.

4.28 The audits indicate that the majority of agencies are compliant with their duties under Section 11 of the Children Act 2004 and in fact striving to enhance their services and practice through improvements. Significant concerns were raised about one agency, Oakview Hospital and these were in the process of being addressed. Historically there had been a number of allegations made against staff at the hospital and BSCB had become involved earlier when the hospital was undergoing significant proprietary and managerial changes. The Care Quality Commission (CQC) had also found areas for concern in an earlier inspection, which were addressed and on re-inspection the standards were met. Concerns about practice and monitoring were expressed by members of the QA&PM Committee and the agency was asked to provide a fuller report at a later date. The agency were in a transitional phase with management and staff changes, whilst also updating their systems and procedures and responding to inspection. On re-submission of their Section 11 it was clear that significant improvements had been made in terms of staff training. Comprehensive quality, monitoring and recording systems were put in place. Concerns about the number of allegations against staff were explored within the context of the changes and the nature of the institution. Challenge from other agencies including the police and Children's Social Care included asking Oakview to remind placing authorities / agencies of their duty to notify Bromley Children's Social Care. Oakview improved their systems to emphasise this to referrers and the local authority are monitoring notifications.

4.29 At various points in the Section 11 programme, agencies challenged each other to provide evidence of compliance such as monitoring and service changes. Examples include the youth service having clear records of *all* training undertaken by staff and improved access to BSCB training for early years providers, the provision of details of the hospital's school and education provision by South London and Maudsley NHS Trust.

4.30 A pattern in the Section 11 for health

partners was the uncertainty and implementation of significant strategic and operational changes in the health sector. Partners followed NHS structural changes closely, seeking assurance that the role of the 'named safeguarding' officer remained within the governance structure of all agencies.

4.31 Safeguarding arrangements within commissioned services was raised as an important area to monitor within London Borough of Bromley Education Care Health Services (ECHS). As more services and functions are outsourced to external providers, members recognised the importance of securing safeguarding arrangements. The issue was raised at ECHS senior management team in a bid to ensure consistency across the council.

4.32 Agencies are asked to rate their compliance to the standards using the following status:

- Red – not achieved, significant delays, concerns about practice.
- Amber – delays, further development required, moving towards achievement/ effective practice.
- Green – achieved, good progress or working effectively

Agency Challenges

4.33 Agencies identified challenges faced by their organisation as part of the strategic context. The police structure at both borough level and child abuse investigation command experienced staff reduction and re-configuration of services. Health agencies moved into a new phase with the development and launch of clinical commissioning groups, and SLHT went into administration and eventually the Princess Royal University Hospital has come under the management of the Kings College Hospital Trust. This has been a considerable undertaking and has been closely monitored by BSCB as staff changes occurred. During the period, the government's programme on schools becoming academies was implemented. All secondary schools in Bromley have become academies over the past two-three years, with a number of primary schools also making the change. There have been significant implications for local authority support services, however safeguarding lead officer support for schools remains in place.

4.34 Operational challenges were also evident. The health sector has a tradition of using agency staff, necessary for the flexibility required in the care sector. Local Authority Designated Officer reporting and information shows that this can be associated with higher levels of allegations against professionals. Details about the use of agency staff in SLAM and Oakview, their training, criminal and disclosure barring service (DBS) records were issues that arose during section 11 enquiries. Both agencies had robust plans to move towards a reduction of agency staff, using bank staff (employed by and trained by the organisation).

4.35 The youth service audit raised issues for partners to encourage their use of CAF for older young people to obtain a comprehensive assessment of need. The exploration by all agencies around working with young people contributed to a focus on this age group in multi-agency audits and in particular the audit on Missing Children.

4.36 The national consultation on proposals to change the early years sector adult-child ratios was closely monitored for its possible impact on safeguarding standards and provider arrangements. Cost of training and its implications for accessing training were also reviewed by the partners.

How agencies addressed BSCB priorities

4.37 All agencies, to varying degrees engaged with BSCB priorities including:

- involvement in the child sexual exploitation strategy, training and provision of services

- Involvement in reviewing and rewriting the missing children procedure in 2013.

4.38 A number of agencies were able to highlight their membership of BSCB groups, committees and panels at various levels all of which support BSCB priorities. Agencies were able to evidence support for operational groups such as the hospitals Psycho-social meeting which facilitates discussion between health and social care professionals on patients with mental health issues and their families.

Conclusion & Future Development

4.39 The revised process for undertaking Section 11 self-audit has been robust and effective. It has facilitated interagency challenge through holding agencies to greater account. In a number of areas it has led to service improvement. It enabled BSCB to work effectively with partners as they underwent significant structural and operational changes. The QA & PM Committee managed the process, agreeing the schedule, monitoring actions and issues that arose.

4.40 Going forward the QA& PM Committee has implemented several improvements for 2014-15 in order to improve the process. This includes:

- Amending the self-audit tool to help agencies to clearly identify services delivered by agencies within the borough
- Changing standard 7 to ask agencies to state how Board priorities are specifically being met by the agency.
- Improving the issues and actions log to also show compliance with the standards and actions in relation to specific standards, alongside challenges made by the Board.

MULTI-AGENCY AUDITS

4.41 BSCB between April 2013 and March 2014 undertook three multi-agency audits covering *Child Protection Arrangements, Missing Children* and *Early Intervention Arrangements*. An audit of the *Voluntary Sector* commenced, but due to a poor response it was not concluded. Proposals for a different approach are to be developed.

4.42 In addition, the audit programme for 2014 was agreed by the Board in January 2014. A case review into domestic violence and audits on core group effectiveness and child protection plans; neglect; child sexual exploitation; and a re-audit of missing children are planned for the 2014-15.

4.43 An analysis of BSCB's multi-agency audits conducted in 2013-14 identifies many themes relevant to practice. Much learning relates to assessment, information sharing, referral quality and ensuring that the views of young people are taken into account in service delivery. The summary below highlights a number of key findings related to these broad areas. The findings from each audit are available on the BSCB website within practice guidance. BSCB encourages agencies to share the guidance widely with relevant staff.

4.44 Each audit considers the process and effectiveness of procedures through exploring individual cases. They investigate the quality of working relationships between partners to safeguard children and draw on relevant data about performance to set the audit in context. The scope of audits is refined and developed by a small team of key partner agencies who form a Multi-Agency Audit Group. This group convenes to manage and have oversight of the audits. A Multi- Agency Audit Team acts as a panel to draw together the findings of each agency to formulate overarching recommendations.

4.45 The Child Protection Arrangements Audit considered the process from Section 47 referral to Child Protection Review meeting. In fact, questions related to early intervention and case history enabled

auditors to comment on timeliness and appropriateness of response. Missing children are extremely vulnerable and, by the nature of their absence, less visible. The audit focused on how agencies worked together to protect these young people from harm. It considered the services received by a sample of young people aged 11-17 who had gone missing several times; the usefulness and effectiveness of the missing procedures; professional awareness of the vulnerability of missing children; assessment and planning for the child or young person. Early Intervention focused on the appropriate use of CAF and processes within agencies to monitor and manage cases where one or two agencies were involved and which did not meet the threshold for social care. The focus was on effective assessment, appropriate information sharing and management of cases including monitoring and case closure.

Good Practice

4.46 Each audit provided evidence of good practice and it is possible to identify three key themes that can be applied more widely to practice across agencies. In conducting the audits it was particularly helpful when case files were linked to supervision records. Not only was it noted that decision-making processes were more transparent and auditors noted that in those cases case drift was less evident. Audits indicated that where there was frequent communication between partner agencies on a case, the outcome for children was enhanced. Interventions appeared to be more likely to be effective. Referrals to social care were generally good and timely. Audits also suggested that agencies valued inter-agency panels and forums where cases could be discussed.

4.47 One example of good partnership work related to protecting an unborn child. It demonstrated prompt and accurate referral, good quality assessment and persistence and good discharge planning across agencies in protecting an unborn baby out of hours, where the mother had parental mental health issues.

Key areas where safeguarding is going well

4.48 Audits highlighted a number of areas where Bromley partners currently work together effectively to protect and safeguard children and young people living in the borough:

- Evidence of timely referrals being made to children's social care with mainly accurate information included. Some agencies are aware of the range of support and early intervention services available locally;
- Regular supervision of cases and management oversight in agencies;
- Child protection plans, which are now modelled on the Strengthening Families approach to child protection conferences, are outcome focused and plans tend to be smart;
- CAF is being used by agencies and the CAF team escalate appropriately to social care;
- Where there is a lead for a case or there is frequent good communication and information sharing between professionals working on a case, outcomes for the child appear enhanced;
- Young people are generally seen regularly and their views are heard, though could be better recorded.

Key areas for improvement

4.49 Specific areas for improvement emerged from the audits such as improving assessment through raising professional awareness of the risk factors and vulnerabilities associated with child sexual exploitation and missing children. Details for these can be found within the Board's practice guides which are available from the website. Child sexual exploitation was a priority for the Board over the past year and awareness raising activities were being undertaken or about to commence for several agencies:

- Reviewing risk regularly such as changes to

family circumstances such as household composition or where a case is not progressing make reviewing risk regularly an important practice issue;

- The use of the CAF to support good information sharing requires continued promotion;
- In general, referrals to other agencies or to social care are appropriate and timely. It was noted that where referrals were detailed, clear and accurate with correct family details provided, this supported the receiving agency to respond appropriately and promptly;
- Supervision could be used more effectively to help staff to reflect on the risk factors associated with complex cases- e.g. neglect and case drift, apparent compliance or working with challenging parents.

4.50 A key area for development for the board is to capture the views of children and young people. This is an area that all agencies continue to develop to ensure that their views are evidenced and it can be seen how they contribute to decisions being made about them.

The Impact of Audit

4.51 Auditing has impacted practice and a number of the key multi-agency strategic and operational impacts are captured below. In addition, this led to an immediate change to the way in which a specific child or young person was being worked with. In one case it led to a re-referral to social care, in another to interventions by additional teams and access to additional services and in another improved coherence between agencies working with the young person.

4.52 A strategic outcome was to push forward development of the Child Sexual Exploitation (CSE) *procedure* to support professionals in working with young people and in joint work to protect young people. It also led to improved *recording and monitoring* as now Multi Agency Sexual Exploitation (MASE) meeting minutes are formally linked to social care electronic records for relevant young people with a child protection plan. This supports CSE being embedded in the child protection process and supports more effective analysis of risk factors. Plans for a specific audit on CSE is planned for autumn 2014.

4.53 The audit of missing children led to significant changes to the care pathway for children who repeatedly runaway. A *new service* was established to address the needs of this particular group with support being provided for those over 10 years old by the Teenage and Parent Support Service which is a social work led service within London Borough Bromley. In addition, concerns about missing children will go to the same panel that leads on sexual exploitation. This approach provides a more *coherent and co-ordinated* approach to some very vulnerable young people. A revised procedure was agreed in November 2013.

4.54 The identified good practice from the above audits in relation to supervision has led to *safeguarding supervision* being incorporated within the BSCB Training programme for 2014-15. Promoting good practice in safeguarding supervision is considered to directly improve reflective practice among the wider network of professionals and to enhance professional confidence in working with complex cases.

4.55 It became increasingly clear in the audit process that the voice of young people who are children in need or who have a plan was not always systematically captured in records and therefore it was not always clear how their needs and wishes improved practice. As a result of the findings the Borough has reviewed and re-specified its contract with an advocacy service. Clearer feedback should be available to social workers and other professionals more quickly. Young people will benefit from feeling that their viewpoint has been understood and taken into account in decision-making.

