REVIEW OF PUBLIC HEALTH AND JOINTLY COMMISSONED CHILDREN SERVICES

Contents

[1] National Child Measurement Programme

1. BACKGROUND

During 2015/16 the Council reviewed its provision of both public health services for children (school nursing, health visiting, family nurse partnership, obesity services) and children's residential respite and therapeutic services provided jointly with the CCG (Hollybank, speech and language therapy and occupational health).

The CCG is re-commissioning community health services from October 2017 and has set up a programme to retender services.

A working group has been set up with representation from LBB (Public Health and Health Integration Programme) and the CCG to:

- review Public Health Children's services (0-19) with a particular focus on services for the 5-19 year group

- make recommendations for the future delivery of speech and language and occupational therapy services to schools

- make recommendations for the future delivery of provision for children with long term conditions and disabled children's residential respite

- establish the impact of the proposed changes to services commissioned by LBB on community health services and to determine whether there are any functions which need to be included in the specification for the community contract

This report provides information in the following areas:

- What is the need for well-being service in children 5-19 years?
- What works in relation to preventative and well-being services for this group? This section seems to be describing at present elements of what works rather than actual interventions/programmes known to work
- What is currently commissioned or provided/
- What are the legal and statutory responsibilities of different agencies in relation to child well-being and safeguarding?
- What are the identified gaps in service provision?

2. ASSESSMENT OF NEED

2.1. Child Well-being Needs Assessment: Executive Summary

This report describes the population of children and young people aged 0-18 in Bromley in terms of size of population and the ethnic make-up of that population, together with estimates of projected changes to that population.

The report then describes how prevention could affect the health and wellbeing of the children and young people of Bromley. Prevention can be primary, secondary or tertiary.

Primary prevention aims to prevent a problem before it occurs by identifying families within the population who are more likely to suffer poor outcomes for their children. Section A uses evidence to identify risk factors in families in Bromley.

Secondary prevention aims to identify a potential or emerging problem in a child or young person at an early stage in order to minimise the impact of that problem. Section B reviews what we know about emerging health, education and social care needs of children and young people in Bromley. This section will focus on children with identified low level needs, for example those known to Children's Social Care from Early Intervention Family Support or those identified as having Special Educational Needs but who do not have a statement or EHC Plan.

Tertiary prevention aims to minimise the impact of a known need.. Some information about tertiary prevention will be set out in Section C. Information in this section will include those CYP known to the school nursing service as needing an individualised Healthcare Plan in school, those children with EHC Plans or statement of SEN, Looked After Children and young people known to the Youth Offending Service, and those on a Child Protection Plan.

Key findings on demography

- The greatest population growth 2015 to 2025 will be in secondary school age children.
- Certain wards have a higher concentration of ethnic minorities than others. The North-West of Bromley has the highest proportion of ethnic minority population and the North-East of the borough has the highest proportion of Gypsy Travellers, in particular the wards of Cray Valley East and West.
- There may be a higher disease burden due to the increased risk amongst certain BME groups, and evidence suggests a lower life expectancy amongst Gypsy Travellers as well as higher prevalence of long term illness.

Key findings from Section A: Risk factors in families in Bromley

- Mental health issues in parents in Bromley is at least as common as national rates
- Illness and disability of parents is of concern, especially in areas of higher deprivation

- Smoking in pregnancy is more common in Bromley than in London, and is particularly high in pregnant young people under the age of 20 and pregnant women in routine and manual occupations.
- Recorded drug and alcohol misuse in Bromley is below the national average. However the proportion of pregnant women in substance misuse services and hospital admissions for substance misuse are both higher than national and London averages. These should be reviewed after an update of the data in 2016.
- Domestic violence is recorded more frequently in Cray Valley wards and Mottingham and Chislehurst North
- Homelessness of families with children is higher than national rates. There are increasing numbers of households with children residing in temporary accommodation and outside Bromley
- Families affected by unemployment, housing and financial difficulties and require support are more likely to live in the Crays, Mottingham or Penge
- Teenage pregnancy rates are reducing significantly, although still more frequent in areas of higher deprivation. Late booking for antenatal care in pregnant teenagers is of concern.

Key findings from Section B: Emerging health, educational and social care needs

- The distribution of children with Special Educational Needs across the borough is higher in some wards, notably the Cray Valley wards, Bromley Common and Keston, Orpington, and Plaistow and Sundridge.
- Smoking rates in young people in Bromley are higher than London and national rates.
- Young people between 15 and 24 years old continue to have the highest rates of new STIs. Males of all ages are more affected by new STIs than females
- Of the 90 young people in treatment in Bromley in 2014-15, 70% were using two or more substances (this may include alcohol) and 97% began using their main problem substance before the age of 15 years.
- Nearly a third of children in Year 6 in Bromley are either overweight or obese. Pupils obese in reception year were more likely to remain obese at year 6 in Crystal Palace, Mottingham and Chislehurst North, Cray Valley East and Cray Valley West
- Some wards have a higher proportion of children living in families who are receiving support: Biggin Hill, Cray Valley West, Plaistow and Sundridge, and Mottingham and Chislehurst North
- Community and hospital services indicate that young people in Bromley have a high level of need for support around self harming behaviour. A brief survey of emotional health concerns in secondary schools in Bromley in 2015 confirms this.
- A quarter of young people in contact with the YOS have health needs.

- The number of exclusions of primary school pupils is very high.
- There is no data on LGBT in young people in Bromley, although this is a known risk factor for several adverse outcomes in this age group.
- Vulnerability and safeguarding concerns in EHE children and young people may not be identified. This is of particular concern for young people who may be EHE for longer periods of time.
- There appears to be significant under-reporting or lack of identification of CSE in Bromley, particularly by health services

Key findings from Section C: minimising the impact of a known need

- At least 200 children and young people with complex health needs but no EHC Plan or Statement require support to attend school, and this number is increasing. A total of 600 children and young people in Bromley schools require some nursing support to access school.
- Compared to similar areas there are higher rates in Bromley of children with speech, language and communication needs, children with severe, profound and multiple learning difficulties, and pupils on the autistic spectrum. Pupils with behavioural, emotional or mental health needs are more likely to attend independent schools
- Some indicators, for example on substance use in Bromley Looked After Children, are reassuring. Others raise concerns:
  - Exclusions from school and persistent absence of Bromley LAC are higher than statistical neighbours, London and national data.
  - The proportion of LAC who are Not in Education, Employment or Training is also higher than comparators. This may be due in part to the relatively high rates of LAC with Special Educational Needs in Bromley.
  - The proportion of LAC who have been convicted or subject to a final warning or reprimand during 2014 was also higher than comparators, although the numbers are small.
  - The predicted increase in the number of UASC will require support from health as well as social care agencies.
- Initial contacts to assessments by children's social care services have begun to level off and in the case of referrals decrease significantly based on levels prior to 2011. This is likely to be due to the success of the targeted approach of the MASH service

These key findings are discussed in more detail in Section 6 of this paper.

2.2. Evidence of Effectiveness of Preventative Services

Background

The following provides a brief overview evidencing 'what works' in terms of prevention. The Chief Medical Officer illustrates a strong case for a shift to prevention in her Annual Report 'Our Children Deserve Better: Prevention Pays' (2012). Early intervention and preventive measures have a significant impact on health outcomes. Furthermore, improving the lives of children and young people brings significant economic benefits.

