CITY OF YORK COUNCIL

Notice of a public meeting of

Health and Wellbeing Board

To: Councillors Runciman (Chair), Ramsay (Vice-Chair), Brooks, Cannon and Craghill,

Sharon Stoltz	Director of Public Health, City of York Council
Martin Farran	Corporate Director- Health Housing and Adult Social Care, City of York Council
Jon Stonehouse	Corporate Director-Children, Education and Communities, City of York Council
Tim Madgwick	Deputy Chief Constable, North Yorkshire Police
Sarah Armstrong	Chief Executive, York CVS
Siân Balsom	Manager, Healthwatch York
Julie Warren	Locality Director (North), NHS England
Colin Martin	Tees, Esk and Wear Valleys NHS Foundation Trust
Patrick Crowley	Chief Executive, York Teaching Hospital NHS Foundation Trust
Phil Mettam	Accountable Officer, NHS Vale of York Clinical Commissioning Group (CCG)
Rachel Potts	Chief Operating Officer, NHS Vale of York Clinical Commissioning Group (CCG)
Mike Padgham	Chair of Independent Care Group

Date: Wednesday, 23 November 2016

Time: 4.30 pm

Venue: The Snow Room - Ground Floor, West Offices (G035)

A G E N D A

1. Declarations of Interest (Pages 3 - 4)

At this point in the meeting, Board Members are asked to declare:

- any personal interests not included on the Register of Interests
- any prejudicial interests or
- any disclosable pecuniary interests

which they may have in respect of business on this agenda. A list of general personal interests previously declared is attached.

2. Minutes (Pages 5 - 14)

To approve and sign the minutes of the last meeting of the Health and Wellbeing Board held on 7 September 2016.

3. Public Participation

It is at this point in the meeting that members of the public who have registered their wish to speak can do so. The deadline for registering is **Tuesday 22 November 2016** at **5.00 pm.**

To register please contact the Democracy Officer for the meeting, on the details at the foot of this agenda.

Filming, Recording or Webcasting Meetings

Please note this meeting will be filmed and webcast and that includes any registered public speakers, who have given their permission. This broadcast can be viewed at http://www.york.gov.uk/webcasts.

Residents are welcome to photograph, film or record Councillors and Officers at all meetings open to the press and public. This includes the use of social media reporting, i.e. tweeting. Anyone wishing to film, record or take photos at any public meeting should contact the Democracy Officer (whose contact details are at the foot of this agenda) in advance of the meeting.

The Council's protocol on Webcasting, Filming & Recording of Meetings ensures that these practices are carried out in a manner both respectful to the conduct of the meeting and all those present. It can be viewed at: http://www.york.gov.uk/download/downloads/id/11406/protocol_for_webcasting_filming_and_recording_of_council_meetings_20160809.pdf

Themed Meeting- Children and Young People

4. City of York Safeguarding Children Board Annual Report 2015/16 and Safeguarding Update (Pages 15 - 192)

The purpose of this report is to present the City of York Safeguarding Children Board Annual Report 2015/16 and provide an update on key issues between April and October 2016 as agreed in the protocol with the Health and Wellbeing Board (HWBB).

5. "Everybody's Business Conference"-One Year On (Pages 193 - 200)

This report was requested to inform the Board of progress made since the report to the Board in March 2016 that summarised the feedback received at the "Everybody's Business" conference on Young People's mental health on 25th November 2015.

Other Business

6. Strengthening Safeguarding Arrangements through an Inter Board Protocol (Pages 201 - 218)

Over recent months work has taken place to produce an inter board protocol to strengthen safeguarding arrangements. The final version is at Annex A to this report and the Health and Wellbeing Board are asked to sign up to these working arrangements.

7. **Update on Suicide Prevention: City of York Suicide Audit - a review of deaths by suicide within the City of York between 2010 and 2014** (Pages 219 - 292)
The purpose of this report is to present the results of the audit of deaths by suicide as recorded by the York Coroner Service during 2010-2014. The audit was conducted in order to better understand suicide in York and to help inform the development of a local suicide prevention action plan which will support the aspiration for York to become a Suicide-Safer Community.

8. **Health Protection Assurance** (Pages 293 - 300)
The report describes the health protection responsibilities for local authorities which came into force on 1 April 2013, including local arrangements for delivery and assurance of the local response to the revised regulations.

9. **Progress report from the Integration and Transformation Board** (Pages 301 - 354)
This report gives an update on the work of the Integration and Transformation Board since the last meeting of the Health and Wellbeing Board and also provides a routine update on the progress of the Better Care Fund.

10. **Update on Mental Health Facilities for York** (Pages 355 - 360)
This report updates the Health and Wellbeing Board on the Mental Health Facilities for York.

11. **Healthwatch York Reports** (Pages 361 - 408)
This report asks Health and Wellbeing Board (HWBB) members to receive two new reports from Healthwatch York;
    - Antenatal and Postnatal Services in York (Annex A)
    - Closure of Archways: Changes to Intermediate Care Services in York (Annex B)

12. **Bootham Park Hospital Scrutiny Review Final Report** (Pages 409 - 412)
This report presents the Health and Wellbeing Board (HWBB) with the final report of the Bootham Park Hospital Scrutiny Review and information around actions taken to restore full mental health services to York.

A copy of the full report and its associated annexes is available online along with the minutes from when it was considered by the Health & Adult Social Care Policy & Scrutiny Committee in September 2016.

13. Forward Plan (Pages 413 - 418)
To consider the Board's Forward Plan.

14. Urgent Business
Any other business which the Chair considers urgent under the Local Government Act 1972.

Democracy Officer:

Name- Judith Betts
Telephone No. – 01904 551078
E-mail- judith.betts@york.gov.uk

For more information about any of the following please contact the Democracy Officer responsible for servicing this meeting:

- Registering to speak
- Business of the meeting
- Any special arrangements
- Copies of reports and
- For receiving reports in other formats

Contact details are set out above.

This information can be provided in your own language.

我們也用您們的語言提供這個信息 **(Cantonese)**

এই তথ্য আপনার নিজের ভাষায় দেয়া যেতে পারে। **(Bengali)**

Ta informacja może być dostarczona w twoim własnym języku. **(Polish)**

Bu bilgiyi kendi dilinizde almanız mümkündür. **(Turkish)**

یہ معلومات آپ کی اپنی زبان (بولی) میں بھی مہیا کی جاسکتی ہیں۔ **(Urdu)**

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Agenda Annex

Extract from the
Terms of Reference of the Health and Wellbeing Board

Remit

York Health and Wellbeing Board will:

- Provide joint leadership across the city to create a more effective and efficient health and wellbeing system through integrated working and joint commissioning;
- Take responsibility for the quality of all commissioning arrangements;
- Work effectively with and through partnership bodies, with clear lines of accountability and communication;
- Share expertise and intelligence and use this synergy to provide creative solutions to complex issues;
- Agree the strategic health and wellbeing priorities for the city, as a Board and with NHS Vale of York Clinical Commissioning Group, respecting the fact that this Group covers a wider geographic area;
- Collaborate as appropriate with the Health and Wellbeing Boards for North Yorkshire and the East Riding;
- Make a positive difference, improving the outcomes for all our communities and those who use our services.

York Health and Wellbeing Board will not:

- Manage work programmes or oversee specific pieces of work – acknowledging that operational management needs to be given the freedom to manage.
- Be focused on the delivery of specific health and wellbeing services – the Board will concentrate on the “big picture”.
- Scrutinise the detailed performance of services or working groups – respecting the distinct role of the Health Overview and Scrutiny Committee.
- Take responsibility for the outputs and outcomes of specific services – these are best monitored at the level of the specific organisations responsible for them.
- Be the main vehicle for patient voice – this will be the responsibility of Health Watch. The Board will however regularly listen to and respect the views of residents, both individuals and communities.

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Health & Wellbeing Board
Declarations of Interest

Patrick Crowley, Chief Executive of York Hospital
None to declare

Rachel Potts, Chief Operating Officer, Vale of York Clinical Commissioning Group
None to declare

Mike Padgham, Chair Council of Independent Care Group
- Managing Director of St Cecilia's Care Services Ltd.
- Chair of Independent Care Group
- Chair of United Kingdom Home Care Association
- Commercial Director of Spirit Care Ltd.
- Director of Care Comm LLP

Siân Balsom, Manager Healthwatch York

- Chair of Scarborough and Ryedale Carer's Resource
- Shareholder in the Golden Ball Community Co-operative Pub

Councillor Douglas

- Member of Mental Health and Learning Disabilities Partnership Board
- Governor of Leeds and York Partnership NHS Foundation Trust
- Governor of Tees, Esk and Wear Valleys NHS Foundation Trust

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Agenda Item 2

City of York Council — Committee Minutes

Meeting	Health and Wellbeing Board
Date	7 September 2016
Present	Councillors Runciman (Chair), Brooks, Cannon and Craghill,

Sharon Stoltz, (Director of Public Health-CYC)

Martin Farran, (Director of Adult Social Care, CYC)

Jon Stonehouse, (Director of Children's Services, Education and Skills-CYC)

Rachel Potts, (Chief Operating Officer, NHS Vale of York Clinical Commissioning Group)

Julie Warren, (Locality Director (North) NHS England),

Jane Hustwit (Chair of Trustees, York CVS) (Substitute for Sarah Armstrong),

Mike Proctor (Deputy Chief Executive, York Teaching Hospital NHS Foundation Trust) (Substitute for Patrick Crowley),

Ruth Hill (Director for Operations, York and Selby, Tees, Esk and Wear Valleys NHS Foundation Trust) (Substitute for Colin Martin),

Keren Wilson (Chief Executive, Independent Care Group) (Substitute for Mike Padgham)

Inspector Bill Scott (North Yorkshire Police)(non affirmed substitute for Tim Madgwick)

Apologies	Keith Ramsay (Lay Chair of NHS Vale of York Clinical Commissioning Group) and Siân Balsom (Manager, Healthwatch York)

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16. Declarations of Interest

Board Members were invited to declare any personal, prejudicial or disclosable pecuniary interests, other than their standing interests, that they had in relation to the business on the agenda.

Inspector Bill Scott declared a personal interest in the remit of the Board as a member of Tees, Esk and Wear Valleys NHS Foundation Trust and the Mental Health and Learning Disabilities Partnership Board.

The Chair noted that although Inspector Bill Scott was not an appointed substitute for Tim Madgwick, she would grant him temporary speaking rights for the meeting.

No other interests were declared.

17. Minutes

Discussion took place about whether any action had been taken following the Board's suggestion of removing the word 'co-production' from all Sustainability and Transformation Plans (STP) documents. It was noted that this reference reflected a wider relevance on the process of public engagement and transformation at a local level.

Resolved: That the minutes of the Health and Wellbeing Board held on 20 July 2016 be approved as a correct record and then signed by the Chair.

18. Public Participation

It was reported that there had been no registrations to speak at the meeting under the Council's Public Participation Scheme.

19. Appointments to York's Health and Wellbeing Board

The Board received a report which asked them to confirm two appointments to the Board.

Reference was made to the increase of representation of the NHS Vale of York Clinical Commissioning Group (CCG) on the Board, following the appointment of the Vice Chair at the previous meeting. This meant that there were three CCG Board Members on the Health and Wellbeing Board.

Officers reported that a governance review undertaken would consider the Board's membership.

Resolved:

That;

- Fiona Phillips, Assistant Director- Consultant in Public Health be appointed as a substitute member of the Board for Sharon Stoltz.
- That the appointment of Phil Mettam, Accountable Officer at NHS Vale of York Clinical Commissioning Group (CCG) be noted.

Reason: In order to ensure proper representation on the Health and Wellbeing Board.

20. Rehabilitation and Recovery, Adult Mental Health Service Developments in York and Selby

Consideration was given to a report which informed the Board of the progress to date around Rehabilitation and Recovery, adult mental health service developments in York and Selby.

The report included the background and context associated with the temporary closure of Acomb Garth Adult Rehabilitation and Recovery Unit in York and the progress to date following a Quality Improvement event held on 29 February -2 March 2016.

The Director of Operations and Locality Manager for Adult Mental Health from Tees, Esk and Wear Valleys NHS Foundation Trust presented the report.

The Board were informed that a capital bid would be submitted to central government for a crisis café to be open at all hours.

It was noted that the crisis café could be based at Sycamore House and that this could be managed in addition to other activities and services being provided there.

In regards to inpatient mental health care in York, it was confirmed that there were no rehabilitation facilities in York, but that a senior nurse had been appointed to visit those patients in rehabilitation beds. There were also no plans to reopen Acomb Gables as a rehabilitation or recovery unit, it would be used as an older people's unit.

Resolved: That the report be received and noted.

Reason: To keep the Health and Wellbeing Board updated in relation to progress.

21. Mental Health Inpatient Facilities for York

Board Members received a report which updated them on the current position on mental inpatient health facilities in York. The Director of Operations from Tees, Esk and Wear Valleys NHS Foundation Trust introduced the report.

It was confirmed that due to a fire, Peppermill Court would not open until the first week of October.

Male beds for dementia patients would be provided at Acomb Gables from Winter 2016 along with additional outpatient bed space.

It was noted that issues such as a significant overprovision of older people's beds in mental health inpatient facilities and that more work needed to be done on patient flows would be identified in the consultation document for the new mental health hospital.

In response to a Member's question about financial information about the new mental health hospital. It was reported that it would cost approximately £29m for the building, but that the costs would be reviewed in terms of the site.

Resolved: That the update on the work undertaken to address the transformation of mental health services and the proposed plans for the new hospital be noted.

Reason: To keep the Health and Wellbeing Board up to date with developments in relation to mental health inpatient facilities for the city.

22. Update on the work of the Joint Strategic Needs Assessment/Joint Health and Wellbeing Strategy Steering Group

The Board received an update report on work that had been undertaken by the Joint Strategic Needs Assessment/Joint Health and Wellbeing Strategy Steering Group (‘the Steering Group’) since its establishment in late 2015.

Board Members were informed that two needs assessments had taken place over the past year, one on Learning Disabilities and one on Self Harm. Two further needs assessments were planned on Autism and Student Health. The Chair highlighted that delegation would be given to the Mental Health and Learning Disabilities Partnership Board to lead on reporting back on progress achieved on implementing the recommendations from the needs assessments to the Steering Group.

The Director of Public Health informed the Board that the JSNA/JHWBS Steering Group work plan would be included as part of the next JSNA/JHWBS Steering Group update report to the Board.

It was reported that the new Joint Health and Wellbeing Strategy (JHWBS) would be written using a whole life course approach, examining wellbeing through to aging and end of life care.

A draft would be shared with the Board for initial comments. The final version would be brought for sign off to the Board in January.

Board Members were informed that there would be an eight week consultation period for the new JHWBS; the draft document would be shared with the Board.

It was hoped that the first edition of an external newsletter would be launched alongside the JHWBS.

In response to how broader topics such as integration and finance would fit with the new Joint Health and Wellbeing Strategy, it was noted that the JHWBS would set out vision and aspiration. There remained a number of system wide issues that would need to be addressed to realise the ambitions set out in the strategy.

Resolved: (i) That the report be received and noted.

(ii) That the recommendations arising from both the self harm and learning disabilities needs assessments be agreed.

(iii) That the Mental Health and Learning Disabilities Partnership Board implement the recommendations from the need assessments.

Reason: To update the Board on progress made with the JSNA and the JHWBS.

23. Update from the Integration and Transformation Board

Consideration was given to a report which summarised discussions which had taken place at the Integration and Transformation Board.

The Director of Adult Social Care introduced the report and informed the Board that the ITB had taken on the responsibility for management of the Better Care Fund (BCF) in the Vale of York area.

He highlighted that the development of the ITB reflected a longer term change in thinking and as such there was a need for a joint commissioning strategy and joint commissioning plan. He spoke about a Joint Commissioning Forum which would allow for discussion to take place outside of the ITB. This forum would look at the shift from community based models of care and market development in health care. Other topics would also include, rehabilitation services and intermediate care in the city, for example the future proposals for Archways.

Board Members raised the following points;

- The ITB would bring together providers and commissioners in one place.
- None of the organisations involved in the Sustainable and Transformation Plan shared the same geographic boundaries, which meant that the ITB would allow for locality based decision making.
- Consideration of a Terms of Reference for the Joint Commissioning Board would be brought to the Health and Wellbeing Board.

Discussion took place on the closure of Archways Intermediate Care Unit during which the following comments were raised;

- Archways was an invaluable resource for those discharged from hospital who needed support before they returned home.
- Why was an effective resource being closed before a suitable replacement had been put in place?
- Patients were more likely to stay in hospital as a result of the closure of the rehabilitative unit.
- The hospital was looking to increase overall capacity rather than reducing resources at Archways.

The Deputy Chief Executive of York Teaching Hospital NHS Foundation Trust informed the Board that;

- There was evidence that many patients could be cared for in their own homes if community support was given.
- In order to develop further community services, maintaining Archways alongside this could not be done.
- GPs, consultants all supported the closure.
- Their commitment was to inform the staff involved first.

Further comments raised included;

- There would still be some inpatient beds available for rehabilitative care in the city.
- Was the setting the best use of resources for the care provided?
- Further work needed to be carried to enable real co-production with service users, as the consequences of service change on the system had not been made explicit.

- The closure of Archways would be considered in more depth at the next meeting of the Health and Adult Social Care Policy and Scrutiny Committee.

Resolved: (i) That the report be received and progress noted.

(ii) That the work being done to develop a joint commissioning strategy be supported.

(iii) That comments made around the need for a Joint Commissioning Board be considered and noted.

(iv) That a further report on the Section 75 Agreement be received by the Board.

Reason: To keep the Health and Wellbeing Board updated on progress being made by the Integration and Transformation Board.

24. Alcohol Strategy Consultation Response

Consideration by the Board was given to a report which presented the findings of the public consultation on the draft Alcohol Strategy for York 2016-2021.

It was recommended that the Safer York Partnership (SYP) be delegated responsibility to finalise and sign off the draft Alcohol Strategy. The Director of Public Health commented that she would be reviewing the public health membership of the SYP as she felt that it had not paid sufficient attention to the health impacts.

Resolved: (i) That the consultation response to the draft alcohol strategy be noted, and that it be acknowledged that the strategy is being amended to take account of this prior to being finalised for publication.

(ii) That the delegation of responsibility for strategic oversight of the delivery of the alcohol strategy to the Safer York Partnership be approved.

(iii) That it be agreed to receive annual reports detailing progress on the implementation of the alcohol strategy.

Reason: To support the delivery of an alcohol strategy for York that will reduce alcohol-related harm across the city.

25. Verbal Update on Sustainability and Transformation Plans

The Board received a verbal update on Sustainability and Transformation Plans (STP) in the NHS in the Vale of York area.

The Chief Operating Officer from NHS Vale of York Clinical Commissioning Group (CCG) informed the Board that a Draft STP had been submitted to NHS England in June which identified areas where work needed to take place. Each of the localities within the STP area had been asked to prepare a local plan, this was not finalised in the Vale of York area. Partners to the Integration and Transformation Board (ITB) were involved in an ongoing piece of work to develop this local plan.

Concerns were raised about the Humber Coast and Vale (HCV) STP and the relationship with the work of the Integration and Transformation Board. Comments included;

- The STP process was not at this stage open and transparent.
- There was public concern over a large scale reorganisation of the NHS and there needed to be public information about what cuts would be made.
- How would the high level STP plan link with the local plan and what opportunities would there be for localities to influence plans at all levels?

The Board felt that it was useful to consider what could be shared around the HCV STP. The Locality Director (North) NHS England underlined that any changes to services within the NHS would be publicly consulted upon.
Resolved: That the verbal update be received and noted.

Reason: So that Members are kept informed of developments in Sustainability and Transformation Plans in the NHS in the Vale of York area.

26. Forward Plan

Board Members were asked to consider the Board's Forward Plan for 2016/17.

It was suggested that a Suicide Prevention Update be added to the Board's November meeting.

Resolved: That the Board's Forward Plan be approved with the amendment detailed above.

Reason: To ensure that the Board have a planned programme of work in place.

Councillor Runciman, Chair
[The meeting started at 4.30 pm and finished at 6.40 pm].

Health and Wellbeing Board **23 November 2016**

Report of the Independent Chair of the City of York Safeguarding Children Board

2015/16 Annual Report of the Independent Chair - City of York Safeguarding Children Board (CYSCB) and Safeguarding Update to October 2016

Summary

1. The purpose of this report is to present the CYSCB Annual Report 2015/16 and provide an update on key issues between April and October 2016 as agreed in the protocol with the Health and Wellbeing Board (HWBB).

Background

2. The Independent Chair of the Safeguarding Children Board is required by statutory guidance to publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. The report should be submitted to the Chief Executive, Leader of the Council, the local Police and Crime Commissioner and the Chair of the Health and Wellbeing Board.

3. The City of York Safeguarding Children Board has the statutory objective set out in Section 14 of the Children Act 2004 *to coordinate* what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and *to ensure the effectiveness of what is done by each such person or body for those purposes*

4. To provide effective scrutiny, the CYSCB should be independent. It should not be subordinate to, nor subsumed within, other local structures.

5. The Health and Wellbeing Strategy includes the key objective of ‘Enabling all children and young people to have the best start in life’. Delivery of this will significantly strengthen safeguarding arrangements for the children of York. Member organisations of the Health and Wellbeing Board and the YorOk Board are represented on the Safeguarding Board.

Main/Key Issues to be Considered

Annual Report 2015-16 (Annexes 1a and 1b)

6. This annual report of the City of York Safeguarding Children Board (CYSCB) covers the year ending 31 March 2016.

   The work of the Board is driven by its vision:

   “For all the children of York to grow up in safety and to always feel safe”

7. The last two years have been characterised by continuous improvement and steady forward progress, coupled with growing partnership involvement, purpose, and respect. Consequently, the Board is able confidently to set its priorities for action in 2016 and beyond.

8. Within this report we have set out the achievements made this last year but also identified the improvements that we must continue to address.

9. The Board is confident that safeguarding arrangements in York are robust – but they can always be further strengthened. The challenge will be to maintain the progress of the last three years, at a time of unprecedented pressures on public finances, and through a period of national policy changes (including to the focus and remit of safeguarding boards) without losing sight of what matters most: the safety and wellbeing of children in York.

Safeguarding Update – April to October 2016

Current National Issues

Proposed Government changes to safeguarding arrangements in the Children and Social Work Act 2016

10. These changes are contained within Chapter 2 of the Children and Social Work Bill. The Bill has completed grand committee stage in the House of Lords and is now at report stage. It will then pass to the Commons. There were many objections in the Lords to the process. There is a long list of amendments raised.

11. The primary change is a proposal to abolish LSCBs (Local Safeguarding Children's Boards) in their current form, however there will still be a statutory framework for local safeguarding arrangements as set out below:

    "(1) The safeguarding partners for a local authority area in England must make arrangements for (a) the safeguarding partners, and (b) any relevant agencies that they consider appropriate, to work together in exercising their functions, so far as the functions are exercised for the purpose of safeguarding and promoting the welfare of children in the area.

    (2) The arrangements must include arrangements for the safeguarding partners to work together to identify and respond to the needs of children in the area." "Safeguarding partner", in relation to a local authority area in England, means:

    (a) the local authority;

    (b) a clinical commissioning group for an area any part of which falls within the local authority area;

    (c) the chief officer of police for a police area any part of which falls within the local authority area."

    - The arrangements must include arrangements for scrutiny by an independent person of the effectiveness of the arrangements.
    - Annual report - At least once in every 12-month period, the safeguarding partners must prepare and publish a report on:

      (a) what the safeguarding partners and relevant agencies for the local authority area have done as a result of the arrangements, and

      (b) how effective the arrangements have been in practice."

- Serious Case Reviews (SCR) will be undertaken by a National Child Safeguarding Practice Review Panel which will be appointed by the Secretary of State. It anticipates undertaking 20-30 reviews a year.
- Local child safeguarding practice reviews will continue but the arrangements for decision making are yet to be published. The decision around local reviews will include national consideration.
- Within the bill itself, there is a proposal for the Secretary of State to have the power to exempt councils from legislation, but the Secretary of State must consult with certain bodies before doing that.
- There are proposed statutory arrangements to allow for devolution of responsibilities between local authorities and Clinical Commissioning Groups.
- Transfer arrangements for Child Death Overview Panel (CDOP) to the Department for Health are still to be agreed and published.
- Authorities can continue to have joint CDOP working arrangements across local authority areas as we currently have in York & North Yorkshire County Council in the Bill “child death review partners”, in relation to a local authority area in England, means— (a) the local authority; (b) any clinical commissioning group for an area any part of which falls within the local authority area.”

Local considerations to date

12. At CYSCB meeting on 22nd June the CYSCB agreed the recommendations below and mandated the Chair to follow up these on behalf of the Board.

- The Independent Chair, working with the safeguarding Chief Officers Reference and Accountability Group (CORAG) should initiate discussions on any potential changes to local multi-agency safeguarding arrangements in York. This promotes continuity and reduces risk. (This has been completed)
- Consider how independent scrutiny will be visible in future arrangements.

- Should local multi-agency safeguarding arrangements re-focus their work on local assurance, scrutiny and challenge?
- Consider which multi-agency safeguarding functions or cross cutting issues could benefit from a joint, sub-regional or regional basis.
- Consider an inter-board protocol to reduce duplication, clarify strategic leadership and use partner agency input and business support more effectively. (This is now completed)
- Consider how to plan for the proposed changes in respect of CDOP (Child Death Overview Panel).

13. At the CORAG meeting in October it was agreed that CYSCB is well-placed in respect of new arrangements, with no current concerns as to the compliance of existing arrangements with emerging proposals contained with the Children and Social Care Bill. During 2017 plans for future arrangements will be developed to ensure they are compliant with the new legislation and regulations which are expected for consultation in the autumn of 2017. It was agreed further planning will take place to consider the following questions:

    a) How the proposed statutory safeguarding partners of LA (Local Authority), Police and CCG (Clinical Commissioning Group) wish to make decisions on new arrangements post the legislation.
    b) How arrangements will be supported and funded in future.
    c) How the wider engagement of other partners that currently exists should be sustained.
    d) Should the statutory safeguarding partners have an executive strategic board with the current LSCB (Local Safeguarding Children Board) arrangements amended to be focused on delivery and implementation?
    e) How the proposed statutory safeguarding partners of LA, Police and CCG wish to make decisions on new arrangements post the legislation.
    f) How arrangements will be supported and funded in future.
    g) How the wider engagement of other partners that currently exists should be sustained.
    h) Should the statutory safeguarding partners have an executive strategic board with the current LSCB arrangements amended to be focused on delivery and implementation?

New Joint Targeted Area Inspections

14. In August 2016, Ofsted, the Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Her Majesty's Inspectorate of Probation started the second round of Joint Targeted Area Inspections (JTAI) of services for vulnerable children and young people. This will involve jointly assessing how local authorities, the police, health, probation and youth offending services in an area provide “front door” services and are working together to identify, support and protect children affected by domestic abuse. The next round of inspections is expected to focus on neglect.

Government Consultation on Mandatory Reporting and acting on child abuse and neglect

15. This Government consultation concluded on 13th October. It was discussed at the Board in August and it was agreed that individual organisations should consider making their own representations and that it was unlikely that there would be sufficient consensus across the Board members to provide a common response on behalf of the Board.

16. Below is a short extract from the ADCS (Association of Directors of Children’s Services) and LGA(Local Government Association) position for your information:

“ADCS and the LGA oppose the introduction of mandatory reporting or a duty to act for the following reasons:

“There is no evidence that mandatory reporting systems will provide greater protection for children and young people nor lead to better outcomes. We are concerned that the resulting increase in inappropriate contacts / referrals risks weakening the child protection system in this country, a system that is widely recognised as one of the safest and most successful in the world.”

“An unintended consequence of mandatory reporting could be distortion of social responsibility. Communities should be empowered to recognise the early signs of all forms of abuse and neglect and be confident in responding appropriately to this risk instead of being reliant on the state to act at all times.”

17. When the results of the consultation are published the Board will consider any local impact which may occur as a result of any legislative change that follows.

CQC - A review of the arrangements for child safeguarding and health care for looked after children in England

18. The Care Quality Commission (CQC) undertook a 2-year programme of Looked After Children & Safeguarding reviews. (*Annex 2*) The CQC overview report was published in July 2016. This was discussed at the CYSCB in August with a presentation from the CCG.

19. The report is being shared with clinical safeguarding governance meetings and safeguarding networks. York and North Yorkshire are in a good position with all children in care work commissioned from Harrogate and District NHS Foundation Trust. To continue to improve, the Board agreed to coordinate an "is it true for York" exercise to assess ourselves (and particularly our health partners) against the key recommendations as an additional consideration of the Annual Section 11(S11) of the Children Act (2004) Audit (see below for information on S11 Audit).

Progress on CYSCB priorities April to October 2016

Neglect

20. Neglect remains an ongoing challenge both nationally and locally. At the end of 2014-15, 46.4% of the children subject to a Child Protection Plan in York were under the category of "neglect". This percentage has risen during the year and is higher than last year (37%)

21. The combined factor of 'neglect', 'parental substance misuse' and 'absent parenting' (all of which could be considered as 'neglect') is the most prevalent factor in referrals and enquiries to CSC.

22. Neglect has been found to be a risk factor for a range of longer-term impacts in adolescence and adulthood. Neglect may be one reason why young people go missing from home. Currently, missing children are the often focus of concerns around CSE but once a child has been found, all reasons – including neglect – should be considered

23. The range of indicators, and the evidence about the long-term impacts of neglect, emphasise the importance of early identification to prevent significant deterioration of emotional and physical health and development in children. All professionals have a responsibility to act when they suspect neglect

24. This is an area where there is still a need to accelerate work to update plans and ensure we have a clear strategy, action plan and measures in place to monitor impact over time.

25. The Board sub group has made progress led by the Director of Public Health and a successful seminar was held in July. Around 70 practitioners from many agencies and organisations discussed ideas on addressing neglect and heard from Professor Jan Horwath, Emeritus Professor of Child Welfare from the University of Sheffield.

26. A new assessment tool 'The Graded Care Profile' is being introduced in York this to identify and address neglect.

Early Help

27. The Early Help sub group is informed and steered by the YorOk the sub group of the HWBB, however, in accordance with the statutory guidance Working Together 2015 this sub group also reports to the LSCB on issues of quality, effectiveness and outcomes.

28. Local Area Teams and a new operating model should be in place by December 2016 for launch in 2017. Threshold Guidance: This is being updated by the Children's Advice Team and will be presented to the CYSCB in December

Domestic Abuse

29. The leadership and governance of Domestic Abuse sits with the Safer York Partnership. The CYSCB set up a sub group to give additional attention to children affected by Domestic abuse. This group will complete its work by the end of the financial year.

30. It aims to gather a clearer understand of:

    - The child/young person's experiences of agency responses to domestic abuse

- Professional awareness of the impact of Domestic Abuse for children / young people
- The ability of the wider children's workforce to identify and respond to children and young people who experience domestic abuse
- The availability and access to specialist interventions for children/young people who experience domestic abuse.
- The CYSCB are also pleased to report that Operation Encompass (a scheme to inform schools of domestic abuse incidents) is being piloted some York schools. This is being led by the police. The Local Area Teams will be involved in Operation Encompass and midwives are being informed of DA happening in the family home, so will potentially also be involved with Operation Encompass.

Child sexual abuse including CSE

31. A particular highlight this year has been the Board's work, in partnership with the NSPCC, to initiate and carry out a very successful campaign -'It's Not Ok' - to raise awareness about child sexual abuse and exploitation.

32. The CYSCB Chair wishes to thank all concerned for the excellent work and partners for providing funding and in kind support. Schools have requested a continuation of the programme for new year groups and the Chair agreed to explore opportunities via school reps and the DCS.

33. Sarah Arnott Commissioner from the Police & Crime Commissioners Office attended the CYSCB meeting in October and gave an overview and summary of the services (relevant to CSA & E) which have been commissioned by the PCC. There is still a need to sustain therapeutic support available over a significant period for adults who were child victims of abuse.

Multi Agency Safeguarding Audit (S.11 Audit)

34. Section 11 of the Children Act 2004 places a specific duty on named agencies to comply with standards set out in the S11 Guidance. A key element of the CYSCB Learning and Improvement Framework is the Section 11 audit tool.

The audit tool is a review process based on self-evaluation by partner agencies helping to identify areas of good practice and areas that need to be improved. The CYSCB is undertaking the audit jointly with North Yorkshire Safeguarding Children Board. A joint multi-agency event will be held on 9th March 2017 with North Yorkshire Safeguarding Children Board to share and discuss the initial findings. Each agency represented will be expected to provide their self-assessment and a brief action plan on how they are going to progress any areas for development. A separate self-audit format has been produced for schools.

Peer Review

35. A peer review of the CYSCB as part of the regional sector led improvement programme, has been commissioned and was undertaken in late October. When received, the learning from this will be discussed at a board development day in late November and will inform future planning. The Chair of the HWBB, along with the Chairs of other key boards provided input to the review

Consultation

36. This section is not applicable to this report.

Options

37. The report is for information only and as such there are no options for the Board to consider.

Analysis

38. This section is not applicable to this report

Strategic/Operational Plans

39. This topic relates to the theme of the CYC Council Plan “Protect vulnerable people”.

Implications

40. **Financial** - an agreement is in place for the budget for 2017/18. Costs for any serious case reviews undertaken are not factored into the core budget and will therefore be allocated to funders on the same proportion as core funding.

41. There are no other known implications associated with the recommendations in this report.

Risk Management

42. Any national proposals emerging from the national review may impact on Board partner commitment and require further review of the structure, priorities and work of the Board during the 2017.

43. We are still awaiting our Ofsted inspection with the programme further delayed; to be completed by December 2017.

Recommendations

44. The Health and Wellbeing Board are asked to:

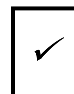
- Receive the Annual Report of the Independent Chair of the CYSCB and reflect on the key messages and priorities when considering plans.

- Note the update on progress on safeguarding priorities between April and October 2016.

Reason: To ensure the HWBB Board demonstrates it gives full consideration to the advice from the CYSCB

Contact Details

Author:	**Chief Officer Responsible for the report:**
Simon Westwood Independent Chair City of York Safeguarding Children Board	Jon Stonehouse Director of Children's Services, Education and Skills City of York Council

Report Approved  **Date** 02.11.2016

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:

- More detailed information can be found on the Safer York Website http://www.saferchildrenyork.org.uk
- Working Together 2015

  https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
- York Children & Young People's Plan

  http://www.yor-ok.org.uk/workforce2014/Dream%20again%20and%20YorOK%20Board/dream-again---the-children-and-young-peoples-plan.htm
- York Health and Wellbeing Strategy
  https://www.york.gov.uk/downloads/file/858/joint_health_and_wellbeing_strategy

Annexes

Annexes 1a and 1b: Executive Summary and Full Annual Report of City of York Safeguarding Children Board 2015/16
Annex 2: CQC Report 'Not Seen Not Heard'

Glossary

ADCS	(Association of Directors of Children's Services)
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CORAG	Chief Officers Reference and Accountability Group (Safeguarding)
CQC	Care Quality Commission
CYSCB	City of York Safeguarding Children Board
HWBB	Health and Wellbeing Board
JTAI	Joint Targeted Area Inspections
LSCB	Local Safeguarding Children Board
LGA	Local Government Association
YorOK	York Children's Trust

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City of York
Safeguarding Children Board

Annual Report 2015/2016
Executive Summary

Working with children, families and professionals to make our children's lives safer

CITY OF YORK COUNCIL

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If you see something, say something.

About this Document

This document is a short summary of the 2015-16 Annual Report for the City of York Safeguarding Children Board. The full report, with additional supporting information as appendices, is available on the Safeguarding Children Board website at: http://www.saferchildrenyork.org.uk/annual-reports-and-business-plan.htm

Foreword

This is my third annual report as Independent Chair of the City of York Safeguarding Children Board (CYSCB) and covers the year ending 31 March 2016.
The work of the Board is driven by its vision:

"For all the children of York to grow up in safety and to always feel safe."

The last two years have been characterised by continuous improvement and steady forward progress, coupled with growing partnership involvement, purpose, and respect. As a consequence, the Board is able confidently to set its priorities for action in 2016 and beyond.

In my first annual report I said I was struck by the commitment to continuous improvement in York and that the culture here is child-centred, open and transparent. In my second report I said that partnership working was very strong in operational practice and strategic oversight. That has continued and strengthened over the last two years.

2015-16 has been a period of significant change for the Board as we implemented a new Board structure, working arrangements and staff changes. I want to record thanks to Joe Cocker and Dee Cooley, who left during the year, for their work over a number of years; and to Juliet Burton, our new Business Manager for keeping a focus on improvement through a period of significant change.

Within this report we have set out the achievements made this last year but also identified the improvements that we must continue to address. A particular highlight has been the Board's work, in partnership with NSPCC, to initiate and carry out avery successful campaign -'It's Not Ok' - to raise awareness about child sexual abuse and exploitation.

The Board is confident that safeguarding arrangements in York are robust - but they can always be further strengthened. The challenge will be to maintain the progress of the last three years, at a time of unprecedented pressures on public finances, and through a period of national policy changes (including to the focus and remit of safeguarding boards) without losing sight of what matters most: the safety and wellbeing of children in York. It is a challenge for which we are well equipped. On behalf on the Board I want to thank everyone, especially parents and carers for their dedication and effort in helping to make York a safer place for children and young people.

Simon Westwood, Independent Chair of City of York

Formal Summary Statement

The City of York Safeguarding Children Board (CYSCB) is a statutory body set up in accordance with the Children Act 2004, and in line with the guidance in Working Together (2015)[1]. The Board is a robust partnership of enthusiastic members, dedicated to the improvement of practice which safeguards children in York.

Information about our work, and our current membership, plus advice, guidance and links to other useful websites is available on our website: **http://www.saferchildrenyork.org.uk/**.

This Report is an Executive Summary of our work during 2015-16. Overall, our Board believes that arrangements for safeguarding children in York during this period were robust and effective; that there is a strong commitment to safeguarding children across the York partnership; and that frontline practice continues to improve.

This Executive Summary sets out brief details as to how we have reached our conclusions. It also describes our priorities for the year ahead, and the key messages we would like readers to take away. There is a great deal of further detail, and supporting evidence, in our full report, which is available on our website.

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

Some facts and figures

York is a unitary authority with a population of just over 204,000. In 2014, the number of children aged 0-19 living in York was 44,200. The Black and Minority Ethnic (BME) population in 2015 was 9.8% compared to 4.9% in 2001.

The city is relatively prosperous, with the level of people claiming of out of work benefits statistically lower than regional and national averages. However, 7% of York's population (around 14,000 people - adults and children) live in areas classified as being in the 20% most deprived areas in the country.

CYSCB monitors a wide range of performance data from a variety of sources. Our full report contains many facts and figures, including an illustrative scorecard. Some of the most pertinent statistics from last year are as follows:

- 171 Early Help Assessments were recorded by the Advice Team as initiated in 2015-16;
- the number of re-referrals within 12 months to Children's Social Care dropped by half;
- up to 80% of children aged 0-4 who live in the most deprived 10% of local areas have been registered with a Children's Centre;

Up to 80% of children 0-4 who live in the most deprived 10% of areas have been registered with a Children's Centre

- York has better school attendance than the national average;
- the percentage of referrals to Children's Social Care with neglect as a factor has risen during the year to 17.3% at year end and is higher than it was in 2014-15;
- the most recent health data (2014-15) for hospital admissions for dental caries (tooth decay) shows that York has a higher number than the national average;
- the percentage of referrals to Children's Social care with sexual abuse as a factor has remained the same as 2014-15;
- the percentage of referrals in which Child Sexual Exploitation is a concern at the point of referral has risen since last year;
- the number of children recorded as missing from home or care increased slightly;
- the number of first time entrants to the Youth Justice system has risen slightly since last year, but remains low and in line with national trends;
- the rate of young people sentenced to custody continues to remain very low and has fallen over the last two years;

3,600 enquiries in 2015-16

- Children's Social Care received just over 3,600 enquiries in the whole of 2015-16;
- 191 children were receiving a service from the Child In Need teams in March 2016;
- at the end of March 2016, 135 children were subject to Child Protection Plans;
- throughout 2015-16 the average social work caseload has remained at 15 cases;
- the number of children in the care of the local authority has fallen during the year from a peak of 203 to 191 by the end of the year;
- there has been a reduction in the number of children looked after outside of York;
- 100% of care leavers were in suitable accommodation at the end of the year and 70.5% in education, employment or training (an improvement on last year);
- there has been a 13% decrease in the number of child deaths in North Yorkshire and City of York over the last 5 years.

What children and young people have told us

As highlighted in our Annual Report for 2014-15, a joint Voice and Involvement Strategy has been agreed by the YorOK Board[2] and the City of York Safeguarding Children Board. A detailed report looking at work undertaken against this strategy has been produced and is available on the Children's Trust website[3].

Our full report sets out a range of views expressed by children and young people through a variety of means. Our Board particularly noted that, according to the latest UMatter Survey of children who are looked after:

- 87% of young people felt the council provides good quality placements for children and young people in care;
- most young people (86%) were happy with foster carers.

The Board also noted the extent to which children and young people in York are able to help shape major strategies such as the new Children and Young People's Plan. During consultation on this document, safeguarding was highlighted a number of times as a key priority.

Generally, young people, parents and carers feel that York is a safe place and a good place to live and grow up.

Even though there is much to commend, there are still improvements to be made:

- voice at different tiers of need: so that every child whether receiving support at any level has an opportunity to express a view;
- voice in assessments: every child who participates in an assessment should be able to contribute to that assessment;
- pre-verbal or non-verbal "voice": those children and young people who are unable to express their wishes and feeling verbally because they are too young or because they communicate in a different way, will be heard;
- voice and change: children and young people will be consulted and heard when changes are made to services which affect their lives.

...young people in York are able to help shape major strategies...

[2] As a reminder, "YorOK" is the name of York's Children's Trust.
[3] See www.yor-ok.org.uk/workforce2014/Voice/voice-and-involvement.htm

How we are doing as a Partnership

The Board has reviewed progress against the thematic priorities for development that we set ourselves last year:

- The primary focus of the **Early Help** Group has been the project for remodelling the provision of prevention and early help services across the city. This will see the formation of three local area multi-disciplinary teams working together to ensure a seamless service and robust systems for information sharing. The Board hopes to see that a greater number of situations will be addressed through early working alongside families and communities: we look forward to further updates and to full initiation of the new service in late 2016. The Early Help Group will oversee a full revision of the Board's Threshold Guidance in 2016.
- The **Neglect** Sub-group was set up with the aim of responding to the apparently high levels of neglect cases reaching the threshold for statutory intervention. The Sub-group has developed a city-wide Neglect Strategy, to be finalised later in 2016. In addition, the Sub-group has worked with the local authority and public health services to initiate training on the Graded Care Profile which will see practitioners use a common language and common assessment approach to cases of neglect.
- The **Child Sexual Abuse and Exploitation/Missing from Home and Care** Sub-group has been active in supporting the joint CYSCB/NSPCC 'It's Not Ok' campaign addressing child sexual abuse and exploitation and raising awareness. Around 2000 Year 7 children have seen the play and taken part in the workshop; to date there have been more than 4,500 hits on the 'It's Not Ok' website. The campaign has been a successful collaboration between a range of agencies and organisations; interest has been expressed by other local authorities wishing to use the model.
- A child or young person who goes **missing from home** can be vulnerable to abuse including sexual abuse and sexual exploitation. In 2015-16 there were 657 reports of children or young people missing from home or care. However, many of these were the same individual on more than one occasion. The Board is assured that those individuals who appear to be of particular concern are discussed at a multi-agency meeting so that support can be provided. Every child or young person who has been reported as missing during 2015-16 has been found.
- Children **missing from education** can also be vulnerable. During 2015-16, 124 children were reported as not at the school they were registered at in York. The vast majority were found at other schools or found to have moved elsewhere. For those few not immediately located, consultation takes place with Children's Social care to ascertain whether there is any reason to be concerned.

- The **Domestic Abuse** Sub-group was set up to look at the impact of Domestic Abuse on children in York. Data indicates an increasing percentage of reports of incidents to North Yorkshire Police in which children were present. This does not necessarily mean that more children are witnessing domestic abuse; it may suggest that police officers are getting better at recording this. However, CYSCB has been keen to understand the prevalence of domestic abuse and the perspective of children and young people in York. This understanding can then inform and support the overall Domestic Abuse Strategy.
- CYSCB has worked with North Yorkshire Safeguarding Children Board to raise awareness of **Female Genital Mutilation** (FGM) across the workforce and to provide local guidance. This has included FGM briefings to practitioners and access to e-training. Although the number of suspected FGM cases in York is not high, there has been a rise in the number reported to Children's Social Care as awareness has increased.

...raise awareness of Female Genital Mutilation (FGM) across the workforce and to provide local guidance.

The Board has also assessed York's other work with children and young people, particularly those who are vulnerable:

- Children's Social Care received just over 3600 **contacts** in the whole of 2015-16, 645 met the threshold for referral (i.e. were the subject of further assessment and intervention by CSC). Both these numbers are lower than in previous years. The percentage of repeat referrals has also dropped since the beginning of the year which suggests that cases are being closed or stepped down with a more lasting outcome.
- At the end of March 2016, 135 children were subject to a **child protection plan** with 100% reviewed within timescales. This equates to a rate of 37 children per 10000 population. Over half the child protection plans were listed under the category of neglect. York had 27.3% of children subject to a child protection plan for the second time, more than double the percentage at the same time the previous year. CYSCB understands that this variation was subject to robust scrutiny by Children's Social Care and is assured that no issues of concern were identified.
- The number of **children and young people in the care of the local authority** at the end of March 2016 was 191 (53 per 10,000). There has been a year on year decrease since 2012-13 when the number was 243 (68 per 10,000).
- 100% of York's **care leavers** are living in appropriate accommodation. 6 care leavers are at University.
- Sixty four percent of children waited less than 20 months between entering care and being **adopted**.

- In 2015-16 there were 86 full-time equivalent **Social Workers** in employment working directly with children and families, suggesting an average of 15 cases per Social Worker.
- In 2015-16, 231 families with multiple and complex needs entered the 'Family Focus' programme (known nationally as 'Troubled Families').
- 2015-16 saw 477 new entrants to the youth justice system. The figure has fluctuated over the last 4 years and is on a par with 2013-14. However the percentage of reoffending has dropped since previous years.
- In 2015-16, 90% of final Education, Health and Care Plans were issued within statutory time limits and 90.6% of Year 11 Leavers with special needs were still in learning 3 months after they finished Year 11. We are satisfied that the majority of our disabled children are well supported in their education and aspirations.
- We have also been following with interest the roll out of the School Cluster Pilot to strengthen the emotional and mental health support arrangements for children and young people in universal school settings.
- There has been very positive engagement with schools in 2015-16.

The Board also invited the individual agencies who make up our partnership to submit an up-to-date assessment of the state of safeguarding in their organisation. This enables us to share best practice and, where necessary, to challenge each other. These assessments have been published within our full report: they contain a wide range of innovations and improvements to local safeguarding arrangements. Any general learning points that have emerged have been taken into account in determining our priorities for the year ahead.

Formal Audits and Reviews

Our Board also undertakes a series of more formal audits and reviews in order to provide assurance that safeguarding arrangements are in place, and to serve as a prompt for any improvements that can be made. In 2015-16 we conducted two types of formal audit:

- The "Section 11" Audit: Section 11 of the Children Act 2004 places a statutory duty on key agencies and bodies to make arrangements to safeguard and promote the welfare of children. As usual, in 2015-16 CYSCB worked with the North Yorkshire Safeguarding Children Board on the Section 11 Audit as several partner agencies work across York and North Yorkshire. All key partners who deliver (or commission) services for York responded. There were no significant multi-agency safeguarding concerns across the agencies identified. Some recurring themes were identified, especially around information sharing: these have been followed up.
- Multi-agency Case File Audits: In April 2016 the former Case File Audit Group became the Partnership Practice Scrutiny and Review Group (PPSRG). This multi-professional group met on 6 occasions during 2015-16 , looking in particular at processes around child protection, Child In Need Plans, and children in care long term under Section 20 of the Children Act (i.e. with parents' consent). Findings from all of these audits were shared with CYSCB. Relevant agencies were asked for assurance that findings were noted and actions taken. For example, assurance was given to the board that all Section 20 arrangements now have recorded signed consent from parents.

There were no cases which merited Serious Case Review (SCR) during 2015-16. The Case Review Group has nevertheless reviewed the action plans of earlier Learning Lessons Reviews from previous years, to ensure all actions have been followed up. At year end 2015-16, one Learning Lessons Review is under way in regard to a neglect case. The action plan from this Review will be followed up and monitored in due course.

CYSCB shares the Child Death Overview Panel (CDOP) with North Yorkshire Safeguarding Children Board in order to review the death of every child (up to the age of 18 years). In 2015-16 there were 11 child deaths in York. A Rapid Response audit was completed by the CDOP Coordinator for all unexpected child deaths that occurred between 1 April 2015 and 31 March 2016. The audit gave assurance that there are effective systems in place; however, it did highlight significant cross-boundary issues and a lack of bereavement support; this being addressed by services across the city and county.

There were a total of 50 contacts received by the Local Authority Designated Officer in 2015-2016. This figure has increased marginally since 2014-2015. Out of the 50 contacts, 30 were referrals and 20 were consultations. The largest single category of concern was sexual abuse (48%), followed by physical abuse (28%), neglect (14%) and emotional abuse (4%).

Finally, all agencies and schools are required to give assurance to CYSCB about their safer recruitment practice through the Section 11 audit and an audit of schools' safeguarding arrangements. The Board is satisfied that partner organisations and schools operate according to safer recruitment guidance.

Our performance as a Board

City of York Safeguarding Children Board meetings, which take place quarterly, are always well attended by members, both statutory and non-statutory, and by advisors. Minutes of our meetings are available on our website, as is an up-to-date list of Members. We have a key strategic relationship with York's Children's Trust (YorOK): the Chair of our Board is a Member of the Trust and reports regularly to it; equally, we review and challenge Trust information on a regular basis.

We consider that we work well as a Board, in a spirit of robust challenge and support. However, we could always improve further, and we therefore agreed a new structure from April 2015. Within the new structure, there is greater input of other agencies rather than an over-focus on Children's Social Care. The new structure is working well: the Board and the Sub-groups make good use of available data and information. There has been a full revision of the CYSCB Learning and Improvement Framework to reflect changes in the Board's structure and the ways in which it carries out its work. A copy of this is available on our website[4].

During 2016 we are revising and refreshing our Business Plan. The Business Plan enables us to see progress against agreed priorities and to understand where further progress needs to be made. Our Business Plan relates to our priorities, with the 'voice of the child' and 'children with disabilities' running throughout.

[4] http://www.saferchildrenyork.org.uk/cyscb-ways-of-working.htm

THE SIMPSONS

Training and development

The Board has continued to provide a programme of learning and development opportunities throughout 2015-16. Courses are linked to Board priorities, core knowledge requirements and emerging issues and lessons. Quality and content is overseen by our Learning and Development Sub-group. The latest Training Brochure, which conveys the richness and range of our offering, is available on our website [5].

Attendance at our multi-agency training events is usually good, with numbers at, or close to, the preferred target for each course. The Children's Advice Team have delivered a wide range of Early Help training to delegates throughout 2015-2016; in total, 129 professionals attended this training.

The Team also delivered 8 bespoke training sessions at primary schools across York. IDAS (Independent Domestic Abuse Services) delivered training to a total of 29 delegates from various agencies in relation to domestic abuse and managing risk and supporting families.

During 2015-2016, Female Genital Mutilation (FGM) briefing was delivered to professionals to give an understanding of the practice. The Safeguarding Advisor (Education) has continued to deliver whole school safeguarding training to staff in York schools during 2015-16: this training now incorporates important information around FGM and the Prevent duty.

A new learning and development needs assessment will be undertaken in 2016 to ascertain multi-agency training needs across the workforce. This will include scoping the safeguarding training within single agencies in order to avoid duplication and to ensure that CYSCB meets its remit to monitor safeguarding training.

The principles of equality and diversity are at the heart of the all the training we offer. We challenge agency delegates as to whether they make their services accessible to all, including those with physical disabilities or learning difficulties that may require specific tools, aids or language. Our safeguarding training also addresses the issues of cultural norms and whether practitioners understand the difference between a safeguarding matter and a cultural matter. As York's population changes, we will keep these issues under review.

A new learning and development needs assessment will be undertaken in 2016 to ascertain multi-agency training needs across the workforce.

[5] www.saferchildrenyork.org.uk/learning-and-development.htm

The priorities and challenges for next year

Our view is that the existing priorities identified in last year's Report remain valid – but that some of their component elements may need to change:

- CYSCB has learnt that while robust and effective systems for early help exist already, there are improvements to be made in terms of the rising number of enquiries to Children's Social Care (CSC) which may possibly indicate a lack of confidence amongst early help practitioners. The Board is therefore interested to see the new operating model for Early Help which will be developed during 2016 and which will launch in early 2017. The Board has requested an update on the planning and initiation of the project and hopes to see increased whole-family working, with agencies and organisations collaborating to prevent issues and problems escalating to crisis level such that there is a requirement for statutory intervention.
- The number of referrals and enquiries to Children's Social Care and the percentage of Child Protection Plans under the category of 'neglect' has remained a concern to CYSCB. 2016 will see the launch of the new City of York Neglect Strategy. The Board will then face the challenge of testing the understanding of practitioners in terms of assessing and addressing neglect and of measuring outcomes. CYSCB will stage a Neglect Event later in 2016 in order to raise awareness. The Board will also want to monitor the impact of the new Graded Care Profile on standardisation of assessment of neglect and in improved outcomes for children and young people.
- 2015-16 saw the rollout of the 'It's Not Ok' campaign. In terms of the number of children, young people, practitioners, teachers, parents, carers and members of the public that the campaign reached, it was deemed to be very successful. The challenge for the Board, and partners such as NSPCC, will be to ensure that this good work becomes embedded via the use of tools and information packs in schools.
- CYSCB continues to work with partners on ensuring that the processes for identifying and protecting children who go missing from home and care are improved. CYSCB will monitor and challenge the work of Children's Social Care and North Yorkshire Police in ensuring that information about children who go missing, particularly at night and at the weekend, is shared and that return interviews are carried out in order to understand why and where children are going.
- Whilst a significant amount is now known about the numbers of children witnessing domestic abuse and the percentage of children who are present at reported incidents, the Board is keen to ensure that the plight of, and impact on, children witnessing domestic abuse remains a key priority for strategic leaders in York and North Yorkshire.

The Board has identified the following additional priorities and challenges:

- The national review of Local Safeguarding Children Boards being undertaken in 2016 on behalf of the government - the Wood review[6] - will result in changes to the way that LSCBs function. CYSCB is prepared for possible changes and confident that it will continue to operate as a strong partnership.
- During 2016, CYSCB will strengthen its relationship with other strategic Boards. A protocol is already in place with the YorOk (Children's Trust) Board and with the Health and Wellbeing Board but CYSCB will seek to extend this to include the Safer York Partnership and the Safeguarding Adults Board.
- CYSCB will be challenging partners to assure the Board that we are doing everything possible to support and improve young people's emotional and mental health.
- CYSCB is committed to refining its capacity to understand outcomes and impact. The revised Business Plan will mean that the objectives set in the Plan are reviewed regularly (formally at least annually but also at more frequent intervals). In addition to scrutinising the data pertinent to their area and highlighting and responding to issues and exceptions, each Sub-group will look for assurance that outcomes for children and young people in York have been improved.
- During 2016 CYSCB will undertake further work on understanding and analysing multi-agency training needs.
- During the year ahead we will seek advice to ensure the Board is fully up to speed with the current and projected nature of York's population, and any challenges this might pose for our safeguarding work - as well as the opportunity to reach out to new community-based groups.

[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526329/Alan_Wood_review.pdf

Key messages for readers

This year, the Board would like to convey the following key messages. Many of these messages are the same messages as last year but this is because they still matter:

For children and young people

- We are still listening and your voices are the most important of all voices. We think we are getting better at listening to you but we are continuing to work on new ways of hearing you.
- Your wellbeing remains at the heart of our child protection systems.
- We want to hear from you about how services can be improved to ensure your wellbeing, to prevent you being harmed, and to protect you.

For the community

- You are in the best place to know what is happening to children and young people and to report your concerns if you think something are happening.
- Protecting children is everybody's business. If you are worried about a child, contact the Children's Front Door (contact details below).

For City of York Safeguarding Children Board partners and organisations

- The protection of children is paramount. How do decisions that your agency makes affect children and young people?
- You are required to assure this Board that you are discharging your safeguarding duties effectively and ensuring that services are commissioned for the most vulnerable children.
- Are you making sure that the voices of all children and young people are informing the development of services?
- Take notice of the voices of vulnerable children. Listen and respond, particularly if they disclose abuse.
- Children and young children may not always verbalise their feelings. Be aware of other non-verbal ways they may indicate to you that they are distressed or worried.
- Use your representative on our Board to make sure the voices of children and young people and front line practitioners are heard.
- Ensure your workforce is able to contribute to the provision of safeguarding training and to attend training courses and learning events.
- Know the priorities of the Board and take these into account. Share responsibility in the delivery of the Board's work.
- Be prepared to evidence your agency's safeguarding processes via the annual Section 11 audit and event and via assurance reports to the Board.
- This Board needs to understand the impact of any organisational changes on your capacity to safeguard children and young people.

[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526329/Alan_Wood_review.pdf

For schools

- Make sure that you are compliant with the processes which all schools, in the maintained, non-maintained or independent sector, must follow to safeguard their pupils.
- In particular ensure that you are familiar and compliant with 'Safeguarding Children in Education' guidance and the new guidance which will be implemented in September 2016.
- Be aware of and compliant with safer recruitment processes.

For practitioners

- Make sure that you attend safeguarding courses and learning events required for your role and that you are constantly up to date with changes in safeguarding practice, guidance and legislation. These change all the time.
- Be familiar with, and use, the multi-agency tools designed for you: e.g. our 'Threshold Guidance' and the online safeguarding procedures .
- Resist complacency. Just because certain issues such as Child Sexual Exploitation, Trafficking, Female Genital Mutilation and other similar problems are rare in our community, does not mean that they are not present. Indeed, they may be even harder to spot.
- Be 'professionally curious' with other practitioners and when working with children and young people.

For everyone

'If you see something, say something'

If you see something, say something.

City of York
Safeguarding Children Board

www.saferchildrenyork.org.uk/

Contact details for the Safeguarding Children Board
CYSCB Chair: Simon Westwood
CYSCB Manager: Juliet Burton

CYSCB, City of York Council,
West Office, Station Rise,
York,
YO1 6GA
Tel 01904 555695

www.saferchildrenyork.org.uk/contact-us.htm

How to report concerns about a child or young person

If you have a concern that a child is vulnerable or at risk of significant harm please contact the Children's Front Door:
Phone for advice: **01904 551900**
or, using a referral form:
Email: **childrensfrontdoor@york.gov.uk**

Post: The Children's Front Door, West Offices, Station Rise, York, YO1 6GA
More information and a referral form are available at:
www.saferchildrenyork.org.uk/concerned-about-a-child-or-young-person.htm

CITY OF YORK COUNCIL

City of York
Safeguarding Children Board

Annual Report 2015/2016

Working with children, families and professionals to make our children's lives safer

CITY OF YORK COUNCIL

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Foreword by the Chair

This is my third annual report as Independent Chair of the City of York Safeguarding Children Board (CYSCB) and covers the year ending 31 March 2016.

The work of the Board is driven by its vision:

"For all the children of York to grow up in safety and to always feel safe."

The last two years have been characterised by continuous improvement and steady forward progress, coupled with growing partnership involvement, purpose, and respect. As a consequence, the Board is able confidently to set its priorities for action in 2016 and beyond.

In my first annual report I said I was struck by the commitment to continuous improvement in York and that the culture here is child-centred, open and transparent. In my second report I said that partnership working was very strong in operational practice and strategic oversight. That has continued and strengthened over the last two years.

2015-16 has been a period of significant change for the Board as we implemented a new Board structure, working arrangements and staff changes. I want to record thanks to Joe Cocker and Dee Cooley, who left during the year, for their work over a number of years; and to Juliet Burton, our new Business Manager for keeping a focus on improvement through a period of significant change.

Within this report we have set out the achievements made this last year but also identified the improvements that we must continue to address. A particular highlight has been the Board's work, in partnership with NSPCC, to initiate and carry out a very successful campaign -*'It's Not Ok'* - to raise awareness about child sexual abuse and exploitation.

The Board is confident that safeguarding arrangements in York are robust - but they can always be further strengthened. The challenge will be to maintain the progress of the last three years, at a time of unprecedented pressures on public finances, and through a period of national policy changes (including to the focus and remit of safeguarding boards) without losing sight of what matters most: the safety and wellbeing of children in York. It is a challenge for which we are well equipped. On behalf on the Board I want to thank everyone, especially parents and carers for their dedication and effort in helping to make York a safer place for children and young people.

Simon Westwood, Independent Chair of City of York Safeguarding Children Board

Formal Summary Statement

The City of York Safeguarding Children Board (CYSCB) is a statutory body set up in accordance with the Children Act 2004, and in line with the guidance in Working *Together (2015)*[1]*.* The Board is a robust partnership of enthusiastic members, dedicated to the improvement of practice which safeguards children in York.

Information about our work, and our current membership, plus advice, guidance and links to other useful websites is available on our website: http://www.saferchildrenyork.org.uk/. We work closely with other strategic boards including the York Health and Wellbeing Board, the YorOK Board, the Safer York Partnership and the Safeguarding Adults Board.

Consultation with children and young people tells us that they think York is a good and a safe place in which to grow up. CYSCB continues to monitor, challenge and support services to ensure that all children and young people in York, as far as possible, continue to be safe, well cared for and happy. In line with the new Children and Young People's Plan 2016-20, CYSCB focuses particularly on those children and young people who are most vulnerable.

It is a fundamental principle of the way in which we work that all Children and Young People in York should be treated with dignity and respect and have their voice heard regardless of their age, gender, ability, race, ethnicity, religion, sexual orientation and circumstance.

This Report is a summary of our work during 2015-16.

Overall, our Board believes that arrangements for safeguarding children in York during this period were robust and effective; that there is a strong commitment to safeguarding children across the York partnership; and that frontline practice continues to improve.

In reaching this conclusion, we have:

- **challenged** those who work directly with children and young people to listen to what they are saying and to respond to them appropriately, including re-shaping services to meet their needs. **Chapter 2** has more detail;
- **monitored** data and information on a regular basis**. Chapter 3** tells you what we have learnt from this including:
    - up to 80% of children in the most deprived 10% of local areas are registered with a Children's Centre;
    - there are increasing referrals to Children's Social Care with neglect or domestic abuse as a factor;
    - The number of re-referrals within 12 months to Children's Social Care has dropped since the beginning of the year;

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[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

  - Throughout 2015-16 the average social work caseload has remained at 15 cases;
  - the number of children subject to a child protection plan in York was 135 on 31 March 2016 (it was 124 last year);
  - the number of children in the care of the local authority has fallen during the year from a peak of 203 to 191 by the end of the year;
  - The rate of young people sentenced to custody has fallen over the last two years;

- **reviewed** how we are doing as a Partnership, including an assessment as to how far we have achieved the actions we identified for ourselves in last year's Annual Report. This is covered in **Chapter 4**;
- **invited** our partners to contribute accounts of the work they have carried out over the last year to safeguard children. These are summarised in **Chapter 5** and, in more detail, in **Appendix F**;
- **conducted** a series of formal audits of our safeguarding arrangements, including:
  - a "Section 11" audit process (Children Act 2004) at an event held jointly with colleagues from North Yorkshire Safeguarding Children;
  - case reviews of frontline practice which have included themes such as children who are in the care of the local authority with their parents' consent, children who are subject to child protection plans and children who have been affected by domestic abuse;

  We had no serious case reviews in 2015-16 but we have looked at cases from which lessons have been learned. Our formal audit activity is covered in **Chapter 6;**
- **updated** our guidance in relation to Female Genital Mutilation and Reporting Allegations Against Professionals;
- **overseen** the revision of York's Early Help Strategy which will see the establishment of multi-disciplinary and multi-agency local area teams during 2016;
- **initiated and carried** out a very successful campaign -*'It's Not Ok'* - to raise awareness about child sexual abuse and exploitation;
- **provided training** on working together to safeguard children, on domestic abuse, and about female genital mutilation. Our training programmes are described in **Chapter 7**;
- **reviewed and revised** our '*Learning and Improvement Framework'* which describes the way the Board assesses what it knows and how it addresses this. **Chapter 8** contains an assessment of our performance as a Board, whilst **Appendices D-F** contain more details about our membership, structure and finances.

We recognise that there are always improvements to be made. Our new Board structure is still taking shape and we are continuing to learn, to improve our systems, and to find out

about issues which need out attention. However, we are confident that our new structure is focused more on our priorities, with every Sub-group examining and interrogating data and information. We are revising our Business Plan so that each element of that plan reflects the Board's priorities and in order for progress to be measured against agreed outcomes each year, in accordance with our *Learning and Improvement Framework*. **Chapter 9** sets out our priorities for the year ahead.

We have, as usual, set out key messages for everyone, at the end of our report, as well as contact details: these are in **Chapter 10**.

A shorter Executive Summary of this report is available on our website.

This report is formally the responsibility of the independent Chair, Simon Westwood. Its contents have been accepted by the CYSCB. In line with statutory guidance in Working Together 2015, it will be submitted to Chief Executive, the Leader of the Council, the local Police and Crime Commissioner and the Chair of the Health and Well-being Board.

Chapter 1: Some facts and figures

York is a unitary authority which is predominately urban with some rural areas. It has a population of just over 204,000[2]. Data published by Public Health England in 2016 shows that in 2014, the number of children aged 0-19 living in York was 44,200[3]. People aged below 20 years old account for 21.6% of York's population. In 2014, the number of 0-4 year olds was 10,600, equivalent to 5.2% of the population. Findings from Public Health England project that by 2025, the number of children living in York aged 0-19 will be 47,300. Further detailed demographic information on York is available online on the York Health and Wellbeing website[4]. Additional characteristics of York are also available in the Council Plan 2015-2019[5].

There are 68 schools in York: 50 Primary, 9 Secondary, 6 Independent Schools, 2 Special Schools and 1 Pupil Referral Unit (Danesgate). At the time of writing, data released from the Local Authority Schools' Service reports that 7 Primary Schools in York are academies with a further 3 converting to academies at the end of this academic year. There are currently 3 secondary schools which are academies in York. The city also has over 100 voluntary organisations offering services for children and young people.

In 2015, York Health and Wellbeing Board reported that York has become more culturally and religiously diverse. The Black and Minority Ethnic (BME) population in 2015 was 9.8% compared to 4.9% in 2001[6]. Public Health England states that in 2015, there were 2,125 children of BME origin living in York, making up 10.1% of the school population[7]. The ethnic composition of York changes year on year. York's most ethnically diverse ward is Heslington where 35% of the city's BME population reside, owing to the high number of international students attending York University[8]. In the coming year, we will seek further guidance to ensure that as a Board we are fully up-to-date with York's changing population and its possible implication for our safeguarding work.

At the end of March 2016 there were 135 children on child protection plans in York. The number of looked after children in the city at year end was 191. During 2015-16, York set out a new *Strategy for Children and Young People in Care*[9]; CYSCB had input into its construction.

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[2] http://www.neighbourhood.statistics.gov.uk/dissemination/LeadKeyFigures.do?a=7&b=6275327&c=York&d=13&e=13&g=6383071&i=1001x1003x1004&m=0&r=1&s=1459766461250&enc=1

[3] http://www.chimat.org.uk/resource/view.aspx?RID=101746®ION=101630

[4] http://www.healthyork.org/

[5] https://www.york.gov.uk/downloads/file/7880/council_plan_2015-2019

[6] http://www.healthyork.org/the-population-of-york.aspx

[7] http://www.chimat.org.uk/resource/view.aspx?RID=101746®ION=101630

[8] https://www.york.gov.uk/downloads/file/86/census_2011_population_by_area

[9] http://www.yor-ok.org.uk/workforce2014/looked-after-children-strategy.htm

The city is relatively prosperous, with the level of people claiming of out-of-work benefits statistically lower than regional and national averages[10]. Over the last year, the number of people claiming Job Seekers Allowance (JSA) has fallen by 31.7% in York. The JSA claimant count for York represents 0.5% of the working population and contrasts to the regional average which stands at 1.9% and the national average which stands at 1.5%. Alongside this, the number of young people (18-24) claiming has fallen by 48.3% in the last year. However, 7% of York's population (around 14,000 people - adults and children) live in areas classified as being in the 20% most deprived areas in the country.

Recent Public Health figures show that the number of children under the age of 16 living in poverty in York (11.2%) is lower than regional and national averages (20.6% and 18.6% respectively). This represents a decrease of 0.5% from 2014/2015[11].

Children's services in York are overseen by a Children's Trust Board, known as the YorOK Board[12]. CYSCB works closely with YorOK, in a spirit of constructive challenge, and there is reciprocal reporting between the Boards. The YorOK website contains a wealth of valuable information and documents, including the latest *Children and Young People's Plan* for 2016-2020[13].

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[10] http://www.cycbuzz.org.uk/may-2016/latest-news/317-per-cent-fall-in-job-seekers-allowance-claims

[11] http://www.chimat.org.uk/resource/view.aspx?QN=PROFILES_STATIC_RES&SEARCH

[12] http://www.yor-ok.org.uk/

[13] http://www.yor-ok.org.uk/workforce2014/Dream%20again%20and%20YorOK%20Board/Children%20and%20Young%20Peoples%20Plan%202016-2020.pdf

Chapter 2: What children and young people have told us

Involving children and young people, and hearing their voice, is a well established part of how York works to deliver the best possible outcomes for families. There are many forums and mechanisms through which the voice of the child is heard, and all partners strive to translate this into meaningful action. This chapter outlines the key ways in which children and young people are involved in the design and delivery of their own services, and how opportunities for their involvement have been improved in 2015-16.

Children's Engagement Strategy

As highlighted in our Annual Report for 2014-15, a joint ***Voice and Involvement Strategy*** was agreed by the YorOK Board and the City of York Safeguarding Children Board for 2014-2017[14]. The strategy was created through listening to children and young people's views. It sets out a clear vision for our work in this area:

"Children and young people are at the heart of our strategic arrangements. We are committed to ensuring that children and young people have a voice in decision-making, planning, commissioning, design and delivery of services."

Since then, the Safeguarding Children Involvement Group merged with the YorOK Voice and Involvement group to provide a single multi-agency, city-wide group to take forward this vision. A detailed report looking at work undertaken is available on the Children's Trust website[15]. This "***Review of Voice***" document brings together:

- key messages from children and young people;
- examples of how messages from children and young people have shaped service design and delivery;
- how opportunities for children and young people to have a voice have developed over the last year; and
- priority areas in need of further development.

Children and young people's feedback

UMatter Survey for Looked After Children

The latest UMatter Survey of children who are looked after was conducted between February and April 2015. This survey gives children and young people an opportunity to

[14] http://www.yor-ok.org.uk/downloads/Involvement/YorOK%20Voice%20and%20Involvement%20Strategy%202014%20-%202017.pdf
[15] http://www.yor-ok.org.uk/workforce2014/Voice/2015-review-of-voice.htm

voice their opinion on what the local authority should change and improve for those in care. The key messages that came out of the survey were:

- 87% of young people felt the council provides good quality placements for children and young people in care;
- most young people (86%) were happy with foster carers and 72% of young people felt they could talk to a foster carer or social worker if they were ever unhappy in their placement. It is worth noting that the 14% who said they weren't happy with carers was only 7 young people and some had mixed views of foster carers;
- 85% of young people knew how to contact their social worker if they needed them, an improvement from last year when 54% of young people didn't know how to do this;
- 78% of young people knew who their Independent Reviewing Office was, an improvement from last year when fewer than half knew who this was;
- 65% of young people normally attend their reviews. However,35% said they do not attend because their review meetings are 'boring', 'pointless' or 'repetitive';
- 76% of young people knew about their Personal Education Plan: a big increase from the previous year when only 54% of young people knew about their Plan;
- 90% of young people felt their carers take care of their health very well or well, compared to 98% in 2014;
- 85% of young people are aware of the Speak Up service compared to 54% in 2014;
- 81% of young people were aware of their rights and entitlements;
- 85% of young people said workers treated them with respect in comparison to 74% of young people in 2014.

The next UMatter Survey is due to be conducted between September and December 2016. CYSCB has requested the following questions are included in this survey to ensure we hear the voice of children at different tiers of need:

- a child's/young person's experience of being on a child protection plan;
- a child's/young person's experience of having a social worker;
- a child's/young person's experience of having any Early Help support worker.

Stand Up for Us Survey

This survey has been running since 2011 and aims to monitor the prevalence and nature of bullying behaviour in primary and secondary schools in the City of York. The survey has since been further developed to explore aspects of physical health and emotional wellbeing. The survey takes place once every two years with one being conducted in March 2016, the results of which we will consider in the Autumn.

CYSCB Voice and Involvement Sub-group

This Sub-group of our Board engages partners across the sectors in a process that builds capacity, shares resources and expertise, and promotes the voice of children and young people across the city. These are some of the things that the Sub-group has heard in 2015-16, and what has been done in response.

Young people said ...	***So ...***
Children and young people said they would like to be recognised for their community spirit and for volunteering	CYC and Door 84 hold an annual Lord Mayor's awards with partners to say thank you for children and young people's contribution to York
Young people would like more opportunities to go to new places and have new experiences	Partnerships have been developed along with young people to deliver a programme of positive activities
Disabled children and children in the care of the Local Authority wanted friendships to be given more importance when foster carers and other professionals are making assessments that affect their lives.	The Children's Society and the Local Authority deliver the 'Friendship for All' project which provides professional guidance, training resources and a new website to increase friendship in the lives of disabled children and children in care
Young people in care said it is important that elected members and decision makers understand what is like to be in care	The Local Authority enabled young people to deliver training to 17 elected members and senior leaders. In 2016 this will include members of CYSCB.
The Youth Council in consultation with other young people wanted more young people to have the chance to participate in a political process	The Local Authority empowered young people to run a referendum across York secondary schools and over 2,000 young people took part
The Young Inspectors said that they wanted to inspect GP surgeries	Healthwatch commissioned The Young Inspectors to mystery shop GPs' surgeries and to make recommendations that will improve children and young people's experience in the future
The Youth Council said transport is vital to children and young people and not everyone can afford a bike	The Local Authority have supported young people to work with Cannon Lee School to develop the first 'Bike Library', funded by the Clifton Ward
Children and Young People told us that mental health support in schools was critical and designed the 'Minding Minds Award'	A new model of working has put mental health at the top of schools' agenda with the creation of new Well-being Worker posts funded by the Local Authority, and the Vale of York Clinical Commissioning Group
Refugee and migrant children said that	Refugee Action York in partnership with the Local

young people needed a place to meet, socialise and discuss issues and ideas	Authority created a youth club for young refugees
Children and young people said that they wanted to be able to talk to and influence Local Councillors	The Local Authority in collaboration with Cannon Lee School have set up the first under 18 Ward Group in Clifton who are currently transforming provision in their local area and lobbying local councillors
Children and young people said that they needed support with issues like self harm, depression and anger	The Local Authority worked with partners like IDAS and MIND to develop specialist services in partnership with children and young people.
Children and young people said they wanted more people to understand autism.	Professionals worked with young people to understand about autism and advocated on their behalf to improve their experiences at school and college
Young people in care wanted to be more involved in the training of Foster Carers	The *Show Me That I Matter* group now works closely with the fostering team and contributes to foster carer training.
Young people said they wanted access to more information on leaving care	Information has been made more accessible via Facebook. The Independent Reviewing Officers are now routinely asking at reviews, once a young person has turned 16, to make sure they have begun the pathway plan and have enough information about their rights and entitlements.
Children and young people wanted to reduce the stigma of being in care.	The *Show Me That I Matter* group now delivers the *Speak Up and Hear My Voice* training on behalf of young people in care and the *Aspire to More* project was set up with *Inspired Youth* and a blog produced that sets out to inspire young people and care leavers and challenge the negative views. The project has achieved national recognition.