4.56 To enhance professional practice, BSCB has disseminated its findings through circulating practice guidance, e-bulletins and the BSCB newsletter. It has linked learning from the practice guidance to its core training content and held briefings with the Safeguarding Network - the wider professional community working with children and their families.

4.57 It is evident that the programme of multi-agency audits and performance review has a positive influence on the Board's work programme, helping to focus on priorities and make operational improvements which directly impact on young people's lives. The breadth of learning from the range of audits undertaken indicate that it remains important to audit core processes of child protection as well as key themes related to priority areas.

MONITORING SINGLE AGENCY AUDITS

4.58 Each year the QA & PM Committee establishes an audit plan including a review of single agency audits. Inspections are also brought to the attention of the committee and the Board for discussion and monitoring safeguarding actions where appropriate. This year a number of audits were considered and as a result the following agency audits were reviewed in more detail by the QA&PM Committee:

Bromley Healthcare Audit on Health Care Plans of Looked After Children

4.59 This audit was a repeat of an audit reported to the QA&PM Committee in 2010. In 2010 only 50% of health care plans were up to date but this audit found that 98% of health care plans had been monitored and were up to date. The audit also showed there had been increases in the percentage of immunisations which were up to date.

Children's Social Care Audit on the Strengthening Families Child Protection Conferences

4.60 This audit looked at how well the process of the Strengthening Families Child Protection Conferences, which were introduced in August 2012, had been established. The audit identified three areas of concern. An action plan was put in place to address the recommendations.

Bromley Healthcare Audit on Family Needs Assessments

4.61 In previous Serious Case Reviews in Bromley, it has been noted that the role of fathers/men within the family has not been well documented. This audit showed that the Family Health Needs Assessment currently in use is more robust and provides prompts to establish the composition and role of the wider family network. It also helps to raise awareness of significant males within the family home and their impact on the children. The amendment was introduced in December 2013.It was however noted at the time that progress was not yet fully embedded. As a result a repeat audit was requested to be brought back to the QA&PM Committee to monitor improvements in 2014-15.

ALLEGATIONS AGAINST PROFESSIONALS

4.62 There are occasions when a child protection allegation is made against a professional working with children within the borough. These allegations are reported to the Local Authority Designated Officer (LADO) who ensures that any allegations are investigated promptly and appropriately. The LADO ensures that a record is kept of how the allegation was followed up, the decisions reached, the action taken and the final outcome.

4.63 There were 101 allegations in total referred to the LADO service during 2013-14, this compares to 88 for the same period in 2012-13. During the period 2013-14 there were 18 allegations against foster carers, half of the referrals related to foster carers

approved by Independent Fostering agencies or other. A total of 41 allegations were made against staff working in schools, colleges and alternative educational provisions. This represents an increase of 10.5% on the previous year during which 41 referrals were received from the same sector. A total of 23 allegations were received from Early Years (excluding child minders) provisions in Bromley.

4.64 During the year the multi-agency referral form for allegations and the template for recording the decisions agreed at strategy meetings has been redesigned improving the quality of information shared and ensuring actions are SMART. The start of 2014 also saw the implementation of a new application for recording allegations which is integrated with the overall electronic recording system used by children's social care to record safeguarding concerns around children and young people. The allegations application has restricted access thereby maintaining confidentiality.

CHILD DEATHS

4.65 The number of deaths of children in Bromley showed a downward trend to 2011 but has since been rising again, largely due to increasing deaths in teenagers aged 15-18. This year there were eighteen Bromley children who died during 2013-14. The Child Death Overview Panel (CDOP) continues to analyse the information for each child and report its findings to the BSCB Board. In 2013-14 there were four routine CDOP meetings, and one special meeting to discuss a possible suicide.

4.66 A small proportion of cases take longer than twelve months, often due to an impending court case or complex information. National data shows that such cases are more likely to have identifiable modifiable factors which need to be examined in depth. Of the eleven cases reviewed so far from 2013-14, seven were reviewed in less than six months, and the rest within eleven months. However those cases not yet completed at CDOP are mostly very complex cases, including two homicides, and the CDOP panel has not been able to review those cases until the police process is completed.

4.67 There were eleven unexpected deaths in 2013-14 and seven expected deaths. Eight of the deaths were female and ten male. Six of the deaths were in babies less than a month old. Two of these babies died from congenital problems which were complex to treat and a good outcome very unlikely.

4.68 The following key learning and actions have been taken from these cases:

Self-Harm and Risk of Internet

4.69 Children and young people cannot be protected completely from internet sites which may encourage them to self-harm or even commit suicide. In this context it has been recommended that:

- Schools and other services where children may access the internet should continue to block harmful websites;
- Schools and other agencies with responsibility for children and young people should help parents to understand the risks to their children of unlimited internet access and how to set up effective filters;
- Programmes are provided which help children and young people cope with some of the material they are exposed to on the internet. This may include resilience programmes;
- Implications for Early intervention by CAMHS.

Dangers of leaving very young babies with young siblings

4.70 This issue has come up in other cases over the last few years. Key messages from this case was feedback to Health Visitors to

ensure that they are raising awareness of this risk with parents

Measures to ensure that messages about safety of children is passed on effectively to parents from different ethnicity where language is a barrier.

4.71 Public Health to work with Children and Family Centres on accident prevention in young children.

Asthma care in the community

4.72 Asthma is a common illness and usually well controlled but is known to have sudden deterioration. As asthma is a common illness, this can sometimes detract from its potential seriousness. Interventions such as Written Asthma action plans are associated with reduced mortality and may have been beneficial in this case. Regular parent/ patient education about their condition would have alerted parents to the signs of an acute attack and need to seek medical help early. Use of asthma guidelines and regular training for school staff may also have helped school staff to identify signs of deterioration. Following this case, an Asthma event is planned for GPs.

Section 5: BSCB Priorities for 2014-15

5.1 BSCB's priority is to remain focused on safeguarding children, which it delivers through offering training, monitoring agency performance and the development of policies, guidance and strategies as required. Moving forward into 2014-15 a key focus for BSCB will be on improving outcomes for children and young people. The Board's Business Plan for 2014-15 sets out the following priorities which BSCB will work towards:

5.2 The Business Plan is divided into five work areas themes:

- Leadership and Accountability – holding agencies to account and the Board having a strong strategic leadership on safeguarding
- Improve Safeguarding through effective communication – the role of promoting safeguarding and also good interagency working
- Monitoring and Quality Assurance
- Improving outcomes for children and young people who have been harmed or abused or at risk of harm
- Listening to children and young people and improving outcomes.

5.3 Key priorities for 2014-15 include:

- Evaluating the effectiveness of the BSCB training programme;
- Continuing to promote awareness in key areas of child protection including domestic violence, child sexual exploitation and neglect;
- Continuing to monitor the effectiveness of arrangements for safeguarding children missing from home and care, and children missing education;
- Continuing to develop mechanisms to listen to the views of children and young people;
- Reviewing the support, engagement and impact of Lay Members to enable them to develop links between the BSCB and community groups and support stronger public engagement;
- Developing and implementing an annual survey for frontline practitioners to help develop understanding of how well safeguarding practice is working;
- Establishing a Domestic Abuse task and finish group;
- Completing the Serious Case Review commissioned in March 2014 and embedding the learning;
- Develop work around children with mental health problems and young people who self-harm making this a focus of the 2014-15 Annual Conference.

Section 6: Accounts

A summary of the accounts of the BSCB for 2013-14

INCOME	
2012-13 Carry Forward	£81,595
Bromley CCG	£10,324
Oxleas NHS Trust	£10,324
Bromley Healthcare	£10,324
King's College Hospital Trust	£10,324
Metropolitan Police	£5,000
Probation	£2,000
Bromley Mytime	£694
South London & Maudsley NHS Trust	£615
CAFCASS	£550
LBB—ECHS (Adults)	£6,115
LBB—ECHS (Children's Social Care & Education)	£33,686
Annual Conference	£5,850
Training	£33,250
TOTAL INCOME	£210,651

EXPENDITURE	
Staff, consultant, office, Independent Chair	£99,990
Training & Annual conference	£28,981
Serious Case Review	£0
Publications, guidance & resources	£500
TOTAL EXPENDITURE	£129,470
BALANCE	**£81,181**

Section 7: BSCB Membership

Board Membership 2013-14

Independent Chair	Independent
Designated Dr	Bromley CCG
Clinical Director	Bromley Healthcare
DCI Borough Police	Metropolitan Police Service
Director of Quality, Governance and Patient Safety	Bromley CCG
Director of Adult Mental Health and Adult Learning Disability Services	Oxleas NHS Trust
Care Services Portfolio Holder	Council Member
Assistant Chief Officer	National Probation Service
Assistant Chief Officer	Croydon and Bromley CRC
Head of Service Quality Assurance	London Borough of Bromley
Lay Members	Independent
Assistant Director Nursing	King's College Hospital Trust
Quality Improvement Service Manager	CAFCASS
Bromley CFVSF Chair	Voluntary Sector
Assistant Director, Education	London Borough of Bromley
Executive Director, Education & Care Services	London Borough of Bromley
Consultant Public Health Medicine	Public Health
DCI Child Abuse Investigation Team	Metropolitan Police Service
Designated Nurse for Safeguarding	Bromley CCG
Assistant Director, Children's Social Care	London Borough of Bromley
BSCB Performance & Improvement Officer	London Borough of Bromley
BSCB Business Manager	London Borough of Bromley

Professional Advisors 2013-14

Named Nurse	South London & Maudsley Trust
Head of Housing Needs Service	London Borough of Bromley
Asst Director Legal & Support Services	London Borough of Bromley
Lead Officer, Education Safeguarding	London Borough of Bromley
Head of Service Early Years	London Borough of Bromley
Named GP	Bromley CCG
Safeguarding Named Nurse	Oxleas NHS Trust
Named Nurse	Bromley Healthcare
Named Dr	Bromley Healthcare
Named Nurse	King's College Hospital Trust
Named Dr	King's College Hospital Trust

Section 8: Essential Information

Date of Publication: 8 December 2014

Approval Process: Approved at the BSCB Board meeting on 18 November 2014

This publication and other information is available on the Bromley Safeguarding Children Board (BSCB) website:

www.bromleysafeguarding.org

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Appendix One

London Borough of Bromley

Located in South-East London, Bromley is the largest London borough in the city. At approximately 150 square kilometres it is 30% larger than the next largest borough. It has over 45 conservation areas and a wide range of historic and listed buildings.

Although Bromley is a relatively prosperous area, the communities within Bromley differ substantially. The North-East and North-West of the borough contend with similar issues (such as higher levels of deprivation and disease prevalence) to those found in the inner London Boroughs we border (Lambeth, Lewisham, Southwark, Greenwich), while in the South, the borough compares more with rural Kent and its issues.

Bromley benefits from a good number of public parks and open spaces as well as sites of natural beauty and nature conservation.

The latest (2014) estimate of the resident population of Bromley is 320,057, having risen by 21,775 since 2001.

The resident population is expected to increase to 330,361 by 2018 and 339,154 by 2023.

Although the number of 0 to 4 year olds is projected to decrease by 2019 to 21,016 and then to 20,825 by 2024, there has been an increase in the number of live births since 2002. The latest (2014) GLA population projection estimates show that 17.34% of the population is made up of Black and minority ethnic (BME) groups; an increase from 8.4% in 2001.