The evidence presented to date highlights that the life course approach matters (Marmot 2012). Evidence for the life course approach is strong; each stage of life affects the next. In particular, events in the early period of life have a profound effect on the future health and wellbeing of children and young people (CMO 2012). A staggering 80% of children showing behavioural problems at the age of five go on to develop more serious forms of anti-social behaviour (Mental Health of Children and Adolescents in Great Britain, 2004). It is now very well documented that the environment of a child's earliest years can have effects that last a lifetime. Between conception and age three, a child's brain undergoes an incredible amount of change. At birth, the child's brain will already have the majority of the neurons it will have for life. It doubles in size in the first year, and by age three it has reached 80 percent of its adult volume (Lipina 2009).

We know that, when necessary, early intervention for a child at a very young age can be most effective. There are other times too when interventions are highly effective and appropriate. This may be because clinically they will have the most significant impact (e.g. people who give up smoking by the age of 30 will avoid some of the risks of dying early from tobacco-related diseases); or because a person is highly motivated and confident to successfully make behaviour changes that will impact their health and wellbeing. Pregnancy and early parenthood are often identified as stages in life when many people are especially motivated and interventions are particularly successful. Furthermore, there is some evidence that groups provided with information and support at timely points in the development of given types of illness, such as shortly after a first myocardial infarction, may be more motivated to change their behaviours than other populations (Van Berkel 1999, Newsom et al 2015).

Pregnancy and Early Childhood

Key risk factors associated with poorer developmental outcomes in children

Parental Smoking and Drugs and Alcohol use

- There is a need for specific interventions that can access 'hard-to-reach' groups. Smoking prevalence remains high amongst young pregnant women and standard interventions tend not to work

- Front line health practitioners working with families should complete National Centre for Smoking Cessation and Training (NCSCT) specialist training modules such as 'Pregnancy & the Post-Partum Period' to enable them to provide effective cessation support and/or brief advice on: 1. the risks of smoking to women & children/unborn babies; 2. The significant role of partners 3. What NHS Stop Smoking Services provide and how to refer to them them (Healthy Child Programme 2015)

- Randomised Controlled Trials provide substantial evidence for the efficacy of incentives for smoking cessation in pregnancy (BMJ 2015)

- Parental problem drug use has been shown to be one of the commonest reasons for children being received into the care system (NICE guideline No.52). Effective treatment programmes for parents supported by robust referral pathways are key to minimising the risk to families (refer to Bromley's Drugs Misuse Needs Assessment 2015)

- There is some evidence that both integrated services, that is a holistic service that addresses substance misuse as well as maternal and child wellbeing, parenting programmes, child care and other child-centred services in one setting; as well as non-integrated programmes can improve some birth outcomes for infants of women who have substance misuse problems during pregnancy

- Evidence suggests that the more holistic integrated programmes lead to a small improvement in parenting, but not on child protection outcomes (Healthy Child Programme 2015)

- NICE recommends parents who are using drugs are offered behavioural couples therapy as the evidence illustrates that it is more successful that individual-based treatment where one or both parents are misusing drugs

Obesity Prevention in Early Childhood

- Increasing evidence points to the possible impact of interventions targeting early life, such as in utero and infancy, including breastfeeding (CMO 2012)

- Effective components of interventions: decreasing pre-schoolers' screen time; decreasing consumption of high fat/calorie drinks/foods; increasing physical exercise; increasing sleep; modifying parental attitudes to feeding; and promoting authoritative parenting through programmes, such as HENRY(Health, Exercise, Nutrition for the Really Young)

Support for families who need additional support

- There is evidence for the effectiveness of a range of different types of Domestic Violence (DV) interventions concerned with prevention, re-abuse, and the adverse consequences of DV (e.g. impact on mental health). The range of interventions include; advocacy services, skill

building, counselling and therapy. In terms of prevention and an early intervention approach it is paramount that frontline staff are equipped with training and skills so they can spot the signs of abuse in family members and intervene as early as possible

- Young females need gender-sensitive and specific responses acknowledging the importance of experiences of victimisation, positive relationships and improved self-esteem as an exit from crime and violence

- NICE (2014b) recommends providing specialist domestic violence and abuse services for children affected by domestic violence and abuse, matching the support to the child's developmental stage and seeking to address the emotional, psychological and physical harms arising from a child or young person being affected by domestic violence and abuse, as well as their safety. The Bromley Children's Group Work Programme is an evidence based programme that has successful reach and outcomes working with Bromley families

- The Rapid Review of the Healthy Child Programme (2015) purports that there is good evidence to support the commissioning of home visiting interventions in early childhood for at-risk families. They lead to reductions in Child Protection Services (CPS) reports, accident and emergency visits, hospitalisations and self-reports of abuse, as well as an increase in the uptake of immunisations. Home visitation by paraprofessionals holds promise for socially high-risk families with young children, including in the area of reducing harsh parenting

- There is consistently strong evidence to support the use of Family Nurse Partnership (HCP 2015). A recently published randomised controlled trial in the UK of FNP found evidence of better cognitive and language development in the baby, improved attachment between mother and baby, and fewer symptoms of depression in the mother

Positive Parenting & Attachment

- Evidence from a number of longitudinal studies has demonstrated that securely attached children function better across a range of domains including emotional, social and behavioural adjustment, as well as peer-rated social status and school achievement (CMO 2012). Implementing evidence-based interventions to promote secure attachment may limit children developing major social, educational and behavioural problems

- There is evidence to support the use of massage with disadvantaged and depressed mothers of babies (HCP 2015)

- Families may be reluctant to access some types of support because service users are stigmatised in some communities (Becher and Hussain 2003). CFCs in Bromley are careful in the enrolment process for programmes such as HENRY, ensuring that the group is made up of targeted (i.e. any families identified as needing additional support) and

universal (i.e. all families). Providers who recently gave evidence to the APPG (2016) stressed the significance of maintaining an element of universal service provision – open to all rather than just targeted on the most disadvantaged. A universal approach helps to prevent support from being stigmatised as something for "failing families". Furthermore the evidence is that it often enables service providers to identify parents who are dealing with more complex issues at an early stage. This is particularly the case when dealing with problems do not discriminate on the basis of income or geographic location, such as mental health

- NICE guidance recommends the use of evidence-based parenting programmes as a secondary prevention measure for parents of children who have oppositional defiant disorder or conduct disorder or who have been identified as at high risk of developing these disorders

  'Good evidence exists that high-quality programmes focused on strengthening support systems around children and young people (particularly parenting) in combination with developing children and young people's internal resilience have the best chance of improving multiple outcomes'
  (CMO 2012:211).

Older Children and Young People

Obesity treatment

- School-based programmes are effective when diet and physical activity components are included

- There is strong evidence that the involvement of whole families (parents and children) in interventions that promote both healthier diet and more exercise can have an impact on reduction of BMI(NICE 2015, Obesity in children and young people: prevention and lifestyle weight management programmes). There is International recommendations that the core elements of any initiative to address obesity should involve the whole family and include nutrition education, behaviour modification and promotion of physical activity (Sacher, 2010). There is some evidence supporting the effectiveness of specific programmes such as MEND (Swain 2009, Sacher et al 2010)

Emotional Health

- The contribution of schools to developing resilience and enhancing wellbeing as a component of the curriculum is grounded in an extensive evidence base

- The Healthy Schools programme along with SEAL (Social and Emotional Aspects of Learning) for primary schools are whole-school initiatives

designed to develop emotional wellbeing and healthy positive behaviours among school students

- There is evidence that specialist teachers trained in PSHE (Personal Social & Health Education) deliver the most effective health-related teaching, especially in relation to the topics that children are reported to be most likely to want information about, including health exploratory behaviours and sexual health (CMO 2012)

- School support is a protective factor for mental health. A recent Cochrane systematic review of psychological or educational prevention programmes for young people aged 5–19 found some evidence of effectiveness of interventions in reducing the risk of having a depressive disorder.