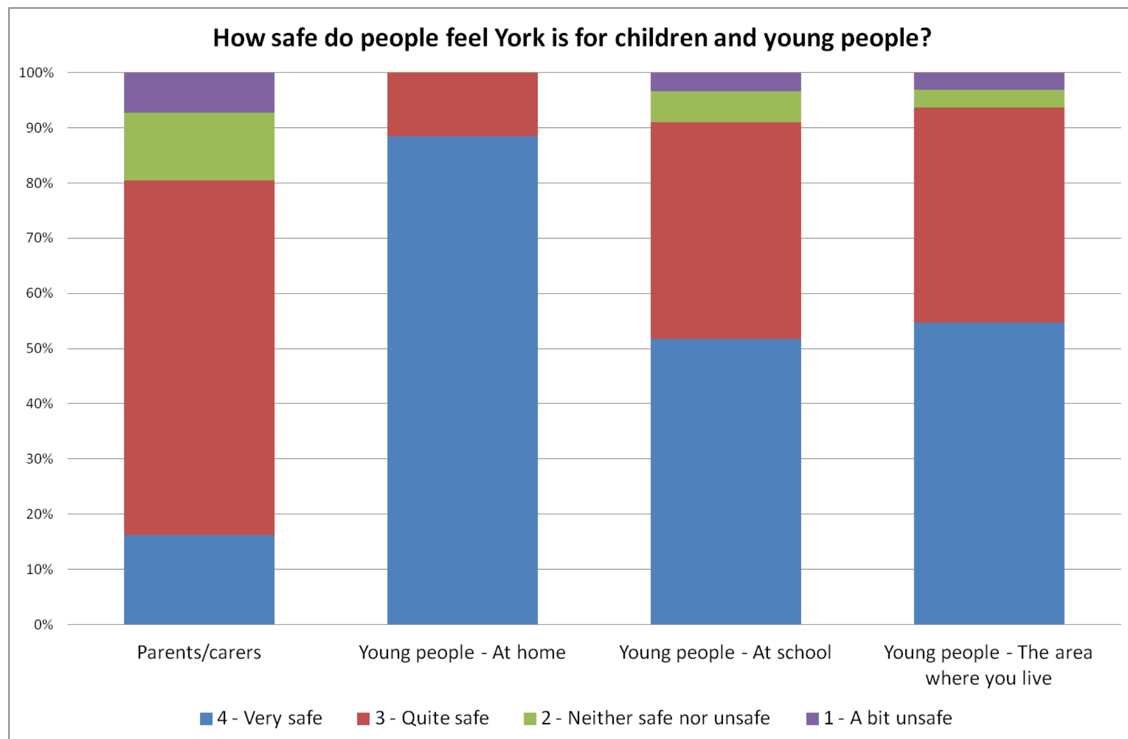
Children and young people shaping services

Children and young people in York continue to shape services at both a strategic and an operational level. Over 70 young people participate in groups, projects and other forums citywide, but the children and young people's voice network reaches out across *all* schools, colleges and communities to make sure diversity is valued, and many more children and young people participate in projects which seek to understand what they have to say. This section sets out some examples of such involvement from the past year.

Children and Young People's Plan

During 2015-16 children and young people helped to shape the new *Children and Young People's Plan* as young researchers and through stakeholder meetings. During this

consultation safeguarding was highlighted a number of times as a key priority. Generally, young people, parents and carers feel that York is a safe place and a good place to live and grow up, as shown in the chart below:



This is encouraging and correlates with other feedback gathered through existing surveys undertaken with children and young people.

Show Me That I Matter

Show Me That I Matter[16] is York's Children in Care Council. It is a monthly forum where care-experienced young people (13+ years of age) raise important issues for discussion with Elected Members and senior managers, with the aim of helping to shape and improve services for looked after children in York. A separate focus group has been established to provide additional space for discussion. As part of *Show Me That I Matter*, the group have developed a young person's interviewing panel which provides input into the recruitment process to the children's social care sector[17].

The group also offers *Speak Up and Hear My Voice* training which aims to help adults understand the needs and experiences of children and young people in care, and the importance of listening and acting on their wishes and feelings. It is an excellent opportunity to learn from young people themselves whilst developing professional skills and knowledge. So far, four sessions of the training have been delivered and have received very positive

[16] http://www.yor-ok.org.uk/workforce2014/Voice/show-me-that-i-matter.htm
[17] http://www.cycbuzz.org.uk/March-2016/in-the-spotlight/am-i-just-a-number-amys-story

feedback from attendees. Further sessions are being planned for 2016 including shorter twilight sessions aimed at Board Members and/or Elected Members

Speak Up

Speak Up is York's Children's Rights and Advocacy Service which helps children understand their rights and provides them with help and support on a wide range of issues. In 2015-2016, 64 children requested the support of advocate's from *Speak Up*; 14 of these resulted in no further action and 50 resulted in the provision of advocacy support. The main issues raised were as follows:

Primary Issues Raised	No. Of Requests	Percentage
Contact	2	3%
Unhappiness with social work service	11	17%
Placement	7	11%
Disagreement with Care Plan	3	5%
Access to support/services	5	8%
Support to express wishes and feelings in decision making process	32	50%
Other	4	6%

Castlegate

Castlegate[18] provides free and confidential information, support, advice and counselling to young people and adults aged 16 to 25 who live in the city of York. A consultation exercise entitled *Have your say* ran from 24 August to 21 September 2015 with the aim of exploring different options for service delivery by analysing young people's needs when accessing these services. 131 young people were involved with the consultation. The participants valued the opportunity to express their views and demonstrated their ability to provide valuable information to decision makers.

Young Inspectors

The young inspectors programme aims to work with a small group of disadvantaged young people and allow them the opportunity to have a voice and say in some of the services they may access. They have the opportunity to go into services and inspect them and give recommendations for improvements from their and other service users' perspective. It also a great opportunity for young people to make friends, gain confidence and self esteem, and receive some lightweight support. The latest inspection was of GP surgeries. The Young Inspectors' key findings included: the importance of 1:2:1 confidential spaces; better mental

[18] http://www.29castlegate.org/

health training for GPs and surgery staff; and being able to access GPs without parents/carers.

Lunch club for deaf children

As a result of feedback from children and young people, the Deaf and Hearing Support Team now operate a lunch club each half-term for deaf children. The event is organised by the children, their teaching assistants, and by the various schools which are used as venues on a rotating basis. Board members will be joining a session of the lunch club to listen to the young people later in 2016.

Schools Health and Well-Being Project

One of York's key objectives in relation to mental health provision has been the initiation of a School "Cluster Pilot" of the Health and Wellbeing Project. This pilot project started in September 2015 and was funded by the City of York Council and Clinical Commissioning Group. The aim was to introduce a new form of partnership working to strengthen the emotional and mental health support arrangements for children and young people in universal school settings. A child group evaluation of the work to date revealed very positive feelings about the project:

Question	**Responses from the group**
What has helped?	- "Talking to each other" - "Knowing what to do when I am angry and worried" - "Making friends with people in the group" - "I have been able to verbalise feelings that feel confusing- which helps me understand them better" - "talking about feelings and emotions and how to solve them"
What have you learnt?	- "New skills for life and coping" - " To do a breathing exercises to relax" - "About emotions and different feelings" - "How to tell people how you feel" - "How to stand up for myself"
Do you feel more able to cope?	- "I feel like I can share my feelings more" - "I know that I can talk to people and I know how to talk now, after speaking about feelings/situations we have talked about solutions" - "It makes me feel like I can open up to everyone" - "It makes me want to come to school far more" - "It has improved my mood" - "It has made my self esteem go up and makes me want to get up in the morning"

Voice Priorities for 2016-2017:

Even though achievements have been made, as evidenced above, many of the priorities set by the Voice and Involvement Group for 2014-15 remain priorities for 2015-16:

- voice at different tiers of need: so that every child whether receiving support at any level or simply accessing universal provision (schools and health services) will have an opportunity to express a view;
- voice in assessments: every child who participates in an assessment, whether early help or statutory, will be able to contribute to that assessment;
- pre-verbal or non-verbal “voice”: those children and young people who are unable to express their wishes and feeling verbally because they are too young or because they communicate in a different way, will be heard.

An additional priority for 2016-17 is:

- voice and change: children and young people will be consulted and heard when changes are made to services which affect their lives. The ongoing re-modelling of early help services has included the voices of children and young people in the re-structure consultation.

Progress made by partners will be reported back to our Board throughout 2016-17 via the Voice and Involvement Group, and we will continue to challenge each other and develop further our approach to listening to the voice of children and young people.

Chapter 3: What the performance data tells us

We changed the structure of our Board at the beginning of 2015-16 so that performance reporting is now closely aligned to our priorities. Early Help, Sexual Abuse and Exploitation, Children Missing, Neglect and Domestic Abuse are the subject of performance updates at each board meeting. In addition, each Sub-group of the Board reviews data pertinent to their area and highlights and responds to issues and exceptions.

Our data comes from a variety of sources: not just Children's Social Care and other local authority services but also from partners such as North Yorkshire Police, York Teaching Hospital, Public Health and voluntary sector services. Together with other information from partners, including regular assurance reports, this data helps us to build a picture of what is happening in terms of safeguarding children.

At **Appendix A** you can see the kind of data that the CYSCB monitors. At **Appendix B** you can see the cycle of reports to the Board through the year and the activity which goes on in between Board meetings.

Early Help

- 171 Early Help Assessments were recorded by the Advice Team as initiated in 2015-16;
- primary schools initiated the most Early Help Assessments followed by Children's Centres and then closely followed by Secondary Schools;
- the number of re-referrals within 12 months to Children's Social Care has dropped since the beginning of the year;
- during the year, up to 80% of children aged 0-4 who live in the most deprived 10% of local areas have been registered with a Children's Centre;
- the latest available figures for persistent absence and total absence in primary and secondary schools show that York has better attendance than the national average;
- the rate of teenage pregnancies - already at its lowest, and below the regional and the national average - is forecast to continue to fall[19];
- the rate of attendances for 0-4 year olds at Accident and Emergency has fallen.

Neglect

- the percentage of referrals to Children's Social Care with neglect as a factor has risen during the year to 17.3% at year end and is higher than it was in 2014-15;

[19] http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=40&geoTypeId=4#iasProfileSection5

- the percentage of referrals and enquiries with neglect as a factor at the point of referral (inc. alcohol and substance misuse by parent and absent parenting) is almost one fifth of all referrals and enquiries;
- The percentage of Social Care Single Assessments in which neglect is identified as a factor has also increased;
- the number of admissions to hospital for children with deliberate or unintentional injuries has remained stable;
- the most recent health data (2014-15) for hospital admissions for dental caries (tooth decay) shows that York has a higher number than the national average.

Child Sexual Abuse and Exploitation (CSA&E)

- the percentage of referrals to Children's Social Care with sexual abuse as a factor at the point of referral has remained the same as 2014-15 as have the number of Single Assessments in which Sexual Abuse has been identified as a factor;
- the percentage of referrals in which Child Sexual Exploitation is a concern at the point of referral has risen since last year;
- these percentages remain low in comparison with other factors such as domestic abuse and neglect;
- the number of reports to police of sexual offences in which victims are under the age of 18 has risen slightly year on year;
- Child Sexual Exploitation is being recognised more as a possible concern for young people accessing sexual health services.

Missing from Home, Care and Education

- the number of children recorded as missing from home or care increased slightly in the numbers recorded in last year by both Children's Social Care and by the Police;
- half of these children are recorded as 'missing' (i.e. they might be at risk) and the other half as 'absent' (i.e. just not where they are expected to be);
- none of these children have remained missing;
- 89% of children reported as 'missing from education' have been located or assessed as 'no concern'. (The other 11% are those carried over at year end for further enquiries.)

Young People and Youth Offending

- the number of first time entrants to the Youth Justice system has risen slightly since last year, but remains low and in line with national trends;
- the rate of young people sentenced to custody continues to remain very low and has fallen over the last two years;

- the percentage of young people who re-offend has remained stable at 36%, in line with, but slightly above the national average.

Disabled children

- 90% of Education, Health and Care Plans were issued within statutory time limits;
- two School Wellbeing Workers based in the East and Southbank school clusters have provided training, support and advice to pastoral staff, and delivered individual and group work to 394 children and young people between October 2015 and March 2016. (The project is being extended in September 2016 to cover all schools in York.)

Contacts and Referrals to Children's Social Care (CSC):

- The Children's Front Door received just over 3600 *contacts* in the whole of 2015-16; 645 of these reached the threshold for Children's Social Care assessment and intervention ;
- the re-referral rate within a 12 month period as an average for 2015-16 is similar to that in 2014-15 at 10.3% but had fallen significantly to 6.3% at the end of the year.

Child in Need

- 191 children were receiving a service from the CSC Child In Need teams in March 2016;
- 3.3% of these children were on the 'edge of care' or 'statutory child protection intervention'.

Child Protection and Court Proceedings

- at the end of March 2016, 135 children were subject to Child Protection Plans; this is slightly more than at the at the same time last year (124);
- as in previous years, the majority of children subject to a plan (55.6%) are listed under the category of neglect, with emotional abuse (36%) a close second. Physical Abuse (3.5%) and Sexual Abuse (4.2%) are well behind these two;
- figures from CAFCASS Care Demand Statistics show that 55 children from York were subject to applications to court for care orders in 2015-16.

Children's Social Care Caseloads

- throughout 2015-16 the average social work caseload has remained at 15 cases (with variations owing to the nature and complexity of cases);
- there has been around 90 % compliance with the requirement for monthly supervisions of social care staff.

Children in the Care of the Local Authority

- the number of children in the care of the local authority has fallen during the year from a peak of 203 to 191 by the end of the year;
- there has been a reduction in the number of children looked after outside of York;
- 100% of care leavers were in suitable accommodation at the end of the year and 70.5% in education, employment or training (an improvement on last year).

Private fostering

- 6 Private fostering arrangements were supported during the year 2015-16;
- 2 Private Fostering Arrangements ended within the period.

Child Deaths

- in 2015-16 there were 11 child deaths in York;
- 6 of the 11 were unexpected deaths - see **Chapter 6** for how these were investigated;
- there has been a 13% decrease in the number of child deaths in North Yorkshire and City of York over the last 5 years.

Chapter 4: How we are doing as a Partnership

This Chapter contains an analysis of our progress as a partnership during 2015-26. It is divided into two sub-sections, examining in turn our progress:

(a) against the five priorities we set ourselves and the actions in last year's Annual Report;

(b) in overseeing York's other work with vulnerable children and young people.

The perspective of individual partner agencies is covered in the next Chapter.

The five priorities we set ourselves last year

In 2015-16 we continued to identify the Board's five priorities as:

- Priority 1: Early Help;
- Priority 2: Neglect;
- Priority 3: Sexual Abuse and Exploitation;
- Priority 4: Missing from Home, Care and Education; and
- Priority 5: Domestic Abuse.

We have also continued to consider data and information on Female Genital Mutilation as new government guidance has been developed.

The work we have done is outlined in the following sections and includes our response to the specific actions identified in last year's report.

Priority 1: Early Help

The Early Help Group reports both to the Children's Trust Group (the YorOk Board) and to the CYSCB. The priorities for this group therefore span the spectrum from universal need up to the provision of statutory intervention.

The Children's Advice Team have recorded the initiation of 171 Early Help Assessments in 2015-16 with most carried out by Primary Schools, Children's Centres and Secondary Schools. The Safeguarding Board has been interested in the percentage of cases passed on for Early Help Assessment by the Children's Social Care Referral and Assessment service when the enquiry and concern does not reach the threshold for Social Care assessment and intervention. The percentage has been low and this has largely been influenced by the lack of consent from families sought by practitioners prior to contacting the 'Children's Front Door'. It is hoped that a change in the referral form used by Children's Social Care and a complete revision of the Threshold Guidance will lead to an improvement in practitioners' confidence in sharing their concerns with parents and young people prior to contacting Children's Social Care in all but the most serious child protection cases.

A primary focus for the Early Help Group since October 2015 has been the project for remodelling the provision of prevention and early help services across the city. This project

will see the formation of three local area multi-disciplinary teams working together to ensure a seamless service and robust systems for information sharing.

As described above, in 2014-15 the Board had expressed some concern about the number of cases which were being referred to Children's Social Care which did not meet the threshold for statutory intervention. The Board has therefore welcomed updates on the planning and progress of this project which is designed to offer a more coordinated and robust early help service with practitioners from all disciplines working together using a 'think family model. The Board hopes to see that a greater number of situations will be addressed through early working alongside families and communities. CYSCB looks forward to further updates and to full initiation of the new service in late 2016.

The Early Help Group will oversee a full revision of the Board's Threshold Guidance in 2016, as part of our assessment and evaluation of the arrangements for the child's journey in York.

Priority 2: Neglect

The Neglect Sub-group was set up with the aim of responding to the apparently high levels of neglect cases reaching the threshold for statutory intervention and in particular the significant number of children subject to a Child Protection Plan under the category of neglect. In terms of the numbers, York is no different from the rest of the country which has seen a surge in the number of reported cases of neglect over the last ten years[20]. Neglect is the most common form of child abuse and can affect a child's development and outcomes for the whole of their life.

The Neglect Sub-group has developed a city-wide Neglect Strategy the draft of which will be out for consultation from July 2016, to be finalised later in 2016. In addition, the Sub-group, led by the Director of Public Health, has worked with the local authority and Public Health services to initiate training on the Graded Care Profile which will see practitioners from Children's Social Care (Social Workers) and the Healthy Child 0-19 Service (Health Visitors and School Nurses) use a common language and common assessment approach to cases of neglect. Training on the Graded Care Profile may, in due course, be extended to other practitioners.

The Neglect Sub-group is planning a multi-agency Neglect Event to be held in July 2016 which will be the launch of the York Neglect Strategy, as well as an opportunity to hear from experts, to learn about the use of the Graded Care Profile, and to share experience and good practice.

Priority 3: Sexual Abuse and Exploitation

The Child Sexual Abuse and Exploitation/Missing from Home and Care Sub-group has met bi-monthly throughout 2015-16 to consider a range of issues and projects in relation not only

[20] https://www.nspcc.org.uk/services-and-resources/research-and-resources/2016/how-safe-are-our-children-2016/

to sexual abuse and exploitation but also in regard to vulnerability in the widest sense including children who go missing from home and care.

The group has considered information from statutory and voluntary services on the range of provision for vulnerable children and has requested research information where gaps in provision have been identified such as information about services for children who have been victims of online sexual abuse.

In February 2016, the Chair of CYSCB, along with the Chair of NYSCB, supported the Police and Crime Commissioner from North Yorkshire in a challenge to NHS England in regard to the newly established Child Sexual Assault Assessment centre at York Hospital. The PCC raised concerns about whether the resourcing of the service, which did not operate 24 hours, meant that children had to access services out of county. CYSCB received assurances from NHS England, the CCG and York Hospital that although this had only happened on one occasion, steps were being taken to look at collaborative working in 2016 so that there is more capacity to see children locally as soon as possible.

During 2015-16 the group has been active in supporting the joint CYSCB/NSPCC *'It's Not Ok'* campaign addressing child sexual abuse and exploitation and raising awareness to prevent this kind of abuse (see ***'It's Not Ok'* section in this report**). The campaign will be evaluated fully later in 2016 and the Board will request further information about its longer-term impact. In the meantime:

- around 2000 Year 7 children have seen the play and taken part in the workshop;
- more than 450 parents have taken part in workshops;
- 273 professionals attended workshops; many attended more than one workshop;
- bus side adverts have had a reach of 137,857 people; 88.9% coverage of the city;
- bin lorries with adverts have covered approximately 320 miles per week, all day, six days a week;
- to date there have been more than 4,500 hits on the '*It's Not Ok'* website.

The campaign has been a successful collaboration between a range of agencies and organisations backed by CYSCB and the NSPCC. Interest has been expressed by other local authorities wishing to use part of, or the whole, model. In early 2016 the campaign was shortlisted for a UK Public Sector Communications Award.

The 'It's Not Ok' Campaign

The *'It's Not Ok'* campaign ran from May 2015 until July 2016 as a joint partnership between the CYSCB and NSPCC. The aim was to ensure that parents, carers, children and young people, professionals and the general public knew how to recognise the signs of child sexual abuse and sexual exploitation, where to get help and advice, and to increase their confidence in saying or doing something to stop the abuse.

The campaign had four distinct phases:

- an in-school play and workshops for children and young people;
- workshops and seminars for professionals;
- workshops and seminars for parents and carers;
- publicity to raise awareness for the wider York community.

For children and young people delivery of the campaign has been mainly through schools, with the NSPCC delivering to primaries, and colleagues from North Yorkshire Police linking with secondary schools to deliver 'risky behaviours' workshops. York St. John University's drama department produced an interactive play and a DVD for Year 7 children. A full workshop on sexual abuse and exploitation accompanied this. As a result:

- 95% of the Year 7s said that they felt the drama had enhanced their understanding;
- 89% said they had experienced a piece of new learning;
- 92% said that they would be able to offer a piece of advice to a young person experiencing sexual abuse or exploitation;
- 83% felt that they would be able to offer a piece of advice to a parent or carer.

What the young people said:

'It showed me what it's like in someone else's shoes. It made me know what to do if it happened to me'
'It helped me understand how people are affected, better than a talk in assembly'
'The play put difficult problems into a format that made it easier for me to understand what child sexual abuse was'
'I learnt that lots of social media sites have report buttons'
'I learnt about grooming and what it is'
'It made us think about ways to solve a problem like the characters…I learnt where to report abuse'
'I already knew most of it. But I learnt that you can get abused by a member of family'

Sessions were provided **for parents and carers** on 'How to parent in a digital age' about keeping children safe online. The sessions addressed:

- online 'grooming';
- online reputation;
- overuse and exposure to inappropriate content.

The campaign website and the CYSCB website also provided information and links for parents, children and young people on online safety.

For professionals a series of workshops took place covering topics such as:

- understanding Child Sexual Abuse and Exploitation and the relevance to your organisation;
- young people's experience of abuse and exploitative relationships;
- sexually harmful behaviour;
- making your organisation safer;
- supporting local communities to respond to the issue of child sexual abuse.

Posters and wallet cards were displayed across the city **for the general public** and selected 'hotspots' were targeted with posters in bus shelters. Buses, bin lorries and police vehicles were used to advertise the campaign and signpost people to the campaign website, to the NSPCC 24 hour helpline and to the police. There were regular pieces about the campaign in the local press.

During 2016 taxi drivers will be trained to recognise the signs of possible child sexual exploitation. This training will be mandatory for every taxi driver wanting to renew their licence. Hotels, pubs and clubs will be provided with information and materials promoting the campaign and given information about useful websites and sources of support. Bespoke training will be provided for local businesses.

The campaign materials and resources will remain available on the website and schools have been provided with further resource packs. It is intended that the play and workshop will continue as a rolling programme for schools and colleges with a DVD provided if a performance of the live play is not possible.

Priority 4: Missing from Home, Care and Education

The CSA&E/Missing from Home and Care Sub-group considers that a child or young person who goes missing from home can be vulnerable to abuse including sexual abuse and sexual exploitation. In 2015-16 there were 657 reports of children or young people missing from home or care reported to police. However, many of these were the same individual on more than one occasion. Only half of these incidents were any cause for concern and the Board is assured that those individuals who appear to be of particular concern and may be putting themselves at risk, are discussed at a multi-agency meeting (police, social care and health) so that support can be provided for them and their carers. Every child or young person who has been reported as missing during 2015-16 has been found.

A new joint North Yorkshire/York LSCB Protocol was agreed with North Yorkshire police in April 2015 in relation to Children Missing or Absent from Home and Care. CYSCB, Children's Social Care and North Yorkshire Police continue to work together to identify all of those children who are of concern and ensure that they receive intervention and support.

Children missing from education can also be vulnerable. During 2015-16, 124 children were reported as not at the school they were registered at in York. The vast majority of these children were found at other schools or found to have moved elsewhere. For those few not immediately located, consultation takes place with Children's Social care to ascertain whether there is any reason to be concerned. 89% of those children missing from education were found or ascertained to be of no concern. One or two cases remain ongoing at the year end.

Priority 5: Domestic Abuse

The York and North Yorkshire Joint Coordination Group for Domestic Abuse and the Safer York Partnership have the overall lead on the strategy for domestic abuse in York. The CYSCB Domestic Abuse Sub-group was formed to bring together agencies such as schools, police, the Independent Domestic Abuse Service (IDAS), health commissioners and providers, to identify and highlight issues relevant to children in York. CYSCB has representation on these Boards.

The Domestic Abuse Sub-group was set up specifically to look at the impact of Domestic Abuse on children in York. Domestic abuse data indicates an increasing percentage of reports of incidents to North Yorkshire Police in which children had been seen to be present. This does not necessarily mean that more children are witnessing domestic abuse; it may suggest that police officers are getting better at recording this. However, domestic abuse is known to be a dominant factor in referrals to, and assessments by, Children's Social Care and CYSCB has been keen to understand the prevalence of domestic abuse and the perspective of children and young people in York. This understanding can then inform and support the overall Domestic Abuse Strategy.

The CYSCB has been pleased that plans for Operation Encompass to be implemented in York are progressing and that this will be launched later in 2016 (this is a scheme to inform

schools of domestic abuse incidents in order for them to support children in families where this may be an issue). This is being led by North Yorkshire Police. CYSCB looks forward to hearing more about progress and outcomes.

Additional Priority: Female Genital Mutilation (FGM)

In 2014-15 CYSCB added Female Genital Mutilation as an area for attention given the increasing national awareness of this as a form of child abuse. With the introduction of national statutory guidance on FGM and the mandatory duty to report suspected FGM[21], CYSCB has worked with North Yorkshire Safeguarding Children Board to raise awareness of FGM across the workforce and to provide local guidance. This has included FGM briefings to practitioners and access to e-training (as described in Chapter 8) and briefings to designated safeguarding leads in schools. Although the number of suspected FGM cases in York is not high, there has been a rise in the number reported to Children's Social Care as awareness has increased over the year.

York's other work with vulnerable children and young people

This sub-section contains an assessment of York's other work with children and young people, particularly those who are vulnerable. It is itself divided into five sub-sections:

(1) Children in contact with Children's Social Care
(2) Family Focus
(3) Those in contact with the criminal justice system
(4) Disabled children
(5) Schools

Children in Contact with Children's Social Care

(In mid- March 2016, Children's Social Care transferred their recording and reporting to a new system. Some of the data and information below ***may not include*** *the whole of Quarter 4 (January to March 2016))*

The Children's Front Door received just over 3600 *enquiries* in the whole of 2015-16. Six hundred and forty five of these contacts were 'referrals' i.e. reached the threshold for Children's Social Care assessment and intervention. Both numbers are lower than in previous years and slightly higher than the England average rate for the end of 2015 (but figures must be seen in the context of the new reporting system and may not be a complete year).

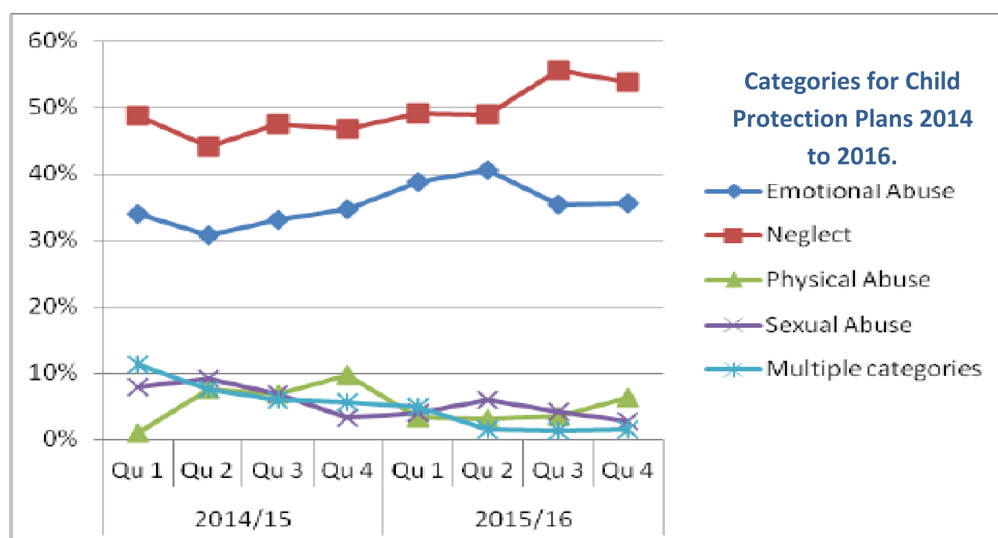
The percentage of repeat referrals within a period of 12 months has, however, dropped significantly since the beginning of the year which suggests that cases are being closed or stepped down with a more lasting outcome.

[21] https://www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information

Children who have a ***Child Protection Plan*** are considered to be in need of protection from either neglect, physical, sexual or emotional abuse; or a combination of two or more of these. The plan details the main areas of concern, what action will be taken to reduce those concerns and by whom, and how we will know when progress is being made.

At the end of March 2016, 135 children were subject to a child protection plan with 100% reviewed within timescales. (York had 124 on 31 March 2015; 125 in 2014; and 128 in 2013.) This equates to a rate of 37 children per 10000 population. This is lower than York's statistical neighbours (53) and the England average (60). York's rate for child protection plans is broadly stable with variations not considered statistically significant given the overall size of the cohort.

On 31 December 2015 over half the child protection plans were listed under the category of neglect (55.6%) (36.8% in 2014 and 43.8% in 2013). This is followed by Emotional Abuse (36%) (41.6% in 2014 and 40.6% in 2013), with Physical Abuse (3.5%) (4.8% in 2014 and 7.8% in 2013) and Sexual Abuse (4.2%) (5.6% in 2014 and 2.3% in 2013) some way behind. 1% of plans are listed under more than one category. The numbers are broadly comparable with statistical neighbours and national averages and York's own historical trends.



On 31 March 2016, York had 27.3% of children subject to a child protection plan for the second time. This is more than double the percentage at the same time the previous year (12.2%). CYSCB understands that this variation was subject to robust scrutiny by Children's Social Care by way of case file audit. CYSCB is assured that no issues of concern were identified and that the increase was not considered indicative of practice or process deficits. (**Chapter 6** refers to CYSCB's own multi-agency audit of cases of children subject to a child protection plan for the second time.)

Care demand statistics from the ***Children and Family Court Advisory and Support Service***[22] (CAFCASS) show that the rate of children in York subject to court proceedings for a variety of orders is below the national and regional average. CAFCASS data records the number of individual children from York as 55. Children's Social Care reports that 16 cases in public law proceedings were initiated by the Local Authority.

The number of ***children and young people in the care of the local authority*** at the end of March 2016 was 191 (53 per 10,000). This is a fall in numbers from 203 at the beginning of the year. There has been a year on year decrease since 2012-13 when the number was 243 (68 per 10,000). York is marginally above its statistical neighbours (50 per 10,000) but lower than regional (64) and national (60) averages.

Most children and young people in the care of the local authority were up to date with their health checks (a snapshot at the end of the year shows that 74% were up to date with health checks and 64% with dental checks) with Children's Social Care and health colleagues working to increase this. Development checks for children under the age of 5 stand at 100%.

100% of York's ***care leavers*** are living in appropriate accommodation, enabling them to safely develop their independence skills, with none in B&B or HMO accommodation, although 7 are in supported temporary accommodation. 6 care leavers are at University.

Sixty four percent of children waited less than 20 months between entering care and being ***adopted***. At the time of this report, 25 children are receiving **adoption support** services.

A new ***Children In Care Strategy*** was published at the very end of the year[23]; CYSCB played a role in its construction. It features six new strategic themes:

- *Ambition – 'good enough' is not good enough*
- *Personalisation – every child and every family is different*
- *Normality – every child and young person is entitled to a normal, stable, caring family life*
- *Trust – we need to trust each other better, and young people even more*
- *Accountability – we need to be clear who is responsible for what*
- *Efficiency – we have to live within our means*

In 2015-16 there were 86 full-time equivalent ***Social Workers*** in employment working directly with children and families. This suggests an average caseload for York of 15 cases per Social Worker which is in line with the national average and marginally above the regional average of 12. For additional scrutiny, caseload monitoring is reported to the Independent Chair and Lead Member. York has a higher vacancy rate than the regional average at 9% (versus 7%) but it is lower than the national average which is 17%. York's turnover rate for Social Workers is lower than both the regional and the national average which means that it

[22] www.cafcass.gov.uk/leaflets-resources/organisational-material/care-and-private-law-demand-statistics/care-demand-statistics.aspx

[23] http://www.yor-ok.org.uk/workforce2014/Childen%20%20Young%20People%20in%20Care%20Strategy%202016%202020.pdf

keeps its Social Workers for longer and the rate of agency workers is half that of the national average.

Private Fostering is when a child under the age of 16 (under 18 if disabled) is cared for by someone who is not their parent or a 'close relative'. This is a private arrangement made between a parent and a carer, for 28 days or more, and the local authority must be informed so that it can assess that the arrangement is suitable for the child. During 2015-16, 4 notifications were received of children privately fostered in York. There were still 2 children privately fostered whose situation was being assessed from 2014-15. Of these six arrangements 2 ended during the year so 4 were still ongoing at the end of March 2016: 2 girls, 2 boys; ethnically - 3 white British; one black African; 3 were teenagers; one was a baby.

‘Family Focus”

The national Troubled Families Programme, known locally as *Family Focus*, is now in the second year of the expanded programme. In 2015-16, 231 families with multiple and complex needs entered the programme. To be eligible for programme families must meet indicators under at least two of the programme’s eligibility headlines. Families entering the programme must consent for their data and information to be shared, must be allocated an appropriate lead practitioner, undergo a whole family assessment and have a family action plan supported by a team-around-the-family to support their needs.

Families who have entered the programme have lead practitioners from a range of services, including Family Focus, Schools, Children’s Centres, Health Visiting, Police and Child In Need Teams. The number of families achieving payment by results (PbR) outcomes is very low to date. To achieve PbR, all family members need to have made sustained and significant progress against the issues that were identified and have no newly identified issues across all six programme headlines. Where the issue is around school attendance, three terms' attendance at 90% is required across three consecutive terms, so we have not yet reached a point where families who were identified as having education issues have been able to show sustained progress in this area.

The Family Focus consent is now embedded into the Family Early Help Assessment document, which means the Family Focus Team are no longer required to ask for additional consent from families before they enter the programme. The team are required to ensure that 259 more families enter the programme by March 2017. Some of these families will be supported through the new early help operating model via Local Area Teams, but other services will need to begin to embrace their role as a Family Lead Practitioner if the Government target is to be achieved.

Those in contact with the criminal justice system

2015-16 saw 477 new entrants to the youth justice system. The figure has fluctuated over the last 4 years and is on a par with 2013-14. However the percentage of reoffending has dropped since previous years.

At the end of 2015-16 the Home Office issued a draft Concordat seeking the voluntary agreement of Directors of Children's Services, Lead Members for Children's Services, Chief Officers and Police and Crime Commissioners to improve local arrangements around the transfer of young people in police cells to local authority accommodation. York has signed up to the Concordat and recognises that police cells are not a suitable place for children. Joint planning between North Yorkshire Police, North Yorkshire Youth Justice Service, York Youth Offending Team and both area Children's Services is currently ongoing to ensure the right pathways are in place to appropriately place young people who are refused bail. The group will actively report to the Board later in 2016-17 to ensure that ongoing developments are monitored.

In August 2015 CYSCB heard the plans that the Youth Offending Team (YOT) were putting in place locally. These included:

- only using custody for the serious few and providing creative alternatives with whom work can be undertaken;
- developing resettlement practices;
- improving multi-agency bail and remand practices.

YOT report that they have clear pathways for arranging secure accommodation for the very rare few who pose a public protection risk and a good agreement with Housing for 16/17 year olds. However, there is still more work to be done. YOT will report back to the Board on progress later in 2016.

Disabled children

Our Board considers the welfare of disabled children along with the welfare and safeguarding needs of all children. As outlined in **Chapter 2**, CYSCB, via the Voice and Involvement Sub-group, has listened to disabled children and been assured that their needs and wishes receive a response and appropriate action.

CYSCB is aware that disabled children can sometimes be more vulnerable to child abuse than other children. CYSCB is committed to giving specific attention to this group of children if it emerges that their safeguarding needs are not being met.

In 2015-16, 90% of final Education, Health and Care Plans were issued within statutory time limits and 90.6% of Year 11 Leavers with special needs were still in learning 3 months after they finished Year 11. We are satisfied that the majority of our disabled children are well supported in their education and aspirations.

We have also been following with interest the roll out of the School Cluster Health and Wellbeing Worker Pilot to strengthen the emotional and mental health support arrangements for children and young people in universal school settings, which was mentioned in **Chapter 2**. Later in 2016 this project will roll out across the whole of York. CYSCB will be interested in hearing about the outcomes and impact of this project via the CAMHS Executive.

Schools

There has been very positive engagement between schools and CYSCB in 2015-16. The Board and Sub-groups have representation from Headteachers from primary and secondary schools along with the head teacher of the 'virtual school' (which considers all children who are in the care of the local authority) and the pupil referral unit, plus a representative from independent schools.

Our Safeguarding Advisor (Education) supports schools by offering regular training and updates on safeguarding issues for designated leads, as well as safer recruitment training for all schools, and bespoke safeguarding training where required or requested. She also supports with advice on safeguarding issues and polices. An audit of schools' safeguarding arrangements will take place in the Summer of 2016.

During 2014-15 (the latest date for which data is available), persistent absence rates (i.e. more than 15% absence) for York secondary schools for 2014-15 (5.7%) were slightly up on 2013-14 (4.6%) but the rate was still better than national averages which had also increased. Attendance in York primary schools was excellent.

In the same academic year, disadvantaged pupils (those eligible for free school meals, looked after or adopted) were achieving better results in terms of narrowing the gap between their achievements and those of their less disadvantaged peers. For GCSE's A*s-Cs (including English and Maths) the gap had narrowed from 39% (2013-14) to 34% (2014-15).

The Independent Chair met with Safeguarding Leads from Private Schools in November 2015 and gave a short presentation to the Headteachers' Conference in January 2016.

There is an Independent Schools Safeguarding Conference planned jointly with North Yorkshire Safeguarding Children Board in June 2016.

Chapter 5. Individual Agency Assessments

As part of our overall assessment of services for vulnerable children and young people, we invited the ***individual agencies*** who are our partners to submit an up-to-date account of the state of safeguarding in their organisation. This enables us to share best practice and, where necessary, to challenge each other. You can read the full set of assessments in **Appendix F.** Below is a summary of the most salient points.

NHS Services

Vale of York Clinical Commissioning Group (CCG)

Safeguarding children assurance processes within the CCG have continued to develop during 2015-16. The Designated Nurse for Safeguarding Children (DNSC) presents a quarterly report to the CCG Quality and Finance Committee. These reports provide assurance, and where necessary flag risks with associated action plans.

In April 2015 the CCG assumed delegated responsibility for the commissioning of Primary Health Care across the CCG locality. In order to support safeguarding children developments, the CCG agreed a collaborative arrangement with 3 other CCGs across North Yorkshire and have recruited to the post of Nurse Consultant for Primary Care (Safeguarding Children and Adults). The CCG has also secured a Named GP for Safeguarding Children. This has led to increased access to expert advice and support on developing safeguarding systems and processes within individual practices. It has also allowed for greater engagement of Primary Care in LSCB-led multiagency audits and Learning Lessons Reviews.

The DNSC has continued to provide support and expertise to health provider organisations across the city. This includes provision of supervision, delivery of supervision skills training and ongoing support to develop safeguarding children systems and processes. In particular, the DNSC has worked closely with colleagues in the TEWV Trust, as the new provider of mental health services across the city, to support their engagement with Board activity.

The CCG has worked closely with provider organisations to strengthen the development and reporting against safeguarding children quality requirements within contracts. The Designated Professionals have updated the CCG's *Safeguarding Children Policy* and *Allegations Against Staff Policy* in line with *Working Together* (2015).

Face-to-face safeguarding children training sessions (including PREVENT) have been arranged for CCG staff during 2016. This will contribute towards an increased awareness of the CCG's role and responsibilities in relation to safeguarding children, and further develop staff's understanding of the role of the Designated Professionals Team.

The Chief Nurse and DNSC have provided consistent support to the Board. The DNSC plays an active role in the work of the Sub groups, including taking the role of Chair for the Case

Review Group. The CCG has continued to make a financial contribution to the Board on behalf of commissioners and providers. An additional financial contribution was made to support the '*It's not ok*' campaign.

Primary Care

The Board has heard from the Nurse Consultant (Primary Care) about safeguarding plans for GP and primary care practitioners in York. Overall the model being implemented increases resilience in this area and improves the capability, capacity and quality of Primary Care in relation to the safeguarding of children and vulnerable adults. Progress identified was:

- new safeguarding arrangements have been developed across CCGs and the NHS;
- dedicated support for GPs is being provided;
- a GP forum has been developed with an action plan in place for needs and concerns. All GP practices should now have a safeguarding lead. The forum was well attended and received;
- a new training strategy for GPs is being prepared aimed at delivering 'hot topics' training around issues and concerns particular to practices;
- a robust support network is being developed which includes practices receiving relevant safeguarding publications and alerts.

The Board has been given assurance that action has begun to map current processes in Primary Care against the revised requirements and that this will highlight and address any risks identified. The new NHS England Safeguarding audit tool has been disseminated to all GP practices. If any areas for development are identified within practices, support will be offered to ensure effective safeguarding arrangements are in place.

York Teaching Hospital and NHS Foundation Trust (YTHFT)

There were significant staffing changes within the Safeguarding Children Team of York Teaching Hospital NHS Foundation Trust (YTHFT) during 2015-16. These included the appointment of a full time Child Sexual Assault Assessment Centre Lead Nurse, a new full time Named Nurse for Safeguarding Children, and an additional '0.8' (i.e. not quite full time) Child Protection Advisor. This has given the team the necessary capacity to take forward a number of initiatives, including raising its profile across the Trust. The Trust Executive Lead for Safeguarding, the Chief Nurse, remains very involved in all safeguarding-children work and is a champion for safeguarding at Board level.

In the last 6 months the Maternity Safeguarding Children Record has been updated by the Safeguarding Children Team, with input from Midwives and their managers, to make the record more 'user-friendly', thus assisting in completion and identification of risk areas. The Team has also developed an *aide memoire* for midwives to assist their assessment of risk in relation to the unborn child: the "CHARM" Assessment Tool. The impact of this tool will be audited at the end of this year, but anecdotal feedback has been very positive.

In anticipation of the move from 1st April 2016 of School Nurses and Health Visitors previously in the Trust's employment to City of York Council, YTHFT arranged that their Safeguarding Children Team would continue to support School Nurses, with a view to providing the same services (advice, support, education and reflective supervision) in the interim whilst arrangements are made for support going forward.

The uptake of Safeguarding Children Training has continued to increase since last year, with an overall rate of 84% (from 65% in 2014-15), and is expected to rise further following a Trust announcement that no member of non-medical staff will be allowed to progress to their next incremental salary increase unless they are up to date with all mandatory training.

The Child Sexual Assault Assessment Centre (CSAAC) is now a fully commissioned service by NHS England (Yorkshire and Humber) and the Office of the Police and Crime Commissioner, with the service being available Monday – Friday during office hours.

The Trust has sent 3 members of staff, 2 Consultant Paediatricians and the Lead Nurse for the CSAAC, on an 8 month training course on Forensic Medical Examinations for Rape and Sexual Assault. This will allow these staff to undertake forensic examinations once all their competency assessments have been completed; in the interim the Trust continues to use Mountain Health Forensic Nurses to undertake the forensic elements of CSA examinations.

There have been significant developments in Safeguarding Children Reflective Supervision uptake for Trust staff. Although national guidance states that it is only 'case holders' that must access such supervision, the Trust has invested in the development of this highly effective supervision for the staff in Paediatrics (including the Special Care Baby Unit) and in the Emergency Department. Staff have hugely valued the delivery model and are already evidencing how they transfer the knowledge into practice.

In order to improve support and education on appropriate referral processes a Safeguarding Children Team Child Protection Advisor has been deployed to have an increased presence in the Emergency Department. The Trust is closely monitoring the impact of this, but envisages a reduction in inappropriate referrals to Social Care. The Child Protection Advisor supports Emergency Department staff in accessing training and reflective supervision, as well as offering general safeguarding-children advice and support. The Advisor will also support the embedding of risk assessment tools into everyday practice.

Within the last 12 months, Female Genital Mutilation (FGM) mandatory reporting has been implemented within the Trust and compliance with FGM training for relevant staff continues to be excellent.

In summary, YTHFT continues to place the highest importance on the Trust's safeguarding children responsibilities and to develop and progress in all areas of this agenda, whilst remaining alert to any areas of deficit which need attention. In addition, the Trust has been promoting the importance of hearing the voice of the child in all of its interactions with children and young people.

Tees and Esk Wear Valley Foundation Trust

During 2015-16, Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) became the provider of mental health and learning disability services in York that had previously been provided by Leeds and York Partnership NHS Foundation Trust. As a result, the safeguarding children team has been increased, with two new staff based in York. The team have a duty system whereby there is a member to provide support and advice to practitioners by telephone. They also provide specialist safeguarding supervision to practitioners.

Safeguarding supervision is mandatory for staff involved with service users subject to a child protection plan or where the service user is a parent/carer taking responsibility for a child/young person with a child protection plan. Work is under way to ensure that the relevant supervision is being provided to all staff. Staff are able to request safeguarding supervision where there are concerns about child.

Staff within TEWV are trained with the appropriate levels of safeguarding children as set out in the Intercollegiate Document *Safeguarding Children and Young people: Roles and Competencies for Healthcare Staff*[24]. The Trust has developed a training package for all adult mental health staff about the impact of parental mental health on children and young people.

The safeguarding children team undertake audits but none has been completed in the York area as yet. There is a full audit programme planned for next year which will include York. The Trust was represented at the recent section 11 event which was provided jointly by CYSCB with North Yorkshire LSCB.

The Trust is committed to the 'Think Family' approach and so children are always part of the assessment when adults access services.

In short: safeguarding children is a high priority within TEWV, which is evidenced by the establishment of a safeguarding team base in York. TEWV are fully committed to ensuring that they are an active partner within CYSCB.

CYSCB has, in turn, been working with TEWV since they took on the commission for Child and Adolescent Mental Health Services in October 2015. In March 2016 CYSCB received an assurance report from TEWV including their plans to:

- increase the numbers in their safeguarding children team for York;
- audit all CAMHS case files in terms with a focus on child protection;
- undertake further audits of safeguarding policies, safeguarding supervision, and of referrals in to Children's Social Care.

[24] http://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%200%20%20%20%20(3)_0.pdf

CYSCB has challenged TEWV to provide a further update, information and data once the systems have been established and are up and running. The Board expects this update in October 2016.

NHS England

The general function of NHS England is to promote a comprehensive health service to improve the health outcomes for people in England. NHS England's roles in terms of safeguarding are direct commissioning and assurance, and system leadership as set out in the revised *Safeguarding Vulnerable People Accountability and Assurance Framework* published in July 2015[25].

Yorkshire and the Humber has an established Safeguarding Network that promotes an expert, collaborative safeguarding system, which strengthens accountability and assurance within the NHS. Representatives from this network attend each of the national Sub Groups/Task and Finish Groups, which include topics around FGM, MCA, CSE, Prevent, Safeguarding Adults and Children.

NHS England has responsibility for sharing pertinent learning from safeguarding serious incidents across Yorkshire and the Humber and more widely, ensuring that improvements are made across the NHS, not just within the services where the incident occurred. The Yorkshire and the Humber Safeguarding Network has met on a quarterly basis throughout 2015-16 to facilitate this. Learning has also been shared across GP practices via quarterly Safeguarding Newsletters.

The Network hosted a safeguarding conference on Challenges for Modern Day Safeguarding Practice on 11 March 2016. Two conferences were also held in the North region on Child Sexual Exploitation for healthcare staff and a series of conferences for healthcare and relevant care sectors on Female Genital Mutilation.

The Network has produced an FGM guide for health care professionals[26], and pocket books on Child Sexual Exploitation and on Prevent.

NHS England has developed a Safeguarding Assurance Tool for use with CCGs across the North Region, which is being implemented from February 2016. NHS England North Regional Designated Nurses will review all action plans to identify key themes and trends across the North Region with a view to identifying common areas requiring support.

NHS England North also received national safeguarding development monies to support improvements in the implementation of NHS responsibilities regarding the health of looked after children. This funding has been used to second two designated LAC nurses within Yorkshire and Humber to develop a benchmarking tool based on standards in national

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[25] https://www.england.nhs.uk/?s=safeguarding+assurance

[26] https://www.england.nhs.uk/north/our-work/safeguarding/

guidance. A report of the trends and themes will be shared with all CCGs in the North via the North Region Safeguarding Steering Group.

Local Authority

Children's Social Care

Work continues to deliver the ambitious *Vision for Children's Social Care* set out three years ago. The *Vision*, welcomed by staff, partners and elected members, identified significant changes in style, environment, skill and tools that all parties wanted to achieve.

Over the past year, Children's Social Care have continued to consolidate the effectiveness of the offer of qualified Social Worker advice at the point of contact. They have broadened the use of evidence-based tools in Single Assessment work, and the resulting plans have become more outcome-focused and are reviewed more systematically.

The commitment to strong professional support is as strong as ever: Children's Social Care undertakes an annual survey of staff about their experience of supervision and the contribution it makes to safeguarding. They continue to scrutinise robustly whether staff are receiving supervision by way of monthly 'scorecard'. Caseloads are also monitored and, where issues emerge, additional resources have been deployed. Through regular case file audits, Children's Social Care continues to develop a learning culture, identifying areas of strength and areas for development.

Over the past year, staff have continued to access a wide range of excellent learning and development opportunities to support them in their ongoing professional development. Training has included Dyadic Developmental Psychotherapy, Graded Care Profile, Signs of Safety, Motivation to Change, Pre-Birth Assessment, AIM training and more. Staff are also offered online research through 'CCInform', a nationally recognised and respected provider of the latest evidence of best practice with vulnerable children and their families.

Children's Social Care has delivered on its commitment to provide its staff with the right tools to do the job. Most significantly, on 21 March 2016 they replaced the old case management system with a new state-of-the-art system called Mosaic. Mosaic offers a range of functions not previously available, yet does so in a modern, easy-to-use and intuitive way with an emphasis on reducing the screen time required. Mosaic was designed to reflect the need identified by Professor Eileen Munro in her national review of child protection to move away from overly bureaucratic processes and focus on outcomes for children and their families.

Despite the significant work done to improve its safeguarding of children and young people over the past year, Children's Social Care recognises there is still more to do. In consultation with staff, over the coming year services will be restructured to create a dedicated service for Children and Young People in Care, provide a quicker response to those on the edge of care, better support permanency, and free up staff working with complex cases within the Family Courts. The service is committed to continuous improvement, and will

enthusiastically implement the actions set out in the *Children and Young People's Plan*, and in the new *Strategy for Children in Care*.

The Criminal Justice Community

North Yorkshire Police

Since January 2016, the relevant police team has been renamed the Vulnerability Assessment Team; the York team is based within the City of York Council Offices. The aspiration of the team is to provide a single point of contact for safeguarding concerns across York and North Yorkshire. The work of the team is critical in the multiagency response to protect children and vulnerable adults from abuse. This is achieved through the identification of safeguarding concerns by police and partners; checking these through a process of multi agency information sharing and risk assessment; and sharing information to ensure that the most appropriate safeguarding response is achieved.

Critical to this process is the joint assessment and screening of child protection referrals. This has been embedded successfully within the Referral and Assessment team in York. A Detective Sergeant is co-located within the referral and assessment centre. This role includes the joint assessment of police referrals, providing a point of contact for the team for safeguarding concerns, conducting joint visits with social care, and critical information sharing between police and social care in respect of children who are at risk of abuse.

"**Operation Liberate**" was launched in the City of York in Summer 2015. The purpose of the operation was to identify young vulnerable people who were out late at night, and who were at risk of becoming victims of crime, or of being drawn into criminal behaviour. The children were taken to a multi agency place of safety before being returned to their parents. The place of safety included representatives from North Yorkshire Police, Sexual Health, Youth Offending Team and the Rock Church. The operation will be repeated in 2016.

"**Operation Vestige**" has been launched within the City of York to manage those vulnerable children that do not meet thresholds for statutory service provision. These children and young people will be visited by officers from local police teams to provide support and seek intervention if necessary.

In conjuction with the NHS, much work has been undertaken during the last 12 months to ensure that there is a consistent and excellent service available to all children who are the victim of sexual abuse. The service and allows for an immediate forensic examination to be conducted by a Consultant Paedritician when an allegation of sexual abuse is made. In addition, any child making a non-recent sexual abuse allegation will also be seen at an appropriate time for an overall medical examination.

North Yorkshire Police undertake internal audits as part of a continued improvement cycle so as to ensure their internal policies, procedures and governance are relevant and having the desired impact. In the last 12 months, they have undertaken audits on how the force responds to CSE and Domestic Abuse. Recommendations from these audits have been added

to the existing comprehensive Action Plans. In addition, CSE training and awareness is being delivered to all frontline staff and a 'toolkit' has been devised for all staff highlighting their powers and procedures and identifying disruption tactics available to deter perpetrators.

The profile of Human Trafficking and Modern Slavery is being raised. Again an action plan is being developed along with a 'toolkit' to assist frontline staff. Literature on neglect, outlining the signs to look for and action to be considered, is being prepared for frontline staff. The 'DASH' risk assessment form used in cases of domestic abuse has been amended to capture information 'through the eyes of the child' so as to ensure the voices of children caught up in these incidents are recorded.

The Board welcomed the supportive action of the Chief Constable and the PCC in redirecting £3m of resources into York and North Yorkshire to tackle areas of vulnerability including:

- a team to investigate online CSE offences;
- a team to investigate child abuse offences in line with the Goddard enquiry;
- the amalgamation of Multi Agency Public Protection Arrangements and Integrated Offender Management to form an Offender Management Unit to tackle those who pose the most serious risk of harm.

Youth Offending

A Short Quality Screening of Youth Offending Work in York by Her Majesty's Inspectorate of Probation was conducted from 22-24 February 2016 and examined 14 cases. Key points:

- All the pre-sentence reports contained a clear assessment of the safeguarding and vulnerability factors relating to the child or young person. Similarly, the custodial cases demonstrated an understanding of vulnerability issues, which were clearly identified and recorded, with plans put in place to manage them appropriately.
- There were a number of examples of both health and substance misuse professionals working with the YOT to provide useful additional assessments and relevant interventions.

Areas to now focus on are improving the robustness of management oversight for the timely identification of safeguarding and vulnerability factors. The YOT recently implemented a new assessment framework 'AssetPlus'. The recommendations are timely in order to implement the new framework in a comprehensive and effective way.

Wetherby YOI – regional provider

The Independent Chair has agreed with with the Chair of Leeds LSCB, which covers Wetherby, that any concerns about safeguarding at Wetherby YOI will be notified to Leeds LSCB as Wetherby YOI are represented on their Board. York Youth Offending Team will keep the Board informed should any concerns arise.

Probation services

2015-16 has been a year of significant change for probation providers, as the new National Probation Service (NPS) and Community Rehabilitation Companies (CRCs) implemented the organisational arrangements that came into effect as part of the Ministry of Justice *Transforming Rehabilitation Programme*. The NPS manage high-risk-of-serious-harm offenders, including those eligible under Multi Agency Public Protection Arrangements (MAPPA). NPS also advise courts on sentencing, conduct risk assessments and determine the allocation of all cases. Responsibilities in relation to safeguarding children cut across both NPS and CRC organisations and safeguarding children has remained a key priority.

The delivery of services to adult offenders (who may be parents or carers) is designed to take into account any impact on children through:

- recognition of factors which pose a risk to children's safety and welfare and implementation of relevant agency procedures to protect children from harm;
- appropriate referrals, information sharing and collaborative multi-agency risk management planning and review;
- seconding Probation staff to Youth Offending Teams;
- providing services to child victims of serious sexual and violent offences;
- providing services to women victims of male perpetrators of domestic abuse who attend the relevant accredited programme, having regard to the needs of any children in the family;
- working with offenders who may be sexually exploiting young people;
- working with, for example: substance misusers; offenders with mental health problems; offenders sentenced to imprisonment; domestic abuse cases; and those offenders identified as benefiting from support with parenting skills.
- attending, engaging, and sharing information with local Safeguarding Children Boards and other relevant agencies, and sharing lessons learnt from Safeguarding Children reviews and other reviews and audits.

NPS has launched a new process management system 'EQUiP ('Excellence and Quality in Processes') which provides all NPS staff with a single source for Safeguarding documents, guidance and processes. E-learning training was launched in autumn 2015 which is being rolled out to all NPS staff. NPS National Interim Safeguarding Children Guidance was issued in June 2015.

Community Rehabilitation Company

Humberside, Lincolnshire and North Yorkshire CRC has responsibility for medium and low-risk-of-harm offenders. In the past year the Company has:

- reviewed and updated its Safeguarding Children Policies and Processes. All staff have been briefed and lead managers monitor and update the processes to reflect legislative changes and any learning from Serious Case Reviews/Serious Further Offence Reviews;
- ensured Case Management systems are equipped to identify cases with safeguarding concerns and staff supervision prioritises such cases;
- worked in co-location with police colleagues, sharing intelligence and expertise;
- continued to manage adult offenders to reduce the risks of harm they pose to children by means of skilled assessment, planning review, multi agency working and targeted interventions;
- designed services to take account of the impact on the whole family - staff are encouraged to conduct regular home visits;
- commenced delivery of an early intervention voluntary domestic abuse perpetrators programme across City of York and North Yorkshire;
- regularly audited processes to provide assurance about the quality of Safeguarding work and to inform local Quality Improvement Plans;

The CRC are members of the CYSCB Domestic Abuse Sub-group where they hope to begin looking at maximising their experience of working with perpetrators to assist and support the work of colleagues in other agencies. They have representatives on the MARAC core groups in York and Selby and support the attendance of case managers.

Priorities for the coming year are to:

1. continue to work closely and co-operatively with NPS colleagues to ensure that interface arrangements work to protect children and minimise risk of harm;
2. increase the understanding within CYSCB of the role and responsibilities of the CRC;
3. explore opportunities to work more closely with Prevention and Early Intervention Services within the community;
4. continue to improve child safeguarding practice and knowledge through local Safeguarding Quality Improvement Plans;
5. provide consistent representation to the CYSCB: the appointment of a new Community Director for York and North Yorkshire, and the establishment of a lead Manager for Safeguarding, will ensure consistency of attendance.

Children and Family Court Advisory and Support Service (CAFCASS)

Cafcass is a non-departmental public body sponsored by the Ministry of Justice. The role of Cafcass within the family courts is: to safeguard and promote the welfare of children;

provide advice to the court; make provision for children to be represented; and provide information and support to children and their families. It employs over 1,500 frontline staff.

The demand upon Cafcass services grew substantially in 2015-16 with a 13% increase in care applications and an 11% increase in private law applications. The following are examples of the continuous improvement of Cafcass's work:

- revision of both the *Quality Assurance and Impact Framework* and the *Supervision Policy* which set out the organisation's commitment to delivering outstanding services, and how staff are supported to achieve this. The Framework integrates the impact of the work on the child into the grade descriptors so that evidence of positive impact must be present for an 'outstanding' grade to be achieved;
- implementation of the *Equality and Diversity Strategy*. This includes a network of Diversity Ambassadors who support the development of staff understanding and skills;
- extending the Child Exploitation Strategy to include trafficking and radicalisation as well as sexual exploitation. Key elements of the strategy include: Ambassadors (at a service area level) and Champions (at a team level) to have a 'finger on the pulse' of local issues and to support learning, training and research;
- working with a range of partners across family justice, children's services and the voluntary sector. Examples include Local Family Justice Boards (Cafcass chairs 12 of the 46 of these), the judiciary, the Adoption Leadership Board and the Association for Directors of Children's Services;
- the development of innovations that are aimed at improving practice and supporting family justice reform. These include: piloting the provision to Family Court Advisers of consultations with a clinical psychologist; the extension of Family Drug and Alcohol Courts; and *the supporting separated parents in dispute* helpline;
- contributing to the government review of Special Guardianship Orders;
- a Service User Feedback Survey, which looked at the interim outcomes for children six to nine months after private law proceedings concluded. The survey looked into whether arrangements ordered by the court had sustained; how effective communication was between parents before and after court proceedings; and whether participants believed that the court order was in their child's best interests.

NSPCC

NSPCC services in York are closely aligned with two of CYSCB key strategic priorities: Child Sexual Abuse and Early Help. The team delivers a therapeutic service (*Letting the Future In*) for children aged 4 to 17 years who have been sexually abused, and their safe carer(s). In 2015-16, 32 children and 11 carers accessed the service from the City of York. The aim of the service is to help children to overcome the impact of the sexual abuse they have

experienced and to offer advice and support to parents. The team participated in a randomised control trial conducted by Bristol and Durham Universities to test the effectiveness of the approach. The findings have been shared with partners from CYSCB.

The sexual abuse service has been working at capacity throughout 2015-16, with established referral pathways with all key agencies.

'*Women as Protectors'* is a group-work service introduced by NSPCC in 2015 for women who are in a relationship with a man who poses a risk of sexual harm to a child. It is designed to assess and enhance the protective ability of female carers with the aim of keeping children safe now and in the future. The programme is being delivered and evaluated in York and across the country to find the very best methods for preventing child sexual abuse and for supporting and protecting children whose lives have been affected by it.

NPSCC has a multi-disciplinary team of social workers and nurse practitioners delivering an early help service called *Minding the Baby*. This is a 27 month home visiting parenting programme that begins during the third trimester of pregnancy and aims to help first time mothers (14-25 yrs) to care for their babies and cope with the challenges of becoming a parent up to the child's second birthday. During the course of 2015-16 the team completed work with 27 mothers from the first programme. The second programme has recruited new mothers via a randomised control trial, with half receiving the programme and half receiving the usual range of services offered in the community. The research findings will be published in 2017 and shared with CYSCB.

NSPCC has worked in partnership with CYSCB colleagues to bring national NSPCC services/resources/research and campaigns to the CYSCB with the aim of bringing 'added value' from a national children's organisation where there is synergy with the business of the Board. An example is the Spotlight research programme that has been published over the past year.

NSPCC is committed to the work of the CYSCB: the *It's Not Ok* campaign, featured earlier in this report, is an example of this. It has achieved national recognition. The Service Manager has been an active member of the CYSCB. During 2015-16, NSPCC also contributed to the work of 3 Sub-groups. NSPCC staff have had regular briefings on the work of the CYSCB and attended workshops and training provided by the Board so that they are aware of lessons from themed audits and from learning lesson reviews.

Chapter 6: Formal audits of our safeguarding arrangements

The Board undertakes a number of formal audit processes in addition to looking to partners and other Boards for the information given in the previous chapters. This enables the Board to identify where improvements can be made, to identify good practice and to be assured about safeguarding across the city. This chapter describes these formal audits. All of the learning that has emerged from them has been fed back to frontline staff as part of our commitment to continuous improvement, in line with our revised ***Learning and Improvement Framework*** which is described in more detail in Chapter 8.

The "Section 11" Audit

Section 11 of the Children Act 2004 places a statutory duty on key agencies and bodies to make arrangements to safeguard and promote the welfare of children.

The *Section 11 Audit* is the Board's annual audit to examine the safeguarding arrangements within local agencies and provides the Board with assurance that agencies are doing what they can to ensure the safety and welfare of children and young people.

As usual, in 2015-16 CYSCB worked with the North Yorkshire Safeguarding Children Board on the Section 11 Audit as several partner agencies work across York and North Yorkshire. Minor amendments were made to the *Section 11 audit tool* to make it easier to complete online in response to agency feedback. This year the tool incorporated questions under 10 categories:

1. Information about the organisation
2. Senior management commitment to the importance of safeguarding and children's welfare
3. Availability to staff of a clear statement about the agency's S11 responsibility.
4. Safer recruitment and supervision.
5. Training and development
6. Roles and responsibilities
7. Learning and improvement
8. Service development taking account of the need to safeguard and promote the welfare of children and being informed, where appropriate, by the views of children and families
9. Effective inter-agency working to safeguard and promote the welfare of children
10. Work with individual children and families.

Among these questions – and new for 2016 – were questions about agencies' policies and procedures in relation to children who are missing or trafficked, and about radicalisation and

extremism. Agencies and organisations were asked to support each response with details of evidence.

All key partners who deliver (or commission) services for York responded – some, such as the Local Authority, providing more than one service. A joint peer learning event took place in February 2016. Partners were given the overall findings from the audit, invited individually to share their self-audit findings, and then asked to challenge each other, in small groups, to identify themes and determine future actions.

There were no significant multi-agency safeguarding concerns across the agencies identified. Some recurring themes were identified. These were:

- information sharing and assurance from agencies and organisations that they were aware of the information sharing protocols;
- single agency safeguarding training and how far this was inclusive of all relevant staff;
- DBS checks and how often these were updated, as there was some variation in this.

York partners subsequently updated on their actions to address these issues in their regular individual assurance reports to the Board. The Board is satisfied that its partners' safeguarding practices cover these issues. A further joint audit will take place with our North Yorkshire counterparts in the coming year, along with a self-audit of voluntary sector organisations.

Multi-agency Case File Audits

In April 2015 the former Case File Audit Group became the ***Partnership Practice Scrutiny and Review Group*** **(PPSRG).** This multi-professional group has a remit to meet on a regular basis to look at the quality of multi-agency working and adherence to safeguarding policy and procedures. It draws on a variety of written material from various agencies from a random selection of cases.

Membership comprises – as a minimum - the following agencies:

- Children's Social Care
- North Yorkshire Police
- Youth Offending Team
- CAFCASS
- Tees and Esk Wear Valley NHS Trust
- York Teaching Hospital
- CCG Consultant Nurse for Primary Care
- Independent Reviewing Officers
- CYSCB Safeguarding Advisor (Education)

The group met on 6 occasions during 2015-16 and in addition worked on new terms of reference and a new audit tool. During the year the ***themes for audit*** were:

- Child protection:
  - A focus on planning and setting SMART, outcome focused objectives
  - The impact of those plans
  - Children who had been subject to a plan more than once with a focus on the initial decision to 'deregister'.
  - Children subject t a CP plan one year on.
- Child In Need plans
- Children in care long term under S20 of the Children Act (i.e. with parents' consent).

The Group's findings included:

Child protection:

- The headings of the child protection plans were considered to facilitate good planning. They were in plain language which was useful for families. Such language should be replicated throughout the plan.
- Plans would benefit from making explicit whether each element had been agreed and understood, particularly by parents, and especially in relation to cases where 'deregistration' was recommended.

Child In Need:

- The objectives set and the tasks set for families were clear and defined.
- There was clear evidence that children were involved in assessment and planning.
- Clarity of expectations with families is a foundation for working with them.
- Written agreements need to clarify "who is doing what" and include professionals and all others involved.

Children in care under S20:

- A more robust analysis of the alternatives to Section 20 at each review with a "balance sheet" approach to the alternatives should be carried out.
- Signed consent must be obtained and recorded for all S20 arrangements.

Findings from all of these audits were shared with CYSCB. Relevant agencies were asked for assurance that findings were noted and actions taken. For example, assurance was given to the board that all S20 arrangements now have recorded signed consent from parents.

At the end of 2015-16 the Chair of the PPSRG, Margaret Harvey, Service Manager CAFCASS, indicated her intention to resign because she has a new post away from York. CYSCB would like to extend its thanks to Margaret for chairing the group throughout 2015-16.

Reviewing Serious Cases and Child Deaths

Serious Case and Learning Lessons Reviews

There were no cases which merited ***Serious Case Review (SCR)*** during 2015-16. One case was considered for SCR but the decision of the CYSCB Case Review Group (CRG) was that it did not meet the criteria either for SCR or for a Learning Lessons Review. This decision was endorsed by the CYSCB Independent Chair and upheld by the National Panel of Independent Experts. While the case did not meet the criteria, CRG was nevertheless able to follow up on some valuable learning points.

The Case Review Group has also reviewed the action plans of earlier Learning Lessons Reviews from previous years. Among others, actions resulting from reviews during the year have included:

- a challenge in regard to therapeutic provision for children and young people subject to online abuse. The strong recommendation about better understanding of the scope and offer of this provision has been picked up by the CSA&E Sub-group for follow up in 2016;
- the setting-up of a task and finish group to develop guidance on the assessment of injuries to non-mobile children;
- a clear pathway developed to address admission to the Children's Ward from the Emergency Department for children and young people requiring CAMHS assessment.

At year end 2015-16, one ***Learning Lessons Review*** is under way in regard to a neglect case. The action plan from this Review will be followed up and monitored by CRG and lessons learned shared with the CYSCB neglect Sub-group.

Child Death Overview Panel

CYSCB shares the Child ***Death Overview Panel*** (CDOP) with North Yorkshire Safeguarding Children Board in order to review the death of every child (up to the age of 18 years) in the York and North Yorkshire area so as to learn any lessons that may help other children and families in the future. The North Yorkshire LSCB administers the CDOP on our behalf.

In 2015-16 there were 11 child deaths in York. On average it takes 6 months for a case to come to panel and delays can be for a number of reasons including Police or Coronial investigations. This means that not all of these cases have yet been discussed to look at possible learning from them.

A Rapid Response audit was completed by the CDOP Coordinator for all unexpected child deaths that occurred between 1 April 2015 and 31 March 2016. The audit gave assurance that there are effective systems in place that are working well and that the attendance of Rapid Response meetings is good. However, it did highlight significant cross-boundary issues

and a lack of bereavement support available to parents within North Yorkshire and City of York. This being addressed by services across the city and county.

CDOP Priorities for 2016-17 are:

- further development of the Performance Framework;
- improved engagement with national campaigns;
- development of a range of 1 minute guides for professionals regarding the Rapid Response Process and what to expect at an inquest;
- further consideration regarding modifiable factors;
- renewed regional CDOP Managers Meetings, to ensure regional learning and sharing of best practice is disseminated in North Yorkshire and York;
- logging of data in which online/telephone health advice is sought to identify potential links with certain categories of child deaths.

A full CDOP Annual Report for 2015-16 is available on our website[27].

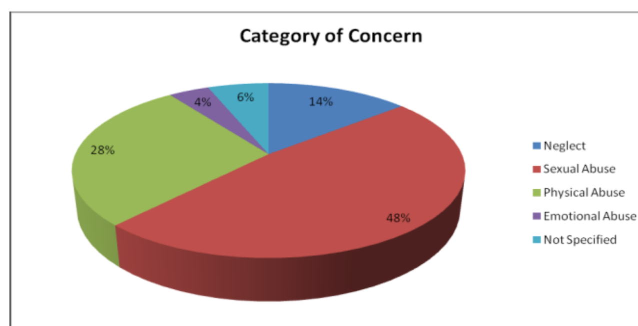
There may be significant changes to the CDOP process in 2016-17 as the Wood Review of LSCBs[28] has made recommendations that it be moved to the Department of Health and that arrangements be carried out on a more regional basis.

Dealing with allegations against professionals

There were a total of 50 contacts received by the Local Authority Designated Officer (LADO) in 2015-2016. This figure has increased marginally since 2014-2015 (45) but remains similar to the figure in 2013-2014 (49). Out of the 50 contacts, 30 were referrals and 20 were consultations.

Category of concern:

The largest single category of concern was sexual abuse (48%), followed by physical abuse (28%), neglect (14%) and emotional abuse (4%). Three cases (6%) could not be categorised. The *'It's Not Ok'* campaign took place in 2015-16 and will have resulted in heightened awareness of sexual abuse.

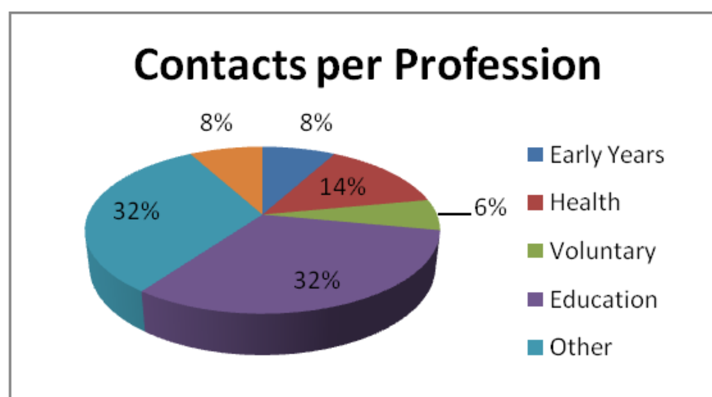


[27] http://www.saferchildrenyork.org.uk/annual-reports.htm

[28] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526329/Alan_Wood_review.pdf

Contacts per profession:

The number of contacts relating to education personnel increased from 13% in 2014-2015 to 32%; however the majority of these were consultations rather than concerns being taken up for action. Managers in education are more likely to contact the LADO for advice than those in other agencies, owing to the close contact that schools have with children, even though most of these consultations would not result in any further action by the LADO. The number of contacts relating to early years professionals has decreased from 22% in 2014-2015 to 8%.



Safe recruitment practices

Finally, all agencies and schools are required to give assurance to CYSCB about their safer recruitment practice through the Section 11 audit and an audit of schools' safeguarding arrangements. The Board is satisfied that partner organisations and schools operate according to safer recruitment guidance.

Chapter 7: Learning and Development

In 2015-2016, the Board has continued to provide a programme of learning and development opportunities on a multi-agency basis. Courses are linked to the Board's priorities, core knowledge requirements and emerging issues and lessons. Partners have continued to support delivery with facilitators from Lifeline, IDAS, NSPCC, Health, Children's Social Care and Education. Independent trainers have been commissioned as appropriate, funded by income generated by delivering bespoke events or levying a small delegate charge.

Quality and content is overseen by the City of York Council's Workforce Development Unit and a new Workforce Development Advisor (Safeguarding) will be appointed in 2016. The latest training offers, which convey the richness and range of our offering, are available on our website[29]. Attendance at our multi-agency training events is usually good, with numbers at, or close to, the preferred target for each course. Courses are not run unless registration rates are viable. Feedback for training is consistently good or excellent, with exceptions usually arising from the relevance of course for the practitioner's role.

The principles of equality and diversity are at the heart of the all the training we offer. We challenge agency delegates as to whether they make their services accessible to all, including those with physical disabilities or learning difficulties that may require specific tools, aids or language. Our safeguarding training also addresses the issues of cultural norms and whether practitioners understand the difference between a safeguarding matter and a cultural matter. As York's population changes, we will keep these issues under review.

The Children's Advice Team have delivered a wide range of Early Help training to delegates throughout 2015-2016. This included:

- Information Sharing
- Using the FEHA Tool
- Early Help Principles Tools and Assessment
- Coordinating Early Help Processes
- Managing and Supervising Early Help
- The Whole Family - Listening to Everyone
- Engaging Families in Challenging Work

In total, 129 professionals attended this training and feedback continues to be positive from attendees. Professionals commented that the training was '*Very informative and well presented'* and that it was *'Very well presented and very clear'*. The Children's Advice Team also delivered 8 bespoke training sessions at primary schools across York. These sessions generally involved most of the teaching staff at each school. The training that was the most frequently requested was 'Engaging families in challenging work' and 'Difficult conversations

[29] http://www.saferchildrenyork.org.uk/learning-and-development.htm

with parents'. IDAS (Independent Domestic Abuse Services) have also delivered training to a total of 29 delegates from various agencies in relation to domestic abuse and managing risk and supporting families. Feedback for this training averaged at excellent.

Female Genital Mutilation became a priority for the Board in 2014-2015. During 2015-2016, an FGM briefing was delivered to professionals to give an understanding of the practice. In the session, information on what FGM is, why this is carried out and who is at risk was provided. The Board also encourages practitioners to undertake online FGM training as delivered on the Home Office website[30].

The Safeguarding Advisor (Education) has continued to deliver whole school safeguarding training to staff in York schools during 2015-16. This training now incorporates important information around FGM and the 'Prevent' duty. Six-monthly updates are run for Education Designated Safeguarding Leads. These are well attended and the feedback from the sessions is very positive. The Safeguarding Advisor (Education) has provided safeguarding training for taxi drivers, passenger assistants and bus drivers involved in the children's transport contract. A Safer Recruitment Training Course was also run for governors and staff. This was very well attended and the feedback positive. A further course is planned during 2016-17.

A new learning and development needs assessment will be undertaken in 2016 to ascertain multi-agency training needs across the workforce. This will include scoping the safeguarding training within single agencies in order to avoid duplication and to ensure that CYSCB meets its remit to monitor safeguarding training.

Training and shared learning will be delivered through a variety of methods, acknowledging that practitioners learn in different ways. Some may learn in a traditional 'classroom' setting; other may prefer seminars where experience, knowledge and skills may be shared. CYSCB already makes use of e-learning and online material.

At the end of 2015, **Dee Cooley** the CYSCB Workforce Development Advisor moved on to take up new opportunities. CYSCB would like to extend its thanks to Dee and is pleased that Dee will continue to deliver some of the CYSCB multi-agency training on a freelance basis.

[30] https://www.fgmelearning.co.uk/

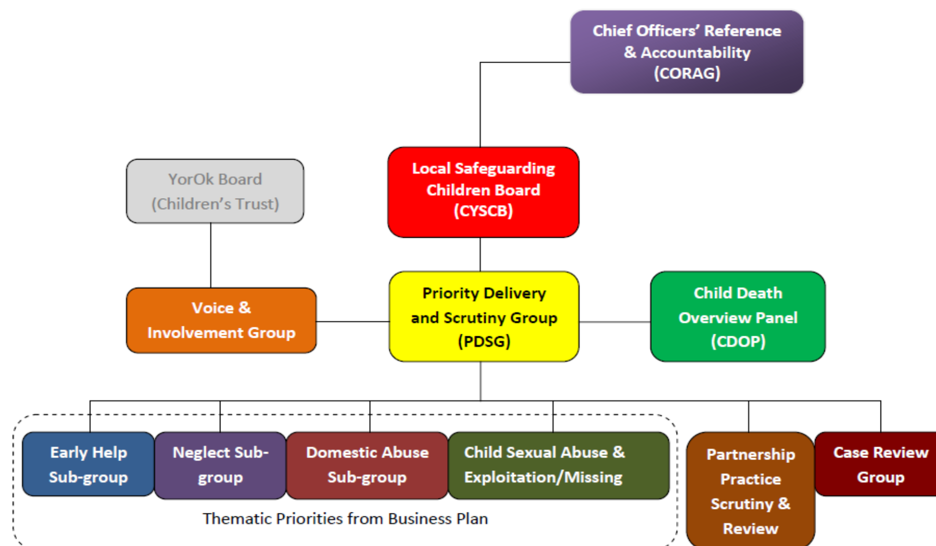
Chapter 8: How are we doing as a Board?