The BME group experiencing the greatest increase within Bromley's population is the Black African community, from 1.1% of the population in 2001 to 4.7% of the population in 2024.

(Source: Bromley Joint Strategic Needs Assessment 2014)

Bromley Safeguarding Children Board

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Report No.

London Borough of Bromley

HEALTH AND WELLBEING BOARD

Date: **Thursday 29th January 2015**

Report Title: **Progress on the Pharmaceutical Needs Assessment 2015-18**

Report Author: Agnes Marossy, Consultant in Public Health, Education, Care & Health Services, London Borough of Bromley.
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Chief Officer: Nada Lemic, Director of Public Health.

1. SUMMARY

1.1. In preparation for consultation a draft of the PNA has been prepared. The Pharmaceutical Needs Assessment (PNA) for Bromley is the formal document of the needs for pharmaceutical services in the area. It is intended to identify what is needed at a local level to guide the current and future commissioning of pharmaceutical services that could be delivered by community pharmacies and other providers.

1.2. The Health and Social Care Act 2012 gave the Health and Wellbeing Board (HWB) the statutory duty to develop and publish a Pharmaceutical Needs Assessment (PNA) by 1st April 2015. Requirements for a PNA are set out in the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. These regulations cover the minimum information to be included in a PNA, the matters which must be considered, and the process to be followed. This process includes formal consultation with specific stakeholders for a minimum of 60 days.

1.3. The statutory consultation period for the PNA ended on 22nd December, and a final draft including the consultation report has now been prepared. This is available here.

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

2.1. The HWB are asked to approve the PNA for publication.

3. SPECIFIC ACTION REQUIRED BY HEALTH & WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

3.1 Whilst the Public Health team within LB Bromley have the lead responsibility for completing the JSNA, a project steering group has been established with representatives from:

- Local Pharmaceutical Committee
- Local Medical Committee
- CCG
- Healthwatch Bromley
- Voluntary Sector Strategic Network
- Communications, LBB
- NHS England

Health & Wellbeing Strategy

Financial

1. Cost of proposal: £41K

2. Ongoing costs: There will be an ongoing maintenance cost, bids were sought as part of the main tender process. The maintenance cost will be up to £5,000 pa.

3. Total savings (if applicable): Not applicable

4. Budget host organisation: London Borough of Bromley

5. Source of funding: Public Health Grant

6. Beneficiary/beneficiaries of any savings: Not applicable.

Supporting Public Health Outcome Indicator(s)

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4. COMMENTARY

Introduction

4.1. The Health and Social Care Act 2012 gave the Health and Wellbeing Board (HWB) the statutory duty to develop and publish a Pharmaceutical Needs Assessment (PNA) by 1st April 2015. Requirements for a PNA are set out in the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. These regulations cover the minimum information to be included in a PNA, the matters which must be considered, and the process to be followed. This process includes formal consultation with specific stakeholders for a minimum of 60 days. The PNA lasts three years, but must be kept up to date and supplementary statements published. If there is a change in circumstances that cannot be addressed through a supplementary statement, a new PNA must be written.

4.2. A PNA is a key commissioning tool to ensure that local areas have high quality pharmaceutical services that meet needs. A PNA sets out the community pharmaceutical services that are currently provided and gives recommendations to address any identified gaps, taking into account future needs. A PNA supports the commissioning intentions for pharmaceutical services and other services that could be delivered by community pharmacies and other providers.

4.3. The completed PNA will inform commissioning decisions by NHS England (Area Teams) on certain pharmaceutical services and may inform the Local Authority, and potentially the Clinical Commissioning Group (CCG), on services not legally termed 'pharmaceutical services' that may be commissioned from pharmacies.

4.4. The Health & Wellbeing Board needs a thorough and robust PNA that complies with the regulations and follows due process. This will ensure that community pharmacy services are provided in the right place and that commissioned services meet the needs of local communities.

Current position

4.5. The PNA Steering Group, together with the commissioned provider (PCC – Primary Care Commissioning) has prepared the final version of the PNA ready for publication. The final version of the PNA has been circulated to members of the Board with this paper.

Consultation

4.6. Formal consultation on the PNA is a statutory requirement. The consultation ran between 17th October and 22nd December. The final version of the PNA includes the consultation report.

Risks

4.7. The Health & Wellbeing Board have a statutory duty to publish the PNA by 1st April 2015, and we are on course to deliver this responsibility.

4.8. The PNA will be included on the Corporate Risk Register as there is a potential for legal challenge if the PNA is considered not to be compliant with regulations or not to have followed due process and not be sufficiently robust to allow for reasonable commissioning decisions to be made. The risk is being mitigated by the processes being followed.

Health & Wellbeing Board Decisions

4.9. The Health and Wellbeing The Health and Wellbeing Board are asked to agree the final version of the PNA for publication at this meeting.

5. FINANCIAL IMPLICATIONS

5.1. The cost of the PCC contract to deliver the PNA is £41,000. There is an ongoing maintenance cost of up to £5,000 pa.

6. LEGAL IMPLICATIONS

6.1. The Health & Wellbeing Board have a statutory duty to publish the PNA by 1st April 2015, and we are on course to deliver this responsibility.

6.2. There is a potential for legal challenge if the PNA is considered not to be compliant with regulations or not to have followed due process and not be sufficiently robust to allow for reasonable commissioning decisions to be made.

Non-Applicable Sections:	**IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROGRESS THE ITEM;** and **COMMENT FROM THE DIRECTOR OF PUBLIC HEALTH**
Background Documents: (Access via Contact Officer)	Update on the Pharmaceutical Needs Assessment, 20th March 2014 Progress on the Pharmaceutical Needs Assessment 2015-18, 24th July 2014 Progress on the Pharmaceutical Needs Assessment 2015-18, 16th October 2014

Report No.

London Borough of Bromley

PART ONE - PUBLIC

HEALTH AND WELLBEING BOARD

Date: **January 2015**

Report Title: Overview of Primary Care Developments

Report Author: Mark Needham, Director of Commissioning, Bromley CCG

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1. SUMMARY

Bromley CCG is developing an ambitious Primary Care transformation programme to support local practices and achieve the best outcomes for patients. This is part of the national and London policy agenda which consists of two key initiatives.

- Primary Care co-commissioning
- London Primary Care framework

And one local initiative

- Review of Primary Care contracts

Detailed papers are attached on the first two

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

For engagement and to note as per NHS England recommendations

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3. SPECIFIC ACTION REQUIRED BY HEALTH & WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

The board is asked to note the developments and feedback on key areas as part of the engagement process to inform the development of the Primary Care vision in the Borough.

Health & Wellbeing Strategy

In principle all:

1. Related priority: Diabetes, Hypertension, Obesity, Anxiety & Depression, Children with Complex Needs and Disabilities, Children with Mental & Emotional Health Problems, Children Referred to Children's Social Care, Dementia, Supporting Carers

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Financial N/A

Supporting Public Health Outcome Indicator(s)

N/A at this point

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4. COMMENTARY

Primary Care co-commissioning

CCGs nationally and in London are submitting an expression of interest to NHS England (30th January 2015) to take on responsibilities around the commissioning of primary care.

- The options are: 1) maintain current arrangements 2) joint commissioning with NHS England 3) delegated commissioning (CCG taking everything including the GP contract)
- As a membership organisation the Governing Body felt it was important to call a **vote** to ensure full engagement and support for our preferred option, as well as implications for changes in our Constitution.
- Potential issues are **perceived conflicts of interest** (ie GPs being part of a commissioning organisation that would hold contracts with their practices) and ensuring robust overall **governance arrangements** with meaningful engagement with local stakeholders and patient groups.
- The CCG is working through the issues at a SE London level and also through a local engagement process including the Health & Wellbeing Board and other forums.
- Our GP members are fully briefed on the process as the topic has been subject to debate at the local Commissioning Clusters and Membership Body meetings
- Whilst we will be guided by our members, our **Executive view** is option a) would not enable us to achieve the scale of our ambition for Primary Care development. No CCG will be allowed to move to level 3 automatically. There is an option, being considered by other CCGs in SE London, to select option 2 (joint) with the intention to move to level 3 in year (delegated).
- Financial risk –the financial risk of taking back responsibilities for the GP contract at this point is significant, as it is not known how the indicative budgets we have received actually

relate to the real cost of Primary Care contracts that we would hold responsibility for under option 3 (delegated commissioning)

- CCGs would take on commissioning responsibilities from 1st April 2015.

London Primary Care Framework

In parallel, the CCG is engaging in January on the development of the framework which outlines key standards or characteristics of primary care provision. This has been developed by NHS England, with significant involvement from stakeholders and clinical leaders.

The framework sets out an ambitious set of challenges for primary care, with the high profile issue of **8am-8pm access to Primary Care.**

Whilst the framework provides a helpful starting point to initiate the debate with our members and stakeholders, it is important that we develop a shared vision of how **Primary Care in Bromley** should look in the next 5 to 10 years. Including, the role of Primary Care in relation to: Integrated networks of health and social care (Local Care Networks) and public health and prevention.

The framework includes an outline of financial resources required to deliver this type of vision, which is aligned with the CCG's aspiration to transfer up to 5% of the operating budget into Primary Care provision over the next 5 years, based on sound, evidenced based business cases. This will require significant system transformation to ensure acute resources are redeployed effectively and appropriately into an out-of-hospital model of care without destabilising the hospital base.

Local initiatives - review of Primary Care contracts

The CCG is also currently reviewing the c£1m of local contracts with Practices (formerly known as Enhanced Services). This will ensure all contracted services are of standardised quality and access for patients across the Borough.

5. FINANCIAL IMPLICATIONS

N/A

6. LEGAL IMPLICATIONS

N/A

7. IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROGRESS THE ITEM

The Members' decision on Primary Care Co-commissioning will be discussed in public at the CCG Governing Body 22nd January 2015.

8. COMMENT FROM THE DIRECTOR OF AUTHOR ORGANISATION

Insert text here - please include a short comment from your respective organisation director.

Non-Applicable Sections:	[List non-applicable sections here]
Background Documents: (Access via Contact Officer)	[Title of document and date]

Primary Care Co-commissioning

Informing membership engagement

November 2014 to January 2015

1. Membership engagement

The purpose of this document is to support member practice engagement in our developing approach to the co-commissioning of primary care in Bromley.

We want practices and patients to shape our approach to co-commissioning as a CCG and help us decide how we should best use the current opportunity for CCGs to take greater control of the commissioning of local primary care services to improve the health of our population.

We had a very useful discussion at our membership meeting on the 26th November and would now like further discussions to take place in practices. We hope this document will be helpful in generating and informing your discussions. We will also be engaging with patients and the public over this period to ensure that their voices are heard.

We first discussed co-commissioning with you in June. Since that time this policy has developed nationally and over the last few months more concrete proposals have been produced by NHS England to inform our decision-making, culminating in the publishing of guidance to take this forward.

The NHS has now published a Five Year Forward View. This document makes clear that a new deal must be created for primary care to secure a sustainable future for the NHS and that co-commissioning of primary care should be established in one form or another across England. National policy appears to have shifted from a position of possibility to a place of certainty.

We are very keen to hear your views. There are a number of aspects to this decision that need to be considered and advantages and disadvantages to each. It is essential that we take this time to thoroughly examine these proposals and make a decision in the best interests of our patients.

2. Primary Care co-commissioning

Primary care co-commissioning provides an opportunity for CCGs to take greater control of the planning, strategic direction, priority setting and decision making around primary care services in their local area.