- There is evidence that approaches focusing on the building of young people's social and emotional skills have greater long-term impacts than deficit-based programmes. Strengthening protective factors or health assets in schools, in the home and in local communities can make an important contribution to reducing risk for those who are vulnerable and in so doing promote their chances of leading healthy and successful lives (CMO 2012)

Specific prevention strategies for targeted groups including; Young People Not In Education, Employment or Training (NEET), Electively Home Educated, Children In Need, Young Carers and Young People known to the Youth Offending Team (YOT) and those with Special Educational Needs (SEN)

- Commission a range community based health services which enable access to young people who might not otherwise attend health services in Primary Care. There is evidence that, in general, many young people are not satisfied with GP services

- National evidence shows that significant numbers of vulnerable and 'hard to reach' groups of young people who had not previously accessed health provision within mainstream services did access the school nurse service

- Compelling evidence illustrates the benefits of vulnerable groups receiving targeted health and wellbeing support as they are likely to experience physical and emotional problems at school, such as disruptive behaviour, difficulty making friends and being bullied

- Implement the 'Foundation Pathway for Young Carers'

- Commission a Health Advisor Role to support clients with specific health needs and to liaise with other professionals within YOT

- Increasing evidence exists which highlights the success of new technologies in engaging young people in healthcare issues

Preventing young people engaging in risk behaviours (including smoking, sexual heath & the use alcohol and drugs)

- Once young people start smoking there is little evidence illustrating successful cessation approaches. The evidence is stronger in relation to stopping them smoking in the first place. There needs to be easily understood tobacco policies in learning environments

- Education content implemented in learning environments inform young people about short and long-term health, and the economic and societal consequences of tobacco use

- There is evidence of success of targeted peer mentoring programmes in areas of greater need (PHE 2016)

- The Chief Medical Officer has called for an alcohol-free childhood up to the age of 15 because evidence suggests that there are no safe drinking limits for childhood

- Promoting prevention measures builds resilience among young people and improves awareness of alcohol harm and delay the age of first use (PHE 2014)

- A review of the effectiveness of school based interventions found evidence that some class room based programmes (life skills approach and skills-based activities) can reduce alcohol use in the medium-term and one produced long term reductions (greater than 3 years) in alcohol use (for further information refer to Bromley's Alcohol Misuse Needs Assessment 2014)

- Training for teachers to conduct age-appropriate participatory sexuality and HIV education can improve students' knowledge and skills

- Offering education about healthy, respectful relationships in schools means that the learning takes place in the context of the peer group, with the potential to learn together. There has been an increasing focus on the call for compulsory sex and relationship education in schools

- Very few young people develop dependency. Those who use drugs or alcohol problematically are likely to be vulnerable and experiencing a range of problems, of which substance misuse is one. This means that the commissioning and delivery of specialist drug and alcohol interventions for young people should take place within the wider children and young people's agenda. The aim is that all needs are met, rather than addressing substance misuse in isolation; and that intervention is successful before problematic use becomes entrenched

- There is evidence that programmes that aim to improve young children's self-control are effective for improving self-control and reducing problem

behaviours. A recent review of the evidence highlighted the success of the *'RisKit Intervention'. The success of the programme included* improvements in relationships, self-perception, discussion / articulation of feelings, emotional expression & anger management *('What works in enhancing social and emotional skills development during childhood and adolescence'2015)*

- Promoting good communication in families (through parenting programmes), feeling connected and having a sense of belonging reduces the chances of young people engaging in high risk behaviours

- Although it's known that risk behaviours in adolescent years are usually a normal part of development, the later the on-set of any risk behaviour the less likely it seems to have a long-term impact on health. It is known that risk behaviours tend to co-occur

- Implement interventions of proportionate universalism (Marmot 2008), as targeted interventions can result in stigmatisation and may increase the risk of 'reactive' risk behaviours (Jackson et al 2012)

Health support to Safeguarding function for children aged 5-18

- Evidenced based approach to safeguarding is set out in *"Best start in life and beyond: Improving public health outcomes for children, young people and families."* Public Health England, January 2016. It involves:
- working in partnership with other key stakeholders to help promote the welfare and safety of children and young people
- working collaboratively to support children and young people where there are identified health needs, or where they are in the child protection system, providing therapeutic public health interventions for the child and family, and referring children and families to specialist medical support, where appropriate
- deliver safeguarding policies and procedures as determined by the Safeguarding Children Board
- Working with the designated school safeguarding lead and local authority services, providing assessments and reports as required
- Contributing to multi-agency decision-making, assessments, planning and interventions, relating to children in need, children at risk of harm and Looked After Children. This includes providing Review Looked After Child health assessments (in accordance with Promoting the Health and Wellbeing of Looked After Children Statutory Guidance 2015) and reports in accordance with the local Safeguarding Children Board policies and procedures and national guidance such as Working Together to Safeguard Children (HM Government, 2015)
- where appropriate and the child or young person is known to the provider, senior team members attend child protection conferences or meetings when

they are the most appropriate health representative and there is a specific outcome to contribute towards

- working within inter-agency and single agency protocols, policies and procedures and in accordance with Working Together to Safeguard Children (HM Government, 2015)

This work identifies potential gaps with resource implications. These are summarised in the Appendix.

3. DESCRIPTION OF CURRENTLY COMMISSIONED SERVICES

3.1. Public Health Services

3.1.1 National Childhood Measurement Programme (NCMP)

3.1.2 Healthy Child Programme – Health Visiting Service, Family Nurse Partnership & School Nursing Service

3.1.3 Drug and Alcohol services for young people

3.1.4 Sexual health services for young people

3.1.1 National Childhood Measurement Programme (NCMP)

Contract value	**£120,746**
Type of contract	**Part of PH in CCG block contract**
Provider	**BHC**
End date of contract	**30th September 2017**

The NCMP measures the weight and height of children in Reception class (aged 4 to 5 years) and Year 6 (aged 10 to 11 years). This is a mandated programme for Public Health. The programme has two key purposes:

1. to provide robust public health surveillance data on child weight status, to understand obesity prevalence and trends at local and national levels, to inform obesity planning and commissioning and underpin the Public Health Outcomes Framework indicator on excess weight in 4-5 and 10-11 year olds

2. to provide parents with feedback on their child's weight status: to help them understand their child's health status, support and encourage behaviour change and provide a mechanism for direct engagement with families with overweight, underweight and obese children.

The Public Health Outcomes Framework (PHOF) indicators illustrate that obesity rates vary considerably across London. In 2015 in year 6 the range was from 10.5 per cent in Richmond upon Thames, to 27.8 per cent in Southwark. Bromley has one of the lowest childhood obesity rates of all London boroughs. However the prevalence of obesity is far more apparent in deprived wards in the borough. Household income data illustrates child obesity prevalence rises as household income falls, and is significantly higher in the lowest income group than in the highest. Childhood obesity is a significant health inequalities issue. The percentage of children in Bromley schools who are obese in their first year in primary school, doubles by the time they reach their final year in primary school. For example with the latest cohort, 7.3% were obese in Reception, this increased to 16.5% by the time these children were in Year 6. Currently over 20% of children in Reception and almost 31% in Year 6 are either overweight or obese, this equates to 1,774 children in one year from Bromley schools.