Over the past two years, the board has been reviewing how it operates to build on its strengths and address any issues hindering its development. A development day and partner consultation and feedback in 2014-15 resulted in a revised model which was adopted at the April 2015 Board meeting and is now in place. Within the new structure, there is greater input of other agencies rather than an over-focus on Children's Social Care, with seven partners represented as chairs of Sub-groups providing a broader spread of input. In 2015-16 the chairs come from the following partner agencies:

- Early Help Sub-group – Children's Trust
- Neglect Sub-group – Public Health
- CSA&E/MfH Sub-group – Children's Social Care
- Domestic Abuse Sub-group – York Teaching Hospital NHS Foundation Trust
- Case Review Group – Vale of York Clinical Commissioning Group
- Partnership Practice Scrutiny and Review Group – CAFCASS
- Priority Delivery and Scrutiny Group - Local Authority Children Services

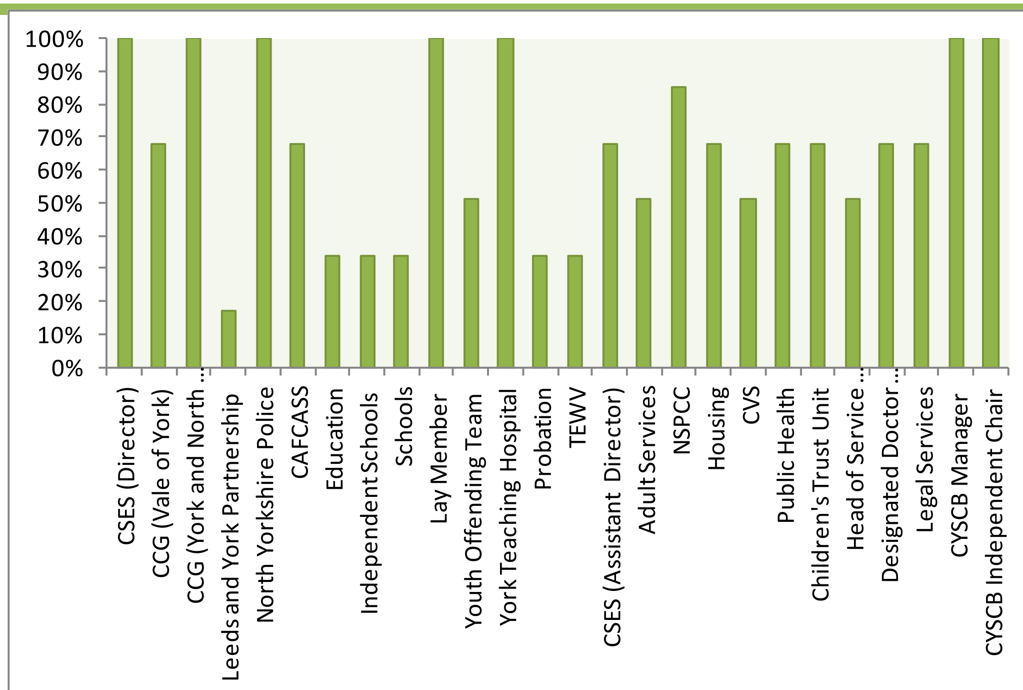
All partners are also asked to contribute to at least one Sub-group if at all possible.

The structure of the Board and its Sub-groups looks like this:



A description of the function of each Sub-group is at **Appendix D**.

Board meetings take place every two months. Partners are committed to attending and Board meetings are always well attended.



CYSCB Attendance 2015-16

Towards the end of 2015-16 and into 2016-17 CYSCB has gained new members as Tees and Esk Wear Valley have taken over the delivery of CAMHS services in York; the new Community Rehabilitation Company (Offender Management) has been created from the split with Probation Services; and IDAS has become a key partner. In addition new individuals in posts with established partners have joined the Board. The full membership on 31 March 2015 is at **Appendix C**.

Minutes of all CYSCB meetings are available on our website.[31]

The Board is financed through contributions from Partners. A table setting this out is at **Appendix E**.

There has been a full revision of the ***CYSCB Learning and Improvement Framework*** to reflect changes in the Board's structure and the ways in which it carries out its work. A copy of this is available on our website[32]. This important document, together with our robust commitment to scrutinising our own, and our partners', performance, encompasses our approach to quality assurance. All of the learning points that have emerged from the process of compiling this Annual Report have been reflected in the *Learning and Improvement Framework*.

The Board and the Sub-groups make good use of available data and information. Each Sub-group, where appropriate, is developing its own dataset and using it to understand issues and the impact of policies; and to support and challenge partners to improve on these. An illustrative scorecard is available at **Appendix A** and an illustration of the reporting cycle at

[31] http://www.saferchildrenyork.org.uk/cyscb-minutes_2.htm
[32] http://www.saferchildrenyork.org.uk/cyscb-ways-of-working.htm

Appendix B. A growing culture of information sharing has meant that these datasets have become truly multi-agency with partners understanding that sharing data and information gives a much clearer picture of safeguarding across services rather than relying on data from Children's Social Care alone.

During 2016 we are revising and refreshing our Business Plan. The Business Plan enables us to see progress against agreed priorities and to understand where further progress needs to be made. Our Business Plan relates to our priorities, with the 'voice of the child' and 'children with disabilities' running throughout.

In addition to a restructure of the Board, the Business Unit which supports the Board has also been reconfigured. The Unit now focuses specifically on the business support function with the Local Authority Designated Officer role being covered temporarily by colleagues in North Yorkshire prior to a dedicated York function being based within Children's Social Care.

During 2015-16 the Board Manager, Joe Cocker, left. Joe had managed the Board for a number of years and had, among other achievements, been responsible for a very comprehensive thematic review of neglect. CYSCB would like to extend its thanks to Joe in acknowledgement of his very significant contribution to the Board over the years.

The Board recognises there are still some areas for improvement; the challenges and priorities are outlined in **Chapter 9**.

Chapter 9: What we have learnt: the priorities and challenges for next year

As a Board, we are committed to continuous improvement: this is reflected in the ***Learning and Improvement Framework*** mentioned in the previous chapter. This chapter sets out our priorities and challenges for the year ahead: these will be reflected in our new Business Plan and, in due course, in a further update to the *Learning and Improvement Framework*.

Priorities

Early Help

CYSCB has learnt that while robust and effective systems for early help exist already, there are improvements to be made in terms of the rising number of enquiries to Children's Social Care (CSC) which may possibly indicate a lack of confidence amongst early help practitioners.

The Board is therefore interested to see the new operating model for Early Help which will be developed during 2016 and which will launch in early 2017. The new model will see three multi-disciplinary local area early help teams established in key areas of the city to provide a city-wide service, but with specific areas targeted where support is most needed at an individual and community level.

The Board has requested an update and dialogue on the planning and initiation of the project and hopes to see increased whole-family working, with agencies and organisations collaborating to prevent issues and problems escalating to crisis level such that there is a requirement for statutory intervention.

In the longer term, the Board will be looking for a decrease in the high level of referrals and enquiries to CSC. In the shorter term, the Board will want to see a higher proportion of enquires to CSC which do not reach the threshold for statutory intervention being stepped down for early help support. This will need there to be sufficient early help practitioners who are well trained and supported in methods of integrated working and assessment.

Neglect

The number of referrals and enquiries to Children's Social Care and the percentage of Child Protection Plans under the category of 'neglect' has remained a concern to CYSCB. CYSCB has therefore focused a significant amount of attention on this matter during 2015-16 and will continue to do so.

2016 will see the launch of the new City of York Neglect Strategy. The draft strategy will go out for consultation and will be endorsed and finalised later in 2016. The Board will then face the challenge of testing the understanding of practitioners in terms of assessing and addressing neglect and of measuring outcomes. CYSCB will stage a Neglect Event later in 2016 in order to raise awareness of neglect as a concern and to look at ways in which practitioners can address this.

During 2016 the Graded Care Profile will be rolled out, initially for use by practitioners in CSC and in the new 0-19 service (health visitors and midwives) in Public Health. The Board will want to monitor how this is impacting on standardisation of assessment of neglect and in improved outcomes for children and young people affected by neglect.

Jointly with partners in York and North Yorkshire, CYSCB will carry out a problem profile project to assess the scale of neglect across the county.

Child Sexual Abuse and Exploitation

2015-16 saw the rollout of the '*It's Not Ok'* campaign. In terms of the number of children, young people, practitioners, teachers, parents, carers and members of the public that the campaign reached, it was deemed to be very successful. The very positive feedback, particularly from young people themselves, confirmed this. Several disclosures were made.

CYSCB is not complacent, however, about this issue. While the full evaluation is still pending and is expected to be completed in 2016, the challenge for the Board, and partners such as NSPCC, will be to ensure that this good work becomes embedded via the use of tools and information packs in schools; and that awareness raising about the impact of sexual abuse and exploitation on children and young people continues.

Children Missing from Home, Care and Education

CYSCB continues to work with partners on ensuring that the processes for identifying and protecting children who go missing from home and care are improved. CYSCB will monitor and challenge the work of Children's Social Care and North Yorkshire Police in ensuring that information about children who go missing, particularly at night and at the weekend, is shared and that return interviews are carried out in order to understand why and where children are going.

The Board is aware that new guidance on children missing from education will be issued in 2016 and will continue to monitor the numbers and to request information on the issues and level of concern in relation to these children.

Domestic Abuse

Whilst a significant amount is now known about the numbers of children witnessing domestic abuse and the percentage of children who are present at reported incidents of domestic abuse, the Board is keen to ensure that the plight of, and impact on, children witnessing domestic abuse remains a key priority for strategic leaders in the York and North Yorkshire Joint Coordination Group, and in the Safer York partnership. The CYSCB Domestic Abuse Sub-group will be identifying the questions and challenges for these strategic groups in relation to such children in York, and lobbying for a county-wide strategy to ensure that services for children and young people are available, funded and supported.

Additional challenges

National LSCB Review

CYSCB is aware that the review of Local Safeguarding Children Boards being undertaken in 2016 on behalf of the government - the Wood review[33] - will result in changes to the way that LSCBs function. CYSCB is prepared for possible changes and confident that it will continue to operate as a strong partnership. All Board members will take part in agreements about any reconfiguration of the Board. Changes to the Serious Case Review process and the Child Death Overview process are also anticipated.

Shared responsibilities and relationships between strategic Boards

During 2016, CYSCB will strengthen its relationship with other strategic Boards. A protocol is already in place with the YorOk (Children's Trust) Board and with the Health and Wellbeing Board but CYSCB will seek to extend this to include the Safer York Partnership and the Safeguarding Adults Board. The joint protocols will identify strategic leads on priority areas such as Domestic Abuse, Mental Health and 'Prevent', among others, and reinforce joint working on many areas of concern.

Support for young people's emotional and mental health

As indicated earlier in the report, CYSCB will be challenging partners to assure the Board that we are doing everything possible to support and improve young people's emotional and mental health. This will have a number of strands:

- we will be working with the new provider of **Child and Adolescent Health Services** in York (see Chapter 5) to further assure ourselves that there is a proper focus on child protection. This may involve further audits of safeguarding policies, safeguarding supervision, and of referrals in to Children's Social Care.
- a particular theme of our work in this area will be **self-harm**, recognising that all agencies already share concerns about this issue. CYSCB will avoid duplicating others' efforts, but will nevertheless undertake a scrutiny role and will seek a report on progress made by agencies on this issue as this remains an area of challenge.
- we will also be interested to hear about the impact of the work to strengthen the emotional and mental health arrangements for children and young people in **schools**, and how this will be further developed.

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33 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526329/Alan_Wood_review.pdf

Outcomes and impact

CYSCB is committed to refining its capacity to understand outcomes and impact. The revised Business Plan will mean that the objectives set in the Plan are reviewed regularly (formally at least annually but also at more frequent intervals). In addition to scrutinising the data pertinent to their area and highlighting and responding to issues and exceptions, each Sub-group will look for assurance from the data and information that outcomes for children and young people in York have been improved. Their scrutiny of, and conclusions from, performance data will be reported to the Priority Delivery and Scrutiny Group and to the Board. This is consistent with our *Learning and Improvement Framework*, which will itself be kept under review and further revised if necessary.

Learning and Development

During 2016 CYSCB, supported by the local authority's Workforce Development Unit, will undertake further work on understanding and analysing multi-agency training needs. Multi-agency training will be commissioned which avoids overlap with training delivered already on a single agency basis. A new training strategy will be agreed and CYSCB will look at a variety of formats for delivering learning and development opportunities.

York's Changing Population

As indicated earlier in this report, the principles of equal opportunities run through all of our work; and in particular we are sensitive to different cultural norms without ever for one moment compromising our commitment to safeguarding children and young people. We recognise that these issues can sometimes pose challenges, and that York's population is changing rapidly. The city will also be welcoming a new group of **refugees** in 2016.

For all of these reasons, during the year ahead we will seek advice to ensure the Board is fully up to speed with the current and projected nature of York's population, and any challenges this might pose for our safeguarding work - as well as the opportunity to reach out to new community-based groups.

Others

There may be other new challenges for the Board:

- Fresh national concerns have emerged during 2015 in relation to children in receipt of **home education** and CYSCB will be asking local authority colleagues and partner agencies what they know about these children and what safeguards are in place.
- CYSCB is aware that there may be increasing challenges in terms of **radicalisation,** potential **modern slavery situations** and **forced marriage.**
- As part of continuous improvement we are committed to the regional arrangements for **peer review** as the last review was in 2013. Therefore, we will commit to a new review later in 2016.

Chapter 10: Key messages for readers

This year, the Board would like to convey the following key messages. Many of these messages are the same messages as last year but this is because they still matter:

For children and young people

- We are still listening and your voices are the most important of all voices. We think we are getting better at listening to you but we are continuing to work on new ways of hearing you.
- Your wellbeing remains at the heart of our child protection systems.
- We want to hear from you about how services can be improved to ensure your wellbeing, to prevent you being harmed, and to protect you.

For the community

- You are in the best place to know what is happening to children and young people and to report your concerns if you think something are happening.
- Protecting children is everybody's business. If you are worried about a child, contact the Children's Front Door (contact details below).

For City of York Safeguarding Children Board partners and organisations

- The protection of children is paramount. How do decisions that your agency makes affect children and young people?
- You are required to assure this Board that you are discharging your safeguarding duties effectively and ensuring that services are commissioned for the most vulnerable children.
- Are you making sure that the voices of all children and young people are informing the development of services?
- Take notice of the voices of vulnerable children. Listen and respond, particularly if they disclose abuse.
- Children and young children may not always verbalise their feelings. Be aware of other non-verbal ways they may indicate to you that they are distressed or worried.
- Use your representative on our Board to make sure the voices of children and young people and front line practitioners are heard.
- Ensure your workforce is able to contribute to the provision of safeguarding training and to attend training courses and learning events.
- Know the priorities of the Board and take these into account. Share responsibility in the delivery of the Board's work.

- Be prepared to evidence your agency's safeguarding processes via the annual Section 11 audit and event and via assurance reports to the Board.
- This Board needs to understand the impact of any organisational changes on your capacity to safeguard children and young people.

For schools:

- Make sure that you are compliant with the processes which all schools, in the maintained, non-maintained or independent sector, must follow to safeguard their pupils.
- In particular ensure that you are familiar and compliant with 'Safeguarding Children in Education' guidance and the new guidance which will be implemented in September 2016.
- Be aware of and compliant with safer recruitment processes.

For practitioners:

- Make sure that you attend safeguarding courses and learning events required for your role and that you are constantly up to date with changes in safeguarding practice, guidance and legislation. These change all the time.
- Be familiar with, and use, the multi-agency tools designed for you: e.g. our 'Threshold Guidance'[34] and the online safeguarding procedures[35].
- Resist complacency. Just because certain issues such as Child Sexual Exploitation, Trafficking, Female Genital Mutilation and other similar problems are rare in our community, does not mean that they are not present. Indeed, they may be even harder to spot.
- Be 'professionally curious' with other practitioners and when working with children and young people.

For everyone:

'If you see something, say something'

[34] http://www.yor-ok.org.uk/workforce2014/Concerned%20about%20a%20child/childrens-front-door.htm
[35] http://www.saferchildrenyork.org.uk/child-protection-procedures.htm

Contact details for the Board

CYSCB website

http://www.saferchildrenyork.org.uk/

CYSCB Chair: Simon Westwood CYSCB Manager: Juliet Burton

CYSCB, City of York Council,
West Office, Station Rise,
York,
YO1 6GA

http://www.saferchildrenyork.org.uk/contact-us.htm

How to report concerns about a child or young person

If you have a concern that a child is vulnerable or at risk of significant harm please contact the Children's Front Door:

Phone for advice: **01904 551900**

or, using a referral form:

Email: **childrensfrontdoor@york.gov.uk**

Post: **The Children's Front Door, West Offices, Station Rise, York, YO1 6GA**

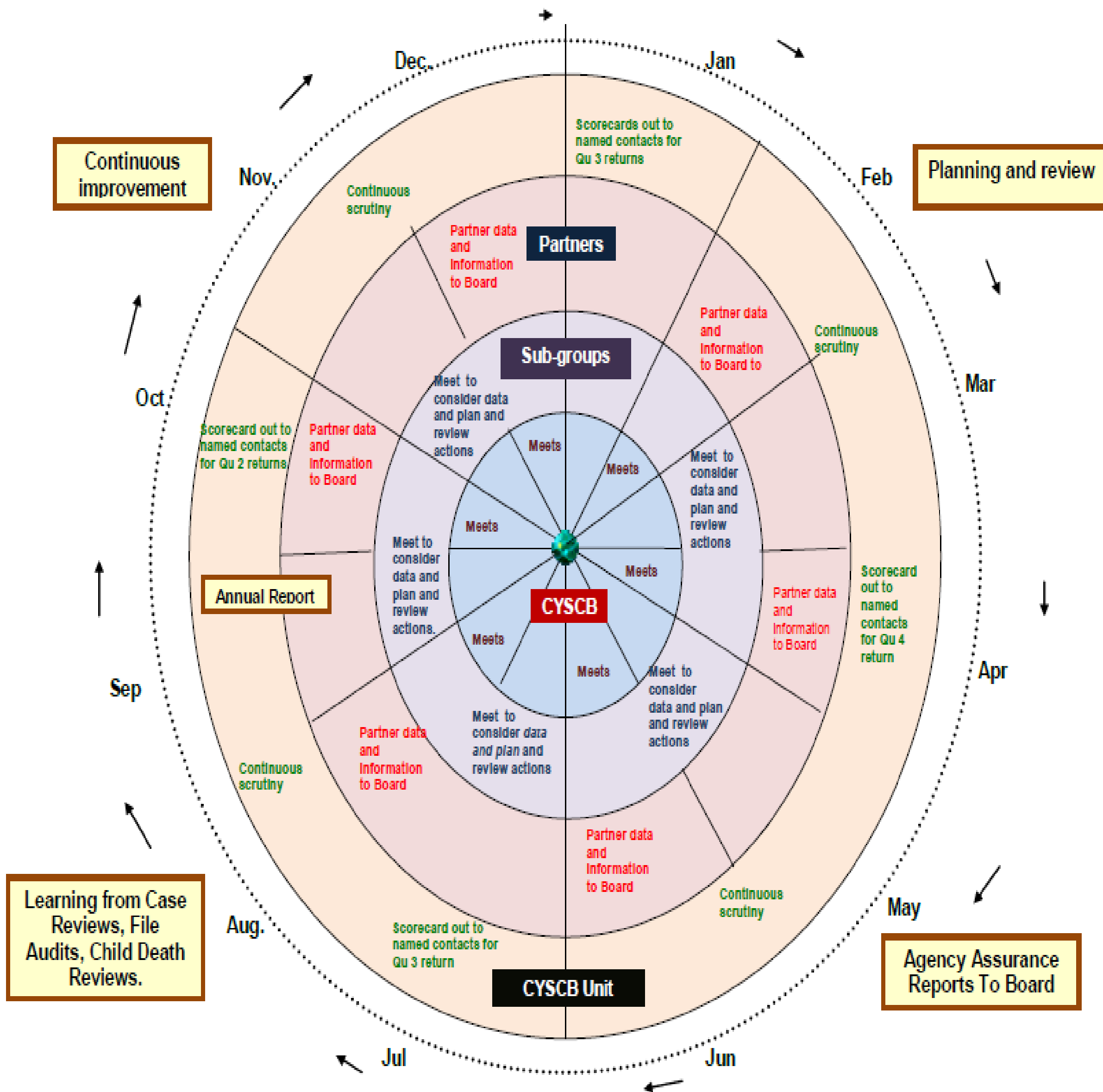
Out of hours please contact the Emergency Duty team on: 01609 780780

More information and a referral form are available at:
http://www.saferchildrenyork.org.uk/concerned-about-a-child-or-young-person.htm

Appendix A. Illustrative Scorecard

CYSCB Priority	Example of Performance Indicator
Early Help	Percentage of cases not meeting CSC threshold, signposted for early help.
Neglect	Percentage of referrals with neglect as a factor at the point of referral (i.e. reaches CSC threshold).
	Number of entries to A&E by unintentional or deliberate injury to children 0-17 (inclusive).
Child Sexual Abuse and Exploitation	Percentage of Single Assessments in which sexual abuse and/or exploitation identified as a factor.
	Number of sexual offences recorded by North Yorkshire Police in which victims are under 18.
Missing from Home, Care or Education	Number of episodes of Missing from Home or Care recorded by North Yorkshire Police and Children's Social Care.
	Number of children reported as Children Missing Education (CME) and percentage of CMEs located or no concern.
Domestic Abuse	Number of incidents of domestic abuse in which children recorded as present by North Yorkshire Police.
	Number of children provided with one-to-one support by IDAS.

Appendix B. CYSCB Reporting Cycle



Dec.
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug.
Sep
Oct.
Nov.
Continuous improvement
Planning and review
Agency Assurance Reports To Board
Learning from Case Reviews, File Audits, Child Death Reviews.
Annual Report
Partners
Sub-groups
CYSCB
CYSCB Unit
Scorecards out to named contacts for Qu 3 returns
Continuous scrutiny
Partner data and information to Board
Partner data and information to Board to
Continuous scrutiny
Meet to consider data and plan and review actions
Meets
Meets
Meets
Meets
Meets
Meets
Scorecard out to named contacts for Qu 2 returns
Partner data and information to Board
Meet to consider data and plan and review actions
Meet to consider data and plan and review actions.
Scorecard out to named contacts for Qu 4 return
Partner data and information to Board
Meet to consider data and plan and review actions
Meet to consider data and plan and review actions
Partner data and information to Board
Continuous scrutiny
Partner data and information to Board
Continuous scrutiny
Scorecard out to named contacts for Qu 3 return

Appendix C. Members of City of York Safeguarding Children Board (31 March 2016)

1. Independent Chair

Name	*Title*	*Organisation*
Simon Westwood	Independent Chair City of York Safeguarding Children Board	City of York Safeguarding Children Board

2. Health

Name	*Title*	*Organisation*
Mandy Robson	Quality and Safety Manager	**NHS England, North Yorkshire and Humber Area Team**
Julie Finch		**NHS England**
Michelle Carrington	Chief Nurse	**NHS Vale of York CCG**
Bev Geary	Chief Nurse – *represented by Sue Roughton*	**York Teaching Hospital NHS Foundation Trust**
Karen Hedgley	Designated Nurse for Safeguarding Children	**North Yorkshire and York CCG**
Sue Roughton	Head of Safeguarding (Children and Adults) *representing Bev Geary*	**York Teaching Hospitals Foundation Trust**
Simon Berriman (not attending – information only)	Liaison officer	**North Yorkshire Local Medical Committee**
Stephanie Govenden	Designated Doctor for safeguarding children	**NHS NY and York**
Karen Agar	Directorate of Nursing and Governance, Tees Esk and Wear Valleys NHS Foundation Trust	**TEWV**

3. Public Health

Name	*Title*	*Organisation*
Sharon Stoltz	Interim Director of Public Health (Joint Chair of CDOP)	**City of York Council Public Health**
Nick Sinclair	Pathways Officer, Substance Misuse Team	**City of York Council Public Health**

4. Education Services

Name	*Title*	*Organisation*
Lorna Savage	Secondary School Head Teacher	**Secondary Schools**
Zoe Lightfoot	Primary School Head Teacher	**Primary Schools**
Tricia Head	Pupil Referral Unit Head Teacher	**Danesgate School**
Matthew Grant	CP Lead	**Independent Schools**

5. Local Authority Children and Young People Services

Name	*Title*	*Organisation*
Jon Stonehouse	Director of Children's Services, Education and Skills	**City of York Council CSES**
Eoin Rush	Assistant Director Children's Services, Education and Skills	**City of York Council CSES**
Dot Evans	Head of Service (Safeguarding)	**City of York Council Children's Social Care**
Angela Crossland	Head of Integrated Youth Support Services and Youth Offending Team	**City of York Council, Youth Services**
Alan Hodgson	YOT and Early Help Group Chair	**City of York Council, Youth Services and CTU**
Niall McVicar	Chair of Voice and Involvement Group	**City of York Council, Children's Social Care**
Jennie Noble	Chair of 'Voice' Sub-group	**City of York Council, Youth Support Service**

6. Local Authority Adults Services

Name	*Title*	*Organisation*
Mark Albiston	Head of Safeguarding Adult Social Care	**City of York Council**
Martin Farran	Director of Adult Social Care	**City of York Council**

7. City of York Safeguarding Adults Board

Name	*Title*	*Organisation*
Kevin McAleese	Independent Chair	**City of York Safeguarding Adults Board**

8. National Probation Service and Community Rehabilitation Company

Name	*Title*	*Organisation*
Louise Johnson	Area Manager (Public Protection)	**York and North Yorkshire Probation Trust**
Vikki O'Brien	LDU Director	**Humberside, Lincolnshire and North Yorkshire CRC Ltd**

9. North Yorkshire Police

Name	*Title*	*Organisation*
Dave Jones	Chief Constable	**North Yorkshire Police**
Nigel Costello	Detective Chief Superintendent	**North Yorkshire Police**

10. Prison Services

Name	*Title*	*Organisation*
Paul Simpson	Head of Offender Management, Safer Prisons and Quality	**HMP Askham Grange**

11. Cafcass

Name	*Title*	*Organisation*
Margaret Harvey	Service Manager	**CAFCASS**

12. Lay Member

Name	*Title*	*Organisation*
Barry Thomas	Lay person	

13. Local Authority Housing Services

Name	*Title*	*Organisation*
Steve Waddington	Assistant Director, Housing and Public Protection	**City of York Council**

14. Voluntary Sector

Name	*Title*	*Organisation*
Sarah Armstrong	Chief Executive	**York CVS**
Debra Radford	Children's Service Manager	**NSPCC**
Sarah Hill	Director, IDAS	**IDAS**

15. Yorkshire Ambulance Services

Name	*Title*	*Organisation*

David Blain	YAS Safeguarding Head of Quality – *represented by designated professionals from CCG*	**Yorkshire Ambulance Service NHS**

16. Local Authority Legal Services

Name	*Title*	*Organisation*
Melanie Perara	Deputy Head of Legal Services	**City of York Council**

17. Local Authority Communication Services

Name	*Title*	*Organisation*
Megan Rule	Communications Officer	**City or York Council**

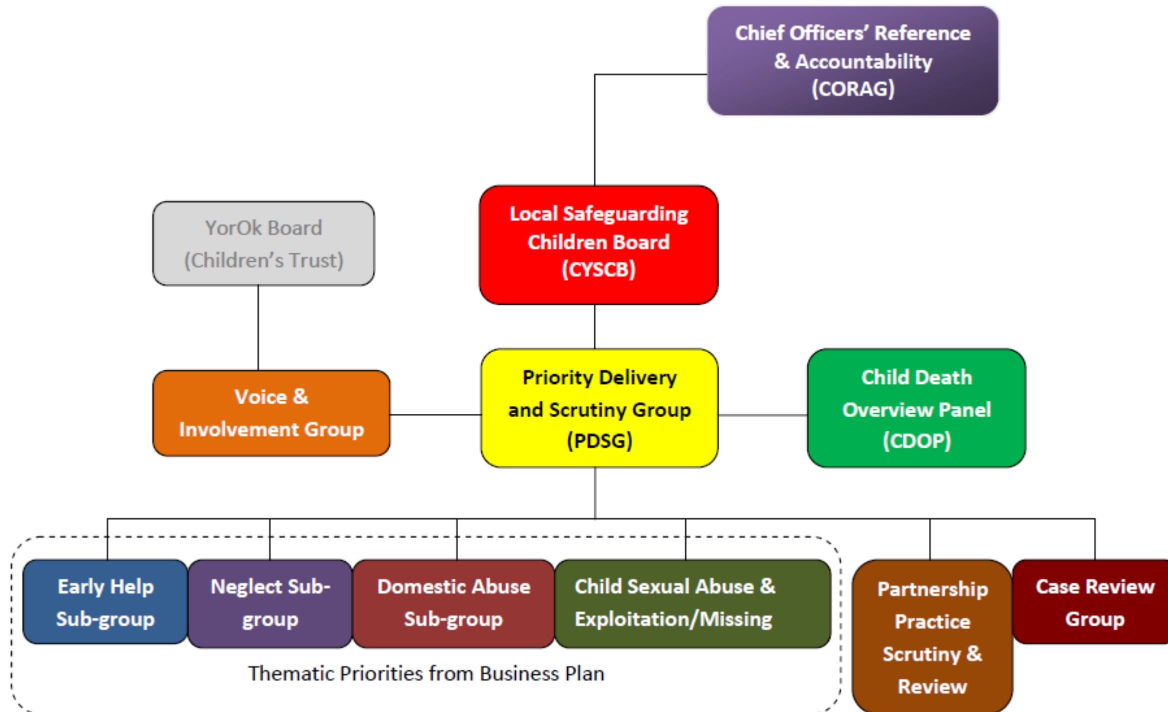
18. CYSCB Officers

Name	*Title*	*Organisation*
Juliet Burton	CYSCB Business and Performance Manager	**CYSCB**
Caroline Williamson	Safeguarding Advisor (Education)	**CYSCB**
Anna Wynne	CYSCB Performance and Governance Officer	**CYSCB**

19. Participating Observers

Name	*Title*	*Organisation*
Cllr Jenny Brookes	Cabinet Member, Education, Children and Young People	**City of York Council**

Appendix D. The Board and Sub-group structure



CORAG

Chief Officers from all agencies in York take their responsibilities equally seriously and following a request from the Independent Chair they established a unique mechanism – the Chief Officers' Reference and Advisory Group (CORAG) - to maintain focus and progress. CORAG meets regularly, and includes the senior officers from the Council, the Police, Health partners, and the Independent Safeguarding Board Chair. Its purpose is not in any way to replace the statutory functions of the LSCB; rather, CORAG serves to ensure that the LSCB can at all times maintain a clear focus on keeping children safe, by swiftly removing any blockages to progress. Its existence offers a powerful demonstration to all staff across all agencies in York that there is no higher priority for any of the agencies than safeguarding children.

Sub-groups

The change of the board structure in April 2015 to one more driven by priorities means performance reporting is more closely aligned to the priorities set by the Board and relayed in the Annual Report. Currently these priorities are:

- Early help

- Neglect
- Child Sexual Abuse and Exploitation
- Children Missing from Home, Care and Education
- Domestic Abuse

Four Sub-groups focus specifically on those 5 priorities:

- **Early Help group** – reports to both the CYSCB and YorOk (Children's Trust) Board.
- **Neglect Sub-group**
- **Child Sexual Abuse and Exploitation/Missing from Home and Care sub group** (one Sub-group looking at both of these priorities in terms of vulnerability and exploitation.)
- **Domestic Abuse Sub-group**

These Sub-groups may be task focused and time limited depending on the scale of the need and the level of challenge required.

Four of the Sub-groups are ongoing and carry out the business of the Board:

- **Voice and Involvement** – looks at the voice of children and young people throughout the whole spectrum of intervention and across all agencies. It seeks to hear and to enhance the input of children and young people into service delivery and planning. The Sub-group reports both to CYSCB and to the YorOk (Children's Trust) Board
- **Partnership Practice Scrutiny and Review** – carries out the auditing of case file material on the Board's behalf. Auditing is based around themes identified by the group itself or in response to other case reviews or local and national priorities.
- **Case Review Group** – considers cases referred for review – Serious Case Review or other form of review – and refers decisions and recommendations to the Independent Chair and the National Panel of Experts. This group also reviews and challenges action plans in response to case reviews – either single- or multi-agency.
- **Child Death Overview Panel (CDOP)** – co-ordinated on CYSCB's behalf by North Yorkshire LSCB. Cross border scrutiny and analysis of all child deaths and reports and data are also disaggregated and analysed for York.

The final Sub-group, the **Priority Delivery Scrutiny and Review Group** serves as the co-ordinating body for the Board. This Sub-group monitors and analyses the performance and quality of interagency safeguarding practice, of learning activities and progress against priorities.

Appendix E. The Board's Finances

Budget

Expenditure (£)	2015-16	Income (£)	2015-16
		Balance B/fwd	- 30,269
Staffing	183,433	CYC Children's Services	70,476
Training Budget	2,769	Vale of York CCG	53,234
Information/Miscellaneous	11,056	Police: North Yorkshire Police	21,988
Recharges	18,840	CYC Education and Skills	14,900
Child Death Review Grant	12,000	NPS North Yorkshire and CRC	6,943
Serious Case Reviews	0	Schools	50,000
Independent Chair	13,139	CAFCASS	550
		Others	15,000
		Child Death Review Grant	12,000
		Serious Case Review	0
	241,238		245,091
Balance C/fwd		C/fwd	-26,416
	241,238		

The year-end budget shows a small in-year surplus of £3.8k, reducing the overall deficit to £26.4k.

The CORAG group has discussed current and future funding arrangements, and will agree the future budgets each year. It has previously been agreed that any funding required for Serious Case Reviews will be met via contributing agencies as the need arises, most probably through contingency funds.

Appendix F. Full reports from around the Partnership

This Annex contains the safeguarding assessment reports submitted by partner agencies. Each sub-section has been written by the individual partner, and references to "we" or "our" should be read accordingly.

NHS Services

Vale of York Clinical Commissioning Group (CCG)

Safeguarding children assurance processes within the CCG have continued to develop during 2015-16. The Designated Nurse for Safeguarding Children (DNSC) presents a quarterly report to the CCG Quality and Finance Committee. These reports provide assurance, and where necessary flag risks with associated action plans, in relation to CCG-commissioned services.

In accordance with '*Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework (2015)*' the CCGs have continued to invest in securing the expertise of the Designated Professionals to support them to discharge their responsibilities as key commissioners of local health services.

Highlights during 2015-16:

In April 2015 the CCG assumed delegated responsibility for the commissioning of Primary Health Care across the CCG locality. In order to support safeguarding children developments within Primary Care the CCG agreed a collaborative arrangement with 3 other CCGs across North Yorkshire and have recruited to the post of Nurse Consultant for Primary Care (Safeguarding Children and Adults). The CCG has also secured a Named GP for Safeguarding Children. This has led to some key developments in terms of safeguarding children training provision, increased access to expert advice and support and guidance on developing safeguarding systems and processes within individual practices. It has also allowed for greater engagement of Primary Care in LSCB led multiagency audits and contribution to the current Learning Lessons Review.

The DNSC has continued to provide support and expertise to health provider organisations across the City. This includes provision of supervision, delivery of supervision skills training and ongoing support to develop safeguarding children systems and processes within these organisations. In particular, the DNSC has worked closely with colleagues in TEWV Trust, as the new provider of mental health services across the city, to support their engagement with Board activity and early engagement in multiagency working.

The CCG has worked closely with provider organisations to strengthen the development and reporting against safeguarding children quality requirements in contracts. Further work is planned for 2015-16 to ensure these QRs and reporting processes are embedded.

The Designated Professionals have updated the CCGs *Safeguarding Children Policy* and *Allegations Against Staff Policy* in line with *Working Together (2015).*

Face to face safeguarding children training sessions (including PREVENT) have been arranged for CCG staff during 2016. It is anticipated that this will contribute towards an increased awareness of the CCG's role and responsibilities with regard to safeguarding children and further develop understanding of the role of the Designated Professionals Team.

CCG support to CYSCB activity

The Chief Nurse and DNSC have provided consistent support to the Board. Due to a change in personnel the role of Designated Doctor was vacant during the latter part of the year; however the

CCG has now recruited to this role and the newly appointed Designated Doctor will be in post from 1st of May 2016.

The DNSC continues play an active role in the work of the Board Sub-groups including taking forward the role of Chair for the Case Review Group.

The CCG has continued to make a financial contribution to the Board on behalf of commissioners and providers. An additional financial contribution was made to support the LSCB-led '*It's not ok*' campaign.

Primary Care

The Board has heard from the Nurse Consultant (Primary Care) about safeguarding plans for GP and primary care practitioners in York. Overall the model being implemented increases resilience in this area and improves the capability, capacity and quality of Primary Care in relation to the safeguarding of children and vulnerable adults. Progress identified was:

- New safeguarding arrangements have been developed across CCGs and the NHS.
- Dedicated support for GPs is being provided.
- A GP forum has been developed with an action plan in place for needs and concerns. All GP practices should now have a safeguarding lead. The forum was well attended and received.
- Training of GPs : a new training strategy for GPs is being prepared aimed at delivering 'hot topics' training around issues and concerns particular to practices when GPs are available to attend.

The Board has been given assurance that action has begun to map current processes in Primary Care against the revised requirements and that this will highlight and address any risks identified. The new NHS England Safeguarding audit tool has been disseminated to all GP practices. If any areas for development are identified within practices, support will be offered to ensure effective safeguarding arrangements are in place.

A robust support network is being developed which includes practices receiving relevant safeguarding publications and alerts.

York Teaching Hospital and NHS Foundation Trust (YTHFT)

Within the past financial year there have been significant staffing changes within the Safeguarding Children Team of York Teaching Hospital NHS Foundation Trust (YTHFT). We have appointed a full time Child Sexual Assault Assessment Centre Lead Nurse in November 2015, a new full time Named Nurse for Safeguarding Children in January 2016, and an additional 0.8 wte Child Protection Advisor. This has given the team the necessary capacity to take forward a number of initiatives in the last 12 months, including raising the profile of the team with staff across the Trust. The Trust Executive Lead for Safeguarding, the Trust Chief Nurse, remains very involved in all Safeguarding Children work and is a champion for Safeguarding at Trust Board level.

In the last 6 months the Maternity Safeguarding Children Record has been updated by the Safeguarding Children Team, with input from Midwives and their managers, to make the record more 'user-friendly', thus assisting in completion and identification of risk areas by Midwives. The Team has also developed an aide memoire for midwives to assist their assessment of risk re the unborn child: the CHARM Assessment Tool. Impact of the introduction of this tool will be audited at the end of this year, but anecdotal feedback has been very positive.

Throughout all of our work we have been promoting the importance of hearing the Voice of the Child in all of the Trust's interactions with children and young people, and are pleased to report that at the

latest interviews for staff for the Children's Ward we included young people in the interviewing process.

In anticipation of the move from 1st April 2016 of School Nurses and Health Visitors previously in the Trust's employment to City of York Council, YTHFT arranged that their Safeguarding Children Team would continue to support School Nurses, with a view to providing the same services (advice, support, education and reflective supervision) in the interim whilst arrangements are made for support going forward.

Training uptake has continued to increase since last year, with an overall uptake rate in relation to Safeguarding Children Training of 84% (an increase from 65% in 2014-15), and is expected to rise further following a Trust announcement that no member of non-medical staff will be allowed to progress to their next incremental salary increase unless they are up to date with all mandatory training.

The Child Sexual Assault Assessment Centre is now a fully commissioned service by NHS England (Yorkshire and Humber) and the Office of the Police and Crime Commissioner), with the service being available Monday – Friday during office hours. So far it has **not** been evidenced that a 24/7 service would be viable, with only one child having needed to travel to St Mary's in Manchester out of office hours since the CSAAC has been fully commissioned (i.e. since September 2015). The Trust has sent 3 members of staff, 2 Consultant Paediatricians and the Lead Nurse for the CSAAC, on an 8 month Forensic Medical Examinations for Rape and Sexual Assault training course. This will allow these staff to undertake forensic examinations once all their competency assessments have been completed; in the interim the Trust continues to use Mountain Health Forensic Nurses to undertake the forensic elements of CSA examinations.

There have been significant developments in Safeguarding Children Reflective Supervision uptake for Trust staff. Although national guidance states that it is only 'case holders' that must access such supervision, the Trust has invested in the development of this highly effective supervision for the staff in Paediatrics (including Special Care Baby Unit) and in the Emergency Department. Staff have hugely valued the delivery model that we have developed and are already evidencing how they transfer the knowledge gained from such supervision in to practice.

In order to improve support and education on appropriate referral processes a Safeguarding Children Team Child Protection Advisor has been deployed to have an increased presence in the Emergency Department. We are closely monitoring the impact of this development, but envisage a reduction in inappropriate referrals to Social Care. The Child Protection Advisor specifically supports ED staff in accessing training (with some training sessions planned to be delivered in ED) and in accessing Safeguarding Children Reflective Supervision, as well as offering general safeguarding children advice and support.

In addition the Advisor will support with embedding the ACHILD and ABCD Safeguarding Children Risk Assessment tools into every day practice; which were introduced in both ED sites in April 2015,

We continue to work closely with all three Local Authorities' Children's Social Care departments to analyse the impact of increased understanding and use of these tools by ED staff. The hypothesis is that the embedded implementation of these assessment tools should also lead to fewer, but more appropriate referrals to Children's Social Care, as well as improved information sharing with other relevant health professionals.

Within the last 12 months FGM mandatory reporting has been implemented within the Trust and compliance with FGM training uptake for relevant staff continues to be monitored, with excellent compliance in most relevant areas. The Named Midwife for Safeguarding Children is continuing to monitor and promote compliance in all areas. The Named Midwife has also worked closely with our three Local Safeguarding Children Boards to deliver brief training events to multi-agency practitioners re FGM, and was chosen to speak at an NHS England Regional FGM Conference.

In summary, YTHFT continues to place the highest importance on the Trust's Safeguarding Children responsibilities and is continuing to develop and progress in all areas of this agenda, whilst remaining alert to any areas of deficit which need specific attention, and working closely with all multi-agency partners.

Tees and Esk Wear Valley Foundation Trust

Executive Summary

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) became the provider of mental health and learning disability services in York that had previously been provided by Leeds and York Partnership NHS Foundation Trust.

Services have been provided as before, with the exception of Adult Mental Health inpatient services, which was due to the closure of Bootham Park Hospital. The plan is under way to have this service back to being provided in York in the summer of 2016.

The issues around technology support and infrastructure for reporting have been resolved and data regarding safeguarding is starting to be reported.

The safeguarding children team has been increased and a Band 8A (full time) is now in post, with a band 7 starting at the beginning of May 2016. Their base is to be within York.

The safeguarding children team have a duty system where there is a member to provide support and advice to practitioners by telephone. They also provide specialist safeguarding supervision to practitioners. Safeguarding supervision is mandatory for staff involved with service users subject to a child protection plan or where the service user is a parent/carer with care taking responsibility for a child/young person with a child protection plan. Work is under way to ensure that the relevant supervision is being provided to all staff. Staff are able to request safeguarding supervision where there are concerns about child.

Staff within TEWV are trained with the appropriate levels of safeguarding children as set out in the Intercollegiate Document (2014,) *Safeguarding Children and Young people: Roles and Competences for Healthcare Staff*. The Trust has developed a training package for all adult mental health staff about the impact of parental mental health on children and young people. Staff in York will also have this training, and there are sessions underway. The clinical records in TEWV also support this by having a tool devised in Teesside about the potential impact of parental mental health, along with the pre-CAF as a tool for helping to consider the impact of parental mental health and the next steps.

The safeguarding children team do undertake audits but none have been completed in the York area. There is a full audit programme planned for next year which will include York. The planned audits are:

- Adult mental health case file audit for child protection,
- CAMHS case file audit for child protection.
- Safeguarding children policy audit, this also includes the staff views about accessibility of the team.
- Safeguarding supervision audit.
- Referral audit for safeguarding referrals into Children's Social Care.
- The impact of parental mental health audit.

Currently the safeguarding children team are compiling an audit bulletin including the audits completed in 2015-16. This will be forwarded to the Board for information once completed.

Voice of the child

This is evidenced within the casefile audits, both CAMHS and adult mental health. The work of CAMHS ensure that the voice of the child is heard. The Trust is committed to the 'Think Family' approach and so the children are always part of the assessment when adults access services.

Key Implications

Safeguarding children is a high priority within TEWV, which is evidenced by the extra establishment of a safeguarding team base in York.

The Trust was represented at the recent section 11 event which was shared with North Yorkshire LSCB. This was to provide assurance to the Safeguarding Children Boards.

The Trust is becoming engaged with the work of the Safeguarding Children Board. This is in development but TEWV are fully committed to ensure that they are an active partner.

NHS England

The overall responsibilities of NHS England in relation to safeguarding

The general function of NHS England is to promote a comprehensive health service to improve the health outcomes for people in England. NHS England discharges its responsibilities by:

- Allocating funds to, guiding and supporting Clinical Commissioning Groups (CCGs), and holding them to account.
- Directly commissioning primary care, specialised health services, health care services for those in secure and detained settings, and for serving personnel and their families, and public health screening and immunisation programmes.

The mandate from Government also sets out a number of objectives relating to safeguarding which NHS England is legally obliged to pursue.

NHS England's overall roles in terms of safeguarding are direct commissioning and assurance and system leadership as set out in the revised *Safeguarding Vulnerable People Accountability and Assurance Framework* published by NHS England in July 2015[36].

NHS England responsibilities in relation to direct commissioned services

NHS England ensures the health commissioning system as a whole is working effectively to safeguard adults at risk of abuse or neglect, and children. NHS England is the policy lead for NHS safeguarding, working across health and social care, including leading and defining improvement in safeguarding practice and outcomes. Key roles are outlined in the Safeguarding Vulnerable People Accountability and Assurance Framework 2015.

This role is discharged through the Chief Nursing Officer (CNO) who has a national safeguarding leadership role. The CNO is the Lead Board Director for Safeguarding and has a number of forums through which to gain assurance and oversight, particularly through the NHS England National Safeguarding Steering Group (NSSG). The National Safeguarding Adults and Children Sub Groups and its Task and Finish Groups report into NSSG.

Yorkshire and the Humber has an established Safeguarding Network that promotes an expert, collaborative safeguarding system, which strengthens accountability and assurance within the NHS commissioning and adds value to existing NHS safeguarding work across Yorkshire and the Humber. Representatives from this network attend each of the national Sub Groups/Task and Finish Groups, which include topics around FGM, MCA, CSE, Prevent, Safeguarding Adults and Children. NHS England Yorkshire and the Humber aims to focus on working in collaboration with colleagues across

[36] https://www.england.nhs.uk/?s=safeguarding+assurance

the north region on the safeguarding agenda and the work on FGM and the CCG peer review process and regional conference is evidence of this.

Sharing learning from safeguarding reviews

In order to continuously improve local health services, NHS England has responsibility for sharing pertinent learning from safeguarding serious incidents across Yorkshire and the Humber and more widely, ensuring that improvements are made across the local NHS, not just within the services where the incident occurred. The NHS England Yorkshire and the Humber Safeguarding Network has met on a quarterly basis throughout 2015-16 to facilitate this. Learning has also been shared across GP practices via quarterly Safeguarding Newsletters.

Safeguarding Serious Incidents

All safeguarding serious incidents and domestic homicides requiring a review are reported onto the national serious incident management system – Strategic Executive Information System (STEIS). There is a process in place to jointly sign off GP IMRs relating to these safeguarding serious incidents as CCGs responsibilities for commissioning of primary care services is increasing. NHS England works in collaboration with CCG designated professionals to ensure recommendations and actions from any of these reviews are implemented. Prior to publication of any child serious case reviews, serious adult reviews or domestic homicide reviews NHS England communication team liaise with the relevant local authority communications team regarding the findings and recommendations for primary care medical services.

Training and Development

Designated safeguarding professionals are jointly accountable to CCGs and NHS England and oversee the provision of level 3 training for primary care medical services. The main source of training for other primary care independent contractors is via e-learning training packages.

NHS England Yorkshire and the Humber Safeguarding Network hosted a safeguarding conference on Challenges for Modern Day Safeguarding Practice on 11 March 2016. This conference was aimed at providing level 4 training for healthcare safeguarding adults and children professionals and leads in the North region. The aim was to increase understanding of challenges and issues of modern day safeguarding practice in relation to suicide and self-harm; trafficking and modern day slavery; trafficking victim/survivor support; Court of protection, community deprivation of liberty and CCGs responsibilities; Mental Capacity Act and Safeguarding Children; Think Family primary care implementation and Self neglect and the Care Act.

Two conferences were held in the North region in March 2016 on Child Sexual Exploitation for healthcare staff and a series of conferences for healthcare and relevant care sectors on Female Genital Mutilation

NHS England Yorkshire and Humber and Yorkshire and Humber Safeguarding Network have produced an FGM guide for health care professionals, which can be accessed in the link below:-

https://www.england.nhs.uk/north/our-work/safeguarding/

NHS England has also developed a *Child Sexual Exploitation – Advice for Healthcare Staff* booklet pocket book and *Prevent* pocket book for health care professionals.

Over the last 12 months a focus on improving the lives of people with a with learning disabilities and/or autism (Transforming Care) has been led jointly by NHS England, the Association of Adult Social Services, the Care Quality Commission, Local Government Association, Health Education England and the Department of Health. The focus for the coming year will be on improving care and services for patients with mental health problems.

Assurance of safeguarding practice

NHS England North has developed a Safeguarding Assurance Tool for use with CCGs across the North Region, which is being implemented from February 2016. NHS England North Regional Designated Nurses will review all action plans to identify key themes and trends across the North Region with a view to identifying common areas requiring support.

NHS England North received national safeguarding development monies to support improvements in the implementation of NHS responsibilities regarding the health of looked after children. This funding has been used to second two designated LAC nurses within Yorkshire and Humber to develop a benchmarking tool based on standards in national guidance and documents such as *Promoting the Health and Well-Being of Looked After Children* and *Intercollegiate Role Framework for Looked after Children; Knowledge, skills and competencies of health care staff.* The two designated LAC Nurses have facilitated the roll out of this peer review benchmarking process across the North which will help identify where there is good practice and the type of improvement work, which we need to focus on. A report of the trends and themes will be shared with all CCGs in the North via the North Region Safeguarding Steering Group. The intention is for the tool to be shared across the country for use following this.

Local Authority Services

Children's Social Care

Overview

Work continues to deliver the ambitious Vision for Children's Social Care set out three years ago. The Vision, welcomed by staff, partners and Members, identified significant changes in style, environment, skill and tools that we wanted to achieve.

Over the past year, we have continued to consolidate the effectiveness of the offer of qualified Social Worker advice at the point of contact. We have broadened the use of evidence-based tools in our Single Assessment work and resulting Plans have become more outcome focused and are reviewed more systematically.

Our commitment to strong professional support is as strong as ever and once again, we undertook an annual survey of staff about their experience of Supervision and the contribution it makes to safeguarding. We continue to robustly scrutinise whether staff are receiving Supervision by way of monthly 'Scorecard'. Also scorecarded on a monthly basis are caseloads and, where issues emerge, additional resources have been deployed. Through regular case file audits, Children's Social Care continues to develop as a Learning Culture, identifying areas of strength and areas for development.

Over the past year, staff have continued to access a wide range of excellent learning and development opportunities to support them in their ongoing professional development. Offered training has included Dyadic Developmental Psychotherapy (DDP), Graded Care Profile, Signs of Safety, Motivation to Change, Pre-Birth Assessment, AIM training and much more. Staff are also offered online research through 'CCInform', a nationally recognised and respected provider of the latest evidence of best practice with vulnerable children and their families.

Finally, over the past year, Children's Social Care has delivered on its commitment to provide its staff with the right tools to do the job. We have continued to review, revise and update key policies and put them online alongside an up-to-date Forms Library. Most significantly, on 21 March 2016 we replaced our decade old case management system with a new state of art system called Mosaic. Mosaic offers a range of functions not previously available, yet does so in a modern, easy-to-use and intuitive way with an emphasis on reducing the screen time required. Mosaic was designed to reflect the need identified by Professor Eileen Munro in her national review of child protection to move away from overly bureaucratic processes and focus on outcomes for children and their families. Mosaic represents a significant financial investment and is driven by a strong commitment to ensure

that systems and processes support effective practice and help achieve the best possible outcome for vulnerable children and young people and their families in the City.

Despite the significant work done to improve its safeguarding of children and young people over the past year, Children's Social Care recognises there is still more to do. In consultation with staff, over the coming year we will restructure our services to more effectively deliver our services. We will for example, create a dedicated service for Children and Young People in Care, provide a quicker response to those on the edge of care, better support permanency, including to those children who have been adopted and free up staff working with complex cases within the Family Courts. We will Make York Home for more young people in care and also increase the management capacity of the Service to support staff in the incredible work that they do. We will improve the independent review of their work to continue to drive up standards and review and renew the way we do assessments. We will be busy. We will not stop improving in the year ahead.

The Criminal Justice Community

North Yorkshire Police

Since 4th January 2016 the police team formally known as the Safeguarding Team / CRU team / MASH team was renamed the Vulnerability Assessment Team 'VAT'. The team is based across two locations in York and North Yorkshire. In York the team is based in the City of York Council Office.

The aspiration of the team is to provide a single point of contact for safeguarding concerns across York and North Yorkshire. The work of the team is critical in the multiagency response to protect children and vulnerable adults from abuse. This is achieved through the identification of safeguarding concerns by police and partners: to then check concerns associated with referrals and information through a process of multi agency information sharing and risk assessment. The information is then shared to ensured that the most appropriate safeguarding response is achieved for the concern.

Team Roles and Responsibilities include:

- To assess safeguarding concerns to reduce the risk to children and adults
- To respond to safeguarding requests for information
- To complete reports for safeguarding strategy meetings and safeguarding conferences
- To identify concerns in respect of CSE across the force
- To identify child protection concerns.
- To identify vulnerable adult concerns
- To coordinate and manage the information sharing process in respect of children at risk of CSE in the City of York.
- To attend child protection strategy meetings and child protection conferences in the City of York
- To manage missing / absent concerns in the City of York.

Critical to this process is the joint assessment / screening of child protection referrals. This has been embedded successfully within the referral and assessment team in York. A Detective Sergeant is co-located within the referral and assessment centre. This role includes the joint assessment of police referrals, providing a point of contact for the team for safeguarding concerns, conducting joint visits with social care and critical information sharing between police and social care in respect of children who are at risk of abuse. This is a developing role but so far has been worthwhile in order to secure positive outcomes for children.

Operation Liberate was launched in the City of York in Summer 2015. The purpose of the operation was to identify young vulnerable people who were out late at night, and who were at risk of becoming victims of crime, or of being drawn into criminal behaviour. The children were taken to a multi agency place of safety before being returned to their parents. The purpose of taking them to a multi agency place of safety was to ensure that strategies were implemted to prevent reouccrung concerns. The place of safety comprised representatives from North Yorkshire Police, Sexual Health, Youth Offending Team and the Rock Church.

Operation Liberate will be launched again in Summer 2016.

Operation Vesitge has been launched within the City of York to manage those vulnerable chidlren that do not meet thresholds for statutory service provision. These children and young people will be visited by officers from local police teams to provide support and seek intervention if necessary.

Child Forensic Examinations

In conjuction with NHS much work has been undertaken during the last 12 months to ensure that there is a consitent and excellent service available to all children who are the victim of sexual abuse. This service is funded by NYP/OPCC/NHS and is provided by York Trust.

Currently the service is provided Monday – Friday and allows for an immeidate forensic examination to be conducted on a child, by a Consultant Paedritician when an allegation of sexual abuse is made. In addition, any child making a non recent sesxual abuse allegation will also be seen at an appropriate time for an overall medical examination. Provision has been made for children to be seen out of hours, although this is outside of the Force Area.

The child service is for all victims up to 16 years of age. However, victims aged 16+ can be seen by the Consultant Paedriticans if deemed appropriate. The SARC has an excellent self referral service for victims 16+ who do not wish to report to the Police.

Training / awareness and Reviews

North Yorkshire Police undertake internal audits as part of a continued improvement cycle so as to ensure their internal policies, procedures and governace are relevant and having the desired impact. In the last 12 months NYP have undertaken audits on how the force responds to CSE and Domestic Abuse. Recommendations from these audits have been added to the existing comprehensive Action Plans.

In addition CSE training and awareness is being delivered to all frontline staff and a ‘toolkit’ has been devised for all staff highlighting their powers and procedures and identifying disruption tactics available to deter perpetrators.

The profile of Human Trafficking and Modern Slavery is being raised in the force. There are links to CSE with this legislation. Again an action plan is being developed along with a ‘toolkit’ to assist frontline staff.

Literature on neglect outlining the signs to look for and action to be considered is being prepared for frontline staff.

The ‘DASH’ risk assessment form used in cases of domestic abuse has been amended to capture ‘through the eyes of the child’ so as to ensure the voice of children caught up in these incidents are captured.

North Yorkshire Police are working with the ‘Railway Children’ organisation to deliver CSE and wider vulnerability training/awareness to transport companies, in particular bus drivers which will build on the work already undertaken by Local Authority colleagues with taxi drivers. It was evident during Operation Liberate that children were using local bus companies to travel around the city.

Youth Offending

A Short Quality Screening of Youth Offending Work in York by Her Majesty's Inspectorate of Probation was conducted from 22-24 February 2016 and examined 14 cases. Key points:

- All the pre-sentence reports contained a clear assessment of the safeguarding and vulnerability factors relating to the child or young person. Similarly, the custodial cases demonstrated an understanding of vulnerability issues, which were clearly identified and recorded, with plans put in place to manage them appropriately.
- There were a number of examples of both health and substance misuse professionals working with the YOT to provide useful additional assessments and relevant interventions.

Areas to now focus on are improving the robustness of management oversight for the timely identification of safeguarding and vulnerability factors. The YOT recently implemented a new assessment framework, 'AssetPlus'. The recommendations are timely in order to implement the new framework in a comprehensive and effective way.

Wetherby YOI – regional provider

The Independent Chair has agreed with with the Chair of Leeds LSCB, which covers Wetherby, that any concerns about safeguarding at Wetherby YOI will be notified to Leeds LSCB as Wetherby YOI are represented on their Board. York Youth Offending Team will keep the Board informed should any concerns arise.

Probation services

2015-16 has been a year of significant change for probation providers, as the new National Probation Service (NPS) and Community Rehabilitation Companies (CRCs) implemented the new organisational arrangements that came into effect as part of the Ministry of Justice Transforming Rehabilitation Programme. The NPS manage high risk of serious harm offenders, including those eligible under Multi Agency Public Protection Arrangements (MAPPA). NPS also advise courts on sentencing, conduct risk assessments and determine the allocation of all cases. Responsibilities in relation to safeguarding children cut across both NPS and CRC organisations and safeguarding children has remained a key priority. There have been a number of HMIP Thematic reviews during 2015-16 looking at the early implementation of the Transforming Rehabilitation programme, which have included a continued focus on safeguarding practice and improving quality and outcomes. The NPS acts to safeguard children and young people and improve outcomes through activity at both an operational and strategic level including:

- The management of adult offenders in ways that will reduce the risk of harm they may present to children by means of: skilled assessment and risk management planning and review; and the delivery of well targeted interventions;
- The delivery of services to adult offenders (who may be parents/ carers) that address factors related to offending behaviour which takes into account any impact on children;
- Recognition of factors which pose a risk to children's safety and welfare and implementation of relevant agency procedures to protect children from harm, through appropriate referrals, information sharing and collaborative multi-agency risk management planning and review;
- Seconding Probation staff to Youth Offending Teams (YOTs);
- Providing services to child victims of serious sexual and violent offences;
- Providing services to women victims of male perpetrators of domestic abuse who attend the relevant accredited programme, having regard to the needs of any children in the family;

- Minimising the risk of poor outcomes for children, but also in supporting and securing improved outcomes for children. This includes work with offenders who may be sexually exploiting young people;
- Working with, for example: substance misusers; offenders with mental health problems; offenders sentenced to imprisonment; domestic abuse cases; and those offenders identified as benefiting from support with parenting skills. Probation providers are alert to issues impacting on children and young people in its core work with adult offenders and ensure appropriate referral to services to address risk of abuse or neglect;
- Attending, engaging, and sharing information with local Safeguarding Children Boards and other relevant agencies, including as part of MAPPA (Multi Agency Public Protection Procedures) and sharing lessons learnt from Safeguarding Children reviews and other reviews and audits;
- NPS national groups which pick up on related cross cutting themes e.g. CSE; Serious Organised Crime (SOC); Domestic abuse; and Prevent and are then reflected in NPS divisional arrangements and improving local delivery;
- The launch of a new NPS process management system 'EQUiP ('Excellence and Quality in Processes') which provides all NPS staff with a single source for Safeguarding documents, guidance and processes.
- E learning training launched in autumn 2015 which is being rolled out to all NPS staff;
- NPS National Interim Safeguarding Children Guidance issued in June 2015.

Community Rehabilitation Company

Introduction

The National Probation Service (NPS) and Community Rehabilitation Companies (CRCs) came into existence on 01 June 2014, as part of the Ministry of Justice Transforming Rehabilitation Programme. HLNY (Humberside, Lincolnshire and North Yorkshire) CRC has responsibility for medium and low risk of harm offenders and responsibilities for safeguarding children cut across both CRCs and the NPS. This report is the first submitted by HLNYCRC and will reflect our focus on Child Safeguarding Board priorities so far. Activity has focussed on improving outcomes for young people and children through activity at both operational and strategic level.

CRC Board Representation

Due to staff changes and a period of organisational restructure our representation at the board has been under review. The appointment of Vikki O'Brien as Community Director for York and North Yorkshire and the establishment of a lead Manager for Safeguarding, Elizabeth Knowles, will ensure consistency of attendance.

Safeguarding Activities

- The HLNY CRC has reviewed and updated its Safeguarding Children Policies and Processes. All staff have been briefed and lead managers monitor and update the processes to reflect legislative changes and any learning from Serious Case Reviews/Serious Further Offence Reviews.
- Our Case Management systems are equipped to identify cases with safeguarding concerns and staff supervision prioritises such cases and considerations of risk management.
- CRC staff continue to work in co-location with our Integrated Offender Management police colleagues, sharing intelligence and expertise.

- Staff continue to manage adult offenders to reduce the risks of harm they pose to children by means of skilled assessment, planning review, multi agency working and targeted interventions.
- Delivery of services takes account of the impact on the whole family and staff are encouraged to conduct regular home visits to make sure they are being alert to issues which might impact on children and young families.
- As a lead provider of DA services, we deliver BBR programmes as ordered by the Criminal and Civil Court. In addition we have commenced delivery of an early intervention voluntary domestic abuse perpetrators programme across City of York and North Yorkshire.
- Local delivery takes account of emerging issues such as CSE, Serious and Organised Crime, Prevent etc.
- Regular audit processes to provide assurance about the quality of Safeguarding work and to inform local Quality Improvement Plans.
- HMIP Quality and Impact Inspection this year will provide us with further feedback and confirms the strength of our local relationships.
- The CRC are members of the CYSCB Domestic Abuse sub group where we hope to begin looking at maximising our experience of working with perpetrators to assist and support the work of our colleagues in other agencies.
- We have representatives on the MARAC core groups in York and Selby and support the attendance of case managers.
- Whilst the National Probation Service second staff to YOTs, the CRC York office has established a specialist Transition to Adult Officer to improve the management of the transfer of young people between the two agencies.

Priorities for the coming year are to -

1. Continue to work closely and co-operatively with our NPS colleagues to ensure that interface arrangements work to protect children and minimise risk of harm.
2. Increase the understanding within the CoYSCB of the role and responsibilities of the CRC.
3. Improve our partnership working. Our service delivery model and IT infrastructure will change significantly in the next 12 months and we plan to be less office based. We are exploring opportunities to work more closely with Prevention and Early Intervention Services within the community.
4. Continue to improve our child safeguarding practice and knowledge through our local Safeguarding Quality Improvement Plans
5. To provide consistent representation to the CoY SCB.

Children and Family Court Advisory and Support Service (CAFCASS)

The following submission relates to the contribution of CAFCASS (the Children and Family Court Advisory and Support Service) to Local Safeguarding Children Boards nationally although all aspects of the work described have also been undertaken in York.

Cafcass is a non-departmental public body sponsored by the Ministry of Justice. The role of Cafcass within the family courts is: to safeguard and promote the welfare of children; provide advice to the court; make provision for children to be represented; and provide information and support to children and their families. It employs over 1,500 frontline staff.

The demand upon Cafcass services grew substantially in 2015-16 with a 13% increase in care applications and an 11% increase in private law applications. The grant-in-aid provided by the Ministry of Justice was smaller than the previous year. Notwithstanding this, Cafcass has met all of its Key Performance Indicators.

The following are examples of work undertaken by Cafcass in 2015-16 to promote the continuous improvement of our work and support reform of the Family Justice:

Revision of both the **Quality Assurance and Impact Framework** and **Supervision Policy** which together set out the organisation's commitment to delivering outstanding services and the ways in which staff are supported to achieve this and the quality of work is to be monitored. The Framework integrates the impact of the work on the child into the grade descriptors so that evidence of positive impact is to be present, alongside compliance with the expectations of Cafcass and the Court, for an outstanding grade to be achieved.

Implementation of the **Equality and Diversity Strategy**: This entails: a network of Diversity Ambassadors who support the development of staff understanding and skill; the holding of workshops; a themed audit on the impact of diversity training on practice.

Extending the **Child Exploitation Strategy** introduced in 2014-15 to include trafficking and radicalisation as well as sexual exploitation. Key elements of the strategy include: Ambassadors (at a service area level) and Champions at a team level to have a 'finger on the pulse' of local issues and to support learning; training and research (including a study of 54 cases known to Cafcass in which radicalisation was identified as a feature).

Working with a **range of partners** across family justice, children's services and the voluntary sector: Examples include Local Family Justice Boards (Cafcass chairs 12 of the 46 of these), the judiciary, the Adoption Leadership Board and the Association for Directors of Children's Services with whom Cafcass has developed the social work evidence template for use in care cases, and with whom we are developing good practice guidance for children who are accommodated by the local authority

The development of **innovations** that are aimed at improving our practice and supporting family justice reform: These include: piloting the provision to our Family Court Advisers of consultations with a clinical psychologist; the extension of Family Drug and Alcohol Courts; *the supporting separated parents in dispute* helpline (a pilot across five service areas aimed at promoting out-of-court settlements of disputes where safe to do so).

Contributing to the government **review of Special Guardianship Orders** has included a small piece of research that was included in the government's response to the consultation.

A **Service User Feedback Survey**, which looked at the interim outcomes of children six to nine months after private law proceedings concluded. Specifically the survey looked into whether arrangements ordered by the court had sustained; how effective communication was between parents before and after court proceedings; and whether participants believed that the court order was in their child's best interests.

NSPCC

NSPCC services in York are closely aligned with two of CYSCB's key strategic priorities namely Child Sexual Abuse and Early Help. The team delivers a therapeutic service (Letting the Future In) for children, and their safe carer(s), aged 4 to 17 years who have been sexually abused. In 2015-16, 32 children and 11 carers accessed the service from the City of York. The aim of the service is to help children to overcome the impact of the sexual abuse they have experienced and to offer advice and support to parents. The team participated in a randomised control trial (RCT) conducted by Bristol and Durham Universities to test the effectiveness of the approach. The findings were published February 2016 and have been shared with partners from CYSCB. The sexual abuse service has been working at capacity throughout 2015-16, with established referral pathways with all key agencies. The service is always in high demand providing the only specialist sexual abuse therapy service in

York and North Yorkshire. A waiting list was introduced during the last quarter of 2015-2016 due to a lack of capacity to allocate new referrals. We have also continued to use capacity/other resources within the team to try and respond to the needs of children and their families for the sexual abuse service.

'Women as Protectors' is a group work service introduced by NSPCC in 2015 for women who are in a relationship with a man who poses a risk of sexual harm to a child. It is designed to assess and enhance protective ability of female carers with the aim of keeping children safe now and in the future. It provides education, emotional support and guidance. Direct work is offered to all children in the family as well as joint work with the children and the female carer if it is required. Written reports and recommendations can be given to the referring agency outlining risks, strengths and protective factors. At the end of the group women can receive individual support from a trained and supervised volunteer for up to 18 months if they request this. The programme is being delivered and evaluated in York and across the country to find the very best methods for preventing child sexual abuse and for supporting and protecting children whose lives have been affected by it. To date referrals have come from York and 3 of the surrounding Local Authorities. Due to the fact that 2 out of the 3 trained staff moved on to new jobs we had to suspend the group work and volunteer programme during quarters 2 and 3 and delivered the programme on a one to one basis. The group work programme resumed in February 2016 with 5 mothers attending regularly and we have 8 volunteers in training.

NPSCC has a multi-disciplinary team of social workers and nurse practitioners delivering an early help service called Minding the Baby (MTB). It is a 27 month home visiting parenting programme that begins during the third trimester of pregnancy and aims to help first time mothers (14-25 yrs) to care for their babies and cope with the challenges of becoming a parent up to the child's second birthday. MTB aims to promote positive attachments and to ensure the mental health and well-being of mothers and their babies. During the course of 2015-2016 the team completed work with 27 mothers from the first programme. The second programme has recruited new mothers via a randomised control trial (RCT), with half the mums-to-be (17) receiving the programme and half receiving the usual range of services offered in the community. The study is being conducted by Prof. Pasco Fearon of University College London, one of the world's leading experts on infant mental health. The research findings will be published in 2017 and shared with CYSCB at this time.

NSPCC is committed to the work of the CYSCB and the Service Manager has been an active member of the CYSCB and the PSDG. During 2015-2016 NSPCC contributed to the work of 3 Sub-groups. NSPCC staff have had regular briefings on the work of the CYSCB and attended workshops and training provided by the Board so that all staff are aware of lessons from themed audits and from learning lesson reviews. NSPCC has worked in partnership with CYSCB colleagues to bring national NSPCC services/resources/research and campaigns to the CYSCB with the aim of bringing 'added value' from a national children's organisation where there is synergy with the business of the Board for example sharing the Spotlight research programme that has been published over the past year. The CYSCB and NSPCC Sexual Abuse Campaign launched in May 2015. Over the course of 2015-2016 a comprehensive programme has been delivered to children, parents, professionals and communities across the City. At the time of writing the final evaluation reports are being written and it is hoped that we can share our learning with partners across the City of York and in other parts of the UK. The feedback has been overwhelmingly positive as a result of the hard work and commitment of all key partners to make the campaign a success and there is no doubt that working together we have achieved so much more than the endeavours of any single agency.

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NOT SEEN, NOT HEARD

A review of the arrangements for child safeguarding and health care for looked after children in England

JULY 2016

Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation
Caring – treating everyone with dignity and respect
Integrity – doing the right thing
Teamwork – learning from each other to be the best we can

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Foreword

Children and young people have the right to be protected from abuse and exploitation and to have their health and welfare safeguarded. Yet in 2013, UNICEF reported that the UK ranks 16th out of the 29 most advanced economies in the world in terms of the overall wellbeing of their children (including material wellbeing, health, education, behaviours and risk, and housing and environment). Although the trajectory is that of improvement, children's health services still have a way to go to ensure that the care they provide is improving children's lives and keeping them safe.

There is unwarranted variation across England in the quality of the arrangements in health services for child safeguarding and for looked after children. These are some of society's most vulnerable children. Over the last 40 years we have seen a plethora of reports providing lessons to be learned from scandals and serious case reviews and an abundance of guidance that describes the elements that contribute to effective safeguarding systems and what children say matters most to them. The gaps are well documented, so why haven't they been addressed?

Children and young people need to be listened to, and need to feel that those looking after them actually care about them. In the majority of cases, individual healthcare staff demonstrate passion and determination in their work to keep children safe. However, the structures and systems to support them are not always in place. From workforce planning, training and supervision, to the use of technology to improve data sharing, to working effectively together across health, education, social care and justice – many areas are still not getting it right for children.

As an organisation, we recognise the importance of high-quality joined-up care, even before a child is born, as an integral part of the care people should receive throughout their childhood and into their adult life. We inspect children's services to assess the effectiveness of arrangements in health for safeguarding and for looked after children. We are committed to encouraging the improvements needed to ensure that children and young people are kept safe and are supported to achieve their best health and wellbeing potential.

This report shares what we found, including where there are concerns, but also champions what can be achieved when commissioners and providers understand the needs of children and young people, and work together with them and other agencies to ensure their services are making a difference.

Children must be put at the heart of how services are designed and delivered. Their needs must be seen and their voices must be heard. Health services and their staff need to work more effectively together to start closing the gaps in the arrangements in the very services that are there to keep children and young people safe and thriving. No child should be left behind.

David Behan
Chief Executive
Care Quality Commission

Summary

Children and young people in care, and those with safeguarding concerns, remain some of the most vulnerable in our society. Yet not all get the help they need when and where they need it.

The Care Quality Commission (CQC) has been reviewing the health care aspects of children's services in England, under Section 48 of the Health and Social Care Act, since September 2013. The 'Children Looked After and Safeguarding' (CLAS) in-depth inspections assess how health services in a local authority area work together to provide early help to children in need, improve the health and wellbeing of looked after children, and identify and protect children who are at risk of harm. In this report, we analyse the findings of our inspections and focus on the experiences of children to see whether services make a difference to them, and we make recommendations for improvement.

When health and safeguarding systems fail, the voice of the child has almost invariably been lost. Two thirds of the children we spoke to on our inspections said they did not feel involved in their care and therefore did not see the point in accessing the care and support they needed. Healthcare providers are required to involve children in their care, yet were rarely able to demonstrate how they achieved this, or how they engaged children in the design, delivery or improvement of their services. Where children were meaningfully engaged with, it was done at every level, from being involved in planning their own care to contributing to the design of services to better serve children's needs.

The NSPCC advocates that listening to children improves their emotional, mental and physical health. The only way to check whether services are improving outcomes relating to health and wellbeing is to measure them. The review found that when providers and commissioners monitored appropriate outcomes, they knew exactly what was making a difference in their area and could focus their efforts and resources where it mattered most. However, the extent to which such outcomes were being monitored and used effectively to improve care varied significantly.

With the right questions and support, children's services can discover the risks and harms that threaten many children, including those from parental ill-health, sexual exploitation and female genital mutilation. The extent of these problems is still largely unknown, and how well children are being protected from them, even less so. Most areas are not yet effectively identifying and protecting children at risk of these hidden harms.

The review also found that the needs of children in transition are overlooked. This includes those

transitioning from children's to adult health services and looked after children who are moving area or leaving care. The experiences of these young people are poor as health services are failing to help them prepare for the next stage in their life. Access to the emotional and mental health support they need remains a significant concern as the provision of child and adolescent mental health services (CAMHS) is not meeting their needs. Where services were effectively helping children who need these services, they worked together to produce meaningful care plans for the future, enabled access to the right specialists and were flexible around age and geographical boundaries to ensure that support did not end abruptly.

The solutions to these complex problems do not lie solely with individuals. Many highly motivated and skilled staff working with children want to make a lasting difference. However, it is often obstacles within the system that prevent progress being made. Health professionals are in a strong position to address children's health and welfare needs and identify safeguarding concerns, but no single person can have a full picture of a child's circumstances. To keep children safe, health staff must share appropriate information in a timely way.

Children's inspectors found that health professionals have improved how they assess risk and recognise safeguarding concerns. However, this review identified problems in how those risks are then shared with different services. Practitioners frequently did not articulate their views of the risks to the child or set out what they expect from the referral – leaving the receiving team unclear of the concerns. As a result, actions were delayed or failed to take place at all. This was prevalent across the health system, but particularly in primary and emergency care settings.

The review found that the quality of information sharing was strengthened by robust partnership working, supported by investing in long-standing, trusting relationships across agencies. It was also supported by compatible electronic systems that flagged concerns about vulnerable children, as well as shared policies and pathways that helped staff to be clear on what should be done, when, where and by whom, and reduced variation in practice. This highlights the need for system-wide collaboration and investment in compatible electronic systems that flag concerns nationally.

Ensuring that these systems are in place and working effectively across the entire health system requires strong oversight, governance and leadership. CQC has found that across all sectors the quality of leadership closely correlates with the overall quality of a service, and children's services were no exception. Given the challenges in promoting and protecting the welfare of all children, and the difficult financial context, increased resources cannot be the only solution. Areas with good leadership worked creatively to ensure their services made the most of their capacity, anticipated gaps and ensured that the right staff, training, supervision and skill mix were in place.

There is unwarranted variation in child safeguarding arrangements and provision for the health and welfare of looked after children in England. This report shares and celebrates examples of innovative and outstanding care to demonstrate what is possible and intends to be a resource in order to drive improvement. It also makes recommendations for how commissioners, providers and frontline healthcare professionals can strive towards protecting and promoting the health and welfare of children.

CQC's key recommendations

1. Children and young people must have a voice

Listening to children is the paramount safeguarding activity. All healthcare providers should engage children at each stage of their care planning in order to help them be involved in, and take ownership of, their own treatment and care. Providers should also seek children's views on what needs to be done to improve the services they use. This includes ensuring that children with complex and severe developmental, physical, emotional and mental health needs also have their views heard and represented.

2. The focus must be on outcomes

Care providers and commissioners should substantially shift their focus towards achieving better outcomes for children. All services providing health care need to work collaboratively with children to determine locally-relevant ways to measure outcomes to regularly evaluate the impact they are having on the children who use their services. These measures should be used to track changes in outcomes (including emotional wellbeing) over time and to inform how resources are allocated and services are planned. Health assessments and care plans should also be focused on outcomes and be regularly reviewed to ensure that progress is being made towards goals that have been set jointly with children themselves.

