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Brent

Health Partnerships Overview and Scrutiny Committee

Tuesday 18 March 2014 at 7.00 pm
Boardrooms 3 and 4 - Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ

Membership:

Members Councillors:	**first alternates** Councillors:	**second alternates** Councillors:
Daly (Chair)	Mitchell Murray	Moloney
Hunter (Vice-Chair)	Sneddon	Brown
Colwill	Baker	Kansagra
Harrison	Singh	Naheerathan
Hector	Aden	Al-Ebadi
Hossain	Ogunro	RS Patel
Leaman	Green	Cheese
Ketan Sheth	Gladbaum	Van Kalwala

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The press and public are welcome to attend this meeting

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members

Item Page

1 Declarations of personal and prejudicial interests

Members are invited to declare at this stage of the meeting, any relevant financial or other interest in the items on this agenda.

2 Deputations (if any)

3 Minutes of the previous meeting held on 28 January 2014 1 - 10

The minutes are attached.

4 Matters arising (if any)

5 Mental Health Services in Brent 11 - 46

The report provides an overview of the mental health services provided in Brent for people with severe mental health issues. The report is divided into two parts:

- Community Mental Health Services
- Acute Mental Health Services at Park Royal: including details of wards, structure, patient data and information on discharge/transfer delays.

6 Task Group Report on Tackling Violence against Women and Girls in Brent 47 - 202

Members of the Health Partnership Overview and Scrutiny Committee (HPOVS) on a number of occasions, expressed an interest in forming a task group to tackle violence against women and girls in Brent; focusing on Female Genital Mutilation (FGM), Honour Based Violence (HBV) and Forced Marriages (FM).

The task group was agreed by HPOVS in March 2013 and has used this time to conduct an in-depth review into harmful practices. The task group report is attached as appendix A.

7 Future of Central Middlesex Hospital and Willesden Centre for Health 203 - 238

The reports are attached.

8 Redesign and Investment in Diabetes Services in Brent 239 - 262

Members will remember that, at the last committee meeting in January, it received a report that outlined the range of diabetes services provided in Brent. The committee requested that a follow up report be provided to this meeting with more details on the planned changes to the way diabetes services are delivered that were mentioned in the original report. In response to the committee's request, this report outlines the rationale for changes in services. The redesigned services will focus on providing integrated care in a community setting in line with national and local guidance and priorities.

A subsidiary report is also attached, which provides an update on the Diabetes Task Group recommendations which were reported to, and approved by, the committee in February 2013.

9 18 Weeks Referral To Treatment Incident and Urology Serious Incident 263 - 268

The reports are attached.

10 Health Partnerships Overview and Scrutiny Committee work programme 2013/2014 269 - 270

The work programme is attached.

11 Date of next meeting

The next meeting of the Health Partnerships Overview and Scrutiny Committee will be confirmed at the Annual Council meeting on 4 June 2014.

12 Any other urgent business

Notice of items to be raised under this heading must be given in writing to the Democratic Services Manager or his representative before the meeting in accordance with Standing Order 64.

Please remember to SWITCH OFF your mobile phone during the meeting.

- The meeting room is accessible by lift and seats will be provided for members of the public.

Brent

MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Tuesday 28 January 2014 at 7.00 pm

PRESENT: Councillor Daly (Chair), Councillor Hunter (Vice-Chair) and Councillors Colwill, Harrison, Hector, Hossain, Leaman and Ketan Sheth

Also present: Councillor Hirani (Lead Member for Adults and Health)

NHS representatives present: Dr Sarah Basham (Co-Clinical Director, Brent Clinical Commissioning Group), David Cheesman (Director of Strategy, North West London NHS Hospitals Trust), Isha Coombes (Manager, Brent Clinical Commissioning Group), Rachel Donovan (NHS England), Sarah Mansuralli (Deputy Chief Operating Officer, Brent Clinical Commissioning Group), Jo Ohlson (Chief Operating Officer, Brent Clinical Commissioning Group), Jonathan Wise (Chief Finance Officer, Brent Clinical Commissioning Group).

Council officers present: Mark Burgin (Senior Policy Officer, Assistant Chief Executive Service), Toby Howes (Senior Democratic Services Officer, Legal and Procurement), Phil Porter (Strategic Director, Adult Social Care) and Melanie Smith (Director of Public Heath, Assistant Chief Executive Service).

1. **Declarations of personal and prejudicial interests**

None declared.

2. **Minutes of the previous meeting held on 4 December 2013**

RESOLVED:-

that the minutes of the previous meeting held on 4 December 2013 be approved as an accurate record of the meeting.

3. **Matters arising (if any)**

None.

4. **Diabetes Services in Brent**

Melanie Smith (Director of Public Health) presented the report that had been jointly produced by the council's Public Health Team, Brent Clinical Commissioning Group (CCG) and NHS England. Members were aware that diabetes was of particular concern in the borough and noted that 22,097 people were on GP diabetes registers in Brent. Diabetes UK had estimated a diabetes prevalence rate of 10.5% overall in Brent in October 2013, although rates varied across the borough. It is estimated that one in four people with diabetes in London are undiagnosed and are at high risk of developing long term complications. The committee heard that there

had been a 38% increase in diabetes rates for NHS Brent between 2008/09 and 2012/13. Melanie Smith informed members that those with diabetes in Brent were more likely to develop complications arising from their condition than the general population, including heart disease, stroke, foot disease that may necessitate amputation, kidney disease and loss of sight. However, early diagnosis, good diabetic care and self management could all be effective in preventing complications from arising. Melanie Smith referred to the findings from the 2011/12 National Diabetes Audit that identified that people with diabetes in Brent were less likely to suffer complications than the national average of those with diabetes, despite the borough's relatively high levels of deprivation. This served as evidence that both health services and residents were responding well once diabetes was diagnosed.

Isha Coombes (Manager, Brent CCG) then summarised the current diabetes services currently operating in the borough. A total budget of £9.493m had been set for diabetes services for 2013/14 and it included a range of services. This included health promotion and prevention of diabetes schemes run in conjunction with the CCG and the council, including physical activity programmes, healthy eating, diabetes awareness raising, risk assessment and health checks and the Moving Away from the Pre-diabetes programme. The council commissions the NHS Health Check programme offered by Brent GPs aimed to prevent diabetes as well as heart disease, stroke, kidney disease and certain types of dementia. The council was also working with Diabetes UK through a community engagement programme, using community champions to promote awareness of diabetes for the high risk groups in the borough. Isha Coombes advised that diabetic patients were currently managed in primary care under the standard General Medical Services (GMS)/Personal Medical Services (PMS) contract, including additional health checks under the Quality and Outcomes Framework (QOF), a voluntary scheme which all Brent practices participated in. Other schemes to tackle diabetes included the Brent GP insulin initiation scheme, which had been rolled out across Brent in April 2012 and the Ealing Integrated Care (ICO) Organisation service that helped patients with type II diabetes, secondary care services and the Brent diabetic eye screening service. The latter is commissioned by NHS England from Ealing ICO. Those patients with positive screening tests would subsequently be referred to ophthalmology services at Central Middlesex Hospital (CMH).

Isha Coombes then outlined the proposals for the diabetes service redesign commencing in April 2014. The committee heard that Brent CCG recognised the need to invest in diabetes services, particularly as diabetes was expected to continue to rise in the borough. A redesigned integrated pathway community based service would realise a number of benefits, including:

- Providing a consultant led service where patients were seen by a multi-disciplinary team and treated in one appointment rather than a series of appointments
- Achieving value for money, ensuring patients were treated in the most appropriate environment according their needs at the right cost
- Opportunities to upskill GPs and practice nurses in diabetes care
- Facilitate early discharge back to GP care
- Develop a clinical network of care to provide tiers 1 and 2 care within localities.

Isha Coombes advised than Brent CCG had agreed an additional £693K of funding to enhance and further develop the community based integrated diabetes pathway, including increasing clinical capacity through additional specialist staff. Members heard that the redesigned service would improve health outcomes through:

- Providing early detection and identification of diabetes
- Involving patients in the decisions around personalised care planning
- Developing patient knowledge, skills and confidence for better self-management
- Demonstrating robust and clinical outcomes
- Targeting high risk populations

During members' discussions, Councillor Colwill stated that the report lacked any reference to the task group on diabetes that he had chaired, including the recommendations it had made and he asked what progress had been made on these. A member acknowledged that overall most Brent GP practices were achieving a high number of points for the diabetes domain of QOF, however they enquired what steps were being undertaken to improve the small number that were underachieving. Surprise was expressed that the Wembley site was unable to cope with demand for diabetic eye screening and why had there not been extra clinics laid on or staff redistributed accordingly. Further information was also sought in respect of initiatives to support healthy eating in Brent. A member commented that the report needed more detail in order for the committee to fully scrutinise the matter and the report focused too much on providing an overview, whilst he felt the section on diabetes service redesign was also too brief. He suggested that there could be more details, for example, on plans for diabetes services in the Kingsbury locality as it had the highest diabetes prevalence in the borough.

The committee enquired whether the £9.493m designated for diabetes services was inclusive of the council's public health spend. In noting that the QOF was optional, clarity was sought as to whether it was included as part of NHS Brent contracts and what was the total spend on GPs participating in the scheme. Details of NHS England funding for commissioning of diabetic eye screening services for Brent and funding for the Brent GP insulin initiation scheme and the Ealing integrated care pathway programme was sought. Clarity was sought as to whether the ophthalmology services commissioned by Brent CCG at CMH were different from community based services and on community screening services in Brent. It was also enquired whether an interpretation service was available for patients whose first language was not English and what was the total number of diabetic consultants in the borough.

In reply to the issues raised, Melanie Smith stated that the report explained the current position in respect of diabetes services, so some initiatives such as healthy eating were still in the process of being developed. She acknowledged the role played by the diabetes task group and the recommendations that it had made and the task group would be referred to in future reports. Members noted that all of the task group recommendations had been referenced, however those relating to schools would be more difficult to achieve, whilst there were also resource limitations in respect of the recommendations relating to green gyms. However, a number of methods were being considered in respect of awareness raising,

including working with Diabetes UK and using community champions as an outreach. Melanie Smith advised that the high demand for diabetic screening in the borough was very welcome and exceeded that in other areas and consideration of how to reconfigure the service to cope with this demand was being undertaken. She advised the committee that there were practical difficulties in identifying the exact public health funding allocated for addressing diabetes as resources were allocated to address risk factors for a range of conditions, for example promotion of physical activity might reduce diabetic risk but would also improve mental wellbeing. The committee noted that Ealing ICO operated community diabetic eye screening in the borough at Wembley, the Jeffery Kelson Centre at CMH and Willesden Community Hospital and Melanie Smith added that in some cases, it was more useful to monitor and screen patients rather than refer them to the ophthalmology service.

Isha Coombes confirmed that the funding allocated by Brent CCG for diabetes service included both primary, community and acute care. For the Ealing ICO integrated pathway, the funding would increase from £391K in 2013-14 to nearly £1m in 2014-15. Members noted that Brent CCG commissioned an interpreters service for all services, including diabetes, and liaised with the service providers to put in place the appropriate arrangements. The committee also heard that there was presently one full time diabetes nurse consultant and five diabetes specialist nurses and the new model would include additional staff as set out in section 10.6 of the report.

Jo Ohlson (Chief Operating Officer, Brent CCG) acknowledged that diabetes prevalence was highest in the Kingsbury locality, however it was also a significant issue across the whole of the borough and early diagnosis was critical in achieving positive outcomes. In respect of Brent CCG commissioned services at CMH, Jo Ohlson clarified that although diabetic clinical services were not part of out of hospital care, some eye conditions may be unrelated to diabetes and so the service covered a range of possible conditions. She added that future reports could include more information on pathways, staff and intervention.

Dr Sarah Basham (Co-Clinical Director, Brent CCG) acknowledged that the Wembley site was underperforming, however this was partly attributable to both it being a small centre and because it operated on a walk-in basis. Steps were being taken to ensure practices were up to speed through investment in training and through staff cascading their skills, such as those qualified in the Brent GP insulin initiation scheme, and through peer pressure to raise standards, however most practices were scoring above the national average. Dr Sarah Basham advised that many GPs in the borough were already insulin initiation scheme trained, however the process of initiating a patient was a lengthy one and required regular contact with the patient. Where practices could not provide a particular service, they could facilitate access to those that could.

Rachel Donovan (NHS England) added that those practices that were underperforming would be assessed to identify the underlying reasons for this and then given the appropriate tools to be able to improve. She confirmed that GP practices were remunerated for providing diabetes services under the QOF and that the total spend on this could be provided.

The Chair stated that the committee had felt that more information in future reports was necessary in order for effective scrutiny to be able to take place, including financial details. The Chair added that a description of the type of information that members wished to be provided at future meetings would be sent to the council's Public Health Team and Brent CCG. She also requested further details in respect of the diabetes service redesign from April 2014.

5. **Brent Clinical Commissioning Group finances**

Jonathan Wise (Chief Finance Officer, Brent CCG) introduced the report and outlined Brent CCG's finances in the context of the national financial framework, explaining that NHS England would be responsible for allocating funding to CCGs for the next two years. Members heard that CCGs' statutory functions were more restrictive than they had been for primary care trusts. Hospitals received most of their income from CCGs, as well as NHS England and local authorities, through national tariffs. Jonathan Wise drew members' attention to Brent CCG's financial position, which was relatively healthy and a surplus budget of £26m had been agreed for 2013/14. Brent CCG had also agreed to be part of two pan-CCG financial arrangements, the first to support the Shaping a Healthier Future implementation and the second an agreement with Harrow and Hillingdon CCGs to be part of an in-year risk share arrangements. Jonathan Wise advised that the supplementary paper circulated prior to the meeting provided an explanation of the process of how risk share arrangement would operate. He informed members that Brent CCG had been awarded the minimum level of growth in 2014/15 and 2015/16 as it had been assessed as being overfunded in 2014/15. He advised that the uplift of 2.14% for 2014/15 and 1.7% in 2015/16 would not keep pace with the estimated 3.4% per annum increase in cost pressures that were expected due to local demand and cost growth.

During members' discussion, it was queried whether the national tariffs influenced clinical decisions in any way and was there any possibility of local tariffs being applied. In respect of Brent CCG's agreement with Harrow and Hillingdon CCGs, it was commented that their financial situation was not particularly healthy and why was there no mention of Brent CCG having an agreement with Ealing CCG whose financial position was stronger. An enquiry was made as to whether community and out of hospital services were subject to national tariffs. It was commented that there were significant costs involved that did not actually include costs of commissioning services and treating patients, such as contingency costs, and a further explanation of this was sought. Moreover, it was asked how end of life services would continue to be provided in view that funding on this had been reduced. A member commented that if more patients wished to see out their lives at home rather than hospital, this would impact on resources in social care. Members also queried why NHS England did not fund GP's IT equipment. In respect of Shaping a Healthier Future, it was asked whether Brent CCG had allocated 2% headroom funding for last year as well as 2013/14 and did other CCGs do the same. Turning to investments, the committee queried whether these would contribute towards primary care network development and achieving better GP outcomes and improving primary care hub access. It was also commented that the proportion of spending on GPs was considerable and what steps were being taken by NHS England to raise GP standards. A member also asked what the Procurement Panel would be recommending to the Governing Body on 29 January

with regard to commissioning of all services currently commissioned through a local enhanced service agreement.

In reply to members' queries, Jonathan Wise advised that nationally set tariffs were expected to be used to pay hospitals, although there could be some circumstances where local tariffs could be used where there had been a prior agreement to do so. In respect of Brent CCG's agreement with Harrow and Hillingdon CCGs, he explained that each CCG had produced their plans regarding Shaping a Healthier Future at the beginning of the year and once they had agreed the arrangement with NHS England, they were expected to adhere to it. Jonathan Wise added that it was sensible to have a wider geographical sphere and in any case each CCG's starting point in respect of Shaping a Healthier Future was independent from their overall financial situation. Members noted that Brent CCG had allocated 2% of headroom funding in the last two years and whilst some CCGs had allocated the same, others had not due to their financial situation, in which case consideration would be given as to what the appropriate allocation would be. Jonathan Wise confirmed that 1% of spend per annum was allocated for contingency costs, whilst the CCG also had a financial responsibility in respect of its estate, even where it was under utilised and so the CCG was committed to maximising use of its' estate. Members noted that an explanation of corporate running costs had been provided in the supplementary report circulated prior to the meeting.

Jo Ohlson added that discussions would take place over what services it would be possible to provide for less and she confirmed that national tariffs did not apply to community and out of hospital services. In respect of end of life services, she advised that this service would be re-configured, including saving costs in hospital admissions, especially as some patients preferred to see their last days at home and they could receive pain relief medicines too. It was noted that hospital admissions in such cases were already reducing. Jo Ohlson advised that GPs were being encouraged to work together and there was a support team to help facilitate primary care network development and there were also incentives for GPs to improve outcomes. Three primary care hubs had also been identified to offer extended opening hours. She explained that whilst funding was being reduced for hospitals, a significant amount of it was being diverted to out of hospital care as GPs were expected to offer more services and a number of procurement exercises were being undertaken during commissioning to run such services. Jo Ohlson added that some spend, such as on Shaping a Healthier Future, was non-recurrent. With regard to the local enhanced service agreement, the Procurement Panel would be recommending that these services continue to be commissioned to help continue to raise standards in out of hospital care.