Although it is referred to as co-commissioning of 'Primary Care' the current opportunity outlined by NHS England is focused on general medical services only, at least for 2015/16.

We now anticipate that some form of co-commissioning will exist in every part of the country but it is clear that the level of involvement in this can be determined by CCGs. The options are:

1. Greater Involvement in NHS England decision-making
2. Joint decision making by NHS England and CCGs
3. CCGs taking on delegated responsibilities from NHS England

The remainder of this document refers to these as the levels of co-commissioning and it is this level of involvement that is central to this engagement process. We must give focus to one overriding question:

What form of co-commissioning of primary care services in Bromley would deliver the best outcomes for patients in Bromley

3. What is the wider context?

This discussion is not held in isolation. It sits as part of a drive towards the alignment and focus of decision making of the various parts of the health and social care system towards meeting the needs of a local population – across primary and community care, social care, acute, mental health and specialist care. This is often referred to as 'Place-based commissioning'.

Importantly it seeks to identify and bring commissioners together to use one pot of money to meet the specific needs of the local population, whilst recognising that budgets for all parts of the system are shrinking. In the context of a reducing 'pot' it is critical we can all demonstrate the best possible value is being derived from every pound spent. We believe that in order to do that funds will need to be shifted to those parts of our system that represent the best value.

It is our long held belief that best value is derived from preventative and early action in all parts of the system and through the enhanced delivery of community based and integrated care.

The Five Year Forward View (October 2014) also describes the need for new models of care to which primary care will relate and it outlines 'A new deal for primary care' – See the extract at **Appendix One**. Amongst the steps it outlines to achieve this it includes:

Give GP-led Clinical Commissioning Groups more influence over the wider NHS Budget, enabling a shift in investment from acute to primary and community services (p19)

4. What are the stated aims of co-commissioning?

The overall aim of primary care co-commissioning is to harness the energy of CCGs to create a joined up, clinically-led commissioning system which delivers seamless, integrated out-of-hospital services based around the needs of local populations.

NHS England identifies the potential benefits as:

- Improved access to primary care and wider out-of-hospitals services, with more services available closer to home;
- High quality out-of-hospitals care;
- Improved health outcomes, equity of access, reduced inequalities; and
- A better patient experience through more joined up services.

And co-commissioning is…

…the beginning of a longer journey towards place-based commissioning.

…a critical enabler of the *NHS Five Year Forward View*: both to implement the new deal for primary care, and to support the development of new models of care…

5. Does this advance our local commissioning goals?

Primary care transformation - At present our commissioning strategy is to transform and ultimately invest more in the primary care system for Bromley believing this will allow us to improve services and the outcomes they secure for our population. At present our ability to do that is limited to those areas where we can make decisions in respect of primary care such as the Local Improvement Scheme. We are unable to take decisions about the wider investment of primary care funds or to determine the proportion of overall NHS spend they represent. This is important as under current arrangements the allocation of funds to primary care, as a standalone national budget, is likely to reduce in future years.

Integrated care and commissioning for outcomes - In terms of integrated approaches to care delivery we have been clear that we wish to commission all providers to work together and be rewarded for the outcomes they secure for residents. Primary care is currently commissioned in isolation from the rest of the local system.

At present we are unable to determine local outcomes that will be rewarded in contracts or to align them with other parts of the system.

Enablers of change - In terms of those things that enable and support change we are unable to agree and fund areas like estates development, IT and workforce changes in a locally responsive way – different parts of the system are responsible for these changes in silos and creating an agreed and localised approach may be advantageous.

Incentives - Where incentives or contracts do change we do not have decision making power in this area. Should PMS be reviewed or QOF arrangements change - this is

currently without reference to local circumstances. Co-commissioning could allow us to localise these levers for change.

A primary care system that is shaped by local commissioning intentions is likely to enhance our ability to achieve progress in these areas or to mitigate the consequences of the current financial challenges the country faces.

6. How is Primary Care commissioned now?

The current commissioning landscape for primary care is complex, with up to three different commissioners – CCGs, NHS England and local authorities… The NHS has recognised the need to make it easier for commissioners to work together and better integrate out-of-hospital services.

Primary Care is commissioned and contracted by NHS England. The commissioning (planning, determination of priorities etc.) of these services is undertaken on a national basis – once for England. The contracting of these services is also undertaken by NHS England but the actual contract management happens regionally and for us this is undertaken by an Area Team for South London. Neither process is currently adjusted for local circumstances – the arrangements are often referred to as a Single Operating Model or SOM.

Importantly co-commissioning offers the opportunity to localise much of this activity and focus it upon local circumstances and population need.

The commissioning and contracting of Optometry, Community Pharmacy and Dentistry is not currently part of the co-commissioning 'offer' and will continue to be undertaken in this way.

Contractual payments, revalidation, appraisal and related activities would also be excluded from this development and would be undertaken by NHS England going forward.

At the current time CCGs do have some involvement and are required under law to 'support' NHS England in improving the quality of primary care services in their local areas.

The CCG has interaction with NHS England around local primary care issues BUT we have no decision making power and our position is one of influence only. In this sense we believe we are already at the first level of co-commissioning.

7. What will be different under co-commissioning of primary care?

The three levels of co-commissioning impact on how things will be different:-

Primary care function	Greater involvement	Joint commissioning	Delegated Commissioning
General practice commissioning	**Potential for involvement in discussions but no decision making role**	**Jointly with area teams**	**Yes**
Pharmacy, eye health and dental commissioning	**Potential for involvement in discussions but no decision making role**	**Potential for involvement in discussions but no decision making role**	**Potential for involvement in discussions but no decision making role**
Design and implementation of local incentives schemes	**No**	**Subject to joint agreement with the area team**	**Yes**
General practice budget management	**No**	**Jointly with area teams**	**Yes**
Complaints management	**No**	**Jointly with area teams**	**Yes**
Contractual GP practice performance management	**Opportunity for involvement in performance management discussions**	**Jointly with area teams**	**Yes**
Medical performers' list, appraisal, revalidation	**No**	**No**	**No**

So what about the hoops to jump through?

At the greater involvement level there is no significant offer made to CCGs. As a result there are few if any 'hoops' to jump through.

Under the joint decision making arrangement we will be asked to create governance and delivery arrangements that are fit for purpose and this would be designed and agreed in partnership with NHS England.

Under delegated arrangements we would be subject to an assurance process that tested our ability to take this responsibility and hold us to account for undertaking it effectively.

8. A 'SWOT' analysis

An analysis of the options has been carried out across South East London in relation to Options 2 and 3, to support your discussions. We have not completed this for Option 1 – greater involvement as this gives minimal change locally.

.

We believe that the remaining two options do represent an enhanced opportunity to make a difference for patients through a different commissioning arrangement and the record of views below provides further detail in that context:

Option 2: Joint decision making

Strengths	Weaknesses
• Enhanced ability to achieve locally responsive, higher quality, equitable and accessible primary care services • Joined up approach to the commissioning of integrated care and pathway delivery that will drive better value and experience of care • Greater opportunity to shift funding from acute to primary and community care settings • Allows a phased approach to co-commissioning with opportunities to learn from the experience of others with delegation as they test the new system – This model allows for greater responsibility to be taken in future • Limited approach may be commensurate with the resources available locally. • The model offers more 'structured influence' in comparison to current arrangements. • Mitigates risk of any transition period where NHS England commissioning roles are changing and of any future policy development post-election	• Fails to maximise local decision making power with shared decision making with a national body • This option may have low impact on changing the health system as a whole in Bromley. • There is less opportunity to influence primary care transformation without full control over commissioning. • Potential NHS England organisational destabilisation could jeopardise their effective involvement in this arrangement. • Model remains more complex than other levels and potentially harder to engage with • Model does not include community pharmacy.
Opportunities	**Threats**
• Opportunity for a phased approach to taking on all primary care commissioning. • To work collaboratively across south east London and benefit from knowledge and experience of NHS England commissioning staff and leadership. • A gradual approach would reduce the risk of us losing sight of the important things we are currently doing. • The CCG would do a better job than NHS England in making primary care commissioning work well and link effectively to our current strategic plans. • Enhanced opportunity to deliver local, south east London and now Five Year Forward View for primary care transformation	• Working with NHS England, where there is a low level of local knowledge or potentially low level of capacity to apply local commissioning intentions. • Taking on additional financial risks. • CCG may be less well-resourced under this joint approach to co-commissioning as opposed to full delegation. • Conflicts of interests are heightened although less so than under full delegation. • Potential to change the dynamic of the CCG as a membership organisation.

Option 3: Delegated responsibilities

Strengths	Weaknesses
• Enhanced ability to achieve locally responsive, higher quality, equitable and accessible primary care services • Joined up approach to the commissioning of integrated care and pathway delivery that will drive better value and experience of care • Greater opportunity to shift funding from acute to primary and community care settings • Offers good strategic fit with the CCG in terms of our programme boards and the local development of population based budgets and commissioning. • It's a high impact model, offering the CCG greater influence (e.g. over QOF and future primary care investment more directly). • Offers the CCG clarity in regard to its responsibilities. • Would support improved engagement of primary care. The CCG understands and therefore can better shape general practice and primary care services. It is also better placed to understand the drivers of variation and take appropriate and proportionate action to address it. • This model would give us more influence over enablers such as premises development.	• There is a challenge in taking on contract management of CCG member practices. • Potentially for more conflicts of interests for CCG governing body members and the wider membership. • Clear uncertainty over whether the CCG will have the workforce capacity and capability to assume full responsibility. • This represents a more significant change in the roles and responsibilities of the CCG at pace. • Model does not include community pharmacy.
Opportunities	**Threats**
• The CCG is well placed to identify more productive and efficient ways forward for primary care in Bromley. It offers the opportunity to support innovation in practice. An opportunity to commission primary care services which are responsive to local need. • To align Key Performance Indictors and incentives to local need and local priorities. • Offers further opportunities to give additional support to general practice and shift resources / care into the community.	• Conflict of interest may weaken clinically-led commissioning. Public perception of conflict of interest. • Potential to change the dynamic of the CCG as a membership organisation. • Significant extra administrative burden for additional assurance processes. • Lack of capacity and a threat to our ability to complete other important work. • Lack of capacity to work effectively with poorly performing practices in need of support.

9. What else should we be thinking about?

It is important that we are aware of a number of issues that will be critical to making any form of co-commissioning work. We also have to be honest in saying things may change.

As a result those areas are outlined below along with emerging thinking in these areas where it is developed. It is important member practices are engaged in these areas as well.

Financial impact

At present the CCG is not in receipt of the indicative budget it would receive for co-commissioned areas. Ahead of any decisions being made the CCG would want absolute clarity on this and any future commitments or liabilities that may have been made ahead of April 2015.

We do not believe ambiguity in this area should slow our thinking and engagement on what is best for our patients - the financial position for primary care will, in very general terms, be similar at the start whether we co-commission in the ways described above or not.

Our discussions therefore surround the best way to address financial issues and with what level of CCG involvement.

Managing Conflicts of Interest

There is no doubt that with co-commissioning, at any level, conflicts (perceived or actual) heighten. We have robust mechanisms for dealing with this now and we would need to consider how best to enhance them.

However our guiding principle is to retain the maximum possible clinical input.

Resourcing

Primary care is not currently commissioned by the CCG and the management costs of running the organisation do not reflect this responsibility. All parts of the NHS administration are shrinking – CCGs will have reduced their running costs by 10% by 1 April 2015 and NHS England must make greater reductions -15% in the same timeframe.