Table 1. NCMP data for overweight and obese children in Bromley

Year Group	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Reception: Overweight	12.3%	13.2%	12.9%	12.9%	13.1%	13%	12.2%
Reception: Obese	7.3%	8.2%	7.8%	7.4%	8%	8.3%	7.9%
Year 6: Overweight	15.5%	14.3%	14.5%	15.7%	14.9%	14.5%	14.3%
Year 6: Obese	16.0%	17.2%	16.4%	15.6%	17.1%	15.4%	16.5%

Weight management

Contract value	**£187,820**
Type of contract	**Part of PH in CCG block contract**
Provider	**BHC**
End date of contract	**31st March 2017**

There are currently two licensed evidenced-based healthy weight programmes for children and families in Bromley; HENRY and MEND.

HENRY (Health Exercise Nutrition for the Really Young)
The HENRY Programme plays a key role in preventing childhood obesity. There are two elements to Bromley's HENRY programme; training for health and community practitioners and 'Let's Get Healthy with HENRY' family programmes. Training is offered to health and community practitioners to enable them to work more effectively with parents of babies and pre-school children around healthy weight and lifestyle concerns. HENRY parenting courses are available to Bromley families and are delivered in the Children and Family Centres. This year the delivery of the programme will be trialled in one of the borough's larger Primary schools. Families participate in an eight week course supporting them to develop a healthier and more active lifestyle for the whole family.

MEND (Mind Exercise Nutrition Do It!)
This multi-component weight management programme provides support for the families of children aged 4-13 years identified through National Childhood Measurement Programme (NCMP) as being overweight and obese. It meets the NICE *'Managing overweight and obesity among children and young people: lifestyle weight management services'* (PH45) recommendations for children's Tier 2 weight management support; combining healthy eating/nutrition advice, physical activity and behaviour change. Ninety nine children and their families participated in Bromley programmes in 2015-16. Sixty four of these children and their families are defined as completers of the programme. Of those who did complete the programme, 86% maintained or decreased their BMI.

3.1.2 The Healthy Child Programme (HCP)

The Healthy Child Programme is a public health programme for children, young people and families, which focuses on early intervention and prevention. It offers a programme of screening tests, immunisations, developmental reviews, information and guidance on parenting and healthy choices. The HCP is core to the specifications the Health Visiting and School Nursing Service deliver to. It is universally available to all Bromley families and aims to ensure that every child gets the good start they need to lay the foundations of a healthy life.

The Healthy Child Programme aims to:

• Help parents develop and sustain a strong bond with children
• Encourage care that keeps children healthy and safe
• Protect children from serious disease, through screening and immunisation
• Reduce childhood obesity by promoting healthy eating and physical activity
• Identify issues early, so support can be provided in a timely manner
• Make sure children are prepared for and supported in education settings
• Identify and help children, young people and families with problems that might affect their chances later in life

Health Visiting Service

Contract value	**£3,454,000**
Type of contract	**Standard contract**
Provider	**BHC**
End date of contract	**30th[t] September 2017**

In 2015 the Government mandated certain elements of the Healthy Child Programme. This mandation was designed to support a smooth transfer to allow local authorities to provide universal services that give parents and their babies the best start in life. The mandated elements are the five universal health visitor assessments that form part of the '4-5-6 Model for Health Visiting'. This model offers a framework for health visiting teams to provide universal and non-stigmatising services to all families with children under 5 years of age. The model includes a four level service model (Community, Universal, Universal Plus and Universal Partnership Plus) and five mandated elements include;

- Antenatal health promoting visits
- New baby review
- 6-8 week assessment
- 1 year assessment
- 2 to 21/2 year review

Nationally six High Impact Areas were identified. The intention is for these areas to be prioritised and ensure resources are targeted appropriately, according to health need and to maximise health outcomes. They describe the areas where the 0-5 workforce can and should have a significant impact on health outcomes. The 6 High Impact Areas are:

1. Transition to parenthood and the early weeks

2. Maternal (perinatal) mental health
3. Breastfeeding
4. Healthy weight (healthy diet and being active)
5. Managing minor illnesses & reducing accidents
6. Health, wellbeing & development at 2 years & support to be 'ready for school' at 5 years

The Health Visiting Service is universally available to all families living in Bromley who have a child under the age of five years old. The remit includes the mandated checks but also includes a wide range of issues relating to the health and development of pre-school aged children. There is a strong focus on prevention, health promotion, early identification and early intervention. Through direct contact with all families, the service identifies and supports those who need additional support and targeted interventions, for example, parents who need support with their emotional or mental health The service works with families on positive parenting through motivational interviewing and evidence based approaches, and to support behaviour change leading to positive lifestyle choices.

The Health Visiting Service forms part of multi-agency teams that support families that have complex needs e.g. a child with special educational needs or disability, or where there are identified safeguarding concerns. The Health Visiting Service currently works in close partnership with LBB's Early Intervention Service to support families with additional needs, e.g. to participate in parenting programmes. There are plans to further integrate the services over the coming years to minimise duplication and to ensure early, appropriate and holistic support is offered to families most in need.

Health visitors provide health input to safeguarding processes for children aged 0-4 years (see section 3.3).

Family Nurse Partnership (FNP)

Contract value	**£180,000**
Type of contract	**Standard contract**
Provider	**BHC**
End date of contract	**30th September 2017**

FNP is a highly effective programme designed to mitigate the risks of young parenthood. The licensed structured programme, delivered by specially trained family nurses, went live in Bromley in September 2014. This intensive preventive programme for vulnerable first time young parents begins in early pregnancy and ends when the child reaches 24 months. This service is based on good evidence that intensive support to vulnerable families can have a significant impact on outcomes. By improving the attachment between the baby and the mother and supporting young mothers in their parenting role, many of the long term outcomes related to poor attachment can be reduced or avoided. These adverse outcomes include behaviour and mental health problems in the child, poor education outcomes and involvement of Children's Social Care. Bromley currently has two

Family Nurses (FNs) who provide support up to 50 vulnerable mothers. The Bromley FNP programme is moving its focus from mother's age to broader vulnerability factors such as being a care leaver or known to Children's Social Care. A recently published randomised controlled trial in the UK of FNP found evidence of better cognitive and language development in the baby, improved attachment between mother and baby, and fewer symptoms of depression in the mother. Locally, strong attachment between FNP babies and their young parents, with good levels of child development for those babies have been observed and ASQ's are evidencing good early child development outcomes.

School Nursing Service

Contract value	**£960,066**
Type of contract	**Part of PH in CCG block contract**
Provider	**BHC**
End date of contract	**31st March 2017**

LBB has been responsible for commissioning School Nursing services since April 2013. The current service mainly provides Tier 1 and 2 health interventions in community and education settings and has established relationships within primary and secondary care. This is a universal service, but most of the work is targeted work with children with medical conditions and children where there are safeguarding concerns. Schools within the borough work with over 48,000 school aged children within the state funded sector, which comprises Academies, maintained schools, a Pupil Referral Unit and 2 Further Education Colleges. The Community Nursing service commissioned by Bromley CCG, provides support to Bromley's Special Schools other thanThe Glebe which is covered by Bromley Healthcare's School Nursing Service, currently commissioned by Public Health.

The number of pupils in schools which School Nursing supports is increasing year on year. Targeted groups of children and young people who are a priority for the School Nursing service include Children Looked After, Children in Need, children with statements of Special Educational Need, young people known to the YOT, young carers, and children with long-standing illness.

School Nursing Services are a core part of the Healthy Child Programme (HCP) building on the support in the early years and sustaining this for school-aged children and young people to improve outcomes and reduce inequalities through targeted support.