David Cheesman (Director of Strategy, North West London NHS Hospitals Trust) advised that there was more flexibility in terms of agreeing tariffs for community services. He added that the Urgent Care Centre's tariffs at CMH had been closer to national tariffs, however lessons had been learnt and their were opportunities to reduce costs in this area. Rachel Donovan advised that NHS England had devolved costs to the CCGs for GP funding, including for IT equipment. With regard to improving GP standards, CCGs had been delegated powers to achieve this through commissioning and improving services locally. Phil Porter (Director of Adult Social Care) advised that in respect of end of life care, those who had chosen to remain at home would have access to prompt healthcare.

The Chair requested more information at a future meeting on end of life services, including details of how those remaining at home had been increased, the number who were looked after and the number who had been re-admitted to hospital. She also stated that Brent CCG finances would be revisited at a future meeting.

6. **Brent Clinical Commissioning Group commissioning intentions 2014/15**

Sarah Mansuralli (Deputy Chief Operating Officer, Brent Clinical Commissioning Group) presented the report that outlined the key aims and desired outcomes of Brent CCG's commissioning intentions. The main intention was to help fulfil the improvements identified as necessary and provide more community provision. The committee noted that the providers shared the CCG's intentions and the aims would be achieved through collaborative working between the CCG, service providers, patients and the public. The CCG had undertaken benchmarking exercise across four nationally defined domains, however data had not been available for the fifth domain in relation to treating and caring for people in a safe environment and protecting them from avoidable harm, so local data was being obtained. Members heard that CCG's commissioning intentions had been supported at draft stage by the EDEN Committee and the final proposals would be reported to the EDEN Committee on 29 January, following which their feedback would be available. Sarah Mansuralli emphasised the importance of producing clear commissioning intentions as these were instrumental in shaping the CCG's investment plans. The CCG's intentions were both broad and ambitious and aimed to maximise patient outcomes and experience.

During members' discussion, a member queried whether the proportion of acute contracts making up 73% of the Brent CCG contract was what the CCG had intended. In noting the intention for providers to work collaboratively towards electronic records, she noted that such initiatives had not worked in the past and she enquired what steps would be put in place to ensure that this was more successful this time. She expressed her approval of proposals with regard to the assessment tariff, mental health and elderly care and added that the conference on dementia in December 2013 that had included the attendance of Dr Ethie Kong and some Members of Parliament had been a worthwhile exercise. In view of this, she queried why dementia had not been explicitly included in the report. Another member welcomed the overall purposes of the CCG commissioning intentions, however she felt that they lacked specificity and in view of the financial constraints, she enquired what areas would be focused on and what consultation had been undertaken with patients. A member asked if podiatry services would be available, especially as some diabetic patients would benefit from this. In respect of dementia, he enquired how the quality of assessments would improve to ensure they got the appropriate level of care.

With regard to intentions for outpatients' services, it was queried how these would be delivered in view that the CCG's Quality, Innovation, Productivity and Prevention (QIPP) investment plan for 2014/15 was subject to a 3% budget reduction. In respect of community health services and pathways, information was sought in respect of plans, including the budget allocated for it and a timetable for implementation. It was commented that intentions for community paediatrics lacked detail and further information was sought, particularly in respect of services for children with acute diabetes. Further details were also sought in respect of proposals for mental health services for children and eating disorders .

In reply to the issues raised, Sarah Mansuralli advised that there was an investment programme for 2013/14 in respect of dementia and this was already showing improvements in diagnosis rates and further data would be forthcoming on this. A 'dementia café' had been jointly set up by Brent CCG and the council and this was indicative of the progress that had been made in this area. Sarah Mansuralli added that treating dementia was one of NHS England's priorities. In respect of outpatients services, the improvements would be delivered through competitive dialogue to achieve the appropriate model of delivery and it was felt that QIPP targets would be met at reduced cost. Members heard that a project initiation document was in place to deliver community health services and pathways and once a business case had been produced, budget details would be drawn up. Sarah Mansuralli drew members' attention to page 70 in the report that outlined commissioning intentions for children's services including mental health. She added that eating disorders amongst children was especially prevalent in the borough, however such a condition was addressed by the Child and Adolescent Mental Health Service (CAMHS).

Jo Ohlson added the CCG action plan provided specific details on how the commissioning intentions would be achieved, whilst podiatry services for diabetic patients would continue, although stricter criteria for access to this service would apply for non-diabetic patients. Isha Coombes added that there would be increased capacity for podiatry services. In respect of children with acute diabetes, she advised this would be addressed through both an acute provider and taking a holistic approach and would include the support of a specialist nurse.

The Chair requested that in future for all reports going to committee, any associated documents that could provide further detail that may be of interest to members should be referenced in the reports. She also requested further information on services for children with acute diabetes and the commissioning of Tier 3 services from the Royal Free Hospital.

7. **18 Weeks Referral To Treatment Incident and Urology Serious Incident**

David Cheesman presented this item and began by referring to the Northwest London Hospitals Trust (NWLHT) capacity paper. He stated that the NWLHT continued to carry out waiting lists initiatives and following the review of demand and capacity, the NWLHT had planned an increase in internal capacity with the majority of work being carried out by CMH. In addition, the CCGs within the NWLHT had agreed to fund additional capacity through outsourcing and as a result of this, the BMI Healthcare Group, the Hillingdon Hospitals Trust and the Royal National Throat, Nose and Ear Hospital had been selected as providers.

Turning to the urology serious incident, David Cheesman advised that a review of urology patients on the planned waiting list in October 2013 had identified that 196 patients had waited over ten weeks for a flexible cystoscopy appointment. This had resulted in an investigation to see if any patient's safety had been affected and results would be reported to the NWLHT Board in March. David Cheesman added that to date, the investigation had not identified any patients who may be at risk of harm, however the seriousness of the incident could not be underplayed.

During members' discussions, a member queried whether Brent was funding the whole exercise when only 20% of patients were from Brent. She referred to a

national audit report that had stated that 58 out of 100 hospitals had problems with waiting lists and asked if a fundamental flaw was responsible for the system not working properly. Further observations were sought with regard to review of mortality rates whilst on the waiting list and what were the plans to meet the needs of patients requiring routine surgery in future. It was also asked whether there was any data available on the additional time patients had waited on top of the 18 weeks that they had been on the waiting list.

In reply to the issues raised, David Cheesman advised that Brent CCG was only funding its patients' treatment and not from the whole waiting list. He emphasised the need for sound data to evaluate ways to ensure that the 18 weeks referral to treatment could be achieved and external organisations were being used to help with this. In addition, effective management of waiting lists was also necessary. He advised that investigations continued in respect of review of mortality rates for those patients on waiting lists, including assessing whether the condition of patients had worsened. In respect of routine surgery, steps were in place to increase capacity both internally and through external sites, however this would need time to be achieved. Members noted that there were sufficient staff to operate clinics and operational theatres. David Cheesman advised that data was not yet available concerning how long patients had waited in addition to the 18 weeks they had already remained on the waiting list, although efforts would be made to provide this.

The Chair requested an update on this item at a future meeting.

8. **Plans for Central Middlesex Hospital**

In noting the report provided, the Chair advised that members wished to defer this item to the meeting on 18 March to allow more time to consider this matter and also to consider it in the context of mental health and the paper on Shaping a Healthier Future.

9. **Health Partnerships Overview and Scrutiny Committee work programme 2013/2014**

The Chair requested that the mental health services paper be included as part of the plans for CMH report at the meeting on 18 March, whilst sexual health was to be deferred to a future meeting. In respect of public health, this should be placed on the agenda for meetings as more detail and important developments emerge.

10. **Any other urgent business**

In noting that this would be David Cheesman's last meeting before he joined a hospitals' trust in South London, members placed on record their thanks for his contributions at the committee meetings and wished him all the best for the future.

11. **Date of next meeting**

It was noted that the next meeting of the Health Partnerships Overview and Scrutiny Committee was scheduled to take place on Tuesday, 18 March 2014 at 7.00 pm.

The meeting closed at 9.15 pm.

M DALY
Chair

Brent	**Health Partnerships Overview and Scrutiny Committee** 18th March 2014 **Report from the Assistant Chief Executive**
For Action	Wards Affected: ALL

Mental Health Services in Brent

1.0 Summary

1.1 The report provides an overview of the mental health services provided in Brent for people with severe mental health issues.

1.2 The report is divided into two parts:

- Community Mental Health Servies;
- Acute Mental Health Services at Park Royal: including details of wards, structure, patient data and information on discharge/transfer delays.

2.0 Recommendations

2.1 The committee is recommended to question officers on the current mental health provision and planned changes to service to satisfy themselves that it is fit for purpose.

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Central and North West London NHS
NHS Foundation Trust

NHS
Brent
Clinical Commissioning Group

Brent

Joint report to Health Partnerships Overview and Scrutiny Committee

An Overview of Brent Mental Health Services

1. Introduction

1.1 This report has been written for the Health Partnerships Overview and Scrutiny Committee by officers from NHS Brent CCG, Brent Council and Central and North West London NHS Foundation Trust (CNWL) on the provision of adult mental health services in Brent. The report is split into two distinct parts. The first part of the report sets out an overview of community mental health services in Brent. The second part of the report provides an overview of acute mental health services based at Park Royal.

2. Mental Health in Brent

Commissioners and Providers

2.1 The commissioning and provider landscape for mental health services is complicated, but is crucial to understanding how the system works. Brent council, NHS Brent CCG and NHS England all commission mental health services. The council commissions mental health social care services; the CCG commissions secondary mental health services; NHS England commissions mental health primary care services and a small number of specialist services.

2.2 The council commissions its mental health social care services from CNWL NHS Foundation Trust, which provides an integrated mental health service in Brent based at Brondesbury Road and Park Royal. The bulk of Brent CCGs commissioned mental health services are also provided by CNWL, but it does have a number of smaller contracts with other providers. The service provided by CNWL comprises a number of different functions including assessment, brief treatment, care co-ordination, early intervention, assertive outreach, acute, community, and residential care for people with mental health conditions. Brent council staff are integrated into CNWL teams, working

alongside other mental health professionals providing integrated mental health and social care services.

2.3 It is important to understand that the majority of people with a mental health problem are not in the care of CNWL, but are treated by their GP in primary care. GPs are commissioned by NHS England. Also active in Brent are a range of voluntary sector organisations providing services for people with mental illness. Some of these organisations are commissioned by the council or CCG, others aren't. There are also a number of private sector providers that deliver services, such as accommodation and support to service users in supported accommodation, or care packages in the community to enable service users to remain in their own home. The council commissions services from private and voluntary sector providers to meet the needs of service users requiring additional social care support. The CCG individually and jointly commission inpatient and residential care for patients with mental health disorders requiring complex or continuing healthcare.

Mental Health Need

2.4 At least one in four people experiences a mental health problem at some point in their life and mental ill-health represents up to 23% of the total burden of ill health in the UK. It is the single largest cause of illness. Half of the individuals with mental health problems first experience symptoms before the age of 14 and three-quarters of individuals experience symptoms before their mid twenties. Depression is also the most common mental health problem in people aged over 65, with 13-16% having sufficiently severe depression to require treatment. The society-wide costs of mental health problems have recently been estimated at £105 billion, and the costs of treatment alone are expected to double in the next twenty years.

2.5 The table below sets out the number of people who are Brent mental health service users and under the care of one of the CNWL teams. Consultant Psychiatrists are involved in the treatment of all patients on the Care Programme Approach (CPA), which forms about 47% of CNWL's caseload. The Care Programme Approach ensures that there is multi-disciplinary input with both a named psychiatrist and a named care co-ordinator, whose responsibility it is to ensure that all professionals and services are working to together in line with each service user's agreed care plan and that formal review meetings involving the service user, carers and professionals are held regularly.

Adult Services	Total Cases as at 31/12/2013
Assessment and Brief Treatment Service	510
Acute Service - Home Treatment Team (Crisis)	259
Community Recovery Service	1380
Community Rehabilitation Service	344
Total	**2493**

2.6 Of the total number cases being treated in the community, 43 have an associated condition of learning disability or learning difficulty, such as

Asperger's syndrome; significant impairment of behaviour requiring attention or treatment; and other developmental disorders of speech and language. In addition, 686 service users have conditions associated with substance use, such as mental and behavioural disorders due to harmful use of drugs and/or alcohol, and other substances such as tobacco.

2.7 From the 2012 data there were 39 individuals identified within local services, with a Personality Disorder (PD), although local clinicians have questioned this data and believe the true incidence of PD to be significantly higher. Service Users with a diagnosis of Personality Disorder are treated according to their individual needs within generic services. This ensures that these individuals are enabled and assisted to integrate within general mental health services. Tertiary referrals are commissioned through specialist personality disorder units as required. PD Patients are treated in local generic services such as psychology, psychotherapy, out-patients psychiatry, CMHTs and day hospital. For patients who cannot be contained or treated within generic services secondary services, Tier 4 referral such as the Tavistock, and Portman and the West London MH Trust's Cassel Unit are commissioned to meet specific and complex needs by NHS Brent CCG. As part of 2014-15 commissioning intentions, NHS Brent CCG has committed to completing an audit of the numbers of people who have a diagnosis of personality disorder to inform future commissioning decisions around dedicated provision and inform the development of a specific pathway for patients with PD.

2.8 Brent has a lower rate than the London and England averages for hospital admissions for mental health conditions[1]. Other national indices for mental health prevalence in Brent suggest that mental health prevalence is in line with the London average. Brent is -

- below the London average and slightly below the England averages for admissions for depression-related conditions
- equal to the London average and almost twice than the England average for admissions for schizophrenia, schizotypal and delusional disorders
- in line with England but lower than the London average for patients on a Care Programme Approach (CPA)

Indicator	Brent average	London average	England average
Rate for hospital admissions for mental health conditions 2009-12	214	250	243
Rate of hospital admission for depression-related conditions 2009-12	30.5	37	32.1
Rate for hospital admissions for schizophrenia, schizotypal and delusional disorders 2009-12	103	103	57
Percentage of adults (18+) with depression, 2011/12	6.62	8.07	11.68
Allocated average spend for mental health (£ per head),	228	201	183

[1] Hospital Episode Statistics, The NHS Information Centre for health and social care, and Office for National Statistics

2011/12			
Numbers of people using adult & elderly NHS secondary mental health services, rate per 1000 population, 2010/11	3.5	3.4	2.5
Numbers of people on a Care Programme Approach, rate per 1,000 population, 2010/11	6.5	7.4	6.4

2.9 The Brent Mental Health Needs Analysis provides information on estimated percentage of the population with depression across all the wards in Brent. This indicates that there are 7 wards with 11% and above prevalence of depression. These are:

Ward	Locality	IMD Score	% of population with depression
Harlesden	Harness	43.63	12.0%
Stonebridge	Harness	42.48	12.2%
Kilburn	Kilburn	39.22	11.9%
Kensal Green	Harness	32.43	11.1%
Willesden Green	Willesden	31.63	11.4%
Mapesbury	Kilburn	26.32	11.1%
Queens Park	Kilburn	25.98	11.1%

2.10 Locally, the Quality and Outcomes Framework (QOF) is a scheme for General Practice which aims to improve the quality of care patients are given by rewarding practices for the quality of care they provide to their patients. Practice and CCG scores in the QOF are a useful indicator and overall practices in Brent have improved in comparison with other CCGs in recent years but improvements specific to mental health indicators are required to improve physical and mental health outcomes in Brent.

2.11 The tables below provide an indicator of Brent CCG performance by localities, based on individual practice performance in each locality. The numerator and denominator are population based with the difference between the 335,666 and 345,315 relating to the labelling of indicators as 'the practice can produce a register….' resulting in the lower figure for all localities, indicating that if a practice doesn't have a register the population is excluded from the calculations.

Locality	Patients with a history of depression coded at any time (Numerator)	Denominator	Recorded Prevalence
Harness	6,207	82,819	7.49%
Kilburn	4,455	73,439	6.07%
Kingsbury	7,288	77,168	9.44%

Wembley	4,368	49,722	8.78%
Willesden	3,684	52,518	7.01%
NHS BRENT CCG	26,002	335,666	7.75%
LONDON AREA TEAM	537,062	8,818,097	6.09%
NHS England	4,050,019	55,124,171	7.35%

2.12 The highest number of patients with a recorded depression is in the Wembley locality, with Kilburn rate being in line with the London average.

Locality	**The number of new diagnoses of depression in the practice during this QOF year (Numerator)**	**Denominator**	**Recorded Prevalence**
Harness	274	85,072	0.32%
Kilburn	340	77,696	0.44%
Kingsbury	342	77,168	0.44%
Wembley	75	52,861	0.14%
Willesden	175	52,518	0.33%
NHS BRENT CCG	1,206	345,315	0.35%
LONDON AREA TEAM	38,556	8,988,175	0.43%
NHS England	334,773	55,805,855	0.60%

2.13 However, the number of new diagnosis in 2012/13 indicates that Kilburn and Kingsbury had more new cases with Wembley seeing a decline. Overall the number of new diagnosis of depression was below the London and England average.