3. More must be done to identify children at risk of harm

The risks to many children are not always obvious and require a continuous professional curiosity about the child and their circumstances. The emphasis must be on both identifying and supporting those in need of early help, as well as those at risk of 'hidden' harms. Services should significantly improve how 'Think Family' practice is embedded in all adult services, particularly in adult mental health. They should also support staff in improving how they identify, protect and support children at risk of child sexual exploitation and female genital mutilation. More also needs to be done to recognise and protect children at risk of new and emerging harms such as trafficking and radicalisation.

4. Children and young people must have access to the emotional and mental health support they need

Children's experiences of transitions in health are unacceptably poor. Significant improvements need to be made in how young people experience transitions in health services, especially as they leave paediatric care and enter adult mental health and substance misuse services. Commissioners and providers of services should ensure that looked after children who are moved out of an area have arrangements for continuity of health reviews and have priority to continue to access health services that they were previously receiving, particularly emotional and mental health support. They should also ensure appropriate support and services for those who are leaving care during this often vulnerable time in their lives. Access to mental health support and treatment for all children must be addressed as a priority, especially in CAMHS.

"I'm not a case; I'm not a piece of paper. I'm a human. I need you to see that if you're going to help me."

A recent care leaver, The Who Cares? Trust

Introduction

It is everyone's responsibility to safeguard children.[a] Although local authorities have overarching responsibility, every organisation and person who comes into contact with a child has a role to play.[1]

This includes staff in health services who are in a strong position to address children's health and welfare needs and safeguarding concerns. However, no single person can have a full picture of a child's circumstances and therefore services have to work closely together to ensure that children are kept safe.

Society has changed dramatically over the last 50 years, with leaps in technology and increased global mobility presenting new challenges. Children are groomed for sexual exploitation and radicalisation on social media, and young people from certain communities can be at risk of trafficking and female genital mutilation. The number of children identified as having been abused or exploited is only the tip of the iceberg – many more are suffering in silence.[2]

As new risks emerge and more children are identified as being in need because of abuse or neglect, it is more crucial than ever that staff across health and social care, education, the police and the justice system all work together.

One of the earliest pieces of safeguarding legislation introduced in the UK was the Health and Morals of Apprentices Act 1802, which prevented children working in mills and factories at night and for longer than 12 hours a day.[3] Almost two centuries later, the Children Act 1989 gave every child the right to protection from abuse and exploitation and to safeguarding of their welfare.[4] Over the last 40 years there has been a plethora of reports containing lessons to be learned from scandals and serious case reviews, of guidance describing what elements contribute to effective safeguarding systems and of what children say matters most to them.[5,6,7] But where are we now?

Over the last two years, the Care Quality Commission (CQC) has reviewed the effectiveness of arrangements for safeguarding and looked after children in health services in England, under Section 48 of the Health and Social Care Act 2008. CQC assesses how health services in a local authority area work together to provide early help to children in need, improve the health and wellbeing of looked after children, and identify and protect children at risk of harm. The focus is on the experiences of children and how services make a difference to them.

a. In this report a child is defined as anyone who has not yet reached their 18th birthday. 'Children' therefore refers throughout to 'children and young people'.

The Children Looked After and Safeguarding (CLAS) reviews involve in-depth inspections of the arrangements in primary care services, acute hospitals, mental health services (including child and adolescent mental health services (CAMHS)) and community services (including health visiting, school nursing, sexual health and substance misuse services).

In order to build on existing knowledge about what makes care effective for looked after children and in child safeguarding, and what barriers prevent children from getting the care they need, the findings of the review have been analysed and common themes identified. Although the findings are specific to how services are working together in health care, most issues identified are very relevant to other sectors, including children's social care, education and the police.

This report gives an overview of the findings, celebrates and shares good practice and makes recommendations on what needs to be done differently to keep children and young people safe.

How we carried out this review

We carried out extensive qualitative analysis of the 50 reports written by CQC's Children's Services Inspection team from September 2013 to December 2015, while focusing on the recurring themes within them (the list of reports included in the analysis is in appendix A). The coding framework used to identify these themes was developed from the 'lines of enquiry' used when reviewing health services in local authorities. Themes were added to the framework where the analysis highlighted a need for further detail. The findings formed the evidence for the report and are presented in footnotes. It is important to note that local authorities were selected for earlier inspections based on risk, so this analysis may reflect a selection bias. We therefore do not present quantitative data as percentages because of this, but also because we could not assume that if a report did not comment on an issue (such as female genital mutilation) there was an absence of work in that particular area.

Focus group work

The identified common themes and findings were discussed with the following groups of people:

- A focus group with senior leaders in child safeguarding and looked after children involved in health care in England.
- An expert advisory group (see appendix B).
- Two voice sessions with recent care leavers from The Who Cares? Trust.
- A focus group comprising inspectors from CQC's specialist Children's Services Inspection team.

The remit of these reviews is extensive, so these discussions helped to focus on the key issues and identify the legislative and political context as well as the priorities and emphasis of the main findings in this report. The expert advisory group comprised a broad range of stakeholders including commissioners, providers, frontline healthcare professionals, designated and named professionals, representatives from other sectors including Ofsted, the Department for Education, Department of Health and voluntary sector organisations that represent children. The voice sessions were run with recent care leavers from The Who Cares? Trust to capture their views and experiences on being in and leaving the care system.

Who this report is for

This report has been written primarily for those who design, run and work for children's health services, but is also relevant to other sectors. This includes senior managers in NHS England, the Department of Health, Department for Education and Ofsted, local authority chief executives, directors of children's services and chairs of local safeguarding children boards (LSCB). It is also important for senior managers within organisations that commission and provide services for children and families, including social workers and professionals from health services, adult services, the police, education, youth justice services and the voluntary and community sector who have contact with children and families. All health professionals should read the

findings and follow the recommendations so that they can best respond to children's needs. We have also published **key points from the review** specifically for children and young people, as well as a **video** that highlights some of the key findings and recommendations.

As well as sharing what CQC found from the review, this report is intended to be a resource to drive improvement. We include many examples of good and innovative practice to highlight and celebrate what can be achieved. After reading this report, we invite readers to complete the reflection template (appendix C) to consider what you have learned, identify additional learning needs and make an action plan for how this will help you to change your practice in future.

1

The child's voice: the silence is deafening

When health and safeguarding systems fail, it is often because the voice of the child has not been heard.[1]

The United Nations Convention on the Rights of the Child (UNCRC, 1989) protects the right of children and young people to be involved in all decisions that affect their lives.[8]

Looked after children in care, as well as those subject to child protection processes, often feel powerless. Children want to be respected, involved in decisions and plans, and informed of the outcomes of assessments and decisions that affect them.[7] This empowers them and gives them confidence and competence. The extent to which children are listened to significantly influences how safe and happy they feel.[9]

The silence, however, is deafening. The review found that children were often not involved in decisions about their care and their views were not represented, such as in case conferences. The majority of children that the inspectors spoke with said they did not feel involved in their care.[b] This led to care plans that were impersonal and contained only basic information. Children said that missing this vital opportunity to engage with them meant they did not see the point in accessing the care and support they need.

LISTENING TO AND ENGAGING CHILDREN

In Salford, services were taking strides to improve how they listened to and engaged children at multiple levels. Frontline staff in Salford Royal NHS Foundation Trust were holistic in their assessment of children and young people, capturing their version of events and wishes, and including a comprehensive picture of what life was like at home. The quality of health reports to child protection case conferences was good. They demonstrated clear analysis of risk and protective factors, and priority was given to reflecting the voice and experience of the child.

The trust had set up a group to seek feedback from young people and their families attending hospital. Action was also being taken in community health services, such as the development of **'Talking Mats'** and employing new methods for engaging young people, especially those with communication difficulties.

Services in Salford developed an extensive range of **useful resources** on capturing the child's voice in a number of settings including the Common Assessment Framework (CAF).

b. Across the 50 reports, we analysed quotes from children to see whether or not they perceived their voice was heard in services. Of the 69 quotes that mentioned voice or involvement, 26 were positive and 43 quotes were negative about this.

Providers of care are required to involve children in their care, yet they were rarely able to demonstrate how they achieved this, or how they engaged them in the design, delivery or improvement of their services.

Where services engaged meaningfully with children, it was done at every level of their care. Children were involved in planning their own health and treatment, were included in child safeguarding procedures and their views were fed back and informed improvement of services to better meet children's needs. This included children with complex communication needs, particularly those with multiple physical health problems or severe learning disabilities.

"They just say the same things about visiting a dentist or optician every year even though my optician has said I don't need to go for two years. The medical still says I have to go every year just because I'm in care so I feel it's a waste of time."

A young person in care (taken from a CLAS report)

IMPROVING ENGAGEMENT WITH HEALTH ASSESSMENTS

The designated nurse for looked after children in Solihull successfully engaged with young people who had entered care at a later age or had been resistant to accepting support in the past. Her team developed a 'decliner pathway' to improve engagement with those who had previously been hard to reach. Using different strategies to listen to their needs, the team improved engagement for this group of young people with their health assessments, from 79% to 93% in one year.[10]

"I could have gone so far in life if I had the opportunity to deal with my abuse as a child. I wish someone would have listened. I seemed articulate, OK, I ticked the boxes, so they moved me along. I seemed fine. You go into the job because you care but along the line it goes a bit wrong. Don't let it. If I was your child or your niece, how would you find out how I really was? Talk to me like that, talk to me like you actually care."

A recent care leaver, The Who Cares? Trust

MEETING THE NEEDS OF A CHILD WITH A LEARNING DISABILITY

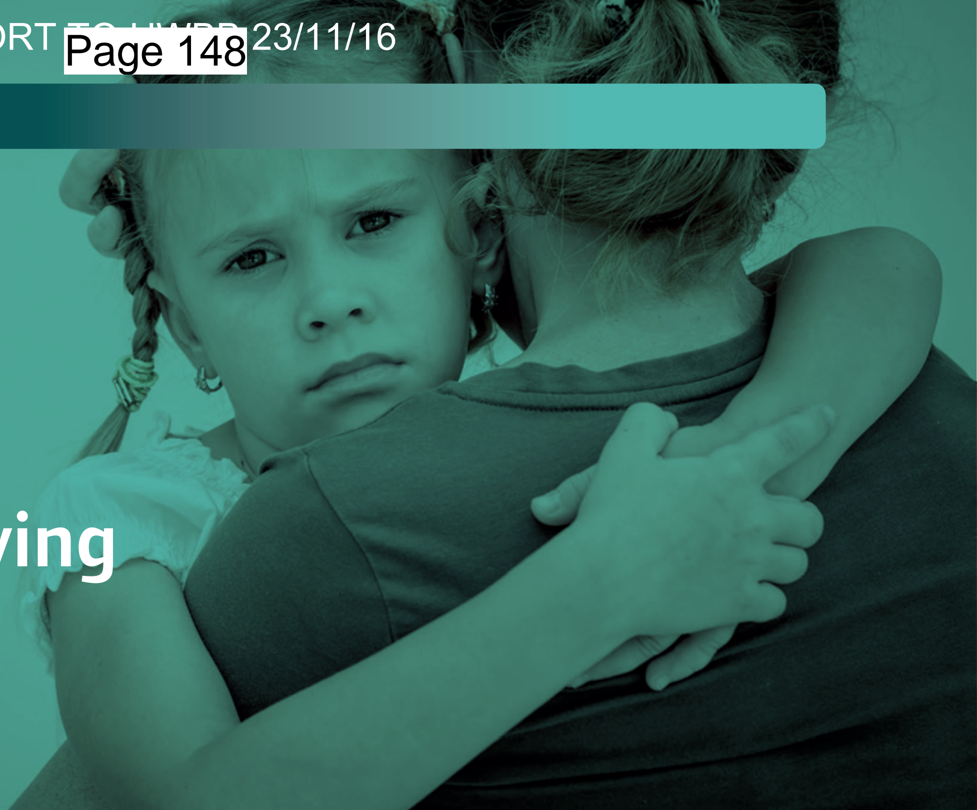
In Cheshire West and Cheshire, a child protection plan for a child with a learning disability and health needs was tailored to the needs of the mother, as she also had a learning disability that affected her ability to meet the child's needs effectively. The plan was in an easy-to-read format to help build her understanding of what was expected of her. Her capacity to meet her child's development needs was improved considerably by developing a range of visual cues, which supported her to ensure safe routines.

RECOMMENDATIONS

Listening to children is essential to effective safeguarding. All healthcare providers should engage children at each stage of planning their care in order to help them be involved in, and take ownership of, their own treatment and care.

In practice this means:

- All health staff seek, hear and act on the voice of the child. They should involve children at each stage of their health care planning, and listen and respond to their views about what is important to them.
- All providers and local authorities empower children in meaningful ways to feed back on their experiences of care, with a particular emphasis on how the service is helping to improve their health and wellbeing.
- All children are involved in giving feedback on and co-designing their local services, ensuring they are as accessible and relevant as possible.
- All practitioners, providers and commissioners listen to the children who do not necessarily have a voice, including those with complex and severe developmental, physical, emotional and mental health needs.
- CQC continues to seek and report on the experiences and views of children who use health services as part of our single and joint-agency inspections.



2

The 'so what' factor: improving outcomes for children

Despite improvements in child health in the last 40 years, children in England have poorer health and wellbeing outcomes than those in comparable countries.[11]

The only way to check whether services are improving children's health and welfare is to measure the associated outcomes. The review found that outcomes relating to children's health and wellbeing are not consistently being monitored in children's health services. Where this was being done well, providers and commissioners were able to demonstrate that they knew exactly what was making a difference in their area and could focus their efforts and resources where it mattered most. The outcomes that they measured also considered the child's family.

In the worst examples, providers failed to define and monitor meaningful outcomes for children at every stage – from identifying early needs and the effectiveness of safeguarding arrangements, to the health and wellbeing of looked after children and children leaving care.

The variation in how services look at outcomes for children is unacceptable. Most CLAS reviews made recommendations that related to improving how outcomes for children are monitored.[c] Limited reporting about needs, outcomes and gaps in services for children – particularly those who are looked after – means that providers and commissioners are not informed when planning or improving the care they deliver.

> **"I slept through my therapy sessions for three and a half years. I went because if I didn't go, she would have told my foster parents. She woke me up when the time was up and I left. The professionals should have met up to check if it was working for me. It was a waste of time for everyone."**
>
> **A recent care leaver, The Who Cares? Trust**

Early intervention

The care that a child receives during their earliest years, even before they are born, is critical to their future health and wellbeing.[12] A child is considered to be 'in need' if they are unlikely to reach or maintain a reasonable level of health or development, or their health or development will be significantly impaired without the provision of services, or if the child is disabled.[4]

c. There were 75 recommendations related to outcomes across 36 of the 50 reports. They varied between one mention per report, to five mentions in one report.

A GOOD RANGE OF EARLY HELP SERVICES

Vulnerable children and families in Gloucestershire had access to a range of early help services that were delivering positive outcomes. For example:

- A substance misuse parenting group was delivering sessions on parenting, healthy eating, play/interaction skills and behaviour management.
- A support and education group was addressing attachment issues for parents and young children.
- A programme was set up to support children experiencing, or at risk of, chronic neglect due to a combination of substance misuse, poor mental health and/or domestic abuse.
- A practitioners' advice line and foster carer drop in sessions were available to discuss mental health issues.

To improve outcomes for these vulnerable children, their needs must be identified and addressed early. The review found a worrying loss of focus in recognising children in need early on. Specifically, there was a gap for those identified as needing further help but who did not meet the threshold for child protection. Information is not routinely collected on this group of children, and as a result, the scale of the problem – and whether services are improving it – is unknown. It can only be inferred from the increasing prevalence of abuse and neglect that it is not being prevented sooner.[2] These children are not being adequately recognised or supported by health services.

The review found that midwives played an important role in identifying and supporting vulnerable women in antenatal and postnatal services, including teenage parents. Early intervention programmes were also essential to continue the support after birth. Where this was being done effectively, there was a range of early help services, all of which kept children's outcomes at the focus of how they plan, deliver and review care.

A PROACTIVE EARLY HELP STRATEGY

In Middlesborough, children, young people and families who were not making sufficient progress in early intervention programmes were discussed at regular multi-agency forums. These were made up of senior staff from agencies across the partnership (including Children's Social Care, CAMHS, Sure Start Children's Centres, Integrated Youth Support Service, Parenting Services and Neighbourhood safety teams) and provided specialist targeted support, advice and consultation to practitioners. They were identifying trends and emerging issues with more challenging families to achieve positive outcomes through joint initiatives. Outcomes had been identified for children and young people as part of their Early Help Strategy, and were being used to measure progress.

Using meaningful care planning to improve outcomes for looked after children

Looked after children often enter care with a worse level of health than their peers. They are more likely to have mental health issues, emotional disorders, hyperactivity conditions and autistic spectrum disorders. For example, 45% of looked after children have mental health disorders – rising to 72% for those in residential care – compared with 10% of the general population aged five to 15.[13] They leave care with increased risks of substance misuse, mental health problems, homelessness and offending. Their educational and employment achievements are significantly less, with 41% of 19-year-old care leavers not in education, employment or training (NEET) in 2013/14, compared with 15% for all 19-year-olds.[14]

"I just don't see the point of the health reviews, same routine and don't see any difference."

A young person in care

In recognition of these inequities, guidance states that every looked after child should have a health plan describing how their identified needs will be addressed to improve their health outcomes.[15] The number of looked after children with up-to-date health checks has steadily increased nationally (88.4% in 2014 compared with 76.8% in 2011).[16] However, this review found that the quality of health planning was often poor, particularly in setting objectives and measuring outcomes.

All children in care should be involved in prompt, high-quality health assessments, supported by 'SMART' (specific, measurable, achievable, realistic and timely) health plans that are regularly reviewed. The outcomes should be tracked over time to ensure that services are supporting children to achieve better physical and mental wellbeing.[15] Where this was done well, children were empowered to take ownership of their health plan. However, health assessments were not 'SMART' in half of CLAS reports, indicating that many areas did not routinely set goals or measure outcomes for individual looked after children.[d]

A LACK OF SMART PLANNING LEADING TO POOR CARE PLANS

In one area, we found examples of initial health assessments and associated plans to be extremely poor, lacking depth and exploration of emotional health and wellbeing. Some were significantly overdue. Maternal and paternal health histories were not consistently gathered and the health plans did not contain SMART objectives. Staff were therefore unable to identify existing and potential health needs and plan for the future for these very vulnerable children and young people.

Improving emotional health and wellbeing outcomes for looked after children

Emotional health and wellbeing are key contributors to improved outcomes, including better learning and achievement, as well as to the longer-term potential of young people as they transition into adulthood.[17]

In March 2015, the Department for Education and Department of Health updated statutory guidance on promoting the health and wellbeing of looked after children.[15] This outlines the requirement of local authorities to use the strengths and difficulties questionnaire (SDQ), which is a screening tool that offers measures of wellbeing and resilience and enables young people to give their view on how they feel and the progress they are making towards their own goals.

SDQs are used to monitor the emotional health of looked after children aged five to 16 at a national level. In 2015, there were 36,140 children in this age range in England who had been looked after for at least 12 months. Of these children, 72% had a SDQ assessment.[18] Half had a score that was borderline or a cause for concern.[e]

The CLAS reviews paint a far worse picture. SDQs were being used in a meaningful way in only a small minority of areas.[f] The vast majority were not routinely using SDQ scores to inform health assessments or reviews, to appropriately flag concerns or to trigger a more in-depth assessment.

d. 24 of 50 reports specifically noted concerns that health assessments were not 'SMART'.

e. A score of 0-13 is normal, 14-16 is borderline and 17-40 is a cause for concern.

f. Of 38 reports that commented on the quality of SDQ assessments, 33 noted that they were not being used appropriately, at all or in a way that informed health reviews in a meaningful way. Five noted them as being used effectively to inform health reviews.

NOT USING SDQS TO THEIR MAXIMUM POTENTIAL

In one area, SDQs were sent out to foster carers but young people were not routinely asked to complete their own. This was a missed opportunity for those young people to contribute to the assessment and planning of their emotional health and wellbeing.

In another area, there was a protocol for moderate to high scores in SDQs to be reviewed, but no arrangements to monitor this or to collate outcomes to ensure that children received the right services to meet their needs.

Where services were using SDQs effectively, they were:

- Documenting scores in health assessments and reviews (particularly if they were done by social care staff) and ensuring they informed children's plans and goals.
- Using them appropriately as a screening tool, rather than replacing a full mental health assessment where needed.
- Ensuring those with abnormal scores (i.e. 14 and above) were reviewed by specialist professionals, for a more in-depth assessment.
- Following up and tracking subsequent scores to show outcomes of interventions.

RECOMMENDATIONS

Care providers need to substantially shift their focus towards monitoring outcomes for children. Each part of the system, at each level, has a vital contribution to make.

In practice this means:

- Health services prioritise meeting the needs of children who would benefit from help and support early on, including those who do not meet the threshold for child protection proceedings, but have still been identified as benefiting from further support.
- Health assessments and reviews in all settings follow the Department of Health's guidance to ensure they are focused on action and outcomes for children.
- Screening tools for emotional health and wellbeing, such as strength and difficulties questionnaires (SDQs), are completed annually for every child in care, meaningfully contribute to their health reviews, and are routinely monitored to inform the impact of interventions. Those with abnormal scores are reviewed by an appropriate mental health specialist.
- All health services work collaboratively with children to determine locally-relevant outcome measures, in order to regularly evaluate the impact they are having. These measures should be used to track changes in outcomes (including emotional wellbeing) over time and inform resource allocation and service planning.

3 Quality of information sharing in multi-agency working

Sharing information is vital to safeguarding and promoting the welfare of children. Poor information sharing is repeatedly identified in serious case reviews (SCRs) as contributing to the deaths or serious injuries of children.[19] To keep children safe it is essential that health and social care staff and local agencies share appropriate information in a timely way and challenge partner agencies to work effectively with them.

The review found that health professionals have improved how they assess risk and recognise safeguarding concerns in children. However, we identified problems in how those risks are then shared with different services. The quality of referrals and reports varied considerably, particularly to multi-agency safeguarding hubs (MASH), child and adolescent mental health services (CAMHS) and contraception and sexual health services (CASH).

Practitioners frequently did not articulate their views on the risks to the child and did not set out what they expected from the referral – leaving the receiving team unclear of the concerns. For example, health professionals communicated specific details about the child's health, but often failed to give a holistic picture of the child's circumstances. As a result, actions were either delayed or failed to take place at all. These issues were particularly apparent where referrals had been made from general practice and A&E departments to social care.

VARIABLE PRACTICE UNDERMINING EFFECTIVE REFERRALS

In one area, the CLAS report outlined significant concerns about how health practitioners across services made referrals to children's social care. Highly variable approaches were being used within and across health services, undermining the effectiveness of safeguarding arrangements. This made it difficult for operational managers to put in place effective quality assurance and governance processes to drive improvement or ensure sustainable consistency.

The referrals that inspectors saw were of poor quality. They did not routinely provide a clear rationale for the referral, articulate the risk of harm to the child, set out the expected outcome or demonstrate the use of threshold guidance.

There was little guidance on how to make safeguarding and child protection referrals. Although a referral template was available, referrers could choose not to use it, and most had not. The result was a system that did not support health practitioners in making quality referrals that would facilitate good decision-making in children's social care.

Accident and emergency (A&E)

A&E departments and minor injury units did not consistently record key information in line with NICE guidelines.[20] There was a lack of effective documentation in many areas, with some common gaps.[g] These included:

- Documenting the exact nature of the relationship of the accompanying adult, or about their caring responsibilities.
- Capturing the child's own account of what happened, and where possible, independent of their carer.
- Identifying and documenting risks specifically in the 16-18 years age group.

The review identified examples of poor quality referrals where the risks to the child were not clearly expressed in the referring documentation, despite evidence in the notes that a thorough risk assessment had been made.

Primary care

The contribution made by primary care services to child protection cases was inconsistent, with the majority of areas needing to strengthen arrangements.[h] In many cases there had been no GP contribution at all. Where GPs had been involved, the information submitted about the child's health was frequently too basic. GPs are often in the unique position of knowing the child and their family for many years and can make significant contributions to the safeguarding process.

The most common factors for the lack of GP engagement were:

- Lack of awareness of responsibilities in contributing to child protection cases. Some GPs also lacked confidence in understanding the differing thresholds and procedures for children in need, child protection and looked after children.
- No template or guidance for encouraging and standardising GP submissions to case conferences. Some had developed standardised templates but they were not always used, or were not effective in prompting the correct information.[i]
- Barriers that prevented GPs attending case conferences in person. These included conferences being organised during surgery hours, in inconvenient locations and at late notice. In the large majority of cases no alternative arrangements had been made to facilitate GP participation.[j]
- Not being kept informed by other agencies. In many areas, information sharing by other health staff with GPs was absent or ineffective.[k]
- Capacity problems, including recruitment difficulties and limited resources, which affected the consistency and quality of GP contributions. This included vacant named GP posts in several areas. Where named GPs were appointed, they were often positively supporting safeguarding practice in primary care.

g. 16 of 50 reports contained negative comments about documentation within A&E departments.

h. Of the 45 reports that mentioned GP contribution to child protection case conferences, 31 noted the need to improve in this area.

i. Reports in 12 areas noted a lack of guidance or templates and nine had templates that were being used inconsistently.

j. Reports in 17 areas showed the barriers that prevent GPs attending case conferences. These included holding them during surgery time (5), in inconvenient locations (2), at late notice (4), and having a lack of alternative arrangements in 13 reports.

k. Inspectors noted a lack of, or ineffective, information-sharing by other health staff with GPs in 20 reports.

LACK OF GP ENGAGEMENT IN CHILD PROTECTION

In one area GPs were not routinely responding to requests from school nurses and other professionals for information relating to the health of children subject to child protection plans. There was no evidence of GP attendance at case conferences in the child protection cases reviewed. The GP reports that were reviewed contained very basic information and little that would inform the parenting capacity of the adult or the child-parent interaction that was observed.

Improving quality through partnership working and shared frameworks

One barrier to sharing confidential information about children, their families and carers, was a lack of trust about how other agencies would interpret and use information. The review found that where relationships were strong between primary care and other services (including the CCG and the designated doctor), information was shared more appropriately and child protection engagement and contributions followed better practice.

Face-to-face meetings, such as multi-disciplinary team meetings and safeguarding forums also improved the quality of shared information. GPs' strongest partnerships were with health visitors, with whom they often had regular contact. Information-sharing arrangements were much more variable between GPs and school nurses, midwives and CAMHS, where there had been fewer opportunities to work closely together.

SUCCESSFULLY DEVELOPING THE DEVON ASSESSMENT FRAMEWORK

In Devon, an **alternative early help model** had been developed to provide a more integrated system for identifying any type of need for children and young people aged 0 to 25 years. This was developed as a comprehensive system that included support across education, health and social care.

The model was viewed positively across the system. Children's inspectors saw some examples where it had been effective in supporting families and reducing children's vulnerability.

The consistency of information sharing was also improved through the use of standardised templates or frameworks, such as the Common Assessment Framework (CAF). The CAF was designed to help coordinate the assessment of a child who could benefit from early support.[21] Where the CAF was used, staff considered a more holistic view of the needs of the child when assessing and planning their care.

However, where the CAF identified children who required support through early help, there was significant variation in the recording and communicating of information compared with those under more formalised child protection plans.

RECOMMENDATIONS

Although improvements have been made in how health staff identify safeguarding concerns, a number of issues have been identified that have a detrimental impact on the quality of information-sharing, which must not stand in the way of the need to promote the welfare and protect the safety of children. These should be addressed as a priority across health systems.

In practice this means:

- Providers ensure that healthcare staff are trained in how to articulate the risks identified to a child and made aware of local policies. This should be delivered at a multi-professional level to improve understanding of how each agency uses information.
- Healthcare staff across agencies strengthen relationships through joint training and regular contact in order to nurture trust and work together more effectively.
- Providers develop clear guidance and templates to standardise the information that is shared where appropriate, such as case conference reports, and embedded into practice. Referrals and reports are regularly audited for quality assurance.
- GPs are supported to better contribute to child protection meetings and case conferences. This may include improved flexibility in arrangements such as time, format, location, notice given and use of technology.
- GPs contribute to case conferences, even when they are unable to attend, for example by providing a comprehensive report that is discussed with the social worker or conference chair ahead of the conference date.

4

The five 'P's that support multi-agency working

In addition to assessing risk and communicating it, keeping children safe requires collaborative working across the health sector, as well as with educational, social care and justice organisations.

The review identified the systems that exist to facilitate effective multi-agency working at several levels:

- **Physical systems** (IT or paper-based) – support accurate and timely documentation and information sharing.
- **People** – facilitate joined-up working and strengthen partnerships. It is often individuals who work hard to ensure that any gaps in existing systems are anticipated and avoided.
- **Policies, protocols and pathways** – help staff to be clear on what should be done when, where and by whom, and reduce variation in practice.

Children experienced more coordinated, joined-up and efficient care where there were arrangements for how to share information, make referrals and provide support. This was the case for child safeguarding arrangements as well as for looked after children's services.

Physical systems

Being aware of previous concerns or potential vulnerabilities is vital to ensuring that a child's risk is fully assessed, particularly for services without a continuity of care to the child, such as A&E departments, minor injury units, walk-in centres, GP out-of-hours services and sexual health units. A number of areas had integrated and compatible electronic systems that used alerts to flag vulnerable and looked after children.

In A&E departments, examples of well-designed electronic systems were seen that prompted practitioners to ask certain questions and record particular information, ensuring that vital information is not missed.

EFFECTIVE FLAGGING SYSTEMS IN A&E DEPARTMENTS

Several effective flagging systems across trusts in Kent reflected good practice. For example, electronic flagging systems in A&E identified those who were subject to a child protection plan. In Darent Valley Hospital, young people with 10 or more attendances were automatically reviewed by the consultant paediatrician responsible for safeguarding.

Flagging systems were also helping to identify vulnerable, safeguarded or looked after children in GP records, maternity units and CASH services. Missing children and those identified as being at risk of domestic violence were also flagged at multi-agency risk assessment conference (MARAC) meetings.

In primary care, single patient information systems across many health disciplines were used as an effective information sharing tool. They offered a way of capturing essential safeguarding information, and could be used to ‘task’ other professionals to follow up with the child, which was helping to prevent missed actions.

Where integrated systems were not in place, there was an over-reliance on staff to remember to explore and record all the key information related to assessing a child, including relying on children or families to declare their child protection or looked after status. There was also a reliance on individual members of staff to remember those at risk and contact other agencies to corroborate information.

THE CHILD PROTECTION INFORMATION SHARING (CP-IS) PROJECT

CP-IS is a national project designed to improve the level of protection given to children who present in unscheduled NHS healthcare settings. Building on existing infrastructure, it allows healthcare staff to identify if a child is subject to a child protection plan or is looked after. This supports them in their decision-making and encourages communication with social care.

Access to CP-IS information is controlled by NHS smartcard security. Local authorities feed information from their social care systems into a secure central data store area in the NHS national Spine. While health staff are registering a child at their care setting they are then informed of the child’s child protection status.

A record of who has viewed the indicator flag is available to social care and healthcare staff, allowing them to see if a child has visited a range of different unscheduled care settings. This is important, as serious case reviews have demonstrated that abusive and neglectful behaviour can be masked by moving between different services.

As of April 2016, 24 local authorities had implemented CP-IS, equating to 28,054 or 23% of child protection records being uploaded to the Spine.[22] There is a NHS Standard Contract requirement that NHS organisations implement CP-IS by 31 March 2018. The national implementation of CP-IS is endorsed by CQC.

INCOMPATIBILITIES IN MATERNITY

In one area, five hospitals were using one IT software system for their electronic patient records in the maternity departments, but the sixth had implemented a different system. This raised concerns about the consistency of information exchange between maternity providers across the city, particularly because women had the choice to deliver in any one of the city's hospitals. The community midwives therefore had access to different levels of data for the different women they cared for. This created additional work for staff, introduced the risk of error and the possibility that the needs of newborn and unborn children could be missed.

INEFFECTIVE FLAGGING SYSTEMS IN A CASH SERVICE

The electronic management system in use in one sexual health service did not automatically flag young people under the age of 13 or those who were looked after. The arrangement required professionals to use special notes to ensure their vulnerability was captured, and these had to be separately checked to inform any re-presentation. The local professionals recognised that this was not providing the levels of assurance required and it was highlighted as an organisational risk.

People

The people who were responsible for ensuring that children's care was joined-up, with robust information sharing arrangements, were essential to a system that was keeping children safe.

For example, in primary care the services worked more effectively to identify and act on risks to children where there were identified people who were responsible for overseeing safeguarding, including named GPs. Unfortunately these posts were not always filled and individuals taking on these roles frequently did not have the capacity to fulfil all of their responsibilities.

Effective safeguarding was often seen in A&E departments that had a paediatric liaison practitioner. Where this role was effective, the practitioner acted as a coordinator for children's health and safeguarding. For example, they:

- Coordinated weekly paediatric A&E meetings and child safeguarding training.
- Anticipated gaps in provision and ensured that alternative arrangements were made.
- Developed new pathways of care (such as an under-16 self-harm pathway, and a paediatric summary form).
- Strengthened relationships with other services, such as CAMHS.
- Regularly attended multi-agency meetings.
- Took responsibility for the quality assurance of decision-making and referrals.

Policies, protocols and pathways

Concerns about children are less likely to be missed where there are jointly agreed ways of working that everyone understands and knows how to access. One example is a policy for when children do not attend (DNA) an appointment. It is important to highlight that the children themselves do not actually 'DNA' appointments; rather, it is that they are not brought to appointments by their family or carer, which could be a flag for further safeguarding concerns. This has led to the proposal that DNAs are reframed as 'was not brought' (WNB) events, which should trigger the question "why were they not brought?"[23]

COMMON FEATURES IDENTIFIED BY CLAS REVIEWS OF A SAFE PAEDIATRIC A&E DEPARTMENT

- **Compatible IT systems that reliably flag vulnerable children, those who are looked after or considered to be at risk.**
- **A paediatric liaison practitioner in post to take the lead on ensuring coordinated care for children's health and welfare.**
- **Review systems in place to assure decision-making on action and referrals.**
- **All areas of the paediatric A&E waiting room visible by staff (important both for monitoring a child's clinical condition, but also for observing interactions between children and the person(s) accompanying them).**
- **Sufficient qualified and experienced paediatric staff in post, and all staff up to date with safeguarding training.**
- **An established self-harm pathway with access to CAMHS assessment and inpatient treatment where necessary.**
- **Close working with adult A&E staff, particularly on training and sharing information about parents who present with behaviours of concern.**

The review found that without a DNA/WNB policy, practitioners lacked guidance to ensure consistent practice in minimising risks to children.[I] Early signs of disengage ment from a service could be a cause for concern, so it is crucial that all services have a jointly agreed process for when a child is not brought to an appointment, to ensure that concerns are appropriately followed up.[20]

Where DNA/WNB policies worked particularly well:

- A triage-process ensured that the level of risk to any one child was reviewed before proportionate action was decided.
- Staff pursued individual cases with determination and care to ensure that the child or their carer was aware of the appointment and process.
- They were jointly agreed and spanned across more than one service, or at trust level, and they were well understood by staff across all agencies.
- A multi-agency response was in place where appropriate.

ROBUST DNA/WNB POLICIES

West Sussex: Surrey & Sussex Healthcare Trust had a robust DNA protocol in place. Where a child failed to attend an appointment two or more times (or recurrent rescheduling of appointments) the case was automatically discussed at the weekly safeguarding meeting. If a child left A&E before being seen, notification for follow-up was sent to community health and primary care services to ensure that their needs were met.

Torbay: In the cases we reviewed, all health services (including GPs and adult services) demonstrated robust responses in line with the local shared DNA policy for children who did not attend who were identified as being vulnerable or subject to child protection plans. The safeguarding children's team was copied into DNA letters for children who were subject to child protection plans. This information was then forwarded to the relevant community health practitioner for follow-up.

I. We made recommendations in 7 of 50 reports to improve implementation or adherence to at least one DNA/WNB policy.

OUTSTANDING CHILD SAFEGUARDING PRACTICE IN PRIMARY CARE

Huntingdon Road Surgery in Cambridge was recently rated outstanding by CQC for the 'safe' key question, in part due to the safeguarding work being carried out.

The practice's safeguarding lead was active in ensuring that children were kept safe. A comprehensive library of safeguarding information had been developed that was available to all staff on the practice's intranet, including local safeguarding newsletters, case conference reports, guidance on female genital mutilation, and safeguarding templates. Safeguarding policies and protocols were detailed and appropriately tailored to the practice.

There was a robust system of recording keeping, including responding to requests for safeguarding information and ensuring that all staff were up to date with safeguarding training. The practice had recently hosted a training event that included discussing lessons learned from serious case reviews in the area and presentations from representatives of the multi-agency safeguarding hub, Cambridgeshire Sexualised Behaviour Service and Cambridge constabulary.

The practice had carried out a detailed audit of the quality of coding of safeguarded children in case notes, which identified areas for improvement. There had also been active follow-up of children on child protection plans who had not attended immunisation appointments.

Note: This example did not form part of the CLAS reviews but has been included as an example of robust safeguarding practice in primary care.

Following up missed appointments can ensure that children and families in early need of help are identified and that appropriate support is given. This is also important in midwifery services, where working together with health and social care services to support women and families can make a difference.

The table below collates the good practice that was seen across several areas where this was working well, and illustrates how effective multi-agency working can be supported by policies, protocols and pathways.

The review identified a worrying gap in child safeguarding policies, protocols and pathways in minor injury unit (MIU) departments. Many MIU departments were unable to demonstrate that child safeguarding issues had been fully considered. This raises major concerns for the welfare of children accessing emergency care through these services.[m] The table below summarises the features of concern.

m. We visited a minor injury unit in 25 reviews, and made recommendations in 10 of those reports to review and improve the safeguarding arrangements.

Multi-agency working to provide early help: What 'good' looks like	
Pre-birth protocols	Midwives use pre-birth assessment templates to identify and follow up concerns about the health and wellbeing of mothers or the safety of their unborn babies, including appropriate use of a common assessment framework (CAF). • Systems alert staff to existing knowledge about vulnerable cases. • Clear policies are used to escalate a safeguarding concern. • Non-attendance at appointments is routinely followed up. • Antenatal home visits are considered where appropriate.
Pathways	• Clear pathways for specialist support are available for women and their partners who: – have learning disabilities – have mental health problems – have drug or alcohol misuse problems – have experienced domestic violence – are teenagers (e.g. family nurse partnership) • Joint clinics are available in some areas, and specialist midwives support colleagues with complex cases and in both internal and multi-agency liaison.
Partnerships	• Teams work together as part of early help multi-agency meetings attended by health (including CAMHS), police and social care. • Community midwives meet regularly with health visitors and GPs to discuss and jointly visit vulnerable mothers-to-be in their area. • There is effective liaison between maternity and A&E departments, adult substance misuse and mental health services. • Maternity services routinely receive all police reports involving women who are pregnant or have recently given birth. • Midwives and health visitors prioritise attendance at child protection meetings. • A common pathway exists to ensure that there is a consistent response with all appropriate agencies involved.
(These examples were collated from good practice seen across several areas including Solihull, Stockton-on-Tees, Swindon, Wiltshire and South Gloucestershire)	

Causes for concern in MIU departments	
Protocols, policies and pathways	• Limited links with other MIU or A&E departments, with staff reliant on voluntary disclosure about other recent attendances. • No policy for logging child attendances or formal process to follow up those who attend. • No safeguarding alert or flagging system on the electronic system in use and no facility for staff to flag records manually. • Limited access to risk assessment tools, e.g. for child sexual exploitation (CSE). • No self-harm pathway for young people.
Documentation	• Notes illegibly written. • No details of the accompanying adult or person with parental responsibility. • No written account of the history according to the child. • No safeguarding prompts on admission templates. • Discharge paperwork not completed. • Poor quality onward referrals with lack of articulation of the risks to the child.
Staffing, training and supervision	• No paediatric-trained staff in the department. • Frontline MIU staff not trained to appropriate levels of safeguarding competence. • Extensive use of locum doctors and bank or agency nurses without appropriate governance and supervision to ensure safe practice. • No formal safeguarding supervision in place, such as access to a safeguarding lead with advice and guidance available on an (at most) ad-hoc basis.
Quality assurance	• Notes not routinely audited to assess quality of record-keeping, including of safeguarding issues. • Lack of oversight and clinical governance of safeguarding.

RECOMMENDATIONS

Effective multi-agency working that involves seamless information sharing must be supported by compatible electronic systems, people in post to ensure that the whole complex system is working well together, and agreed ways of working in the form of policies, protocols and pathways. Health services should have all these elements in place to ensure coordinated care for children.

In practice this means:

- All areas have compatible electronic systems that are able to reliably flag concerns and share information about vulnerable children and families across sites and agencies. In unscheduled care services, this should include implementing the **Child Protection – Information Sharing (CP-IS) project**.
- All services have processes in place to coordinate the follow-up of concerns about children, particularly in unscheduled care settings. A named individual(s) should ensure that these processes are regularly audited and reviewed.
- All agencies have jointly agreed protocols for dealing with the situation where a child is not brought to an appointment.
- Providers of minor injury units review the effectiveness of their child safeguarding arrangements and ensure that they meet appropriate standards.

5 Finding the hidden child

The National Society for the Prevention of Cruelty to Children (NSPCC) estimates that for every child identified as needing protection from abuse, another eight are suffering abuse in silence.[2]

However, there is insufficient drive in our health and social care system to find out the prevalence of safeguarding issues to look for these missing thousands. The focus is predominantly on what practitioners are doing for those children who have already been identified as being at risk.

Finding the 'hidden child' is about taking a holistic approach when children are assessed and cared for in addition to maintaining a professional curiosity about their situation and the people around them. It is also about how effectively staff listen to and involve children. Young people who have recently left care told us that trust in the professional is crucial and that they won't open up about issues unless they feel that the person actually cares. They implored staff in health services to take the time to get to know them, and to be curious about the things that don't add up. This is vital to identifying children in early need of help, as well as those who have been suffering for years.

> **"Sometimes it feels that people are just doing a job – I won't share if I don't think you care."**
>
> **A recent care leaver, The Who Cares? Trust**

The CLAS reviews have shone a light on areas where children are most often overlooked, including adult health services – particularly mental health and substance misuse – through a 'Think Family' approach, as well as the structures in place to identify some of the most concealed and dangerous risks to children: child sexual exploitation and female genital mutilation. These agendas for child health and safeguarding have had a renewed focus but how well embedded they are varies significantly across the country.

Think Family

Joined-up working between adult and children's services to meet the needs of families is a major challenge. Adult care and children's care have different legal frameworks, policies and practices. Information-sharing between the two has traditionally been poor. As a result, the 'hidden child' is not always considered when an adult is seen in a service with, for example, mental health problems, domestic violence, or substance misuse concerns.

'Think Family' is a national agenda, first introduced by the Cabinet Office's Social Exclusion Taskforce in 2007.[24] The Think Family approach in adult health services is about understanding the effect of the family situation on the child, identifying early risk to children and ensuring that the support provided by all services is coordinated and focused on problems affecting the whole family.[25] The framework to support the child and family is provided in the 2015 guidance, *Working Together to Safeguard Children*.[1]

The Think Family approach has been widely accepted as good practice, yet the review found significant variation in the extent to which it is understood and embedded in the work of frontline health staff. For example, Think Family practice was not well embedded in the majority of adult mental health services.[n] Staff did not consistently consider the impact of parental mental ill-health on children. Even where questions about children were included in recording systems, the clarity, consistency and detail of these varied.

THINKING FAMILY WITH HIGH-RISK MEDICINES

In the adult substance misuse service in Birmingham, there were robust arrangements to ensure that any risks to children were identified as part of the assessment process. Where children were in the household, information was provided about the safe handling and storage of medication, such as methadone, to ensure their safety.

There was a process of on-going risk management, which enabled early follow-up of any additional support or safeguarding concerns for children.

Where Think Family was well-integrated in adult mental health services:

- Detailed risk assessment tools were in place for adults in contact with children.
- Adult mental health teams carried out home visits for a complete assessment of the home environment, including children staying or living there.
- Information-sharing protocols were in place to ensure that attendance at child protection case conferences was prioritised, contributions submitted and social services informed if adults miss appointments and the child is identified to be at risk.
- Care plans and relapse indicators routinely recorded the needs of the child and parenting goals were consistently actioned in recovery plans.
- Children's health professionals were invited to attend adult mental health inpatient discharge planning meetings.
- Active engagement work promoted awareness of, and developed, systems to support the Think Family approach.

The Think Family approach was better integrated in adult substance misuse services than in mental health, as CQC has found in previous work with Ofsted.[26] Good practice was supported by reliable recording and reporting systems, close managerial oversight, robust quality assurance and involvement in joint training.

n. Of the 34 reports that mentioned Think Family practice in adult mental health services, 25 noted that practices were not embedded (although a number of those areas were working towards this approach) and nine commented that the approach was well integrated.

Think Family in adult substance misuse services: What 'good' looks like	
Identifying risk	• Risk assessments and screening tools ensured a joint focus on the needs of any children present in the family, including unborn children, and they were revisited regularly when circumstances changed.
Forward planning	• Contingency plans for children were made as part of recovery plans, in the event that a parent deteriorated or failed to engage.
Joint working	• Reliable liaison with health visitors and school nurses helped children whose parents were service users to access support services. • Effective joint working with local midwifery services, adult mental health services and lead child health professionals. • Joint visits undertaken where appropriate. • Consistent use of a multi-agency template when making referrals, which were prompt and the risks to the child well-articulated. • Additional support for families available, for example, through a specialist family support team.
Information sharing	• Robust information-sharing arrangements were in place across the system, including for example, about the safe handling and storage of high-risk medication where children were in the household.

RECOMMENDATIONS

Think Family practice, where fully integrated into a service, supports the holistic assessment of children and their families, and helps to identify children at risk. Significant improvement is required in adult services to embed a culture where the needs of children are routinely considered and addressed.

In practice this means:

- Significant improvement is made in embedding Think Family in all adult health services, particularly in adult mental health services, to consistently consider the needs of any children in contact with a service user, who might be at risk of harm.
- Improved recording of all relevant information about children and families, integrated IT systems that facilitate the sharing of information, and closer joint working, information sharing and training between adult and children's services.
- A family perspective is developed at all levels of health, including policy and performance indicators, in order to make progress in the Think Family approach.
- CQC ensures that Think Family is embedded in our inspection approach across all adult health services, including mental health services.

WORKING TOGETHER TO IDENTIFY RISK

In Stockport's adult drug and alcohol service, thorough risk assessments were undertaken about parental/carer responsibilities and contact with children. Home visits were offered routinely for service users with children under five years old. The team liaised with health visitors and schools to help children of service users to access support.

The area had developed a 'central youth' hub for a number of services, including a substance misuse service, specialist teenage pregnancy midwife and family nurse partnership. The services shared information where risks were identified and worked cooperatively with other services, including the looked after child health team, multi-agency sexual exploitation group and children's social care, to ensure young people's safety.

Child sexual exploitation

Child sexual exploitation (CSE) involves taking advantage of a situation, context or relationship (invariably involving an abuse of power) in order to coerce a child to accept something (such as food, gifts, money, affection, protection) in exchange for sexual acts or activity.[27]

The review found the majority of local authority areas had gaps or concerns in the arrangements to identify and protect children from CSE.[o] In local authority areas where the identification of CSE was ineffective, there was poor awareness of the risks, coupled with an inadequate joint approach to information sharing and risk management. There was also a lack of multi-agency working or protocols, particularly in emergency departments, and limited links to existing child protection processes.

"You have to find out what's going on behind the scenes to keep us safe. I was scared into not telling anyone the bad things my foster carer was doing because she threatened me, but there were signs."

A recent care leaver, The Who Cares? Trust

This very challenging area requires a strong partnership approach across health, social care, and the police and justice system, supported by formalised decision-making arrangements, protocols for information-sharing and engagement across services. Where this worked well, arrangements took many different forms across the country, including multi-agency groups or risk panels, CSE best practice forums and other formalised multi-professional pathways. However, most areas were still in the early stages of their response to CSE.

Contraception and sexual health (CASH) services have a significant role to play in CSE. The review found most services had screening and risk assessments in place, but many needed to improve in order to be effective.[p] Where there was a robust approach, it was supported by the use of risk assessment proformas, such as 'Spotting the Signs of CSE'.[28] When used effectively, the assessment was repeated each time a young person presented, allowing practitioners to fully assess potential vulnerabilities at each and every contact. It additionally provided the opportunity for an in-depth discussion with the young person about their circumstances, as well as their emotional health and wellbeing.

o. 36 of the 49 reports that mentioned CSE described at least one gap or concern in the arrangements in place to identify and protect children and young people from CSE.

p. 22 reports mentioned strength of screening and risk assessments, of which 13 had robust arrangements and 9 needed improvements.

Other services used creative approaches to engage with those most at risk of CSE, supported by a range of targeted education campaigns such as:

- outreach services aimed at children and young people most at risk of CSE
- promotional materials placed in identified 'hotspots' of risk
- courses on CSE targeted at young people
- use of creative materials to explain risks to young people, such as a short film called 'My Dangerous Lover Boy', and an educational resource called 'Love or Lies'.[29]

Across all services, the review highlighted a significant lack of awareness of CSE among staff, including limited knowledge of national guidance on assessing consent and confidentiality in those under 18 years old and the legal obligations concerned with children younger than 13 years. Practitioners themselves told inspectors they did not feel fully skilled and equipped to recognise the indicators that may suggest a child is at risk from CSE.

EXEMPLARY WORK ON CHILD SEXUAL EXPLOITATION

Swindon's local safeguarding children board (LSCB) had developed a protocol for managing risk across agencies, which included outlining the roles and responsibilities for those working with children deemed to be at high risk of CSE.

The multi-agency risk panel was well attended by children's social care and sexual health services, police, the youth offending team, locality teams, and CAMHS. It linked well with the LSCB sexual exploitation and runaways sub-group.

The panel introduced a **vulnerability checklist** to support risk assessment and discuss cases deemed to be high risk. Where young people were approaching 18 years old, transition plans were considered, as were pathways into adult safeguarding or other appropriate risk management forums to ensure on-going protection.

The inspection noted good work across services:

- Sexual health – Swindon Integrated Sexual Health was making a significant contribution in identifying young people at risk of CSE while delivering a supportive and high-quality contraception and sexual health service, which young people wanted to engage with.
- School nurses – working jointly with school safeguarding leads, school nurses had developed a four-week targeted course for young women identified as being at risk of CSE.
- CAMHS – a practitioner from the outreach service for children and adolescents team was effectively supporting those considered to be at high risk from CSE.

The panel's work was further supported by the Swindon multi-agency information sharing protocol, which ensured that no single agency was holding on to information about risks to children.

Female genital mutilation

Female genital mutilation (FGM) is the term used to describe any procedures that involve partial or total removal of the external female genitalia for non-medical reasons.[30] It is prevalent in specific ethnic populations in Africa and parts of the Middle East and Asia.

FGM is illegal in England and Wales under the FGM Act 2003.[31] Health and social care professionals and teachers now have a duty to report known cases of FGM to the police if the girl is younger than 18 years old.[32] Amendments to the FGM Act 2003 in 2015, together with increasing national awareness, has meant that the inspection's focus on FGM in more recent CLAS reviews has increased compared with those reviewed in 2013.

Some individual practitioners have developed a high level of understanding of the risks and associated cultural issues, and are raising awareness of the issues on local and national levels. Although some local authorities have an improved awareness of the women who have undergone FGM and the risks to young girls, most were not challenging it effectively.

The review found effective, well-embedded work on FGM in only a small minority of areas.[q] Where there was partial or no work on FGM, this was often underpinned by a lack of awareness among practitioners and resulted in insufficient risk assessments. Good practice was also let down by an absence of comprehensive policies, training and joined-up working.

RESPONDING TO CULTURE-SPECIFIC RISKS

Brent has a cultural and ethnic population that suggests large numbers of women are at risk of FGM. Maternity services were offering two clinics at both main hospitals for reversals, as well as clinics for counselling and follow-up support. The Head of Midwifery was passionate about the issue, contributing to local and national discussion on how best health services can prevent FGM and support women and children. Plans were in place to work with the local population and other key stakeholders, recognising the sensitivities around this practice and the need to engage communities.

DEDICATED MIDWIFERY SERVICES

Specialist midwifery services for women who have undergone FGM were in place across providers in Birmingham. Innovative practice and consultation with local communities was seen, including work with a local Somalian Women's Group, on how best to support women when disclosing FGM. For example, pictorial bookmarks had been developed to help women explain to practitioners the extent of their injury. '**Birmingham Against FGM**' had become a part of the local safeguarding children board sub-group, focusing on education of GPs and raising community awareness of FGM.

Where FGM was disclosed to midwives, a 'cause for concern' form was generated and shared with the woman's GP and health visitor. However, there was limited consideration of information sharing with school nursing if the woman had other female children of school age.

UNACCOMPANIED ASYLUM SEEKING CHILDREN

More recent CLAS reports have focused on how health services are meeting the needs of unaccompanied asylum seeking children (UASC). In one area, the review found that medical staff undertaking assessments of UASC did not have specific training or support in working with this minority group. The initial health assessments seen did not demonstrate awareness of issues relevant to their asylum seeking status that may impact on physical or emotional wellbeing. These issues were undermining effective care planning.

q. Of the 28 reports that commented on FGM work, just 5 noted that it was well-embedded in practice.

RECOMMENDATIONS

The hidden harms to children from child sexual exploitation and female genital mutilation make keeping children safe a particularly challenging task. A robust approach from the health sector, working closely with social care and the police, is vital to identifying and protecting children at risk of these, and other, hidden harms.

In practice this means:

- All healthcare staff are enabled to take the time to build trusting relationships with the children and young people they work with, in order to create the environment for them to find out about issues that could be hidden from view.
- Health services appoint a lead person for both CSE and FGM who is responsible for ensuring that cases of CSE and FGM are appropriately handled, monitored and recorded.
- Standardised, multi-agency training programmes and supervision are available to all staff working in health. This should include how to identify risks and signs of CSE and FGM, how to ask the relevant questions of children, and how to escalate concerns. It must include UK law on reporting FGM.
- There are multi-agency policies and pathways and information-sharing arrangements in place to protect those who are at risk of CSE or FGM, or have undergone FGM.
- Services seek to understand and meet the physical, mental and emotional health needs of those who have been victims of CSE and women and girls who have undergone FGM.
- Commissioners and local safeguarding children boards identify the risks in their local communities, working with the voluntary sector organisations and those who have experienced CSE and FGM, so that their response meets the needs of their communities.

6

Transitions and access

Children's transitions to adult services in health

When young people with health needs leave paediatric care to join an adult service, their experience of that transition can be very variable. As CQC found in the 2014 report on children's transitions to adult health services, *From the pond to the sea*, young people and families are often confused and at times distressed by the lack of information and support about which services are available to meet their complex health needs.[33] The absence of an established pathway or dedicated changeover process leads to a poorly organised and frustrating transition for young people.

KEY FINDINGS: FROM THE POND TO THE SEA: CHILDREN'S TRANSITION TO ADULT HEALTH SERVICES

The report recommended that services follow existing good practice guidance to ensure that young people are properly supported through transition. From the age of 14, every young person with complex physical health needs should have:

- A key accountable individual responsible for supporting their move to adult health services.
- A documented transition plan that includes their health needs.
- A communication or 'health passport' to ensure relevant professionals have access to essential information about them.
- Health services provided in an appropriate environment that takes account of their needs without gaps in provision between children's and adult services.
- Training and advice to prepare them and their parents for the transition to adult care, including consent and advocacy.
- Respite and short break facilities to meet their needs and those of their families.

The report also recommended that commissioners should listen to and learn from the experiences of young people and their families, GPs should be involved at an earlier stage in transition planning and that adolescence/young adulthood should be recognised across the health service as an important developmental phase.

The need for a supportive transition applies to all health services, but this review has built on the findings from CQC's transitions report to share what was working well in mental health and substance misuse services. The CLAS reviews identified some good practice:

- Services had a dedicated transition worker to coordinate a smooth transition for young people from children's to adults services.
- Good partnership working was evident, for example, between CAMHS and young people's substance misuse workers, with adult mental health and substance misuse workers, and with looked after children's nurses.
- Regular professional meetings discussed young people aged 17 who were likely to need ongoing services from the adult team. These informed joint 'transition clinics' run with the young person, the children's service and the adult's service during the period of transition (often six months).
- Panels or teams were in place to review young people in transition and arrange support for those who may not meet the criteria for adult mental health services.
- To inform future improvement, services asked for feedback from young people on their experience of transitioning to adult services.

CLEAR TRANSITION PATHWAY

There was a robust transition policy and pathway for young people moving from the CAMHS to the adult mental health teams in Wakefield. The transition process started when the young person was 17½ years old, continuing for up to six months. During the transition period, the services worked jointly and involved the young person. Appointments were usually held in familiar CAMHS settings. These arrangements enabled stability and ensured that young people were not lost in the system during this critical time.

However, children's experiences of transition in health services can still be very poor, with significant variation seen in the transition pathways in place particularly from CAMHS to adult mental health services. More needs to be done to meet the recommendations made in *From the pond to the sea*.

Continuity of care for looked after children when moving area

Many children in care are moved several times a year, often outside their home local authority area.[r] In 2013, more than one in 10 looked after children lived more than 20 miles from their home community.[34] The review identified a number of concerns about care provision in transition for these looked after children and young people.

> **"When we've been moved out of borough, the care we're getting suddenly gets cut off then we have to start again when we go somewhere new, usually at the end of the waiting list. Why shouldn't we be prioritised to restart our care in the new area?"**
>
> **A recent care leaver, The Who Cares? Trust**

A child placed out of area is frequently unable to access health services, such as regular health assessments or CAMHS, as neither the home or out-of-area local authority will accept responsibility for the commissioning or funding of the service. This leaves vulnerable young people without access to the care they need for long periods.

Where health reviews were carried out regularly, the looked after children's nurse often retained responsibility and continued to travel to see the child. Continuity of care also worked well where provision had been made at a commissioning level, for example, providing specific out-of-area services.

r. For the year ended 31 March 2014, 35% of young people leaving care aged 16 or above had five or more different placements in the care system, **NAO (2015).**

CONCERNS ABOUT ACCESS FOR LOOKED AFTER CHILDREN

Looked after children health teams in one area were experiencing difficulties in ensuring that children placed out of area were able to access health services, including health assessments. Work with social care was on-going to ensure that services were in place before placements were made. There were also recognised problems in children accessing CAMHS if placed out of area. This meant that some children were disadvantaged by being placed out of their home county.

Young people told inspectors they frequently had to join the end of a waiting list when they moved out of an area or returned to their home area. Many felt they should be prioritised to access services, given their inequity of service when moved and more complex needs. This is supported by both NICE guidance and the Education Select Committee's 2016 report.[35, 36]

CQC agrees that no looked after child should face unfair delays in accessing the health services they need, particularly when they are moved to another area. This should be reflected in statutory guidance and addressed by close liaison between different local authorities and CCGs.

Transition to independence for care leavers

The period of transition in establishing independence is especially difficult for young people in care. Despite this, the review found that support for care leavers was unacceptably poor, with health services failing to cater for their needs or help to prepare them for the next stage in their life. Only a minority of areas were providing good health support for care leavers.[s]

Care leavers told inspectors that when agencies fail to ensure that their health information stays with them on their journey through health and social care, there is a significant and detrimental impact on them as young adults. Most young people did not have adequate health support as they left the care system; they were not routinely given their health history or age-appropriate health information packs, and told us they did not feel involved in their leaving care plan.

"A lot of kids in care, we don't know our history, we don't know if there's family health problems. It would be good to give us a chance to have an MOT at 18 so we know where we are. We've got no one to ask about inherited things. We don't know anything."

A care leaver

The review identified effective approaches to encourage young people to have better ownership of their health history and plans, such as through the use of 'health passports'[t, 37]. However, only a very small minority of CLAS reports noted that these were being given to care leavers consistently.[u]

GOOD USE OF HEALTH PASSPORTS

Young people leaving care in Middlesborough were offered a comprehensive health summary by way of a 'passport', developed in consultation with young people in care. The passport was tailored to each individual. All young people leaving care were advised of their family health histories (where known), immunisation status, how to register with a GP and dentist and who to contact if they needed any more information. Any information was also provided in a format that best suited their individual needs.

s. In the 24 reports that specifically commented on health support for care leavers, six noted this being good or well-developed, and 18 noted it being underdeveloped.

t. NHS England has produced a **passport template** developed by young users, which they can use to detail their own story.

u. Five of 50 reports noted the comprehensive use of health passports or summaries for care leavers that were consistently in place and working well.

Another concern for looked after children was the lack of support they received after leaving care. Young people in care have to leave by their 18th birthday and some have to live independently as soon as they leave care. A third of young people aged 16 or over who left care in 2013/14 did so before their 18th birthday.[38]

"I don't know why the system thinks a 16 year old is an adult. Kids in care haven't even had a childhood. How can we be an adult at 16?"

A care leaver, The Who Cares? Trust

In 2013, the government published the Care Leaver Strategy, setting out how it planned to improve support for care leavers.[39] However, the review found support options for these vulnerable young people were frequently inadequate and reliant on inflexible age boundaries, particularly for those who fell outside the threshold for adult mental health services yet had emotional needs that affected their future prospects.

"I felt let down by the adolescent CAMHS unit. Once I was 18 it was as though I was at the end of the road."

A young woman on an adult mental health ward

The Education Select Committee 2016 recommended more flexibility around age boundaries, in which transition is based on individual circumstances rather than absolute age.[36] This was highlighted as particularly important for CAMHS, which should offer access for care leavers until the age of 25 if necessary. In May 2016, the Government announced its intention to introduce a Children and Social Work Bill to improve the support for children leaving care. It includes the extension of the right to a personal adviser for all care leavers up to the age of 25, who will make sure care leavers receive the support they need.[40]

EFFECTIVE MENTORING FOR CARE LEAVERS

Older looked after children and care leavers were very well supported by weekly drop-in sessions at a local café in Stockport. They attended regularly and told inspectors that they valued the opportunity to come to a safe environment where they could immediately access health and daily living advice from volunteer mentors in a non-judgemental setting.

Care leavers who were young mums told inspectors they appreciated meeting the designated looked after child nurse every week at the café to get parenting advice and reassurance.

"Coming here to the café every week is great. I have two babies now and I get such helpful advice about being a mum. I get sexual health advice too as I don't want to get caught out again". A care leaver in Stockport

Since accessing the mentoring service, one care leaver with frequent attendances at A&E for serious self-harm had not attended A&E and had not required intervention from the crisis mental health team.

The review found that in areas where services offered extended support beyond the age of 18, there were often improved outcomes as a result. CQC therefore supports these developments. Young people leaving care should have access to more healthcare provision and support in the vulnerable years before and after their transition to independence.

COMMON FEATURES IDENTIFIED FROM CLAS REVIEWS OF GOOD SUPPORT FOR CARE LEAVERS:

- **Good support around health for care leavers starts in care, with young people supported to understand how to access the health care they need, such as booking a doctor's appointment.**
- **Final health reviews take place in a timely manner and contain information in previous reviews (including from their GP), birth and early health history, immunisations and family history. This could be given in the form of a 'health passport' or other comprehensive and accessible document.**
- **The young person is involved in making a meaningful shared health plan to prepare for the future and is given all the information they need to ensure they can access the services and support they might need.**
- **There is flexibility to offer the young person additional support and guidance up to age 25, if appropriate.**
- **Specialist support is offered to those who become pregnant upon leaving care or while still in early adulthood.**

Access to CAMHS for all children

CQC's concerns about access to mental health support extend beyond those for looked after children, to all children. The astonishing statistic that one in 10 children aged five to 16 have a mental health problem, with half being established by the age of 14, was published over 10 years ago.[41, 42] Despite this, minimal up-to-date data is available and many children still experience delays or difficulties accessing CAMHS or local counselling services, leaving them feeling unsupported and unsafe. The review found problems throughout CAMHS from early intervention to the transition to adult services.

> **"The waiting list for counselling was so long then I was only offered 10 sessions. You think 10 hours is enough to talk through the 20 years of abuse I've lived through? It shouldn't be time-limited."**
>
> A recent care leaver, The Who Cares? Trust

In the UK, CAMHS has traditionally been organised in a four-tier system, with tier 1 providing general advice and treatment for less severe mental health problems by non-mental health specialists, leading up to tier 4, which provides highly specialist services for children with serious problems, such as specialist outpatient teams and inpatient units. That said, many areas are moving away from the tier system and to 0-25 services, integrated pathways with single points of contact or new models such as Thrive.[43]

The review found that in several areas, a lack of tier 2 and 3 provision meant that those who did not meet high diagnostic thresholds or looked after children who were not in stable care placements were turned away. This led to long waits, a knock-on effect on other services, such as school counselling to help those in early need of emotional support, and significant additional pressures on tier 4 services as children's needs were not addressed in a timely way.

This led to inpatient beds being frequently unavailable, which meant young people would be given a bed in a different part of the country or placed on an adult mental health ward or medical paediatric ward. In addition, there were gaps in out-of-hours services, a lack of direct access to CAMHS and long waiting lists for specialist services, including for those with a learning disability, attention deficit and hyperactivity disorder and those needing post-traumatic support.

The 2015 *Future in Mind* report set out a vision of improved joint working and paid particular attention to vulnerable groups.[44] This was endorsed by the recent 'Five year forward view for mental health', which called for an end to the chronic underfunding of mental health services.[45] The CLAS review findings highlight the devastating impact this is having on children now, and on their futures.

"I was put on a long waiting list for CAMHS. I felt like I had to do something stupid [i.e. hurt myself] for them to realise how serious things were."

A recent care leaver, The Who Cares? Trust

RECOMMENDATIONS

The period of transition for many young people is already complicated by more acute mental and emotional health needs, so it is unacceptable for access to services to become more difficult. Their experience of transitions in health remains poor. Services need to work together to significantly improve young people's experience of transitions in health, particularly in mental health and substance misuse services as well as for looked after children who are leaving care or moving area. Access to mental health support and treatment for all children must be addressed as a priority, and should include enabling those who work with children in all settings, including education and social care, to provide the right support for children and young people.

In practice this means:

- The recommendations in *From the pond to the sea* are taken forward for all services to improve young people's experience of the transition from paediatric to adult services. In addition, those who do not meet the threshold for adult services, particularly in mental health, are offered alternative support.
- Looked after children who are moved out of area (or are returning to their home area) have robust arrangements in place for continuity of health reviews and are given priority to continue to access the health services they were previously receiving.
- Looked after children's services provide a comprehensive document (such as a health passport), to include a joint plan for their physical and emotional health, access to relevant information, and local options for additional support. Their care history should be summarised and include early and family histories.
- CAMH services receive the necessary funding and support to be able to meet the rapidly rising demands. This must be supported by improved identification and support of mental and emotional health problems for all children at an earlier stage.

7

Leadership

Good leadership at every level is critical to safeguarding the health and welfare of children. CQC routinely reviews how well-led health and adult social care organisations are and has found that the quality of leadership closely correlates with the overall quality of a service.[46]

Governance arrangements give the organisational oversight to make decisions such as how resources are allocated, workforce is managed, risk is identified and problems are anticipated and managed. The review found that where this was working well, providers and CCGs routinely monitored performance such as waiting times, the quality of referrals and significant events. Good governance tools and processes support openness and were common in all areas with strong leadership.

In contrast, where there were concerns about leadership in CLAS reports, services had a range of governance issues that undermined the organisation's quality and safety; from poor data quality or a lack of staff meetings and supervision, to out-of-date guidance and policies due to a lack of appropriate auditing. This was evident at provider, CCG and trust levels. In most areas, there were recommendations for at least one provider to review governance arrangements.

Significant complexity in commissioning processes and arrangements, as well as contract monitoring, acted as a barrier to solving many local issues, such as the provision of care for looked after children placed out of area. These issues were as prevalent in recent reviews as those inspected soon after CCGs were formed. To address these issues, there is a need for robust organisational oversight, clarity of roles and responsibilities and strong leadership across health systems.

Workforce and capacity

Despite staff working hard to protect and promote children's health and wellbeing, the review highlighted widespread workforce and capacity concerns. The areas that were managing well worked creatively to ensure their services had the right staff and skill mix in place. For example, succession and contingency planning was used to anticipate and address workforce issues. Although locum, bank and agency staff can be vital to avoiding short-term gaps in provision, over-reliance on temporary staff affected resource management and consistency of care. Where workforce planning was not being done proactively, this affected the quality of training, supervision and quality improvement activity.

A significant issue was that of capacity for designated and named professional roles that provide safeguarding expertise and leadership through health and multi-agency partnerships. In England, designated professionals for safeguarding are statutory roles.[47] In addition, every health provider is expected to have a named nurse, doctor and midwife (where applicable) to support and effectively coordinate safeguarding activities. However, many areas were unable to fill posts, and where posts were filled, the professional was often stretched beyond their capacity. These concerns spanned across designated professionals for safeguarding, those for looked after children and named professionals.

One contributing factor was a lack of clarity of the role and responsibilities. CCGs are expected to employ designated doctors and nurses for safeguarding children, as well as for looked after children, or secure their expertise through an appropriate service level agreement (SLA) with a provider organisation. The SLA should set out the practitioner's responsibilities and what support they can expect to help them fulfil their designated role. Our review found that in practice this was not always the case. The responsibilities for looked after children professionals are outlined in an intercollegiate framework, but again this was not always clearly agreed at a local level.[48] Where professionals lacked clarity in their role, this made it more difficult to prioritise competing demands or manage their workload efficiently. Another concern noted was that individuals shared several posts, which limited their ability to fulfil all their required functions, such as governance and audit arrangements.

A knock-on effect of not managing capacity was on continuous quality improvement. Strides in making improvements to services were often hampered by lack of capacity of individual staff, exacerbated by insufficient supervision to support and sustain improvements. Where continuous quality improvement was achieving measurable impact, the work was part of a rigorous programme of multi-agency audit, which identified the areas for development and both support and supervision was in place to drive improvement across multiple services.

LACK OF CLARITY IN ROLES AND RESPONSIBILITIES OF LOOKED AFTER CHILDREN DOCTORS

In one area there were two designated doctors for looked after children, but the commissioning and service delivery arrangements for these posts were unclear. The doctors' roles were not underpinned by clear job descriptions and there were inadequate arrangements to ensure that looked after children had timely initial health assessments. An unacceptable inequity of service was being delivered to some very vulnerable young people.

While individual practitioners had been aware of and raised concerns about the gaps in the service, this has not led to action, as there had been inadequate governance and a lack of management oversight or prioritisation of the situation for some time.

STRONG SAFEGUARDING LEADERSHIP

Designated professionals were represented at the two trusts' safeguarding board in Stockton on Tees and were an integral part of the safeguarding governance and reporting framework. The LSCB had formed a multi-agency learning lessons and an improving practice sub group. The designated nurse was the vice chair. This group was managing the investigations of a recent spate of incidents across member organisations and monitoring the progress of actions against agreed action plans.

The executive nurse and designated safeguarding children professionals provided clear and effective leadership on safeguarding children practice. Key professionals and the designated safeguarding team met weekly to embed safeguarding awareness across the CCG.

Training and supervision

Staff who work with children in healthcare settings should be trained to the level recommended in intercollegiate guidance for children.[49] Yet in almost all areas, the review identified concerns about safeguarding training in at least one service.[v] There were inconsistencies in the content, provision and uptake of safeguarding training across health services.

Training content was good where it included updates on topical subjects, was responsive to the needs of staff, and covered local and regional protocols and pathways, such as the multi-agency risk assessment conference referral process. Training provision and uptake were effective where the programme was delivered regularly in a multi-agency setting with support to ensure staff attendance.

INADEQUATE SUPERVISION ARRANGEMENTS ACROSS ALL SERVICES

In one area significant gaps were identified in supervision across several agencies, including midwifery services, CAMHS, adult mental health, health visitors and emergency departments. For example, community midwives were holding on to many cases that involved significant safeguarding concerns. On reviewing the notes, inspectors found drift in some cases and a lack of clarity in child protection processes. In another service, there was no evidence of formal supervision and no clear action planning recorded in patient records. The report recommended that supervision practice be strengthened for all healthcare staff in this area and that discussion and action plans from supervision be clearly documented in the patient records.

Supervision arrangements were also variable. Supervision allows the opportunity for challenge and reflection, strengthening casework and supporting the child and their family. Where supervision was effective, it was delivered in a number of settings including individual, group and reflective practice sessions. On the other hand, where supervision was not prioritised, staff lacked confidence and cases were not given sufficient direction. This led to drift and was a barrier to timely intervention in child safeguarding concerns.

Local safeguarding children boards (LSCBs) have a duty to scrutinise the safeguarding arrangements of agencies and undertake statutory and non-statutory reviews. They play a role in developing policies and guidance, providing training, and supporting information sharing between and within organisations. The review found on the whole that health engagement in the work of LSCBs was good. This was strengthened by:

- Close working with CCGs, and across the health system, including senior managers, designated and named professionals, CAMHS and practitioners from community child health.
- Arrangements for monitoring performance, such as attendance at child protection case conferences, uptake and attendance of safeguarding training, and multi-agency audits to identify areas for development.
- Identifying and recommending priorities for development in certain areas, such as self-harm and child sexual exploitation.
- Agencies being effectively held to account for outcomes in safeguarding, including reviewing reports on key performance targets.
- Having robust systems for taking on board the outcomes from learning events, particularly serious case reviews.

An active NHS England Area Team was also important to providing strategic direction and support across an area and encouraging continuous improvement in safeguarding procedures.[w]

v. 46 of the 50 reports noted at least one provider where we had concerns about the safeguarding training provision, uptake or learning.

w. NHS England Area Teams are now Local Offices of NHS England.

EFFECTIVE LEADERSHIP ACROSS HEALTH

Strong and effective leadership was underpinned by improvement-driven senior health managers and named professionals in Cheshire West and Chester. Priority was given to partnership working: open, mature, supportive and challenging working relationships were noted between health organisations and with the local council and police service at a number of levels.

The two CCGs were innovative and collaborative in their approach, and had clear contract management and performance monitoring arrangements in place. NHS England Area Teams and CCGs were working closely together, and with the Council's Public Health team, to implement NHS reforms. The Safeguarding Forum met regularly and had made good progress in addressing its development agenda.

The NHS England Area Team provided good strategic direction and peer support for the work of designated professionals, including in strengthening their capacity.

Health engagement in and support for the work of the LSCB and its working groups was good. Local health commissioners were being effectively held to account by the LSCB for the delivery of quality improvements. Recent peer review work with LSCB members involved 'walking the floor' and seeing at first hand the safeguarding practices of other agencies, reflecting a positive learning culture.

COMPLEX COMMISSIONING AND DELIVERY ARRANGEMENTS FOR CAMHS

In one area, all four CAMH services (tiers 1-2, 2-3, 4 and specialist services for looked after children) were each commissioned by and provided by different organisations.

Tier 3 services had recently undergone significant change and reconfiguration, compounded by long-standing recruitment issues. Vacant posts meant the team had limited capacity to respond to the demands, leading to extensive waits for initial assessments and access to services. There was a lack of a clear pathway or single point of access for CAMHS that would support timely decision-making or signposting to alternative services where young people do not meet the threshold for a specialist service.

Young people presenting with self-harm in A&E departments were not routinely offered admission. Arrangements that were sometimes made were to age-inappropriate general wards. Due to lack of appropriate facilities, especially at tier 4, children were experiencing long inpatient stays. With insufficient alternative provision locally, practitioners were struggling to provide an appropriate package of care.

On inspection, a number of cases were seen where referrals to CAMHS had not been made due to a lack of confidence in the service.

These widespread problems in the delivery of children's mental health services were of great concern. An intense focus from the CCGs on performance and management across the services was starting to lead to improvement, but much work remained to be done to improve access for young people to much-needed support and therapy.

RECOMMENDATIONS

The way in which an organisation is led has a significant impact on the safety and effectiveness of care for children. A lack of oversight has knock-on effects on workforce and capacity, supervision and training, and ultimately the delivery of safe, high-quality care. In the current challenging climate, financial resources cannot be the only answer. The solution should involve every level in health from NHS England, Public Health England, CCGs and executive leadership roles to the frontline health staff who should be supported in their roles to keep children safe.

In practice this means:

- Designated professionals for safeguarding children and looked after children have their roles, responsibilities and accountabilities explicitly defined in job descriptions, aligned with expectations laid out in statutory and intercollegiate guidance.
- Commissioners and providers ensure designated and named professionals are in post and have sufficient resources, supervision and support to enable them to fulfil their responsibilities effectively.
- Commissioners and providers plan effectively to ensure the right staff resources are in place to meet the challenges across the system, which goes beyond simple numbers and includes skill mix, deployment, support and staff development.
- Training and supervision are prioritised across health systems to ensure that staff have the right skills and experience to best protect children.
- Commissioning arrangements have robust accountability structures for child health and safeguarding, with clarity given from the Department of Health where this has been uncertain, such as who is accountable for implementing the lessons learned from a serious case review.
- Leaders engage with their staff, as well as with children, to build a shared ownership of quality and safety that embeds a culture of quality improvement, and they are supported to deliver improvements.

Conclusion and recommendations

The findings from the CLAS reviews highlight that health services are not consistently protecting and promoting the health and welfare of children. The unwarranted variability across the health system is very worrying. Much more must be done to listen to and involve children, ensure that services are improving outcomes, strengthen the quality of information sharing and joint working, and identify and protect those at risk from hidden harms.

Going forward, services should not simply react to new and emerging forms of abuse and harm to children, but be constantly aware and up to date with information available about risks. This information should feed into regular multi-agency training programmes and contribute to the continual evaluation of services.