Universal:

- **Screening**
  Vision screening is offered to all children in Reception Year in maintained schools and Academy schools.

- **Personal, Social & Health Education (PSHE)**
  PSHE support is mostly offered in the form of a whole day to year 9s focused on healthy relationships, sexual health and risk behavior. Also

talks on issues such as puberty or hand hygiene to Year 5 & 6 and secondary school groups

- **Healthy Schools Award Scheme**
  The service co-ordinates the Healthy Schools Award Scheme; working with schools to improve specific aspects of health & well-being in their school communities. Bromley has one of the highest number of awards of all London boroughs

Targeted

- **Safeguarding**
  See Section 3.3

- **Health Care Plans and training**
  Nurses ensure individualised Health Care Plan (add number here with School Nurse input) for children with complex health condition are written and updated. They provide support to the school support and staff training. In 2015-16 approximately 353 staff across the school system received training from the School Nursing Service to enable them to support access to education for children/ young people with medical needs. One to one teaching of school staff on a range of health issues is provided by the nurses e.g. buccal midazolam administration, gastrostomy feeds, EpiPen use

- **School management plans**
  The service works with schools to develop and maintain up to date management plans for common health conditions such as diabetes, asthma, epilepsy and allergies

- **One to one support for students**
  This is delivered mainly through drop-in sessions in a number of secondary schools across the borough. Students go and see the school nurse to discuss a range of issues e.g. stopping smoking, peer relationship issues, self-harm issues. The service often does an initial assessment with a young person and can then refer and/or signpost students to the relevant service that can provide on-going support

- **Specialist School Nursing support to specific groups**
  See section 3.3

3.1.3 Drug and alcohol services for young people

Contract value	**£1,600,000**
Type of contract	**Standard contract**
Provider	
End date of contract	**31st March 2018**

The aim is to commission an integrated, recovery oriented treatment service for people with alcohol and/or drug misuse to meet the following objectives.

- To reduce health and social harm related to substance misuse.
- To support individuals in achieving long-term abstinence or reduce individual's levels of substance misuse.
- Achieve harm reduction including reduction in anti-social behaviour, reduction in domestic violence and reduction in substance misuse related crime.
- Improvement in physical and mental health and well-being of people affected by substance misuse including a reduction in deaths related to substance misuse and a reduction in hospital admissions related to substance misuse, improvement in measurable mental health outcomes, reduction in blood-borne infections.
- Long-term abstinence as measured by successful completion of treatment and a reduction in relapse rate.

Young Persons Substance Misuse Service

The overarching aim of the service is to increase opportunities for identification of young people with substance misuse and prevention. The service provides an integrated pathway to substance misuse services ensuring young people are always supported and have swift access to a high quality, evidence-based, integrated specialist treatment system. The service works with a range of partners providing advice and information and signposting to young people and families, community members, professionals and community workers.

3.1.4 Sexual Health Services for young people

Contract value	**£1,112,983**
Types of contract	**Framework, standard and Part of PH in CCG block contract**
Provider	**BHC**
End date of contract	**31st September 2017**

Bromley commissions a range of community contraception services to reduce unintended pregnancies with a specific focus on reducing teenage (under 18) conception rate and controlling sexually transmitted infections (Chlamydia and HIV). These include contraception advice and methods such as long-acting reversible contraception (LARC), Emergency Hormonal contraception (EHC) and condom scheme along with a range of health education and advice for young people in local schools and colleges.

These services are:

Contract	Annual Value
Contraceptive and Reproductive Health Services	£719,562
Health Improvement Service that includes: - Sex Relationship Education (SRE) - Associated Training Programmes - Outreach Programmes - Condom Distribution Schemes	£227,812
HIV Community Nurse Specialist Service	£165,609
TOTAL	**£1,112,983**

Contraception and Reproductive Health Services provide all methods of contraception along with health promotion and advice for all age groups, including male clients, from a number of health clinics in the community.

There are three components to **Health Improvement Services** – Sex and Relationship Education (SRE), Outreach and Condom Distribution Schemes.

The local SRE programme (Your Choice Your Voice) is a universal programme and is delivered to year 9 pupils in schools in Bromley. The programme aims at empowering young people by building their knowledge, confidence and resilience to make the right decision about their sex and wellbeing. An associated training

programme is available to support professionals, parents and carers regarding SRE.

The two condom distribution schemes, one for young people and one for Men having sex with Men (MSM) and Black African/Caribbean Communities are effective and value for money programmes. They help to prevent unplanned pregnancies and transmissions of STIs. Outreach programmes that deliver health promotion and safe sex messages are designed to target those particularly hard to reach high risk population such as young people outside of school setting, gay men and Black African communities.

HIV Community Nurse Specialist Service is to support people newly diagnosed and those living with HIV in managing their conditions effectively. It aims at preventing late and very late HIV diagnosis. It also enables people affected by HIV to protect themselves from acquiring new STIs and avoiding onward transmission through regular screening and prevention interventions; to increase focus on self-management approaches and live independently. thereby reducing demand on costly health and social care.

3.2. Jointly commissioned services

3.2.1 Speech and Language Therapy

Contract value	**£1,451,000**
Type of contract	**LA & CCG contracts (see below)**
Provider	**BHC**
End date of contract	**30th September 2017**

Introduction
A large number of children and young people with speech, language and communication needs (SLCN) will not need specialist intervention but those that do need quick and efficient access to the appropriate expertise.

The benefits of early identification and intervention are widely recognised. It is particularly important that in the early years there is no delay in making provision as identifying needs at the earliest point and making effective provision is acknowledged to improve long term outcomes for children. A key challenge is therefore to ensure that all children and young people who have SLCN are identified and able to access appropriate therapy provision as early as possible.

Estimates suggest that around 10% of all children may have long-term and persistent SLCN, and 7% of children and young people have significant speech and language impairment likely to need special or targeted interventions at some stage in their development.

Table 1: Bromley's Projection of need based on prevalence estimate of 7%

Age	2015	2020	2025
0 - 4 years	1470	1421	1407
5 – 10 years	1701	1771	1729
11 – 18 years	2030	2100	2317

SEN local authority data notes that 27.3% of Bromley primary school pupils with an SEN have SLCN listed as their primary need.

- Special schools - 5.1%
- Primary schools - 27.3%
- Secondary schools - 13.3%

SLCN is also most often identified as a need for children & young people with ASD. 649 children in Bromley have ASD listed as their primary SEN need. However, this only reflects those with ASD as a *primary* need. Many children will have another primary need listed, such as specific learning difficulty or moderate learning difficulty, but will also have an ASD diagnosis, meaning the true figure will be much higher than 649. SLCN is extremely high among Bromley pupils.

Current Spend

Agency	Annual spend	
CCG	£1.148m	
LBB	£303,000 (within CCG block contract since September 2015)	
LBB	School place funding (increased)	
LBB	Funding out of borough school placements awarded by Tribunals	
Schools	A number of schools have commissioned Service Level Agreements (SLAs) with BHC or independent providers funded from the schools own resources	

Current Provision

Bromley Healthcare (BHC) is commissioned by Bromley CCG within the terms of the CCG Community Contract to provide the SLT service. BHC undertakes the majority of assessments for Bromley's children and young people, to identify the level of need and determine whether that need can be met, or partially met, within existing resources.

Bromley has seen an increase in demand for speech and language services meaning that the current commissioned resource cannot meet demand.

Similar pressures are also seen in the Occupational Therapy (OT) service.