Locality	**The practice can produce a register of people with schizophrenia, bipolar disorder and other psychoses (Numerator)**	**Denominator**	**Recorded Prevalence**
Harness	1,000	85,072	1.18%
Kilburn	982	77,696	1.26%
Kingsbury	843	7,168	1.09%
Wembley	412	52,861	0.78%

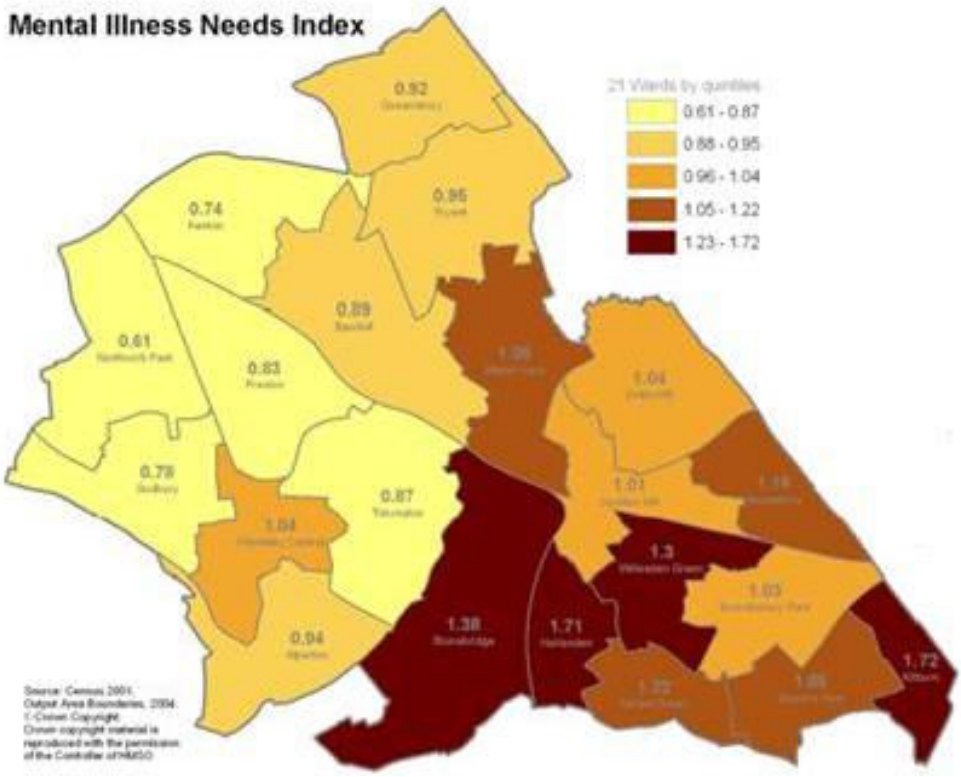
Locality	The practice can produce a register of people with schizophrenia, bipolar disorder and other psychoses (Numerator)	Denominator	Recorded Prevalence
Willesden	727	52,518	1.38%
NHS BRENT CCG	3,964	345,315	1.15%
LONDON AREA TEAM	92,559	8,988,175	1.03%
NHS England	469,260	55,745,396	0.84%

2.14 The number of practices who have a register of patients with severe and mental illness in Brent exceeds both the London and England averages, indicating that primary care are aware of patients with significant mental health concerns.

Locality	The practice can produce a register of patient with learning disabilities (Numerator)	Denominator	Recorded Prevalence
Harness	271	82,819	0.33%
Kilburn	156	73,439	0.21%
Kingsbury	372	77,168	0.48%
Wembley	116	49,722	0.23%
Willesden	139	52,518	0.26%
NHS BRENT CCG	1,054	335,666	0.31%
LONDON AREA TEAM	23,917	8,810,300	0.27%
NHS England	203,992	55,081,314	0.37%

2.15 The number of practices that keep a register of patients with Learning Disabilities is higher than the London average but lower than the England average. It is expected that a programme to improve access to health checks for people with learning disabilities launched in 2013/14 will have a positive impact on this indicator in future.

Fig 1: Brent mental health needs index, by ward



Age	Brent Pop. Composition		Variance	CNWL Brent Caseload Composition		Variance
	2001 Census	2011 Census		2010/11	2012/13	
0-17	22%	23%	+1%	9%	17%	+8%
18-64	66%	67%	+1%	73%	61%	-12%
65+	11%	10%	-1%	18%	22%	+4%
Ethnicity	**2001 Census**	**2011 Census**	**Variance**	**2010/11**	**2012/13**	**Variance**
White	45%	36%	-9%	42%	40%	-2%
Mixed	4%	5%	+1%	4%	4%	0%
Asian	28%	34%	+6%	18%	18%	0%
Black	20%	19%	-1%	29%	24%	-5%
Other	3%	6%	+3%	7%	12%	+5%

Fig. 2: Breakdown of CNWL Brent caseload composition [source: CNWL]

3. Community Services Provision

3.1 The Mental Health Community Services in Brent provide an integrated Health and Social Care service across three distinct services -

(i). Assessment and Brief Treatment Service

3.2 The purpose of this team is to provide a single point of entry/access, including initial assessment to Brent Mental Health Service. Referrals are made either through GPs or self-referrals. The team provides a joint health and social care service by offering short-term, multi-disciplinary interventions. Support is holistic and practical in nature and ranges from helping individuals to deal with housing issues to making psychological therapy referrals.

3.3 This service works with people with less complex health and social care needs, who can benefit from time-limited support and signposting to other local community resources. Where on-going support is required, individuals can be referred on to the recovery teams within the service.

(i). Community Recovery Service

3.4 Brent CCG and Brent Council commission a range of community recovery services via CNWL:

- Community Recovery Team – multi-disciplinary team (health & social care) supporting people with severe and enduring mental health problems in the community who require long term input from secondary mental health services.

- Assertive Outreach Team – as above but with a smaller caseload, supporting people who require more intensive input in order to maintain their health and social stability.

- Early Intervention Service – as above but supporting service users (under the age of 35) who are experiencing a first episode of psychosis.

- Employment, Welfare & Support Service – a team of local authority employed support workers who provide practical support to service users supported by the above teams.

- Carers' Assessors – two local authority support workers who assess carers' needs, provide respite breaks, respite payments and organise carers' forums and workshops.

3.5 All the service users open to these teams are supported under the Care Programme Approach. An integral part of the Care Programme Approach is to ensure that all risks posed to or by the service user are formally and regularly assessed and recorded. There is a risk management plan in place for each service user (where it is needed). The service user's care plan should also reflect and mitigate identified risks.

3.6 Each of the teams within Community Recovery Service is either able to provide directly or refer service users for:

- Psychiatry
- Community Nursing
- Occupational Therapy
- Psychology
- Psychotherapy
- Employment support
- Social Work

3.7 Interventions include:

- Diagnosis
- Prescription of medication
- Monitoring of medication and associated side effects
- Keeping people safe (Safeguarding)
- Emotional and practical support
- Help with accommodation
- Monitoring of physical health
- Provision of meaningful daily activities
- Support with education and employment
- Longer-term talking therapies
- Smoking cessation
- Culturally specific services

3.8 Service users can also access directly the Central and North West London Trust's Recovery College, which provides a wide range of courses aimed at service users, carers and professionals alike. These courses are designed to:

- Help people develop their skills and understanding,
- Help people identify personal goals and ambitions,
- Create a fun, positive and safe environment for learning and exploring recovery.
- Give people the confidence and support to access opportunities and resources available to them.

3.9 The focus of all the interventions listed above is to assist service users to improve their quality of life, develop their independence, achieve their own personal goals and eventually, when able to do so, move out of secondary services.

(iii). Rehabilitation Services

3.10 Rehabilitation services provide long-term care and support to service users with ongoing mental health needs in 24 hour staffed placements, either in in-patient units or the community. Rehabilitation services provide intensive therapeutic treatments to help people develop independent living skills and improve their quality of life.

- Community Rehabilitation Team – multi-disciplinary team (health & social care) supporting people with severe and enduring mental health problems who are living in 24 hour supported placements. The team provides a placement monitoring role to service users in out- of- borough placements and a CPA care coordination role to those in placements in Brent.

- Brent Community Rehabilitation Units – The Rehabilitation Service Line manages 74 beds in in-house supported accommodation. Of the 74 service users supported in this scheme, 28 receive floating support and the remaining 46 receive 24 hour support.

3.11 As with the Recovery Services, all the service users open to these teams are supported under the Care Programme Approach.

3.12 The Community Rehabilitation Team is able either to provide directly or refer service users for the same services as the Community Recovery Services, with a couple of additions:

- Liaison with housing providers
- Move-on support

3.13 Interventions for services users in the Community Rehabilitation Teams are similar to those in Recovery services, but also include “My Move” training, to help manage tenancies to prepare service users for step down from residential accommodation and into more independent accommodation options.

3.14 Teams also liaise with a wide range of voluntary or private organisations to provide additional support to service users, such as outreach support, day care, personal care and accommodation. Service users who meet the criteria for social care can also be referred to the Self Directed Support Panel which can sanction a wide range of creative, individualised services, designed to maintain service users’ quality of life and to help prevent a relapse of their mental health and to avoid hospital admissions and/or referrals to specialist residential placements. Where appropriate, payments can be made directly to service users to enable them to purchase agreed services directly.

4. Staffing

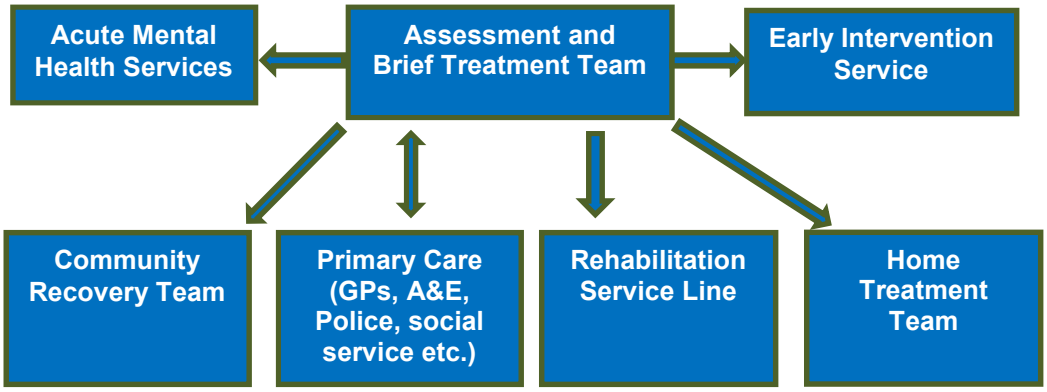
4.1 The Brent Community Teams are made of social workers, nurses, occupational therapists, consultant psychiatrists and junior doctors (experienced doctors training to be psychiatric specialists). The breakdown is as follows:

Brent Team	Social Workers	Nursing Staff	Occupational Therapist	Psychiatrists	Junior Doctors
Assessment and Brief Treatment Team	3	3	1	1.5	3
Community Recovery Team	14	11	2	2.8	0
Assertive Outreach Team	4	5	1	2	0
Early Intervention Service	2	7	1	2	0
Community Rehab Service	3	6	2	1	1
Home Treatment Team	2	16.68	1	1	
TOTAL (WTE)	**26**	**32**	**7**	**11.3**	**4**

5. Assessments

Assessment and Brief Treatment Team

5.1 The Assessment and Brief Treatment Team provides a single point of contact for GPs, primary care practitioners, local mental health organisations, councillors, service users and carers. All referrals are treated in the same way, the service user is contacted to make a convenient time for which they can be seen. The diagram below sets out the team's referral flows.



5.2 The average waiting time for first assessment in Assessment and Brief Treatment (ABT) Team from April 2013 to December 2013 for Brent is 5.9 weeks. Patients are clinically assessed and triaged and placed on the waiting list accordingly, ensuring that those with the most urgent and vulnerable receive some timely intervention. Clinical triage of referrals can result in discussions with primary care about how best to manage the patient until the ABT can become formally involved or an alternative service pathway, A&E Liaison, Acute Psychiatric Liaison services.

5.3 CNWL has undertaken an audit on demand and capacity for the ABT service to understand why waiting times have increased. The audit discovered that the number of referrals accepted by ABT has increased significantly since 2010. 358 more referrals have been accepted, which represents a 22% net increase. Caseloads for each team member have also risen as a result. The team was working with 291 more patients in 2013 than in 2011, a 57% net increase. Face to face contacts with patients have also gone up since 2011. The proportion of known patients being referred to the service has also increased from 46% in 2010/11 to 54% in 2012/13. From observation, more service users are presenting with psychosocial stressors (mainly linked to housing, immigration, financial, asylum issues and post-traumatic stress disorder (PTSD)), compared to the same time last year.

5.4 The Brent ABT Team has instigated changes in management of the appointment process to help reduce the overall rate of service users not attending their appointment to free up more spaces to reduce waiting times. All service users are telephoned prior to their appointment to find out if they are still able to attend or not. They are telephoned at the point when they are sent an appointment letter. Then they are telephoned one to two days prior to their appointment and on Friday if their appointment is on the Monday. In

addition to the telephone calls they are sent a text message 1 to 2 days prior to their appointment. This has reduce Did not Attends (DNA) to within the target of 13.1% across Brent Borough.

5.5 The table below is a typical referral profile for the service from January 2013 to Jan 2014 –

Referrals	Routine (28 days)	Urgent (24 hrs.)	Grand Total
Jan-13	197	2	199
Feb-13	212	2	214
Mar-13	236	2	238
Apr-13	200	2	202
May-13	262	0	262
Jun-13	232	1	233
Jul-13	270	3	273
Aug-13	223	14	237
Sep-13	234	19	253
Oct-13	212	39	251
Nov-13	141	70	211
Dec-13	167	66	233
Jan-14	47	34	269
Total	2633	254	3075

5.6 The increase in urgent referrals results in increased use of staff time dedicated to telephone contact with referrers, patients and carers. They can result in an earlier appointment slot within duty cover and increase the burden of clinical workload on staff. This may have an impact on routine waiting times, as those cases are seen later to try to accommodate the urgent referrals.

5.7 To address this, Brent CCG has been working with other North West London CCGs who commission services from CNWL, within the North West London Mental Health Programme Board, to develop an urgent care pathway with consistent standards relating to service interventions and response times. The development of the pathway is now complete but further work in 2014-15 is required to locally implement this pathway to improve waiting times for urgent mental health care.

Mental Health Act Assessments

5.8 Approved Mental Health Professionals (AMHPs) are responsible for Mental Health Act assessments, when it is considered that someone needs to receive assessment or treatment in hospital for serious mental disorder. It is the AMHP's duty, when two medical recommendations have been made, to decide whether or not to make an application for the detention of the person who has been assessed. This is a local authority responsibility, carried out by AMHPs who work for the council, but who are based with CNWL. The Council cannot delegate its AMHP function to another organisation.

5.9 This is an extremely important role and one that has to be approached with careful consideration of the service user, as ultimately people can be sectioned under various parts of the Mental Health Act. The social care model places great emphasis on using the least restrictive models of care. It is not uncommon for AMHPs to spend a considerable amount of time planning for an assessment and working with a service user prior to carrying out an assessment to ensure that other options are explored before the assessment is undertaken. The number of assessments carried out in Brent over the last three years has fallen, partly because of the willingness to look at other options before carrying out an assessment.

5.10 In January 2014 there were 41 referrals to the Mental Health Act Team, based at Brondesbury Road, and the AMHPs based at Park Royal. Of the 41 referrals –

- Fourteen section 2 applications were made (section 2 of the Mental Health Act allows a person to be admitted to hospital for an assessment of their mental health and receive any necessary treatment for up to 28 days);
- Eight section 3 applications were made (section 3 of the mental health act allows a person to be admitted to hospital for treatment for up to six months. It must be necessary for the patient's health, safety or for the protection of other people and treatment cannot be provided unless the patient is detained in hospital);
- There were five informal admissions for treatment, again reflecting an approach which emphasizes using less restrictive options when at all possible.
- Seven service users were put onto Community Treatment Orders (CTO), which AMHPs also have to agree. Patients that have previously been sectioned under the Mental Health Act can be released from hospital under a CTO, which means they will receive supervised treatment in the community. If a clinician feels the patient is deteriorating, under the terms of the CTO they can be recalled to hospital for treatment.

6. Improving Access to Psychological Therapies (IAPT)

6.1 Improving Access to Psychological Therapies (IAPT) is a national programme to identify and treat common mental illness, with an additional focus on increasing employability and reducing benefits reliance. It provides a community-based primary care service. The main treatment approaches recommended in IAPT services are cognitive behavioural therapy (CBT), Dynamic Interpersonal psychotherapy (DIT), Interpersonal Therapy, Couples behavioural therapy and Counselling for Depression. Referral into the IAPT service is via GPs.

6.2 The Brent IAPT service was established in 2010. The service providers initially were CNWL for tier three, MIND for tier two, and Richmond Fellowship (employment advisors). In January 2012, additional investment was approved, which consolidated tiers two and three into one service specification, provided by CNWL. The employment advisor element of the IAPT service was re-procured, with Twining Enterprise awarded the contract; taking over the service in November 2012.