Commissioners and partners must engage with children to fully understand their needs and concerns, and then use that information to design and provide the required services. Only then will they be able to monitor outcomes with much greater confidence that they are properly meeting the needs of their young population.

A key priority for the future is redressing the importance of prevention. Services must not lose sight of neglect, not least because it is the most common reason for taking child protection action in England.[2] When resources are limited it seems all too easy to lose focus on supporting those who would benefit from early help and support, when problems are only just emerging. The importance and effectiveness of early intervention cannot be overstated and must be addressed with urgency for the safety of our society's most vulnerable children.

Many examples of good and outstanding care have been championed, which should encourage and inspire those working in the health system to realise the possibilities of what can, and should, be achieved in child safeguarding and for looked after children. The recommendations in this document provide a framework for commissioners and providers to drive improvement in their services.

RECOMMENDATIONS

The child's voice: the silence is deafening

- All health staff seek, hear and act on the voice of the child. They should involve children at each stage of their health care planning, and listen and respond to their views about what is important to them.
- All providers and local authorities empower children in meaningful ways to feed back on their experiences of care, with a particular emphasis on how the service is helping to improve their health and wellbeing.
- All children are involved in giving feedback on and co-designing their local services, ensuring they are as accessible and relevant as possible.
- All practitioners, providers and commissioners listen to the children who do not necessarily have a voice, including those with complex and severe developmental, physical, emotional and mental health needs.
- CQC continues to seek and report on the experiences and views of children who use health services as part of our single and joint-agency inspections.

The 'so what' factor: improving outcomes for children

- Health services prioritise meeting the needs of children who would benefit from help and support early on, including those who do not meet the threshold for child protection proceedings, but have still been identified as benefiting from further support.
- Health assessments and reviews in all settings follow the Department of Health's guidance to ensure they are focused on action and outcomes for children.
- Screening tools for emotional health and wellbeing, such as strength and difficulties questionnaires (SDQs), are completed annually for every child in care, meaningfully contribute to their health reviews, and are routinely monitored to inform the impact of interventions. Those with abnormal scores are reviewed by an appropriate mental health specialist.
- All health services work collaboratively with children to determine locally-relevant outcome measures, in order to regularly evaluate the impact they are having. These measures should be used to track changes in outcomes (including emotional wellbeing) over time and inform resource allocation and service planning.

Quality of information sharing in multi-agency working

- Providers ensure that healthcare staff are trained in how to articulate the risks identified to a child and made aware of local policies. This should be delivered at a multi-professional level to improve understanding of how each agency uses information.
- Healthcare staff across agencies strengthen relationships through joint training and regular contact in order to nurture trust and work together more effectively.
- Providers develop clear guidance and templates to standardise the information that is shared where appropriate, such as case conference reports, and embedded into practice. Referrals and reports are regularly audited for quality assurance.

- GPs are supported to better contribute to child protection meetings and case conferences. This may include improved flexibility in arrangements such as time, format, location, notice given and use of technology.
- GPs contribute to case conferences, even when they are unable to attend, for example by providing a comprehensive report that is discussed with the social worker or conference chair ahead of the conference date.

The five 'P's that support multi-agency working

- All areas have compatible electronic systems that are able to reliably flag concerns and share information about vulnerable children and families across sites and agencies. In unscheduled care services, this should include implementing the **Child Protection – Information Sharing (CP-IS) project**.
- All services have processes in place to coordinate the follow-up of concerns about children, particularly in unscheduled care settings. A named individual(s) should ensure that these processes are regularly audited and reviewed.
- All agencies have jointly agreed protocols for dealing with the situation where a child is not brought to an appointment.
- Providers of minor injury units review the effectiveness of their child safeguarding arrangements and ensure that they meet appropriate standards.

Finding the hidden child

- Significant improvement is made in embedding Think Family in all adult health services, particularly in adult mental health services, to consistently consider the needs of any children in contact with a service user, who might be at risk of harm.
- Improved recording of all relevant information about children and families, integrated IT systems that facilitate the sharing of information, and closer joint working, information sharing and training between adult and children's services.
- A family perspective is developed at all levels of health, including policy and performance indicators, in order to make progress in the Think Family approach.
- CQC ensures that Think Family is embedded in our inspection approach across all adult health services, including mental health services.
- All healthcare staff are enabled to take the time to build trusting relationships with the children and young people they work with, in order to create the environment for them to find out about issues that could be hidden from view.
- Health services appoint a lead person for both CSE and FGM who is responsible for ensuring that cases of CSE and FGM are appropriately handled, monitored and recorded.
- Standardised, multi-agency training programmes and supervision are available to all staff working in health. This should include how to identify risks and signs of CSE and FGM, how to ask the relevant questions of children, and how to escalate concerns. It must include UK law on reporting FGM.
- There are multi-agency policies and pathways and information-sharing arrangements in place to protect those who are at risk of CSE or FGM, or have undergone FGM.

- Services seek to understand and meet the physical, mental and emotional health needs of those who have been victims of CSE and women and girls who have undergone FGM.
- Commissioners and local safeguarding children boards identify the risks in their local communities, working with the voluntary sector organisations and those who have experienced CSE and FGM, so that their response meets the needs of their communities.

Transitions and access

- The recommendations in *From the pond to the sea* are taken forward for all services to improve young people's experience of the transition from paediatric to adult services. In addition, those who do not meet the threshold for adult services, particularly in mental health, are offered alternative support.
- Looked after children who are moved out of area (or are returning to their home area) have robust arrangements in place for continuity of health reviews and are given priority to continue to access the health services they were previously receiving.
- Looked after children's services provide a comprehensive document (such as a health passport), to include a joint plan for their physical and emotional health, access to relevant information, and local options for additional support. Their care history should be summarised and include early and family histories.
- CAMH services receive the necessary funding and support to be able to meet the rapidly rising demands. This must be supported by improved identification and support of mental and emotional health problems for all children at an earlier stage.

Leadership

- Designated professionals for safeguarding children and looked after children have their roles, responsibilities and accountabilities explicitly defined in job descriptions, aligned with expectations laid out in statutory and intercollegiate guidance.
- Commissioners and providers ensure designated and named professionals are in post and have sufficient resources, supervision and support to enable them to fulfil their responsibilities effectively.
- Commissioners and providers plan effectively to ensure the right staff resources are in place to meet the challenges across the system, which goes beyond simple numbers and includes skill mix, deployment, support and staff development.
- Training and supervision are prioritised across health systems to ensure that staff have the right skills and experience to best protect children.
- Commissioning arrangements have robust accountability structures for child health and safeguarding, with clarity given from the Department of Health where this has been uncertain, such as who is accountable for implementing the lessons learned from a serious case review.
- Leaders engage with their staff, as well as with children, to build a shared ownership of quality and safety that embeds a culture of quality improvement, and they are supported to deliver improvements.

Appendix A: CLAS reports for local authority areas included in the analysis for the review

- Barnsley
- Bath and North East Somerset
- Bedford
- Birmingham
- Brent
- Cambridgeshire
- Cheshire West and Chester
- Cornwall
- Coventry
- Cumbria
- Darlington
- Derby City
- Devon
- Doncaster
- East Riding of Yorkshire
- Essex
- Gateshead
- Gloucestershire
- Harrow
- Herefordshire
- Hertfordshire
- Kent
- Kingston on Thames
- Lincolnshire
- Luton
- Middlesborough
- Newham
- Norfolk
- Northamptonshire
- Nottingham City
- Reading
- Redbridge
- Rochdale
- Rotherham
- Salford
- Sandwell
- Sheffield
- Solihull
- Somerset
- South Gloucestershire
- Stockport
- Stockton on Tees
- Swindon
- Thurrock
- Torbay
- Wakefield
- Waltham Forest
- West Sussex
- Wiltshire
- Worcestershire

Appendix B: Organisations represented on the expert advisory group

CQC is grateful for the time, support, advice and expertise given to the review by representatives from the following organisations.

- Association of Independent LSCB Chairs
- Barnardo's
- Clinical commissioning groups (nine areas)
- Department of Health
- Department for Education
- Designated Professionals Network
- National Children's Bureau (NCB)
- National Society for the Prevention of Cruelty to Children (NSPCC)
- NHS England (Children and young people, safeguarding and mental health directorates)
- Office of the Children's Commissioner
- Ofsted
- Primary Care Child Safeguarding Forum
- Public Health England
- Royal College of General Practitioners
- Royal College of Nursing
- The Who Cares? Trust

Appendix C: Template for reflection and action plan for continuous professional development CPD

(name)	

has read CQC's national report on the review of the arrangements for safeguarding children and health care for looked after children in England.

(Date)	

(Time taken for reading and reflection)	

What have you learned?
What additional learning needs have you identified (personal and organisational) and how will you address these?
How will reading this report change your practice and have an impact on those you work with? Consider how you might evaluate this.

References

1. Department for Education, **Working together to safeguard children** March 2015
2. NSPCC, **How safe are our children?** 2015
3. **Health and Morals of Appendices Act 1802**
4. **The Children Act 1989**
5. **The Victoria Climbie Inquiry: report of an inquiry by Lord Laming**, January 2003
6. Department for Education, **Haringey local safeguarding children board: first serious case review – child A**, November 2008
7. Department for Education, **Munro review of child protection: final report – a child-centred system**, May 2011
8. **The United Nations Convention on the Rights of the Child**
9. NSPCC, **Achieving emotional wellbeing for looked after children: a whole system approach**, 2015
10. Cope S, **A one year longitudinal study on effectiveness of strategies to engage 'hard to reach' looked after children, Archives of Disease in Childhood, 100:A7**, 2015
11. **UNICEF (2011) Innocenti Report Card 11: Child well-being in rich countries**
12. Department of Health, **Improving Children and Young People's Health Outcomes: a system wide response**, 2013
13. Mooney et al, **Promoting the health of looked after children: a study to inform revision of the 2002 guidance**, 2009
14. National Audit Office, **Care leavers' transition to adulthood**, 2015
15. Department for Education and Department of Health, **Promoting the health and wellbeing of looked-after children. Statutory guidance for local authorities, clinical commissioning groups and NHS England**, 2015
16. Department for Education, **Outcomes for Children Looked After by Local Authorities in England as at 31 March 2014**,2015
17. Department for Education, **A framework of outcomes for young people**, 2012
18. Department for Education (National Statistics), **Children looked after in England including adoption 2014 to 2015**, (table 15b)
19. Ofsted, **Learning lessons from serious case reviews 2009-2010**, 2010
20. NICE, **Child maltreatment: when to suspect maltreatment in under 18s**, 2009
21. HM Treasury, **Every Child Matters**, 2003
22. Health & Social Care Information Centre, **Child Protection – Information Sharing Spring Newsletter**, 2016
23. Munro E, **Review: Children and young people's missed health care appointments: reconceptualising 'Did Not Attend' to 'Was Not Brought' – a review of the evidence for practice, Journal of Research in Nursing, 17:2, 193-194**, 2012
24. Cabinet Office, **Reaching out: Think Family**, 2007
25. Social Care Institute for Excellence, **Think child, think parent, think family**, 2012
26. Ofsted and CQC, **What about the children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems**, 2013

27. Department for Education, **Safeguarding children and young people from sexual exploitation**, 2009

28. **www.brook.org.uk/our-work/spotting-the-signs-cse-national-proforma**

29. **www.mydangerousloverboy.com/**

30. World Health Organisation (WHO), **Factsheet on Female Genital Mutilation**, 2016

31. **Female Genital Mutilation Act 2003**

32. HM Government, **Multi-agency statutory guidance on female genital mutilation**, 2016

33. Care Quality Commission, **From the pond to the sea: children's transitions to adult health services**, June 2014

34. Department for Education (National Statistics), **National statistics: children looked after in England including adoption**, 2013

35. NICE, **Looked after children and young people**, 2010

36. Education Select Committee, **Mental health and wellbeing of looked after children**, 2016

37. **www.londonhp.nhs.uk/wp-content/uploads/2011/03/Children-in-care-health-passport.pdf**

38. National Audit Office, **Care leavers' transition to adulthood**, 2015

39. HM Government, **Care Leaver Strategy: A cross-departmental strategy for young people leaving care**, 2013

40. **Children and Social Work Bill [HL] 2016-17**

41. Kessler et al, **Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication** *Arch Gen Psychiatry* Jun;62(6):593-602, 2005

42. Green et al, **Mental health of children and young people in Great Britain 2004**, London, Palgrave, 2005

43. **www.thriveapproach.co.uk**

44. Department of Health, **Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing**, 2015

45. Mental Health Taskforce, **The five year forward view for mental health**, 2016

46. Care Quality Commission, **The state of health care and adult social care in England**, 2015

47. NHS England, **Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework**, 2015

48. Royal College of Paediatrics and Child Health, Royal College of Nursing, Royal College of General Practitioners, **Looked after children: knowledge, skills and competence of health care staff. Intercollegiate role framework**, 2015

49. Royal College of Paediatrics and Child Health, **Safeguarding children and young people: roles and competences for health care staff. Intercollegiate document**, 2014

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CQC–339–072016

Health and Wellbeing Board 23 November 2016

Report of Consultant in Early Intervention Psychiatry and Deputy Medical Director, Tees, Esk & Wear Valleys NHS Foundation Trust, on behalf of the York Student Mental Health Network

How the issues raised at the conference held in November 2015 (“Everybody’s Business,”) have been taken forward

Summary

1. This report was requested to inform the Board of progress made since the report to the Board in March 2016 that summarised the feedback received at the “Everybody’s Business” conference on Young People’s mental health on 25th November 2015.

Background

2. A conference was held on 25 November 2015 at the National Science Learning Centre at the University of York entitled “Everybody’s Business.” It explored mental health issues for young people aged 0-25, and it was jointly commissioned by the CAMHS Executive and the Higher York Board.

3. It came about because the Higher York Board was concerned at the rising incidence of student mental health problems. The conference was successful and well-subscribed, and a report on the conference was made to the Health & Wellbeing Board in March 2016.

Main/Key Issues to be Considered

4. This report provides an update on developments consequent to the Everybody’s Business conference, in addressing the key issues that emerged from the feedback to the conference.

Consultation

5. The ‘Everybody’s Business’ conference engaged with a wide range of young people.

Options

6. This report is for information only and there are no options for the Health and Wellbeing Board to consider.

Analysis

7. The following themes emerged from the Conference and progress on these themes is reviewed sequentially below:

Planning and Commissioning

(i). *"It is essential that Commissioners take account of the strong evidence of the rising incidence of poor mental health in young people, of all ages"*;

I believe that commissioners are sighted on this. Although there is little available additional funding (as ever), there are initiatives planned or underway that will have positive impact. Some of these are evidenced below.

(ii). *"York's substantial body of HE students, 10% of the population, needs to be given appropriate attention in local plans and strategies, and in the JSNA"****;***

The overall health needs of the higher education population, including their mental health needs, are currently subject to a consultation and subsequent development of a specific Student Health Needs Assessment, led by Public Health.

(iii). *"There is an appetite to work on a multi-agency basis, across sectors (including the third sector) and age ranges, to address the issues of young people's mental health."*

This appetite has been built on substantially with the convening of the York Student Mental Health Network. (see specific notes below)

Transitions

(iv). *"This was the theme that came up most frequently at the Conference: we still seem to be poor at transferring information and support across key transition points, especially primary to secondary schools; school to college; sixth form to University; and Child and Adolescent Mental Health Services (CAMHS) to Adult Services. There are particular issues for University students who*

may arrive from another location and find themselves having to restart the process of getting the care and support they need, often with significant waiting times. Do we need to design a mental healthcare plan, designed to follow the young person from one institution to another?"

There has been some progress in improving transition across some of these interfaces. A Transition Panel was set up to improve transition between CAMHS and adult mental health services in November 2015, and this has met on a monthly basis since then. Other agencies have been invited and attended, and there is still an intention to develop the process further, with wider involvement. The panel deals with about 10-15 young people each month, and although a significant minority will ultimately be transferred to secondary adult mental health services, all will have key data logged with the single point of access, and a passport issued to the young person and family summarising their previous difficulties and potential needs, should they present to any service in the future. There is also a project underway to adapt this passport specifically for students who may move elsewhere to study. The work of the panel and plans to develop it further will be evaluated in early 2017.

Early Intervention; This is an issue that was considered by the York Student mental Health Network (see below)

Support for the Workforce

(v). *"There is an urgent need to support the academic workforce who may be in most regular contact with young people – including teachers, lecturers and pastoral staff – to identify mental health problems and to respond appropriately";*

(vi). *"Mental Health First Aid" was frequently cited as an example of good practice in training non-health professionals;*

This training has been made available to some staff, but there is a continuing need for this and different options (and prices) such as ASSIST and Safetalk, have been discussed. It is hoped that training will be more widely available in 2017 and beyond. Training needs for different groups across the City will be considered as part of the Suicide Safer work the Director of Public Health is leading.

(vii). *“Others mentioned Networks of support for staff – similar to the cluster project pilot – giving external support and supervision for staff in stressful situations.”*

(viii). I think there remains a need to consider this more strategically

(ix). The CAMHS Cluster pilot has been positively evaluated and has secured funding from Health and the Local Authority to roll out this early intervention service model to all schools across the city from September 2016 onwards. The new service called School Wellbeing Service is managed by the Local Authority, clinically supported by CAMHS and based in schools. It has 6 Wellbeing Workers linked to the 6 geographical clusters of schools across York. The aim of the service is to strengthen the mental health support arrangement in schools to intervene early and support children and young people effectively with emerging mental health issues and concerns. The service is currently supporting schools and children and young people around issues of low mood, anxiety, self harm, resilience and self regulation.

<u>Specific Issues (1): Self-harm and suicide</u>

(x). *“Suicide prevention should feature more prominently in the JSNA;”*

This is being addressed directly through the JSNA/Joint Health and Wellbeing Strategy Steering Group. Suicide prevention will be included in the Student Health Needs Assessment. A conference took place on 28th October at the University of York for people affected by suicide jointly hosted by North Yorkshire Police and the York Public Health Team, to raise awareness and share stories as part of the plans for developing a suicide-safe city.

(xi). *“We need a better understanding of the incidence of self-harm in York, whether certain groups of young people are over-represented, and what can be done to help;”*

This continues to be the case, although significant improvements have been made in in terms of how this data is collected. The presence of a 24 hour Liaison service in the Emergency department and in York Hospital, along with the establishment of CAMHS practitioner posts to provide further capacity for assessment and support for young people under 16 as well, has

enhanced the service provision for young people, particularly those who present with self-harm or related issues.

Specific Issues (2): Body image and self-esteem

(xii). *Key concerns here included how schools and other institutions in York are addressing these issues, access to early help when criteria for secondary care aren't met, and how the needs of young men can be overlooked.*

I am not aware of any evidence that these issues have been significantly addressed since the conference report.

Communications

(xiii). *"The pathways to support are complicated and hard to understand – how can staff and families understand the pathways better? Communication between stakeholders and providers needs to improve; Across the conference as a whole there was high demand for similar events and increased communication and information-sharing between services"*

In response to this recommendation and in response to serious incidents involving students in late 2015 and early 2016 a number of meetings were set up with overlapping membership and similar goals. These groups came together for a joint meeting and workshops on 5th May 2016, which (informally at that stage) marked the establishment of the York Student Mental Health Network (YSMHN). The inaugural meeting and workshop included a wide local membership from the Universities of York and York St John University as well as York College and Askham Bryan College. There was good representation from students, both graduate and undergraduate, primary and secondary health, crisis services, public health, voluntary sector, counselling and pastoral care. The Chief Executive Officer (CEO) of Student Minds attended and was impressed that such a multi-agency meeting had been convened. Professor Jo Smith, who has led the suicide safe initiative at the University of Worcester made a presentation and helped to facilitate the workshops. Samaritans and Nightline were also contributors. The workshops focussed on the themes of: Access, Capacity, Prevention and Early detection/intervention. A large number of pledges were made by the participants and the next steps agreed. Further meetings of the network took place on 28th July, 8th September and 17th November. A follow-up

conference or event is under consideration for student mental health day on 2nd March 2017.

(xiv). The University of York Student Mental Ill-health Task Group: Report to the Vice-Chancellor March 2016

https://www.york.ac.uk/media/studenthome/features/2016/Student%20Mental%20Ill-health%20Task%20Group%20Report%20Mar%202016.pdf

This important report was commissioned in response to a number of sad incidents of suicide or unexplained death affecting students at the university.

The report highlights issues of national as well as local relevance, and summarises evidence of escalating mental health needs within the student population. It makes a number of recommendations that overlap heavily with those of other reports including those from the “everybody’s business” feedback. The recommendations were grouped under two main recommendation headings:

Recommendation 1: take immediate steps to improve University support for student mental health

Recommendation 2: ensure a high-level and coordinated approach to improve mental health services for students in York and North Yorkshire

The University subsequently facilitated a “Mental Health as a Research Focus” Workshop on Tuesday 27 September 2016 to develop the twin goals of encouraging and supporting mental health research, and supporting the mental health and wellbeing of its own community

Strategic/Operational Plans

8. As a multi-agency response, I believe that this aligns with the strategies of all of the stakeholder organisations, particularly the Care Commissioning Group strategy for mental health in York and the Student Health Needs Assessment. The feedback following the conference was 100% in favour of a future conference, perhaps biennially, and this would provide an opportunity to further develop

and consolidate the appropriate organisational and multi-agency (joint) strategies.

9. In addition to this a new Joint Health and Wellbeing Strategy for the city is currently being developed. The draft of this contains a key priority around emotional and mental health and wellbeing and has specific references to transitions, student health and self harm. The new Strategy is due to be launched in March 2017.

Implications

10. **Financial** – see risks below

11. **Human Resources (HR)** - There are no significant HR implications

12. **Equalities** - There are no significant implications

13. **Legal** – There are no significant implications

14. **Crime and Disorder** – There are no significant implications

15. **Information Technology (IT)** – effective information between stakeholder IT systems would facilitate closer working

16. **Property** – There are no significant implications

Risk Management

17. The main risk relates to inaction, in failing to address the high prevalence and escalating concerns around the mental health of young people.

18. There is a risk that the recommended actions are not adequately resourced and it is imperative that all of the agencies involved work closely together to achieve the desired improvements within the available resources

Recommendations

19. The Health and Wellbeing Board is asked to consider the progress and direction in addressing the issues raised by the "Everybody's Business" conference in November 2015 and the subsequent report to the Board in March 2016.

    Reason: To keep the Health and Wellbeing Board aware of progress made.

Contact Details

<table>
<tr><td>Author:

Stephen Wright
Consultant Early Intervention Psychiatrist & Deputy Medical Director
Tees Esk & Wear Valleys NHS Foundation Trust</td><td>Chief Officer Responsible for the report:
Jon Stonehouse
Corporate Director Children, Education & Communities
Report Approved ✓ Date 11.11.2016
Sharon Stoltz
Director of Public Health
City of York

Report Approved ✓ Date 11.11.2016</td></tr>
</table>

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers: None

Annexes

None

Glossary

CAMHS: Child & Adolescent Mental Health Services

JSNA: Joint Strategic Needs Assessment

NYCC: North Yorkshire County Council

 Agenda Item 6

Health and Wellbeing Board 23 November 2016
Report of the Chair of the Health and Wellbeing Board

Strengthening Safeguarding Arrangements through an Inter Board Protocol

Summary

1. Over recent months work has taken place to produce an inter board protocol to strengthen safeguarding arrangements. The final version is at Annex A to this report and Health and Wellbeing Board are asked to sign up to these working arrangements.

Background

2. Having established a protocol in 2014 with the Health and Wellbeing Board and YorOK, the Independent Chair of the City of York Council Safeguarding Children Board initiated work, with the approval of the Chief Officer Reference and Accountability Group (CORAG), to develop this further to include the Safeguarding Adults Board and Safer York Partnership.

3. The draft new Inter-board protocol was considered at a meeting of the Chairs of these Boards in June and consultation followed. The final draft protocol was agreed at a meeting of the Chairs on 15th September 2016. The draft protocol, attached, sets out the strategic leads for key safeguarding issues, identified the supporting boards and working arrangements for challenge, oversight and reporting between the Boards.

4. The protocol has already been agreed and endorsed at the YorOk Board, the Safer York Partnership, the Safeguarding Adults Board and the City of York Safeguarding Children's Board.

Main/Key Issues to be Considered

5. The inter board protocol sets out the expectations of the relationship and working arrangements between City of York Health and Wellbeing Board; its children's sub-board YorOK; the

Safeguarding Children Board; the Safeguarding Adults Board and the Safer York Partnership. It covers their respective roles and functions, membership of the boards, arrangements for challenge, oversight and scrutiny and performance management.

6. The protocol sets out a number of key principles namely:

- Safeguarding is the business of all Boards.
- The Boards will know each other's business.
- A culture of scrutiny and challenge will exist across the Boards.
- The Boards will work together to avoid duplication and ensure consistency.
- At the heart of their decision making, the Boards will remain focused on delivery that benefits people in York
- The Boards share a commitment to a strategic approach to understanding needs including analysis of data and engagement with stakeholders.
- The Boards are committed to developing a joined up approach to assessing the effectiveness of services and identifying priorities for change, including where services need to be commissioned, improved, reshaped or developed.

Consultation

7. The Chairs of all the Boards referenced in paragraph 2 of this report have been involved in producing this document. Senior officers have also had input into this piece of work.

Options

8. The Board can:

   a. agree to the Chair of the Health and Wellbeing Board signing the inter board protocol and adopting its principles

   or

   b. not agree to Chair of the Health and Wellbeing Board signing the inter board protocol and adopting its principles

Analysis

9. Much work has gone into the preparation of the inter board protocol and to date it has been signed by 3 of the 4 board Chairs.

Strategic/Operational Plans

10. This report relates to the “protect vulnerable people” theme of the City of York Council’s Council Plan

Implications

11. There are no known implications associated with the recommendations in this report.

Risk Management

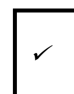
12. The Boards have a common purpose – to promote joint working and co-operation between partners to improve safeguarding and wellbeing in the City of York. Should the Boards not work together in a coherent and effective way there is a risk that this will not happen

Recommendations

13. Health and Wellbeing Board are asked to agree to the Chair signing the inter board protocol.

Reason: To ensure an effective working relationship between the Boards.

Contact Details

Author:	**Chief Officer Responsible for the report:**			
Cllr C Runciman Executive Portfolio Holder for Health & Adult Social Care	Sharon Stoltz Director of Public Health			
	Report Approved		**Date**	10.11.2016
Tracy Wallis Health and Wellbeing Partnerships Co-ordinator				

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report
Background Papers:
None

Annexes
Annex A – Inter Board Protocol

Glossary
CORAG - Chief Officer Reference and Accountability Group

ANNEX A

Strengthening Safeguarding Arrangements in York

Inter-Board Working Protocol

City of York

Health & Wellbeing Board and its sub board
YorOK (Children's Board)

Safeguarding Children Board

Safeguarding Adults Board

Safer York Partnership

October 2016

1. Introduction

1.1 This document sets out the expectations of the relationship and working arrangements between City of York Health & Wellbeing Board (HWBB) and its children's sub board YorOK, Safeguarding Children Board (SCB) Safeguarding Adult Board (SAB) and Safer York Partnership (SYP). It covers their respective roles and functions, membership of the boards, arrangements for challenge, oversight and scrutiny and performance management

1.2 The Chairs of the Boards have formally agreed to the arrangements set out in this document, which will be subject to review when significant legislative or organisational changes require it. This will include any changes that arise following the enactment of the Children and Social Work Bill 2016.

2. Principles

This protocol sets out the principles underpinning how the Boards work within their defined remits, the interface between the boards and the practical means by which effective co-ordination and coherence between the Boards will be sustained.

The core principles are:

- **Safeguarding is the business of all Boards.**
- **The Boards will know each other's business.**
- **A culture of scrutiny and challenge will exist across the Boards.**
- **The Boards will work together to avoid duplication and ensure consistency.**
- **At the heart of their decision making, the Boards will remain focused on delivery that benefits people in York**
- **The Boards share a commitment to a strategic approach to understanding needs including analysis of data and engagement with stakeholders.**

- **The Boards are committed to developing a joined up approach to assessing the effectiveness of services and identifying priorities for change, including where services need to be commissioned, improved, reshaped or developed.**

3. The Health & Wellbeing Board and its children's sub-board YorOK

3.1 The Health & Wellbeing Board (HWBB) is a partnership of providers and commissioners of community, health and social care services in the City of York.

3.2 The Board commissions programmes of work to improve health outcomes and reduce health inequalities for residents living in City of York.

3.3 The basis for decisions about strategy and design for service delivery is the Joint Strategic Needs Assessment (JSNA) in City of York.

Within this context the overarching strategy for Health and Wellbeing Strategy and "the Children's Plan for children should focus on prevention, early intervention and local delivery of care, provided within effective and integrated models of service delivery.

3.4. Functions of the Board as set out in the terms of reference are:

- In order to advance the health and wellbeing of the patients and residents in York, to encourage persons who arrange for the provision of any health or social care services to work in an integrated manner.
- To provide such assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 between the Council and NHS bodies in relation to the exercise of NHS functions or health related functions of the Council.
- To exercise the functions of a local authority and its partner clinical commissioning groups under sections 116 and 116A of the Local Government and Public Involvement in Health Act

2007 relating to joint strategic needs assessments, and health and wellbeing strategy.

- To exercise the statutory functions of a Health and Wellbeing Board in relation to the carrying out and publication of pharmaceutical needs assessments.
- To exercise any other functions of the Council which the Council has determined should be exercised by the Board on its behalf in accordance with section 196(2) of the Health and Social Care Act 2012 including:

3.5 The HWBB’s key areas of lead responsibility are**:**

- The provision of expert advice and strategy on health and wellbeing across the city and input to commissioning as required
- Development and implementation of delivery plans for seamless pathways and integrated service delivery.
- Agreeing operational processes to deliver joined up care.
- Driving forward the further integration of multi-agency services.
- ‘Unblocking’ pathways where organisational boundaries are causing challenges.
- Driving change and bring challenge to encourage new ways of working.
- Agreeing joint working principles e.g. information sharing, consensus on consent etc.

YorOK Board

3.6 YorOK is the name of York's former *Children's Trust* arrangements. This is the local partnership that brings together all partners and organisations responsible for providing services for children, young people and families, focusing on a shared commitment to improving children’s lives.

The aim of the YorOK board is to ensure that all children have the support they need to ensure they are healthy, stay safe, enjoy life and achieve well at school and beyond, make a positive contribution to society and achieve economic well-being.

3.7 YorOK sets key priorities for partnership working with children and young people. The Children and Young People's Plan (2016-20) sets the direction for everyone working to improve outcomes for people working with children and young people

3.8 Four Priorities for 2016-2020:

- Early Help
- Emotional and Mental Health
- Narrowing Gaps in Outcomes
- Priority Groups – Children and young people in care, Young people not in education, employment or training, Young carers, refugees, children living in poverty

3.9 The functions:

- Publish Children's Plan. This takes into account data about how things are going, including the Joint Strategic Needs Assessment (JSNA) and performance information.
- Agree an Early Help Strategy that outlines our ambition for early help services for children and families, and the principles that guide us. It explains the strategic framework within which the services have been designed, and how we organise them. It describes the delivery of those services, and the priorities for developing them further
- Champion, influence and add value to services for children and young people.
- Ensure the voice of children and young people is represented in both strategic planning and service delivery.
- Bring together resources to develop, implement and evaluate joint strategies, programmes and projects which improve outcomes for children and young people. Develop shared responsibility mechanisms.
- Monitor and evaluate the impact of improvements made through integrated working.
- Identify and disseminate areas of good practice.
- Developing children's workforce planning in partnership

4. Safeguarding Children Board

4.1 The SCB is a statutory partnership with responsibility for agreeing how relevant local organisations will co-operate to safeguard and promote the welfare of children. The SCB's role is to monitor and evaluate the effectiveness of local arrangements to safeguard all children.

4.2 The SCB's key lead responsibilities are to:

- Develop policies and procedures for safeguarding and promoting welfare of children in the area of the authority, including policies and procedures in relation to the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention, ensuring safe recruitment and working practice, investigating allegations and concerns and training provision.
- Monitor and evaluate the effectiveness of what is done by the Local authority and Board partners individually and collectively to safeguard and promote the welfare of children and advise them on ways to improve.

- Communicate and raise awareness of the need to safeguard children and promote the welfare of children to those who work with children including volunteers and members of the public

- Through the Child Death Overview Panel (CDOP) collect and analyse information about child deaths with a view to learning from experience and safeguarding and promoting the welfare of children

- Participate in the local planning and commissioning of children's services to ensure that they take safeguarding and promoting the welfare of children into account

- Undertake reviews of cases where abuse or neglect of a child is known or suspected, a child has died or a child has been seriously harmed, and there is cause for concern about the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

5. Safeguarding Adults Board

5.1 The Safeguarding Adults Board (SAB) oversees and leads adult safeguarding across the city in order that all agencies contribute effectively to the prevention of abuse or neglect of vulnerable people. It has a strong focus on partnership working. The work of the Board includes the safety of patients in local health services, the quality of local care and support services, and the effectiveness of prisons and approved premises in safeguarding offenders.

5.2 The Board's Vision, stated in the 2016/19 Strategic Plan, is that the SAB aims to ensure that agencies supporting adults who are at risk or in vulnerable situations, and the wider community, can, by successfully working together:

- Establish that **Safeguarding is Everybody's Business**
- Develop a culture that does not tolerate abuse
- Raise awareness about abuse
- Prevent abuse from happening wherever possible
- Where abuse does unfortunately happen, support and safeguard the rights of people who are harmed to:
  - ✓ stop the abuse happening
  - ✓ access services they need, including advocacy and post-abuse support
  - ✓ have improved access to justice
  - ✓ have the outcome which is right for them and their circumstances.

5.3 Under the Care Act 2014 it is a legal requirement for the SAB to have a Strategic Plan and to produce an annual summary of its progress. The Strategic Plan for 2016/19 is on the website under "Board". It follows the six guiding principles of the Care Act:

EMPOWERMENT
PREVENTION
PROPORTIONALITY
PROTECTION
PARTNERSHIP
ACCOUNTABILITY

5.4 The SAB must arrange a Safeguarding Adults Review (SAR) when an adult dies as a result of abuse or neglect, whether known or

suspected and there is concern that partner agencies could have worked more effectively to protect the adult. An SAR must also be arranged if an adult has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

6. Safer York Partnership

6.1 The Safer York Partnership (SYP) provides a governance structure for partners to work together to prevent and reduce crime, offending and substance misuse and the fear of crime in York. SYP provides both the strategic direction for community safety and local delivery of community safety outcomes across the City of York.

6.2 Its key functions are to:

- promote collaborative partnership working between statutory and non-statutory partners
- commission and implement a strategic assessment and partnership plan to reduce crime and disorder
- approve Domestic Homicide reviews as required.

6.3 Each year North Yorkshire Police produce a Joint Strategic Intelligence Assessment (JSIA) using information gathered from all responsible authorities, wider partners and the community. SYP uses this information to develop its strategic priorities. It's five strategic priorities are:

Protecting Vulnerable people
Reducing the Harm caused by alcohol
Reducing Victims of anti- social behaviour
Reducing Victims of crime
Prevent

6.4 The Crime and Disorder Act 1998 requires a three-year Community Safety Plan to be created, based on a Joint Strategic Intelligence Assessment of partners' data and information. The current plan is for 2014-17 but is refreshed annually to ensure that the partnership is able to respond to emerging issues.

6.5 The Safer York Partnership has the responsibility to understand the nature and extent of crime and disorder issues including offending and substance misuse issues and to set out a plan to address them.

7. The Relationship between the Boards

7.1 The roles and responsibilities of the respective bodies are different but complementary. All are statutory Boards with the exception of YorOK which is a sub-board of the HWBB.

They have a common purpose – to promote joint working and co-operation between partners to improve safeguarding and wellbeing in the City of York. To work together on areas of mutual interest.

7.2 In City of York, the HWBB is chaired by an elected member of the Council, its children's sub board YorOk is chaired by the Lead Member for Children's Services (City of York Council) the SCB and SAB are chaired by independent persons and the Safer York Partnership is chaired by a senior officer of the Council.

7.3 The Director of Children's Services represents the SCB on the HWBB. The Lead Member for Children (Chair of YorOK) is a participant observer on the SCB. The Chair of the HWBB, Lead Member for Adult Services and Director of Adult Services are members of the Safeguarding Adult Board. The Heads of Safeguarding or the Assistant Directors of Adult and Children provide links between the safeguarding boards.

7.4 The Independent Chairs of SCB and SAB will present annual reports to the HWBB and will also attend as/when necessary, in order to present update reports and assist/advise on the development of effective plans and service delivery arrangements. Similarly, representatives of HWBB will attend other Boards when there are issues of common interest and purpose and to provide assurance about the contributions of the boards to safeguarding arrangements in the City.

7.5 SCB and SAB will offer support, guidance, advice, challenge and scrutiny to HWBB to enable the partner organisations to discharge their safeguarding responsibilities effectively.

7.6 The HWBB and YorOk will work with the SAB, SCB and SYP:

- to develop and interpret the Joint Strategic Needs Assessment with respect to safeguarding and promoting the welfare of residents in York

- to develop a clear understanding of the effectiveness of current services, including where services might need to be improved, reshaped or developed
- to ensure priorities for change are delivered

7.7 The HWBB will consider within its remit any Community, Health and Social Care services the provision of which is the responsibility of its members; this will include safeguarding children and adult services.

7.8 The SAB and SCB are not bodies which directly commission or delivers services. YorOK and the HWBB provide expert advice around all issues of health. HWBB supports the shaping of health strategy and priorities for the city to reduce health inequalities and improve outcomes for all. Commissioning decisions remain the remit of the relevant commissioning groups.

8. Practical arrangements to secure co-ordination of business

8.1 An annual planning meeting of all chairs plus business support and lead officers will be held in June of each year to set out a broad strategic work plan for the year reviewing the Lead Boards and reporting arrangements for each work stream. The Boards will share their refreshed plans for the coming financial year to ensure co-ordination and coherence. To facilitate this cycle, business managers will seek to align meeting schedules as far as possible. Respective Business Managers will maintain an informal network to share issues of common interest and to assist in the co-ordination of each Board's business. Quarterly meetings will be held between respective Business Managers to ensure cross-referencing of a forward look and connectivity of relevant areas of business progressing though the Boards.
This will help to avoid duplication of work, gaps in policies and services and more aligned agenda-setting processes. This meeting will also identify any areas for consideration in the budget setting process for the following year.

8.2 As early as possible, but no later than September each year, the Independent Chairs of the two Safeguarding Boards will publish an Annual Report which comments on the effectiveness of safeguarding in City of York. The Annual Reports will be submitted to the Chair of the HWBB as well as the Safer York Partnership, the Chief Executive of the Council, the Leader of the

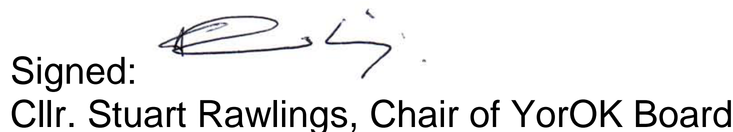
ANNEX A

Council and the Police and Crime Commissioner. These may include recommendations and areas for HWBB and SYP to consider in the refresh of the Health and Wellbeing Strategy and the Safer York plans.

8.3 There will be reciprocal arrangements for each board to identify named representatives who will have the responsibility to ensure that each Board is aware of overlapping issues and provide an update on relevant strategies and action plans.

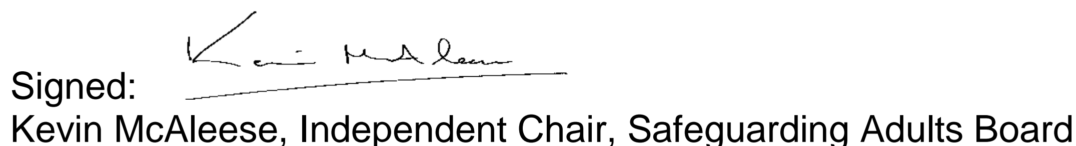
This protocol was approved by the chairs below and remains in force and will be reviewed annually at a meeting of the relevant Chairs.

Signed:
Cllr. Carol Runciman, Chair of Health and Wellbeing Board

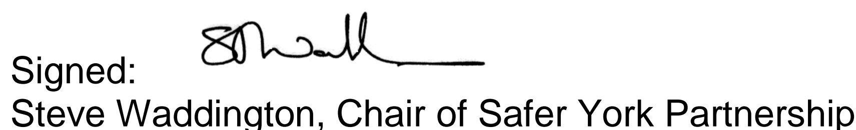


Signed:
Cllr. Stuart Rawlings, Chair of YorOK Board

Signed:
Simon Westwood, Independent Chair, Safeguarding Children Board



Signed:
Kevin McAleese, Independent Chair, Safeguarding Adults Board



Signed:
Steve Waddington, Chair of Safer York Partnership

October 2016

Governance diagram – Strategic 'Lead' and Support Boards

Key
- Lead Board
- Supporting Board

	Safer York Partnership	Safeguarding Adult Board	Safeguarding Children Board	YorOK Board	Health and Wellbeing Board
Safeguarding Children (including early help)	Supporting Board		Lead Board	Supporting Board	Supporting Board
Safeguarding Adults	Supporting Board	Lead Board			Supporting Board
Complex Crime and Safeguarding* (see below)	Supporting Board	Supporting Board	Supporting Board		Supporting Board
Neglect	Supporting Board	Supporting Board	Lead Board	Supporting Board	Supporting Board
Children's Emotional Health and Well-Being (inc. CAMHS) ** (see below)			Supporting Board	Lead Board	Lead Board
Domestic Abuse	Lead Board	Supporting Board	Supporting Board	Supporting Board	Supporting Board
Drugs and Alcohol	Supporting Board	Supporting Board	Supporting Board	Supporting Board	Lead Board
Child Sexual Exploitation	Supporting Board	Supporting Board	Lead Board	Supporting Board	Supporting Board
Children Detained or in Custody	Supporting Board		Lead Board		
Community Safety (inc. Prevent)	Lead Board	Supporting Board	Supporting Board		
Adult Mental Health (inc. suicide and self-harm)		Supporting Board			Lead Board

*North Yorkshire Police have the operational delivery lead on Complex Crime and Safeguarding (covers FGM, Trafficking, Sham Marriages, Gangs and Violence, extremism, hate crime, modern slavery
** The CAMHS executive oversees child and adolescent mental health plans. The Local Authority are responsible for the lead on the Youth Offending Board and Strategic Partnership for Children in Care

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Health and Wellbeing Board **23 November 2016**

Report of the Director of Public Health

Update on Suicide Prevention: City of York Suicide Audit – a review of deaths by suicide within the City of York between 2010 and 2014

Summary

1. The purpose of this report is to present the results of the audit of deaths by suicide as recorded by the York Coroner Service during 2010-2014. The audit was completed for the 60 people who died by suicide in York during this period for whom Coroner case files were available.

2. The audit was conducted in order to better understand suicide in York and to help inform the development of a local suicide prevention action plan which will support our aspiration for York to become a Suicide-Safer Community.

Background

3. Suicides are not inevitable. They are often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity. This can only be done by working collaboratively across all sectors within York. Suicide causes much distress to the families and friends affected and this is one of the key areas for consideration in suicide prevention.

4. The numbers of suicides occurring within a timeframe or locality are usually calculated as a rate. Hence the suicide rate is based on how many people out of every 10,000 or 100,000 people in the population are recorded as having taken their own life or died through accident or poisoning of undetermined intent.

5. The suicide rate in York for 2013-2015 was 14 suicides per 100,000 of population and this is significantly higher than the national and regional rates (10.1 and 10.7 per 100,000 respectively).

6. In 2013-15 York had the highest suicide rate when compared to other local authority areas that have similar levels of deprivation. Deprivation has been used as a comparison because death by suicide is more common among people who live in deprived areas. In 2013, one of the peak years for suicides in York, the age adjusted suicide rate for males of working age (18-64) was the fourth highest in England.

7. Therefore it is important that we have an effective and evidence-based suicide prevention plan in place across the City to halt the continued rise in suicide deaths.

8. The All Party Parliamentary Group (APPG) on Suicide and Self-Harm published an 'Inquiry into Local Suicide Prevention Plans in England' in January 2015. The APPG considered that there were three main elements that are essential to the successful implementation of the national strategy for suicide prevention. All local authorities must have in place:

    - Suicide audit work to understand local suicide risk and identify any emerging trends
    - A suicide prevention plan in order to identify the initiatives required to address local suicide risk
    - A multi-agency suicide prevention group to involve all relevant statutory agencies and voluntary organisations in implementing the local plan.

9. Under the Health and Social Care Act 2012, Public Health responsibilities transferred to the local authority. Suicide prevention is one of the indicators in the Public Health Outcomes Framework and so it falls under the strategic responsibility of the local authority Director of Public Health.

10. There is a North Yorkshire and York Suicide Prevention Task Group that has been in place for some time and this group has developed an action plan which is based on the six areas for action set out in the national strategy for suicide prevention. It is fair to say that the action plan has been mainly focused on North Yorkshire up to now and work has started on the development of a City of York suicide action plan which takes account of the particular issues for the City e.g. the needs of the student population.

11. The North Yorkshire and York Suicide Prevention Task Group has been led by the North Yorkshire Public Health Team since it was established. The Chair of the Task Group has recently been passed to the City of York Director of Public Health. Work is underway on a stock take of the group, review of membership and refresh of the action plan and this work will be completed over the next few months.

12. The decision to undertake separate suicide audits for North Yorkshire and York was based on this need to take account of the differences in geography and population and to identify any common themes that we could work collaboratively to address. However the two audits looked at deaths by suicide over the same time period, 2010-2014, and used almost identical methodologies. The geographical proximity that the two audits cover and the collaborative approaches to suicide prevention that partner agencies across both local authority boundary areas have, enabled shared learning and the consideration of joint approaches to reducing suicide in these areas.

Main/Key Issues to be Considered

13. The completion of a suicide audit is a key element of local suicide prevention work to help identify ways in which suicide rates might be reduced.

14. The suicide audit was led by the City Of York Council Public Health Team and reviewed all deaths by suicide as recorded by the York Coroner Service during 2010-2014. The audit was completed for the 60 people who died during this period for whom records were available but acknowledges that this did not allow the audit of files relating to all of the people who died by suicide during this time period. The audit team estimate that there were possibly an additional 13 people who died by suicide during this time but definitely an additional 10 people for whom case files were not available.

15. The objectives of the audit were to:

    - Compare local, regional and national data and trends

    - Identify local risk factors, groups at risk or localities of higher incidence

- Establish the extent and nature of contact with various services by those who subsequently completed suicide
- Provide an insight into common situations, stresses and triggers which led to suicide
- Inform future prevention strategies in conjunction with a review of the evidence base for them
- Provide a bench mark of evidence to inform future audits and evaluate prevention strategies
- Develop a sustainable system for future data collection
- Explore opportunities to intervene, provide support and address gaps in service in order to reduce or mitigate further risk

Key Findings

16. A summary of the key findings is presented below. The full suicide audit report can be found as an **Annex** to this report.

17. An audit template was used to record information that described the circumstances surrounding the death by suicide. Data and thematic analysis were carried out on this information which highlights that across the 60 people whose records were examined across this time period:

    - The average age at death was 42.8 years
    - An estimated 2,249 years of life were lost by suicide
    - Approximately three quarters of people were single, divorced or separated. 44% lived alone
    - Whilst suicide affects people from a full range of backgrounds there was a higher proportion of death by suicide amongst people living in more deprived areas.
    - 48% had a physical or sensory health condition at time of death; 47% had a history of substance misuse; 40% had a history of self-harm; 37% had a diagnosed mental illness and 25% had previously attempted suicide.

- Hanging was the most common method of suicide; the majority of incidents took place in the person's own home; although seven incidents took place on the railway
- About half of the people left a suicide note
- 22 out of 60 people in the York sample (37%) had drunk alcohol prior to their death, 14 people were over the drink drive limit and seven of these were heavily intoxicated at the time of death
- For over half of the people who died, there were warning signs or evidence of poor risk prior to their suicide e.g. suicide intent, suicidal thoughts or significant behavioural change
- A thematic analysis identified the main themes linked to suicides to be:
    - History of self-harm / suicide attempts
    - Diagnosed mental health problems
    - Loneliness and isolation / lack of engagement
    - Undiagnosed mental ill health / emotional distress
    - Family / relationship problems
    - Substance misuse
- In the year prior to death, 63% had a recorded visit to their GP; 52% had taken up psychiatric treatment; 40% had contact with specialist mental health services and 28% had attended the Emergency Department at hospital
- 32% of the people had either declined some form of psychiatric treatment or shown a lack of adherence to their medication / treatment plan in the year prior to death
- Whilst 28 people had a history of substance misuse, only four had a treatment record in York, suggesting a possible lack of engagement with substance misuse services
- 13 people (22%) were City of York Council adult social care clients or current City of York Council housing tenants at the time of death

- 43 people had previous contact with the police as victims, persons reporting a crime, suspects, offenders, witnesses and subjects (e.g. concerns for safety or missing person). 37 of these had contact in the 12 months prior to their death.

- 51 out of 60 people (85%) had some recorded contact in the 12 months prior to their death with at least one agency or organisation, leaving nine people (15%) who had no recorded contact. The average age of the people who died but had no contact with services was 32.3 years which is younger than the average age of those who had been in contact with some agency – which was 44.6 years

18. There is an intention that the audit process will be completed again to review death by suicide over the period 2015-2019. In the interim period, City of York Council will continue to work collaboratively with key partner agencies to raise awareness about suicide risk and suicide prevention in order to reduce death by suicide.

Consultation

19. The purpose of the audit was to review the records of deaths by suicide over the period 2010-2014 made available to the audit team by the Coroner's Office.

20. A conference took place on 28 October 2016 hosted by the University of York and organised jointly by North Yorkshire Police and City of York Public Health. The conference focused on addressing some of the themes identified in the suicide audit around mental health and suicide prevention, including a theme on support for those affected by suicide through hearing the stories from those who have lived experience. The conference was very well supported with around 75 delegates participating.

Options

21. There are no options to consider. The report sets out the key findings from the City of York Suicide Audit and review of deaths by suicide within the City of York between 2010 and 2014.

Analysis

22. The suicide audit report makes a number of recommendations based on the findings of the audit. These are to:

- Achieve Suicide-Safer Community accreditation
- Develop a local suicide prevention strategy
- Ensure that recommendations contained in the National Confidential Inquiry into Suicide and Homicide by People with mental Illness (October 2016) are considered, implemented and embedded into the policies and practices of local commissioned mental health services.
- Implement a regular programme of suicide audits and use these to inform suicide prevention priorities and development needs
- Develop the local real-time suicide surveillance process to include consideration of people who may be at particular risk of suicide in order to improve responses designed to reduce suicide risk and prevent potential suicides from happening
- Provide more responsive support arrangements to those affected by the suicide of someone they knew.
- Raise awareness about the groups most at risk from suicide and the need to assess risk of suicide for people being supported by services
- Develop a communication approach for the city that includes raising awareness amongst those at most risk from suicide and that supports their friends and family to be able to act.

23. It is proposed that the North Yorkshire and York Suicide Prevention Task Group consider these recommendations when developing the joint strategic framework for suicide prevention across both local authority areas. The newly established post of Suicide Prevention Lead Officer for City of York will have responsibility for developing a local suicide prevention action plan that is bespoke for York.

24. One of the areas to be considered in due course is the availability of prompt support for people recently bereaved or otherwise affected by suicide. ‘Postvention’ is the term used for the practical and emotional support provided to people following the loss of a loved one or close acquaintance through suicide, or otherwise affected by such incidents. This is widely recognised as an important element of suicide prevention work because of the known direct risk to those who are bereaved and the need to

support people though a particularly traumatic period of their life. Some local authorities have bespoke postvention services directly linked to police/coroner referral processes and these have been high-lighted as national best practice.

Strategic / Operational Plans

25. The suicide audit findings will be valuable in informing our local approach to suicide prevention across the City of York and our vision to become a "Suicide-Safer Community".

<u>Why become a Suicide-Safer Community?</u>

26. The Suicide-Safer Communities designation honours communities that have implemented concerted, strategic approaches to suicide prevention. The nine pillars in this designation reflect the core elements of suicide prevention strategies around the world. The designation celebrates and acknowledges those communities who have made significant progress in reaching their suicide-safer goals, and helps others understand what strategic steps they can take to prevent suicide on a community level.

27. The work is co-ordinated around 9 pillars of action:

- Leadership/ Steering Committee
- Background Summary
- Suicide Prevention Awareness
- Mental Health and Wellness Promotion
- Training
- Suicide Intervention and Ongoing Clinical/Support Services
- Suicide Bereavement
- Evaluation Measures
- Capacity Building/ Sustainability

28. In order for a community to be designated a Suicide-Safer Community there is an accreditation process based on a review of documentation evidencing all 9 areas. Designation is for five years with a review at five years for re-designation.

29. Suicide-Safer Community designation is a public affirmation of, and testament to include community-wide safety from suicide as a priority contribution in creating a safer, healthier and hope-filled life for its citizens. In this way the work will support our aspirations for better mental health for our residents of all ages.

30. The Mental Health and Learning Disabilities Partnership Board received a discussion paper on Suicide-Safer Community at the meeting on 25 July 2016 and agreed to recommend that the Health and Wellbeing Board endorse a direction of travel for the City of York to achieve Suicide-Safer Community designation.

Council Plan

31. The proposal directly relates to the Council Plan 2015-19 priorities:
    - **'A prosperous city for all'**
    - '**A focus on frontline services'** - to ensure all residents, particularly the least advantaged, can access reliable services and community facilities.
    - **'A Council that listens to residents'** – to ensure it delivers the services they want and works in partnership with local communities

Specialist Implications

Financial

32. At this point it is unclear what the direct cost implications to becoming a designated Suicide-Safer Community may be. There will be further work undertaken to understand the potential resource implications of the accreditation process. One of the foundations of accreditation, however, is the provision of suicide prevention training for operational staff and community members.

33. Living Works which designed the 'Suicide Safer' model promotes two of its suicide prevention courses which are delivered by accredited trainers working within various organisations. Relevant training is either the two day 'ASIST (Applied Suicide Prevention Skills Training) or the three hour 'Safetalk' courses. Both are designed to raise awareness of the issue of suicide and improve the confidence and communication skills of delegates when engaging with someone who may be contemplating suicide.

34. An initial programme for the delivery of Safetalk to operational staff in the city, funded by Public Health England is due to conclude in January. Hence only a relatively small proportion of staff in front line roles has been trained and to achieve accreditation it is essential that further training provides much more comprehensive coverage. There will therefore be financial implications to individual partners in supporting such training to ensure that employees are equipped with a key work and life skill. Costs are not yet quantifiable as they are dependant on the required extent of workforce coverage and the optimum ratio for delivery of the two courses.

35. Other work on suicide prevention can still be organised around the 9 pillars within existing resources since it provides a useful framework for co-ordinated community action.

Human Resources (HR)

36. There are no Human Resources implications from this report.

Equalities

37. There are no equalities implications from this report.

Legal

38. There are no legal implications from this report.

Crime and Disorder

39. There are no crime and disorder implications from this report.

Information Technology (IT)

40. There are no IT implications from this report.

Property

41. There are no property implications from this report.

Risk Management

42. There are no risks associated with this report.

Recommendations

43. The Health and Wellbeing Board is asked to:

- Receive the City of York Suicide Audit 2010-2014 report and approve its publication as one of the suite of documents supporting the Joint Strategic Needs Assessment for York

- Note the intention to repeat the audit process to review death by suicide in the City of York over the period 2015-2019.

- Support the recommendation from the suicide audit that the findings be used to inform a local suicide prevention action plan for the City and delegate this responsibility to the Chair of the North Yorkshire and York Suicide Prevention Task Group.

- Endorse the vision and direction of travel for the City of York to become a Suicide-Safer Community

- Agree to receive annual reports detailing progress on implementation of the local suicide prevention action plan and highlighting any key areas of concern

Reason: To support the work on suicide prevention and the vision for York to become a Suicide-Safer Community.

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Report Approved	√	**Date** 09/11/16

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers

National Suicide Prevention Strategy for England 2012

https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&sqi=2&ved=0ahUKEwj895Hnkd_OAhUkBMAKHTa3AS8QFggjMAA&url=https%3A%2F%2Fwww.gov.uk%2Fgovernment%2Fpublications%2Fsuicide-prevention-strategy-for-england&usg=AFQjCNF73slsz7KGPcBGz2QHvmw8yHQ9Ew&bvm=bv.130731782,d.d24

Public Health England. Guidance for developing a local suicide prevention action plan. September 2014.

https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan

Public Health England. Identifying and responding to suicide clusters and contagion.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/45930 3/Identifying_and_responding_to_suicide_clusters_and_contagion.pdf

North Yorkshire Suicide Audit 2010-2014

http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwjUwZS5kd_OAhWIC8AKHRa-CHkQFggjMAA&url=http%3A%2F%2Fdemocracy.northyorks.gov.uk%2FFunctionsPage.aspx%3Fdsid%3D78094%26action%3DGetFileFromDB

&usg=AFQjCNFaTHHFS_5tcp1i_9Ot3f_n2XuEYg&bvm=bv.130731782,d.d24

Suicide- Safer Communities

https://www.livingworks.net/community/suicide-safer-communities/

Annex

City of York Suicide Audit – a review of deaths by suicide within the City of York between 2010 and 2014.

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City of York Suicide Audit

- a review of deaths by suicide within the city of York between 2010 and 2014

CITY OF YORK COUNCIL

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Executive Summary

The York five year suicide audit reviewed 60 deaths which took place between 2010 and 2014. Files reviewed related exclusively to coroner's inquest conclusions of suicide and so did not include deaths by 'accident or poisoning of undetermined intent' which are included in the wider definition of suicide by the Office of National Statistics. The audit was conducted in line with national guidance in order to enable better understanding of the pattern of suicide in the local area. Findings will inform suicide prevention plans and activities to be used to develop the local aspiration for York to become an accredited 'Suicide-Safer Community'.

There has been an increasing trend in suicides within the last decade in England and this has been replicated in York with some years seeing comparatively high levels of suicide, particularly in men.

An audit template was used to record information obtained from coroner's files which contain evidence and information relevant to individual deaths by suicide. Data and thematic analysis was carried out on this information which highlighted that across those 60 people who died by suicide in York during the time period:

- 83 % were male
- The average age at death was 42.8 years
- Approximately three quarters of people were single, divorced or separated.
- 44% lived alone
- There was a higher proportion of death by suicide among people living in more deprived areas notwithstanding the fact that suicide affects people from a wide range of backgrounds
- 48% had a physical or sensory health condition at time of death; 47% had a history of substance misuse; 40% had a history of self-harm, 37% had a diagnosed mental illness; and 25% had previously attempted suicide
- Hanging was the most common method of suicide
- the majority of incidents took place in the deceased's own home or other private premises whilst seven incidents took place on the railway.
- Around 50% of people left some form of suicide note
- 22 out of 60 people (37%) had consumed alcohol prior to their death, 14 were over the drink drive limit and seven of these were heavily intoxicated at the time of death
- For over half of the people who died there were warning signs or evidence of risk prior to their suicide e.g. suicide intent, suicidal thoughts or significant behavioural change
- A thematic analysis identified the main themes linked to the suicides to be: history of self-harm/suicide attempts, diagnosed mental health problems, loneliness and isolation/lack of engagement, undiagnosed mental ill health/emotional distress, family/relationship difficulties and substance misuse

- In the year prior to death, 63% had a recorded visit to their GP, 52% had taken up psychiatric treatment, 40% had contact with specialist mental health services and 28% had attended the Emergency Department at hospital
- 32% of the people had either declined some form of psychiatric treatment or shown a lack of adherence to their medication/ treatment plan in the year prior to death
- Whilst 28 people had a history of substance misuse only four had a treatment record in York, suggesting a possible lack of engagement with substance misuse services
- 13 people (22%) were clients of City of York Council as either housing tenants or having been subject of Adult Social Care records (open or closed) at the time of death.
- 43 people had previous contact with the police as victims, persons reporting a crime or incident, suspects, offenders, witnesses or subjects (e.g. 'concern' for safety or missing person). 37 of these had contact in the 12 months prior to their death
- 51 out of 60 people (85%) had some recorded contact in the 12 months prior to their death with at least one agency or organisation, leaving nine people (15%) who had no recorded contact. The average age of the people who died who had had no contact with services was 32.3 years which is noticeably younger than the average age of those who had been in contact with some agency(44.6 years of age).

Recommendations

- Work towards achieving formal 'Suicide Safer Community' accreditation for the city of York with Living Works.
- Develop a suicide prevention framework for York and an accompanying multi-agency 'Framework' of objectives, risks actions and outcomes.
- Ensure that recommendations contained in the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (October 2016) are considered, implemented and embedded into the policies and practices of local commissioned mental health services.
- Undertake a regular programme of suicide audits, including a wider scope to cover 'deaths by accident/poisoning of undetermined intent' to be used to inform suicide prevention priorities and development needs
- Develop 'suicide surveillance' and real time 'early alert' processes to improve the multi-agency response, lower and mitigate suicide risk and reduce the number of completed suicides and attempts.
- Provide more responsive support arrangements to those affected by suicide. Include people who are bereaved through suicide, recently or historically, those experiencing suicidal ideation or caring for others and those who have been otherwise touched by suicide through loss of an acquaintance or presence at the scene of a related incident.
- Ensure that those people who are affected by suicide are able to have their views and experiences heard and the opportunity to contribute to suicide prevention activity.
- Raise awareness around which groups are at 'high risk' or 'vulnerable' to suicide amongst front-line staff ensuring that those staff receive training to enhance their skills in communicating with and protecting someone who may be at risk.
- Develop a communication plan for the city to include awareness raising, encourage help-seeking, open and non-judgemental approaches and dialogue between those at risk and those in contact with those at risk.

Introduction

In 2013, the leading cause of death for 20-34 year olds in England and Wales was suicide (including deaths through injury/poisoning of undetermined intent). Suicide remains the leading cause of death for men aged 35-49 accounting for 13% of all deaths. Every 40 seconds, someone somewhere in the world dies by suicide (WHO, 2014). Across the world, suicide is the second leading cause of death among young people aged between 15-29 years (after road related deaths).

Between 2006-2015, 136 City of York residents died by suicide. A further 46 people died through accident or poisoning in cases where the coroner could not establish, beyond reasonable doubt, that they had died by suicide.

The numbers of suicides occurring within a timeframe or locality are usually calculated as a rate. Hence the suicide rate is based on how many people out of every 10,000 or 100,000 people in the population are recorded as having taken their own life or died through accident or poisoning of undetermined intent.

The suicide rate in York for 2013-2015 was 14 suicides per 100,000 of population and this is significantly higher than the national and regional rates (10.1 and 10.7 per 100,000 respectively). In 2013-15 York had the highest suicide rate when compared to other local authority areas that have similar levels of deprivation. Deprivation has been used as a comparison because death by suicide is more common among people who live in deprived areas.

In 2013, one of the peak years for suicides in York, the age adjusted suicide rate for males of working age (18-64) was the fourth highest in England.

Every life lost to suicide is a tragedy and is likely to have a significant effect on the emotional health and wellbeing of those touched by it. For some people that may be during the immediate aftermath or over the following months. For others the experience of that loss or simply the knowledge that a loved one such as a parent, partner, sibling or child took their own life, can stay with them forever and undermine their long-term ability to thrive.

The unexpected death of a family member or close friend through any cause can be the most significant traumatic event in a person's life. A loss through suicide can be completely shattering, intensifying feelings and responses associated with bereavement and leaving people with enduring emotions and questions with which they often never fully come to terms. Research suggests it may even render them more at risk of suicide themselves at some time in the future (BMJ Open 2015) Whilst the full human cost is impossible to quantify or measure, it is also difficult to place a financial cost on any individual suicide or on the incidence of suicide generally. In 2013, Public Health England estimated the average cost per suicide to be £1.7 million. Placing a monetary value on the loss of life may be considered insensitive by some, whilst others may question what factors and timeframes should be included in the calculation. What is indisputable is that the economic burden of suicide falls upon everyone in a society and that it is significant.
This report primarily relates to the audit and subsequent analysis of 60 suicides which occurred within the city of York over a period of five years between 2010-2014. It makes reference to the audit of 227 suicides during the same time period in the North Yorkshire County Council area.
The two audits were almost identical in their methodology and objectives and were conducted consecutively over the autumn and winter of 2015/16 with the majority of team members being involved, to some degree, in both. The geographical proximity of the two audit areas and the collaborative approaches to suicide prevention that partner agencies across both local authority areas have, enabled shared learning and consideration of joint approaches to reducing suicide across the county as a whole.

The York audit considered deaths of people across a wide range of ages, backgrounds, status, stages of life and living circumstances.

The audit included people with diagnosed mental ill-health conditions who were receiving treatment from mental health services which were, in some cases, endeavouring to manage a known risk of suicide on a weekly or even daily basis.

It included people who had previously received such treatment but were no longer in touch with services and people whose mental or physical ill-health was currently being managed and treated by primary care services. Significantly the audit also included cases where the deceased had not had any contact with health professionals for a considerable time and some cases where there had been no prior indication whatsoever to anyone of suicidal ideation or emotional turmoil.

All causes of avoidable, premature death are deserving of attention and resources to prevent unnecessary loss of life. Relatively few people die in York through suicide when compared with the leading causes of death. However when the number of 'years of life lost' is considered rather than simply the number of lives lost, the impact of suicide is particularly poignant.

Average life expectancy in York is currently 80.1 years for men and 83.5 years for women. The average age of the York audit cohort was 42.4 for men and 47.8 for women. A calculation based on these figures shows that those sixty people taken together were deprived of 2,249 'years of lost life', around 37 years per person, as a result of suicide.

It is anticipated that that this report will be read by stakeholders and partners who have the desire, influence and resources to affect change. It is hoped that it will provide an insight into the common situations, stresses, risk factors and catalysts which led those who took their lives to the conclusion that suicide was their only option. It is also hoped that this work will highlight any potential gaps in services in terms of their availability, profile, accessibility and credibility amongst people who may benefit from using them.

The audit team members who undertook this audit recognise the very sensitive nature of the information reviewed and their privileged position in being granted access to intimate details of peoples' lives and deaths. The coroner, in supporting this research, sought strong reassurances in relation to confidentiality of personal information and the anonymity of individuals when that information was subsequently collated and presented. The audit team has endeavoured to respect that need in reporting its findings. Whilst case studies used within this report are based on information found within the audit the names of individuals and some of the details have been changed to avoid possible identification of specific cases and further distress being caused to loved ones.

This report does not attempt to express a view or position on the ethicality of suicide. It is not a crime in UK law to take one's own life and has not been since 1961. Throughout the report we have avoided the term 'to commit' suicide in favour of phrases such as 'complete' or 'die by' suicide or 'take one's own life. This reflects guidance from Samaritans and other national support charities based on feedback and preferred terminology of those people directly affected by suicide.

[1] Suicides are reported by the year in which they were registered rather than the year in which the death occurred. The ONS definition of suicide includes deaths given an underlying cause of intentional self-harm or an injury/poisoning of undetermined intent.

Part (i) Context-Suicides in York over the last decade

Numbers of suicides in York 2006-2015

A total of 182 deaths by suicide among York residents were registered in the 10 year period 2006-2015. 136 of these had a clear coroner's outcome of suicide and a further 46 were from accident / poisoning of undetermined intent[1].

Table 1: Number of Suicides in York 2006-2015

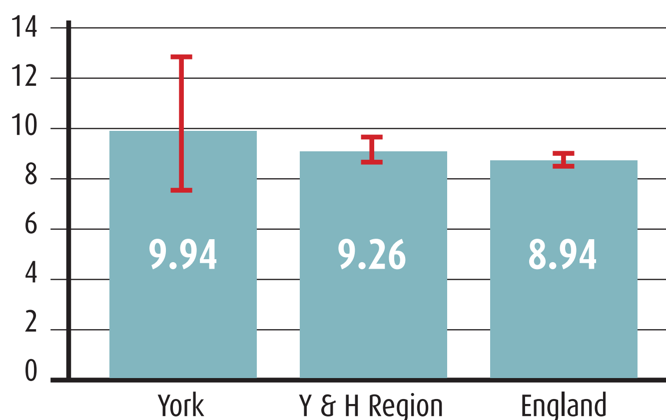
	Year of Registration										
Intent	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total
Intentional	7	9	22	10	15	11	10	21	13	18	136
Undetermined	4	4	1	4	3	7	1	9	3	10	46
Total	**11**	**13**	**23**	**14**	**18**	**18**	**11**	**30**	**16**	**28**	**182**

Source: Primary Care Mortality Database (PCMD)

Suicide Rates in York

Published suicide figures are calculated as rates per 100,000 of population and are adjusted to take into account differences in the age breakdown of different areas. The latest published rates are for the three year period 2013-2015. The rate in York is 14 suicides per 100,000 of population and this is significantly higher than the national and regional rates (10.1 and 10.7 per 100,000 respectively). (Public Health England, 2016a).

Figure 1: York suicide rates compared to Region/England 2013-2015



Source: Public Health Outcomes Framework (2016)

In 2013-15 York had the highest suicide rate when compared to other local authority areas that have similar levels of deprivation. Deprivation has been used as a comparison because death by suicide is more common among people who live in deprived areas.

Figure 2: York suicide rate compared to Local Authority areas with similar levels of deprivation 2013-2015

Area	Count	Value	95% Lower CI	95% Upper CI
England	14,429	10.1	10.0	10.3
Second least deprived decile (IMD2010	1,661	9.8	9.3	10.3
York	74	14.0	10.9	17.6
Warwickshire	175	11.8	10.2	13.7
Cheshire East	115	11.4	9.4	13.7
Gloucestershire	171	10.6	9.0	12.3
Dorset	117	10.6	8.7	12.7
West Sussex	220	10.1	8.8	11.5
North Yorkshire	164	10.0	8.5	11.6
Leicestershire	164	9.3	7.9	10.9
Cambridgeshire	155	9.1	7.7	10.6
Wiltshire	116	9.0	7.4	10.8
Bromley	68	8.1	6.3	10.3
Sutton	36	7.0	4.9	9.8
Merton	37	7.0	4.8	9.8
Harrow	45	7.0	5.1	9.4
City of London	4		-	-

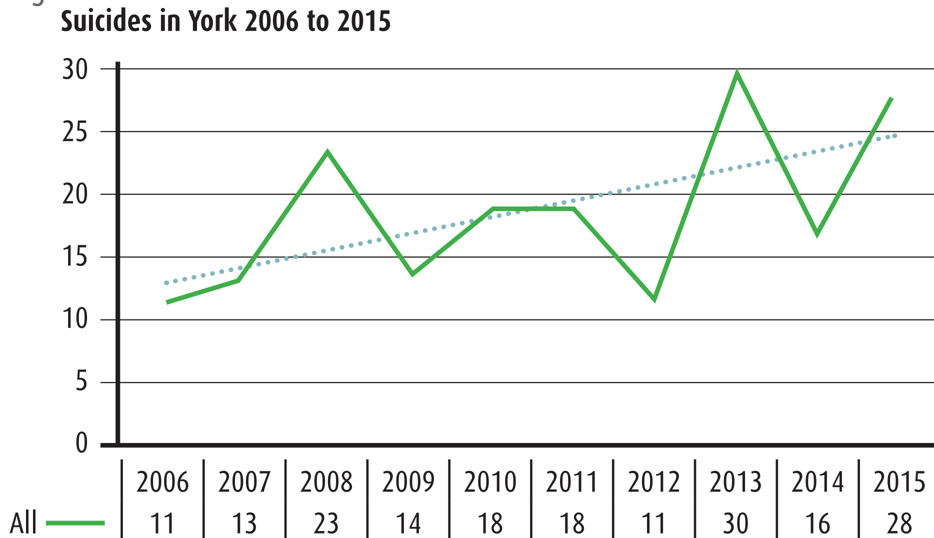
Source: Public Health Outcomes Framework (2016)

In 2013, one of the peak years for suicides in York, the age adjusted suicide rate for males of working age (18-64) was the fourth highest in England.

Suicide Trends in York 2006-2015

There has been an increasing trend in suicides in York the last 10 years. There have been sharp peaks in some years e.g. 2008, 2013 and 2015.

Figure 3: Trend in suicides in York 2006 to 2015

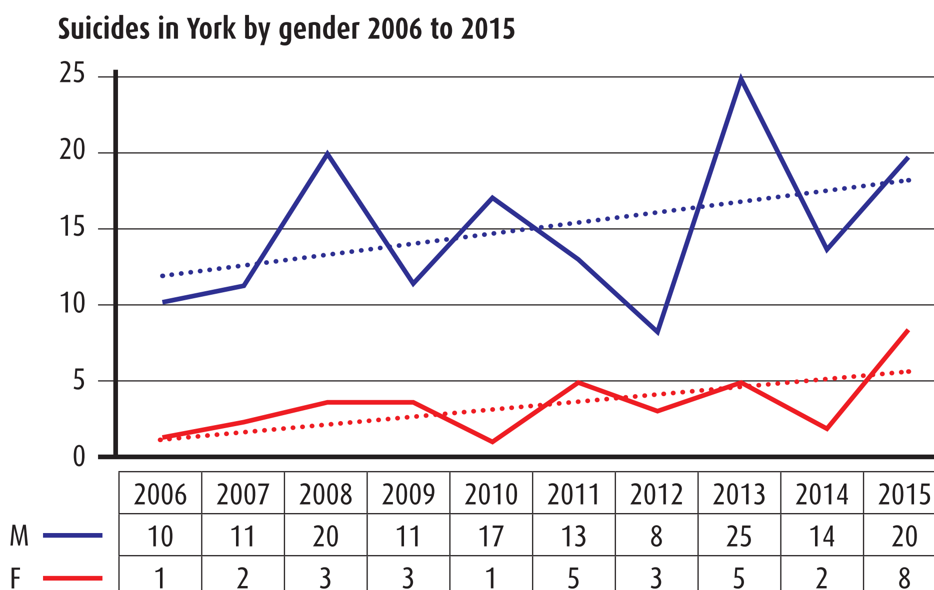


	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
All	11	13	23	14	18	18	11	30	16	28

Source: primary care mortality database

The trend has been increasing for both males and females in York over the last 10 years. The 'peak' years tend to be due to sharp increases in male suicides, however in 2015 there were more female suicides (8) than in previous years.

Figure 4: Trend in suicides in York by Gender 2006 to 2015



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
M	10	11	20	11	17	13	8	25	14	20
F	1	2	3	3	1	5	3	5	2	8

Source: primary care mortality database

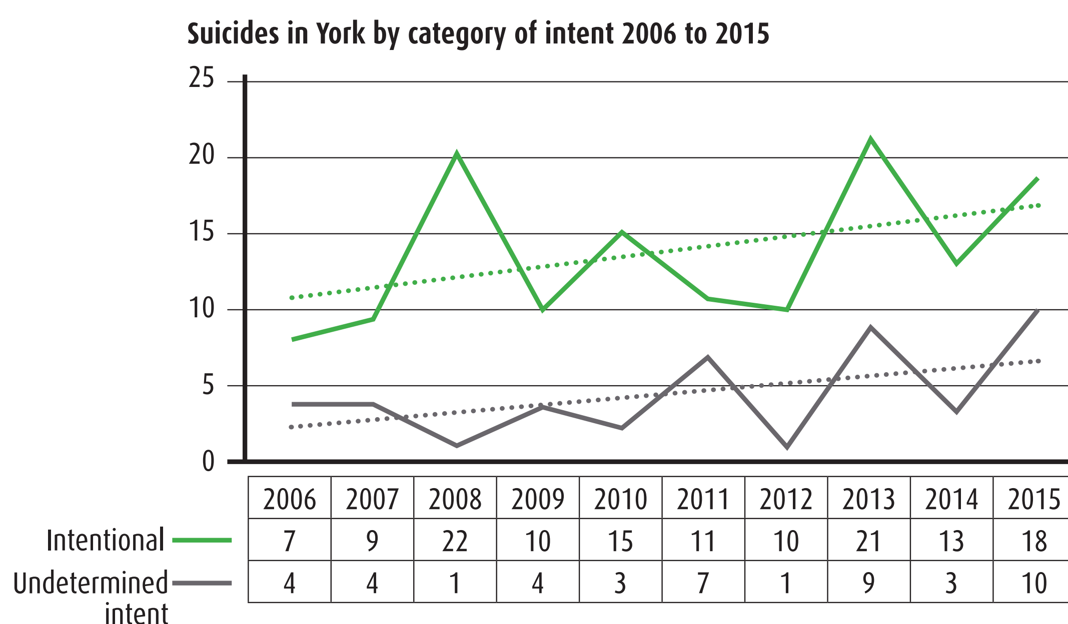
Published figures about death by suicide are calculated based on how many deaths occurred that were classed as one of two groups of ICD 10 codes:

- Intentional self-harm (X60-X84) – Conclusion of suicide
- Event of undetermined intent (Y10-Y34) – Open conclusion.

ICD 10 codes are used within health care services to classify what conditions or injuries people receive treatment for or die from.

If these are analysed separately it can be seen that the 2008 peak was due to intentional self-harm whereas in 2013 and 2015 there was also an increase in deaths with 'undetermined intent'.

Figure 5: Trend in suicides in York by category of intent 2006 to 2015



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Intentional	7	9	22	10	15	11	10	21	13	18
Undetermined intent	4	4	1	4	3	7	1	9	3	10

Source: primary care mortality database

Suicide Prevention Profile for York

Public Health England produced a suicide prevention profile highlighting risk factors for each local authority (Public Health England, 2016b).