In any scenario we would need to find efficient and effective ways to manage the system we are either responsible for or working with.

Working together

In light of some of these constraints and issues there is currently active consideration being given to the operation of some functions to support co-commissioning across the six CCGs in south east London – this may allow economies of scale and more objectivity in reviewing conflicts of interest for example. However, an important principle remains – irrespective of shared functions or joint working there would always be a borough focused set of commissioning intentions and local autonomy in decision making.

We would collaborate where it makes sense or works.

10. Where to find out more? What are other CCGs saying?

The LMC has information available on its website –

www.lmc.org.uk

NHS England have also published its next steps guidance which provides a good overview:-

http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf

Guidance is also available from NHSCC:-
http://www.nhscc.org/policy-briefing/things-consider-making-decision-ccgs-involvement-primary-care-commissioning/

Although we know that CCGs across England are considering and reconsidering their positions on co-commissioning we do know that the expressions of interest submitted nationally in the summer indicated the following spread of views across England and London.

Commissioning Form	England	London
A – Influence	19	3
B – Joint Decision making	103	27
C – Full delegation	74	2

Appendix One

Five Year Forward View (October 2014) Extract Page 19

'A new deal for primary care'

General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain. Even as demand is rising, the number of people choosing to become a GP is not keeping pace with the growth in funded training posts - in part because primary care services have been under-resourced compared to hospitals. So over the next five years we will invest more in primary care.

Steps we will take include:

- Stabilise core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas.
- Give GP-led Clinical Commissioning Groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.
- Provide new funding through schemes such as the Challenge Fund to support new ways of working and improved access to services.
- Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles, and in returner and retention schemes and ensure that current rules are not inflexibly putting off potential returners.
- Expand funding to upgrade primary care infrastructure and scope of services.
- Work with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.
- Build the public's understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit.

Strategic Commissioning Framework for Primary Care Transformation in London

Briefing for the Bromley membership
January 2015

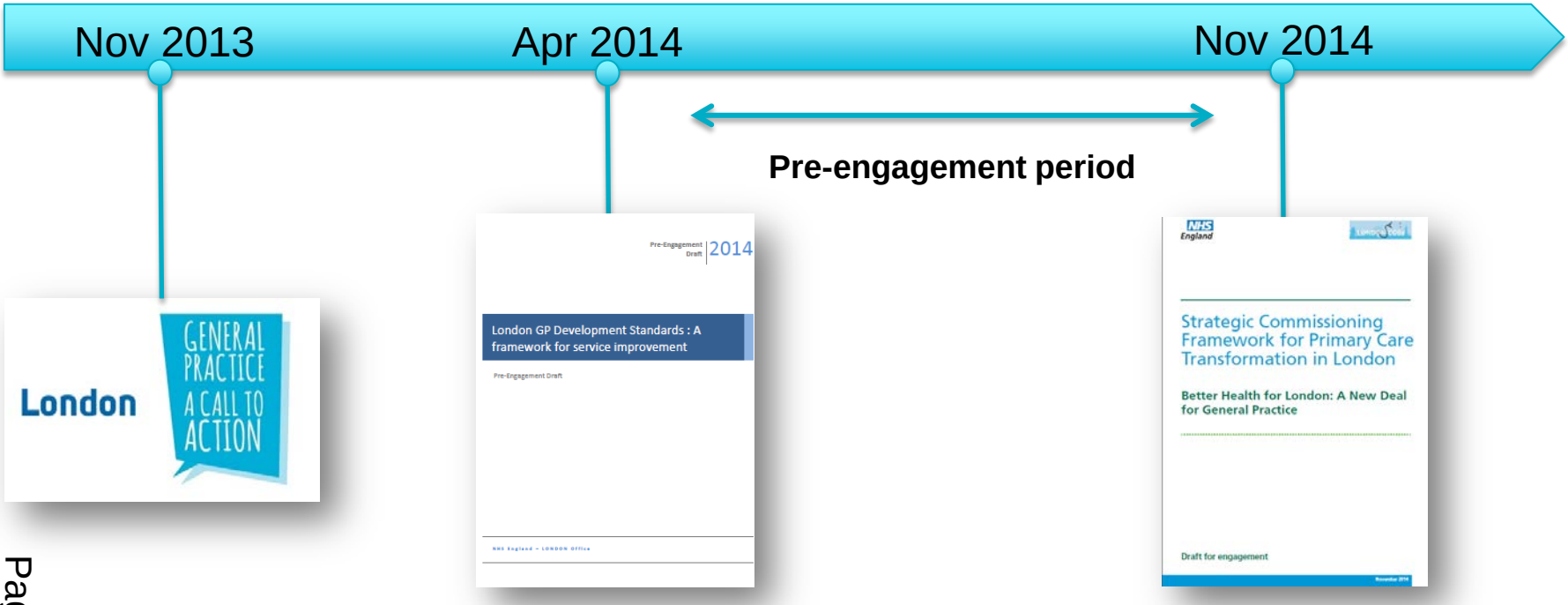
There is significant focus on the need for change in Primary Care

Both the Five Year Forward View and the London Health Commission report set out several objectives for Primary Care:

- **Stabilise core funding for general practice and review how resources are fairly made available**
- **Give CCGs more influence over the NHS budget – investment: acute to primary & community**
- **Provide new funding through schemes such as the Challenge fund – innovation, access**
- **Expand as fast as possible the number of GPs, community nurses and other staff.**
- **Design new incentives to tackle health inequalities**.
- **Expand funding to upgrade primary care infrastructure and scope of services**
- **Help the public deal with minor ailments without GP or A&E**
- **Potential new care models** such as Multispecialty Community Providers (MCPs) and Primary & Acute Care Systems (PACS)

- **Increase the proportion of NHS spending on primary and community services**
- **Invest £1billion in developing GP premises**
- **Set ambitious service and quality standards for general practice**
- **Promote and support general practices to work in networks**
- **Allow patients to access services from other practices in the same network**
- **Allow existing or new providers to set up services in areas of persistent poor provision**

London has also been working on how some of the challenges faced by general practice could be mitigated



The ***Call to Action*** outlined some of the challenges of General Practice in London..

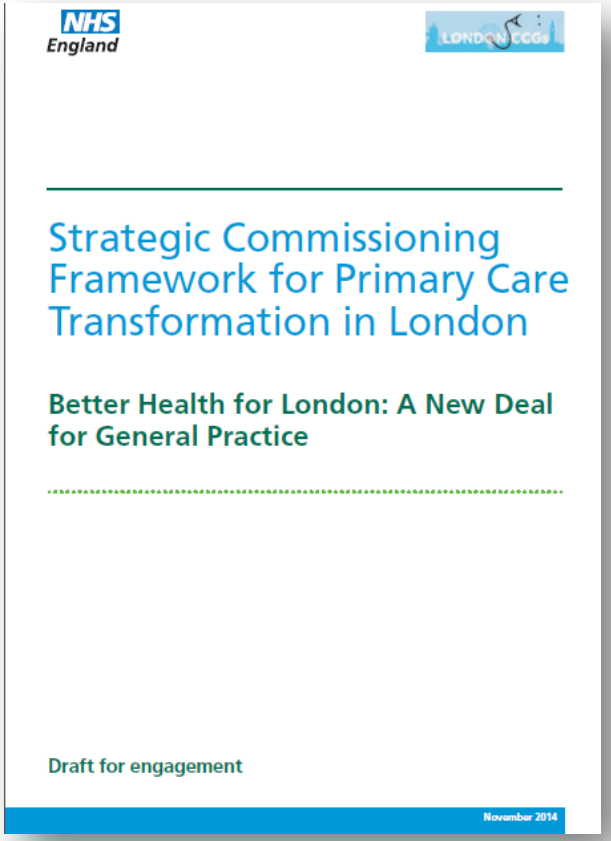
In April a draft publication was released, which outlined **a new patient offer.**

Since then there has been **considerable engagement** to **further strengthen this offer**, and understand the necessary **considerations for delivering it.**

The Strategic Commissioning Framework

The result is a draft *Strategic Commissioning Framework*, aiming to support transforming primary care in the capital

- A new vision for General Practice
- A new Patient offer described in a general practice specification
- A description of considerations for making it happen



A new vision for General Practice in London

Patients and clinicians alike have told us about the importance of three areas of care. This forms the basis of the new patient offer (also called the specification)

Accessible Care

Better access primary care professionals, at a time and through a method that's convenient and with a professional of choice.

Coordinated Care

Greater continuity of care between NHS and other health services, named clinicians, and more time with patients who need it.

Proactive Care

More health prevention by working in partnerships to reduce morbidity, premature mortality, health inequalities, and the future burden of disease in the capital. Treating the causes, not just the symptoms.

What is the… Accessible Care Specification for the Service Offer

The Accessible care specifications for service offer describes changes to enable patients to feel confident that they **can access general practice in a way which meets their needs**

The expert panel that developed these was chaired by **Dr Tom Coffey,** a GP Partner at Brocklebank Group and Chair of NHS Wandsworth CCG.

Patient choice	Patients are given a choice of access options and can decide on the consultation most appropriate to their needs
Contacting the practice	Patients can make appointments with only one click, call or contact and can access more services online
Continuity of care	Patients have a named GP who is accountable for their care and can book appointments up to 4 weeks ahead. Practices provide flexible appointment lengths as appropriate
Routine opening hours	Patients can access pre-bookable routine appointments 8 am – 6.30 pm Monday to Friday and 8 am – 12 pm on Saturdays
Same day access for urgent conditions	Patients with urgent conditions can access a consultation on the same day within routine surgery hours
Emergency care	Practices have systems to ensure patients receive appropriate care and in appropriate time in the case of emergencies
Extended opening hours	Patients can access primary care 8am – 8pm every day in their local area for immediate, urgent and unscheduled care

..But what does this mean for patients?

"I will be able to book ahead with my GP, at least four weeks ahead"

"I will only have to make one call or click in order to make an appointment"

"I will be able to have consultations via telephone, email or skype"

What is the… Coordinated Care Specification for the Service Offer

The Coordinated Care specifications for service are about outlining a way that clinicians, patients, and others come together to better **help patients achieve their desired health outcomes**

The expert panel that developed these was chaired by **Dr Rebecca Rosen,** a senior fellow in Health Policy at the Nuffield Trust and a General Practitioner in Greenwich

Case finding and review	Practices identify patients who would benefit from coordinated care and proactively review them on a continuous basis
Care planning	Patients identified for coordinated care have a care plan
Patients supported to manage their health and well-being	Practices create an environment in which patients have the tools, motivation and confidence to take responsibility for their health and wellbeing
Named clinician	Patients needing coordinated care have a named GP/lead clinician and team from which they routinely receive their care
Multi-disciplinary working	Patients needing coordinated care receive multidisciplinary reviews

..But what does this mean for patients?