6.3 IAPT is subject to a national access target of 15%, with a target 50% recovery rate. As a 'third wave' implementer, Brent has never received the additional Department of Health funding support to help achieve this target. Brent CCG currently funds IAPT to achieve 9% (with a budget of £1.4m in 2013/14). A business case is currently being considered to increase investment by £0.5m, to increase access to 11% by the end of 2014/15.

6.4 Appendix 1 provides a 'snapshot' breakdown of service users accessing IAPT services, by ethnicity, age, gender and reason for referral.

7. Carers

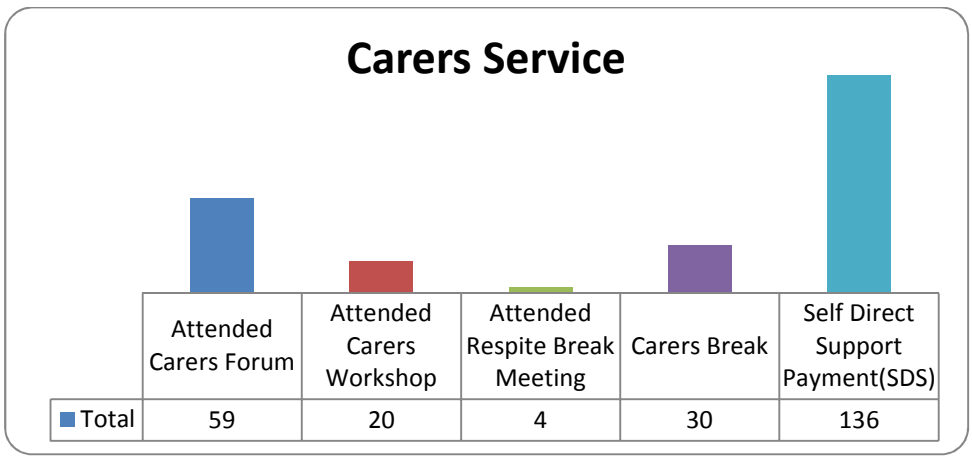
7.1 All identified carers are assessed and reviewed by care coordinators and the carer assessors. A carer's assessment identifies the needs of carers to ensure their continuous support to the service user. They are asked questions about how caring affects their social life or work and whether they have any health problems or financial difficulties that may affect their ability to care for the service user. Carers do not have to have an assessment if they prefer not to, but providers are required by law to offer assessments.

7.2 The main services available to carers after assessment are:

- Respite payment through Self Directed Support (SDS)
- Information and advice (mainly signposting)
- Help to complete SDS forms
- Opportunities to participate in carer's forums and workshops (during these workshops carers are able to receive advice and support from the various professionals involved with the service users.)

7.3 CNWL staff are trained to give information to carers about mental health conditions and treatment but personal information about the person they care for remains confidential unless the person involved has consented to sharing their personal information with their carer(s).

7.4 From 1 April 2013 to December 2013, carers benefited from one or more of services below:



8. Complaints and Advocacy Services

8.1 Service users who have a complaint about a specific service are asked to use the complaints system in place at CNWL, which includes an escalation process. Service users with complaints about health services may take their complaint to the Parliamentary and Health Service Ombudsman. Services users with complaints about a social care service can escalate their complaint through the council's complaints process if they are not satisfied with the initial response from CNWL. If, after investigation by the council's complaints service the service user still isn't satisfied, the complaint could be referred to the Local Government Ombudsman.

8.2 Advocacy services in Brent have been provided for the last ten years by Loud and Clear, a user-led organisation based in Wembley that provides mental health advocacy and user involvement services across North West London.

8.3 The service provides support to people accessing services, maintaining engagement with services, pursuing complaints and supporting people with issues relating to their social exclusion. The advocacy provided is in the form of support, information and representation to meet the needs of the local population and deliver national targets. People using the service are supported to overcome the barriers to social inclusion and take an active role in making decisions about their lives, particularly in relation to mental health and social care services. Peer advocacy support is also provided through training, group work and coaching, enabling mutual support among people using mental health services

9. Translation Services

9.1 Details on translation services are included at Appendix 2 of this report.

10. Commissioning budget and investment in community mental health

10.1 The budget and service lines for 2014/15 are still subject to contract negotiations taking place with CNWL and a verbal update will be given to the Committee. The budgets for 2013/14 for the various contracts and services that the CCG has for mental health services (including those outside the scope of this report) is set out below (forecast at month 10; all figures are approximate).

Mental Health Budget 2013/14	**£'000**
CNWL	
Inpatient services	11,600
Day Services	1,000
Child and Adolescent t Mental Health Services	1,700
IAPT	1,400
LD	2,050
Community	10,300
Memory	

	700
Rehab	2,100
A&E Liaison	150
Dementia Memory Services (plus scans and medications)	523
Psychiatric Liaison Services	427
	31,950
Dementia Services (Other)	
GP Quality Performance Scheme	121
Training Programme	48
Dementia Café	40
	209
Other NHS MH Contracts in place	
W London MH Trust	416
Barnet, Enfield & Haringey MH Trust	233
Tavistock & Portman MH Trust	35
Camden & Islington NHS FT	420
	1,104
MH Continuing Care and Complex Placements budget	
Mental Health (Younger Adult)	3,840
Adult Mental Health	911
Adult MH-Cost per Case	203
Children & Families-CPC-CAMHS	137
	5,091
Third Sector Mental Health Services	
Brent Users Group (BUG)	39
IMHA – Loud and Clear- Voice Ability	49
Brent Centre for Young People	133
Brent MIND	60
Southside Partnership (Fannon - Community development services)	175

Carers Services	568
Brent Carers Centre	61
Twining Employment Services for IAPT	96
	1,181
Acute Mental Health Admissions (NWLH and Imperial	708
Total CCG Spend on Mental Health Services	**40,243**

10.2 In addition to the investment in the psychiatric liaison and IAPT services already outlined, Brent CCG is or is planning a range of investments in mental health services.

- Shifting Settings of Care: an Out of Hospital contract, providing community nurses to give medication injections to stable patients with serious mental illness – to be agreed by the CCG in March/April, and linked to achieving QIPP changes
- Health & Wellbeing team: a pilot that has been running since June 2013 (due to end in 2014), this project has now been rolled out to all five Brent localities. This is about supporting service users with mental health needs discharged from secondary care to re-engage with their community - promoting their physical as well as their mental wellbeing by encouraging service users to see their GP; helping them access benefits, helping them join social groups, contact voluntary sector for any support, etc. It will be evaluated with a view to be included in a 'primary care plus' model, currently under development.

10.3 The CCG, working with Harrow and Hillingdon, will be reviewing the IAPT and CAMHS services to assess need, outcomes and identify good practice locally and nationally. Services may then be re-scoped across a three-borough model (but ensuring that there always remains a local focus).

10.4 Brent Council spends approximately £7m per year on adult mental health services provided by Central and North West London NHS Foundation Trust (CNWL). The service forms a critical element of the Council's approach to fulfilling its duties under the NHS and Community Care Act 1990 and the Mental Health Act 1983.

10.5 The mental health service has previously had an overspend of approximately £1m per year. A mental health improvement project and an efficiency programme have been put in place during 2013/14 that set out to reduce the overspend. As a result of joint working, the overspend stood at £0.377m at the end of December 2013, which is a significant reduction on where it has been, and is part of an on-going downward trend. The improvement project has ensured a shift away from using residential placements and has had a significant impact in terms of cost avoidance. The phase 2 improvement project will build on this work through a stronger focus on reducing residential placements as well as a fundamental redesign of the service.

10.6 The details on the council's mental health spend is set out below.

MH operational budget 2013/14	**Reporting budget 2013/14**
Management Services	£346,204
Recovery Team	£1,094,020
Assessment and Brief Treatment Team (ABT)	£276,108
Mental Health Act Team	£246,159
Employment, Welfare and Support Team	£444,737
Early Intervention Service (EIS)	£100,244
Assertive Outreach Team (AOT)	£189,321
Inpatient Service	£160,590
Carers Team	£124,765
Forensic Team	£57,714
Supporting People Service	£31,110
Alliance Close	£19,090
Community Rehabilitation Service (CRS)	-£37,115
Wembley Park Drive	£310,496
Self Directed Support (SDS) Panel	£50,000
	£3,413,443
MH purchasing budget 2013/14	**Reporting budget 2013/14**
Mental Health Nursing Care	£27,056
Mental Health Residential Care	£1,827,417
Mental Health Supported and Other Accommodation	£1,712,666
Mental Health Direct Payments	£93,317
Mental Health Home Care	£11,978
Mental Health Day Care	£38,220
Mental Health Adult Placement	£74,800
Mental Health Bed & Breakfast	-£229,424
	£3,556,030
TOTAL	**£6,969,473**

11. Brent CCG "Quality, Innovation, Productivity and Prevention ("*QIPP*") programme for mental health

11.1 The national QIPP programme is a broad policy agenda, aiming to provide better standards of care at lower cost. The CCG is charged with achieving annual QIPP targets and reducing costs year-on-year to enable reinvestment in more innovative models of care. This is in addition to national requirements to reduce baseline budgets across acute and non-acute budgets.

11.2 The 2014/15 QIPP programme between Brent CCG and CNWL is still being negotiated (as are CQUINS and the quality and information schedules) and as such have yet to be agreed.

11.3 The 2013/14 QIPP programme across all CCG services was £11.057m, of which some £1,750 related to mental health services:

	£'000
Savings on budget 2012/13 FYE (carried/forward)	829
Repatriation of patients from out of area	700
CNWL contract savings	125
Savings on small contracts	96
BEH* contract savings	300

* Contract with Barnet-Enfield-Haringey MH Trust

12. Mental Health Improvement

12.1 Brent Council, Brent CCG and CNWL have recently completed a mental health improvement project. It has been agreed to set up a phase 2 project to build on the changes achieved in phase 1 and secure further improvements in the mental health service in Brent. The phase 1 project was set up because of concerns the council had with CWNL, in particular that the services provided had become overly "medicalised" at the expense of social care and that there needed to be a greater focus on recovery and the achievement of social outcomes.

12.2 Given that the project was initiated because of problems with working the relationship between the council and CNWL, it is encouraging that relationships have improved significantly and that the council, CNWL (and Brent CCG) have agreed to set up a Phase 2 project. The phase 1 project identified a number of issues that will be addressed in the coming months, particularly the need to improve the quality of core assessments, which reflect the needs of service users and inform care plans. There are questions about the generic care coordination role that is used in the integrated service and whether jobs need to be redefined. Greater clarity and responsibility for commissioning will also be taken forward in phase 2, so that there is a closer link between the council, which commissions services such as accommodation and support, and CNWL care coordinators who work most closely with service users and will understand the needs of people in Brent.

12.3 There were a number of positive outcomes from the phase 1 project including a reduction in the number of service users in residential care – 19 at the time of writing. Moving service users from residential care into supported living is generally better for the service user, promoting independence and self reliance and assisting with recovery. It is an approach the council and CNWL want to build on, by continuing to move service users into more independent accommodation options, where it is appropriate to do so. Through closer working between Adult Social Care Commissioning, Housing and CNWL staff, new accommodation options have been opened up to CNWL care coordinators, including the use of social housing, which has assisted the step down process.

12.4 Another of the phase 1 project work streams was concerned with Section 117 after care. There is a duty under section 117 of the Mental Health Act to provide aftercare services to certain patients who have been detained under the Mental Health Act until the council and CCG agree that the service user no longer needs it. Case law has led to services under s117 being free to service users and therefore not eligible for charging. However, a practice of not reviewing and discharging from Section 117 was in place in Brent and

across the country, which inhibits supporting people to move back to full independence away from statutory services. Although progress through the project on discharge or variation of s117 services hasn't been as advanced as hoped at the beginning of the project this needs to be seen in context. Despite slow progress with this work stream Brent is leading the way in London in attempting to address s117. No borough appears to have a set procedure for s117 discharge, but we have managed to agree a procedure with CNWL and Brent CCG to do this. We are clear which service users are subject to s117 and put in place a series of reviews to ensure that s117 status is accurate and properly reflected in care plans. A small number of discharges and variations to s117 status will happen in the coming months, testing our discharge procedure. The actual process of discharge involves complex liaison between care coordinators, psychiatrists, service users, families and carers. Care coordinators and psychiatrists have to agree that it is in the service user's interests to vary or discharge s117. Care coordinators are clear that accurate recording of s117 and how it relates to care plans is crucial and we would anticipate further changes in working practice and culture as the work on this area is embedded through phase 2.

12.5 Mental Health Act Assessment work of the AMHP Service is described above in the report. There had been concerns about consistency of service and difficulties implementing the AMHP back up rota. A service improvement plan for the AMHP service has been completed (and jointly agreed) and the recommendations will be implemented up to April 2014, which will resolve the identified issues. Work has taken place to inform team managers of the changes to the AMHP service, that there will be one team based on two sites – Brondesbury Road and Park Royal. AMHPs in service lines will rotate into the team for two consecutive days each month to work on Mental Health Act activity and ensure the council has sufficient AMHPs to maintain its statutory responsibilities. Reporting lines and supervision structures have been tightened up so that AMHPs receive the emotional and supervisory support they need to work effectively. There remains a focus on training new AMHPs, to ensure Brent has sufficient number of AMHPs. Two prospective candidates are in the process of applying to start AMHP training courses, one in March 2014, the other in September 2014.

12.6 Performance and finance information has improved as a result of work carried out through the project. This has been seen in terms of accuracy and relevance to service performance. Performance information is more consistent, and isn't being retrospectively updated month to month. The Section 75 meetings provide a monthly forum where service performance issues are picked up and challenged. There are robust finance monitoring meetings in place, where service managers are held to account on spending and budget forecasting.

12.7 The terms of reference for the phase 2 project are to be agreed at a meeting between the council, CNWL and CCG chief executive's, but it is likely that there will be five workstreams, based around the following areas -

(i). Completion of the Phase 1 Project

- Continued focus on reducing residential care placements
- Improvements in recording of Section 117 and reviewing cases to vary or discharge s117 where appropriate
- Implementation of AMHP options appraisals

- Implement training programme on good quality core assessments within the Adult Social Care department

(ii). Review of Social Care Resources / HR Review

- Review job descriptions and locations of Brent ASC staff in CNWL integrated teams – Are staff working in the right service areas to ensure the social care model is relevant to Brent Mental Health Services and that the council's aims for the service are being achieved? For example, are more social workers needed in the ABT Team to ensure assessment objectives are met and that there is a reablement focus to the work of the service?

(iii). Reducing the use of Residential Care (Micro Commissioning)

- Supporting people to lead healthy and active lives in the community – reducing the number of services users in residential care placements
- Reducing the flow of service users moving into residential units, working with CNWL teams to explore other accommodation options and to increase the use of with SDS packages
- Tenancy support for service users in hospital (long term hospital admissions), so that they can be discharged home
- Work with the council Commissioning Team to ensure that the right types of accommodation services are commissioned and available for service users in Brent.

(iv). Develop a Joint Commissioning Framework between Brent Council and Brent CCG (Macro Commissioning)

- Council and CCG to agree a joint commissioning framework for mental health services, which will include:
  - Shared objectives
  - Shared outcomes expected from the service
  - Incorporate the outcomes of the HR review, set out in the work stream above, leading to an integrated workforce plan

(v). Using IT to make service delivery more efficient

- Ensure care coordinators have access to Framework I and other council IT systems (ETweb, Oracle, Intranet) from Brondesbury Road and other CNWL sites in Brent.
- Consider ways in which IT can enable service delivery and make services more efficient.

Appendix 1 - Brent IAPT Service breakdown of referrals by age, gender, ethnicity and diagnosis – April to December 2013

Age

18-30 years	1,161	31%
31-40 years	931	25%
41-64 years	1,532	41%
Over 65	114	3%
TOTAL	**3,738**	

Gender

Male	1,354	36%
Female	2,384	64%
Total	**3,738**	

Ethnicity

White	1,210	32%
Mixed	164	4%
Asian	553	15%
Black	500	14%
Other	161	4%
Not stated	1,150	31%
TOTAL	**3,738**	

Primary Diagnosis

Depression	1,596	43%
Generalised anxiety disorder	592	16%
Mixed anxiety and depression	670	17%
Post-traumatic stress disorder (PTSD)	172	5%
Agoraphobia and panic	139	3%
Phobias (including social phobia)	80	2%
Obsessive Compulsive Disorder (OCD)	72	2%
Mental disorders not otherwise specified (includes adjustment disorder)	253	8%
Other	164	4%
TOTAL	**3,738**	

Appendix 2 - Use of interpreter / translation services in Brent

	Oct. 2011	Nov. 2011	Dec.2011	Jan. 2012	Feb. 2012	Mar. 2012	Apr. 2012	May 2012	Jun. 2012	Jul. 2012	Aug. 2012
Brent	**Face to Face Interpreting (Language is Everything) Sessions**										
	101	103	87	61	72	90	83	98	89	97	115
	Face to Face Interpreting (Language is Everything) Costs										
	£12,608.75			£2,596.10	£3,703.90	£4,211.10	£3,513.75	£5,265.10	£4,732.25	£4,486.25	£5,600.65
	Telephone Interpreting (Language is Everything) Calls										
	1	2	2	0	1	1	1	1	1	4	4
	Telephone Interpreting (Language is Everything) Costs										
	£4.00	£58.50	£12.00		£7.50	£6.00	£24.00	£36.00	£7.00	£103.00	£25.50
	Translation requests										
	Nil										
	Most Requested Languages										
	Arabic	Persian Farsi	Persian Farsi	Persian Farsi	Persian Farsi	Arabic	Portuguese	Somali	Persian Farsi/ BSL	Arabic/ Polish	Arabic/ Persian Farsi

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Brent Acute Mental Health Services
Park Royal

Report for Brent Health Overview & Scrutiny Committee

March 2014

1. Outline of Acute Services based at Park Royal

Brent Acute Mental Health Service consists of four wards, a Home Team and support services i.e. AMHP/ social worker team, therapies service and various administrative support staff.