For many of the risk factors, York had a significantly lower value compared with the national average. For example York has lower levels of unemployment, less homelessness and fewer alcohol related hospital admissions. There were, however, some risk factors where York had a significantly higher value than the national average:

- The percentage of people with a high anxiety score
- The percentage of children aged 10-18 years who have formally entered the youth justice system
- The percentage of households occupied by a single person aged 65 or over.
- The percentage of emergency hospital admissions for intentional self-harm.

Part (ii) York Five Year Suicide Audit 2010-14

Background and drivers

The Government's 2012 document 'Preventing suicide in England, a cross–government outcomes strategy to save lives' highlighted the need for local authorities and other statutory, voluntary and private sector organisations to work in partnership with local communities to reduce the incidence of suicide and to provide better support for those affected by it.

Government strategy supports the view that suicide is not inevitable for anyone and that appropriate interventions at the right time and for the right people can, and do, save lives. It provides clear direction to local authorities and other stakeholders, highlighting the benefits of much closer partnership working, improvements to information sharing and data gathering and sharing and replication of best practice initiatives. A key message is the concept of the problem of suicide and its causes being 'owned' by and responded to jointly by partners and communities.

In 2014, in response to this guidance, a North Yorkshire and York multi-agency Suicide Prevention Task Group was created to consider and seek to address the issue of suicide across the local authority areas of North Yorkshire and the City of York. Chaired by the Director of Public Health, the group has representation from a wide range of stakeholders including police, NHS, clinical commissioning groups, mental health services, substance misuse services, Network Rail, higher education institutions, Samaritans, other voluntary sector organisations and community members - some of whom are themselves personally affected by suicide.

One of the six key objectives within the government strategy is to 'support research, data collection and monitoring'. A large amount of research has been conducted world-wide to identify causes, risk factors and interventions aimed at reducing suicide and in the UK research at a national level has been under-way for several years. The strategy, however, stresses the need for local research to be conducted and developed to better inform stakeholders responsible for service delivery within local authority areas. Its message is that it is imperative for those seeking to take action to reduce suicide locally to have more precise and up to date information regarding trends, high risk groups, prevalent methods, location hotspots and triggers which resulted in recent deaths within the communities they serve.

A priority for the task group was therefore the completion of a five year county-wide suicide audit. A holistic study of suicide within the local area had not been previously conducted and it was apparent that there were clear gaps in the knowledge and understanding about the pattern of suicide across the area.

Aims

The aims of the audit were to:

- Compare local, regional and national data and trends
- Identify local risk factors, groups at 'high' or 'raised' risk and localities of higher incidence
- Establish the extent and nature of contact with various services by those who subsequently completed suicide
- Provide an insight into common situations, stresses and triggers which led to suicide
- Inform future prevention strategies in conjunction with a review of the evidence base for them
- Provide a bench mark of evidence to inform future audits and evaluate prevention strategies
- Develop a sustainable system for future data collection
- Explore opportunities to intervene, provide support and address gaps in service in order to reduce or mitigate further risk

Method

The most relevant single source of information relating to individual suicides is the records and evidence collated during coroners' inquests. The Coroner responsible for conducting inquests into deaths occurring in City of York agreed to an information sharing protocol and granted the suicide audit team access to case files. The cases examined were identified from information provided by the Coroner's office, linked to Office of National Statistics (ONS) data and cross-referenced with data about deaths from the Primary Care Mortality Dataset.

Each individual file was read by a member of the audit team and information entered onto a generic electronic template. This template included multiple choice or free text boxes for recording demographic information, facts relating to the death such as date, place and cause of death, medical history and details of contact with various services. A free text box was used to include general notes in relation to particular circumstances, lifestyle, significant events or history which were believed to have resulted in or contributed to the suicide. After reading the complete file the reviewer returned to a list at the top of the template to indicate which 'triggers' for suicide appeared to be the most relevant to that individual death.

Analysts from City of York Council's Strategic Business Intelligence Hub analysed both the quantitative and qualitative data that was collected. Quantitative data was analysed to identify the range of socio-demographic and lifestyle characteristics, patterns and trends among individuals who had taken their own life that are discussed throughout this audit report.

Qualitative data supplied to the audit was grouped into a range of themes to facilitate identification of common issues impacting on the day to day lives of individuals who had chosen to end their lives. The outcome of the qualitative analysis was considered alongside the findings from quantitative analysis to provide a wider, richer intelligence based insight into the common characteristics and antecedents of individuals who had chosen to complete suicide, and identify socio-demographic groups which may be at raised risk.

Audit scope

The York suicide audit considered:

- Deaths recorded between 2010 and 2014 where inquests were held in York and which resulted in the coroner recording the cause as 'suicide.'
- Death of people who resided outside of York who died by suicide within the city.
- Cases where individuals died by suicide outside of England and the body was repatriated to the city as the location of their residence or family home.
- Cases in which the deceased resided in York and died in the North Yorkshire County Council area (as those files were also available to the audit team).

The audit did not consider:

- Deaths which were recorded as 'accidents or poisoning of undetermined intent'.
- Deaths of people who resided in York and who died elsewhere in England (other than in North Yorkshire as above) as those investigations fell under the jurisdiction of the coroners for those other areas
- Incidents of attempted suicide or serious self-harm not resulting in death. However, between the start of the audit process and the publication of the findings, a real-time surveillance process has been established which allows a faster response to identification of risk factors associated with local suicide. The intention is to further develop this method to be better able to identify and respond to risk factors in cases which did and did not result in death in an attempt to reduce future suicide attempts and death by suicide.
- A number of cases which were not available for review due to on-going proceedings or other reasons.

58 of the 60 people considered within the scope of this audit were York residents (or had their family home in York) at the time of death. The other two people lived outside York but completed suicide in the city.

Limitations and challenges of data collection

Whilst the information contained within coroners' files proved invaluable as a source of evidence regarding suicide it should be noted that such files do not include all material necessary to provide a comprehensive and complete picture of its character and causes.

The objectives of a coroner's enquiry and those of a suicide audit differ markedly, most significantly in relation to individuals' motivation to complete suicide. It is a coroner's responsibility to establish 'how' someone came about their death rather than 'why' someone chose to die by suicide.

Whilst how someone died i.e. the method was of clear interest and value to the audit team, the reasons why someone completed suicide were considered to have most significance to the research.

A coroner's enquiry only collates evidence and information which is made available through a police investigation or provided by services and organisations which hold information relevant to a death.

Some information regarding deceased individuals, their lifestyles or health history or recent stresses is not available within such files –or known even to those closest to them -and in many cases only the deceased themselves knew the true causes or catalysts of their suicide.

A number of case studies are used in the following audit element of this report. These scenarios are based on circumstances faced by those who died and provide an insight into the common antecedent history and life stresses encountered by them. However, to avoid possible identification of individuals, changes have been made to names, age, gender or living circumstances.

York Suicide Audit Findings

Demographics

Of the 60 people in the York sample, 50 (83%) were men and 10 (17%) were women. This is the same as the gender breakdown in the North Yorkshire audit which considered 227 deaths of which 83% were male. This also reflects the position in England (78%) and internationally where data shows that men account for more than three quarters of people worldwide who complete suicide. The national strategy provides the following explanation for this:

> "Men are at greater risk for a number of reasons. Many of the clinical and social risk factors for suicide are more common in men. Cultural expectations that men will be decisive and strong can make them more vulnerable to psychological factors associated with suicide, such as impulsiveness and humiliation. Men are more likely to be reluctant to seek help from friends and services. Linked with this, providing services appropriate for men requires a move away from traditional health settings. Men are also more likely than women to choose more dangerous methods of self-harm, meaning that a suicide attempt is more likely to result in death."

Case study

Brian, who was in his late forties, had recently been through an acrimonious divorce, the settlement of which had left him with significant debts. He struggled with depression which he attributed to his marriage break-down and a long term ill-health condition, arthritis which was worsening, but he had not discussed his mental health with his doctor. He had not previously self-harmed and he did not drink alcohol to excess. He took his own life whilst staying at his friend's address. He left a note in which he said he could no longer cope with the prospect of bankruptcy , reduced contact with his children and unmanageable physical pain.

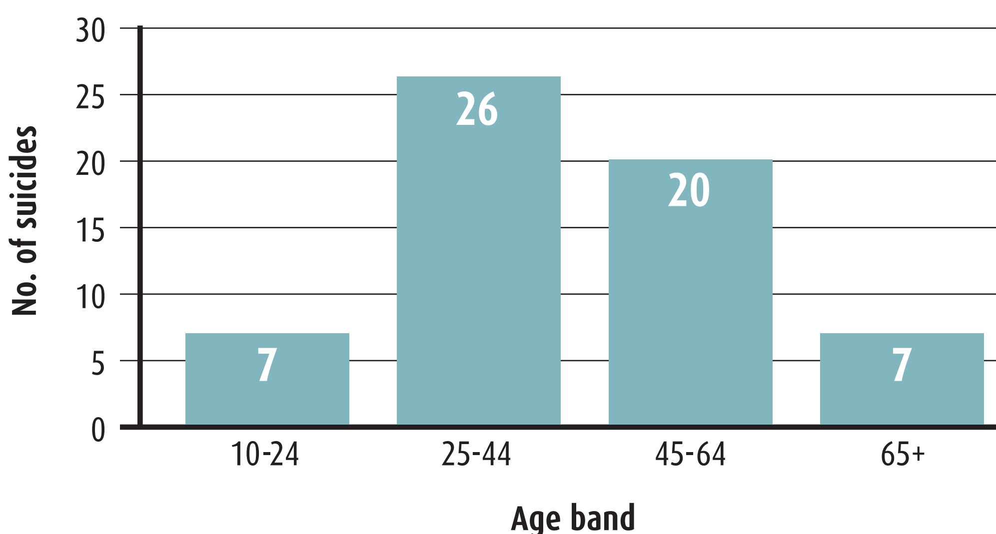
Age at Death

Death by suicide occurred in a wide range of people aged anywhere between those in their teenage years to those in their eighties.

The average age at death was 42.8 years overall (41.9 years for men and 47.4 years for women).

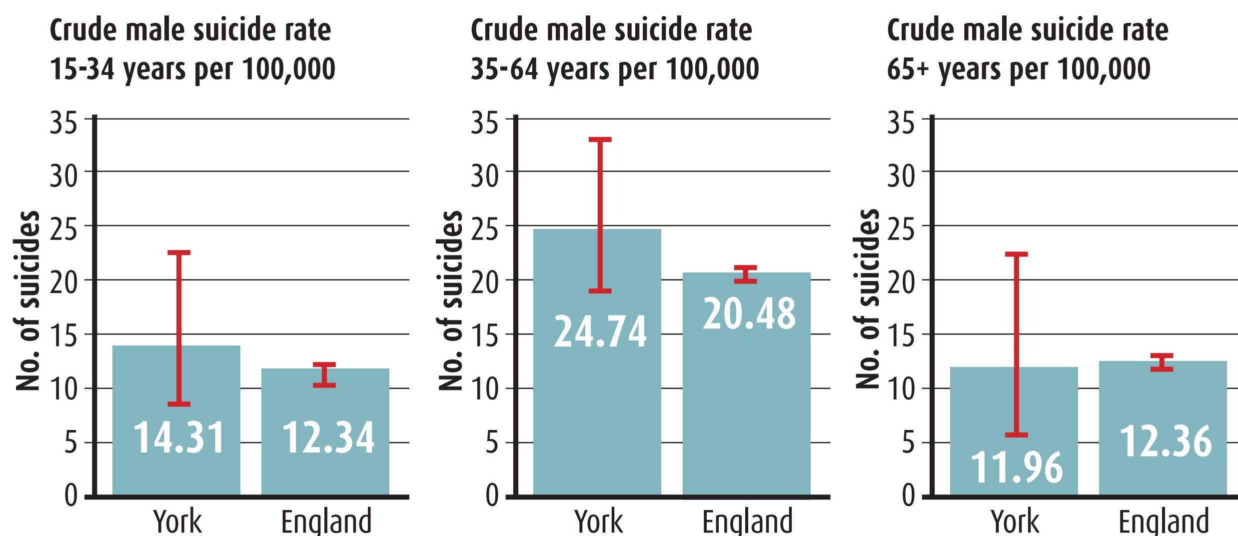
The most common age group for people to take their own lives (overall and for men only) was 45-54. For women, the most common age group was among women aged between 25-34.

Figure 6: Age at which people took their own lives



Age specific male suicide rates are available for York for the period of the audit (Public Health England, 2016). These are shown in the figure below for the period 2010-2014. It can be see that rates in York for the three age bands (15-34, 35-64 and 65+) are not significantly different from the national averages.

Figure 7: Age specific male suicide rates: York v England: 2010-2014



Based on the age at death of each person in the York cohort and the average life expectancy in York, the sixty people who died were deprived of a total of 2,249 years of lost life as a result of suicide.

Case study

Liam, who was in his forties, was struggling at work. He didn't feel he was capable of the tasks expected of him and didn't receive support from managers or colleagues. It was a very male dominated environment and no one ever discussed personal issues. He became increasingly anxious and reluctantly booked an appointment with his GP. During his consultation he found it difficult to describe the extent of his anxiety and feelings of low self-worth. A close friend had taken her own life a few weeks earlier and this had hit Liam very hard. He suffered episodes of low mood but had not previously self-harmed, used drugs or drunk to excess. He took his own life one afternoon without having given his partner any indication that he was feeling so desperate. He had sent her a text apologising and explained that he could no longer bear the stress but didn't go into any detail. The post-mortem revealed that he had drunk alcohol that day but not a substantial amount.

Ethnicity

Ethnicity was recorded for 48 people in the York sample. 47 people (98%) were identified as White or White British.

It is recognised nationally that there are gaps in the way that data is collected in relation to ethnicity and this was also apparent during the York audit, with ethnicity data missing from 12 of the 60 files. The national strategy suggests that Travellers, and in particular, Gypsy and Traveller men are more at risk of suicide and mental ill-health when compared to the general population.
The audit did not indicate that this was the case in York during the period considered and there was

no suggestion that a higher risk of suicide was associated with any particular ethnic minority group. The largest proportion by far of death by suicide was of people from White or White British ethnicity (90.2% of York's population are White British based on the 2011 Census).

Sexuality

Sexuality was recorded for 37 people in the York sample, 35 people (95%) were recorded as Heterosexual and 2 people (5%) as Homosexual.
National data indicates that people who are lesbian, gay, bi-sexual or transgender are more susceptible to mental ill-health, self-harm and bullying and are, as a result, at greater risk of suicide.

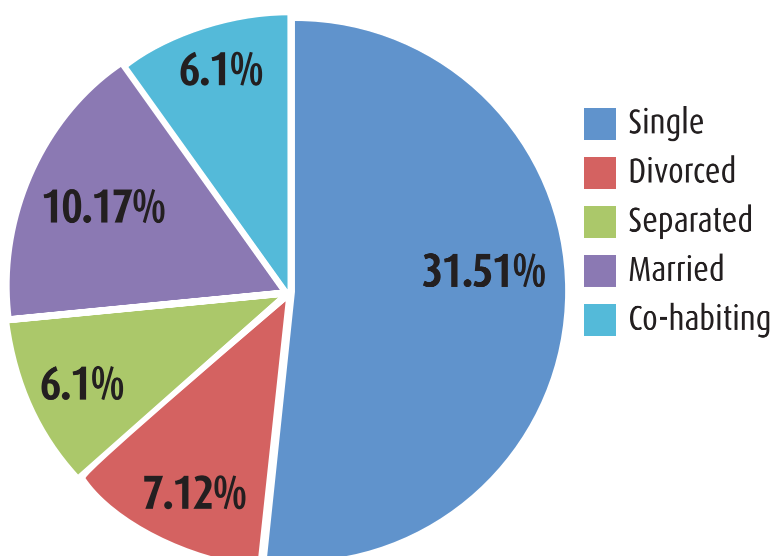
Definitive data collection in relation to sexuality is not possible from coroners' files and the audit only provides an indication of the likely sexuality profile of just over half of the cohort where it was specifically referenced or could be reasonably assumed.

There was no evidence in the audit of sexuality or bullying related to sexuality or gender identity being factors which contributed to completion of suicide within this specific cohort

Marital status

Approximately three quarters of people in the York sample were either single, divorced or separated (44 out of 60 people, 73%). The detailed breakdown by marital status is shown in the chart below.

Figure 9: Marital status



'Marital status' in itself does not provide clear clues in relation to vulnerability to suicide particularly as legal marital status of those in the cohort was often at variance with their actual domestic arrangements at the time of their death.

However, relationships in general and breakdown in intimate relationships in particular featured as a significant contributory factor in the deaths considered through this audit.

Whilst some of those who completed suicide were in stable, loving relationships or had supportive extended family there was a common theme of recent relationship breakdown or estrangement from family.

In some cases, particularly where this was linked to other risk factors such as mental ill-health or alcohol misuse the breakdown of a relationship or the perception that the relationship was ending proved to be the catalyst which triggered suicide.

There were also instances of acrimonious divorce proceedings – either recent or historical – often leading to significant debt or estrangement from children which appeared to compromise individuals' emotional resilience. This, combined with other factors such as mental ill-health in the form of depressive illness or anxiety, appeared to generate feelings of mental anguish, guilt, hopelessness or despondency resulting in eventual suicide.

Housing status

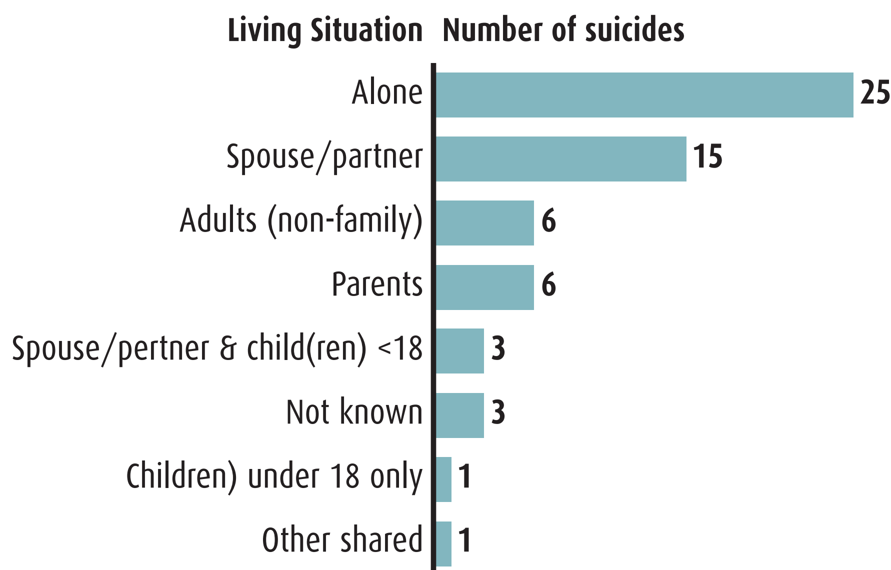
Housing status was recorded for only 40 of the 60 people in the York sample. 18 out of 40 people (45%) were owner occupiers, 16 (40%) were private renters and 6 (15%) were council tenants. National data suggests that homelessness can be a significant risk factor for both mental ill-health and suicide. The cohort did not include anyone who could be considered a 'rough sleeper' i.e. living on the city's streets and there was no one who was a resident or temporary resident at a homeless hostel.

There were, however, several people whose accommodation was unstable including people housed under very temporary arrangements; such as staying with friends or employers or where rent arrears or other difficulties were likely to result in imminent eviction.

Living situation at time of death

Living situation at the time of death was recorded for 57 of the 60 people in the York sample. 25 out of 57 (44%) were living alone at the time of taking their own life.

Figure 8: Living Situation at the time of death



Whilst living alone does not necessarily indicate social isolation it is noteworthy that almost half of the cohort were such at the time of their death. Generally the presence of supportive relationships within a home environment-family, friends or house-mates can be considered a protective factor perhaps because someone who is vulnerable has the opportunity to talk through difficulties or worries or to reduce feelings of loneliness. Conversely, where there is a lack of or limited human contact within the home or absence of interaction with people elsewhere then vulnerable people can lose a sense of perspective and the ability to rationalise or problem solve, creating a significant risk factor (Mental Health Foundation and Campaign Again Living Miserably).

In a minority of cases reviewed , the individual lived a reclusive lifestyle with little or virtually no contact with other people or services. Others became more reclusive in the days or weeks prior to their death often as a result of deteriorating mental health or drug or alcohol dependency. In the majority of cases where social isolation was considered a factor in the suicide, it was apparent that it was not an individual's deliberate lifestyle choice. Instead it was a situation brought about by circumstances beyond their control and which was clearly detrimental to their quality of life and emotional wellbeing.

There were examples in the cohort of the breakdown of a personal relationship or relationships which contributed to an absence of regular contact with family, friends or neighbours. This lack of interaction appeared to aggravate mental ill-health or feelings of loneliness or hopelessness, perpetuating seclusion and leading to suicidal ideation. The fact that in some cases the body of the deceased was not discovered for several days or even weeks after their death is a clear indication that people can live isolated, reclusive lives in a city and this negatively impacts both personal and community resilience.

Case Study

Diane, who was in her forties, had no previous history of mental health although she did self-harm on one occasion some years ago when a relationship had ended. She was not known to local services and had not seen her GP for some time. Diane was prone to periods of low mood and she frequently self medicated by drinking alcohol at levels well above recommended limits whilst not actually being dependent on alcohol. She had been in a stable relationship but her partner called an end to it unexpectedly, partly due to her drinking. Diane took this very hard and increased her alcohol intake substantially. Around a week after the relationship ended she drank excessively and completed suicide without leaving a note.

Place of birth

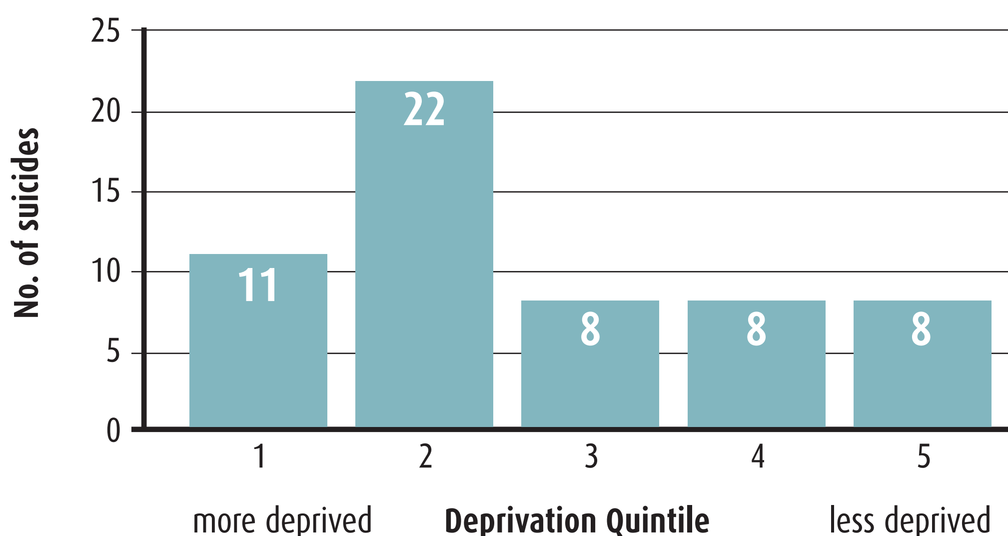
Place of birth was recorded for 58 of the 60 people in the York sample. 29 people (50%) were born in York, 25 (43%) were born elsewhere in the UK and four people (7%) were born outside the UK.

Socio-Economic Status

Deprivation is acknowledged as a factor that increases risk of suicide. The audit team considered whether the level of deprivation that a person experienced was a defining factor in local deaths by suicide and it can be shown that there was over-representation in suicides among people living in more deprived areas. However, due to the small number of cases reviewed, we cannot draw a clear conclusion from this data that locally, deprivation is a statistically significant risk factor.

- Almost 60% of people dying by suicide (33 out of 57) lived in the most deprived 40% of York.
- Almost 40% of all people dying by suicide (22 out of 57) lived in the second most deprived quintile

Figure 9: Number of suicides by deprivation quintile (York residents n= 57)



There are, however, some differences identified as part of the analysis that are worth noting. There was a difference in the age at death between those who were financially poorer when compared to those who were better off. People who died by suicide and were from poorer backgrounds, tended to die at an earlier age than those who were wealthier.

Age	Higher Deprivation	Lower Deprivation
45 and under	61%	50%
46+	39%	50%

The method of suicide seemed to differ slightly too, with people from poorer backgrounds being slightly more likely to use poisoning or hanging as methods and less likely to jump or lie before a train than people with higher incomes.

Method	Higher Deprivation	Lower Deprivation
Self-poisoning	27%	17%
Hanging/Strangulation	55%	42%
Jumping/lying in front of a train	6%	21%

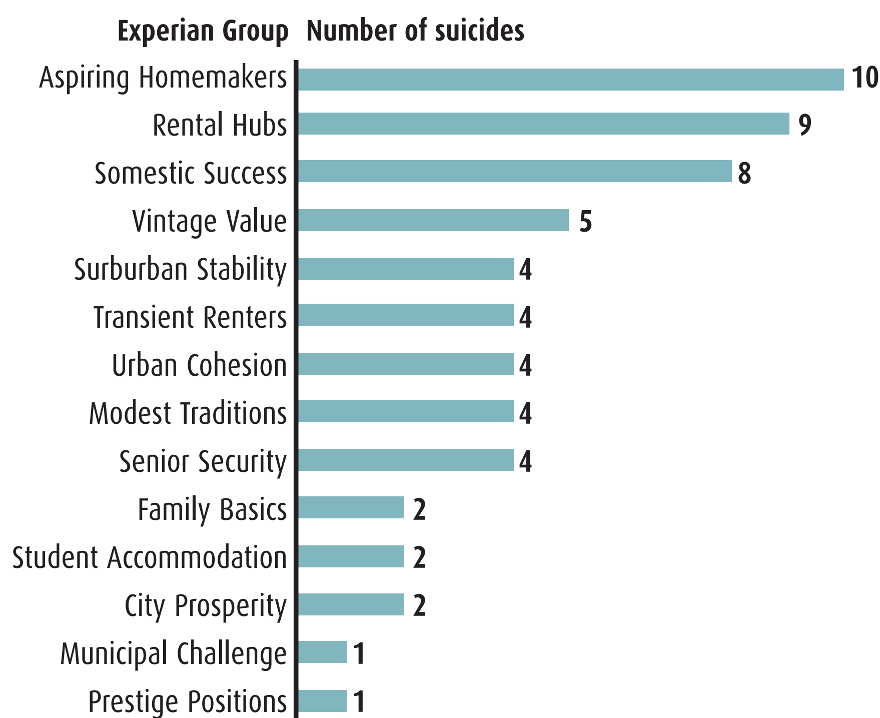
One impact of deprivation is that it contributes to negative impacts on the health and wellbeing of those who are from poorer areas. The Marmot review into health inequalities identifies deprivation as a factor in contributing to reduced mental health and wellbeing. Whilst the important negative impact that deprivation has on the health and wellbeing of York residents is acknowledged, there were no statistically significant findings as part of this audit that highlight this.

Experian Household Segmentation

The Mosaic/Experian segmentation classification divides all households into 16 high level 'groups' and 66 lower level 'types' based on a range of socio-demographic data. The postcode of residence for people in the York sample can be used to identify the household groups and types in which people lived.

Fourteen of the sixteen household groups are represented in the York sample. The household groups seen most frequently in the sample are 'Aspiring Homemakers' (10 people), 'Rental Hubs' (9 people) and 'Domestic Success' (8 people).

Figure 10: Number of suicides by Experian Household Group



Brief descriptions of the most frequently seen household groups are shown below.

- Aspiring Homemakers: Younger households settling down in housing priced within their means
- Rental Hubs: Educated young people privately renting in urban neighbourhoods
- Domestic Success: Thriving families who are busy bringing up children and following careers.

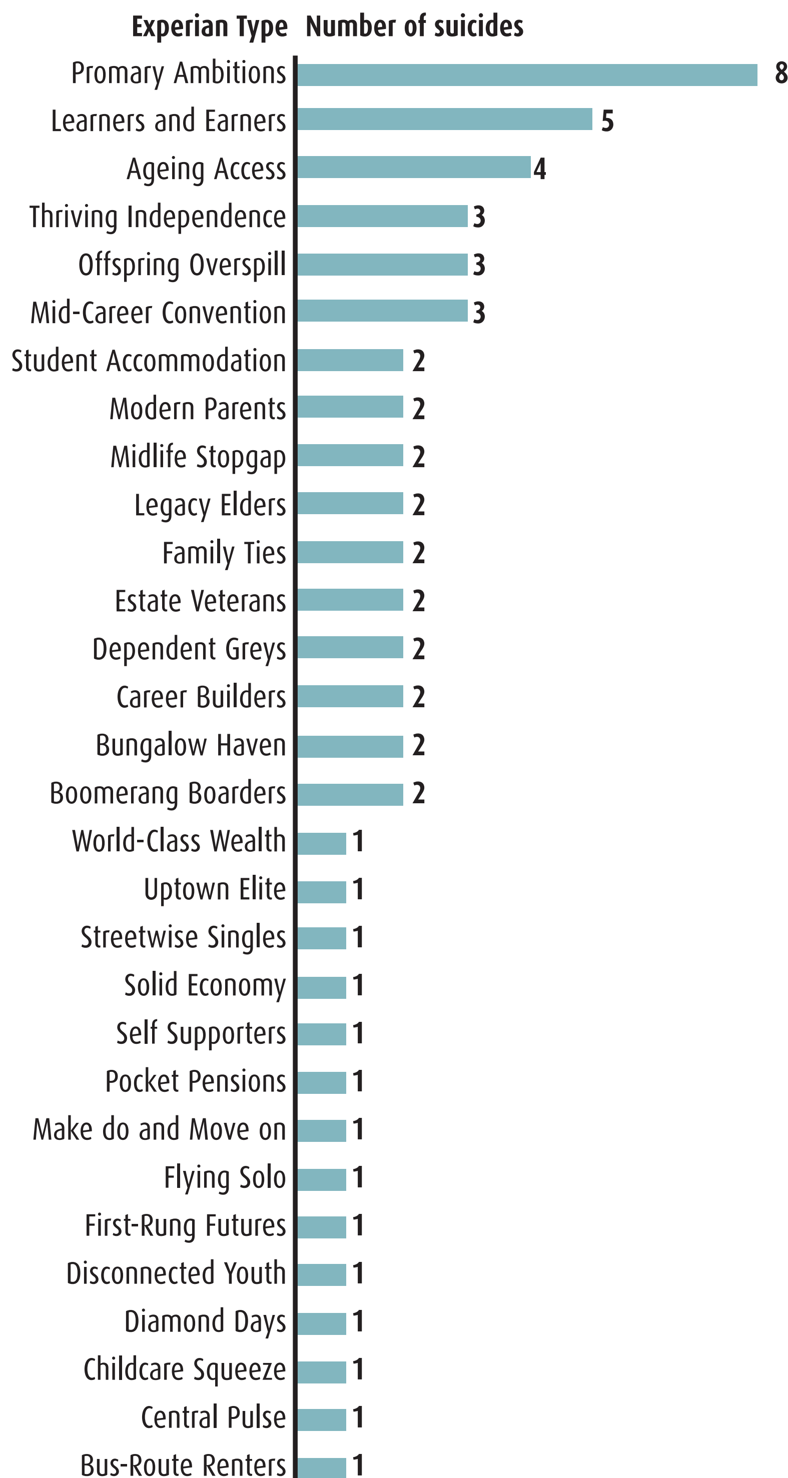
This data highlights the broad impact that suicide has across the full range of society and that suicide can affect people regardless of their socio-economic status, ethnicity or background.

Thirty of the 66 household types are represented in the York sample. The household types seen most frequently in the sample are 'Primary Ambitions' (8 people), 'Learners and Earners' (5 people) and 'Ageing Access' (4 people).

Brief descriptions of the most frequently seen household types are shown below.

- Primary Ambitions: Forward-thinking younger families who sought affordable homes in good suburbs which they may now be out-growing
- Learners and Earners: Inhabitants of the university fringe where students and older residents mix in cosmopolitan locations
- Ageing Access: Older residents owning small inner suburban properties with good access to amenities.

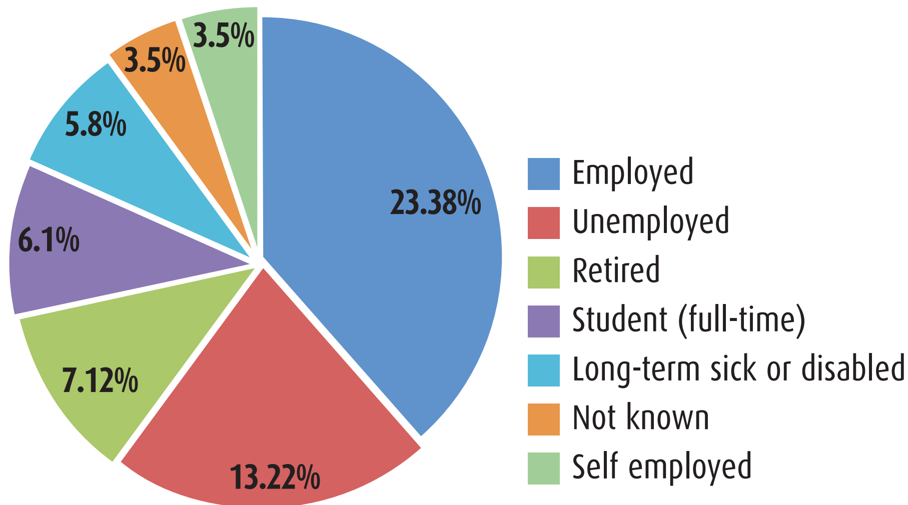
Figure 11: Number of suicides by Experian Household Type



Employment status

Employment status at the time of death is shown in the chart below. 26 people (43%) were in employment at the time of death, 13 (22%) were unemployed and six (10%) were students.

Figure 13: Employment Status

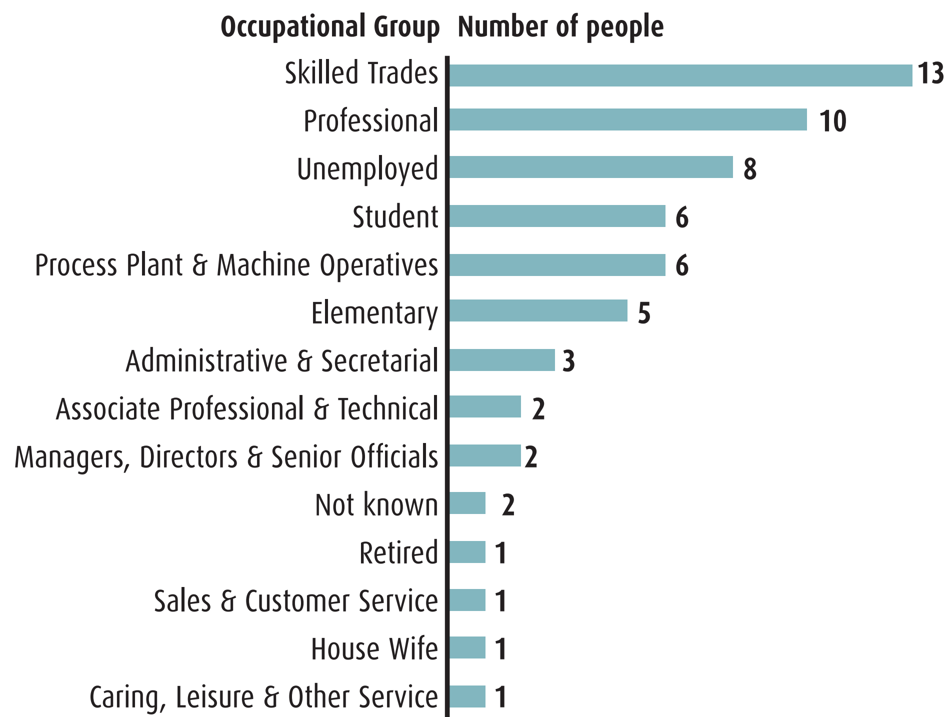


Retired people were comparatively under-represented in the York city audit. York's population in 2014 was 204,439 and people aged 65 and over accounted for 18% (36,459) of the overall population. However, a lower proportion of retired people completed suicide compared with the percentage of retired people within the general population.

By contrast in the North Yorkshire audit almost 25% of the cohort were retirees which more closely reflects their representation within the general population (People 65 and over make up 23% of the total population (137,356 of 601,536 people).

Occupation

Figure 14: Occupation groups



A wide variety of occupations and positions were represented within the cohort and no specific careers or jobs featured to indicate clear occupational risk. This demonstrates how suicide can affect people across a range of social, class, wealth and professional backgrounds.

Almost a third of the cohort were employed in jobs of either 'process, plant and machine operatives' or 'skilled trade occupations'. Whilst the sample is too small to reach clear conclusions there may well be a correlation between skilled or semi-skilled work, involving an element of manual dexterity, and suicide. This indicates a possible link to 'practical' people favouring methods of suicide which have a high lethality e.g. suicide by hanging.

It also perhaps suggests a link to traditional male orientated roles where workplace settings promote a more machismo culture thereby reducing employees' inclination to show apparent weakness or seek – or have access to - support during periods of emotional vulnerability.

There were instances in both the York and North Yorkshire audits which identified links to workplace stresses in some of the people who completed suicide.

In some cases the individual believed they were struggling with work pressures, were not well regarded or were being considered for dismissal or redundancy, often despite evidence and reassurance to the contrary.

There were instances of employees being subject to poor performance or disciplinary and misconduct proceedings which had a considerable effect on their emotional and mental health.

Some people were suspended from work and were directed not to have any contact with colleagues during an investigation (thereby perhaps causing or contributing to social isolation and reducing access to support networks). Others received notice of risk of redundancy, reduction in pay or other unfavourable work related news through formal correspondence or management contact in circumstances where support and assistance was either not offered or was declined.

It was apparent that those subject of such procedures often anticipated calamitous outcomes from them – envisioning loss of long held career opportunities, employment, financial security or status with potentially serious implications to other aspects of their life and lifestyle.

History of self-harm/previous attempt(s)

24 out of 60 people in the York sample (40%) had a history of self-harm. For fourteen of these people (23%) the self-harm had occurred within a year prior to death.

15 out of 60 people (25%) had a previous suicide attempt recorded. For seven of these people, the attempt had been made within a year prior to death.

Five people had two or more self-harm incidents within the year prior to death.

The nature of self-harm can differ markedly and is not necessarily linked to suicidal ideation or attempts. Some self-harm, even that which causes serious injury, can be conducted for reasons other than suicide.

Mental health professionals recognise that such behaviour sometimes acts as a way to prevent suicide or manage extreme psychological distress. However, it is generally accepted and highlighted in the national strategy that people who self-harm are significantly more vulnerable to suicide at some stage and the underlying causes of that harm may be similar to those which prompt suicide.

Clearly, previous suicide attempts also indicate that someone is at serious, heightened risk and it is important that such behaviour is not disregarded, rationalised or dismissed by professionals, family or friends, even if the person exhibiting the behaviour does so themselves.

Prior intimation of suicide/ideation

From the cases analysed, 52% (31 people) were known to have previously had suicidal thoughts. This was made up of: 14 people who were recorded as having expressed suicidal thoughts; 13 people who had stated suicide intent to their GP; and four people who exhibited significant behavioural

change prior to death.

There are many examples in the audit where the deceased had exhibited very clear suicidal ideation and self-harm behaviour in the days, weeks, months or years prior to their death. Some of those people had been diagnosed with significant mental health conditions, many of which were associated with suicidal ideation, and were in the care of mental health services. Those services were often aware of the general risk that the service user presented to themselves and risk management plans were in place aimed at maintaining regular contact and endeavouring to keep the person safe. Despite the efforts of services, family or friends to manage identified risk some of those community based patients made apparently spontaneous decisions to complete suicide.

In other cases, there was an apparent lack of engagement or disclosure by the patient with medical professionals where the deceased either denied or downplayed any suicidal ideation or previous attempts. The true reasons why the deceased felt unable to disclose their distress or talk about their feelings was known only to themselves although it may be speculated that this was through embarrassment, stoicism, self-denial or fear of the consequences. They might have suspected that full disclosure could lead to them being detained under the Mental Health Act or even recognised that professionals would prevent them taking the path to suicide which they had decided upon.

Social stigma in relation to suicidal thoughts can contribute to the risk by discouraging people from seeking help. It can prevent disclosure of suicidal thoughts through individuals' fear of being judged or of being detained in a mental health institution. The issues of stigma are similar to those seen in relation to mental ill-health generally and present significant challenges to those seeking to reduce risk and encourage more open communication.

Medical Conditions/Diagnoses

22 people out of 60 in the York sample (37%) had received a diagnosis of a mental illness within a year prior to their death by suicide. At the time of death, the range of diagnoses included: depressive illness (21 people, 35% of the sample), anxiety/phobia/panic disorder/OCD (15 people, 25%) and alcohol misuse (8 people, 13%).

29 out of 60 people (48%) had a physical and/or sensory disabling condition (non-psychiatric) at the time of death. 10 people were taking non psychiatric medication at the time of death.

Substance misuse history

28 out of 60 people (47%) had a history of alcohol or drug misuse (or both). For 23 of these people, the alcohol or dug misuse had occurred within a year prior to death.

20% of the deaths by suicide considered within this audit had some description of history of drug misuse recorded within the information contained in the coroner's files but only two people had been

known to substance misuse treatment services in York.

Within the information reviewed as part of the audit, a large number of people who had died by suicide had some reference to misuse of either drugs or alcohol. Alcohol use was much more commonly recorded than drug use.

Some case files clearly identified that a person had had alcohol dependency but none were currently in receipt of support from drug and alcohol services.

It is apparent that substance dependency or near dependency featured as a prevalent factor in their lives and contributed to the challenging conditions they found themselves in.

Alcohol consumption in particular appeared to present as a significant risk factor to many. This was either seen in the way it resulted in or aggravated other stresses (such as mental ill-health problems, loss of employment or relationship breakdown) or the effect that heavy consumption had on an individual's cognitive functioning and decision making immediately prior to their death which precipitated their suicide.

Both long term alcohol misuse and 'binge drinking' sessions presented significant risk and many of the deaths appear to be directly or indirectly related to alcohol use in some way.

Of particular significance is the fact that so many people would in all likelihood have been diagnosed with an alcohol use disorder by a medical professional had they engaged with services and disclosed their alcohol use.

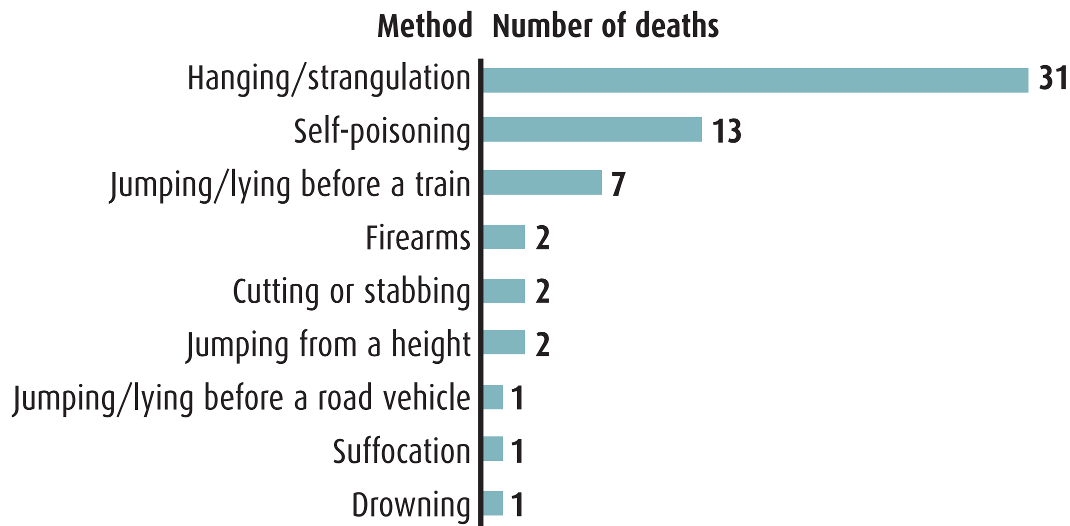
From the evidence considered as part of the audit process, many of those who died had what was likely to be a daily alcohol intake which could indicate some level of possible alcohol dependency. The actual level of alcohol use might often only be known to close family members, friends or the person themselves. Some however had been diagnosed with alcohol use disorder by their GP and were either attempting to manage it with treatment or had disengaged, declined or discontinued treatment. Whilst the long and short term health risks associated with excessive alcohol consumption are well known to medical professionals and widely publicised to the public the strong correlation between alcohol use and suicide may not be as widely recognised.

Suicide Event

Method

The most common methods of suicide in the York sample were hanging/strangulation (31 people, 52%) self-poisoning (13 people, 22%) and jumping/lying before a train (7 people, 12%). The methods did not vary between men and women.

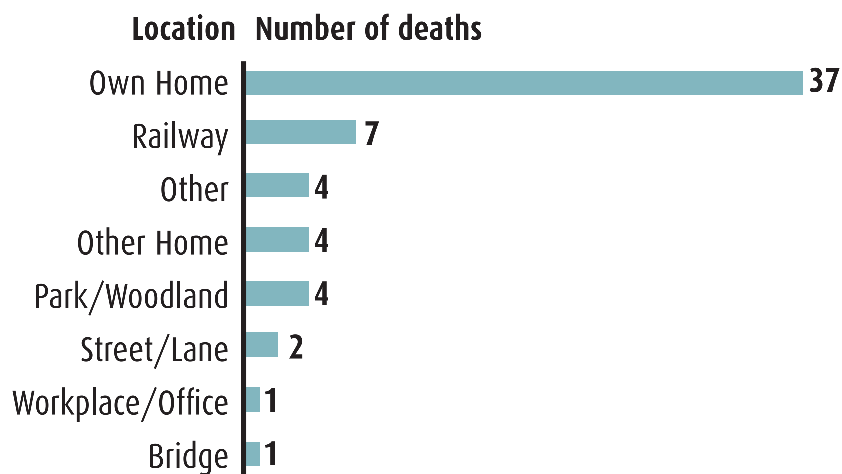
Figure 12: Method of suicide



Incident/event location

The majority of suicide incidents took place in the person's own home (37 incidents, 62%). Seven incidents took place on the railway (12%).

Figure 13: Incident/Event Location



One of the most effective means of reducing suicide is to 'reduce access to the means'. This is one of the key areas for action in the national strategy and includes initiatives such as:

- Limiting the volume of tablets or medicine available on prescription or for sale over the counter and curtailing the availability of certain drugs which have identified links to suicide
- Erecting signs or posters at public hotspot locations such as bridges which encourage help seeking or increase the likelihood of third party intervention
- Encouraging individuals disclosing suicidal ideation to relinquish the tools with which they have contemplated using such as knives, poisons or ropes
- Reducing ligature points in hospital wards, prisons or police cells and securing doors, windows or structures which facilitate access to heights
- Reducing the availability of pro-suicide websites and books or instructional literature which provides sources of information on methods of suicide.

A significant challenge in relation to this approach is presented by the fact that 'hanging and strangulation' is by far the most prevalent method of suicide nationally and this was reflected in the cases considered for York.

Reducing access to the means of hanging and strangulation within the home is particularly difficult in view of the range of commonly available implements which can be used and the likely levels of privacy which reduce the chances of third party intervention. The situation is intensified by general public perception, re-enforced by portrayals in the media and on television and film drama that hanging is the most efficient, effective and relatively pain free method of completing suicide.

This may well be untrue and there are common reports of significant physical injury or brain damage arising from unsuccessful attempts at suicide by hanging which cause long term disability, life-limiting or capacity limiting effects.

At a national level the need to change public perception in relation to the effects of hanging is recognised. Local suicide prevention plans needs to acknowledge and be realistic about the likelihood of direct influence in this specific area and that the emphasis should be about endeavouring to ensure people are less inclined to complete suicide and therefore not need to consider effective methods of doing so.

This demonstrates that an effective prevention strategy considers all areas of positive action at both an individual level by seeking to prevent individual deaths and at a population level by improving general levels of resilience and support service provision.

Case Study

Marco was in his thirties and from Eastern Europe. His wife remained in their home country with their child and he sent money back for them. He worked as a joiner and shared a house with some work colleagues from a variety of countries. Marco became increasingly withdrawn and took time

off work claiming to be sick. His housemates noticed that he began to behave very much out of character and appeared paranoid that neighbours and the landlord were entering the property and removing things from the house. He began locking himself in his room for several days at a time and came out only occasionally to eat or to receive a delivered package. He ordered a book online which detailed various ways in which to complete suicide. During an occasion of his self isolation, he took his own life whilst in his room using one of the methods described in the book. He left a note in his native language which was jumbled and incoherent saying that he'd been told he had to die by voices in his head.

Suicide note

A suicide note was left by 32 of the 60 people who died (53%). 26 of these notes were handwritten and the remainder were sent by text (2), computer/email (2) and social media (2). 56% of men (28/50) left a suicide note compared to 40% (4/10) of women.

Whilst the majority of suicide notes were hand written their nature, content and length varied considerably. A number of notes were written well in advance of the completed suicide, some lengthy and clearly considered, demonstrating a clear, long-held commitment to that course of action. Typically these related to people with long term mental ill-health problems who had struggled with suicidal ideation for some time but it also included people more recently diagnosed with terminal or life-limiting illness.

Others contemplated the difficulties associated with increasing old age, illness or disability and stated their desire to avoid the worsening impact on themselves or the burden on their loved ones. Many of the notes, short or long, gave some indication of the triggers for suicide in messages to family, friends, employers or neighbours.

Some cited specific reasons such as relationship breakdown, bereavement, long term or acute illness or physical pain whilst others simply suggested an inability to tolerate further mental anguish, stress or difficult circumstances without further explanation.

The section below provides an indication of the level of alcohol consumption amongst the cohort at the time of death and many of the notes left appeared to be written whilst their authors were under the influence of alcohol. Many were short, apparently hastily written notes which often offered an apology or sought forgiveness either for the suicide itself or for the deceased's previous behaviour or perceived failures. Friends, families and professionals were frequently thanked for their love or support by individuals who insisted that suicide was the only choice available to them.

The fact that someone did or did not leave a suicide note and the general contents of those notes do not in themselves provide a greater insight of how to prevent suicides.

What perhaps is indicated though is the extent of apparent pre-planning in comparison with those events which appeared to be relatively spontaneous.

Many people had clearly previously or regularly considered suicide and some may have intimated this to others. It seemed that for many people though the final decision to die by suicide was made on the spur of the moment, at a time when they were affected by alcohol or drugs or when they had simply lost a sense of perspective on the issues they were facing.

People completed suicide during periods and even particular times when their resilience was at its lowest level and when accompanied or combined with other short term risk factors such as heavy alcohol or drug consumption which, if experienced separately, might have had a different outcome. There is a view that people who are prone to more spontaneous behaviour as opposed to those who ruminate may be at more risk of completing suicide and there were indications of this in the audit.

Alcohol/non prescribed drugs taken at the time of death

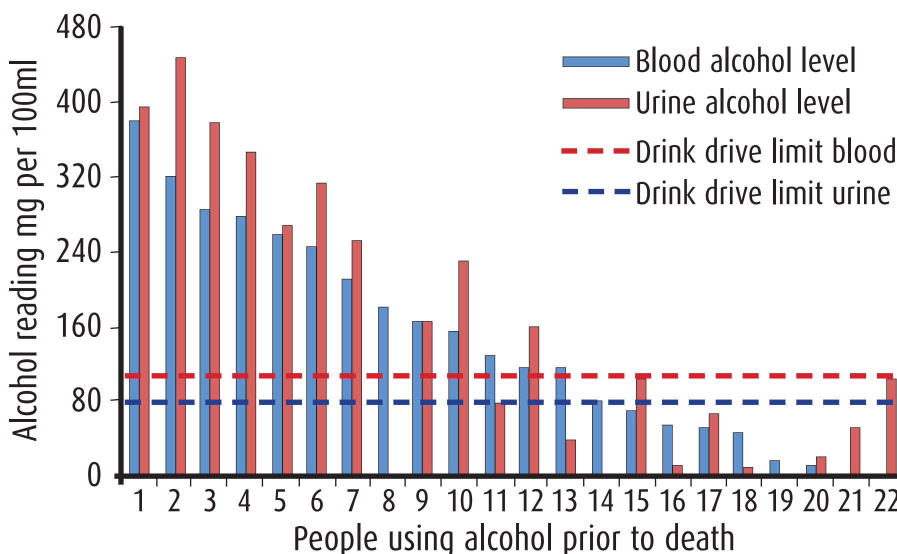
22 out of 60 people in the York sample (37%) had taken alcohol prior to their death based on information in the coroner's file. Blood and/or urine alcohol levels for these 22 people are shown in the chart below. 14 people were over the drink drive limit and seven of these were heavily intoxicated at the time of death[2].

[2] In the UK the drink driving limit is: 35 micrograms of alcohol in 100 millilitres of breath; or 80 milligrams of alcohol per 100 millilitres of blood; or 107 milligrams of alcohol per 100 millilitres of urine.

Table 2: Alcohol levels for those who had taken alcohol prior to death

Person	Blood alcohol level	Urine alcohol level	Level of alcohol
1	n/a	52	below the drink drive limit
2	n/a	20	
3	18	n/a	
4	49	10	
5	51	68	
6	55	13	
7	71	104	
8	n/a	105	
9	82	n/a	over the drink drive limit
10	115	38	
11	116	160	
12	130	78	
13	156	231	
14	165	166	
15	182	n/a	
16	210	252	significantly intoxicated
17	246	313	
18	258	268	
19	278	347	
20	285	378	
21	321	448	
22	380	395	

Figure 14: Alcohol levels for those who had taken alcohol prior to death



In addition to blood analysis results, tests indicated that five people had taken non prescribed drugs prior to death. This included cannabis, opiates, stimulants and pain killers.

The number of people where alcohol was a contributing factor in the death compared to drug use was far more common.

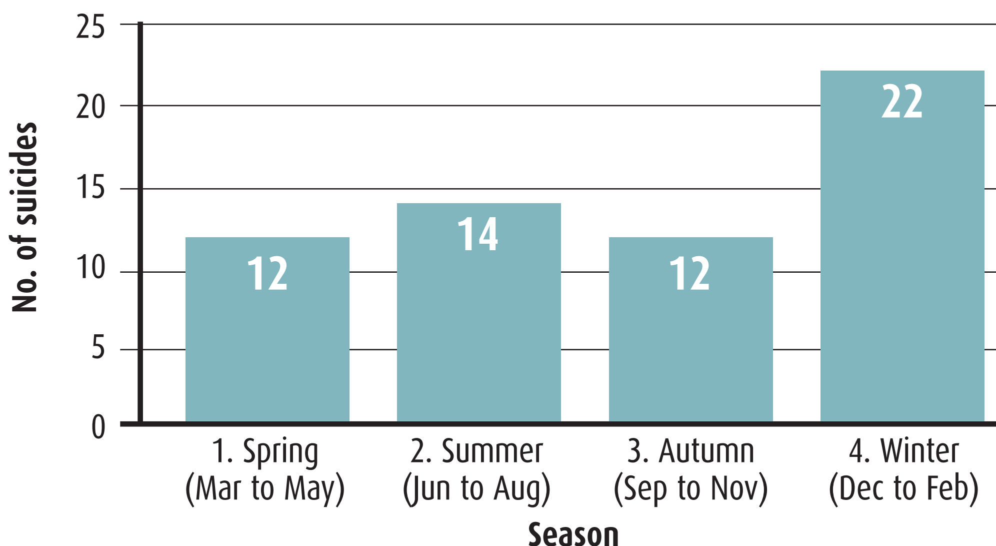
Case Study

Janine's daughter was killed in a road collision three years earlier and she had struggled to overcome her grief. She began to drink excessively which aggravated her depressive moods. Janine was in her fifties when she lost her job as a result of her drinking and sickness record and was referred to alcohol treatment services by her GP due to the amount she was drinking. She attended some talking therapy sessions to support her mental ill-health which helped. One day though she drank excessively and took her own life at home leaving a note to say she was sorry but could not cope with life without her daughter

Suicide event by time of year

Suicide events in the York sample took place fairly evenly throughout the calendar year but the highest number occurred in the winter months (December to February).

Figure 15: Season of Suicide Event



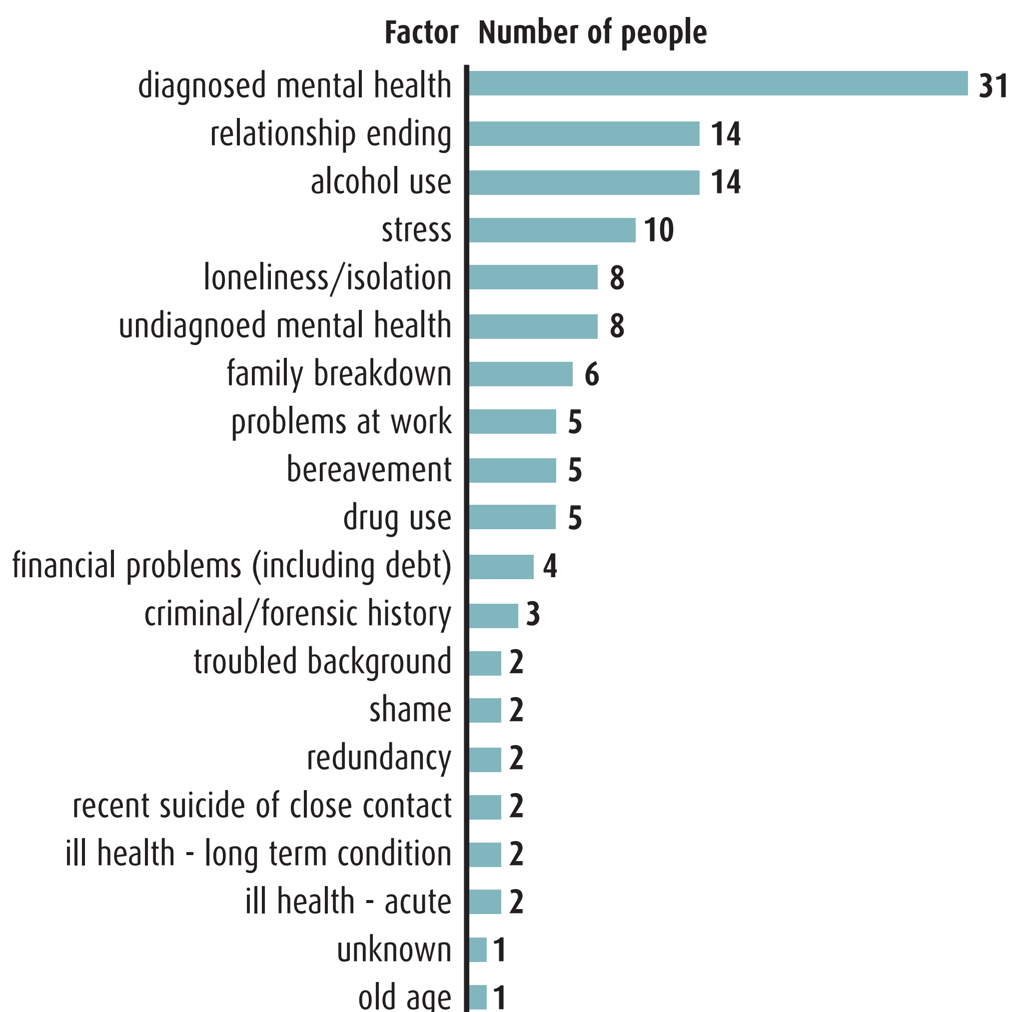
Prior intimation of suicide/ideation

For over half of the York sample (31 people out of 60, 52%) there were warning signs/evidence of risk prior to suicide. 13 people were recorded as having explicitly stated suicide intent, 14 people were recorded as having expressed suicidal thoughts and four people had significant behavioural change recorded prior to death.

Triggers/ factors contributing to suicide

Based on the contents of the coroner's file, the key factors contributing to the suicide were identified by the auditor, using a pre-determined list. An average of two factors per person was identified. The main factors were: diagnosed mental health condition (31 people, 52% of cases); relationship ending (14 people, 23% of cases), alcohol use (14 people, 23% of cases); stress (10 people, 17% of cases); loneliness/isolation (8 people, 13% of cases) and undiagnosed mental health (8 people, 13% of cases).

Figure 16: Risk Factors contributing to suicide



The most common combination of risk factors were: diagnosed mental health with loneliness and isolation (5 people); with stress (4 people); with bereavement (4 people); and with alcohol use (4 people).

Table 3: Common combinations of risk factors

Combinations of risk factors	No. of people with this combination
Diagnosed mental health / Loneliness - isolation	5
Diagnosed mental health / Stress	4
Diagnosed mental health / Bereavement	4
Diagnosed mental health / Alcohol use	4
Diagnosed mental health / Relationship ending	3
Undiagnosed mental health / Alcohol use	2
Undiagnosed mental health / Stress	1

Thematic Analysis

A separate process of identifying themes contributing to suicide was undertaken using the notes section of the audit template.

This process enabled the audit team to identify a more complete range of themes based on the full range of written information contained within the files.

This process allowed the audit team to identify common themes in the case files for each person and identify the potential risks or contributing factors in a much more comprehensive way that allowed more detailed consideration about whether risk factors were recurring themes for a person or how several independent risk factors might be combined together. This identified a greater number of risk factors than the method of using a pre-defined list to assess risk factors and allowed instances of a theme to be identified multiple times. This process also identified a different combination of risk factors being more prevalent.

The themes identified are shown in the table below.

Table 4: Themes contributing to suicide.

Theme	No.
History of self-harm/suicide attempts	48
Mental ill health (diagnosed)	43
Loneliness and isolation/lack of engagement	31
Mental ill health (undiagnosed)/emotional distress	29
Family/relationship problems	28
Substance misuse	25
Criminality	18
Bereavement	17
Work issues	15
Physical health problem	16
Behaviour change	9
Financial problems	8
Carer	3
Sexuality	1
Veteran	1

Table 5: Combination of themes contributing to suicide

Combination of Themes	No.
History of self-harm/suicide attempts and Mental ill health (diagnosed)	19
History of self-harm/suicide attempts and Family/relationship problems	16
Mental ill health (diagnosed) and Loneliness and isolation/lack of engagement	15
History of self-harm/suicide attempts and Substance misuse	14
Mental ill health (diagnosed) and Mental ill health (undiagnosed)/emotional distress	14
History of self-harm/suicide attempts and Mental ill health (undiagnosed)/ emotional distress	11
Mental ill health (diagnosed) and Family/relationship problems	11
Mental ill health (diagnosed) and Substance misuse	8
History of self-harm/suicide attempts and Physical health problem	5

Using this method of analysis, the most common risk factor is identified as history of self-harm or previous suicidal attempt.

A detailed breakdown of what was included within each theme is provided below.

Table 6: List of Themes and Sub-Themes

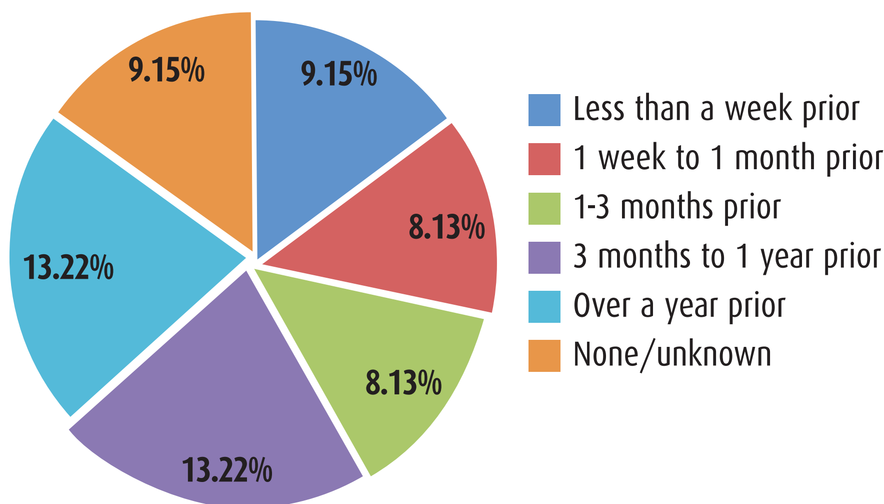
Theme	Sub-Themes
Family/ relationship problems	Childhood experience of being in care, childhood experience of abuse, experience of domestic abuse, spouse suffered mental ill-health, no family support network, plans to end relationship, recent divorce, relationship problems, family problems, family history of mental ill-health, relationship ended, relationship breakdown, ex-partner entered new relationship, childhood experience of family breakdown
Behaviour change	Not coping with change to circumstances, Accusations of inappropriate behaviour, Behaviour change prior to suicide, Change in circumstances
History of self-harm/suicide attempts	Previous suicide attempt, risky behaviours reported, previous threat of self-harm, previous suicidal ideation, safeguarding and vulnerability concerns, history of self-harm, threatened suicide, planned suicide in advance, poor Self-care, threatened suicide, lack of self-care, previous suicide attempt – multiple, suicidal thoughts, at risk of suicide, lied about herself, thoughts of self-harm, recent self-harm
Bereavement	Suicide of friend, Recent miscarriage, Bereavement, Suicide of partner, Suicide of family member, Loss
Mental ill-health (diagnosed)	Accessing telephone support, history of detention under mental health act, history of mental ill-health, history of mental ill-health – anorexia, history of mental ill-health – anxiety, history of mental ill-health – depression, history of mental ill-health - low mood, history of mental ill-health - specific disorder, history of mental ill-health – ocd, history of mental ill-health – schizophrenia, mental ill-health – anxiety, mental ill-health - depression and anxiety, mental ill-health - low mood, mental ill-health - social anxiety/agoraphobia, mental ill-health, mental ill-health - depression
Mental ill-health (undiagnosed)/ emotional distress	End suffering, ex-partner entered new relationship, feelings of guilt, felt unloved, identified as not coping, low mood, low self-worth, perception that 'let people down', poor quality of life, problems coping with feelings of guilt, problems coping with perceived failure, stress, suicide followed argument, suicide was a response to perceived social shame, unable to cope with bereavement, unable to cope with change in circumstances, unable to cope with loss, unable to cope with redundancy, unable to cope with relationship ending, undiagnosed mental ill-health, worried about lack of success/failure
Financial problems	Debt, experience of poverty/deprivation, financial problems, gambling addiction

Carer	Carer
Work issues	Employment problems, long-term sickness absence from work, loss of employment, recently started new job, redundancy, relationship problems – colleagues, resigned from job, sickness absence from work, suspension from work, work related stress
Substance misuse	Alcohol addiction, alcohol dependency, alcohol misuse, gambling addiction, history of alcohol dependence, history of binge drinking, history of drug use, history of drug use – cannabis, history of substance misuse, relapse from drug recovery, substance misuse

Prior contact with services: Primary care

The chart below shows the most recent contact with primary care prior to death by suicide amongst the 60 people. 38 people (63%) had a recorded visit to the GP in the year prior to death. 25 people (42%) had a recorded visit less than three months prior to death and 17 of these people saw their GP in relation to mental health. Nine people saw their GP in the week prior to death (7 for mental health).

Figure 17: Breakdown of most recent contact with primary care prior to death by suicide



22 people had seen their GP for mental health problems in the year prior to death and seven of these people had attended five or more times in that period.

For two people, clear suicide intent or suicide plans were documented by the GP. For another 12 people the GP had documented that thoughts and ideas about suicide had been expressed but without intent or plans.

24 people (40%) from the 60 self-harmed. 13 of those people (22%) were treated in hospital due to their injuries within the year prior to death.

Mental Health Services

31 people (52%) had taken up psychiatric treatments in the 12 months prior to death. The broad types of treatment were: prescribed medication (28 people); talking therapies (11 people) and social interventions (2 people).

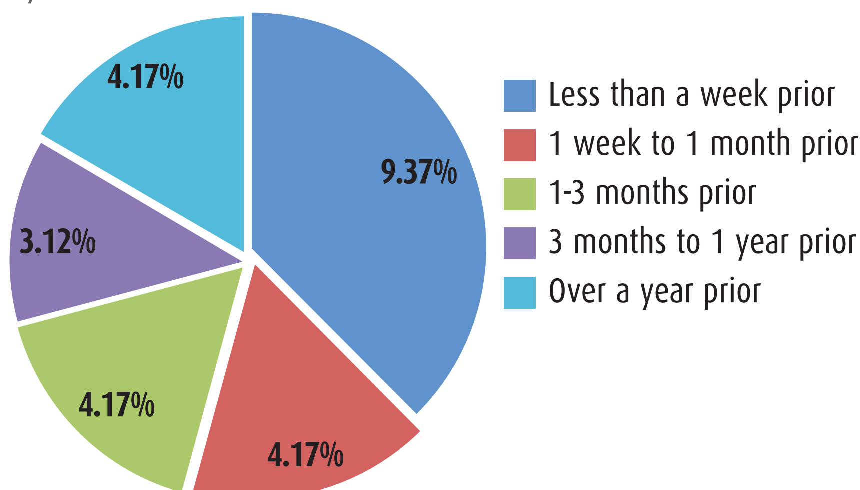
11 people were recorded as having declined some form of psychiatric treatment in the year prior to their death. Information on adherence to medication/treatment plans in the year prior to death was recorded for 21 people and 17 of these did not adhere to their plan.

24 people (40%) had contact with specialist mental health services in the year prior to death and nine of these had contact in the week prior to death. A further three people were referred but not seen. The majority of people (17) had contact as part of ongoing treatment but seven people had a one off contact. The majority of contacts were community based or outpatient appointments.

Case study

Dora who was in her late 20s was diagnosed with Bi-polar disorder some years ago and had previously been detained under the Mental Health Act. She had a history of self-harm by cutting some of which was severe. She was in a long-term, stable relationship and had an active social life with a good job arising from strong academic attainment. She did not take drugs or drink alcohol to excess. Dora had recently been admitted to a mental health hospital as a voluntary patient having expressed suicidal thoughts after her beloved Collie dog has been knocked down by a car. As a result of appearing to respond well to treatment and providing reassurance that she was no longer contemplating suicide Dora was permitted a short period of home leave. She took her own life in a public place not far from her home when she was left alone briefly by her partner. She did not leave a note.

Figure 18: Breakdown of most recent contact with specialist mental health services prior to death by suicide.



Emergency Department

17 people (28%) had attended the Emergency Department in the year prior to death and 12 of these had attended in the three months prior to their death. This figure may be higher in view of the potential for treatment or episodes to be omitted from Coroners' files. Whilst some of those seeking treatment may have been known to mental health services or primary care with identified suicidal ideation or self-harm, others may not.

The Emergency Department visit, particularly if in connection with a suicide attempt, self-harm or mental health crisis may have been the first and perhaps only indication of the patient's vulnerability to suicide.

The attendances were for a mixture of physical and mental health reasons. Six people were admitted to hospital following the emergency department attendance. Seven people had elective hospital admissions in the year prior to death and two of these were for mental health issues.

There is insufficient information available to identify any patterns in relation to reasons for attendance or outcome. However, 11 of the 60 people attending had a history of self-harm and 31 of the 60 had a diagnosed mental health condition.

Emergency Departments have an important role to play in identifying and responding to risk when people present in distress, with mental health conditions or due to self-harming injury.

Other Agencies Involved

The Coroner files indicated that 17 people were involved with other agencies in the 12 months prior to their death. The main services recorded were substance misuse services (6 people), social services (4 people) occupational health (4 people) and the faith community (3 people).

Cross referencing with other data sets

To obtain further information for the audit, the details of the York cohort were cross checked against local client databases for substance misuse, adult social care and council house tenants. North Yorkshire Police also checked the details of the York cohort against their records and provided an aggregated summary of contact history with the criminal justice system.

Substance Misuse

Four people from the case files reviewed had a substance misuse treatment record. None were in treatment at time of death, having been discharged between five and 18 months previously. In three cases alcohol/drug use was already flagged in coroners file (although known drug was not referenced in one case). In one case, alcohol/drug use was not recorded in the Coroners file despite being known to be an issue to at least one other service.

This does indicate some discrepancies between the information known to local services and that which was known to the Coroner.

Previous analysis showed that 28 out of 60 people (47%) had a history of alcohol or drug misuse (or both) and that for 23 of these people, the alcohol or drug misuse had occurred in the 12 months prior to death. However, only four people had a substance misuse treatment record which suggests a lack of engagement with treatment services but those people who may well have benefited from such treatment.

Adult Social Care

20 people had a record on the York Adult Social Care database (as customers rather than as carers). 10 people had open episodes prior to their death which means they had some form of need identified by Social Care Services. These were: disabled blue badge (5); mental health services (3); safeguarding (2); occupational therapist (1); warden call (1) and telecare (1).

Seven of the 10 people were identified with specific support needs that showed six people were classed as having a physical disability, frailty or sensory impairment and the other person was classed as ‘vulnerable’.

City of York Council Housing Tenants

Three people from the cohort were City of York Council housing tenants at the time of their death and three more had previously been tenants some years prior to their death.

Overall, 13 people were current customers of City of York Council at the time of death as either tenants or Adult Social Care customers.

'The extent and nature of contact by Adult Social Care with the deceased varied considerably from individual to individual. The majority involved cases which had been 'closed' some time prior to the death. Of those, four cases involved assessment of individuals where following assessment –in some instances by an Approved Mental Health Professional- it had been determined that no further action was necessary at that time. One case involved a recent social care assessment where no further action was taken as a result of a transfer to a care facility. Another related solely to a disability Blue Badge application.

Of those cases where the status was still classed as 'open' at the time of death one involved a person who was in receipt of a health related service albeit there had been no indication of safeguarding or mental health concerns. Two cases involved referral to mental services- one very recent and at allocation stage –without ongoing involvement of social care.

Contact with the police

43 people (72%) had previous contact with the police as victims, persons reporting, suspects, offenders, witnesses and subjects (e.g. concerns for safety or missing person). 37 of these had some form of contact with the police in the 12 months prior to their death.
The table below shows that the main types of police contact were subject of concern for safety/ person (18 people); arrest (13) and victim (8).

Table 7: Type of Police Contact for York Cohort

Type of Police Contact	No.
Subject - concern for safety/missing	18
Arrest	13
Victim	8
Suspect	4
Warning	3
Witness	3
Detained under s.136 Mental Health Act	1
Person reporting	1
Stop and Search	1

13 people came to the attention of the police in the week prior to their suicide and six of these were reported as missing from home and categorised as high risk.

Two people were arrested within the 24 hours prior to their deaths and for another person, an arrest was imminent but not carried out due to their suicide. One person had also been arrested in the week prior to their suicide and another person had been arrested a few weeks prior to their suicide. Four people were due to appear in court within two weeks of their suicide, including two who were due in court on the day of their death.

13 people had 'police markers' which highlight information that should be brought to the attention of officers when dealing with those individuals. The most frequently occurring markers were 'ailment' (9 people); 'suicidal' (5); 'drugs' (5); 'weapons' (5) and 'mental disorder' (4).
In addition to the five people with suicide 'markers' eight other people had previously come to the attention of the police as suicidal, including previously attempting suicide.

Case study

Callum had a good job some savings and was in a new relationship which was going well. He had a close circle of friends and was considering buying a house because he had been offered a promotion. He'd never suffered with any mental ill-health or substance abuse issues and had never been in trouble with the police. One day he was arrested at work on suspicion of downloading indecent images of children. The police seized his personal laptop and his mobile phone after searching his home address. Whilst in police custody Callum was offered the chance to speak with a doctor but he declined. He also said he didn't want anyone informed of his arrest. The police established that Callum's niece was temporarily staying at his home address and so he had to find an alternative place to stay on his release from custody on bail. He spoke with a friend and explained that this was all a misunderstanding and that he was not being charged. The friend agreed for him to be bailed to his address. Callum left the police station and did not have the means to contact anyone as the police had his phone. He was aware of the images that the police would find on his laptop and that it would lead to a prison sentence. He realised that his new relationship would end and that his parents would insist he left their house. That evening, he wandered around the city for several hours and drank excessively in a pub. He took his life that night after booking into a hotel.

General contact with agencies

Taking into account information obtained from the coroner's files and cross referencing with other client databases, 51 out of the 60 people (85%) had some recorded contact in the 12 months prior to their death with at least one of the following: GP, psychiatric treatment services, emergency department, , adult social care, City of York Council housing team, elective hospital admission, criminal justice system and substance misuse treatment services or 'other support services' Nine people (15%) had no recorded contact with any of the above. This was a slightly younger cohort with an average age at death of 32.3 years compared with the age of those who had been in contact with some agency in the last year (44.6 years).

Conclusions

This analysis of York suicides is based on a relatively small sample of deaths over a five year period and this inevitably places some limits on the number of clear conclusions that can be drawn from the audit. Whilst findings from this audit do not necessarily reflect the full picture of suicide past and future in York, they do allow a comprehensive analysis of suicide, the risks and contributory factors that led to the death of those 60 people between2010-2014.

National research suggests some groups are at higher risk of suicide when compared to the general population but these were not notably represented within the local audit e.g. people who are lesbian, gay, bi-sexual or transgender or those going through a period of uncertainty or questioning about their sexuality.

The city is also home to others at recognised raised risk such as offenders recently released from prison and ex-forces personnel, particularly early leavers.
Guidance discusses emerging issues such as the influence of social media and so called 'cyber-bullying', which whilst not revealed as prominent issues by the audit are clearly very current, influencing factors within our communities, particularly amongst the younger generation and potentially those groups which are at higher risk.