"I will be supported to manage my own health with greater confidence, knowledge and responsibility"

Patient

"My care will be coordinated, rather than fragmented and transitions between services will be seamless"

What is the… Proactive Care Specification for the Service Offer

The Proactive Care standards aim to outline how general practice can better support patients in **staying well**

The expert panel that developed these was chaired by **Dr Nav Chana**, a GP and senior partner at the Cricket Green Medical Practice, Mitcham

Proposed standards	Description
Co-design	Primary care works with patients, their families and communities to co-design approaches to improving health and wellbeing
Developing assets and resources for improving health and wellbeing	Primary care works with others to develop assets and resources that will empower people to remain healthy and connected with their community
Personal conversations focused on individuals' health goals	Patients are routinely asked about wellbeing and their capacity and goals for improving their health
Health and wellbeing liaison and information	Patients have access to wellbeing liaison and information helping them to achieve health and wellbeing
Patients not currently accessing primary medical care	Primary care reaches out to people who have difficulty accessing services or would benefit from greater access. Practices have a plan for unregistered people

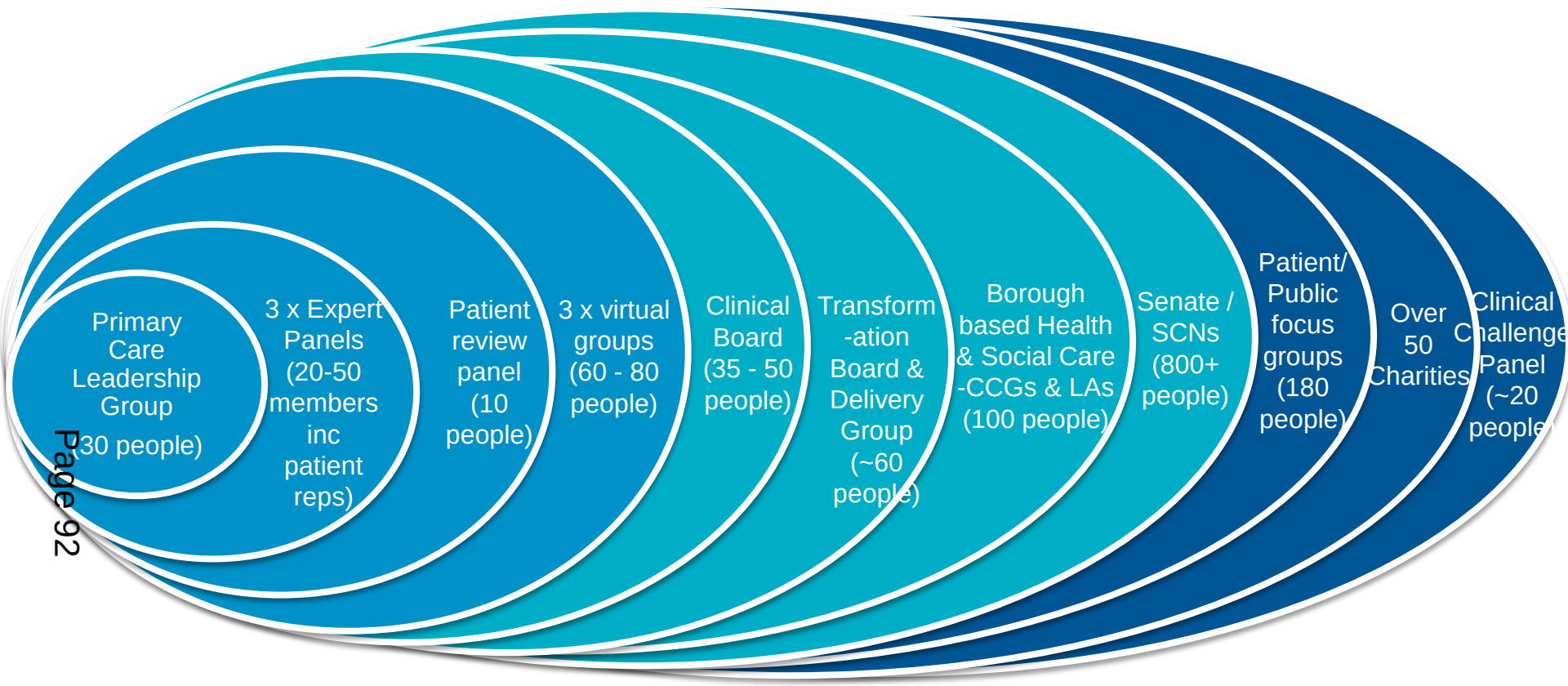
..But what does this mean for patients?

"I will have information tailored to my needs on when, where and how to access health and wellbeing support in my community"

"My local practices will work with our local communities to discuss the population's health needs and co-design new services in the community that support people to stay well

..Which has been widely tested

Following an initial development stage, the specification has been tested with a widening range of patients, clinicians and other stakeholders. Around **1,500** people have now been involved in testing this.



The *Strategic Commissioning Framework* which has been released for engagement reflects the feedback gathered from the above discussions.

The Framework includes several areas of focus to support delivery of the specification

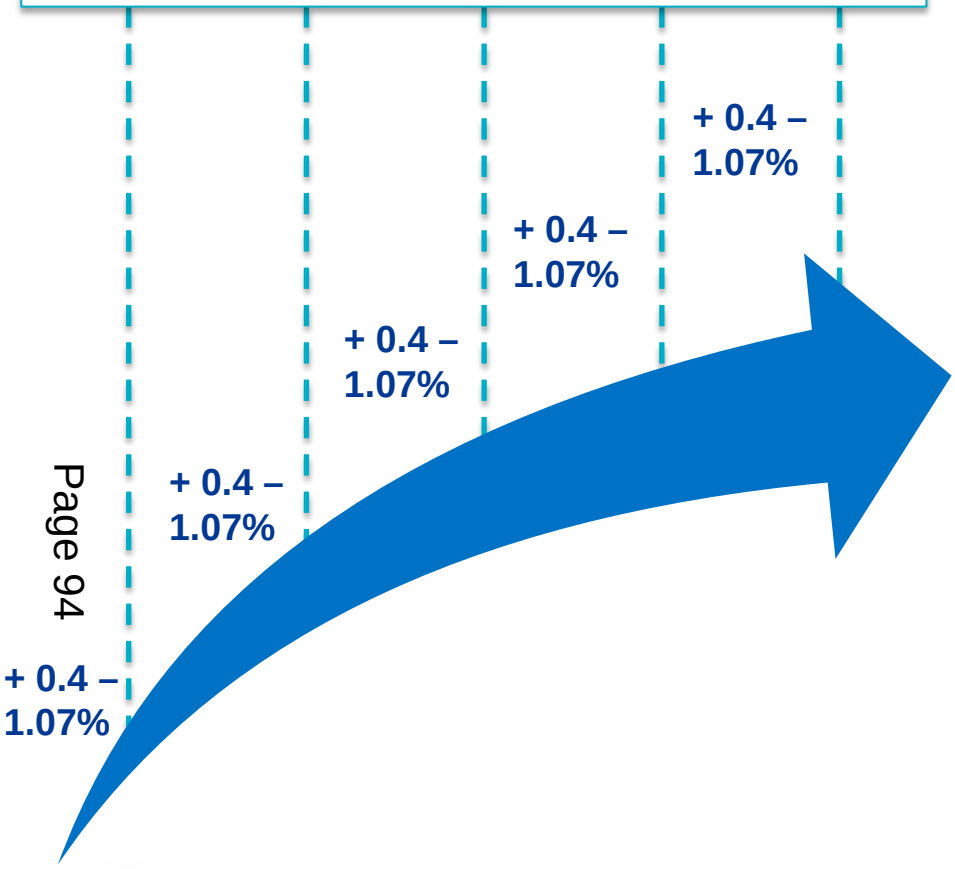
Models of Care	• This area proposes collaborating across groups of practices, and with other partners
Commissioning	• This area outlines the importance of supporting commissioners to work together and support to CCGs taking on co-commissioning
Financial Implications	• This includes the estimated cost shift towards Primary Care required to deliver the new specifications, and the year on year funding shift to achieve this (see next slide)
Contracting	• This area looks at contractual considerations of delivering the specifications e.g. contracting at a population level
Workforce Implications	• This area looks at the need for the right roles and skills in a practice and as part of a wider team
Technology Implications	• This area looks at the ways technology could be used to deliver the specifications and maximising its use to support empowerment and innovation
Estates Implications	• This area references the findings of the London Health Commission in terms of the variability of Primary Care estate and recommendation for investment
Provider Development	• This area outlines the importance of supporting providers to deliver the specifications and some of the potential areas for development
Monitoring and Evaluation	• This area outlines ways in which tools (largely already existing) can be used to support faster adoption of best practice, as well as for commissioner assurance

The specification will require investment…

A **high level estimation** of the cost of delivering the new service has been made. This will be further developed in parallel to the engagement phase, but indicates what a gradual shift in funding might look like, and an overall year on year cost increase

Years 1 – 5

Example gradual shift in funding towards Primary Care



Years 6 +

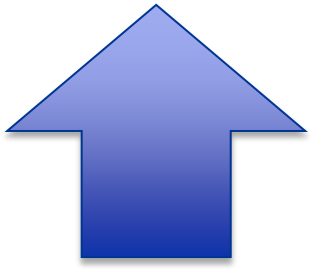
Annual costs of providing the new service offer

Overall shift of **2 – 5.36% of total health spend today**

An annual cost of **£310 – 810m**

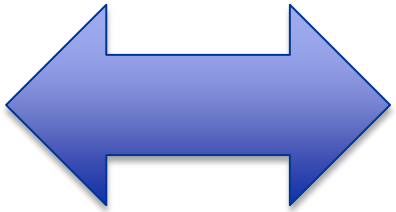
…and changes to the workforce..

The *Framework* also outlines that to deliver the specification, a larger and more diverse workforce is required.



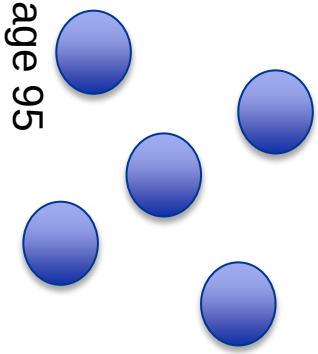
INCREASE EXISTING ROLES..

We will need more GPs and nurses to deliver the change

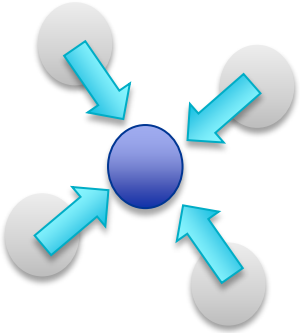


BROADEN THE TEAM..

There will need to be more new roles to support the clinicians



…AT A PRACTICE LEVEL



..OR ACROSS SEVERAL PRACTICES

Next Steps

The next stage of engagement has begun, and is expected to continue until April 2015. This document will be refreshed and reissued at the end of that period.

- Transforming primary care: *General practice – A Call to Action* was published to start a debate.
- A set of specifications for General Practice was led by expert GPs, building on the national vision for primary care.
- The Specifications were tested over the summer with a wide range of patients, the public, charities and independent clinicians as the other aspects of the Strategic Commissioning Framework were developed
- The developing Strategic Commissioning Framework, was shared at the end of November 2014
- There will be a period of **further planning and engagement** by CCGs and their partners, with NHS England, **from December 2014 to March 2015**
- **Implementation** is expected to start from **April 2015** and will take place over **the next 5 + years**

Bromley CCG Members are asked to consider…

1. Confirmation that the *Framework* covers the correct areas?
2. Are there other areas that should be considered in the *Framework* that currently aren't?
3. How could the *Framework* be strengthened?
4. What could help general practice deliver this specification?
   - What provider development is needed?
   - What workforce is needed?
   - How can technology support?

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Report No.