The wards are as follows:
18 bed Triage (assessment) Ward - Shore
24 bed Treatment ward - Pine
24 bed treatment ward - Pond
13 bed male Psychiatric Intensive Care Ward (PICU) - Caspian
79 beds in Total

Please note - there is also a Low secure Ward, Tasman and a step down rehabilitation ward, Java, based on the Park Royal site. In addition to this there is a Mother and Baby unit and Memory Clinic. All of these are managed separately from the Brent Acute Service so will not be included in the report below.

2. The Acute Service Model

2. 1 Home Treatment Team

This team offers those referred to the acute service with an alternative to admission and facilitates and supports early discharge of patients from the ward. It is available 24/7 service and provides patients with intensive support at home for a limited period of time. This can be for up to three months. The team gate keeps all referrals to the Acute Service to ensure only those who require an acute inpatient stay are admitted.

The team works in close partnership with the wards and with the services that refer patients i.e. the community teams, the Emergency Duty Team (Social Care), A&E, Court Diversion, 136s(police), Psychiatric Liaison and Assessment and Brief Treatment Team.

2.2 Triage Ward

This model supports a clear, pathway from the point of assessment in conjunction with the Home Treatment Team to admission where the patient is assessed on a daily basis including weekends by a multidisciplinary team for a maximum of 14 days. The patient, at any stage when safe and appropriate to do so may then be either discharged under the care of the HTT, or to other parts of the pathway such as to the care of the Recovery Team (Community mental health team).

Patients are also, where needs and risks indicate, transferred to Treatment wards to continue the recovery process. This model offers the assurance that staff are skilled in assessment, recovery approach and risk management and that prompt decisions are made by senior staff regarding a patient's care within 24 hours. The Triage ward also employs a Social Worker who provides assessments regarding wider social care needs. This role is key to supporting clear, robust and holistic discharge plans, which begin to be formulated for all patients at the point of admission. This is to ensure that where possible discharge arrangements are communicated clearly to all those supporting the patients in the community and minimises the risk of delayed discharges.

During the course of the last year approximately half of the patients admitted to the Triage ward have been discharged home within two weeks, some with the support of the Home treatment team, whilst the other 50% are transferred to the Treatment wards. Another key change and improvement in our care delivery has been the reduction of Consultant Psychiatrists to a single consultant post per ward. This supports effective team working, daily decision making, robust communication sharing

and clinical leadership. For many patients the amount of time spent in hospital has reduced considerably and we have received positive feedback regarding this from patients and carers in the triage evaluation completed in January 2013.

2.3 Treatment Wards

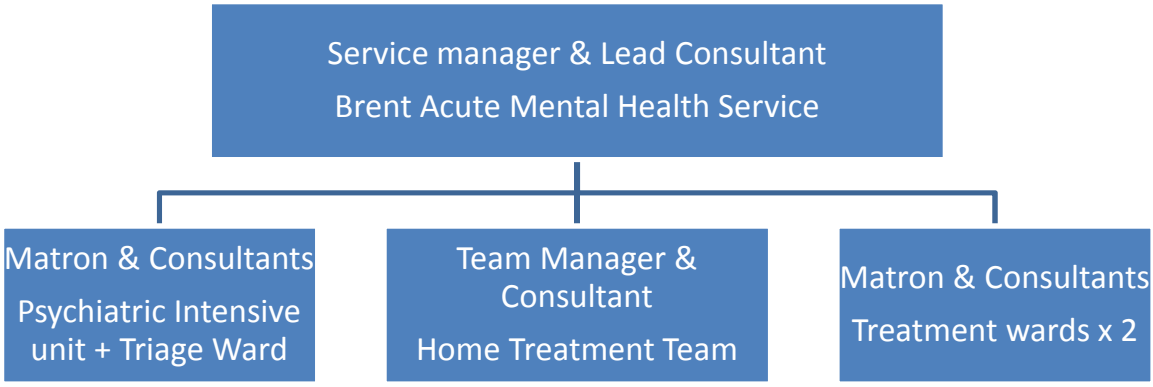
For those patients who require a more prolonged stay than that cannot be fulfilled through a two week period on the triage ward are transferred to a treatment Ward. The principles of a treatment ward are recovery focused, supporting collaboration and partnership working with patients and their families, building on the patients' strengths and skills and facilitating patients to recognise their potential for development. The model recognises the importance of moving away from the 'patient in the sick role' towards supporting patients to regard themselves as autonomous people. The teams' focus is in the identification of realistic life goals for patients and supporting the patient to achieve these.

This work is supported by a wide range of disciplines on the ward including nursing staff. Each ward has an Occupational Therapist providing assessments and ward and community based activities. The wards have Activity Co-ordinators - these roles focus on a wide range of individual and group work to enhance the therapeutic experience for the patient. There are plans to recruit Peer Support Workers who have lived experience; evidence suggests that these workers can offer invaluable interventions to our patients.

3. Workforce & Leadership

All patients admitted to the Brent acute service are cared for by a multidisciplinary team. The workforce for acute is a mix of medical, nursing, therapies, psychological, administrative and social care staff.

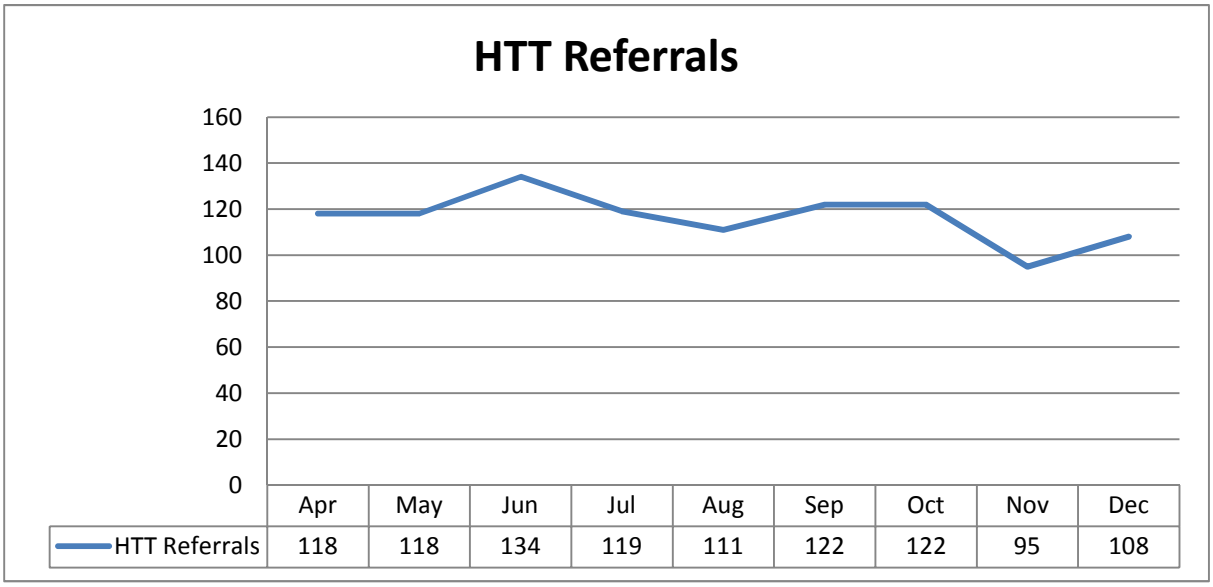
The leadership and management structure for Brent Acute Service mirrors that of the Trust i.e. it jointly led and manager by a Lead clinician and manager. Please see the leadership & management structure for Brent Acute Service below.



4. Patient Flow Activity

4.1 Home Treatment Team Referrals

In Brent, there is one Home Treatment Team (HTT). The team helps to avoid admission to a mental health inpatient ward by supporting people in acute mental crisis in their homes. The team also helps people who have been discharged from hospital as they make the transition back into the community. From April 2013 to December 2013, the team have had a fairly steady rate of referral as demonstrated in Graph 1.



Cases as at 31/12/2014	Total = 259

The number of patients deferred from admission to an inpatient bed through effective gate keeping by the Home Treatment Team is shown below.

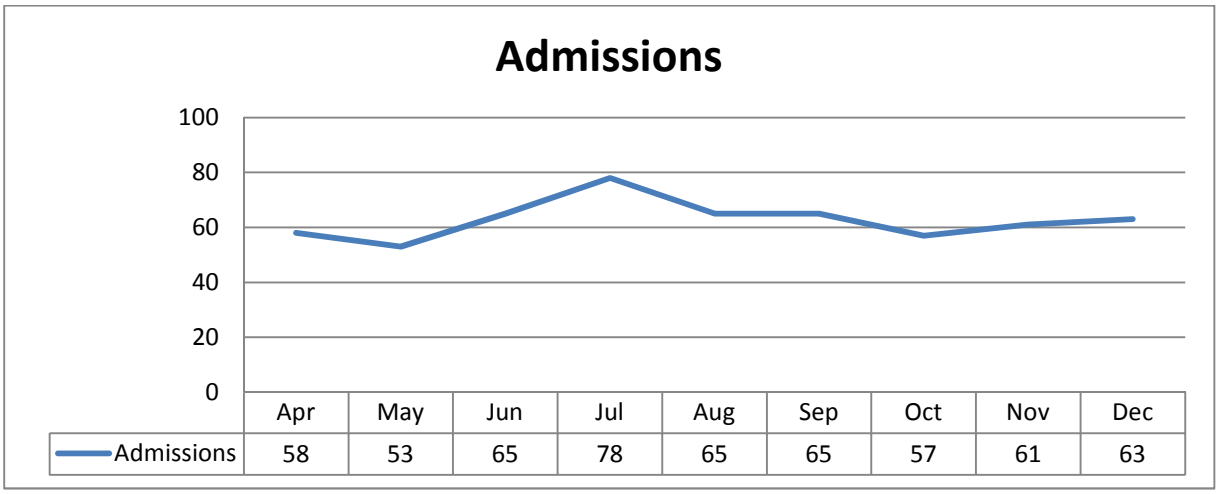
	HTT Referrals	No of admissions	% prevented admissions
Apr	118	58	51%
May	118	53	55%
Jun	134	65	51%
Jul	119	78	34%
Aug	111	65	41%
Sep	122	65	47%
Oct	122	57	53%
Nov	95	61	36%
Dec	108	63	42%

The primary sources of referral to the Home Treatment Team come via the pathways listed below.

Referral Source	Total	% of Referrals
Accident And Emergency Department	551	53%
Other service or agency	281	27%
Other Clinical Speciality	121	12%
Police	68	6%
Social Services	10	1%
Self	7	1%
Courts	4	0%
Permanent transfer from another Mental Health NHS Trust	4	0%
Education Service	1	0%

4.2 Admissions

Graph shows the total number of admissions per month from April 2013 to December 2013, for all four Adult Inpatient Wards in Brent. This includes 2 treatment wards, 1 triage ward and 1 psychiatric intensive care unit (PICU). Apart from the peak in number of admissions in July, there has been a fairly consistent rate of admissions throughout the period with slight variations as would be expected.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Admissions	58	53	65	78	65	65	57	61	63

4.3 Emergency Re-admissions

Emergency re-admissions are those patients who were re-admitted within 30 days of being discharged. Monitor has set an upper threshold of 7.5% for this. The re-admissions mostly relate to patients with a personality disorder, patients who relapse due to non compliance with medication and those who have substance misuse needs.

	2012	2013
% Emergency Re-admission	9.4%	8.7%

Brent has slightly higher than national average re-admission rates, which in 2012 was 8.7%. Other London Trusts had an average re-admission rate of 8% in 2012. National data for 2013 is currently not available.

The reasons for readmissions can be complex and whilst this time of year is difficult for patients and the wider social economic environment does play a part there does seem to be more that could be learnt about the patterns and triggers for readmission. To gain a greater understanding of the contributing factors behind these numbers the Acute Service Line Is planning to do a detailed analysis of all incidences of emergency readmissions within the Acute Service Line over the last year.

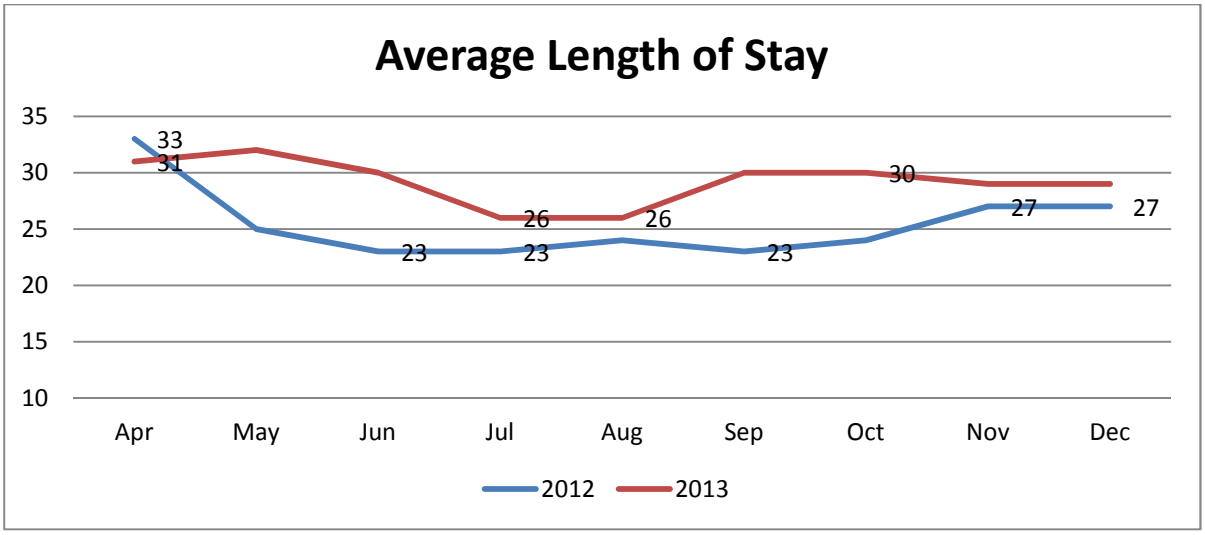
4.4 Average length of stay (LOS)

The Acute Service Line is committed to reducing length of stay for inpatients. In Brent there was a steady reduction in length of stay from April to July, however this steadily increased again until October. However, this relates to complex issues which make it hard to discharge patients even when they may be clinically ready for discharge.

As part of the implementation of the ambitious programme of work to redesign clinical pathways under the Acute Service Line, it was identified that the systems around patient flow / bed management needed to be transformed. The Patient Flow model was rolled at Park Royal in November 2011, initially as a pilot that has subsequently become embedded and forms the foundation for the management of patients in and out of acute and PICU beds. It differs from operational bed management by taking a proactive approach in managing demand and patient flow and utilises demand and bed management principles to synchronise and sustain patient flow throughout the entire Acute Service Line

The patient flow model that has been successfully implemented here in Brent and has positively supported us in our commitment to ensuring patients are only in for as long as they need to be. The Patient flow model incorporates the following elements:

- Triage Ward
- Single consultant per ward
- Daily Multidisciplinary clinical reviews
- Date of discharge identified on day of admission
- Dedicated patient flow manager and discharge coordinator working as part of the Home treatment Team
- Onsite provision of a CAB worker and housing (Brent Council) worker
- Daily patient flow meetings
- Contingency planning for out of hours

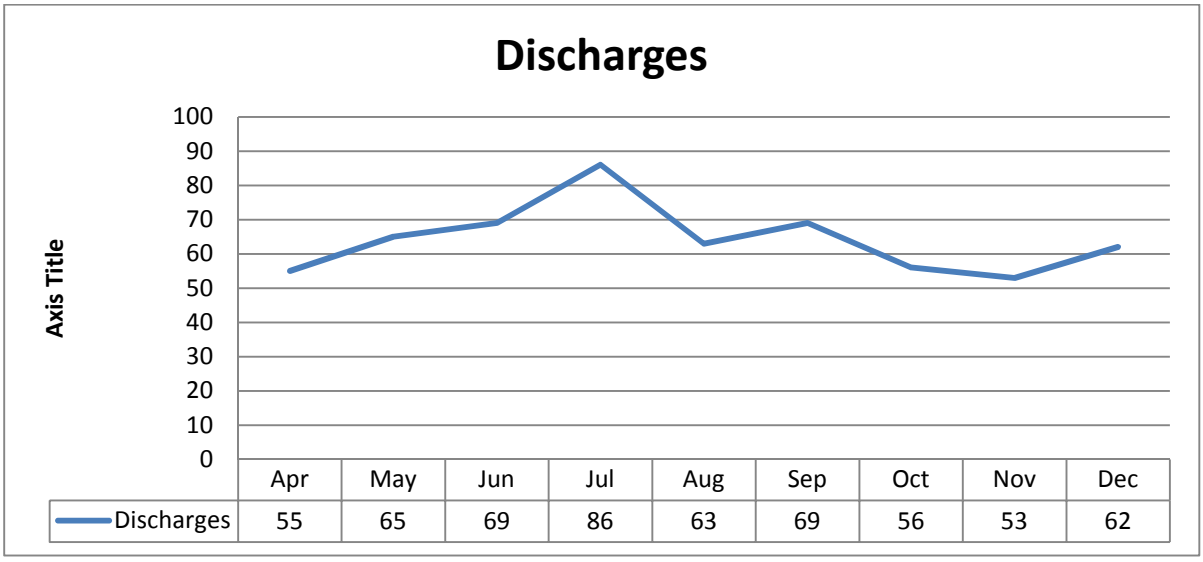


4.5 Access to beds

Patients are guaranteed access to a bed in the acute service when they need it. Whilst there are some patterns to the demand for beds the nature of an acute mental health service is that there is an element of unpredictability. The Patient flow model ensures there is sufficient flow within the system to meet any demand for beds as and when it is needed so that people requiring admission do not experience a wait for bed.