In addition to the range of risk factors that Public Health England identify, this audit identified that the presence of a diagnosed mental health problem or undiagnosed mental distress combined with a history of self-harm or previous suicide attempts is a common combination of risk factors for the people in York who died by suicide. Alcohol was also identified as a risk factor and when used at a time of emotional distress it might have the effect of impairing judgement and influencing a decision towards suicide.

Whilst the sample in the York audit was relatively limited there are clear themes and commonalities in the lifestyles and risk factors amongst those who chose to complete suicide.

Those at highest risk appear to be:

- Men approaching and in middle age, particularly those aged between 40-55 years old
- People with diagnosed mental ill-health particularly that which is:
  - Border-line Personality Disorder (BPD) schizophrenia, Depressive illness, acute anxiety, Post Traumatic Stress Disorder(PTSD)
  - Untreated
  - Recently diagnosed and so not yet subject to effective treatment
  - Inconsistently treated due to lack of or limited engagement by the patient with services and/or non-compliance with medical/treatment plans
  - Recurring, having been previously treated but not recognised or responded to by the sufferer or services
  - Considered mild depressive illness or anxiety, managed by primary care where the patient may not fully disclose the severity of their low mood or suicidal ideation

- People with symptoms of undiagnosed mental ill health, particularly depressive illness and anxiety which is not recognised, disclosed or managed by the person affected and which leaves them vulnerable in the event of compounding life stresses
- People who have previously self-harmed, attempted suicide or experienced suicidal ideation
- People who are drug or alcohol dependant or who regularly use substances, particularly at times of combined life stresses or linked with mental ill-health (dual diagnosis). This includes people who may not be dependent drinkers or drink regularly to excess but who on occasion 'binge drink' particularly if linked to or brought on by periods of low mood/depressive episodes precipitating a spontaneous, alcohol fuelled decision to complete suicide
- People experiencing multiple life stresses either simultaneously or successively over a long, medium or short time frame particularly if linked to or aggravated by mental ill-health. Such stresses include bereavement or other significant loss, breakdown of intimate relationships, particularly if acrimonious, unwanted estrangement from family or children, unmanageable debt, business failure, insecure accommodation or employment, workplace stress particularly related to performance issues or disciplinary action, loneliness and social isolation, behaviour and mood changing addictions including gambling
- People who have experienced or witnessed significant trauma such as sexual abuse, domestic violence, others' suicide or violent death including those who come into professional contact with victims or such incidents
- People who have been in recent contact with the police, particularly where an arrest, charge or conviction is likely to have catastrophic consequences to their lifestyle, relationship, status, employment or liberty. At particular risk are those arrested or charged and granted bail in relation to offences concerned with Indecent Images of Children (IIOC)
- People who have long term, acute or debilitating physical health conditions particularly if linked to an onset of depressive illness, diagnosis of terminal illness or if the condition causes a significant change to quality of life or perception of what the future holds.

Whilst there might be a belief that professionals including GPs, social workers, health visitors, police officers, nurses and other public sector workers are those who will be best placed to identify people at risk of suicide, there are still people who complete suicide who did not have any contact with these professionals or services.

Approximately 15% of the deaths considered by this audit were of people who had no known contact with any services or public sector workers in the weeks and months prior to their deaths. This makes it important to consider how we can work with people and communities to better identify and support those who might be at risk of suicide.

Risk factors are wide ranging but often include significant life changes such as new or recurring mental health problems or emotional distress, family or relationship problems, new or recurring substance misuse problems, bereavement, work related problems, or physical health issues. The Faculty of Public Health's "Better Mental Health for All" report identifies that experiencing two or more adverse life events in adulthood can be associated with developing mental health problems and for some this can have a cumulative effect following on from adverse life experiences in childhood.

There is a growing body of evidence which identifies that communities can act as assets in many ways and can help to support individuals' positive health and wellbeing through factors such as social inclusion and positive social networks. The 'Fair Society, Healthy Lives' Marmot review into health inequalities identified the important role of communities in supporting physical and mental health and that physical and social characteristics of communities and how able a community is to support and promote healthy behaviours can have an impact on wellbeing related inequalities.

It is very difficult to predict which individuals affected by significant or multiple life stresses or exhibiting consequential harmful behaviours will be the ones who attempt or complete suicide. Many people experiencing one or more of those life stresses and engaging in harmful behaviour may be included in an identifiable 'suicide high risk group' but may never contemplate taking their own life. Others affected may not behave out of character, continue to present as they always have despite their inner turmoil and then unexpectedly die by suicide. Any strategy or action plan which aims to reduce suicide must consider a more holistic approach by seeking to find ways to mitigate the effects of common life stresses affecting the wider population whilst at the same time seeking to support those who are known to be at higher risk.

Recent Developments

By the time this audit was undertaken all of those deaths reviewed had occurred between eighteen months and five and a half years previously.

Some of the incidents had been subject to serious incident review processes by services which had some level of contact with, or responsibility for the deceased prior to their death.

Hence in some cases the coroner's files included reports detailing formal investigations into the circumstances of individual deaths produced internally by service providers or by national bodies such as the IPCC or the Health and Safety Executive.

In the majority of cases those reports contained 'lessons learned' recommendations which were subsequently, and for the most part, introduced and embedded into the policies and operating procedures of the organisations concerned.

As a result, some of those policies and procedures or lack of such which may have been identified through the audit as gaps or areas of increased organisational risk may well have now been addressed.

Similarly, national or local policies or initiatives specifically relating to mental health and suicide prevention or improved support have been introduced by a number of organisations in direct response to the recognised risk and the effects of suicide amongst certain groups or sections of the population.

These include initiatives such as:

- Emergency Psychiatric Liaison Service: Support arrangements available to people presenting to the emergency department in emotional distress.
- Co-ordinated, collaborative working between Samaritans, Network Rail and BritishTransport Police to reduce incidents of suicide on the national rail network.
- Facing the Future: A national three year pilot of collaborative working between Samaritans and Cruse Bereavement Support to provide peer support counselling sessions to people bereaved through suicide. One of the pilot areas is York
- Ways to Wellbeing Social Prescribing Pilot: A pilot programme that provides social prescribing interventions through York CVS to patients referred from some GP practices in York
- YorWellbeing Service: A service under development which will support people to improve physical and mental health and wellbeing which aims to prevent ill-health – both physical and mental.
- Firearms Licensing: In April 2016, the Home Office and British Medical Association introduced national updated guidance to ensure that GPs are cognisant of the fact that a patient may be a shotgun or firearms certificate holder and therefore have access to weapons. GPs are advised to liaise with the local police service to ensure that issues in relation to substance misuse or relevant mental ill-health difficulties are brought to the attention of the Firearms Licensing Department

- University of York Student Mental Health Task Group
- Mental Health and Substance Misuse Dual Diagnosis Network
- Coroners' Court Support Service
- York Mental Health Forum
- North Yorkshire and York Suicide Prevention Task Group
- North Yorkshire and York Crisis Care Concordat
- York Community Covenant (to support military personnel, their families and military veterans).

Each of the above undertakings represents real progress and recognition by some agencies that innovative and proactive approaches are crucial in order to prevent unnecessary loss of life through suicide. Findings from the audit clearly demonstrate that suicide is a very complex issue. Work to significantly reduce it over the long term must be similarly multifaceted and effectively co-ordinated. Effective suicide prevention plans must have the full commitment of all relevant stakeholders at strategic level, ensuring that this issue is considered, and demonstrated to be, a priority within their individual organisations and in collaborative, partnership working.

In considering a meaningful, strategic and multi-agency approach the Director of Public Health for York has recently announced an ambition for York to become a 'Safer Suicide Community'. Such 'status' is awarded to communities which demonstrate clear commitment by 'Living Works' a Canadian company which has operated within the field of suicide prevention for several decades.

The below explanation is taken from Living Works' website:

> "The Suicide-Safer Communities designation honors communities that have implemented concerted, strategic approaches to suicide prevention. The nine pillars in this designation reflect the core elements of suicide prevention strategies around the world. The designation celebrates and acknowledges those communities who have made significant progress in reaching their suicide-safer goals, and helps others understand what strategic steps they can take to prevent suicide on a community level".
>
> In acquiring an official "Suicide-Safer Community" designation, communities will be recognized for their efforts as leaders in formulating and implementing suicide prevention initiatives on a sustainable and ongoing basis over time. Those that seek and prepare for designation engage in an opportunity to identify their community strengths and opportunities for improvement in the area of suicide prevention.

Suicide-Safer Communities are passionate in their belief that suicide is preventable and that suicide prevention is a shared responsibility where every person from policy makers to individual community members has the potential to make a difference and save a life. It is a community that believes that everyone has a fundamental right to a life lived with dignity with the supports and resources accessible to ensure a future filled with hope and possibility.

The designation of "Suicide-Safer Community" is a prestigious honor awarded to a community where multi-sectoral entities, in agreement that suicide is a serious community health problem, are engaged with individuals, organizations and stakeholders collaboratively to strategize, create, implement, and sustain efforts around nine 'pillars of action' ".

Recommendations

The following recommendations reflect information and apparent gaps in service revealed by the York suicide audit together with national suicide prevention guidance and recognised best practice:

- Work towards achieving formal 'Suicide Safer Community' accreditation for the city of York with Living Works.
- Develop a suicide prevention strategy for York and an accompanying multi-agency 'Framework' of objectives, risks actions and outcomes.
- Ensure that recommendations contained in the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (October 2016) are considered, implemented and embedded into the policies and practices of local commissioned mental health services.
- Undertake a regular programme of suicide audits, including a wider scope to cover 'deaths by accident/poisoning of undetermined intent' used to inform suicide prevention priorities and development needs
- Develop 'suicide surveillance' and real time 'early alert' processes to improve the multi-agency response, lower and mitigate suicide risk and reduce the number of completed suicides and attempts.
- Provide more responsive support arrangements to those affected by suicide. Include people who are bereaved through suicide, recently or historically, those experiencing suicidal ideation or caring for others and those who have been otherwise touched by suicide through loss of an acquaintance or presence at the scene of a related incident.
- Ensure that those people who are affected by suicide have the their views and experiences heard and the opportunity to contribute to suicide prevention activity
- Raise awareness around which groups are at 'high risk' or 'vulnerable' to suicide amongst front-line staff ensuring that those staff receive training to enhance their skills in communicating with someone who may be at risk.
- Develop a communication plan for the city to include awareness raising , encourage help-seeking, open and non-judgemental approaches and dialogue between those at risk and those in contact with those at risk.

References

Better Mental Health for All: A Public Health Approach to Mental Health Improvement (2016) London: Faculty of Public Health and Mental Health Foundation.
http://www.fph.org.uk/better_mental_health_for_all

Pitman A, Osborn DPJ, Rantell K, King MB. Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults. BMJ Open. 2016
European Commission, European Pact for Mental Health and Well-being (2011). Making the long-term economic case for investing in mental health to contribute to sustainability
http://ec.europa.eu/health/mental_health/policy/index_en.htm

Living Works (2016). Suicide-Safer Communities.
https://www.livingworks.net/community/suicide-safer-communities/

Public Health England (2016a) Public Health Outomes Framework. Available at:
http://www.phoutcomes.info/public-health-outcomes-framework#page/3/gid/1000044/pat/10039/par/cat-39-9/ati/102/are/E06000014/iid/41001/age/285/sex/4 [Accessed 3 November 2016]

Public Health England (2016b) Suicide Prevention Profile. Available at:
http://www.phoutcomes.info/public-health-outcomes-framework#page/4/gid/1000044/pat/6/par/E12000003/ati/102/are/E06000014/iid/41001/age/1/sex/4 [Accessed 22 May 2016]

The Marmot Review (2010). Fair Society, Healthy Lives
http://www.instituteofhealthequity.org/

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci

Appendix

Glossary of Terms

Alcohol dependence is a previous psychiatric diagnosis in which an individual is physically or psychologically dependent upon drinking alcohol. In 2013 it was reclassified as alcohol use disorder (alcoholism) along with alcohol abuse in DSM-5.

ASIST a two day programme which offers 'suicide alertness' training. Delegates are taught how to recognise when a person may have thoughts of suicide, to communicate effectively with them and to connect them to suicide intervention resources to keep them safe in the short term. It is effectively suicide prevention first aid.

Cohort a group of subjects who shared a particular event during a particular time span. In this context the term relates to the sixty individuals whose deaths through completed suicide were considered by the audit.

CMHT Community Mental Health Team.

Cyber-bullying is any form of bullying which takes place online for example via social networking or gaming sites or through messaging apps.

Dual diagnosis (also called co-occurring disorders, COD) in this context is the condition of suffering from a mental illness and a co-morbid substance abuse problem.

IHTT Intensive Home Treatment Team (Mental Health Service).

IAPT Improving Access to Psychological Therapies a national NHS programme introduced with the aim of increasing the provision of evidence-based treatments for anxiety and depression via primary care.

IPCC Independent Police Complaints Commission.

MHFA Mental Health First Aid.

Experian designed to improve the reporting of small area statistics built up from groups of output areas (OA).

Office of National Statistics is the UK's largest independent producer of official statistics and is the recognised national statistical institute for the UK.

Protective factors lifestyle influences which serve to improve an individual's resilience and thereby make them less susceptible to suicide such as good mental health, supportive family and friends, stable employment or accommodation.

Risk Factors lifestyle influences which increase an individual's vulnerability to suicide such as poor mental health, lack of support or close relationships, bereavement through suicide, drug and alcohol dependency, unstable employment, housing or financial position. These should not be considered suicide indicators, however.

Safetalk a three hour condensed version of ASIST training aimed at raising awareness of suicide indicators and enhancing the confidence and skills of delegates in communicating effectively with someone at risk.

Self-Harm The National Institute for Health and Care Excellence (NICE) Guidance definition is used in this report: any act of self poisoning or self injury carried out by a person, irrespective of their motivation. This commonly involves self poisoning with medication or self injury by cutting. Self harm is not used to refer to harm arising from overeating, body piercing, body tattooing, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself.

Social Prescribing is a way of linking patients in primary care with sources of support within the community. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and wellbeing.

Suicide is the act of intentionally causing one's own death.

Talking Therapy a method of treating psychological disorders or emotional difficulties that involves talking to a therapist or counsellor, in either individual or group sessions

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Chinese (Traditional)

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CITY OF YORK COUNCIL

Health and Wellbeing Board 23 November 2016

Report of the Director of Public Health

Health Protection Assurance

Summary

1. The report describes the health protection responsibilities for local authorities which came into force on 1 April 2013, including local arrangements for delivery and assurance of the local response to the revised regulations.

2. Health and Wellbeing Boards are required to be informed and assured that the health protection arrangements properly meet the needs of the local population.

Background

3. Health protection is the domain of public health which seeks to prevent or reduce the harm caused by communicable diseases and to minimize the health impact from environmental hazards such as chemicals and radiation and adverse weather events.

4. This broad definition includes the following functions within its scope, together with the timely provision of information and advice, ongoing surveillance and alerts and tracking of existing and emerging threats to health:

- National programmes for vaccination and immunisation
- National programmes for screening, including those for antenatal and newborn; cancer (bowel, breast and cervical); diabetic eye screening and abdominal aortic aneurism screening
- Management of environmental hazards including those relating to air pollution and food

- Health emergency preparedness and response, including management of incidents relating to communicable disease (e.g. TB, pandemic flu) and chemical, biological, radiological and nuclear hazards

- Infection prevention and control in health and social care community settings

- Other measures for the prevention, treatment and control of the management of communicable disease as appropriate and in response to specific incidents

5. The scope of health protection is wide ranging. The scale of work undertaken by local government to prevent and manage threats to health will be driven by the health risks in the Local Authority area.

System Responsibilities for Health Protection

6. The Secretary of State for Health has the overarching duty to protect the health of the population.

7. From 1 April 2013, the NHS reforms arising from the Health and Social Care Act 2012, transferred health protection responsibilities to the following organisations:

- Public Health England (PHE) brings together a wide range of public health functions and is responsible for delivering the specialist health protection response to incidents and outbreaks

- NHS England (NHSE) is responsible for the commissioning and implementation of national screening and immunisation programmes across Yorkshire and Humber

- NHS England is responsible for the co-ordination and support for the Local Health Resilience Partnership (LHRP), which along with preparedness, co-ordinates any NHS multi-agency response to an emergency. The local authority Director of Public Health is co-chair of the LHRP. City of York Council is represented by the Director of Public Health for North Yorkshire County Council who fulfils this role for both local authorities currently.

- The Vale of York Clinical Commissioning Group is responsible for commissioning treatment services where this is required as part of a strategy to control communicable disease.

8. City of York Council, in addition to existing responsibilities for environmental health and emergency planning, is responsible for commissioning sexual health services and is an associate commissioner for community infection and prevention control service provision e.g. in Care Homes

9. The Council has a statutory duty under the Health and Social Care Act 2012 and associated regulations, to provide information and advice to relevant organisations and to the public and has an oversight function to ensure that all parties discharge their roles effectively for the protection of the local population. This duty is discharged through the Director of Public Health.

10. The City of York Council Director of Public Health is a member of the North Yorkshire Health Protection Board whose remit is to seek assurance regarding outcomes and arrangements relating to most aspects of health protection for residents in North Yorkshire and York.

11. The Director of Public Health is also a member of the Yorkshire and Humber Directors of Public Health, Health Protection Assurance Group. The membership of this group includes Public Health England and NHS England colleagues and provides oversight of the screening and immunisation programmes commissioned by NHSE as well as general assurance across the public health system.

Main/Key Issues to be Considered

12. Performance against health protection outcomes, including immunisation and screening, is reported through the Public Health Outcomes Framework. The Public Health Outcomes Framework (PHOF) is a national set of indicators, set by the Department of Health and used by local authorities, NHS and Public Health England to measure public health outcomes. It is regularly updated and is available at www.phoutcomes.info

13. Areas where York has good outcomes include:

    - Childhood immunisation uptake rates are all similar or better than the England average
    - Uptake of screening for breast and cervical cancer, diabetic eye screening and abdominal aortic aneurysm screening (AAA) is better than the England average

- Healthcare-associated infections can develop either as a result of healthcare interventions such as medical or surgical treatment or from being in contact with infection in a healthcare setting. This covers a range of infections with the most well known being caused by methicillin-resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C.diff). The rates of infection in the Vale of York CCG are low which is a positive position. There is good practice in relation to the joint post infection reviews being undertaken by the CCG and Infection Prevention and Control Team to identify any learning and where improvements can be made.

14. Those areas where there is scope for improvement with further work required include:

    - Uptake of seasonal flu vaccination in eligible groups is significantly lower in York compared to the England average for individuals ‘at risk’ and in people aged over 65

    - Uptake of bowel cancer screening which is lower than the England average

    - The detection rate for Chlamydia in 15 to 24 year olds is below the national average but further examination of the data suggests that this is due to a lower incidence of the infection in York as opposed to a problem with the screening programme

    - Although overall numbers are low, York has a higher than national average infection rate for some sexually transmitted infections such as genital warts and genital herpes. We are particularly concerned about the late diagnosis of HIV with an average of eight years between infection and diagnosis. These late diagnoses represent missed opportunities for treatment and prevention and further work is being undertaken to improve this position and raise awareness of the importance of HIV testing.

Consultation

15. No consultation has taken place. The Health and Wellbeing Board is required to receive an assurance report. However the Vale of York CCG and Public Health England contributed to the production of the report.

Options

16. There are no options. The Health and Wellbeing Board is required to receive and note the assurance of health protection arrangements for the local population.

Analysis

17. This report forms part of the governance arrangements to provide the Health and Wellbeing Board with assurance that the health protection responsibilities are assured and good outcomes are maintained and poor performance is addressed.

Strategic/Operational Plans

18. The report directly relates to the Council Plan 2015-19 priorities:

- ‘A prosperous city for all’
- ‘A focus on frontline services’

Specialist Implications

19. There are no specialist implications from this report.

Risk Management

20. There are no risks from this report.

Recommendations

21. The Health and Wellbeing Board is asked to:

- Receive the report and note the content
- Note the intention to include a more detailed report on the Forward Plan for the Health and Adult Social Care Policy and Scrutiny Committee on those health protection outcomes requiring improvement and the actions being put in place to address these.
- Approve the establishment of a local Health Protection Group to support a multi-agency approach to addressing health protection issues for the City of York to be led by the Director of Public Health.

Reason: To enable the Health and Wellbeing Board to be assured that there are effective health protection arrangements in York that meet the health needs of the local population.

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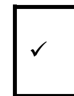
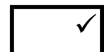
Sharon Stoltz Director of Public Health Sharon.stoltz@york.gov.uk	**Report Approved**  **Date** 09/11/2016

Specialist Implications Officer(s)
Not applicable

Wards Affected: **All** 

Annex

Glossary

Glossary

Health Protection Assurance Report

Abbreviation	Meaning/ explanation
AAA	Abdominal aortic aneurysm (AAA) screening is a way of detecting a dangerous swelling (aneurysm) of the aorta – the main blood vessel that runs from the heart, down through the abdomen to the rest of the body.
C. Diff.	Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel and cause diarrhoea.
The ‘Council’	City of York Council
Diabetic Eye Screening	Diabetic retinopathy is among the most common causes of sight loss in the working age population. The condition occurs when diabetes affects the small blood vessels in the retina. It may not cause symptoms Until it is quite advanced. All people with diabetes are at some risk of getting diabetic retinopathy and should take up the offer of diabetic eye screening.
HIV	Human Immunodeficiency Virus. The virus attacks the immune system, and weakens your ability to fight infections and disease.
MRSA	Methicilin- resistant Staphylococcus Aureus is a type of bacteria that's resistant to a number of widely used antibiotics. This means MRSA infections can be more difficult to treat than other bacterial infections.
NHS.	National Health Service
NHSE	NHS England. NHS England leads the National Health Service (NHS) in England setting priorities and the direction of the NHS to encourage and inform the national debate to improve health and care.
PHE	Public Health England is an executive agency sponsored by the Department of Health. It works to protect and improve the nation's health and wellbeing, and reduce health inequalities.
PHOF	Public Health Outcomes Framework. The Public Health Outcomes Framework 'Healthy lives, healthy people: Improving outcomes and supporting transparency' sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected.
TB	Tuberculosis (TB) is a bacterial infection spread through inhaling tiny droplets from the coughs or sneezes of an infected person. It is a serious condition mainly affecting the lungs but can be cured with proper treatment.
CCG	Vale of York Clinical Commissioning Group.

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Agenda Item 9

Health and Wellbeing Board 23 November 2016

Joint Report of the Chair of the York, Easingwold and Selby Integration and Transformation Board and the Corporate Director Health, Housing and Adult Social Care, City of York Council.

Progress report from the Integration and Transformation Board

Summary

1. Since the last meeting of the Health and Wellbeing Board, the work of the Integration and Transformation Board has led to:

- A final draft of a Section 75 Agreement being produced for our Better Care Fund submission for 2016/17
- Agreement reached on the main components of a Joint Commissioning Strategy
- Progress made on identifying shared system wide priorities for inclusion as part of a local plan to influence the Sustainability and Transformation Plan (STP)

2. This report also provides a routine update on the progress of the Better Care Fund.

Background

3. The Integration and Transformation Board (ITB) has been set up to bring together local leaders to develop a vision and single transformation plan for the local footprint. This plan will inform the larger footprint Sustainability and Transformation Plan (STP) for Humber Coast and Vale and will reflect a bottom up approach to transformation. It takes a community focussed, asset based approach – building upon people's strengths and abilities, rather than being reliant upon traditional statutory services. It is developing actions from the whole system and identifying projects that involve activities that directly interface with one another to enable a focus on breaking down professional, organisational and

cultural barriers that impede progress towards integration. The local plan will become an integral part of the Health and Wellbeing Board's (HWBB) vision and strategy and will both reflect and inform discussions at the larger geographical footprint.

Main/Key Issues to be Considered

4. On 28th July 2016, a Better Care Fund (BCF) plan for 2016/17 was submitted to NHSE and the plan was approved by NHS England on 15th August 2016. A *Section 75 Agreement* between the City of York Council and the Vale of York Clinical Commissioning Group, which sets out the terms and conditions relating to this pooled budget, has since been reviewed, renegotiated and formally submitted to NHSE. This agreement sets out risk management principles, a detailed breakdown of funding and savings and a risk share agreement relating to £1.2 million. **A copy of this Section 75 Agreement is attached in Appendix A.**

5. An external consultant was appointed to draft a Joint Commissioning Strategy for the Vale of York, which should enable partners within the Vale of York to embark upon their service and financial planning for 2017/18 financial year with a shared approach to commissioning. Following further discussion through ITB to finalise this, the draft strategy will be shared with HWBB members.

6. An informal workshop took place on 4th October 2016 to create a better understanding of the separate activities of key partners, achieve better alignment, to support the development of a shared high level plan of activities for the whole system. Further work is required, a task complicated by discussions in relation to the STP process.

7. A multi agency BCF Performance and Delivery Task Group has met several times since the last meeting of the Health and Well Being Board. A Performance Dashboard has been developed and processes are being put in place to monitor and report on service and financial performance. This includes monitoring the main risks to the programme. The group will also support production of the quarterly monitoring reports required by NHS England. **A copy of the last quarterly report to NHS England is attached in Appendix B.**

8. As part of the NHS planning round for 2017/18 an initial timetable has been released for the development of BCF plans.

To support this programme, a Yorkshire and Humber event has been scheduled for 12 December 2016 which will be attended by health and social care colleagues.

9. The Integration and Transformation Board has previously recognised that our local transformation programme is drawing on increasing reserves of existing resources and the need to invest in addition dedicated capacity is essential if we are to keep building momentum. Members recognise the need for dedicated programme management support and are committed to identifying a dedicated programme manager to support the work of the Integration and Transformation Board.

Consultation

10. These issues summarised in this report have been subject to discussion and agreement involving a wide range of partner organisations with York and North Yorkshire.

Options

11. There are no options provided in this report.

Strategic/Operational Plans

12. The plans produced by the ITB will build on the strategic plans of all partner organisations, including the CCG and City of York Council. The plan will also need to align to the Sustainability and Transformation Plan for the area and the York's renewed Joint Heath and Wellbeing Strategy.

Implications

13. The health and social care system in York is under severe pressure. The work of the Integration and transformation Board is critical to developing approaches across the different parts of the system to develop sustainable solutions.

The creation and appointment of a dedicated Programme Manager post is essential to maintain momentum and provide much needed support to all partners.

Risk Management

14. The establishment of an Integration and Transformation Board provides a platform for local system leaders to meet with a focus on

delivery. The Board will identify and lead breakthrough projects that will help break through organisational and professional barriers and bring about culture change. These projects probably represent the biggest risks to the system and to single agencies.

15. Integrated solutions, co-produced with local people, in a spirit of shared enterprise will provide a model of risk management on the largest scale. All partners need to recognise that decisions made in this forum will impact on the whole system, as will the consequences of success or failure.

Recommendations

16. The Health and Wellbeing Board are asked to:

    I. Note and endorse the work to conclude the Section 75 Agreement
    II. Comment on the Joint Commissioning Strategy
    III. Note the progress in relation to producing a single transformation plan for the Vale of York

Reason: To keep the HWBB updated on progress being made by the Integration and Transformation Board

Contact Details

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	Report Approved ✓ **Date** 14.11.2016

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:

None

Annexes/Appendices
Appendix A - Section 75 Agreement
Appendix B - Quarterly report to NHS England re: BCF

Glossary
BCF – Better Care Fund
CCG – NHS Vale of York Clinical Commissioning Group
HWBB – Health and Wellbeing Board
ITB – Integration and Transformation Board
JSNA – Joint Strategic Needs Assessment
NHS – National Health Service
NHSE – NHS England
STP – Sustainability and Transformation Plan

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Annex A

Dated 12 October 2016

The authorship of this document by Bevan Brittan LLP is acknowledged by the Parties. Amendments have been agreed by the Parties

CITY OF YORK COUNCIL

and

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES defined as the BETTER CARE FUND

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THIS AGREEMENT BY DEED is made on 12 October 2016

PARTIES

(1) **CITY OF YORK COUNCIL** (the **"Council"**)

(2) **NHS VALE OF YORK CLINICAL COMMISSIONING GROUP** (the "**CCG"**)

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the City of York.

(B) The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the City of York.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a Pooled Fund for this purpose.

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also means through which the Partners will to pool funds and align budgets as agreed between the Partners.

(F) The aims and benefits of the Partners in entering in to this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Metrics;

c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services;

d) reduce hospital admissions and delayed transfers of care; and

e) maintain social care services

(G) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Partner means, in the context of Clause 24, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreement means this agreement including its Schedules and Appendices.

Annual Report means the annual report produced by the Partners in accordance with Clause 20 (Review)

Approved Expenditure means any expenditure approved by the Partners in writing or as set out in the Scheme Specification in relation to an Individual Service above any Contract Price, Permitted Expenditure or agreed Third Party Costs.

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

BCF Performance and Delivery Group means a group established to provide support in accordance with Schedule 4.

BCF Quarterly Report means the quarterly report produced by the Partners and provided to the Health and Wellbeing Board

BCF 2015 Agreement means the agreement between the Parties in respect of the Better Care Fund for the period commencing 1 April 2016.

Better Care Fund means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

Better Care Fund Plan means the plan agreed by the Partners for the relevant Financial Year setting out the Partners plan for the use of the Better Care Fund as attached as Appendix 1.

Better Care Fund Requirements means any and all requirements on the CCG and Council in relation to the Better Care Fund set out in Law and guidance published by the Department of Health.

CCG Statutory Duties means the Duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the Commencement Date

Commencement Date means 00:01 hrs on 1 April 2016.

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Price means any sum payable under a Services Contract as consideration for the provision of goods, equipment or services as required as part of the Services and which, for the avoidance of doubt, does not include any Default Liability.

Default Liability means any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract to be payable by any Partner(s) as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part) under a Services Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Services Contract.

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and

(h) any other event,in each case where such event is beyond the reasonable control of the Partner claiming relief

Functions means the NHS Functions and the Health Related Functions

Health Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund and for any Non Pooled Fund the Partner that will host the Non Pooled Fund

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes which has been agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.

Integrated Commissioning means arrangements by which both Partners commission Services in relation to an individual Scheme on behalf of each other in exercise of both the NHS Functions and Council Functions through integrated structures.

Joint (Aligned) Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Health Related Functions.

Lead Partner means the Partner responsible for commissioning an Individual Service under a Scheme Specification.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Commissioning Board means the body that is statutorily responsible, at a national level for NHS commissioning as set out in the Health and Social Care Act 2006.

National Conditions mean the national conditions as set out in the National Guidance as are amended or replaced from time to time.

National Guidance means any and all guidance in relation to the Better Care Fund as issued from to time to time by NHS England, the Department of Communities and Local Government, the Department of Health, the Local Government Association either collectively or separately.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the Services and which may be further described in each Service Schedule.

Non Pooled Fund means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification.

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 8.4.

Overspend means any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.

Partner means each of the CCG and the Council, and references to "**Partners**" shall be construed accordingly.

Partnership Board means the Integration and Transformation Board, which is responsible for review of performance and oversight of this Agreement as set out in Clause 19.2 and Schedule 2 or such other arrangements for governance as the Partners agree.

Partnership Board Quarterly Reports means the reports that the Pooled Fund Manager shall produce and provide to the Integration and Transformation Board on a Quarterly basis.

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Permitted Expenditure has the meaning given in Clause 7.3.

Personal Data means Personal Data as defined by the 1998 Act.

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations

Pooled Fund Manager means such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause 10.

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement, including the Council where the Council is a provider of any Services.

Public Health England means the SOSH trading as Public Health England.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement.

Sensitive Personal Data means Sensitive Personal Data as defined in the 1998 Act.

Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.

Services Contract means an agreement entered into by one or more of the Partners in exercise of its obligations under this Agreement to secure the provision of the Services in accordance with the relevant Individual Scheme.

Service Users means those individual for whom the Partners have a responsibility to commission the Services.

SOSH means the Secretary of State for Health.

Third Party Costs means all such third party costs (including legal and other professional fees) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Integration Transformation Board.

Underspend means any expenditure from the Pooled Fund in a Financial Year which is less than the aggregate value of the Financial Contributions for that Financial Year.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date.

2.2 This Agreement shall continue until it is terminated in accordance with Clause 22.

2.3 The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification or if not set out, for the duration of this Agreement unless terminated earlier by the Partners.

2.4 This Agreement supersedes the BCF 2015 Agreement without prejudice to the rights and liabilities of the Partners under the BCF 2015 Agreement.

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme specification.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to commission services. This may include one or more of the following commissioning mechanisms:

4.1.1 Lead Commissioning Arrangements;

4.1.2 Integrated Commissioning;

4.1.3 Joint (Aligned) Commissioning

4.1.4 the establishment of one or more Pooled Funds

in relation to Individual Schemes (the "Flexibilities")

4.2 Where there are Lead Commissioning Arrangements and the CCG is Lead Partner the Council delegates to the CCG and the CCG agrees to exercise, on the Council's behalf, the Health Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions.

4.3 Where there are Lead Commissioning Arrangements and the Council is Lead Partner, the CCG delegates to the Council and the Council agrees to exercise on the CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions.

4.4 Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the

other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

4.5 At the Commencement Date the Partners agree that the following shall be in place:

4.5.1 The following Individual Schemes with Lead Commissioning with CCG as Lead Partner:

(a) York Integrated Care Team
(b) Urgent Care Practitioners
(c) Hospice at Home
(d) Street Triage
(e) Acute activity
(f) CCG Community services, reablement and carers break

4.5.2 The following Individual Schemes with Lead Commissioning with Council as Lead Partner:

(a) Community support packages
(b) Reablement social work provision
(c) Carers support
(d) Community facilitators
(e) Step up/down beds
(f) Telecare falls and lifting
(g) Community equipment
(h) Home adaptations
(i) Disabled Facilities Grant

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include such Functions as shall be agreed from time to time by the Partners as are necessary to commission the Services in accordance with their obligations under this Agreement.

5.3 The Scheme Specifications for the Individual Schemes included as part of this Agreement at the Commencement Date are set out in Schedule 1 Part 2.

5.4 Where the Partners add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme shall be completed and approved by each Partner in accordance with the variation procedure set out in Clause 30 (Variations). Each new Scheme Specification shall be substantially in the form set out in Schedule 1 Part 1.

5.5 The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.6 The introduction of any Individual Scheme will be subject to business case approval by the Integration Transformation Board in accordance with the variation procedure set out in Clause 30 (Variations).

6 COMMISSIONING ARRANGEMENTS

General

6.1 The Partners shall comply with the commissioning arrangements as set out in the relevant Scheme Specification

6.2 The Integration and Transformation Board will report back to the Health and Wellbeing Board as required by its terms of reference.

6.3 The Partners shall comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned.

6.4 Each Partner shall keep the other Partner and the Integration and Transformation Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non-Pooled Fund.

6.5 Where there are Integrated Commissioning or Lead Commissioning Arrangements in respect of an Individual Scheme then prior to any new Services Contract being entered into the Partners shall agree in writing:

6.5.1 how the liability under each Services Contract shall be apportioned in the event of termination of the relevant Individual Scheme; and

6.5.2 whether the Services Contract should give rights to third parties (and in particular if a Partner is not a party to the Services Contract to that Partner, the Partners shall consider whether or not the Partner that is not to be a party to the Services Contract should be afforded any rights to enforce any terms of the Services Contract under the Contracts (Rights of Third Parties) Act 1999 and if it is agreed that such rights should be afforded the Partner entering the Services Contract shall ensure as far as is reasonably possible that such rights that have been agreed are included in the Services Contract and shall establish how liability under the Services Contract shall be apportioned in the event of termination of the relevant Individual Scheme.)

6.6 The Partners shall comply with the arrangements in respect of Joint (Aligned) Commissioning as set out in the relevant Scheme Specification, which shall include where applicable arrangements in respect of the Services Contracts.

Integrated Commissioning

6.7 Where there are Integrated Commissioning arrangements in respect of an Individual Scheme:

6.7.1 the Partners shall work in cooperation and shall endeavour to ensure that Services in fulfilment of the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.

6.7.2 Both Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Partners Financial Contribution in respect of that particular Service in each Financial Year.

Appointment of a Lead Partner

6.8 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Partner shall:

6.8.1 exercise the NHS Functions in conjunction with the Health Related Functions as identified in the relevant Scheme Specification;

6.8.2 endeavour to ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year.

6.8.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

6.8.4 contract with Provider(s) for the provision of the Services on terms agreed with the other Partner;

6.8.5 comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned;

6.8.6 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the "Commissioner" and "Co-ordinating Commissioner" with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

6.8.7 undertake performance management and contract monitoring of all Service Contracts including (without limitation) the use of contract notices where Services fail to deliver contracted requirements;

6.8.8 make payment of all sums due to a Provider pursuant to the terms of any Services Contract; and

6.8.9 keep the other Partner and Integration Transformation Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.

7 ESTABLISHMENT OF A POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for revenue expenditure as agreed by the Partners. At the Commencement Date there shall be a single Pooled Fund in respect of this Agreement.

7.2 Each Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.3 Subject to Clause 0, it is agreed that the monies held in a Pooled Fund may only be expended on the following:

7.3.1 the Contract Price;

7.3.2 where the Council is to be the Provider, the Permitted Budget;

7.3.3 Third Party Costs where these are set out in the relevant Scheme Specification or as otherwise agreed in advance in writing by the Integration Transformation Board

7.3.4 Approved Expenditure as set out in the relevant Scheme Specification or as otherwise agreed in advance in writing by the Integration and Transformation Board

("Permitted Expenditure")

7.4 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Partner.

7.5 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners in accordance with Clause 0.

7.6 Pursuant to this Agreement, the Partners agree to appoint a Host Partner for each of the Pooled Funds set out in the Scheme Specifications. The Host Partner shall be the Partner responsible for:

7.6.1 holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

7.6.2 providing the financial administrative systems for the Pooled Fund; and

7.6.3 appointing the Pooled Fund Manager;

7.6.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

8 POOLED FUND MANAGEMENT

8.1 When introducing a Pooled Fund, the Partners shall agree:

8.1.1 which of the Partners shall act as Host Partner for the purposes of Regulations 7(4) and 7(5) and shall provide the financial administrative systems for the Pooled Fund;

8.1.2 which officer of the Host Partner shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.

8.2 The Pooled Fund Manager for each Pooled Fund shall have the following duties and responsibilities:

8.2.1 the day to day operation and management of the Pooled Fund;

8.2.2 ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification;

8.2.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

8.2.4 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

8.2.5 reporting to the Integration and Transformation Board as required by this Agreement and by the Integration and Transformation Board;

8.2.6 ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement;

8.2.7 preparing and submitting to the Integration Transformation Board Quarterly Reports (or more frequent reports if required by the Integration Transformation Board) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Integration Transformation Board to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met including (without limitation) comply with any reporting requirements as may be required by relevant National Guidance;

8.2.8 preparing and submitting reports to the Health and Wellbeing Board as may be required by it and any relevant National Guidance including (without limitation) supplying Quarterly Reports referred to in Clause 8.2.7 above to the Health and Wellbeing Board.

8.2.9 preparing and submitting reports to NHS England as required.

8.3 In carrying out their responsibilities as provided under Clause 8.2, the Pooled Fund Manager shall:

8.3.1 have regard to National Guidance and the recommendations of the Integration and Transformation Board; and

8.3.2 be accountable to the Partners for delivery of those responsibilities.

8.4 The Integration and Transformation Board may agree to the viring of funds between Pooled Funds or amending the allocation of the Pooled Fund between Individual Schemes.

9 NON POOLED FUNDS

9.1 There are no non-pooled funds in this agreement

10 FINANCIAL CONTRIBUTIONS

10.1 The Financial Contribution of the CCG and the Council to any Pooled Fund for the first Financial Year of operation shall be as set out in Schedule 3.

10.2 The Financial Contribution of the CCG and the Council to any Pooled Fund for each subsequent Financial Year of operation shall be subject to review by the Partners on an annual basis

10.3 Financial Contributions will be paid as set out in Schedule 3.

10.4 With the exception of Clause 13, no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to a Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in Integration Transformation Board minutes and recorded in the budget statement as a separate item.

11 NON FINANCIAL CONTRIBUTIONS

11.1 Unless set out in a Scheme Specification or otherwise agreed by the Partners, each Partner shall provide the non-financial contributions for any Service that they are Lead Partner or as required in order to comply with its obligations under this Agreement in respect of the commissioning of a particular Service. These contributions shall be provided at no charge to the other Partners or to the Pooled Fund.

11.2 Each Scheme Specification shall set out non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of Services Contracts and the Pooled Fund).

12 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

12.1 The Partners have agreed a set of principles that describe the risk sharing arrangements pertinent to the Fund as set out in Schedule 3.

Overspends in Pooled Fund

12.2 The Host Partner for the relevant Pooled Fund shall manage expenditure from a Pooled Fund within the Financial Contributions and shall use reasonable endeavours to ensure that the expenditure is limited to Permitted Expenditure.

12.3 The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT it has used reasonable endeavours to ensure that the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Integration Transformation Board in accordance with Clause 12.4.

12.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Integration and Transformation Board is informed as soon as reasonably possible and the provisions of the relevant Scheme Specification and Schedule 3 shall apply.

Overspends in Non Pooled Funds

12.5 Where in Joint (Aligned) Commissioning Arrangements either Partner forecasts an Overspend in relation to a Partners Financial Contribution to a Non-Pooled Fund that Partner shall as soon as reasonably practicable inform the other Partner and the Integration Transformation Board.

12.6 Where there is a Lead Commissioning Arrangement the Lead Partner is responsible for the management of the Non-Pooled Fund. The Lead Partner shall as soon as reasonably practicable inform the other Partner and the Integration Transformation Board.

Underspend

12.7 In the event that expenditure from any Pooled Fund or Non Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year or where the expenditure in relation to an Individual Scheme is less than the agreed allocation to that particular Individual Scheme the Partners shall agree how the monies shall be spent, carried forward and/or returned to the Partners and the provisions of Schedule 3 shall apply. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners.

13 CAPITAL EXPENDITURE

13.1 Except as provided in Clause 13.2, neither Pooled Funds nor Non-Pooled Funds shall normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

13.2 The Partners agree that capital expenditure may be made from Pooled Funds where this is in accordance with National Guidance.

14 VAT

The Partners shall agree the treatment of each Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.

15 AUDIT AND RIGHT OF ACCESS

15.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the appropriate person or body appointed to exercise the functions of the Audit Commission under section 28(1)(d) of the Audit Commission Act 1998, by virtue of an order made under section 49(5) of the Local Audit and Accountability Act 2014 to make arrangements to certify an annual return of those accounts under Section 28(1) of the Audit Commission Act 1998.

15.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the relevant Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

15.3 The Partners shall comply with relevant NHS finance and accounting obligations as required by relevant Law and/or National Guidance.

16 LIABILITIES AND INSURANCE AND INDEMNITY

16.1 Subject to Clause 16.2, and 16.3, if a Partner (“First Partner”) incurs a Loss arising out of or in connection with this Agreement (including a Loss arising under an Individual Scheme) as a consequence of any act or omission of another Partner (“Other Partner”) which constitutes negligence, fraud or a breach of contract in relation to this Agreement or any Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

16.2 Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Integration and Transformation Board.

16.3 If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 16. the Partner that may claim against the other indemnifying Partner will:

16.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

16.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

16.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

16.4 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement and in the event of Losses shall seek to recover such Loss through the relevant policy of insurance (or equivalent arrangement)

16.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

Conduct of Claims

16.6 In respect of the indemnities given in this Clause 16:

16.6.1 the indemnified Partner shall give written notice to the indemnifying Partner as soon as is practicable of the details of any claim or proceedings brought or threatened against it in respect of which a claim will or may be made under the relevant indemnity;

16.6.2 the indemnifying Partner shall at its own expense have the exclusive right to defend conduct and/or settle all claims and proceedings to the extent that such claims or proceedings may be covered by the relevant indemnity provided that where there is an impact upon the indemnified Partner, the indemnifying Partner shall consult with the indemnified Partner about the conduct and/or settlement of such claims and proceedings and shall at all times keep the indemnified Partner informed of all material matters.

16.6.3 the indemnifying and indemnified Partners shall each give to the other all such cooperation as may reasonably be required in connection with any threatened or actual claim or proceedings which are or may be covered by a relevant indemnity.

17 STANDARDS OF CONDUCT AND SERVICE

17.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective Standing Orders and Standing Financial Instructions).

17.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

17.3 The CCG is subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

17.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

18 CONFLICTS OF INTEREST

18.1 The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in schedule 6.

19 GOVERNANCE

19.1 Overall strategic oversight of partnership working between the Partners is vested in the Health and Well Being Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

19.2 The Partners have established an Integration and Transformation Board to progress development of integrated services for the local population (as defined by the Health and Wellbeing Board population).

19.3 The Integration and Transformation Board is based on a joint working group structure. Each member of the Integration and Transformation Board shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them to make decisions which enable the Integration and Transformation Board to carry out its objects, roles, duties and functions as set out in this Clause 19 and Schedule 3.

19.4 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner’s own statutory duties and organisation are complied with.

19.5 The BCF Performance and Delivery Group will provide operational oversight and monitoring of the individual schemes and overall performance of Providers. It will meet monthly and act in accordance with the risk share principles as set out in Schedule 3.

19.6 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

19.7 The Integration and Transformation Board shall be responsible for the overall approval of the Individual Schemes and the financial management set out in Clause 12 and Schedule 3.

19.8 The Health and Wellbeing Board shall be responsible for ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

19.9 Each Scheme Specification shall confirm the governance arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to the Integration Transformation Board and Health and Wellbeing Board.

20 REVIEW

20.1 The Partners shall produce a BCF Quarterly Report which shall be provided to the Health and Wellbeing Board in such form and setting out such information as required by National Guidance and any additional information required by the Health and Wellbeing Board or National Commissioning Board.

20.2 Save where the Integration and Transformation Board agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review (“**Annual Review**”) of the operation of this Agreement, and the provision of the Services within 3 Months of the end of each Financial Year.

20.3 Subject to any variations to this process required by the Integration and Transformation Board, Annual Reviews shall be conducted in good faith.

20.4 The Partners shall within 30 Working Days of the annual review prepare an Annual Report including the information as required by National Guidance and any other information required by the Health and Wellbeing Board. A copy of this report shall be provided to the Health and Wellbeing Board and Integration and Transformation Board.

20.5 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan.

21 COMPLAINTS

The Partners’ own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services.

22 TERMINATION & DEFAULT

22.1 This Agreement may be terminated by any Partner giving not less than 6 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes.

22.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund Requirements continue to be met.

22.3 If any Partner (“Relevant Partner”) fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

22.4 In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use their best endeavours to minimise disruption to the health and social care which is provided to the Service Users.

22.5 Upon termination of this Agreement for any reason whatsoever the following shall apply:

22.5.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

22.5.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

22.5.3 the Lead Partner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Partner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Lead Partner shall not be required to make

any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

22.5.4 where a Service Contract held by a Lead Partner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows the other Partner may request that the Lead Partner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

22.5.5 the Integration and Transformation Board shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

22.5.6 Termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

22.6 In the event of termination in relation to an Individual Scheme the provisions of Clause 22.6 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

23 DISPUTE RESOLUTION

23.1 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

23.2 The Authorised Officer shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 23.1, at a meeting convened for the purpose of resolving the dispute.

23.3 If the dispute remains after the meeting detailed in Clause 23.2 has taken place, the Partners' respective Chief Executive (the Council) and Accountable Officer (the CCG) or nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

23.5 Nothing in the procedure set out in this Clause 23 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

24 FORCE MAJEURE

24.1 Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

24.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including

evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

24.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

25 CONFIDENTIALITY

25.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 25, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

25.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

25.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Partner:

25.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

25.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25;

25.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REGULATIONS

26.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Regulations to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

26.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Regulations. No Partner shall be in breach of Clause 26 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Regulations.

27 OMBUDSMEN

The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

28 INFORMATION SHARING

The Partners will follow the information governance protocol set out in Schedule 8, and in so doing will ensure that the operation this Agreement complies comply with Law, in particular the 1998 Act**.**

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 29.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

29.1.1 personally delivered, at the time of delivery;

29.1.2 sent by facsimile, at the time of transmission;

29.1.3 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

29.1.4 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

29.3.1 if to the Council, addressed to the Director of Adult Social Care (Martin Farran); Tel: 01904 554045; E.Mail: martin.farran@york.gov.uk;

29.3.2 if to the CCG, addressed to the Chief Operating Officer (Rachel Potts); Tel: 01904 0555787; E.Mail: Rachel.potts@nhs.net

30 VARIATION

30.1 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

31 CHANGE IN LAW

31.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

31.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

31.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 23 (Dispute Resolution) shall apply.

32 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

33 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

34 ASSIGNMENT AND SUB CONTRACTING

The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

35.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

35.2.1 act as an agent of the other;

35.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

37 ENTIRE AGREEMENT

37.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

37.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

38 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

39 GOVERNING LAW AND JURISDICTION

39.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

39.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

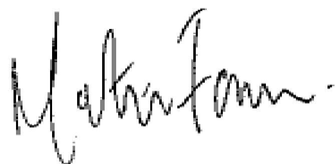
IN WITNESS WHEREOF this Agreement by deed has been executed by the Partners on the date of this Agreement

Signed as a deed on behalf of **VALE OF YORK CLINICAL COMMISSIONING GROUP**

____

Phil Mettam
Accountable Officer

The Common Seal of the **COUNCIL OF THE CITY OF YORK** was hereto affixed in the presence of:



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Martin Farran
Director of Adult Social Care

SCHEDULE 1 – SCHEME SPECIFICATION

Part 1 – Template Services Schedule

TEMPLATE SERVICE SCHEDULE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF INDIVIDUAL SERVICE

The list of Individual Schemes is detailed in Part 2 of this schedule. The detail of the Individual Schemes is in Annex 1 – Better Care Fund submission dated 28 July 2016 attached as Appendix 1 to Schedule 5 of this agreement.

2 AIMS AND OUTCOMES

All schemes contribute to the vision as specified in the BCF submission.

3 THE ARRANGEMENTS

The Lead Partner for each scheme is detailed in Schedule 1 Part 2.

4 FUNCTIONS

The functions of the schemes are described in Annex 1 – the Better Care Fund submission dated 28 July 2016 attached as Appendix 1 to Schedule 5 of this agreement.

5 SERVICES

The services of the schemes provided are described in Annex 1 – the Better Care Fund submission dated 28 July 2016 attached as Appendix 1 to Schedule 5 of this agreement.

6 COMMISSIONING, CONTRACTING, ACCESS

The Lead Partner's commissioning, contracting and eligibility thresholds will be followed for each scheme. These are detailed in Part 2 of this Schedule.

7 FINANCIAL CONTRIBUTIONS

Financial Year 2016/2017:

	CCG contribution	Council Contribution
The Better Care Pooled Fund (Total = £12.203M)	£11.200M	£1.003M

Financial resources in subsequent years to be determined in accordance with the Agreement.

8 FINANCIAL GOVERNANCE ARRANGEMENTS

The overall governance is detailed in Clause 19 and Schedule 3.

9 NON FINANCIAL RESOURCES

The Lead Partner will ensure adequate non-financial resources are deployed to support the Individual Schemes.

10 STAFF

No staff are transferring under TUPE as part of this arrangement. The Lead Partner will ensure adequate staffing resource is deployed to support the schemes.

11 ASSURANCE AND MONITORING

The Lead Partner will be responsible for providing the individual scheme assurance and for managing performance. Each scheme will report to the Integration Transformation Board using a format to be agreed by the Better Care Fund Programme and Delivery Group.

12 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Martin Farran Director of Adult Social Care	West Offices, Station Rise, York, YO1 6GA	01904 554045	Martin.farran@york.gov.uk	N/A
CCG	Rachel Potts Chief Operating Officer	West Offices, Station Rise, York, YO1 6GA	01904 555787	Rachel.potts@nhs.net	N/A

13 INTERNAL APPROVALS

The Lead Partner's internal approval mechanism will operate for each Individual Scheme.

14 RISK AND BENEFIT SHARE ARRANGEMENTS

As per Clause 12 of this Agreement and Schedule 3.

15 REGULATORY REQUIREMENTS

Each Lead Partner will comply with their respective regulatory regime.

16 INFORMATION SHARING AND COMMUNICATION

Information can be shared in line with the Information Governance protocol in Schedule 8.

17 DURATION AND EXIT STRATEGY

The duration of this agreement is 12 months and termination is in line with the provision in Clause 22 of the main agreement.

18 OTHER PROVISIONS

There are no other provisions to consider.

PART 2 – AGREED SCHEME SPECIFICATIONS

Scheme	2016/17 current £'000s	Lead Partner
York Integrated Care Hub	625	CCG
Urgent Care Practitioners (part fund with NYCC & East Riding of Yorkshire Council)	569	CCG
Hospice at Home (part fund with NYCC)	170	CCG
Street Triage (part fund with NYCC)	150	CCG
Remaining acute activity from 15/16 savings target	2,696	CCG
Community Support packages	2,174	CYC
Reablement Social Work provision	137	CYC
Carers Support	655	CYC
Community Facilitators	40	CYC
CCG Community Services Reablement and Carers Breaks	1,684	CCG
Reablement	1,099	CYC
Step Up/Down Beds	300	CYC
Telecare Falls and Lifting	192	CYC
Community equipment	180	CYC
Home adaptations	75	CYC
Carers assessments and Support, Independent Mental Health Advocacy etc	454	CYC
Disabled Facilities Grant	1,003	CYC
Total	**12,203**	

SCHEDULE 2 – GOVERNANCE

Strategic oversight of the BCF is provided by the York Health and Wellbeing Board supported by the Integration and Transformation Board as set out below. Operational oversight and co-ordination of performance data and reporting is met through the BCF Performance and Delivery Group as set out in Schedule 3.

Additional ad hoc reporting to other groups may be required at the request of the Health and Wellbeing Board or partner organisations.

1 Integration and Transformation Board

1.1 The membership of the Integration and Transformation Board will be as follows:

Vale of York CCG; City of York Council; Healthwatch; Tees, Esk & Wear Valley NHS Foundation Trust; York NHS Foundation Trust; North Yorkshire County Council; Vale of York Clinical Network; Voluntary Sector Network.

2 Role of Integration and Transformation Board

2.1 The role of the Integration and Transformation Board shall be to:

2.1.1 provide strategic direction on the Individual Schemes;

2.1.2 receive the financial and activity information;

2.1.3. review the operation of this Agreement and performance manage the Individual Services;

2.1.4 agree such variations to this Agreement from time to time as it thinks fit;

2.1.5 review and agree annually a risk assessment;

2.1.6 review and agree annually revised Schedules as necessary;

2.1.7 request such protocols and guidance as it may consider necessary in order to enable the Pooled Fund Manager to approve expenditure from a Pooled Fund;

2.1.8 co-operate with the Pooled Fund Manager in meeting reporting requirements in accordance with relevant National Guidance; and

2.1.9 report directly to the H&WB on a Quarterly basis in accordance with relevant National Guidance

3 Integration and Transformation Board Support

3.1 The Integration and Transformation Board will be supported by officers from the Partners from time to time.

4 Meetings

4.1 The Integration and Transformation Board will meet monthly at a time to be agreed.

4.2 The quorum for meetings of the Integration and Transformation Board shall be a minimum of one representative from each of the Partner organisations.

4.2.1 Decisions of the Integration and Transformation Board shall be made unanimously. Where unanimity is not reached then the item in question will in the first instance be referred to the next meeting of the Integration and Transformation Board. If no unanimity

is reached on the second occasion it is discussed then the matter shall be dealt with in accordance with the dispute resolution procedure set out in the Agreement.

4.2.2 Where a Partner is not present and has not given prior written notification of its intended position on a matter to be discussed, then those present may not make or record commitments on behalf of that Partner in any way.

4.3 Minutes of all decisions shall be kept and copied to the Authorised Officers within seven (7) working days of every meeting.

5 Delegated Authority

5.1 The Integration and Transformation Board is authorised within the limited delegated authority for its members (which is received through their respective organisation's own financial scheme of delegation) to:

5.1.1 authorise commitments which exceed or are reasonably likely to lead to exceed the contributions of the Partners to the aggregate contributions of the Partners to any Pooled Fund; and

5.1.2 authorise a Lead Partner to enter into any contract for services necessary for the provision of Services under an Individual Scheme

6 Information and Reports

6.1 Each Individual Scheme Manager shall supply to the Integration and Transformation Board, via the BCF Performance and Delivery Group on a regular basis, (monthly except where otherwise specified) the financial and activity information as required under the Agreement.

7 Post-termination

7.1 The Integration and Transformation Board shall continue to operate in accordance with this Schedule following any termination of this Agreement but shall endeavour to ensure that the benefits of any contracts are received by the Partners in the same proportions as their respective contributions at that time.

SCHEDULE 3 - FINANCIAL ARRANGEMENTS, RISK SHARE AND OVERSPENDS

Risk Share Principles (as set out in the BCF Plan)

- Lead Partners should look to share gains as well as losses to incentivise good performance.
- All efficiencies/underspends generated from activities within the scope of the programme are attributed to the programme until the programme is in financial balance.
- When the programme is in balance, ideally any over achievement should be used to fund additional transformation activities and adding to the size of the BCF.
- As the Partnership Board reporting to the Health & Wellbeing Board, the Integration and Transformation Board should support recommendations on where to invest financial gains relating to the BCF plan.
- Lead Partners should spread risks and gains around the system to recognise the responsibilities/contributions of different partners.
- Providers should bear their share of risk and it is the responsibility of the commissioners, lead or joint, to agree a risk management plan with the provider.
- Where services are commissioned then the costs of failure should be recovered through the contract from the provider.
- Lead Partners should make a decision on financial risk share on a scheme by scheme basis.
- When services are jointly commissioned then losses and gains will be split 50/50 between commissioners.
- In a situation where there is a lead commissioner then losses and gains will be managed through discussion between CYC and CCG.

1 Financial Contributions

1.1 Unless the context otherwise requires, the defined terms used in this Schedule shall have the same meanings as set out in Clause 1 of the main body of Agreement.

1.2 Subject to any contrary provision in the relevant Scheme Specification, the Parties agree that Overspends or Underspends shall be managed in accordance with this Schedule 3.

1.3 The following financial contributions shall make up the fund:

		£'s
Disabled Facilities Grant	Pass through grant to the Council	1,003,471
City of York Council contribution		**1,003,471**
Social care protection	Minimum contribution from CCG	3,412,020
Care Act	Indicative commitment – contribution in addition to minimum from CCG	454,000
Social care protection	Additional contribution from CCG	7,333,488
NHS Vale of York CCG contribution		**11,199,508**
	Total	**12,202,979**

The expenditure against the fund of £12.203M is net of £1.2M of additional efficiencies the Partners have jointly agreed proposals for. These are a combination of BCF and non-BCF schemes and are broken down as follows:

- Mental health interventions (£200K)
- Falls project funded by DFG monies (£250K)
- Roll-out of the York Integrated Care Team (£517K)
- Joint commissioning of continuing healthcare (£233K)

1.5 These benefits should play out across core Partner budgets and therefore allow the BCF expenditure plan as described in Schedule 1. Should the sum of £1.2M not be achieved each Lead Partner shall contribute equal amounts up to 50% of £1.2M in order to ensure the Fund is in balance at 31 March 2017. This will be monitored and evaluated as part of the monthly BCF Performance and Delivery Group meeting.

1.6 The following payment schedule shall be applied to the fund:

Date	Method of payment	Payee	Amount
May	Invoice	City of York Council	£3,412,020
June – Q1 payment	Invoice	City of York Council	£473,500
September – Q2 payment	Invoice	City of York Council	£473,500
December – Q3 payment	Invoice	City of York Council	£473,500
March – Q4 payment	Invoice	City of York Council	£473,500
		Total	**£5,306,020**

2. Overspends/Underspends

2.1 The Integration and Transformation Board shall consider what action to take in respect of any actual or potential Overspends.

2.2 The Integration and Transformation Board shall, acting reasonably, having taken into consideration all relevant factors including, where appropriate the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints agree appropriate action in relation to Overspends which may include the following:

2.1 whether there is any action that can be taken in order to contain expenditure;

2.2 whether there are any underspends that can be vired from any other fund maintained under this Agreement;

2.3 how any Overspend shall be apportioned between the Partners, such apportionment to be just and equitable taking into consideration all relevant factors.

2.4 The Partners agree to co-operate fully in order to establish an agreed position in relation to any Overspends.

2.3 Subject to any continuing obligations under any Service Contract entered into by either Partner, either Partner may give notice to terminate a Service of Individual Scheme where the Scheme Specification provides and where the Service does not form part of the Better Care Fund Plan.

2.4 Underspends on individual schemes will first be used by each responsible body to offset overspends on schemes within their overall responsibility. If an overall net underspend by a responsible body occurs this will be returned to the pooled budget for use by agreement of all partners in year.

2.5 Each party to the BCF remains responsible for their contracted expenditure and contribution to the pooled budget.

2.6 There will be flexibility to increase the Pooled Fund subject to agreement by all parties, and by approval of the Health and Wellbeing Board, subject to organisational governance.

3. Financial Governance

3.1 Responsibility for the management of the BCF schemes and activity sits with the BCF Performance and Delivery Group accountable to the Integration and Transformation Board where issues and disputes will be resolved. The Health & Wellbeing Board is the local strategic accountable body for all aspects of the BCF Plan.

3.2 Overall financial management continues to be the responsibility of the individual organisations (the statutory body) and cannot be abdicated to the BCF. Parties to the BCF remain responsible and accountable for delivery of their own financial performance.

3.4 Accounting arrangements will follow those incumbent on the host and appropriate accounting standards will apply.

SCHEDULE 4 – PERFORMANCE ARRANGEMENTS

1. A BCF Performance and Delivery Group has been established to support delivery of the BCF Plan (see Annex 1) for 2016/17.

2. The BCF Performance and Delivery Group will feed into the Integration and Transformation Board to report on operational issues and performance against the key metrics set within the plan.

3. The BCF Performance and Delivery Group will co-ordinate activities to ensure completion of the NHS England quarterly monitoring report as per the milestones set out below (subject to final confirmation of dates each quarter):

Period April 16 – June 16	Quarter 1	return due September 2016
Period July 16 – September 16	Quarter 2	return due November 2016
Period October 16 – December 16	Quarter 3	return due February 2017
Period January 17 – March 17	Quarter 4	return due May 2017

4. The BCF Performance and Delivery Group will be chaired by one of the Lead Partners.

5. Action notes will be maintained by one of the Lead Partners.

6. Freedom of Information – notes will be made available in line with legislative requirements but will not be routinely published.

7. The BCF Performance and Delivery Group will meet regularly, usually on a monthly basis and will include representation from partners of the Integration and Transformation Board (self-selecting).

8. A local performance monitoring dashboard will be produced by the BCF Performance and Delivery Group to monitor performance and inform any reports e.g. local Health and Wellbeing Board, national quarterly returns. This will be shared with partners as required.

SCHEDULE 5 – BETTER CARE FUND PLAN

1. The BCF plan is appended as Appendix 1:

Y:\VOYCCG\Innovation and Improvement\Better Care Fund\BCF Submissions\1617 Submission\York\16-17 Narrative Document\YORK narrative submission HWBB 20072016_FINAL 280716 submitted.pdf.

SCHEDULE 6 – POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

1. If a Partner becomes aware of any actual or potential conflict of interest which is likely to affect this Agreement, the Partner who is aware of the conflict must immediately declare it to the other. The other Partner may then, without affecting any other right it may have under Law, take whatever action under this Contract as it deems necessary.

2. Providers delivering Individual Schemes must ensure that, in delivering the Services, all Staff comply with Law, Guidance and Good Practice in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest. Compliance will be managed in line with the relevant lead Partner's policy and/or contract for the Individual Scheme.

SCHEDULE 7 – INFORMATION GOVERNANCE PROTOCOL

1. As per Multi-Agency Overarching Information Sharing Protocol.

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Cover

Q1 2016/17	
Health and Well Being Board	**York**
completed by:	Elaine Wyllie
E-Mail:	elaine.wyllie@nhs1.net
Contact Number:	01904 555870
Who has signed off the report on behalf of the Health and Well Being Board:	Helen Hirst, Interim Accountable Officer

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	2
3. National Conditions	36
4. I&E	21
5. Supporting Metrics	13
6. Additional Measures	67
7. Narrative	1

Budget Arrangements

Selected Health and Well Being Board: York

Have the funds been pooled via a s.75 pooled budget?	No
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	30/09/16

National Conditions

Selected Health and Well Being Board: York

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within this quarter (in-line with signed off plan) and how this is being addressed?

Condition (please refer to the detailed definition below)	Please Select ('Yes', 'No' or 'No - In Progress')	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:
1) Plans to be jointly agreed	Yes		
2) Maintain provision of social care services	Yes		
3) In respect of 7 Day Services - please confirm:			
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes		
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	Yes		
4) In respect of Data Sharing - please confirm:			
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes		
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes		
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes		
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes		
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes		
7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care	Yes		
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes		

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services

Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.

Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

• To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
• To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number

The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:
• confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
• ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.

This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

8) Agreement on local action plan to reduce delayed transfers of care (DTOC)

Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

• Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
• Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
• Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
• Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
• Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
• Demonstrate engagement with the independent and voluntary sector providers.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: York

Income

Q1 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Total BCF pooled budget for 2016-17 (Rounded)
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£2,799,877	£2,799,877	£2,799,877	£2,799,877	£11,199,508	£11,199,508
	Forecast	£2,799,877	£2,799,877	£2,799,877	£2,799,877	£11,199,508	
	Actual*	£2,799,877					

Please comment if one of the following applies: - There is a difference between the planned / forecasted annual totals and the pooled fund - The Q1 actual differs from the Q1 plan and / or Q1 forecast	

Expenditure

Q1 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Total BCF pooled budget for 2016-17 (Rounded)
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£2,737,377	£2,737,377	£2,862,377	£2,862,377	£11,199,508	£0
	Forecast	£2,737,377	£2,737,377	£2,862,377	£2,862,377	£11,199,508	
	Actual*	£2,737,377					

Please comment if one of the following applies: - There is a difference between the planned / forecasted annual totals and the pooled fund - The Q1 actual differs from the Q1 plan and / or Q1 forecast	Neither condition applies in this case as there are no differences.

Commentary on progress against financial plan:	Progress against the financial plan remains on track.

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB and has been rounded to the nearest whole number.

National and locally defined metrics

Selected Health and Well Being Board:	York

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Current national reporting on NEA includes activity at NHS York Foundation Trust that is incorrectly coded. This relates to a change in ambulatory care pathways implemented in Q4 15/16 that has not been reflected in acute trust recording processes. Activity is currently being monitored and will be reflected once the Trust resubmits a full SUS refresh.

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Performance showed significant improvement in the first two months of the year, due to improvements in Acute discharges. Unvalidated data from Mental Health Services in the 3rd month of the quarter has been added in, which sets the position back leading to 87 more delayed days than planned for in quarter. Outturn for the quarter is 1520.4 Days per 100k population against a planned position of 1456.2 Days per 100k population. A

Local performance metric as described in your approved BCF plan	No Metric Provided
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	BCF Local Metric - Injuries due to falls in people aged 65 and over per 100,000 of population. The forecast annual outturn based on Q1 actual performance shows this metric is currently achieving the target of 2454.7.

Local defined patient experience metric as described in your approved BCF plan	No Metric Provided
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	People who use social care and their carers are satisfied with their experience of care and support services -3A. Overall satisfaction of people who use services with their care and support
Please provide an update on indicative progress against the metric?	Data not available to assess progress
Commentary on progress:	This target is based upon the annual user survey and is not available in year.

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	This target has improved and outturns are lower than the same position last year. At this early stage we are predicting performance will exceed the target of 238 new placements or less (a rate of 620 per 100k or less) by end of year.

Additional Measures

Selected Health and Well Being Board: York

Improving Data Sharing: (Measures 1-3)

1. Proposed Measure: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	No	Yes	Yes	No
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	No	Yes	No

2. Proposed Measure: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Not currently shared digitally
From Hospital	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Not currently shared digitally
From Mental Health	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Specialised Palliative	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable
Projected 'go-live' date (dd/mm/yy)	31/03/20	31/03/20	31/03/20	31/03/20	31/03/20	31/03/20

3. Proposed Measure: Is there a Digital Integrated Care Record pilot currently underway?

Question	Response
Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	No pilot underway

Other Measures: Measures (4-5)

4. Proposed Measure: Number of Personal Health Budgets per 100,000 population

Measure	Value
Total number of PHBs in place at the end of the quarter	12
Rate per 100,000 population	6
Number of new PHBs put in place during the quarter	3
Number of existing PHBs stopped during the quarter	0
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	100%
Population (Mid 2016)	208,748

5. Proposed Measure: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Question	Response
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	Yes - in some parts of Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	Yes - in some parts of Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Q4 15/16 population figures onwards have been updated to the mid-year 2016 estimates as we have moved into the new calendar year.

Narrative

Selected Health and Well Being Board: York

Remaining Characters	30,735

Please provide a brief narrative on overall progress, reflecting on performance in Q1 16/17. Please also make reference to performance across any other relevant areas that are not directly reported on within this template.
With three indicators on track and with no data available until later in the year with the fourth indicator our improvement focus for this quarter will be to develop a proxy measure for the other indicator where no data is currently available and to continue the efforts on DTOC with a particular focus on mental health transfers of care and developing an agreed protocol between the local authority and mental health services provider. Progress on these will be regularly monitored by the Health and Wellbeing Board. To drive forward integration work, an Integration and Transformation Board has been established which feeds directly into the Health and Wellbeing Board. This is overseeing the BCF, and also coordinating the local activity related to the STP. Priorities for this Board include the development of a Joint Commissioning Strategy during Q4 which will pave the way for a joint commissioning plan for 2017/18. This would be supported by a joint Medium Term Financial Strategy. Extensive work locally is needed to develop shared/integrated digital solutions across the health and care sector. A key enabler to developing this agenda is the full and committed involvement of providers. Work is on-going through the development of new models of care and integrated solutions, but requires further focus to develop a roadmap which will hit the targets by 2020. Current focus includes reviewing and developing the universal advice and information offer to facilitate more informed choices and access to support. This is underpinned by a system-wide communications campaign, led by the CVS and partners, to promote self-care and help people identify appropriate support relevant to their needs without always needing to access social care or clinical services. The role of assistive technology in maintaining people's independence is being reconsidered and promoted, whilst a bid is being developed to become an early adopter site for Integrated Personal Commissioning. This bid will be submitted in October.

 Agenda Item 10

Health and Wellbeing Board **23 November 2016**

Report of Director of Operations, Tees, Esk and Wear Valleys NHS Foundation Trust.

Update on Mental Health Facilities for York

Summary

1. This report updates the Health and Wellbeing Board on the Mental Health Facilities for York.

Background

2. Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) became responsible for all mental health and learning disability services across the Vale of York from the 1 October 2015.

3. TEWV took on services during a challenging period. Following the CQC decision not to register services, TEWV had to implement its business continuity arrangements and ensure that it did all that it could to support patients, carers and staff during a very difficult time.

4. When TEWV took on services within the locality, it was acknowledged that there were a number of issues with the Estate. A number of changes to the estate have been undertaken as a consequence of the Bootham Park closure; however, there were also a number of issues around the general maintenance and oversight of estates. TEWV continues to work with NHS Property Services to develop this plan, but the standard of many buildings remains below the level of other TEWV owned sites. There are a number of planned developments to address these issues which are outlined in this report.

Main/Key Issues to be considered

5. The reopening of Peppermill Court in October 2016 now provides Adult mental health beds in York. It offers 24 beds (12 male and 12 female), 136 suite (place of safety) and a base for the crisis team. It is acknowledged that the refurbishment of the existing unit has led to some compromises (for example the reduction in the number of adult beds and lack of en-suite facilities). However, the work with service users and carers has ensured that we have made as many modifications to the unit as can be practically accommodated. There will continue to be close monitoring of bed use in recognition of the difference in the "ideal" number of beds for the locality.

6. A number of estate issues within older persons services have been progressed:

   - Interim modifications to **Worsley Court** (male dementia unit in Selby) to address service requirements including staff attack alarm system/ backlog maintenance/ revisions to door entry have been completed.

   - Minor modifications to **Meadowfields** (female dementia unit in York) – staff attack alarm system have been completed.

   - **Acomb Gables** (previously the rehabilitation unit in York) - work has commenced to upgrade the unit to dementia standards for the transfer of patients from Worsley Court in January 2017. This work will also enhance the community team space and increase outpatient facilities and flexibility.

7. A review of the current buildings from which Community Mental Health Teams (CMHT's) operate has identified a number of constraints with the existing estate. Many of the buildings offer poor patient facing environments, inadequate staff facilities, do not meet Disability Discrimination Act (DDA) requirements and are not optimally configured to meet modern mental health estate expectations. TEWV's tender response outlined new ways of working building on the Vale of York Clinical Commissioning Group's engagement work ("Discover!"), which highlighted a wider community focus.

8. TEWV are developing plans to vacate a number of these poor environments and move to a different model via Community Hubs.

Each hub will offer outpatient and treatment facilities as well as CMHT office space for adults and older people. Our planning assumptions also include providing appointments and services within patients' own homes, GP surgeries and other community venues. We will want to continue to maximise the visibility of mental health practitioners within primary care settings and will continue to work to explore how this can be maximised.

9. A working group is in place and has considered a range of options and undertaken a full option appraisal on possible sites for Community Hubs. This assessment has indicated that there would ideally be 3 main CMHT hubs across the Vale of York. This would cover Selby, York East and York West. Taking each of the Hub areas in turn:

   Selby – The CMHT currently use Worsley Court for accommodation and clinic appointments. Some estate work is planned to modify the facility and this will also enhance the facility to increase the number of clinic rooms. This work is still in development.

   York West - Acomb – The CMHT currently has office space and a small number of clinic rooms at Acomb Gables. Estate works have been agreed as part of the plans to bring Mental Health Older People (MHSOP) beds into this unit. As part of these plans additional clinic space has been developed and will be available from January 2017.

   York East – A new site has been identified – Huntington House at Monks Cross which would enable services from Bootham Park Hospital (including the chapel and driveway), Union Terrace, Huntington Road, (St Andrews) and 22 The Avenue to be relocated. A business case is being compiled to confirm the detailed plans and revenue costs relating to this hub development, but it is anticipated that the new site will be available for patient use from December 2017.

10. Transferring community services into the proposed hubs will improve clinic and patient facing environments, address the need to consolidate a number of separate community bases, which in turn will improve team effectiveness. We want to relocate the Community Mental Health Teams (CMHTs) currently located at Bootham Park Hospital as early as possible in 2017.

11. The Trust, working with City of York Council, Clinical Commissioning Group, and service users, has been successful in bidding for capital funding to support refurbishment of Sycamore House (York) to develop an out of hours safe haven service. This will support the ongoing work aligned to the Crisis Concordat and will supplement existing crisis services.

Consultation

12. Work is progressing to develop plans for a new mental health hospital to open in 2019. The clinical teams have considered the operational requirements and as part of our engagement work with patients, carers, stakeholders and the public we have heard a number of the issues which people want to understand in the planning of the hospital.

13. The consultation process is being led by Vale of York CCG. Full details and the consultation document can be found on the websites for Vale of York CCG - http://www.valeofyorkccg.nhs.uk/latest-news/ .

    Public consultation runs until Monday 16th January 2017, and seeks feedback on the proposed number and configuration of beds and the proposed sites (3 have been shortlisted). Public meetings are being facilitated in a number of locations – York, Easingwold, Pickering, Pocklington, Selby and Tadcaster.

Options and Analysis

14. There are no specific options for consideration as this report is provided for information only.

Conclusion

15. Much of the work over the last year has focused on understanding and addressing a number of estate issues within the locality. Whilst there is more work to do, our next phase of work is concentrated on addressing the pathway changes to enable us to meet new ways of working and to maximise the benefits of these new care environments.

Strategic/Operational Plans

16. The NHS Vale of York Clinical Commissioning Group (CCG) have confirmed the strategic requirement for a new mental health hospital by 2019.

Implications

17.

- **Financial**
- The Strategic Outline Case will consider the financial implications arising from the new hospital.
- **Human Resources (HR)**
- There are no specific HR implications
- **Equalities**
- There are no specific equalities implications
- **Legal**
- There are no specific legal implications
- **Crime and Disorder**
- There are no specific crime and disorder implications
- **Information Technology (IT)**
- There are no specific IT implications
- **Property**
- The estate plans will enhance the mental health patient care environments for the population of York.

Risk Management

18. As part of the Strategic Outline Case for the new hospital there will be consideration of the relative risks associated with this project.

Recommendations

19. The Health and Wellbeing Board are asked:

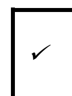
    i. To note the current update around mental health estate provision for York.

    ii. To contribute to the current consultation around the new hospital.

    Reason: To keep the Health and Wellbeing Board up to date in relation to in patient facilities for mental health services in York.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Ruth Hill Director of Operations York & Selby Tees Esk & Wear Valleys NHS Trust Tel No. 01904 294623	Colin Martin Chief Executive Tees Esk & Wear Valleys NHS Trust Tel No 01325 552077

Report Approved  **Date** 11.11.2016

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:
None

Annexes
None

 Agenda Item 11

Health and Wellbeing Board 23 November 2016

Report of the Health and Wellbeing Board Healthwatch York Representative

Healthwatch York Reports

Summary

1. This report asks Health and Wellbeing Board (HWBB) members to receive two new reports from Healthwatch York namely:

   a. Antenatal and Postnatal Services in York (Annex A)

   b. Closure of Archways: Changes to Intermediate Care Services in York (Annex B)

Background

2. Healthwatch York produce several reports a year arising from work undertaken as part of their annual work programme. These reports are presented to the Health and Wellbeing Board for consideration.