Key Pressures

- The number of new pre school aged referrals has doubled since 2011.
- SLT staff recruitment issues across the UK.
- Schools need to consider and understand models that enable effective and cost efficient allocation of resources to support SLCN, including specialists within the classroom, effective training and professional development, targeted interventions and direct specialist support

3.2.2. Overnight residential short breaks (respite) provision

Contract value	**£1,419,305**
Type of contract	**CCG block contract**
Provider	**BHC**
End date of contract	**30th September 2017**

Introduction
Hollybank is an overnight residential short break provision for disabled children and young people which is jointly funded by Bromley Clinical Commissioning Group (BCCG) and London Borough of Bromley. The current OFSTED rating is 'good' in every category (November 2015).

The service purpose is to offer regular planned overnight short breaks with the highest standard of care for children and young people with multiple disabilities, including behaviours that challenge associated with a disability, and complex health care needs, working in partnership with their families and other carers, helping to maintain the disabled child or young person within their family whilst the child enjoys the short break experience

Sevice Users
There are currently 57 service users. The average number of nights per service user is 2.13 per child. The breakdown of primary needs of these children & young people is:-

Autistic Spectrum Disorder	Global Developmental Delay	Physical Disability	Learning Disability	Complex Health Needs
34	**4**	**6**	**7**	**6**

'**High need' service users**
Some service users have exceptionally high needs, most typically in terms of managing their challenging behaviour or managing their complex medial regime and therefore require an exceptional staffing ratio in order to ensure their own safety and the safety of other children and staff. Typically, these children/young people present with a primary diagnosis of Autistic Spectrum Disorder (ASD). Currently 65% of all service users are regarded as 'high need'. This percentage has increased over time.

KEY ISSUES

Value for Money
There is currently more capacity than demand, and the unit costs are higher than the London average, particularly when the provider's 'double occupancy' model is taken into account. The cost per bed per night is £445.67

OFSTED Registration
The current terms of registration restrict the maximum number of nights to 75 per annum. The borough has limited ‘step up’ provision beyond 6 nights per month and therefore has to typically resort to longer term out of borough placements, i.e. weekly residential as a minimum, as the step up.

Children attending out of borough boarding school placements
The local authority’s most recent policy directive is to offer a local education placement to pupils with SEN rather than a day/residential out of borough placement wherever possible. LBB’s recent school place planning report for SEND highlights the growing needs for specialist education places. This will inevitably require the provision of Short Breaks for some of those pupils in order to support their social care and health needs, and to support their families to maintain an in borough day school placement. This supports a view that an overnight residential short break provision will continue to be required, demand for which may increase.

4. STATUTORY AND LEGAL RESPONSIBILITIES

Agency		Legal responsibilities	Legal responsibilities	Statutory guidance
CCG		Children Act 1989: Section 10 & 11 Children Act 2004 Equality Act 2010	Children & Families Act 2014 Health and Social Care Act 2012 NHS Act 2006	Working Together to Safeguard Children, 2015
LBB	**Child social care**		Children & Families Act 2014 Health and Social Care Act 2012	
	Public Health		Children & Families Act 2014 Health and Social Care Act 2012	
	Education		Children & Families Act 2014 Education Act 2002: *Section 175*	Section 100 of the Children and Families Act 2014

Children & Families Act 2014

The Children & Families Act 2014 requires education, health and social care to work jointly and collaboratively to commission support for children & young people with SEND.

NHS Act 2006, 2014 Mandate and 2014 NHS Outcomes determine that CCGs are responsible for commissioning services to meet health needs.

Health and Social Care Act 2012

It was the Health and Social Care Act that effected the transfer of responsibility from the NHS to Local Authorities. This Act also specifies that services are prescribed by the Secretary of State which is generally done through subsequent statutory guidance and strategies.

Part 2, Section 17 of the Act outlines the transfer of NCMP and School Nursing to local authorities. Section 22 outlines Immunisation and screening plans, for

which Public Health have overview responsibilities and some of these functions are carried out by Public Health nurses.

Part 5, Section 195 of the Act outlines the duty for integrated working between the NHS, Public Health and social care

The Act is also the basis for the ring-fenced Public Health Grant to Local Authorities to meet the responsibilities under this Act.

Children's Act 1989

The Local Authority has the responsibility to "safeguard and promote the welfare of children within their area who are in need and so far as is consistent with that duty, to promote the upbringing of such children by their families by providing a range and level of services appropriate to those children's needs".

Children Act 2004

Section 10. Local Authorities have a duty to promote cooperation between relevant partners such as governing bodies of maintained schools, proprietors of academies, clinical commissioning groups and NHS England, with a view to improving the well-being of children so far as relating to their physical and mental health, and their education, training and recreation. The arrangements are also to include protection from harm and neglect.

Section 11 places duties on a range of organisations and individuals to make arrangements for ensuring that their functions, and any services that they contract out to others, are discharged with regard to the need to safeguard and promote the welfare of children.

Education Acts

Education Act 2002: *Section 175* places a duty on:

a) local authorities in relation to their education functions; and

b) the governing bodies of maintained schools and the governing bodies of further education institutions (which include sixth-form colleges) in relation to their functions relating to the conduct of the school or the institution.

to make arrangements for ensuring that such functions are exercised with a view to safeguarding and promoting the welfare of children (in the case of the school or institution, being those children who are either pupils at the school or who are students under 18 years of age attending the further education institution).

A similar duty applies to proprietors of independent schools (which include academies/free schools) by virtue of regulations made under ***sections 94(1) and (2)*** of the **Education and Skills Act 2008**. Regulations made under ***Section 342*** of the **Education Act 1996**, set out the requirements for a non-maintained special school to be approved and continue to be approved by the Secretary of State.

Equality Act 2010
This Act puts a responsibility on public authorities to have due regard to the need to eliminate discrimination and promote equality of opportunity. This applies to the process of identification of need and risk faced by the individual child and the process of assessment. No child or group of children must be treated any less favourably than others in being able to access effective services which meet their particular needs.

The council should always consider its 3 duties in section 149 and they apply to people with protected characteristics and their relationship with the other groups and generally. Age is a protected characteristic.

The United Nations Convention on the Rights of the Child (UNCRC).
This is an international agreement that protects the rights of children and provides a child-centred framework for the development of services to children. The UK Government ratified the UNCRC in 1991 and, by doing so, recognises children's rights to expression and receiving information.

Safeguarding
The legislation relevant to safeguarding and promoting the welfare of children is set out above and summarised in the following table.

Table 1: Bodies covered by key safeguarding duties

Body	**CA 2004 Section 10 - duty to cooperate**	**CA 2004 Section 11 - duty to safeguard & promote welfare**	**Education Legislation - duty to safeguard & promote welfare**	**Commissioning Implications**
Local authorities	Duty to promote cooperation under Section 10 of the Children Act 2004	Ensure their functions and those they commission safeguard children	X In relation to their education functions under section 175 of the Education Act 2002	
Clinical commissioning groups	Reciprocal duty to cooperate under Section 10 of the Children Act 2004		X	
Maintained schools	Reciprocal duty to cooperate under Section 10 of the		X under section 175 of the Education Act 2002 (maintained schools) & via regulations made under section 342 of the	

	Children Act 2004		Education Act 1996 (nonmaintained special schools)	
FE colleges	X		X under section 175 of the Education Act 2002	
Independent schools	X		X Via regulations made under sections 94(1) and (2) of the Education and Skills Act 2008	
Academies and free schools	Reciprocal duty to cooperate under Section 10 of the Children Act 2004		X Via regulations made under sections 94(1) and (2) of the Education and Skills Act 2008	

Statutory Guidance

Working Together to Safeguard Children (WTSC) was updated in 2015. This document outlines the responsibilities of local agencies with regard to safeguarding. Both Health Visitors and School Nurses have a key role in safeguarding as universal services.