4.6 Discharges

Graph below shows the discharges by month from April 2013 to December 2013.

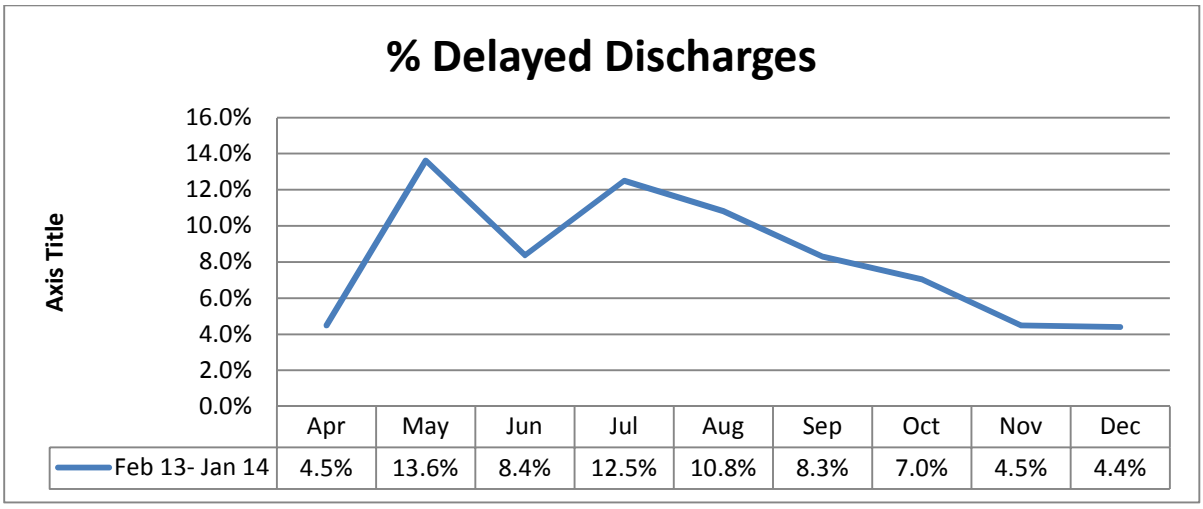


When comparing the number of discharges to admissions, there has been an average of one admission for every discharge throughout the year, demonstrating that throughput has been maintained.

4.7 Delayed Discharges

Delayed Discharges relates to the patients who are clinically fit for discharge but due to a number of reasons, were not discharged at that point. This is measured in terms of the number of bed days which were occupied by patients who were identified as delayed discharges compared against the total number of occupied bed days.

From May 2013 until July 2013, there were high levels of delayed discharges. Monitor has set an upper threshold of 7.5% for Delayed Discharges, and though delayed discharges remained higher than this until October, there is in steady decline month on month. From October to December, delayed discharges have remained fairly low. This is due to the patient flow measures described above and the work of the Mental Health Project which has begun to create a flow across the whole pathway.



The table below detail the reasons for delayed discharges and the number of patients who were delayed due to those reasons.

The most common reason patients are delayed are due to waits for supported accommodation or repairs / deep cleaning to their accommodation.

Reasons for Delay	No of patients
Awaiting Care Package in own home	3
Awaiting Completion of Assessment	2
Awaiting Hostel/Supported Accommodation	10
Awaiting Permanent Housing	2
Awaiting Funding	1
Benefit Problems(s)	1
Client Does Not Accept Plan	1
House to be Made Fit	8
Funding Delayed	1
Team Not Agreed Plan	1

Reasons for Delay	No of patients
Awaiting Community Equipment & Adaptations	1
Disputes	1
Grand Total	**32**

The Acute Service has a range of options used to monitor and resolve delayed discharges. These include:

- Weekly Patient flow tracker circulated widely to all clinical staff in Acute and to key partner service lines and colleagues
- Strategic weekly patient flow management meeting with a specific remit to identify and plan for potential delays in discharge
- Monthly Trust wide patient flow Forum
- Acute staff attend key clinical forums and the funding panel

5. Housing options

There is a range of housing available in Brent for service users dependent on need. In borough there are 121 Supporting People supported housing beds (31 high support, 60 medium support and 121 low support) and 52 supported living schemes (16 high support, 12 medium support and 6 low support + 18 new schemes recently). If the service user is able to manage a tenancy there is access to a social housing quota of 20 for Adult Social Care per annum and support to access private rented accommodation.

If a service user has more complex, high needs an out of borough spot purchased placement will be sought which will be agreed via the Funding Panels.

Over the last 9 months CNWL has been working with the London Borough of Brent on a Transformation Project. This project had 5 work streams and one has focused specifically on reducing the numbers of people in 24 residential care and unblocking in borough 'step down' provision and the supporting processes to help people move through the system smoothly as soon as they are ready. Part of this work stream was reviewing the Panel processes to ensure they do not lead to delays in placements and resulting delays in discharging service users from hospital. The redesigned process will have one Social Care Needs Panel which will look at all requests for social care funded services. The joint Funding Panel with the CCG for joint packages of care will continue.

Alongside this work, focussed work has been undertaken with Care Co-ordinators improving the quality of assessments which clearly identify the eligible needs that are to be met by the recommended care package. The quality of the assessment and required clarity on the need for the placement was often a reason for delay in the panel process.

The next steps of this project will look at further alternatives to residential care, speeding access to the Adult Social Care quota, working with the Housing department to look at private rented options for our service users and looking at how we could better support people's tendencies while in the community and when they are admitted to an acute bed.

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Brent	**Health Partnership Overview & Scrutiny Committee** 18th March 2014 **Report from the Assistant Chief Executive**
For Action	Wards Affected: ALL

Task Group Report on Tackling Violence against Women and Girls in Brent (Covering Report)

1.0 Summary

1.1 Members of the Health Partnership Overview and Scrutiny Committee (HPOVS) on a number of occasions, expressed an interest in forming a task group to tackle violence against women and girls in Brent; focusing on Female Genital Mutilation (FGM), Honour Based Violence (HBV) and Forced Marriages (FM).

The task group was agreed by HPOVS in March 2013 and has used this time to conduct an in-depth review into harmful practices. The task group report is attached as appendix A.

2.0 Recommendations

2.1 The Health Partnership Overview and Scrutiny Committee consider the contents of the report;

2.2 The Health Partnership Overview and Scrutiny Committee approve the 12 recommendations made by the task group.

3.0 Detail

The task group's key findings are as follows:

3.1 The scale and nature of Harmful Practices in Brent

The task group wanted to establish the prevalence of harmful practices in Brent. We found that there was very little data held and the data that was held by the organisations we contacted was not shared between partners. We met with a number of community groups to gather anecdotal evidence based on their experiences and talked to national and local charities with expertise in this area. While we can't be certain about the extent of these practices within Brent we believe that they are significant enough to recommend that a mapping exercise is undertaken to establish the number of women and girls at risk and that this work should be coordinated with partners and specialist charities.

3.2 **Awareness, Knowledge and Criminality**

The task group believes that there is a worrying lack of knowledge and understanding in Brent about harmful practices, the impact they have and the legislation relating to them. All of the women's groups we met with agreed that raising awareness within affected communities was key to tackling harmful practices. The task group recognises the important role that schools have in raising awareness and safeguarding. We undertook some research with school governors and whilst 64% of our respondents were aware of all three offences, only 21% said that they were covered as part of existing safeguarding training.

The task group has therefore made recommendations focussed on community engagement, awareness raising, obtaining resources, involvement in local and national media campaigns and highlighting harmful practices as criminal offences.

3.3 **Partnership working including referral processes and pathways**

The task group found that while there are many organisations currently working with women and girls affected by harmful practices, there was frequently a lack of coordination between partners and a lack of clarity about referral pathways. This contributed to the negative experience of many of the women we talked to. The task group is therefore recommending that a harmful practices strategy is developed within the wider Violence against Women and Girls Strategy which will provide a clear framework for partners to work within. We also recommend that all key staff from relevant agencies undertake training to ensure a better understanding of the issues, identification of those at risk and establishing referral pathways.

3.4 **Services and accessing available funding**

It is clear that for better more coordinated services to be available voluntary and statutory agencies need to work together. This will not only enable organisations within Brent to pursue all avenues of available funding but ensure that services that are commissioned will have a real and lasting impact.

3.5 **Task Groups Recommendations**

1. **That tackling harmful practices becomes a high partnership priority within Brent and that a clear partnership strategy is developed within the context of the wider Violence Against Women and Girls Strategy. The harmful practices strategy should include:**

    1.1. Developing services to protect women and girls at risk

    1.2. Developing services to support women and girls subjected to harmful practices

    1.3. Robust recording and better quality of data and sharing of data from all partners

    1.4. Clear and consistent guidance for reporting risk, pathways for referrals and services

    1.5. Provide clear guidance to all key staff and the public on how to report a crime against a women affected by these issues.

    1.6. A single point of contact is established for those affected

    1.7. The adoption of good practice from elsewhere, health service, local authorities, voluntary sector organisations and educational institutions.

2. **That work in relation to the implementation of the Harmful Practices Strategy is the responsibility of:**

    - **The Children's Safeguarding Board**
    - **The Health and Wellbeing Board**
    - **Safer Brent Partnership**
    - **The Assistant Chief Executive Department will take the overall lead responsibility**

3. **That mapping of practising communities is undertaken to establish the number of women and girls at risk and should be undertaken as part of the Safer Brent strategic assessment process. This work should be completed using tested methodologies, such as those used by Forward and in coordination with Brent's partners and specialist charities such as Forward, the Asian Women's Resource Centre, the Jan Trust and the Iranian and Kurdish Women's Rights Organisation (IKWRO).**

4. **That a programme of community engagement about violence against women focussing on harmful practices is developed which ensures that members of affected communities play a lead role. Awareness raising**

events should be aimed at all sections of the local community, partners, relevant staff and Council Members.

5. **That awareness raising resources, leaflets and posters are clearly displayed in medical and educational establishments particularly GP surgeries, clinics. Hospitals, schools and colleges. These should include a single point of contact for those affected by harmful practices.**

6. **That Brent Council and its partners work with local and national media, including community radio and television stations, to raise awareness and educate the public on harmful practices and the negative effect it has on women and girls in our society.**

7. **That a programme of training is developed for all key staff from all relevant agencies who are likely to have contact with affected women and girls that will ensure a better understanding of the issues, identification of those at risk and referral pathways. Funding is available to the voluntary sector to assist Brent in delivering this training programme.**

8. **That all awareness raising and training activities highlight the changes in the law which make these harmful practices criminal offences.**

9. **That joint working is undertaken with schools to ensure that all head teachers, school governors and those responsible for safeguarding receive training and that all year seven children receive information as part of Personal Social and Health Education (PSHE).**

10. **That Brent Council in conjunction with its partners, particularly Council for Voluntary Services (CVS) Brent, pursue all avenues for available funding and support specialist charities and local voluntary organisations to bid for money from government agencies such as the Forced Marriage unit and the European Union fund.**

11. **That Brent Council along with its partners annually take part in the International UN sponsored awareness day that takes place 6th February each year. Zero Tolerance of Female Genital Mutilation day is set up to make the world aware of Female Genital Mutilation and to promote its eradication.**

12. **That Brent Clinical Commissioning Group (CCG) should commission services for women and girls affected by the harmful practices of Female Genital Mutilation, Honour Based Violence and Forced Marriages.**

4.0 Financial Implications

4.1 None

5.0 Legal Implications

5.1 None

6.0 Diversity Implications

6.1 None

7.0 Staffing/Accommodation Implications (if appropriate)

7.1 None

Background Papers

Task Group Report – Tackling Violence against Women and Girls in Brent

Contact Officers

Kisi Smith-Charlemagne
Scrutiny Officer

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Tacking Violence against Women & Girls in Brent

An Overview & Scrutiny Task Group Report

March 2014

Membership

Councillor Ann John (OBE) Chair
Councillor Patricia Harrison
Councillor Ann Hunter
Councillor Sandra Kabir

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1. Chair's Foreword

The United Nations describes violence against women and girls across the world as a global epidemic. Gender inequality gives rise to many traditional and cultural harmful practices. These include Female Genital Mutilation (FGM), Forced Marriage (FM) and Honour Based Violence (HBV) which are all closely connected along with Domestic Violence. The task group examined all three of these harmful practices and how they impact on women and girls in the London Borough of Brent

The task group's work has been conducted at a time when greater media coverage is shining a long overdue light on these horrifying harmful practices. We have been particularly impressed with the very effective and continuing campaign against FGM conducted by the Evening Standard. We are also aware that there has been an increasing and extensive coverage of these issues on television and radio through specialist investigative and current affairs programmes and the national news networks. As these practices are so hidden and little discussed this is a very welcome development. The Forced Marriage Unit and the FGM helpline set up by the government and the commitment to end FGM within a generation is vital in ending these practices. There are also a number of Parliamentary Select Committees working on different aspects of these issues.

This coverage gives confidence to all those brave women who speak out and the expert organisations that openly campaign against these harmful practices. During our research we met with a large number of truly inspiring women who have, in many cases, harrowing stories to tell. We recognise that it is these women who will play the biggest role in bringing about change within communities affected by these issues, but they need our support.

We are well aware that this report is only one small but important contribution to the huge effort required to tackle violence against women and girls in all its forms. We urge the council and all partners to ensure that the recommendations contained in this report are implemented in full. The individual members of the task group are passionate about these issues and will continue to campaign on them at every possible opportunity.

First of all I would like to thank all of the organisations and individuals who we have met with or visited. They have all made a massive contribution to the work of this task group and the formulation of our recommendations.

I would like to thank my task group colleague Councillors and Officers Councillor Sandra Kabir, Councillor Pat Harrison, Councillor Ann Hunter, Kisi Smith-Charlemagne, Jacqueline Casson and Mala Maru. Their commitment, knowledge and diligence have ensured the success of this piece of work and I am grateful for their support throughout what at times has been an emotional experience.

2. Executive Summary

Violence against women is an illegal, intolerable act and is a human rights violation. It is fundamentally wrong, impacts on the health and wellbeing of women and has wider effects in preventing them from fully contributing to society. It impacts on the wider society through lack of economic development, cost to public services, Health, Social and Police and a lack of societal well being. It is both a barrier to equality and a result of inequality. Female Genital Mutilation Honour Base Violence and Forced Marriages are all illegal and harmful and can never be justified in the name of freedom of religion or belief.

Brent is recognised as one of the most ethnically diverse population in the country and a significant proportion of these communities have religious and cultural ties to areas of the world where the harmful practices of Female Genital Mutilation, Honour Base Violence and Forced Marriages are prevalent. All of these offences are considerably under reported nationally and locally. The task group believes that it is imperative that the council and our partners raise awareness, provide advice and support our communities, and prosecute those who participate in these illegal harmful practices.

The task group's key findings are as follows:

The scale and nature of Harmful Practices in Brent
The task group wanted to establish the prevalence of harmful practices in Brent. We found that there was very little data held and the data that was held by the organisations we contacted was not shared between partners. We met with a number of community groups to gather anecdotal evidence based on their experiences and talked to national and local charities with expertise in this area. While we can't be certain about the extent of these practices within Brent we believe that they are significant enough to recommend that a mapping exercise is undertaken to establish the number of women and girls at risk and that this work should be coordinated with partners and specialist charities.

Awareness, Knowledge and Criminality
The task group believes that there is a worrying lack of knowledge and understanding in Brent about harmful practices, the impact they have and the legislation relating to them. All of the women's groups we met with agreed that raising awareness within affected communities was key to tackling harmful practices. The task group recognises the important role that schools have in raising awareness and safeguarding. We undertook some research with school governors and whilst 64% of our respondents were aware of all three offences, only 21% said that they were covered as part of existing safeguarding training.

The task group has therefore made recommendations focussed on community engagement, awareness raising, obtaining resources, involvement in local and national media campaigns and highlighting harmful practices as criminal offences.