3. The agreed procedure adopted for Health and Wellbeing Board is to receive these reports initially and then delegate these to the JSNA/JHWBS Steering Group who will consider the most appropriate way of implementing the recommendations. This may include incorporating them into ongoing JSNA work; asking other sub-boards of the HWBB to add them to their action plans or considering them for inclusion within the Joint Health and Wellbeing Strategy.

Main/Key Issues to be Considered

4. There are a number of recommendations arising from Healthwatch York's most recently produced reports and these are set out in the tables below:

Table 1 - Antenatal and Postnatal Services in York

Recommendation	Recommended to
Consider the feedback within this report alongside work to address issues raised through the Discover Maternity work, and the National Maternity Review	York Teaching Hospital NHS Foundation Trust
Consider reintroducing face-to-face antenatal classes, this could include working with the voluntary and community sector to provide alternative face-to-face antenatal classes	York Teaching Hospital NHS Foundation Trust
Improve the information available about antenatal services on offer in York, both through the NHS and the 3rd sector	York Teaching Hospital NHS Foundation Trust / NHS Vale of York Clinical Commissioning Group / Family Information Service at CYC
Improve the online antenatal education videos by making them more personal and informative, when updating online content. Consider following a co-production approach to make sure videos address the hopes, concerns, and fears that young mums may have.	York Teaching Hospital NHS Foundation Trust

Table 2 - Closure of Archways: Changes to Intermediate Care Services in York

Recommendation	Recommended to
For future service changes, plans for consultation and engagement with the public / other agencies to be developed at the earliest stage	Health & Wellbeing Board
Commit to co-design and co-production (in line with the Social Care Institute of Excellence definition)	Health & Wellbeing Board
Consider the feedback received to date	Scrutiny committee

Consultation

5. There has been no consultation needed to produce this accompanying report for the Board. Healthwatch York has consulted extensively to produce their reports.

Options

6. This report is for information only and as such there are no specific options for members of the Board to consider.

Analysis

7. Not applicable.

Strategic/Operational Plans

8. The work from Healthwatch contributes towards a number of the themes, priorities and actions contained within the current Joint Health and Wellbeing Strategy.

Implications

9. There are no implications associated with the recommendations set out within this report. However there may be implications for partners in relation to the recommendations within the Healthwatch York report.

Risk Management

10. There are no known risks associated with the recommendations in this report.

Recommendations

11. Health and Wellbeing Board are asked to:

- Receive and comment on the reports from Healthwatch York at Annexes A and B
- Delegate the report to the JSNA/JHWBS Steering Group for further consideration
- Respond to the two specific recommendations for the Health and Wellbeing Board in the report at Annex B

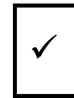
Reason: To keep members of the Board up to date regarding the work of Healthwatch York.

Contact Details

Author:

Tracy Wallis
Health and Wellbeing Partnerships Co-ordinator
Tel: 01904 551714

Chief Officer Responsible for the report:
Sharon Stoltz
Director of Public Health

Report Approved  **Date** 11.11.2016

Specialist Implications Officer(s) None

Wards Affected: **All**

For further information please contact the author of the report

Background Papers:
None

Annexes

Annex A – Antenatal and Postnatal Services in York

Annex B - Closure of Archways: Changes to Intermediate Care Services in York

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Antenatal & Postnatal Services in York

November 2016

healthwatch York

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Antenatal Services in York

Introduction

In September 2013, York Hospital stopped providing antenatal classes for the majority of pregnant women. Physiotherapy face-to-face groups continued for all women and antenatal education continued to be delivered face-to-face for teenage mums, multiple pregnancy and vulnerable women.

Christine Foster, Matron for Maternity, Gynaecology and Sexual Health, said: “We made the decision to move to online-antenatal education in 2013 because less than 30 per cent of pregnant women were attending antenatal classes.”

York Hospital Teaching Trust were the first NHS trust to replace face-to-face antenatal classes with ‘virtual classes’. However, a number of areas have since introduced online antenatal classes, and there are at least nine areas in England, and one in Wales[i], where NHS antenatal classes have been cut or ‘temporarily suspended’.

Why is Healthwatch York looking at Antenatal Services?

We were contacted by the Joseph Rowntree Foundation in October 2015 about the impact York Hospital stopping face-to-face antenatal classes. We also became aware of a number of women contacting the Kyra Women's Project York about access to face-to-face antenatal classes in York.

Kyra Women's Project is an independent service open to all women, offering non-judgmental support and information to all women, empowering them to make informed choices, become stronger and more independent, develop a network of support and achieve their goals[ii].

Healthwatch York decided to find out more about how the stopping of these classes has impacted women's experiences of antenatal and postnatal services in York.

What we did to find out more

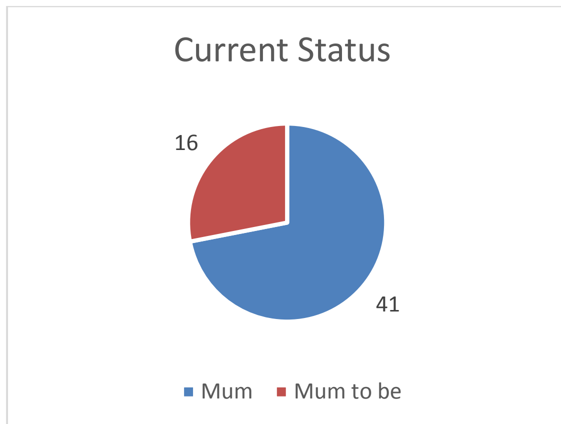
In order to gather women's experiences of antenatal and postnatal services, we worked with Kyra Women's Project and lay representatives on the Maternity Services and Liaison Committee to create a survey.

The survey was launched in December 2015 and closed at the end of February 2016, and we used social media to encourage as many women as possible to tell us about their experiences. Kyra Women's Project shared the survey with all young mother's they were in contact with.

We received 59 responses in total, and this report presents the results of the survey, and what we found out about women's experiences of antenatal and postnatal services in York.

What we found out

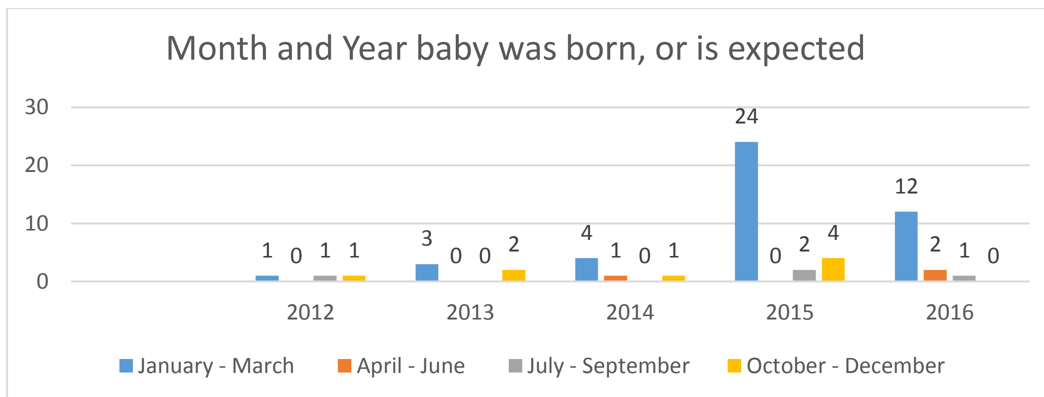
Question 1. Are you a?;



59 people answer the survey in total.

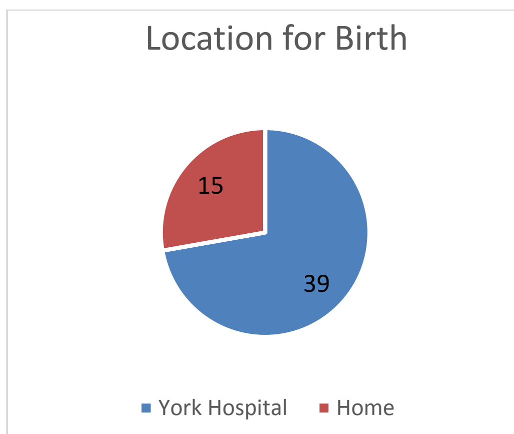
41 of those were mothers already; 16 were Mum's to be.

Question 2. When is baby due or when was baby born? Please give month and year.



Two babies were born prior to 2012

Question 3. Where were you or are you booked to have your baby?



68% said they plan to/have had their baby at York Hospital.

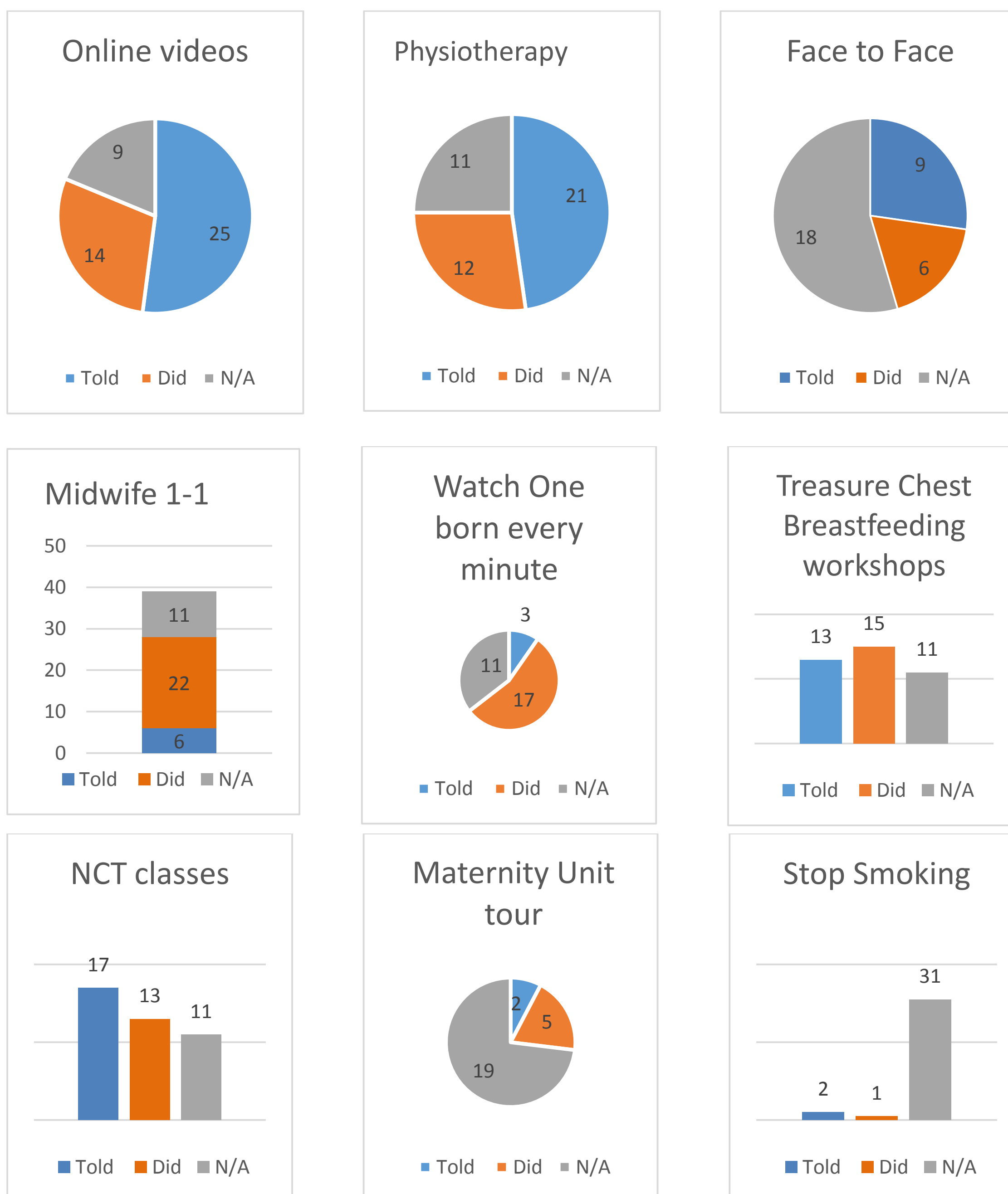
26% plan to/have had their baby at home.

Question 4. Were you offered antenatal education?

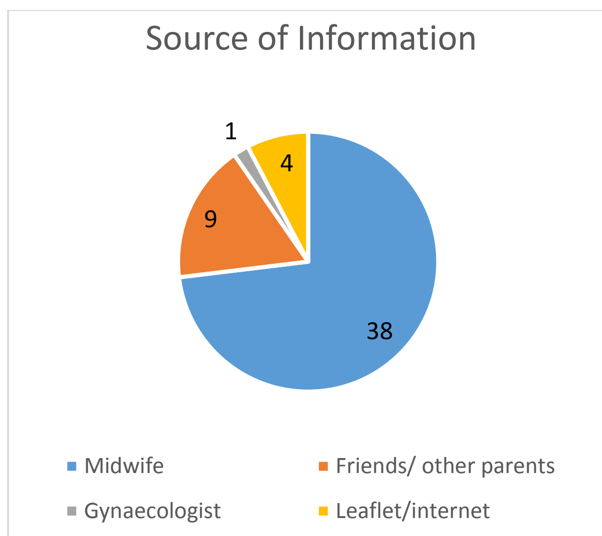
The following diagrams show what antenatal education respondents were offered.

The most **common** antenatal education service offered was online videos, with 25 people being told about it, and 14 people carrying this out.

Physiotherapy was the next **common** antenatal education service recommended to or accessed by respondents, with support to stop smoking and a tour of the maternity unit being the least **common.**



Question 5. Who told you about these?



44 people responded to this question.

The most popular response was that a midwife told women about the different antenatal education options.

Question 6. If you watched the online videos, what is your opinion of them?

The common themes in the responses to this question included:

- Informative in some areas
- Not information or detailed enough in some areas
- Basic, simplistic
- Impersonal
- Not as good as face-to-face classes

Some of the responses are noted below:

- "They were OK. Not the same as being able to ask questions though."
- "Not helpful. Too simplistic, not enough information and no use in learning where to find out more. A poor substitute for the classes that were available in 2012."
- "Informative, easy to understand."
- "Good general overview but lacking in detail"
- "Did not watch"
- "Didn't know they existed"
- "They were ok. Would have preferred classes to meet other expectant parents"

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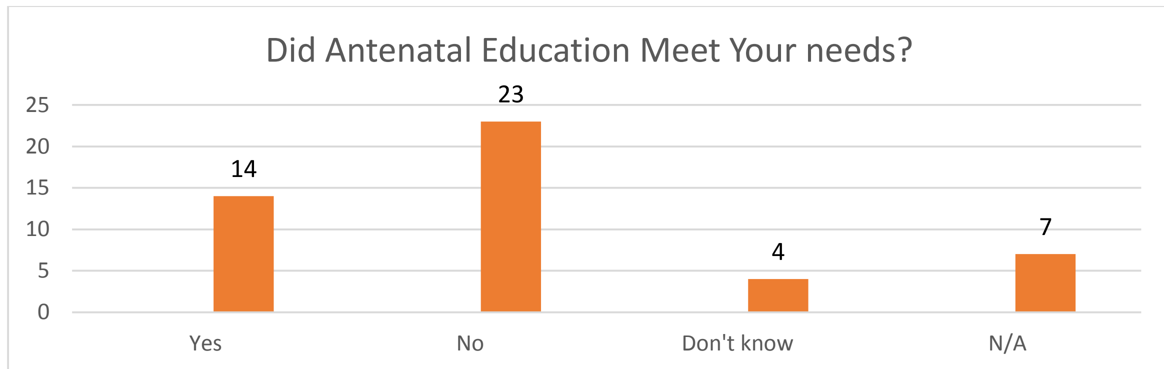
<u>Question 7.</u> Did the antenatal education you received meet your needs?

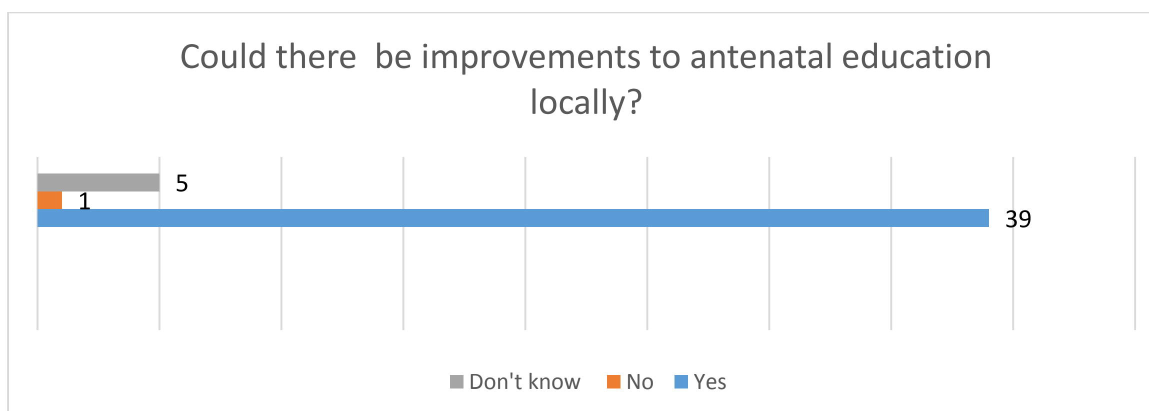


48% of those who responded to this question answered that the antenatal education they received did not meet their needs.

Some of the comments:

- “Most of the education came from my own research”
- “Apart from the classes I paid for there was no/limited opportunity to ask questions and find out information”
- “The private classes did [meet my needs]”
- “Not enough information, and [the] information given did not cover other options. Treasure chest were great though!”
- “The stuff online didn’t interest me – I wanted face to face classes”
- “NHS classes at hospital v[ery] basic and focused on physiological processes”

Question 8. Is there anything that could improve antenatal education locally?



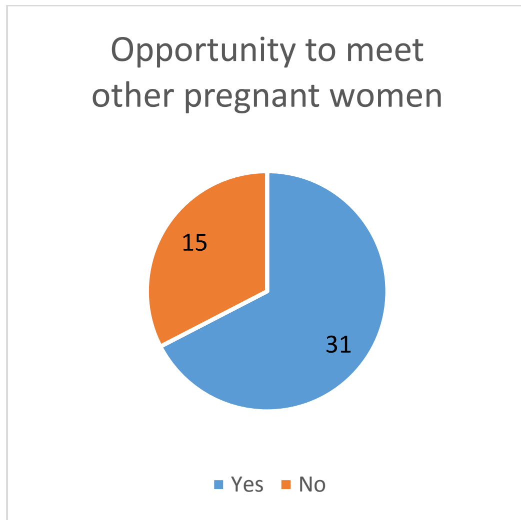
87% of people who responded to this question, answered that antenatal education could be improved locally. 36 people left comments, with the main themes being:

- The need for increased availability of classes
- More free classes
- More face to face antenatal education on offer

Comments:

- “more availability of in-person classes”
- “Availability of antenatal education through the NHS to make this accessible to all and support people through pregnancy and into parenthood”
- “Face to face antenatal classes”
- “antenatal classes should be free”

<u>Question 9.</u> Have you had the opportunity to meet other pregnant women?

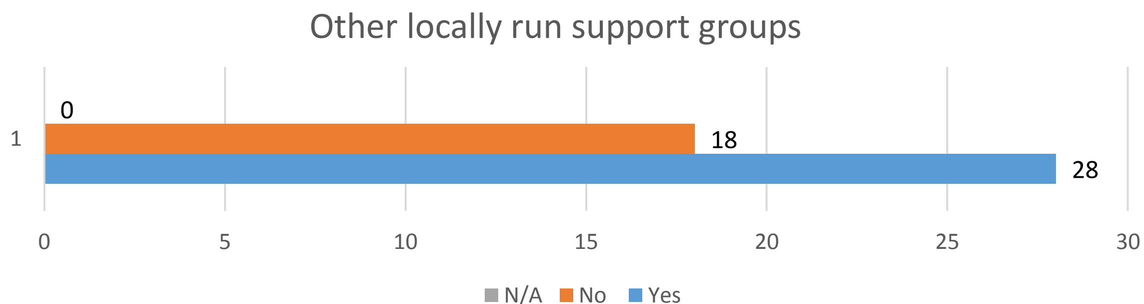


The majority of comments included reference to meeting other pregnant women through their own efforts, and not through services provided by the NHS – for example through pregnancy yoga and paid for antenatal classes such as through the NCT.

Examples of comments:

- "Not because of the NHS but through my yoga class and the online community."
- "Made the opportunities myself, through NCT and pregnancy yoga"
- "I have paid for and attended aquanatal classes in York and met other pregnant women there. Also I have paid for antenatal classes and so met some more mum's to be."

<u>Question 10.</u> Were you told about any other support groups for pregnant women and new mothers that are run locally?

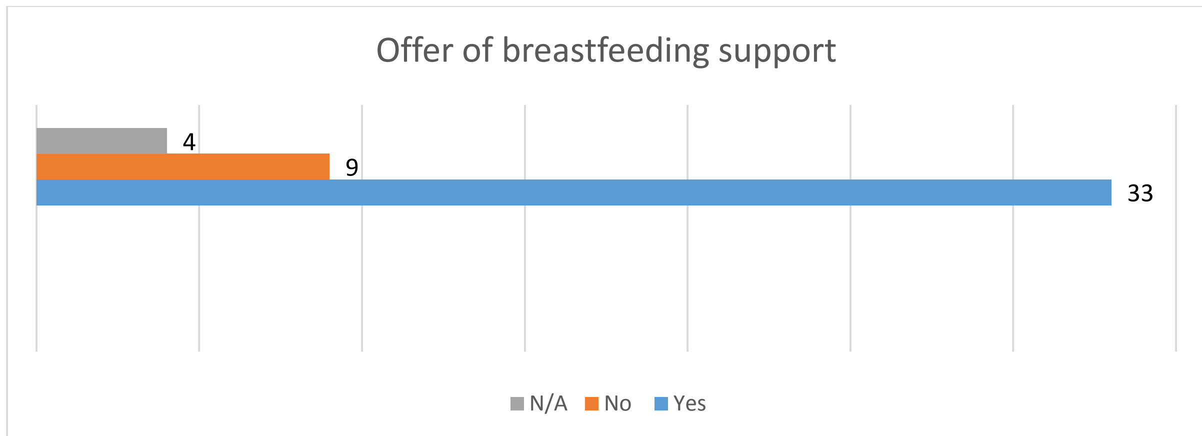


61% of respondents answered yes

39% of respondents answered no

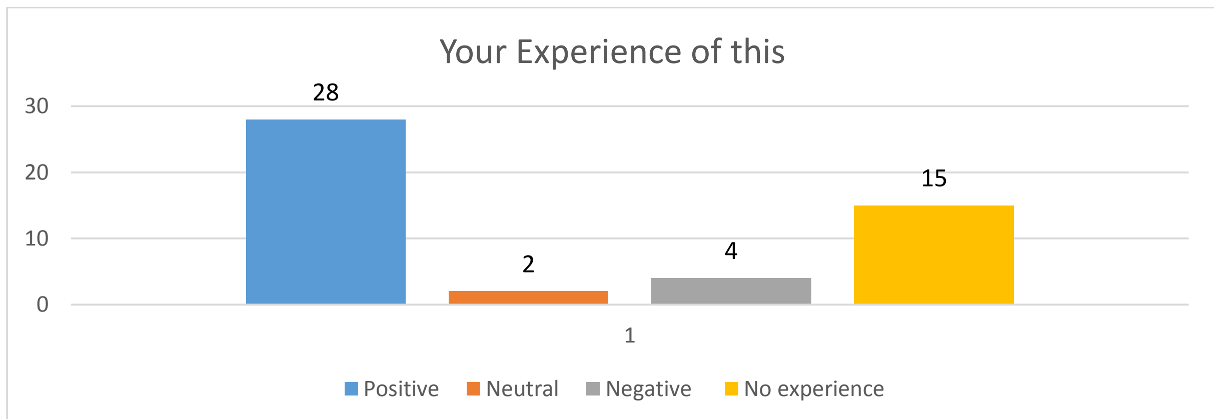
Treasure Chest was the most popular support group mentioned.

Question 11. Have you been offered breastfeeding support?



72% said yes; 20% said no

Question 12. If yes, what was your experience of this?



53% of respondents said they had a positive experience

9% of people said they had a negative experience

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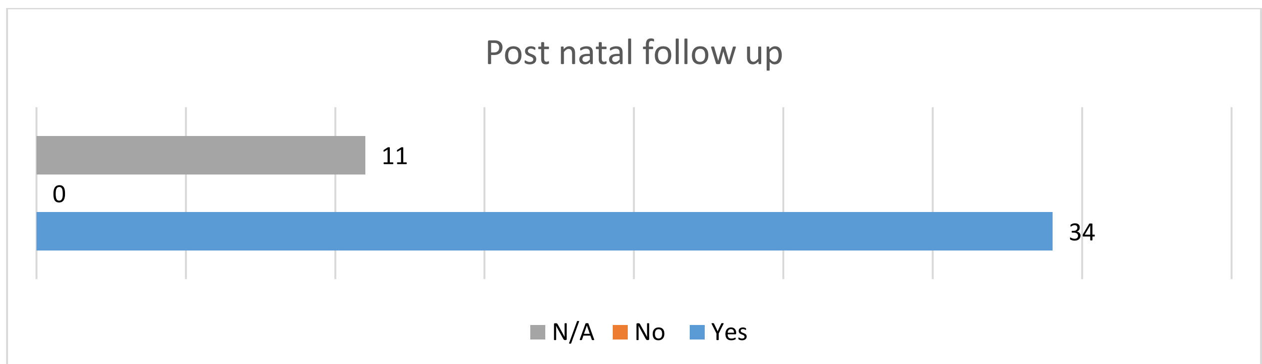
Question 13. Did you receive any postnatal follow up? For example, from a midwife, health visitor or district nurse.

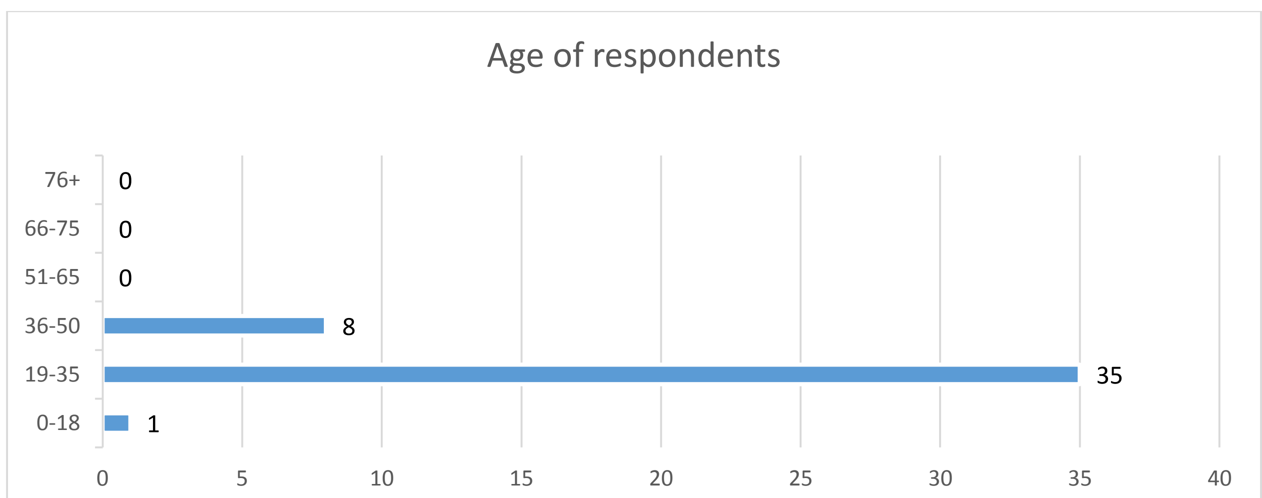


76% of people who answered this question said they did receive postnatal follow up, with no one answering that they had not received any postnatal follow up. 24% answered ‘not applicable’.

Some of the comments following this question included:

- “Very limited with second child”
- “Tick box exercise”
- “The York midwives have been amazing and have really gone out of their way to help me establish breastfeeding”

Monitoring information



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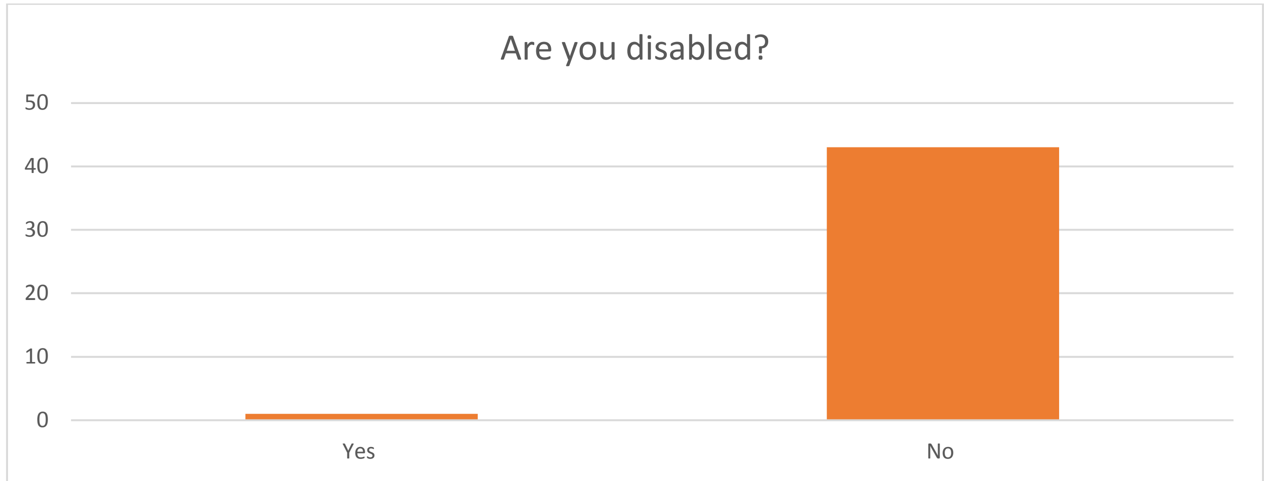

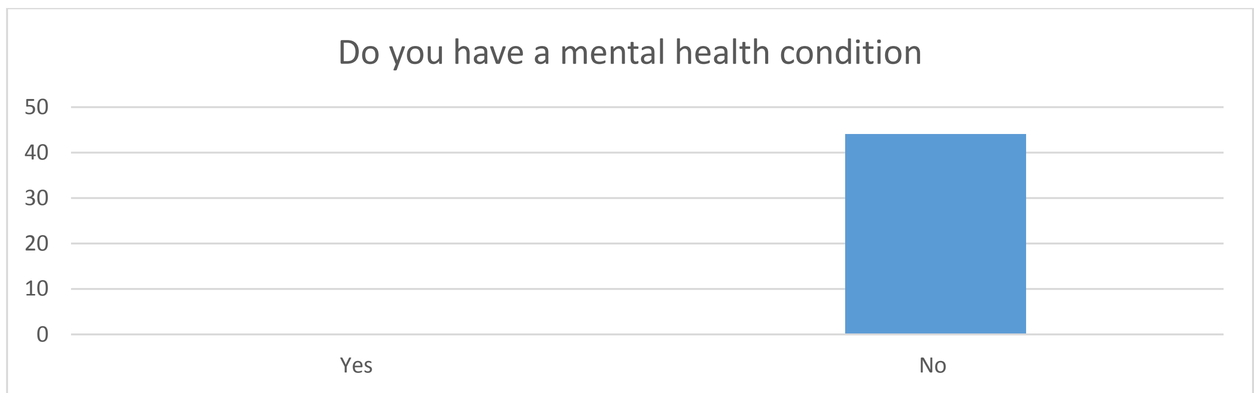

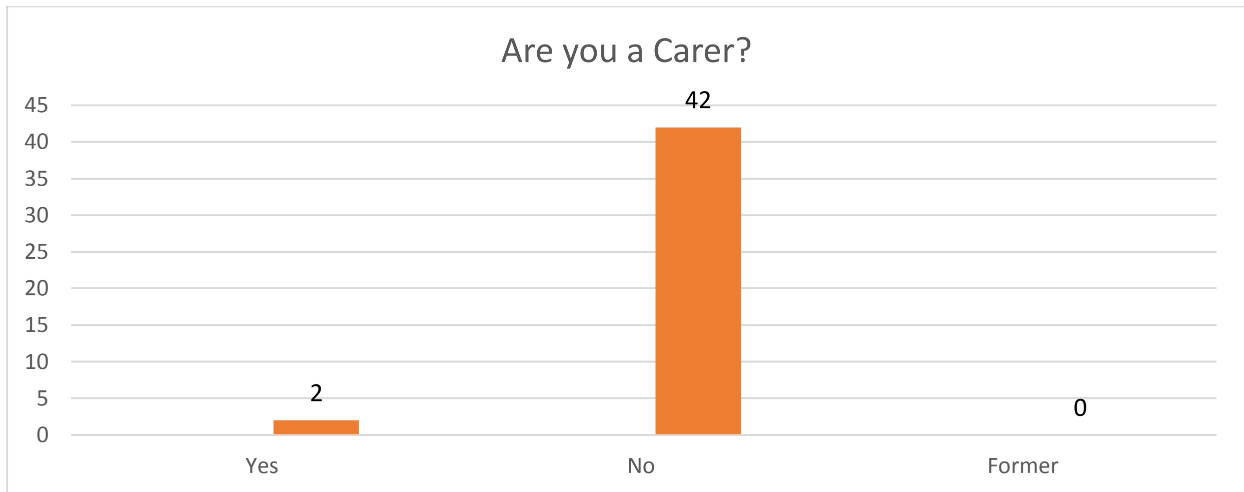

Conclusion

There is a growing acceptance that technology has a role in health and care services, to enable people to take care of their health and care needs. However, the results of our survey suggest that the majority of respondents felt antenatal education could be improved. Further, 48% felt it did not meet their needs. The overall sense we got was that women want more face-to-face antenatal education on offer, particularly in the form of free classes.

It appears that pregnant women seek support and advice from services outside of the NHS, for example by attending antenatal yoga classes, Treasure Chest, and accessing services through the NCT. There was good feedback regarding the breastfeeding support that new mothers got from the NHS and voluntary organisations. All new mums received a postnatal follow up, though one commented that it was more limited compared to previous experiences of postnatal follow up with other children.

Overall, the responses to our survey indicate that antenatal services in York could be improved. The recommendations we set out in order to make improvements are noted below.

Recommendations

Recommendation	Recommended to
Consider the feedback within this report alongside work to address issues raised through the Discover Maternity work, and the National Maternity Review	York Teaching Hospital NHS Foundation Trust
Consider reintroducing face-to-face antenatal classes, this could include working with the voluntary and community sector to provide alternative face-to-face antenatal classes	York Teaching Hospital NHS Foundation Trust
Improve the information available about antenatal services on offer in York, both through the NHS and the 3rd sector	York Teaching Hospital NHS Foundation Trust / NHS Vale of York Clinical Commissioning Group / Family Information Service at CYC
Improve the online antenatal education videos by making them more personal and informative, when updating online content. Consider following a co-production approach to make sure videos address the hopes, concerns, and fears that young mums may have.	York Teaching Hospital NHS Foundation Trust

Appendices

Appendix 1 – Sources of support for pregnant women & young mothers in York

Antenatal classes at York Hospital

Antenatal classes produced by our own staff are now available on our website for you, your family and friends to share at any time during your pregnancy. We hope they will answer many of your questions about your pregnancy and birth at York Hospital. Please remember your community midwife or staff in the maternity unit are always available if you have any concerns and need to speak to someone.

Online ante natal classes from York Hospital
http://www.yorkhospitals.nhs.uk/our_services/az_of_services/maternity_services/online_ante_natal_classes_and_information/

BUMP physiotherapy groups at York and Selby

What is the group about?

If you are pregnant and over 20 weeks you are invited to come to a one off group session. Here an obstetric physiotherapist will give advice, information and exercises to help you to be as comfortable and active as possible in pregnancy and also to help you to prepare for labour.

Who are the groups for?

Pregnant ladies only, from 20 weeks.

However, if you are suffering from any hip, back or pelvic pain in your pregnancy, then initially we would recommend that you attend one of our pelvic pain group sessions.

In order to attend one of these sessions you need to be referred to physiotherapy by your midwife or GP. We will give you an appointment once we have received the referral.

Useful leaflets

York Teaching Hospital NHS Foundation Trust produce a number of useful maternity services leaflets

These can be found online at:

https://www.yorkhospitals.nhs.uk/your_visit/patient_information_leaflets/maternity_patient_leaflets/

Or they can be requested from your midwife.

NCT – National Childbirth Trust
Face to face courses are provided by the NCT in all areas. There is a charge for these courses.

https://www.nct.org.uk/courses/antenatal

Tel: 0300 330 0700

Kyra Bump to Birth Classes
Join our new Bump to Birth ante and postnatal education course. This 3 week workshop will prepare you for the emotional and practical aspects of birth and life with a baby. Our workshop tutor, Lisa, will provide information and support in a safe environment, allowing any woman the opportunity to educate herself for the journey into motherhood. **The course will be held Thursday evenings. These are free of charge.** Please email contact@kyra.org.uk or call 01904 632332.

http://www.kyra.org.uk/our-activities/#Counselling

NHS Choices Antenatal Information
http://www.nhs.uk/conditions/pregnancy-and-baby/pages/antenatal-classes-pregnant.aspx

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[i] http://www.walesonline.co.uk/news/wales-news/antenatal-classes-cut-nhs-trust-2269796
[ii] http://www.kyra.org.uk/

healthwatch York

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Facebook:	Like us on Facebook
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York CVS

Healthwatch York is a project at York CVS. York CVS works with voluntary, community and social enterprise organisations in York. York CVS aims to help these groups do their best for their communities, and people who take part in their activities or use their services.

This report

This report is available to download from the Healthwatch York website: www.healthwatchyork.co.uk

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York

Closure of Archways: Changes to intermediate care services in York

September 2016

healthwatch York

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Closure of Archways:

Changes to intermediate care services in York

Introduction

Archways is a 22-bed Community Unit in York, named after former Lord Mayor and charity volunteer Jack Archer. It was designed to help stop people going into hospital, and to help them leave hospital earlier. People are admitted directly from home, from the Emergency Department or following a hospital stay.

The focus of the unit is to assess what a person needs to be independent, and then support them with treatment and rehabilitation. Most people return to their home with the average length of stay being three to four weeks.
The hospital treats adults over the age of 18 who have a Selby or York GP.

On August 17th it was announced that Archways would close. From 31 December 2016 services currently delivered from Archways Intermediate Care Unit will be provided through the York Community Response Team.

Why is Healthwatch York looking at the closure of Archways?

Following the publicity in The Press about the closure of Archways Healthwatch York has received 19 phone calls and e mails from members of the public. All were against the closure, most expressed their anxiety and concern and asked why there had been no consultation.

This report summarises the feedback received:

- People are concerned about the impact the closure will have on hospital waiting times/shortage of beds/'bed blocking'. They fear it may lead to more re-admissions to hospital
- Concern was expressed that care in peoples' own homes is not always practical, for example if they need hoists, IV drips etc. or cannot use the stairs to get to the bathroom
- Particular concern was expressed for people who live alone and would not be able to prepare food, wash/dress, use the toilet without assistance
- Concern was expressed about how people would manage overnight. Currently the Community Response team finish at 8pm
- People commented on the excellent care they had received at Archways and how good all the staff were

What we did to find out more

Following the announcement of planned closure on 17th August, Healthwatch York issued a statement on its website asking for feedback, both positive and negative. We added this statement to our Facebook page and our twitter feed, encouraging people to get in touch.

The Press amended its story online to invite people to contact Healthwatch York or York Older People's Assembly with their concerns and opinions.

What we found out

Thirteen of the 19 respondents had direct experience of care at Archways either having been patients themselves, or through a close relative or friend and two had been involved professionally (total of 68% of respondents). Another respondent had hoped it would be available on her discharge from hospital; five expressed general concern from their knowledge of provision in York.

The key areas of concern can be summarised under the following headings.

Importance of Archways as a 'bridge' between hospital and home

- Available to all ages
- Some patients virtually immobile on admission, though reason for hospitalisation resolved
- Recovery plans drawn up on admission over 24 hours by multi-disciplinary team
- Availability of instant 24-hour staff help at every stage of recovery
- Specialist care (e.g. physiotherapy) available which may be missing from hospital wards

Importance of Archways as a 'bridge' between home and hospital

- May be referred for rehabilitation to avoid acute hospital admission if unable to cope independently

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Quality of care at Archways

- Excellent staff care, nourishment aids recovery
- En suite rooms promote dignity
- Close, caring monitoring of progress towards full pre-discharge assessment
- Encouragement to be independent

Archways Promotes independence and sense of well being

- Rehabilitative care allays people's anxieties about coping at home
- Lying in hospital bed (e.g. waiting for mealtime) means patients don't get experience trying to manage

Discharge straight home is not desirable or feasible

- Impossible to arrange adequate care at home after discharge
- Needs for specialist equipment – hoists, drips not at home
- Mobility problems: can’t use stairs, can’t get to toilet
- Community response team not 24- hour cover
- Ongoing multi-disciplinary assessment not available

Closure will affect older people most

- Need longer rehabilitation period and help with range of practical issues
- Scepticism/anxiety about proposed ‘full patient management team’

Single householders most affected if need help

- Washing
- Using toilet
- Dressing
- preparing food

Negative impact of closure on hospital

- People discharged too early with insufficient care may need to be readmitted
- Shortage of available beds/bed blocking will extend waiting times for admission

Conclusion

The health and care system must change to meet the challenges of the future. York Hospital believe changes like those proposed at Archways are part of the journey to meet these challenges. However, this journey of change demands a shift in culture. This requires health, care, independent and voluntary sector bodies to work together with patients, families, carers and the public as a whole to redesign services fit for the 21st century. People are concerned about the impact of changes. We need to begin a conversation about how we make the most of the resources we have to meet the growing demand.

We understand this, and want to support the system to face the challenges ahead.

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Recommendations

Recommendation	Recommended to
For future service changes, plans for consultation and engagement with the public / other agencies to be developed at the earliest stage	Health & Wellbeing Board
Commit to co-design and co-production (in line with the Social Care Institute of Excellence definition)	Health & Wellbeing Board
Consider the feedback received to date	Scrutiny committee

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Appendices

Appendix 1 – Press Release from YTH

Archways Intermediate Care Unit

17 August 2016

From 31 December 2016 services currently delivered from Archways Intermediate Care Unit will be provided through the York Community Response Team.

Wendy Scott, Director of Out of Hospital Care, said: “This decision, made jointly by NHS Vale of York CCG and York Teaching Hospital NHS Foundation Trust fully supports our collective ambition to further develop home based intermediate care capacity within the City of York.

“Developing these services is essential given the predicted growth in the elderly population, as research has shown that we may do harm to older people if we delay their transfer or discharge home after their acute recovery phase is completed.

“For example, 10 days of bed rest can cause the equivalent of 10 years of muscle ageing in those aged over 80 years. This is in addition to a loss of confidence and developing an increased reliance on others whilst in an unfamiliar setting such as a hospital ward.

“By offering assessment and care in a patient’s own home or another suitable setting, we are able to gain a more realistic assessment of their needs in terms of immediate recovery and rehabilitation and their on-going care requirements.

“Patients who would currently be admitted to Archways will in future receive their care and support from the Community Response Team, a widely-skilled team who can provide nursing, therapy and social care assessments, rehabilitation support and treatment.

“This team is already operating successfully in York and will be expanded to accommodate a greater number of patients.

“Other services will also be in place that may offer support, for example outreach pharmacy, Advanced Care Practitioners and the Community Discharge Liaison Service.

“Staff affected by this change will be fully consulted and offered alternative roles.”

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Appendix 2 – Healthwatch York call for stories and comments

Archways to close

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Healthwatch York welcomes feedback from members of the public, especially people who have experience of using Archways and their families and friends, about the decision to close the unit and plans to expand assessment and care in your own home. We want to hear all experiences, whether positive or negative, and your hopes and concerns about the new plans. Please get in touch.

Appendix 3 – Full details of comments received

- Dear Sir/Madam, I'm emailing to you today to express my opinion on the closure of Archways hospital unit. Back in 2013 my partners 90 year old grandma was admitted to the care of Archways for a 2nd time after a fall in her home, the care she received was the best us as a family could have hoped for while she was there and I would go as far to say that if she could she would like to still be in there she highly rates her stay. The unit is well run maintained and the staff are very good at the care they provide. As proud supporter of the UK NHS I am ashamed of this news and feel they need to make sharp u-turn and stop closing such units and start investing more into them. The York hospital was not long since in the press for not meeting the wait time, this surely will only add to the problem, as a shortage of beds is route cause without taking up wards with elderly people who need a longer stay to get them rehabilitated. If you need help with anything to keep Archways and other units alike open, with i.e. petitions or anything else then please get back in contact.

- Disabled woman who has broken her leg. She is in hospital in a straight leg plaster and cannot go home because she wouldn't be able to manoeuvre in a wheelchair with her leg out. Her husband is very concerned, she has pressure sores on her heel and is not receiving any physio. Believes she would have been a good candidate for support through Archways.

- Woman who has been through Archways twice. "It's brilliant. The staff are brilliant, the accommodation is out of this world. The food is great. I am so upset that it is closing. How can they do this? I'm back living alone at home. I cried when I had to come home as it was so lovely. I couldn't have had anything better, the staff looked after you day and night. It's so sad, I wish they'd keep it open. I just can't believe they'd close it."

- Proposed Closure of Archways Rehabilitation Unit: Please reconsider. We read in the Press this week with both surprise and

dismay about the proposed closure of Archways. This year we have personal experience of how good the unit is, and how effective it is in bridging the gap between hospital and home care. My wife had been in Intensive Care for several days, followed by several days in an acute ward after which her problem condition had been treated. However, after over a month in bed, she could not walk or deal with any of her most basic needs herself. A return home was impossible at that stage, and she was transferred to Archways; after 2 weeks she had been helped to walk again and gain enough independence in order for me to care for her at home; this was needed for several weeks before she really started to improve. Without Archways I don't know what the proposed action would have been. I would be very interested to hear from those in the NHS Foundation Trust & CCG making the decision what the alternative 'full patient management plan' would have been. As home care was not possible, a longer stay in hospital may have been the only option. Not only would this have taken up a hospital bed, but the concentration of specialist attention that is possible at Archways is likely to be dissipated and less effective in a more general ward where the staff are 'juggling far more balls'. In Archways the staff are able to concentrate on rehabilitation and monitor the progress of patients very effectively- it could be described as an intensive care unit for rehabilitation. We feel very fortunate and thankful that we had Archways to help us at a very difficult time. If it is closed, we fear that others in a similar situation may not be so fortunate. I appeal to the NHS decision makers- please re-examine- I think it really does merit a rethink.

- I was seriously ill 18 months ago. Archways was the turning point for me. Had water on the brain after an operation at hospital. Sent home as bed needed and I wanted to get home. But I wasn't coping. Serious pain in hip. Seen in orthopaedic outpatients. Consultant said "you are not coping, you must go into hospital or into Archways." Admitted straight to Archways from outpatients - luckily they had a bed available. I had an ensuite bathroom. This was brilliant as I had an irritable bladder. You don't always get an

ensuite in hospital but I could not have queued. Medication arrived promptly and food was available three times a day. Archways expected you to get up, get dressed and go to eat. You can't do this in a hospital. Physiotherapists are there. Timed speed of walking. Considerable difference from when you go in to when you leave so you can measure your improvement. I was given exercises to do. Needed support so used the windowsill. Much more privacy to do this than in a hospital. They gently push you to get better. I wanted to so was happy with this. In Archways for 4 or 5 weeks. Now back home, still disabled, still with language challenges, living alone, but coping. Had help at home, they put in place domiciliary care. They microwaved meals, but then who cleans up? Who makes tea in the morning and afternoon? I don't think the help I needed could be provided at home. I needed help in the shower. I relied on friends for shopping. I luckily had a shower and toilet downstairs so my son moved my bed and I lived on one level, but not everyone can do this. I believe it is cheaper in the long run to do this in a suitable facility.

- My wife was in Archways twice. I thought it was a lovely place. I used to go to see her in room 6. The place was very nice. I can't see why they are thinking about closing it down. It helped her recover. It was a nice place to visit. She died last year, so she was in last year.

- Was in Archways for a number of weeks a few weeks ago. I'd never been in hospital before but broke my back and neck in a fall. I went to Archways. Everyone from the cleaners to the nurses couldn't have done more for you. It's really really good. I was really worried about toileting. There was a button to press. It's a real worry for me not being able to go when you want to, but they were there day and night. They worked so hard. My first experience of hospital, such lovely, helpful and kind people. I'm really upset. I live on my own. I don't want to think of a strange woman prowling round my house whilst I can't get about. Such a lovely place, I'm really upset. I've come home, I'm not walking well but I am getting

about and keeping it clean. They are marvellous, could not have been better.

- I am writing to protest on the closure of Archways, York. This service is SO needed here in York. My Mother (then, age 88) was taken to Archways from A&E to recover from a back injury. She was there 3 weeks and was then able to return to her sheltered housing flat which only had a warden Mon – Fri 9am – 5pm. There is NO WAY she could have been safely cared for 'at home' by intermittent daily visits from nurses/carers! She would never have got back on her feet had it not been for the daily input of the staff/physios at Archways. My Mum is lucky, she has family that care for her and love her. Many older people have no family to keep a watchful eye on them and sending them home when in pain and unable to walk/care for themselves is just darn right cruel. Archways is VERY much needed indeed.

- May I express my disgust at the very thought of Archways in York being closed. How short sighted! They do a wonderful job, enabling elderly people to return to their own homes following care and physiotherapy by Archways. Without this facility elderly people will end up spending longer in hospital beds, thus putting even more stress on the already overrun hospital wards. I repeat, SO short sighted. Think again! A retrograde step in the care of deserving elderly population.

- I would like to complain in the strongest possible terms about any proposed plans to close Archways. I know several elderly patients (including my mother) who would never have recovered as well as they did without Archways. The link between hospital and home that Archways provides is absolutely imperative and without it even more funding will be needed to get those convalescing back on their feet. I implore you to reconsider any plans to close the facility.
- I was the Clinical Lead at Archways from 2004 when it opened to 2014 when I took flexi retirement and dropped into a Deputy Sister Post. I have just completely retired in February this year. In my

opinion Since York Foundation Trust took over Community Services, it has been more and more difficult to retain the ethos of Archways, so this news is not entirely unexpected. However I am appalled at the lack of understanding from Senior managers about what the core business of the Unit is. It most certainly is NOT like an Acute ward, where Older Patients function can rapidly deteriorate due to lack of activity in very Busy, acute environments. Archways is an inpatient rehabilitation unit that has been providing rehabilitation services for adults of all ages in York for the past 12 years. It was set up as an Intermediate care in patient facility as Part of the implementation of standard 3 of the National service framework for Older People. The Unit accepts patients from York hospital as a step down service after they have been assessed by the hospital based therapists as not physically able to return home; and a step up facility for patients direct from the community including from the Rapid Assessment Team based in A&E, and the Fast Response Team based in the community, to prevent acute hospital admissions. Whilst part of the Primary Care Trust the team at Archways managed admissions working to a criteria. Some of Unique selling points of the Unit were that we accepted all Adults ages who needed Rehabilitation or Multidisciplinary assessment and we also had single en-suite rooms , perfect to maintain Privacy and dignity. The Patients we accepted from the Community or A&E benefited from an integrated approach to assessment which could be carried out over 24 hrs which wasn't available at home, whilst in an environment which promoted independence at the same time (rather than de condition them as suggested by the CCG spokesperson) by Therapeutic interventions from Therapists, Nurses, Therapy and Care assistants & Patient services assistants. Discharges were planned from admission and were in the main timely with Patients Rehabilitation completed at home where needed. Closing Archways would be not only be a loss of 22 beds but a loss of an in-patient rehabilitation service that provides a pathway for safe discharge intended to prevents avoidable hospital admission, and I would suggest return to Older people becoming caught in the

"revolving door " of acute admissions as outlined by an Audit Commission report in 1997. They concluded "there was too little investment in preventative and Rehabilitative services, leading to unplanned admissions of older people to hospital and, in turn, premature admission to long term residential care." They recommended breaking the vicious circle through investment in Prevention and Rehabilitation (- NSF standard 3 Intermediate Care) Having revisited the Intermediate care standard of the NSF for Older people I believe the statement that "some patients will relieve Rehabilitation in an Acute setting, some can return home from that setting without support but some need further inpatient Rehabilitation or Rehabilitation at home " is still very relevant. That is we still need a variety of options for delivering Intermediate Care. It seems to me that there is still not the infrastructure to provide this level of support in patients own homes over 24hrs. It could be that the Trust have watertight evidence that they have the resources to support losing 22 beds including night support and /or can assure Patients that they can be safely discharged, including being Independent at night, however it seems to me that there is not the infrastructure to support this - I would be very happy to be proved wrong.

- I've had no direct experience of Archways but everything I've ever heard about it is positive. It stops bed blocking and it's a half-way house for people. What worries me is what you put in its place. People are going to be chucked out of hospital before they're right and will have to arrange care themselves. It's putting more pressure on individuals to fund their own care. If you have no money you go without. Where was the consultation on this? It's all very well for the interim boss of the CCG - they can make nasty decisions and then disappear. This must be the CCG trying to claim back some of their £13million. I've just been looking at York Hospital's Annual Review 2014/15 - they were celebrating 10 years of Archways and the good work it does. Surely this closure will put terrible pressure on other sites such as Whitecross and St Helens?

Is their future in doubt? Care homes are closing as well - where do people go? It's a bad decision.

- Just before Christmas 2015 I had a fall and broke my pelvis. I'm 86 and I live on my own. I was in York Hospital for 4 or 5 days and was then transferred to Archways on Christmas Eve. There is absolutely no way I could have managed if I'd come home, even with carers coming in - I couldn't do anything for myself. At Archways they take care of everything - there are physios, someone does all the cooking, they help you get in and out of bed. At first I needed to use bottles to go to the toilet in the night, then as I got a bit better they helped me get up and use the ensuite toilet. If I'd gone home I couldn't have made my own meals and the physios would have had to come round to my house. I couldn't have managed - it would have been bloody impossible. Archways was a life saver to me. They made sure I could manage before I went home, they assessed how I could get about and use the kitchen there. And their Christmas lunch was wonderful! I hope I don't need to use Archways again but I think it needs to be there for other people in the same situation I was.

- I would like to say I was shocked and very disappointed at the proposed closure of Archways. My mum spent 4 weeks in there and received excellent care and attention. The bit in the press is a load of rubbish saying the elderly lose their confidence staying somewhere like Archways, the patients are encouraged to walk to the dining room, my memories of this was seeing a whole line of people including my mum in a line like the conga all with walking frames. I think it is far more scary expecting the elderly to return home straight away after a stay in hospital. My neighbours have also stayed at Archways and given it positive feedback. It will be a great loss to the residents of York

- I'm really angry about this. Why was there no public consultation? The Community Response team finishes at 8pm - what happens after that? Will there be enough staff to run the service? How will

caring for these people in their own homes actually work? How will people be helped to use the toilet (day and night)? They will need hoists set up in their homes. Are they going to have IV drips in their homes? There will be a high risk of people having falls. One of the things Archways does is assess people before they leave to make sure that they can manage at home - what will happen if people are sent straight home?

- I wanted to add my voice to those demanding a re-think on the closure of Archways. Ms Wendy Scott, director of out of hospital care, is quoted in The Press on Wednesday 17th August, as saying "By offering assessment and care in a patient's own home or *another suitable setting*, (italics mine) we are able to gain a more realistic assessment of their needs in terms of immediate recovery and rehabilitation and their on-going care requirements" I would like to know what the "other suitable setting" is and how it differs materially from what Archways is providing at the moment. If it refers to living temporarily with family or friends then she needs to be reminded that this option is not available to many people. She also needs to understand that more and more elderly people live on their own and that the loneliness they experience when unwell does not contribute to a speedy recovery. I would also like to know how it can possibly be more cost-effective to have a team of physiotherapists and I entirely agree that a long stay in hospital is not good for speedy recovery, but that is precisely why Archways is so important in getting people out of hospital quickly and stimulating them towards recovering their independence If the problem is the cost of the unit, then surely some sort of community fund raising like we do for the Hospice could help to off-set the expense. Please do everything you can to force a re-think on this very shortsighted decision, which does not take into account the views of the citizens of York.
- I cannot believe you want to close this valuable and much needed unit, in the past year two of my friends have been in Archways, neither of them could have been cared for at home, one had to learn to walk again, and needed care 24 hours,

the other friend was in a body and neck brace, again needing full care, how can you replace the care given in Archways at home? Without Archways both would have been bed blocking, it just not make sense.
Sorry I cannot be at the public meeting, I hope people will be listened to.

- I am phoning to express concern about the closure of Archways, not so much for myself but for other people. I have to have a revision knee replacement operation and will probably be alright afterwards, but for other people they would not be able to manage with care at home. Archways is a marvellous place.

- I have done two PLACE visits on Archways and have been very impressed with the care they give and the feedback from the patients was also very good. I would like to put on record that the care they give the patients aid in a speedier recovery and also frees up bed space at the hospital. This helps with costs as many of the patients can return home earlier as they have been assisted in an earlier recovery. I am concerned that by discharging patients straight into the community the support will not be there as the services are stretched at the moment and without extra help I worry that people's health will suffer.

Appendix 4 - *Comments from local press stories*

"Archways, the York Hospital unit in Clarendon Court, was set up in 2004 specifically to try to help tackle bed blocking. This happens when patients - often elderly - are ready to leave hospital, but can't go home because the care they would need is not available.
Bed blocking can lead to hospital wards being filled with patients who shouldn't really be there. And it's a growing problem. Over the last year, an average of 22 people every day were ready to leave York hospital, but couldn't because of delays in arranging care.
Archways takes 350 people a year who otherwise would be occupying much-needed hospital beds.
In the circumstances, it seems distinctly odd that the hospital, in conjunction with the cash-strapped Vale of York Community Care Group (CCG), have decided to close the unit.
Both the hospital and the CCG stress the decision has nothing to do with saving money - even though it will save money.
Wendy Scott, York Hospital's director of out of hospital care, says the aim is to care for patients at home instead, because this aids their recovery.
That may well be true. And many patients would no doubt prefer to be looked after at home.
But only if the right care can be provided.
There are those - including Bob Towner of the York Older People's Assembly - who doubt this.
If the right care is in place, we welcome this move. But we fear it could lead to further hospital bed-blocking - or, even worse, patients being sent home before they're ready.
Either outcome would be entirely unacceptable. "

Comment from The Press 17/08/16

"they should be building more places like archways not closing them. Yes they might have a one time lump of money from selling the site but the costs they will incur from bed blocking fines and providing care in the community will continue year after year."

The Press letters 17/08/16

"My sister had a 6 week say in Archways after she was discharged from York Hospital because she needed extra care after having a stroke and Pneumonia and as insulin-dependent diabetes she could not get that sort of care at home. But it seems as the York Teaching Hospital NHS Foundation Trust and Vale of York Clinical Commissioning Group (CCG) are trying to save every penny they can and not really thinking through these plans leaving York people short on services that are needed.

I think this is just another way for the NHS to pass more business to the private sector at inflated prices and York Teaching Hospital NHS Foundation Trust and Vale of York Clinical Commissioning Group (CCG) trying to balance there books.
But by the time they have done this they will be paying out more in finds and care and transporting people a round the country to suitable places for the care they need which will remove and chance of them balancing there books from the sale of the Archways site."

The Press letters 17/08/16

"As a home care worker I see this as yet another cut to vital elderly services and a massive problem for the NHS trust and York hospital in particular where there are always a number of so called bed blockers waiting to be suitably discharged.
It worries me that we will now be looked upon not just as carers but as unskilled Physios and OT s on the cheap and expected to find time to rehabilitate and assess some of the most frail of our elderly people.
Home may be where many of these people would ideally like to spend their final years but the care system just isnt designed to cater for complex post operative needs and with average times given for a home visit being just 15 mins there is no time for social chatting and following exercise regimes.
There are untold numbers of vulnerable frail and elderly and disabled people in their own homes across York who are totally dependent on social service input and not all have the added luxury of a family input.
Its sad that Archways has now been labelled as no further use and the effects will be far and wide and very costly in more ways than just financially."
The Press letters 17/08/16

"Archways was wonderful for my late Father-in-law after a hospital stay. It is obviously a cost-cutting measure and people will not receive the same attention at home. Perfect building for student flats."
The Press letters 17/08/16

"On the face of it this seems a very short-sighted measure. Isn't this exactly the kind of facility we need if the NHS is going to meet the needs of an ageing population?"
The Press letters 17/08/16

"How can an occasional home visit ever provide the service that a purposely-designed 24/7 facility like Archways provides? It's precisely the sort of place that circumvents the hospital bed-blocking problem and eases the patient back to health by placing them under ongoing supervision.
And what's with all those weasel words used as an excuse? "By offering assessment and care in a patient's own home or another suitable setting

(???), we are able to gain a more realistic assessment of their needs in terms of immediate recovery and rehabilitation and their on-going care requirements". Why? How can you know more about everyone's different home environment than you do Archways? Why isn't Archways the "suitable setting" - and if it isn't, how come it's taken 12 years to find out?
The bottom line is, if you do all your assessments and find that being at home isn't the best option, it's too late and you've screwed up seriously."
The Press letters 17/08/16

"Archways is a wonderful resource. It helps to free hospital beds and provides a halfway house to returning home. They should be building more like this not closing them."
The Press letters 17/08/16
"It is shocking news to read of the imminent closure of Archways care home (The Press, August 17). It has provided patients with respite care following operations and lengthy bouts of serious illness for many years. These homes are an essential part of the need to regain confidence for people living alone after a hospital stay and often after trauma. Convalescent homes were phased out many years ago. This was a blow to the needy. Now we see it happening to one of the few such places left here in York. Stating that support will be given at home instead is not the answer. The care staff do their best, but due to the numbers of patient visits they are constantly stretched to the limit. I have known of the elderly being put into their night clothes as early as tea time. They then face ahead a very long evening and night with possibly no contact with another person right through until next morning. Older people need stimulus to keep them healthy and alert and deserve better. Moreover it is a poor reflection on the good name of York's former Lord Mayor, Jack Archer, whose name it bears. "
The Press letters 19/08/16

"I read with both surprise and dismay about the proposed closure of Archways (The Press, August 17). This year we have personal experience of how good the unit is, and how effective it is in bridging the gap between hospital and home care. My wife had been in intensive care for several days, followed by several days in an acute ward, after which her problem condition had been treated. However, after over a month in bed, she could not walk or deal with any of her most basic needs herself. A return home was impossible at that stage, and she was transferred to Archways; after two weeks she had been helped to walk again and gain enough independence in order for me to care for her at home. Without Archways I don't know what the proposed action would have been. As home care was not possible, a longer stay in hospital may have been the only option. In Archways the staff are able to concentrate on rehabilitation and monitor the progress of patients very effectively - it could be described as an intensive care unit for rehabilitation. We feel very

fortunate and thankful that we had Archways to help us at a very difficult time. If it is closed, we fear that others in a similar situation may not be so fortunate. I appeal to the NHS decision makers: please re-examine, I think it really does merit a rethink."
The Press letters 23/08/16

"I WAS so sad to hear of the closure of Archways. My stay there after having kidney failure and being in York Hospital was excellent. If I had not gone to Archways for recuperation and therapy, I don't think I would be where I am today. I would like to say a big thank you to all of the staff for their wonderful care and attention, and wish them all good luck for the future."
The Press letters 23/08/16

"How I endorse your readers' letters about the closure of Archways, which I too was very devastated to hear about. My husband died three years ago but could have done much sooner had it not been for his stays in Archways. Although I visited each day, it gave me a little respite when he was enabled to get back on his feet so I could care for him at home again, which I did for many years. But what about the elderly who live on their own, only relying on spasmodic visits from carers, unable to carry out the simplest of tasks on their own, for example to self-medicate sometimes four times each day? How naive of the powers that be to think that the excellent rehabilitation in Archways can be replicated by the very limited care in the home. It provides healing for body, mind and spirit. I'm afraid the baby may be thrown out with the bath water. Another nail in the coffin of the NHS?"
The Press letters 30/08/16
"The Press article "Closing unit 'will mean worse care'" (September 2) is unfortunately too true. Whoever dreamed this idea up has simply no idea of care needs. From experience, I know that carers have too little time to "care". They deliver a meal but can the patient manage to eat it unaided? They change an incontinence pad but do they have time to wash, dry and comfort the patient? Don't forget too that everything must be recorded. Fill in a log sheet, then it's: "I must go dear, it's four miles to my next call." I say that the money must be found to really care for these patients. More Indians and fewer chiefs perhaps."
The Press letters 06/09/16

"THE sudden announcement of the closure of the Archways rehabilitation centre without consultation with either staff, patients or the public, is just one example of the crisis our NHS is facing under the pressure of Government cuts. At the Health and Well Being Board last week I challenged the closure and the way it had been announced and was told the closure was not a "closure" but a planned "service development" - which will transfer resources to an expanded community rehabilitation team.

It's still unclear to what extent expanded community services that are likely to leave recovering patients on their own for at least some parts of the day or night, can replace the kind of intensive and continuous support and care offered at Archways.
I suspect the only hope for our NHS to survive the current Government assault is for managers to explain more clearly and openly to the public what is happening and why - and for the public to get more informed and challenging.
On September 23 a public meeting at the Priory Street Centre (7.30pm) will discuss the latest plans for wholesale NHS reorganisation (the catchily named STPs) and on September 28 the council's health and social care committee will be examining the Archways decision.“

Letter in The Press 14/09/16 Cllr Denise Craghill, Green group representative, Health & Well Being Board, member Health & Social Care Scrutiny Committee, Broadway West, York

“THE closure of Archways will create even more pressure on the NHS.
Archways takes bed blockers from York Hospital when they require a little more care before returning home, or those who require care packages put in place.
It also takes people who would otherwise go into hospital but can be cared for at Archways.
What we will have in the future is people dying in ambulances outside the hospital because people in A&E can't be found a bed in the wards, as people are blocking the beds because Archways is closed.
Unless the hospital is going to revert to wheeling sick people to the doors of their homes and abandoning them, bed blocking will only get worse.
The clinical commission group (CCG) have a chance to rethink the closure of Archways as they now have a new leader.
The closure of Archways is more about the CCG saving money as the cost of care can be passed on to the council, and they in turn will pass it on to the person who requires the care. They can pay for it.”
The Press letters 20/09/16

healthwatch York

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York CVS

Healthwatch York is a project at York CVS. York CVS works with voluntary, community and social enterprise organisations in York. York CVS aims to help these groups do their best for their communities, and people who take part in their activities or use their services.

This report

This report is available to download from the Healthwatch York website: www.healthwatchyork.co.uk

Paper copies are available from the Healthwatch York office
If you would like this report in any other format, please contact the Healthwatch York office

Health & Wellbeing Board **23 November 2016**

Report of the Chair of the Health & Adult Social Care Policy & Scrutiny Committee

Bootham Park Hospital Scrutiny Review Final Report

Summary

1. This report presents the Health and Wellbeing Board (HWBB) with the final report of the Bootham Park Hospital Scrutiny Review and information around actions taken to restore full mental health services to York. A copy of the full report and its associated annexes is available online along with the minutes from when it was considered by the Health & Adult Social Care Policy & Scrutiny Committee in September 2016.

Background

2. Bootham Park Hospital (BPH) was closed following an unannounced inspection of the psychiatric inpatient services by the Care Quality Commission (CQC) in September 2015. The CQC reaffirmed that the service being provided to patients from Bootham Park Hospital at this time was not fit for purpose and that all clinical services had to be relocated from 30 September 2015.

3. On 20 October 2015 the Health & Adult Social Care Policy & Scrutiny Committee met to consider the circumstances leading to the closure of Bootham Park Hospital and heard evidence from NHS Property Services; Leeds and York Partnership Foundation Trust; Tees, Esk and Wear Valleys NHS Foundation Trust; the Care Quality Commission and NHS Vale of York Clinical Commissioning Group (VoY CCG).

4. As a consequence the Committee agreed to write to the Secretary of State for Health supporting a call for an inquiry / urgent investigation into the hospital's closure.

5. At a meeting on 24 November 2015 the Committee agreed to carry out its own review of the Bootham Park Hospital closure utilising the support of an Independent Expert Adviser, John Ransford, who was prepared to

provide his services on a pro bono basis, and NHS England who were carrying out their own lessons learned review.

6. The Committee also agreed that delegated authority be given to the Chair and (now former) Vice-Chair to set the parameters of the review and they agreed the remit: *"To understand the circumstances leading to the closure of Bootham Park Hospital, to establish what could have been done to avoid the gap in services in York, particularly for in-patients and their families, and identify any appropriate actions for relevant partners."* A Task Group was later established to help carry out this work on behalf of the Committee.

Consultation

7. The Task Group, Independent Adviser and Scrutiny Officer have consulted extensively with NHS England who have in turn been involved in detailed consultation with the partner organisations. The Committee has also been able to question all health partners about the circumstances leading to the closure of BPH. Furthermore, Healthwatch York carried out a major piece of work on behalf of the Committee to gauge the impact of the BPH closure on people who use mental health services in the city, their families, carers and staff and this is included in the link to the full report at paragraph 1.

Analysis

8. Over a series of meetings involving NHS England and all health partners the Task Group and Independent Expert gathered information in support of the scrutiny review. The final report and its associated annexes include a full analysis of the information gathered, conclusions and the Task Group recommendations, which were endorsed by the Health & Adult Social Care Policy & Scrutiny Committee at their meeting in late September 2016. At this meeting the Committee agreed to amend Recommendation (iii) in paragraph 70 was amended at meeting from "A detailed memorandum of understanding to avoid the sudden closure of facilities on the grounds of serious quality or safety concerns should be shared with the Committee within a month" to "Commissioning agents sign up to an understanding that they are more proactive in engaging with people to avoid the sudden closure of health facilities."

Review Recommendations

9. Having considered the evidence gathered in support of the Bootham Park Hospital Scrutiny Review the Health and Adult Social Care Policy &

Scrutiny Committee endorsed the following Task Group recommendations.

10. NHS England should ensure that:

    i. The NHS nominates a named person to be responsible for the overall programme of sustained improvements to mental health services in York. That person to provide regular progress reports to the Council and meet this Committee when requested to review progress;

    ii. Specific details are provided of all mental health services currently provided or planned in the City of York area, with timescales for provision or replacement where appropriate;

    iii. Commissioning agents sign up to an understanding that they are more proactive in engaging with people to avoid the sudden closure of health facilities.

11. Tees, Esk and Wear Valleys NHS Foundation Trust and the Vale of York Clinical Commissioning Group:

    iv. Carry out a full and robust consultation process ahead of the procurement of a new mental health unit in York and that details are shared with this Committee.

12. The Care Quality Commission:

    iv. Should consider varying its internal processes so that there is a procedure for service transfers between providers, rather than treating them as a full deregistration and re-registration procedure.

Committee Recommendations

13. In addition, at their meeting in late September the Health & Adult Social Care Policy & Scrutiny Committee also agreed that:

    i. The Final Report and its recommendations be referred to the Executive *[24th November 2016]* and the Health & Wellbeing Board for endorsement and consideration as appropriate, prior to forwarding them to NHS England.

    ii. Copies of the final report be sent to all the organisations mentioned in the recommendations in paragraphs 10 to 12, above.

iii. Ask those organisations mentioned in the recommendations to respond to the Health & Adult Social Care Policy & Scrutiny Committee within three months.

Council Plan

14. This report is linked to the Focus on Frontline Services and A Council That Listens to Residents elements of the Council Plan 2015-2019.

Risks and Implications

15. There are no risks of implications associated with this report. The risks and implications associated with the review recommendations are detailed in paragraphs 77 and 77 of the final report at Appendix 1.

Recommendation

16. Members of the Health & Wellbeing Board are asked to note the contents of this report and the recommendations arising from the scrutiny review, specifically those that their own organisations are asked to respond to (paragraph 13(iii) refers).

Reason: So Members are aware of the work undertaken by the Health & Adult Social Care Policy & Scrutiny Committee in relation to the closure of Bootham Park Hospital and the measures taken to re-establish services in York.

Contact Details

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Report Approved ✓ **Date** 31/10/2016

Wards Affected: **All** ✓

For further information please contact the author of the report

Background papers

Bootham Park Scrutiny Review Final Report

Health and Wellbeing Board – Meeting Work Programme 2016/17

Wednesday 23rd November 2016 – West Offices			
Item/Topic	**Lead Organisation & Officer**	**Other Contributing Organisations & Participants**	**Scope**
Children and Young People Focused Meeting			
Children's Safeguarding	Independent Chair Simon Westwood	City of York Council Will Boardman Juliet Burton	• To present the Annual Report of the Children's Safeguarding Board • To present an update on the Children's Safeguarding Board
Everybody's Business Conference	City of York Council Dr Stephen Wright Tees, Esk & Wear Valleys NHS Foundation Trust	City of York Council Eoin Rush	• To inform the Board of how the issues raised at the conference held in November 2015 have been addressed • To share the action plan and timescales for responding to these
Other Business			
Inter-Board Protocol	Chair of the Health and Wellbeing Board	Safeguarding Adults Board Children's Safeguarding Board Safer York Partnership YorOK Board	• To approve and agree to the Chair of HWBB signing a protocol setting out how HWBB, YorOK Board, Safeguarding Children Board, Safeguarding Adults Board and Safer York Partnership will work together
Suicide Prevention and Suicide Audit	City of York Council Sharon Stoltz	City of York Council Nick Sinclair Andy Chapman	• Presentation and update on suicide prevention and the suicide audit

Health and Wellbeing Board – Meeting Work Programme 2016/17

Wednesday 23rd November 2016 – West Offices			
Item/Topic	**Lead Organisation & Officer**	**Other Contributing Organisations & Participants**	**Scope**
Healthwatch York	Healthwatch York Siân Balsom		• To receive recent Healthwatch York reports on: ○ Archways (with recommendations for HWBB) ○ Ante Natal Services
Health Protection	City of York Council Sharon Stoltz		• To receive a report Health Protection from the Director of Public Health
Integration and Transformation Board	City of York Council Martin Farran	City of York Council Tom Cray NHS Vale of York Clinical Commissioning Group Rachel Potts	• To receive a progress report from the Integration and Transformation Board to include details on: ○ Joint Commissioning Strategy and Joint Commissioning Board ○ Better Care Fund Quarterly Monitoring ○ Other ITB work streams
Mental Health Facilities for York	Tees, Esk & Wear Valleys NHS Foundation Trust Colin Martin Ruth Hill		• To receive an update on mental health facilities for York
For Information: Bootham Park Hospital Scrutiny Report	City of York Council Cllr. Paul Doughty	City of York Council Steven Entwistle	• To receive the final report and recommendations from the Bootham Park Hospital Scrutiny Report

Health and Wellbeing Board – Meeting Work Programme 2016/17

Wednesday 18 January 2017 - West Offices			
Item/Topic	**Lead Organisation & Officer**	**Other Contributing Organisations & Participants**	**Scope**
YorOK Board	City of York Council Jon Stonehouse	City of York Council Eoin Rush	• To receive the Annual Report of the YorOK Board
Integration and Transformation Board	City of York Council Martin Farran	City of York Council Tom Cray NHS Vale of York Clinical Commissioning Group Rachel Potts	• To receive a progress report from the Integration and Transformation Board
Healthwatch York	Healthwatch York Siân Balsom		• To receive recent Healthwatch York reports on: ○ Dementia Services

Wednesday 8 March 2017 - West Offices			
Item/Topic	**Lead Organisation & Officer**	**Other Contributing Organisations & Participants**	**Scope**
Mental Health Focused Meeting			
Mental Health and Learning Disabilities Partnership Board	NHS Vale of York Clinical Commissioning Group Paul Howatson		• To receive the Annual Report of the Mental Health and Learning Disabilities Partnership Board

Health and Wellbeing Board – Meeting Work Programme 2016/17

Wednesday 18 January 2017 - West Offices			
Item/Topic	**Lead Organisation & Officer**	**Other Contributing Organisations & Participants**	**Scope**
Other Business			
JSNA/JHWBS Steering Group	City of York Council Sharon Stoltz	All HWBB Partners	• To approve and launch the renewed Joint Health and Wellbeing Strategy for York • To receive the work programme and a progress report on the work of the JSNA/JHWBS Steering Group
Director of Public Health's Report	City of York Council Sharon Stoltz		• To receive the annual report of the 2016 and approve the recommendations
Integration and Transformation Board	City of York Council Martin Farran	City of York Council Tom Cray NHS Vale of York Clinical Commissioning Group Rachel Potts	• To receive a progress report from the Integration and Transformation Board
Healthwatch York	Healthwatch York Siân Balsom		• To receive recent Healthwatch York reports on: • Continuing Healthcare

Health and Wellbeing Board – Meeting Work Programme 2016/17

Wednesday 17 May - West Offices			
Item/Topic	**Lead Organisation & Officer**	**Other Contributing Organisations & Participants**	**Scope**
Other Business			
Healthwatch York (to be confirmed)			
Integration and Transformation Board	City of York Council Martin Farran	City of York Council Tom Cray NHS Vale of York Clinical Commissioning Group Rachel Potts	• To receive a progress report from the Integration and Transformation Board
Joint Strategic Needs Assessment/Joint Health and Wellbeing Strategy Steering Group	City of York Council Sharon Stoltz	All HWBB Partners	• To receive an update from the JSNA/JHWBS Steering Group

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