London Borough of Bromley

HEALTH AND WELLBEING BOARD

Date: **Thursday 29th January 2015**

Report Title: **UPDATE ON HEALTH & WELLBEING PRIORITY TASK & FINISH GROUPS**

Report Author: Steven Heeley, Education, Care & Health Services,
London Borough of Bromley
Tel: 0208 461 7472 Email: steven.heeley@bromley.gov.uk

Chief Officer: Terry Parkin, Executive Director, Education, Care & Health Services
Dr Nada Lemic, Director of Public Health.

1. SUMMARY

1.1. The Health & Wellbeing Board endorsed at its last meeting the approach to establishing four "Task and Finish" groups to manage the identified key priorities from the nine Health & Wellbeing Strategy priorities. These four priorities are Diabetes, Dementia, Obesity, and Children with Mental & Emotional Health problems.

1.2. This report updates the Board on the progress to date with the first group meetings.

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

2.1. The Bromley Health & Wellbeing Strategy 2012–15 is a key responsibility of the HWB, setting out how it will meet the needs identified within the JSNA through a number of locally determined priorities. Nine priorities formed part of the initial Strategy agreed in 2012 and four were selected as key priorities last July.

3. SPECIFIC ACTION REQUIRED BY HEALTH & WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

3.1. The Board is asked to note the progress to date of the Task and Finish groups. Board Members are invited to make any initial observations on their involvement so far.

Health & Wellbeing Strategy

1. Related priorities: Diabetes, Children with Mental & Emotional Health Problems, Obesity, Dementia.

Financial

1. Cost of proposal: Within existing budgets.
2. Ongoing costs: Within existing budgets.
3. Total savings (if applicable): Not applicable
4. Budget host organisation: Not applicable
5. Source of funding: Not applicable
6. Beneficiary/beneficiaries of any savings: Not applicable

Supporting Public Health Outcome Indicator(s)

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4. COMMENTARY

Introduction

4.1. The Health & Social Care Act 2012 places a duty on Health & Wellbeing Boards to produce a Joint Strategic Needs Assessment (JSNA) and a Joint Health & Wellbeing Strategy (JHWS). Bromley's existing Strategy was agreed in 2012 with a commitment to annually review and refresh it in order for it to remain relevant and in accordance with emerging needs identified in the annual JSNA.

4.2. The current Strategy has nine agreed priorities as follows:

- Diabetes
- Obesity
- Hypertension
- Anxiety and Depression
- Dementia
- Support for Carers
- Children with Mental & Emotional Health Problems
- Children Referred to Social Care
- Children with Complex Needs and Disabilities

4.3. At the July 2014 Board meeting, it was agreed that four priorities – Dementia, Diabetes, Obesity, and Children with Mental & Emotional Health Problems – were given a greater focus in order to bring together those working in the respective areas to ensure the best possible use of the expertise, knowledge and resources available to the borough.

4.4. The Board further endorsed the establishment of "Task & Finish" working groups for each of the four key priorities at the October 2014 meeting. These groups are chaired by elected members sitting on the HWB, with other board members also represented on each of the working groups. The following sets out each of the groups' membership of Board Members:

Dementia
Priority Lead: Councillor Huntington Thresher
Other Board Members: Councillor Evans, Councillor Smith, Councillor Jefferys

Diabetes
Priority Lead: Councillor Bennett
Other Board Members: Councillor Dunn, Councillor Jefferys, Mrs Linda Gabriel (Healthwatch Bromley), Dr Nada Lemic (Director of Public Health), Dr Andrew Parsons (Clinical Chairman)

Obesity
Priority Lead: Councillor Page
Other Board Members: Councillor Nathan.

Children with Mental & Emotional Health Problems
Priority Lead: Councillor Ellis
Other Board Members: Councillor Cooke & Mrs Linda Gabriel (Healthwatch Bromley).

4.5. Alongside the above board members, each of the groups is supported by appropriate commissioning and clinical leads from Bromley CCG and the Local Authority.

4.6. The groups have each been tasked with initially reviewing the present activity underway or proposed for the respective priority along with reviewing the agreed outcomes using the available commissioning resources. This will then require to be translated into an appropriate

gap analysis before the working group agrees upon an ambitious but realistic action plan which would include stretch targets to ensure the most is made of the opportunities presented through the partnership working catalysed by the Health and Wellbeing Board. The groups each have Terms of Reference to this effect.

4.7. Each group has now met for the inaugural meeting. The following provides a brief update on the progress of each of the priority groups:

Dementia
The dementia group began with a presentation on the current burden in the borough with over 4000 people in Bromley suffering from the condition. This is expected to rise by 308 by 2016 and by 680 people by 2020. The borough is currently underperforming (49.5%) on the overall diagnosis rate of the condition which nationally has been set at 67% as a minimum. It was noted however that Bromley had a good service provision through the Memory Clinic and the quality of the liaison assessment in hospitals.

The group acknowledged the good work to date of the Bromley Dementia Action Alliance and felt it would be sensible to work more closely with them to achieve greater things across the borough. The aim to become a Dementia Friendly Community was also discussed and agreed for further investigation to be reported back to the next meeting. The Council will be holding a 'Living With Dementia' conference on 11th March 2015 and the group was keen for this to be wide reaching within the community. The group also looked at the proposed schemes through the Better Care Fund for dementia and how these would benefit.

Diabetes
The group discussed the burden of diabetes in Bromley, acknowledging that the borough was in a good position with its identification of the condition. GPs were also incentivised to diagnose. Prevalence figures are therefore fairly accurate in comparison to other boroughs. It was confirmed that the increase in prevalence was largely amongst type 2 sufferers and highlighted the cost of the current burden on the NHS, thought to be around 10% of total budget.

A mechanism already existed to identify high risk of diabetes through existing NHS healthchecks with a pilot currently underway with 10 GP practices to involve them in a year-long programme for patients. The sub-group agreed to work on developing a clear pathway for diabetes prevention. They also agreed that more information needed to be provided to patients on the risk of diabetes particularly targeting high risk population groups.

The diabetes group agreed to:

- Increase the % of the population doing physical activity;
- Reduce the overall weight of the borough's population
- Keep under review the diabetes prevention programme, evaluated by NICE, to promote the benefits arisen from it;
- Look at synergies and joint working with the obesity sub-group;
- Work with South London CCGs through the sub-regional commissioning group to look at benchmarking against other local boroughs;
- Find ways of identifying and targeting hard-to-reach groups;
- Utilise different ways of approaching and engaging with community groups.

Obesity
The group discussed the current burden of obesity in Bromley with the headline Message being that the borough has the third highest prevalence of excess weight in London at 65% of the population either overweight (>25 BMI) or obese (>30 BMI), representing approximately 208,820 adults. This both higher than the England average (63.8%). The borough's estimated prevalence of obesity is 21.8% which represents 52,672 adults. The diabetes prevalence in the borough which had increased from 2.73% in 2003/04 to 5.2% in 2012/13 with 13,681 on the diabetes register. The implications and impact were also discussed.

The Council's Public Health team were working with Weight Watchers to deliver a pilot Healthy Weight 12 week programme aiming to reduce weight of individuals by 5-7%.

The group agreed to undertaking an asset mapping exercise, the development of a healthy weight pathway and a Tier 3 Weight Management Plan. They also agreed that there were synergies with the diabetes group and that joint working opportunities could be useful.

Children with Mental & Emotional Health Problems
The group were informed that a Children's Mental Health Needs Assessment had been completed in December 2012 along with a Self Harm Prevention Strategy. The Bromley Y service was accepted and acknowledged as a good offering to those with concerns and issues but was significantly overstretched. An Emotional Wellbeing Forum had also been set up for secondary schools in order to support teachers who deal with pastoral care in schools and was recognised as a useful forum for schools to suggest solutions and new initiatives.

A suicide awareness training had been delivered to some secondary school staff and the training programme was being reviewed to look at whether it can be tailored to offer to GPs. Of most benefit to young people was building resilience to deal with stress and the necessary techniques to manage. Concern was raised about primary age children were exhibiting teenage traits. It was acknowledged that speech and language are very important as difficulties with this often lead to mental health issues at a later stage.

The group received a presentation on the new Community Wellbeing Service which was now a single point of access to emotional and wellbeing services, child and specialist child and adolescent mental health services in Bromley. The new service provided prompt and timely decisions on referrals based on mental health need and risk, high quality, consistent prioritisation and allocation, professional and qualified advice, easy access to information about child and adolescent mental health services, and training and consultation for professionals.

The group had been timely established to think about how the new service and all other initiatives on offer could move forward in the borough. Identified actions included reviewing how better to engage with faith, uniformed and non-uniformed groups to provide better resilience in young people, disseminating good practice, focusing on speech and language services, and to look at early prevention ideas.

5. FINANCIAL IMPLICATIONS

5.1. Work of the priority groups is to be undertaken through existing budgets but with better targeting of resources to see reductions in system costs, for example, through fewer emergency admissions, or reduced numbers of placements in nursing or other residential settings.

5.2. Pre-determined funding for schemes within the Better Care Fund would also potentially contribute to the delivery of specific actions agreed on by the working groups, where relevant such as dementia.

6. LEGAL IMPLICATIONS

6.1. Under the Health and Social Care Act 2012 it is a statutory responsibility of local authorities and clinical commissioning groups (CCGs) to prepare JSNAs and JHWSs, through the Health and Wellbeing Board.

7. IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROGRESS THE ITEM

7.1. The Health & Wellbeing priorities, integration of service delivery and the proposed model of governance requires the full agreement and support from the London Borough of Bromley, Bromley's Clinical Commissioning Group and all other partners of the Health & Wellbeing Board.

Non-Applicable Sections:	**COMMENT FROM THE DIRECTOR OF AUTHORING ORGANISATION**
Background Documents: (Access via Contact Officer)	None.

London Borough of Bromley

Decision Maker:	**HEALTH AND WELL BEING BOARD**
Date:	**29th January 2015**
Decision Type:	Non Urgent Non-Executive Non-Key
Title:	**Health and Wellbeing Board Matters Arising and Work Programme**
Contact Officer:	Stephen Wood, Democratic Services Officer Tel: 0208 313 4316 E-mail Stephen.wood@bromley.gov.uk
Chief Officer:	Mark Bowen, Director of Corporate Services
Ward:	N/A

1. Reason for report

1.1 Board Members are asked to review the Health and Wellbeing Board's current Work Programme and to consider progress on matters arising from previous meetings of the Board.

1.2 The Action List (Matters Arising) and Glossary of Terms are attached.

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2. RECOMMENDATION

2.1 The Board is asked to review it's Work Programme and progress on matters arising from previous meetings.

Non-Applicable Sections:	Policy/Financial/Legal/Personnel
Background Documents:	Previous matters arising reports and minutes of meetings.

Corporate Policy

1. Policy Status: Existing Policy:

2. BBB Priority: Excellent Council; Supporting our Children and Young People; Supporting Independence; Healthy Bromley

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Financial

1. Cost of proposal: No Cost for providing this report

2. Ongoing costs: N/A

3. Budget head/performance centre: Democratic Services

4. Total current budget for this head: £367,636

5. Source of funding: 2014/15 revenue budget

Staff

1. Number of staff (current and additional): There are 10 posts (8.75fte) in the Democratic Services Team

2. If from existing staff resources, number of staff hours: Maintaining the Board's work programme takes less than an hour per meeting

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Legal

1. Legal Requirement: Matters Arising and the Work Programme should be actioned in accordance with statutory obligations.

2. Call-in: Not Applicable

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): This report is intended primarily for Members of the Health and Well Being Board.