Partnership working including referral processes and pathways
The task group found that while there are many organisations currently working with women and girls affected by harmful practices, there was frequently a lack of coordination between partners and a lack of clarity about referral pathways. This contributed to the negative experience of many of the women we talked to. The task group is therefore recommending

that a harmful practices strategy is developed within the wider Violence against Women and Girls Strategy which will provide a clear framework for partners to work within. We also recommend that all key staff from relevant agencies undertake training to ensure a better understanding of the issues, identification of those at risk and establishing referral pathways.

Services and accessing available funding
It is clear that for better more coordinated services to be available voluntary and statutory agencies need to work together. This will not only enable organisations within Brent to pursue all avenues of available funding but ensure that services that are commissioned will have a real and lasting impact.

3. Recommendations

1. **That tackling harmful practices becomes a high partnership priority within Brent and that a clear partnership strategy is developed within the context of the wider Violence against Women and Girls Strategy. The harmful practices strategy should include:**

    1.1. Developing services to protect women and girls at risk

    1.2. Developing services to support women and girls subjected to harmful practices

    1.3. Robust recording and better quality of data and sharing of data from all partners

    1.4. Clear and consistent guidance for reporting risk, pathways for referrals and services

    1.5. Provide clear guidance to all key staff and the public on how to report a crime against a women affected by these issues.

    1.6. A single point of contact is established for those affected

    1.7. The adoption of good practice from elsewhere, health service, local authorities, voluntary sector organisations and educational institutions.

2. **That work in relation to the implementation of the Harmful Practices Strategy is the responsibility of:**

    - **The Children's Safeguarding Board**
    - **The Health and Wellbeing Board**
    - **Safer Brent Partnership**
    - **The Assistant Chief Executive Department will take the overall lead responsibility**

3. **That mapping of practising communities is undertaken to establish the number of women and girls at risk and should be undertaken as part of the Safer Brent strategic assessment process. This work should be completed using tested methodologies, such as those used by Forward and in coordination with Brent's partners and specialist charities such as Forward, the Asian Women's Resource Centre, the Jan Trust and the Iranian and Kurdish Women's Rights Organisation (IKWRO).**

4. **That a programme of community engagement about violence against women focussing on harmful practices is developed which ensures that members of affected communities play a lead role. Awareness raising events should be aimed at all sections of the local community, partners, relevant staff and Council Members.**

5. **That awareness raising resources, leaflets and posters are clearly displayed in medical and educational establishments particularly GP surgeries, clinics. Hospitals, schools and colleges. These should include a single point of contact for those affected by harmful practices.**

6. **That Brent Council and its partners work with local and national media, including community radio and television stations, to raise awareness and educate the public on harmful practices and the negative effect it has on women and girls in our society.**

7. **That a programme of training is developed for all key staff from all relevant agencies who are likely to have contact with affected women and girls that will ensure a better understanding of the issues, identification of those at risk and referral pathways. Funding is available to the voluntary sector to assist Brent in delivering this training programme.**

8. **That all awareness raising and training activities highlight the changes in the law which make these harmful practices criminal offences.**

9. **That joint working is undertaken with schools to ensure that all head teachers, school governors and those responsible for safeguarding receive training and that all year seven children receive information as part of Personal Social and Health Education (PSHE).**

10. **That Brent Council in conjunction with its partners, particularly Council for Voluntary Services (CVS) Brent, pursue all avenues for available funding and support specialist charities and local voluntary organisations to bid for money from government agencies such as the Forced Marriage unit and the European Union fund.**

11. **That Brent Council along with its partners annually take part in the International UN sponsored awareness day that takes place 6th February each year. Zero Tolerance of Female Genital Mutilation day is set up to make the world aware of Female Genital Mutilation and to promote its eradication.**

12. **That Brent Clinical Commissioning Group (CCG) should commission services for women and girls affected by the harmful practices of Female Genital Mutilation, Honour Based Violence and Forced Marriages.**

***Please note that the order of recommendations throughout the body of the report appear in order of importance and not necessarily in the order listed above.**

4. Introduction – Scope of the task groups work

This task group was set up by the Health Partnerships Overview and Scrutiny Committee to investigate ways of tackling the prevalence and impact of Female Genital Mutilation, Honour Based Violence and Forced Marriages.

Female Genital Mutilation and Honour Based Violence are criminal offences which carry jail sentences. In June 2012 the Prime Minister announced that forcing someone to marry will become a criminal offence in England and Wales and this was included in the Anti-Social Behaviour, Crime and Policing Bill which is currently going through Parliament. The new law will be accompanied by a range of measures to increase protection and support for victims with a continuing focus on prevention and will come into force later this year.

A new definition of domestic violence was implemented by the Home Office in March 2013. It includes: "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: Psychological, Physical, Sexual, Financial and Emotional".

The Home office goes on to say that "Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. "Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim". * This definition of controlling behaviour, which is not a legal definition, includes so called **'honour' based violence, Female Genital Mutilation** and **Forced Marriage**, and it is clear that victims are not confined to one gender or ethnic group.

Female Genital Mutilation has been deemed an offence by the Human Rights Council of the United Nations since 1985, and made a criminal offence in the UK in the same year. This was amended in 2003 to cover UK nationals taken abroad. However to date no prosecutions have ever been brought in the UK. In November 2012 The Crown Prosecution Service (CPS) announced a new 10 point action plan for improving detection rates and prosecution. This includes:

- Gathering more robust data on allegations – looking at the reporting duties and mechanisms for medical professionals, social care professionals and teachers.
- Identifying what issues have hindered investigations and prosecutions.
- Exploring how other jurisdictions prosecute crime.

- Ensuring that police and prosecutors work together closely from the start of the investigation.

The CPS will also explore whether it is possible to prosecute offences under other legislation. For instance, it may be easier to support a prosecution under section 5 Domestic Violence, Crime and Victims Act (DVCVA) 2004, as amended by DVCVA 2012, which creates an offence of causing or allowing a child or vulnerable adult to die or suffer serious physical harm.

The definitions that the task group worked to are as follows:

Female Genital Mutilation/cutting – involves the complete or partial removal or alteration of external genitalia for non-medical reasons. It is mostly carried out on young girls at some time between infancy and the age of 15; and its extensive harmful health consequences are widely recognised[1].

Honour Based Violence – violence committed to protect or defend the 'honour' of a family and/or community. Women, especially young women, are the most common targets, often where they have acted outside community boundaries of perceived acceptable feminine/sexual behaviour. In extreme cases the woman may be killed[2].

Forced Marriage – One or both people do not (or in cases of people with learning or physical disabilities, cannot) consent to the marriage and pressure or abuse is used. This also includes child marriages as children are below the age to give informed consent. The pressure put on people to marry against their will can be physical (including threats, actual physical violence and sexual violence) or emotional and psychological (for example, when someone is made to feel like they're bringing shame on their family)[3].

The task group's key findings are focused on:

1. ***The scale and nature of harmful Practices in Brent and Impact of recent legislative changes***

2. ***Awareness, knowledge and criminality***

3. ***Partnership working including referral pathways and processes***

4. ***Services and accessing available funding***

5. Task Group Membership

Councillor Ann John OBE (Chair)
Councillor Patricia Harrison
Councillor Ann Hunter
Councillor Sandra Kabir

[1] The World Health Organisation (WHO)
[2] The Crown Prosecution Service (CPS)
[3] The Forced Marriage Unit (FMU)

6. Methodology

In order to complete the work identified in the scope, and produce a set of recommendations that would start to tackle some of the issues related to the harmful practices of FGM, FM and HBV in Brent, the task group gathered research and evidence from a wide range of sources. This included:

- The Team from FORWARD (Kekeli Kpognon, Maria Aden Naima Ibrahim and Rita Buhanda)
- The Jan Trust (Sana Malik and Sajda Moghul)
- Somali Advice and Information Forum - SAFFI (Rhoda Ibrahim & Yasmin Ali)
- Help Somalia Foundation (Harbi Farah)
- Brent Police/Azure Project (Nicola Butler and Louise Caveen)
- Birmingham City Council (Monika Bindal)
- Bristol City Council (Jude Williams)
- Brent Education Welfare (Stephen McMullan)
- Brent Public Health (Melanie Smith and Imran Choudhury)
- Brent Children's Social Services (Jo Moses)
- Brent Adult Safeguarding (Colin Boughen)
- Brent Local Children Safeguarding Board (Sue Matthews)
- Brent Ward Working (Carol Allen)
- Brent Community Safety (Chris Williams and Mala Maru)
- Northwick Park Hospital/NHS (Florence Acquah & Gloria Rowland)
- Asian Women's Resource Centre (Sarbjit Ganger)
- Iranian and Kurdish Women's Rights Organisation (Nezahat Cihan and Diana Niammi)
- Ashiana Network (Zuleyha Toprak)
- Brent Schools Head (Allyson Moss)

- Brent School Governors (Samira Mohamed)
- Home Office - Forced Marriage Unit & Sexual Violence (Joint Director-Chaz Akoshile)
- Home Office - Sexual Violence Unit (Sean Mcgarry)
- IMKAAN (Sumanta Roy)
- All Parliamentary Party Group (Baroness Jenny Tonge)
- The World Health Organisation – WHO (Glenn Raymond Thomas)
- BTEG Research (Tebussum Rashid)
- G Light Development & Somalian TV (Amran Mohammed)

Members of the task group also attended:

- Capita Conference on Tackling Forced Marriage and Honour Based Violence
- Jazari Community Centre (Abdi Ahmed) to talk to Somali women about FGM
- London Councils European Funding conference
- Brent FGM awareness training
- Jan Trust Forced Marriage awareness training
- Members Development Training on Harmful Practices - Delivered by FORWARD and the Asians Women's Resource Centre
- Brent White Ribbon Seminar
- A visit to Northwick Park Maternity Unit and Well Woman Clinic
- Brent School Governors Annual Conference
- Brent Children's Safeguarding Board Steering Group on FGM
- Iranian and Kurdish Women's Rights Organisation to talk to survivors of forced marriage.
- The launch of All Party Parliamentary Group's report on forced marriage

The task group formed a professional discussion group which consisted of Individuals from the above named organisations, departments and groups. The task group held two meeting where pre-designed questions (Appendix 1 & 2) were used to lead a round table discussion on

FGM, FM and HBV. Members of the task group also reviewed a great deal of literature and academic research in relation to this subject areas and a list of references is set out at the end of this report. Ultimately though, the task group was keen to ensure that this report focused on Brent and produced locally implementable recommendations.

The task group designed questionnaires which were used to gather information and evidence used to support this report at events attended, these included:

- Members Development Training on Harmful Practices - Delivered by FORWARD and the Asians Women's Resource Centre (Appendix 3)

- Brent School Governors Annual Conference (Appendix 4)

7. Policy Context

Local

Traditionally the main focus of the work that has taken place in Brent in relation to violence against women and girls has been on domestic violence and rape. However since 2010 Female Genital Mutilation, Forced Marriage and Honour Based Violence has been gaining prominence and FGM in particular is now one of the priorities of the Safer Brent Partnership. The council and its partners are aware that these harmful practices are taking place in some areas of the borough. However the very nature of these offences and the fact that they are often dismissed as religious or cultural traditions means that they are not discussed openly, are shrouded in secrecy and there is a fear of speaking out against them and reporting them.

National press, the London Evening Standard, BBC Radio 4, television and social media networks have recently been highlighting issues relating to FGM, Forced Marriage and Honour Based Violence. This has included using cases of women and girls in Brent who have become victims.

The charity FORWARD (Foundation for Women's Health Research and Development), The Asians Women's Resource Centre and Northwick Park's African Well Women's Clinic, have undertaken work in Brent to provide services to women who had been subject to harmful practices. Research conducted by the charity FORWARD in 2007 (Appendix 5), showed that second to LB Southwark, Brent had the next highest number of women with FGM that had given birth to children in England and Wales. ASCENT[4] also provided statistics in October 2013 (Appendix 6) on the number of domestic and sexual violence calls placed to their help lines. This showed Brent had the 6th highest number of calls placed in London.

London, National & International

In April 2009 the Mayor of London launched *The Way Forward: A call for action to end violence against women* a consultation on proposed set of actions for dealing with all forms of

[4] Ascent is a project undertaken by the London VAWG Consortium, delivering a range of services for survivors of domestic and sexual violence, under six themes, funded by London Councils.

violence against women in London. This includes the harmful practices of FGM, Forced Marriage and Honour Based Violence. The British government is taking Violence Against Women and Girls very seriously and there is further legislation in the pipeline. Further detailed work is being done by Select Committees.

The existing legislative framework that relates to Tackling Violence against Women and Girls and Harmful Practices includes:

- Prohibition of Female Circumcision Act 1985
- Nationality, Immigration and Asylum Act 2002
- Female Genital Mutilation Act 2003
- Sexual Offences Act 2003
- Asylum and Immigration Act 2004
- Forced Marriage (Civil Protection Act) 2007
- Impending – Forced Marriage (Criminal Act) 2014

There is evidence that nationally awareness about the prevalence and impact of Female Genital Mutilation, Forced Marriage and Honour Based Violence is increasing amongst politicians and policy makers. For instance:

Female Genital Mutilation
In November 2012 the UK government launched a 1 year pilot of the Statement Opposing Female Genital Mutilation. The Statement Opposing FGM, which is currently used in Holland and is known as the 'Health Passport', is pocket-sized and states the law and the potential criminal penalties that can be used against those allowing FGM to happen. In Holland, it is primarily used by families who have migrated to Holland and do not want their children to be subjected to FGM, but still feel compelled by cultural and social norms when visiting family abroad.

The British government has also pledged up to £35m international development aid to help eliminate FGM in a generation. A portion of the new money expected to be around £8m would be spent on research into the best ways of ending the practice. The rest will be used to fund community programmes, with money channelled through the UN programme on FGM, and to support the Home Office in targeting the diaspora, who take children from the UK overseas to be cut.

Forced Marriage
The Anti-social Behaviour Crime and Policing Bill, currently going through Parliament will criminalise both Forced Marriage and breach of a Forced Marriage Protection Order.

Honour Based Violence
The Home Office released its reviewed 2013 action plan *A Call to End Violence against Women and Girls.* The action plan commits to engage with communities who practice 'honour' based violence such as FGM and Forced Marriage to change attitudes and behaviours, with following specific HBV actions:

- Work on the development of guidance and learning programmes for the Police on sexual and domestic violence, including FGM, Forced Marriage, Honour Based Violence and stalking.
- Review the findings from the 'honour' based violence local mapping exercise and identify models of effective practice to share with local areas, particularly those where awareness and activity to tackle forms of Honour Based Violence is low.

In November the London Violence against Women and Girls Consortium sponsored by the Mayor of London launched the Ending Harmful Practices project Women Against Harmful Practices (WAHP). The project which forms part of ASCENT is delivered by a partnership of 8 specialist organisations working across different Black Minority Ethnic and Refugee (BMER) communities in London with women experiencing Female Genital Mutilation, Honour Based Violence, Forced Marriage and other harmful practices. Support includes one to one advice and information on rights, entitlements, intensive casework and advocacy support, therapeutic support groups and counselling. The project also works to raise awareness amongst voluntary and statutory agencies and runs workshops and peer mentoring support for young women.

8. Key Findings and Recommendations

8.1. The scale and nature of Harmful Practices in Brent

The task group were keen to find out about the scale of Female Genital Mutilation, Forced Marriage and Honour Based Violence in Brent. However we soon realised for a variety of reasons, particularly the secrecy and taboos that exist around discussing these issues and the under or incorrect reporting of incidences, there was not an easy way to get this information.

We therefore started at looking at the information that existed nationally and for London. This included:

Violence against women

London has the highest rate of female victimisation in England and Wales.[5] Compared to the rest of the country, London has the lowest percentage of successful outcomes (measured as convictions of prosecuted cases) for violence against women offences (only 62 per cent were successful last year compared to 72 per cent nationally).[6]

Female Genital Mutilation (FGM)

An estimated 6.3 per cent of pregnancies in inner London [7] and 4.6 per cent in outer London are to women with FGM[8]. FGM was outlawed in 1985 by the Human Rights Council of the United Nations, and made a criminal offence in the UK in the same year. This was amended in 2003 to cover UK nationals taken abroad. There have been no convictions in the UK compared to 100 in France. FGM is prevalent in 28 African countries as well as in parts of the Middle East and Asia. FORWARD[9] estimated that over 20,000 girls under the age

[5] Home Office, 2004-8, British Crime Survey. Analysis of data comparing London rates with overall findings
[6] Crown Prosecution Service, 2009, Violence against women Crime Report 2008-2009, p.70
[7] These figures come from the only study in the UK that seeks to estimate prevalence. The research was funded by the Department of Health and undertaken by the Foundation of Women's Health
[8] Forward, 2007, A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales

on 15 are at risk of FGM and 66,000 women in the UK are living with the consequences.

Research was funded from Public Health Brent to the Help Somalia Foundation in September 2013 for a study of the Somalian population in Brent. It shows that there are over five thousand women and children, many of whom have either been cut or are at risk (Appendix 7).