The role of Health Visitors is particularly crucial as they conduct the universal reviews in the 0-5 year olds:

"Local agencies should have in place effective ways to identify emerging problems and potential unmet needs for individual children and families. This requires all professionals, including those in universal services and those providing services to adults with children, to understand their role in identifying emerging problems and to share information with other professionals to support early identification and assessment."

"Professionals working in universal services have a responsibility to identify the symptoms and triggers of abuse and neglect, to share that information and work together to provide children and young people with the help they need."

"The early help assessment should be undertaken by a lead professional who should provide support to the child and family, act as an advocate on their behalf and coordinate the delivery of support services. The lead professional role could be undertaken by a General Practitioner (GP), family support worker, teacher, health visitor and/or special educational needs coordinator."

Both Health Visitors and School Nurses have responsibility to assist with identified health issues:

"Local areas should have a range of effective, evidence-based services in place to address assessed needs early. The early help on offer should draw upon the local assessment of need and the latest evidence of the effectiveness of early help and early intervention programmes. In addition to high quality support in universal services, specific local early help services will typically include family and parenting programmes, assistance with health issues and help for problems relating to drugs, alcohol and domestic violence."

Supporting pupils at school with medical conditions (2014).

Statutory guidance under Section 100 of the Children and Families Act 2014.

1. This places a duty on governing bodies of maintained schools, proprietors of academies and management committees of PRUs to make arrangements for supporting pupils at their school with medical conditions.

2. This places a duty on local authorities to be ready to make arrangements when it is clear that a child will be away from schools for 15 days or more because of health needs (whether consecutive or cumulative across the school year).

Non-statutory guidance under Section 100 of the Children and Families Act 2014.

1. School nurses are responsible for notifying the school when a child has been identified as having a medical condition which will require support in school. Wherever possible, they should do this before the child starts at the school. They would not usually have an extensive role in ensuring that schools are taking appropriate steps to support children with medical conditions, but may support staff on implementing a child's individual healthcare plan and provide advice and liaison, for example on training. School nurses can liaise with lead clinicians locally on appropriate support for the child and associated staff training needs – for example there are good models of local specialist nursing teams offering training to local school staff, hosted by a local school. Community nursing teams will also be a valuable potential resource for a school seeking advice and support in relation to children with a medical condition.

2. Other healthcare professionals, including GPs and paediatricians - should notify the school nurse when a child has been identified as having a medical condition that will require support at school. They may provide advice on developing healthcare plans. Specialist local health teams may be able to provide support in schools for children with particular conditions (eg asthma, diabetes).

3. Local authorities:

- should provide support, advice and guidance, including suitable training for school staff, to ensure that the support specified within individual healthcare plans can be delivered effectively.
- should work with schools to support pupils with medical conditions to attend full time. Where pupils would not receive a suitable education in a mainstream school

because of their health needs, the local authority has a duty to make other arrangements.

4. Providers of health services - should co-operate with schools that are supporting children with a medical condition, including appropriate communication, liaison with school nurses and other healthcare professionals such as specialist and children's community nurses, as well as participation in locally developed outreach and training. Health services can provide valuable support, information, advice and guidance to schools, and their staff, to support children with medical conditions at school.

5. Clinical commissioning groups (CCGs) – commission other healthcare professionals such as specialist nurses. They should ensure that commissioning is responsive to children's needs, and that health services are able to co-operate with schools supporting children with medical conditions. They have a reciprocal duty to cooperate under Section 10 of the Children Act 2004 (as described above for local authorities). Clinical commissioning groups should be responsive to local authorities and schools seeking to strengthen links between health services and schools, and consider how to encourage health services in providing support and advice, (and can help with any potential issues or obstacles in relation to this). The local Health and Wellbeing Board will also provide a forum for local authorities and CCGs to consider with other partners, including locally elected representatives, how to strengthen links between education, health and care settings.

Statutory Duties relating to Short Breaks

The Children and Families Act 2014 requires education, health and social care to work jointly and collaboratively to commission support for children and young people with SEND.

Childrens Act 1989 requires that local authorities provide breaks from caring for carers of disabled children to support them to care for their children at home and to allow them to do so more effectively, and Short Breaks for Carers of Disabled Children 2011 details the 1989 responsibilities more specifically.

NHS Act 2006, 2014 NHS Mandate and 2014 NHS Outcomes determine that CCGs are responsible for commissioning services to meet health needs

The legislation specifically imposes a duty on local authorities to provide short breaks. This duty is not imposed on CCGs.

Joint commissioning agreements must set out:-

- The Education, Health and Social Care provision reasonably required by local children and young people with SEND aged 0 – 25, both with and without EHC plans. This should draw upon local information and data.
- How this provision will be secured and by whom
- What advice and information about Education, Health and Social Care provision is available, and who is responsible for providing advice

- How children and young people with SEND are identified

Health and Education need to work together to design and commission needs-led services that consider universal, targeted and specialist approaches to improve children and young people's communication skills.

For school-aged children, speech and language therapy (SLT) is largely considered to be part of special educational needs provision, rather than a health provision, which places a duty on the local authority to take a lead in providing the service.

Statutory Duties relating to Speech and Language therapy

The Children & Families Act 2014 requires education, health and social care to work jointly and collaboratively to commission support for children & young people with SEND.

It states that 'speech and language therapy and other therapy provision can be regarded as either education or health care provision, or both. It could therefore be included in the EHC Plan as education or health provision. However, since communication is so fundamental in education, addressing speech and language impairment should normally be recorded as special educational provision unless there are exceptional reasons for not doing so. In cases where health care provision or social care provision is to be treated as educational provision, ultimate responsibility for ensuring that the provision is made rests with the local authority'

NHS Act 2206, 2014 Mandate and 2014 NHS Outcomes determine that CCGs are responsible for commissioning services to meet health needs.

Statutory guidance relating to the health of Looked After Children

The statutory guidance, *Promoting the health and well-being of looked after children (March 2015)* and The Intercollegiate Framework 'Looked after Children; knowledge, skills and competencies of healthcare staff' (2015) details how looked after children should be supported by competent healthcare professionals to support LAC to fulfil their potential. Evidence highlights that where looked after children have access to specialist health practitioners their health outcomes improved (Mooney et al).

The initial LAC health assessment must be undertaken by a registered medical practitioner. The statutory guidance, *Promoting the health and well-being of looked after children (March 2015)* states that this practitioner should have skills in assessing development, emotional and behavioural difficulties, and the ability to recognise underlying conditions such as foetal alcohol syndrome. It is therefore best practice that this initial health assessment is conducted by a paediatrician. The review health assessments may be carried out by a registered nurse or registered midwife. A specialist nurse with associated skills and competencies should carry out these LAC reviews.

The Statutory Guidance 2015 states that there should be a named/lead health professional for each child in care who can work as a key contact point for the child and link between health professionals, social worker and carer. Addressing the identified health needs of LAC, including input from local CAMHS services for LAC placed out of Borough, is also one of the key areas that the Statutory and NICE Guidance recommends.

5. RECOMMENDATIONS

This document summarises the information on need, evidence of effectiveness, current services and legal and statutory framework around the health of children and young people.

This document is intended to support the commissioning of health services for children and young people in Bromley from October 2017.