Ward Councillor Views

1. Have Ward Councillors been asked for comments? No

2. Summary of Ward Councillors comments: N/A

3. COMMENTARY

3.1 The Matters Arising table is attached at **Appendix 1.** This report updates Members on matters arising from previous meetings which are ongoing.

3.2 The current Work Programme is attached as **Appendix 2.** The Work Programme is fluid and evolving. Meeting dates subsequent to May 2015 will be added when the Programme of Meetings for 2015/16 is finalised.

3.3 In approving the Work Programme members of the Board will need to be satisfied that priority issues are being addressed, in line with the priorities set out in the Board's Health and Wellbeing Strategy and Terms of Reference which were approved by Council in April 2013.

3.4 The Chairman proposes to reduce the frequency of Board meetings given the establishment of Task and Finish Groups around Health & Wellbeing priorities and the related work and time commitment to attend meetings for all Board Members in between.

3.5 For Information, **Appendix 3** shows dates of Meetings and report deadline dates.

3.6 For Information, **Appendix 4** outlines the Constitution of the Health and Well Being Board.

3.7 **Appendix 5** is the updated Glossary.

APPENDIX 1

Health and Wellbeing Board

Matters Arising/Action List – 29th January 2015

Agenda Item	Action	Officer	Notes	Complete
10 **BCF Updates.** **(16/10/14)**	BCF progress updates to be provided to the Board.	**Richard Hills/** **Clive Uren**	It was proposed at the meeting on 16/10/14 that from time to time, BCF progress updates would be provided to the Board.	**New Action**
Health Care Facilities in Bromley. (20/03/14)	Recommendation to be made to NHS England for an additional GP Practice. NHS England to be invited to a future meeting. NHS London to be asked for a statement on the shortage of GP provision in Bromley Town Centre	**Steve Heeley**	NHS England have been invited to join the HWB as a Co-opted Member. Discussions are ongoing with representatives from NHS England and the CCG to find a resolution on this matter.	**Ongoing**
4 **Non-Voting Co-opted Members.** **(16/10/2014)**	It was noted that the Board should consider its optimum size and nature going forward, before appointing new co-opted Members. Board to consider if it wishes to pursue further guidance from the Department of Health concerning the appointment of Co-opted Members.	**The Board** **Terry Parkin**	As well as considering the size and nature of the Board, it was noted that any future deliberations with respect to appointing additional Co-opted Members, would be undertaken with the full consultation of all Board Members**.** Guidance to be sought from the Department for Health. Three new Co-opted Members have been invited to join the Health and Wellbeing	**New Action** **TBC**

			Board 1-Non Executive Member of the CCG 2-NHS England 3-Chair of Bromley Children's Safeguarding Board.	
5 **Health watch Annual Report (16/10/14)**	Healthwatch Bromley to undertake measures to increase public awareness of the organisation's existence, and of its role in the Health and Social Care sector.	**Linda Gabriel/Folake Segun**	At the previous meeting of the HWB a Member expressed concern that Heathwatch and its activities were not well known amongst the public.	**New Action**
8 **Care Act Impact (16/10/14)**	An update be provided to Board Members after the Autumn Statement regarding BCF funding and the Care Cap.	**Terry Parkin**	At the previous HWB meeting, it was noted that more accurate financial data may be available for calculations after the Chancellor had made his autumn statement**.**	**New Action**
12 **Health and Wellbeing Priorities and Working Groups (16/10/14)**	An update be provided on the progress of the "Task and Finish Groups"	**Chairman**	At the meeting on the 16th October 2014, a Member requested that the Dementia Working Group be set up and get to work as a matter of urgency. The Dementia Task & Finish Group met on Tuesday 20th January 2015.	**New Action**

Appendix 2

HEALTH AND WELLBEING BOARD
WORK PROGRAMME 2013/14

Title	Notes
Health and Wellbeing Board—29th January 2015	
PNA sign off	
Child Deaths Overview Panel Report	
H&W Priorities – Task & Finish Group updates	
HWB Strategy 2014/15 Exception Reporting	
Work Programme and Matters Arising	
Bromley Children's Safeguarding Annual Report	
Healthwatch Funding/Contract	
Health and Wellbeing Board—26th March 2015	
JSNA 2015 Update	
Work Programme and Matters Arising	
Winterbourne View Recommendations Update	
Health and Wellbeing Board—21st May 2015	

Outstanding items to be scheduled
BCF and Care Act Progress Updates
Shortage of GP Provision in Bromley Town Centre
Progress update on Working Groups
Proposal for how paediatric Diabetes could be addressed jointly between the Local Authority and Bromley CCG focussing on a preventative approach.

Appendix 3

Dates of Meetings and Report Deadline Dates

The Agenda for meetings MUST be published five clear days before the meeting. Agendas are only dispatched on a Tuesday.

Report Deadlines are the final date by which the report can be submitted to Democratic Services. Report Authors will need to ensure that their report has been signed off by the relevant chief officers before submission.

Date of Meeting	Report Deadline	Agenda Published
29th January 2015	20th January 2015	21st January 2015
26th March 2015	17th March 2015	18th March 2015
21st May 2015	12th May 2015	13th May 2015

A link to the agenda is emailed to the Board on the publication date. Hard copies are available on request.

Questions
Questions from members of the public to the meeting will be referred directly to the relevant policy development and scrutiny (PDS) committee of the Council, or to other meetings as appropriate, at the next available opportunity unless they relate directly to the work of the Board.
A list of the questions and answers will be appended to the corresponding minutes.

Minutes
The minutes are produced within 48 hours of the meeting. They are then sent to officers for checking. Once any amendments have been made they are sent to the Chairman and once he has cleared them they are sent, in draft format, to members of the board. Please note that this process can take up to two weeks.

The draft minutes are them incorporated on the agenda for the following meeting and are confirmed. Following this approval they are published on the web.

London Borough of Bromley

Constitution

Health & Wellbeing Board

(11 Elected Members, including one representative from each of the two Opposition Parties; the two statutory Chief Officers (without voting rights); two representatives from the Clinical Commissioning Group (with voting rights); a Health Watch representative (with voting rights) and a representative from the Voluntary Sector (with voting rights). The Chairman of the Board will be an Elected Member appointed by the Leader. The quorum is one-third of Members of the Board providing that elected Members represent at least one half of those present. Substitution is permitted. Other members without voting rights can be co-opted as necessary.

1. Providing borough-wide strategic leadership to public health, health commissioning and adults and children's social care commissioning, acting as a focal point for determining and agreeing health and wellbeing outcomes and resolving any related conflicts.

2. Commissioning and publishing the Joint Strategic Needs Assessment (JSNA) under the Health and Social Care Act.

3. Commissioning and publishing a Joint Health & Wellbeing Strategy (JHWS) – a high level strategic plan that identifies, from the JSNA and the national outcomes frameworks, needs and priority outcomes across the local population, which it will expect to see reflected in local commissioning plans.

4. Receiving the annual CCG commissioning plan for comment, with the reserved powers to refer the CCG commissioning plan to the NHS Commissioning Board should it not address sufficiently the priorities given by the JSNA.

5. Holding to account all areas of the Council, and other stakeholders as appropriate, to ensure their annual plans reflect the priorities identified within the JSNA.

6. Supporting joint commissioning and pooled budget arrangements where it is agreed by the Board that this is appropriate.

7. Promoting integration and joint working in health and social care across the borough.

8. Involving users and the public, including to communicate and explain the JHWS to local organisations and residents.

9. Monitor the outcomes and goals set out in the JHWS and use its authority to ensure that the public health, health commissioning and adults and children's commissioning and delivery plans of member organisations accurately reflect the Strategy and are integrated across the Borough.

10. Undertaking and overseeing mandatory duties on behalf of the Secretary of State for Health and given to Health and Wellbeing Boards as required by Parliament.

11. Other such functions as may be delegated to the Board by the Council or Executive as appropriate.

Appendix 5

GLOSSARY:

Glossary of Abbreviations – Health & Wellbeing Board

Acute Treatment Unit	(ATU)
Antiretroviral therapy	(ART)
Any Qualified Provider	(AQP)
Autistic Spectrum Disorders	(ASD)
Behaviour, Attitude, Skills and Knowledge	(BASK)
Better Care Fund	(BCF)
Black African	(BA)
Body Mass Index	(BMI)
British HIV Association	(BHIVA)
Bromley Clinical Commissioning Group	(BCCG)
Cardiovascular Disease	(CVD)
Care Programme Approach	(CPA)
Care Quality Commission	(CQC)
Children & Adolescent Mental Health Service	(CAMHS)
Chlamydia Testing Activity Dataset	(CTAD)
Clinical Commissioning Group	(CCG)
Clinical Decision Unit	(CDU)
Clinical Executive Group	(CEG)
Clinical Leadership Groups	(CLG)
Community Learning Disability Team	(CLDT)
Director of Adult Social Services	(DASS)
Director of Children's Services	(DCS)
Disability Discrimination Act 1995	(DDA)
Dispensing Appliance Contractors	(DAC)
Emergency Hormonal Contraception	(EHC)
Essential Small Pharmacy Local Pharmaceutical Services	(ESPLPS)
Female Genital Mutilation	(FGM)
Florence – telehealth system using SMS messaging	(FLO)
Health & Wellbeing Board	(HWB)
Health & Wellbeing Strategy	(HWS)
Health of the Nation Outcome Scales	(HoNOS)
Hypertension Action Group	(HAG)

Improving Access to Psychological Therapies programme	(IAPT)
In Depth Review	(IDR)
Integration Transformation Fund	(ITF)
Intensive Support Unit	(ISU)
Joint Health & Wellbeing Strategy	(JHWS)
Joint Integrated Commissioning Executive	(JICE)
Joint Strategic Needs Assessment	(JSNA)
Kings College Hospital	(KCH)
Local Medical Committee	(LMC)
Local Pharmaceutical Committee	(LPC)
Local Pharmaceutical Services	(LPS)
Long Acting Reversible Contraception	(LARC)
Medicines Adherence Support Service	(MASS)
Medicines Adherence Support Team	(MAST)
Medium Super Output Areas	(MSOAs)
Men infected through sex with men	(MSM)
Mother to child transmission	(MTCT)
Multi-Agency Safeguarding Hubs	(MASH)
National Chlamydia Screening Programme	(NCSP)
National Institute for Clinical Excellence	(NICE)
Nicotine Replacement Therapies	(NRT)
National Reporting and Learning Service	(NRLS)
Nucleic acid amplification tests	(NATTS)
Patient Liaison Officer	(PLO)
People living with HIV	(PLHIV)
Pharmaceutical Needs Assessment	(PNA)
Policy Development & Scrutiny committee	(PDS)
Primary Care Trust	(PCT)
Princess Royal University Hospital	(PRUH)
Proactive Management of Integrated Services for the Elderly	(ProMISE)
Public Health England	(PHE)
Public Health Outcome Framework	(PHOF)
Quality, Innovation, Productivity and Prevention programme	(QIPP)
Queen Mary's, Sidcup	(QMS)
Secure Treatment Unit	(STU)
Sex and Relationship Education	(SRE)

Sexually transmitted infections	(STIs)
South London Healthcare Trust	(SLHT)
Special Educational Needs	(SEN)
Supported Improvement Adviser	(SIA)
Tailored Dispensing Service	(TDS)
Unitary Tract Infections	(UTI)
Urgent Care Centre	(UCC)
Voluntary Sector Strategic network	(VSSN)
Winterbourne View Joint Improvement Programme	(WVJIP)

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