Appendix. Child Wellbeing Needs Assessment: Key Findings

Key finding	Commissioned service	Potential gap	Recommendation	Cost
Demography				
The greatest population growth 2015 to 2025 will be in secondary school age children.				
The North-West of Bromley has the highest proportion of ethnic minority population and the North-East of the borough has the highest proportion of Gypsy Travellers (GT), in particular the wards of Cray Valley East and West. This may be linked to higher prevalence of long term illness	Targeted services to GT are already in place within maternity and HV services	Targeted services to GT for children aged 5-19	Schools Partnership Board (SPB) to take forward targeted education. Strategic School Health team (SSHT) to include expertise in GT health issues	tbc 0.1WTE Band 7
Section A				
Mental health issues in parents in Bromley is at least as common as national rates	Wellbeing Service for adults	? accessible to most vulnerable	Ensure accessible to most vulnerable. Audit wellbeing service use	None
Illness and disability of parents is of concern, especially in areas of higher deprivation	EIFS service targeted in these areas	? accessible to most vulnerable	EIFS already monitor access by deprivation indicators. Review with Public Health could determine possible additional indicators	None
Smoking in pregnancy is more common in Bromley than in London, and is particularly high in pregnant young people under the age of 20 and pregnant women in routine and manual occupations	Smoking Cessation service commissioned by Public Health	Service de-commissioned from April 2017	Staff training in smoking cessation advice and Skilled Motivational Interviewing in all services working with young people. To be delivered to current staff and added to all future service specifications	Training costs for current staff
Recorded drug and alcohol misuse in Bromley is below the national average. However the proportion of pregnant women in substance misuse services and hospital admissions for substance misuse are both higher than national and London averages.	Drug and Alcohol service commissioned by Public Health		These should be reviewed after an update of the data in 2016 by service provider and Public Health.	None
Domestic violence is recorded more frequently in Cray Valley wards and Mottingham and Chislehurst North	DVA work led by LBB	?Schools engaged fully in DVA work	?Role of SSHT in linking schools to LBB-led work	

Key finding	Commissioned service	Potential gap	Recommendation	Cost
Homelessness of families with children is higher than national rates. There are increasing numbers of households with children residing in temporary accommodation and outside Bromley	Housing work led by LBB, with health implications being reviewed in partnership with PH	tbc	tbc	tbc
Families affected by unemployment, housing and financial difficulties and require support are more likely to live in the Crays, Mottingham or Penge	EIFS service targeted to these areas			None
Teenage pregnancy rates are reducing significantly, although still more frequent in areas of higher deprivation. Late booking for antenatal care in pregnant teenagers is of concern.	Sexual health services commissioned by Public Health	SRE service de-commissioned from April 2017	Strategic School Health team (SSHT) to support schools to deliver SRE, including promoting access to maternity services	0.2WTE Band 5
Section B				
The distribution of children with Special Educational Needs across the borough is higher in some wards, notably the Cray Valley wards, Bromley Common and Keston, Orpington, and Plaistow and Sundridge.	SEND services commissioned by LBB and Bromley CCG			
Smoking rates in young people in Bromley are higher than London and national rates.	See section A			
Young people between 15 and 24 years old continue to have the highest rates of new STIs. Males of all ages are more affected by new STIs than females	Sexual health services commissioned by Public Health			
Of the 90 young people in treatment in Bromley in 2014-15, 70% were using two or more substances (this may include alcohol) and 97% began using their main problem substance before the age of 15 years	Drug and Alcohol service commissioned by Public Health		This work will be led by service provider and Public Health	None
Nearly a third of children in Year 6 in Bromley are either overweight or obese. Pupils obese in reception year were more likely to remain obese at year 6 in Crystal Palace, Mottingham and Chislehurst North, Cray Valley East and Cray Valley West	Weight Management services and Healthy Schools Scheme are commissioned by Public Health	Both services to be de-commissioned from April 2017	Strategic School Health team (SSHT) should include support for the Healthy Schools Scheme and for PSHE in schools	0.2WTE Band 5 nurse
Some wards have a higher proportion of children living in families who are receiving support: Biggin Hill, Cray	EIFS service targeted to these areas		SSHT to support EIFS with specialist health expertise as	0.1WTE

Key finding	Commissioned service	Potential gap	Recommendation	Cost
Valley West, Plaistow and Sundridge, and Mottingham and Chislehurst North			required	Band 7
Community and hospital services indicate that young people in Bromley have a high level of need for support around self harming behaviour. A brief survey of emotional health concerns in secondary schools in Bromley in 2015 confirms this	Wellbeing Service for CYP commissioned by LBB. School CAMHS support pilot commissioned by Bromley CCG.		Transformation Plan led by CCG is key vehicle for this work. SSHT to link closely with this work and schools to ensure optimal support	
A quarter of young people in contact with the YOS have health needs	School Nurse service commissioned by Public Health	SN service de-commissioned from April 2017	SSHT to support this role	0.4WTE Band 7
The number of exclusions of primary school pupils is very high	EWO		Schools Partnership Board (SPB) to take forward. SSHT to support this work	0.1WTE Band 8a
There is no data on LGBT in young people in Bromley, although this is a known risk factor for several adverse outcomes in this age group			SSHT to support schools in collecting this data	
Vulnerability and safeguarding concerns in EHE children and young people may not be identified. This is of particular concern for young people who may be EHE for longer periods of time	EWO		SSHT to support the EWO EHE team with expert advice and some outreach to families of concern	0.1WTE Band 7
There appears to be significant under-reporting or lack of identification of CSE in Bromley, particularly by health services	Health services commissioned by LBB and CCG		Vulnerable Children Panel to take forward supported by SSHT.	0.2WTE Band 7
Section C				
At least 200 children and young people with complex health needs but no EHC Plan or Statement require support to attend school, and this number is increasing. . A total of 600 children and young people in Bromley schools require some nursing support to access school.	CCG commission health services.	Support to schools to enable access to school, including training	SSHT to support this role with: 1. Specialist advice and support to schools 2. Overview of health needs in schools to inform CCG commissioning 3. Training to schools	0.9WTE Band 8a 0.6WTE Band 7 1.0WTE Band 5
Compared to similar areas there are higher rates in				

Key finding	Commissioned service	Potential gap	Recommendation	Cost
Bromley of children with speech, language and communication needs, children with severe, profound and multiple learning difficulties, and pupils on the autistic spectrum. Pupils with behavioural, emotional or mental health needs are more likely to attend independent schools				
Exclusions from school and persistent absence of Bromley LAC are higher than statistical neighbours, London and England.	See Section B		Schools Partnership Board (SPB) to take forward. SSHT to support this work	
The proportion of LAC who are Not in Education, Employment or Training is also higher than comparators. This may be due in part to the relatively high rates of LAC with Special Educational Needs in Bromley			Schools Partnership Board (SPB) to take forward. SSHT to support this work	
The proportion of LAC who have been convicted or subject to a final warning or reprimand during 2014 was also higher than comparators, although the numbers are small	LAC Nurses commissioned by Bromley CCG		SSHT to work closely with LAC nurses	
The predicted increase in the number of UASC will require support from health as well as social care agencies	CCG commission health services		SSHT to work closely with LAC nurses	
Initial contacts to assessments by children's social care services have begun to level off and in the case of referrals decrease significantly based on levels prior to 2011. This is likely to be due to the success of the targeted approach of the MASH service	Safeguarding is function of School Nursing service	SN service de-commissioned from April 2017. No health input to safeguarding function for CYP 5-19 yrs	Working group CCG and LBB to agree health input to safeguarding function for 5-19 year olds	1.5 WTE Band 7