Honour Based Violence (HBV)

Nationally, there are around 12 so-called 'honour' murders a year. The Metropolitan Police recorded 256 incidents linked to 'honour' in the year 2008/09, of which 132 were criminal offences. This is a 60 per cent rise for the year to April 2009. These are the most recent figures available at this time and were collected by a Freedom of information request made by IKWRO. IKWRO have recently produced a report called the *"Postcode Lottery"* which details the UK Police forces failings to correctly recording Honour Based Violence cases (Appendix 8).

Forced Marriage (FM)

January to May 2012[10] - 594 cases where the FMU has given advice or support related to a possible Forced Marriage. 14% of calls involved victims below 15 years old, 87% involved female victims and 13% involved male victims. Countries of Origin: Pakistan (46%), Bangladesh (9.2%), UK (8.7%), India (7.2%), Afghanistan (2.7%), Within the UK the geographical distribution of instances was as follows: London (20.9%), West Midlands (16.7%), South East (10.4%), North West (5.1%), 25 instances involving those with disabilities (23 with learning disabilities, two with physical disabilities and two with both) were brought to the FMU's attention. Seven instances involved victims who identified as lesbian, gay, bisexual, and transgender (LGBT).

Linked to forced marriage, many cultures have a tradition of marrying daughters at a young age. Female children, already malnourished and undervalued, are often married to much older men. In such marriages, females have little power and sense of self-determination. Those who marry early cannot stay in school and often have little motivation or ability to plan their families. Some cultures believe early marriage guarantees a long period of fertility; very young brides may need a smaller dowry. The age of female marriage is slowly rising in most of Africa; but in East Africa and Nigeria, it is dropping as young virgins, considered less likely to be infected with HIV/AIDS are sought as brides. Early marriage is most prevalent in Sub-Saharan Africa and in South Asia. In Bangladesh, 47 percent of women, ages 20 to 24, are married by age 15. In Guatemala, India, and Niger, the rates are 12, 18, and 50%, respectively.

Early marriage and childbearing are closely linked to low educational attainment. In Cameroon, 27% of married women, under age 20, finished seven years of school, compared to 77% of unmarried women. In Guatemala, teenage mothers are five times less likely to finish

[10]The Foreign and Commonwealth Office's Forced Marriage Unit (FMU) May 2012

secondary education than women whose first birth occurs later. Early marriage usually results in early childbearing, with severe consequences for the health of young mothers and their babies. Infants born to teenage mothers are up to 80% more likely to die within their first year than are infants born to mothers aged 20 to 29. Maternal mortality rates are twice as high for women aged 15 to 19 as for women aged 20 to 29. The task group supports the discussions in parliament to legislate for a minimum age of 18 years for marriage and does not support marriage at 16 years with parental consent.

Data for Brent

The task group requested data from the following sources about harmful practices in Brent. Not all of the organisations we contacted were able to provide data, please see all responses in Table 1. Table 2 shows the available data held by sources. There is very little data held anywhere on the local prevalence levels of harmful practices in Brent; and the data that has been recorded, has not previously been readily shared between Brent partners. We are still unsure of the extent of FGM, Forced Marriages and Honour Based Violence incidents in Brent and more work needs to be done. The tables below bear out the strong view expressed frequently that these practices are under-reported.

Table 1 – Written responses to request for Harmful Practice Statistics for LB Brent

Source	Response
FORWARD	No specific Brent data, however FORWARD provided a summary of Brent Community reached this year: • 63 women in total were reached through the work of our outreach worker in different community settings and women attending Coffee morning support and all women were given FGM awareness and information • We worked with 5 one to one support cases from the Brent area. Cases involved referral to Acton African Women's Well Clinic, and educational support • 4 men from the Borough of Brent attend FORWARD Men Advisory Committee • Most of Brent clients we have worked with this year are Muslims, Somali; between the ages of 25 to 60. The marital statuses of most clients are either single and/or lone parents.
TAWRC	Please note that we had considerably reduced staff capacity and these figures are based on two members of staff providing services. We have since expanded and we have 4 members of staff providing services.
Northwick Park/Brent NHS	A database has now been in existence since 2009, the data is used for Freedom of information requests and service planning. The FGM status is recorded in the patients Discharge notes so that Health Visitors and GPs are aware. There is currently no formal procedure for reporting this anywhere else. We undertook 10 reversals this year and 97% of the women who visited the clinic were of Somalian origin.
Brent Police	The criteria for flagging is purposefully vague so that even if there

	is only a perception from the officer that this might be happening, then the flag goes in, to ensure the most appropriate unit deal with the case.
Home Office: FMU	It is not of any significance to collect the name of the borough where forced marriage victims live, it makes no difference to the case or action that the FMU would take.
Home Office: SVU	We do not hold this information.
IKWRO	We keep detailed records of our clients and have provided the figures for Brent clients. Further to our 2010 FOI study of HBV cases across England, we are carrying out a similar study and will have new data to report in the spring on 2014.
IMKAAN	We are unable to provide this information for Brent or any borough as we do not hold this information. It is difficult to collect this data as it is often not recoded and goes unreported.
LB Brent	We started capturing data on FGM, forced marriages and honour bases violence in 2013, no data is available prior to that date.

Table 2 - Shows the amount of harmful practices in March 2012 – April 2013

Source	FGM	FM	HBV
Brent Children's Social Services	0	6	3
FORWARD	-	-	-
TAWRC	-	13	80
Northwick Park/Brent NHS	236	-	-
Brent Police	5	11	18
IKWRO	-	8	4

The task group also met with a number of community groups such as the Somalian Advice and Forum for Information (SAFFI) and the Jazari community group. The discussion group at SAFFI consisted of 13 women and the discussion group at Jazari Community Centre consisted of 31 women. All of the women that attended these groups said that they had been subjected to one of the three types of FGM. Please see case studies of harmful practices within Brent (Appendix 8).

The task group is concerned that a large majority of organisations and charities are still working from the prevalence figures released by FORWARD in October 2007 and that there is currently no coordinated effort by a central body to collect Brent specific data. While we were conducting the task group work we were pleased to hear that FORWARD have been commissioned to undertake a new prevalence study and that there is to be a report released in 2014.

In April 2013 LB Islington conducted a study;[11] the purpose of this study is to establish a more detailed picture of Female Genital Mutilation in Islington. The study adapted the method used by the Foundation for Women's Health, Research and Development (FORWARD; 2007) which used UK census data and national and regional FGM prevalence data to estimate the number

[11] Female Genital Mutilation (FGM) in Islington: A Statistical Study

of women and girls in the UK who were likely to have undergone FGM. The Islington study combined FGM prevalence data with language and ethnicity data for Islington to produce a similar estimate (Appendix 9).

We believe that anecdotal evidence points to much higher incidences of these harmful practices happening in Brent. The under reporting and reluctance of partners to share data means that more work needs to be undertaken to map out the true picture of prevalence using similar methodologies as outlined above.

Recommendation 3

- **That mapping of practising communities is undertaken to establish the number of women and girls at risk and should be undertaken as part of the Safer Brent strategic assessment process. This work should be completed using tested methodologies, such as those used by Forward and in coordination with Brent's partners and specialist charities such as Forward, the Asian Women's Resource Centre, the Jan Trust and the Iranian and Kurdish Women's Rights Organisation (IKWRO).**

8.2. Awareness, knowledge and criminality

Prior to the release of FORWARD's data in 2007, the awareness and knowledge of harmful practices in Brent was limited. Individuals and some services who had dealt with incidents of harmful practices had some awareness of the issues, most of which had came from encountering cases on a day to day basis, however they had not received any formal training and guidance. The release of FORWARD's *'Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales'* in 2007 has provided the platform for those working to eradicate FGM and has highlighted the use of other violent harmful cultural customs. However awareness and knowledge of harmful practices is still not at an adequate enough level to have a significant impact reducing prevalence and improving service provision.

The task group found that there was a serious lack of knowledge within practising communities. Of the women that the task group consulted with, those not born in the UK said that they were unaware of their human rights in regards to FGM and unaware of the physical and mental health complications that it may cause prior to coming here. With Forced Marriages and FGM women were under the impression that it was part of the Qur'an, was Halal and a religious requirement that they could not say no to. The women revealed that various degrees of honour based fear and violence were applied as a form of pressure for them to adhere to their cultural traditions. These women were also unaware of UK laws and criminals charges regarding FGM, Forced Marriages and Honour Based Violence prior to coming here and for a while after arriving.

The women and girls, who were born in the UK, had a better awareness and knowledge about their human rights, UK laws and how/or where to seek help if they are at risk. However these stronger more empowered young women or girls often became the victim of Honour Based Violence, as they are seen as too westernised, too unruly and could not be easily controlled so ultimately may bring shame on their family. Iranian and Kurdish Women's Rights Organisation (IKWRO) and the Jan Trust told us that it was important that professionals

supporting these young women are fully trained and can identify the warning signs, are aware of the correct procedures of engagement and do not put their lives at risk by trying to mediate with parents or family members. FMU guidance states that NO MEDIATION should take place, ONE CHANCE or these young women face abduction, violence and often death. Untrained and poorly trained professionals are putting the lives of these young women at risk. We believe that more support needs to be provided to girls and women who are brave enough to challenge cultural and religious norms.

Prior to starting this review members of the task group had varying degrees of knowledge about harmful practices. The task group wanted to assess the knowledge of other councillors and school governors. Members of the task group proposed the following a strongly worded motion to Council.

- This Council commends the work of the members' task group on Tackling Violence against Women and Girls in Brent. This task group is committed to ending harmful practices by raising public awareness of issues such as Female Genital Mutilation Forced Marriages and Honour Based Violence. These practices, and all instances of violence against women, constitute illegal, intolerable acts and human rights violations.

- This Council notes the positive influence members can wield within communities by encouraging individuals and groups to speak out against harmful practices, which impact on the wellbeing of women and girls in Brent. To ensure that members are fully informed on all these harmful practices and how to deal with them effectively, there will be a member development event held on Thursday 21 November 2013. Sessions will be led by the expert organisations FORWARD and the Asian Women's Resource Centre.

- Members also note the work of the White Ribbon Campaign day- a charitable organisation started by men which seeks to end violence against women. Members whole-heartedly support this cause and will sign the White Ribbon pledge to affirm that they will never condone or remain silent about violent acts against women. A Brent Council event marking White Ribbon Day – the internationally recognised day for the Elimination of Violence Against Women – will be held in the Civic Centre on November 25.

- We call on all members to unite in the fight against these harmful practices, and resolve to end all practices which cause physical or emotional distress to women and girls in Brent within the 5-year target set by the Government earlier this year.

This was passed unanimously. The Member Development training session, delivered by FORWARD and the Asian Women's Resource Centre, on harmful practices was well attended by councillors.

We recognised early in our work the importance of engaging with schools and those who make decisions about teachers and student training. The charities we talked to had informed us that it was quite difficult to get their training programmes into schools. We decided that it would be beneficial to talk to school governors at the Annual Brent School Governors Conference to find out their views. A questionnaire was circulated to all governors who attended the conference and 34 Governors responded. A summary of the responses is as follows:

Q1: Awareness of the offences FGM, FM and HBV

- 64% of school governors are aware of all three offences and
- 70% were aware of at least one or more of the offences.

Q2: Are any of the above covered in your safeguarding training?

- Only 21% said the above offences were covered by existing safeguarding training.
- 36% said they didn't know or were unsure if the topics were covered by existing safeguarding training.

Q3: Are Personal Social Health and Education (PSHE) lessons in school's curriculum?

- 70% of schools governors said that PSHE lessons form part of the school's curriculum.

Q4: If yes, would you like to see these topics included in the PSHE lessons?

- 61% would like to see these topics included in PSHE lessons (but age-appropriate).

Q5: How do you ensure pupils receive information about sensitive subjects, particularly with regard to the dangers and existence of these offences?

- 30% of school governors said they were either unaware of or didn't know what the schools did to inform pupils of sensitive information.
- Some school governors (15%) suggested that they already utilise the PSHE or other curricula to ensure pupils had the information they needed.
- Other school governors suggested that information could be conveyed to parents and carers through various meetings and literature.

Q6: What kind of training and materials would your school need in order to cover the topics?

- 42% of school governors left this question blank – the highest on the survey.
- Many of the comments on what type materials would be required involved some type of workshop or training material such as literature and videos for staff, parents and pupils. Some suggested people share experiences or have a re-enactment of the crimes.

Q7: To your knowledge, is there any work currently being done at your school to tackle these problems?

- Only 6 (18%) of school governors said their school was currently working to tackle one or more of these offences.
- Most (70%) either reported that their school was not currently working to tackle these offences or they did not know if work was being undertaken on these topics.

Q8: Does your school currently employ a nurse?

- Nearly half (48%) of school governors reported that there was either no school nurse employed at the school or they were unsure if there was one.

Q9: In your opinion, what would you like to see schools do to protect females against the above?

- When asked what they would like to see in their schools to address these issues, most (24%) school governors suggested some type of training for staff and education for parents and pupils.
- Other suggestions included raising awareness and creating safe spaces for pupils to talk about such issues.
- One governor suggested that schools need to address children being taken out of school to travel abroad for long periods.

Q10: Would you know what outside (the school) bodies to contact, either to get information you need to cover these topics or to get direct support if needed?

- When asked if they knew what outside body to contact (if needed), most 73% of school governors responded by saying either no or that they were not sure who to contact.

We found some good examples of educational establishments within Brent who have made positive encouraging steps to deal with harmful practices and safeguarding. For instance the College of Northwest London who currently runs a programme called *"Feel Safe, Be Safe"*, which offers advice and support to students who do not feel safe or have safeguarding concerns. The college advertises this service on the student intranet and has published and distributed booklets to students. Students can contact the service by text, e-mail or a single phone number which is constantly manned. So far the college has been able to support a number of students including helping girls who were being forced into marriage. Evidence from colleges elsewhere in London confirms this. The task group strongly supports the establishing of a single point of contact for women and girls affected by these issues and we are keen that the example of a single point of contact is used by partners when developing services in Brent. We would also like to highlight the Stonebridge School Safeguarding Policy agreed in January 2014 (Appendix 10), which specifically includes FGM and sets out the signs that children may exhibit. A copy of this is attached to this report.

We believe that there is a real opportunity to work with schools and to ensure that all head teachers and school governors receive training on harmful practices and that an appropriate level of information focussed on respect and equality between the sexes is offered to all year seven pupils.

The Impact of recent legislative changes

Domestic Violence Legislation now covers controlling behaviour, which includes so called 'honour' based violence, female genital mutilation and Forced Marriage. As mentioned earlier the UK government introduced clauses in the Anti-social Behaviour Crime and Policing Bill which will criminalise both forced marriage and breach of a Forced Marriage Protection Order.

Prior to introducing this the Home Office conducted a survey on criminalising Forced Marriage and received 297 responses to the consultation,

Of the total number of 297 responses:

- 54% of respondents were in favour of the creation of a new offence;
- 37% were against the creation of a new offence;
- 9% of respondents were undecided;
- 80% felt that current civil remedies and criminal sanctions are not being use effectively.

A few of the women and professionals that the task group engaged with expressed some concern that recent legislative changes would result in harmful practices being driven underground. Discussions are currently taking place in parliament, about raising the age of consent for marriage from 16 years to 18 years.

The Task group supports raising the age for consent to marriage and the criminalisation of Forced Marriages and welcomes the roll out of the legislation later this year.

Recommendation 4

- **That a programme of community engagement about violence against women focussing on harmful practices is developed which ensures that members of affected communities play a lead role. Awareness raising events should be aimed at all sections of the local community, partners, relevant staff and Members.**

Recommendation 5

That awareness raising resources, leaflets and posters are clearly displayed in medical and educational establishments, particularly GP surgeries, clinics, Hospitals, schools and colleges. These should include a single point of contact for those affected by harmful practices.

Recommendation 6

That Brent Council and its partners work with local and national media, including community radio and television stations, to raise awareness and educate the public on harmful practices and the negative effect it has on women and girls in our society.

Recommendation 7

That a programme of training is developed for all key staff from all relevant agencies who are likely to have contact with affected women and girls that will ensure a better understanding of the issues, identification of those at risk and referral pathways. Funding is available to the voluntary sector to assist Brent in delivering this training programme.

Recommendation 8

That all awareness raising and training activities highlight the changes in the law make these harmful practices criminal offences.

Recommendation 9

That joint working is undertaken with schools to ensure that all head teachers, school governors and those responsible for safeguarding receive training and that all year seven children receive information as part of Personal Social and Health Education.

Recommendation 11

That Brent Council along with its partners annually take part in the International UN sponsored awareness day that takes place 6th February each year. Zero Tolerance of Female Genital Mutilation day is set up to make the world aware of Female Genital Mutilation and to promote its eradication.

8.3. Partnership working including referral processes and pathways

Throughout the task group's work it was noted that a large proportion of the professionals and stakeholders who were doing work to tackle harmful practices were working independently. This is especially evident in relation to the data. The data was captured using inconsistent methods, was not shared with other partners, and was not used to benchmark incidences or plan for provision and service needs.

The task group found evidence that since 2010 there has been a more noticeable effort in partnership working, however women and girls are still experiencing poor treatment and support and this is often because of a lack of partnership working. Pathways and referral processes differ from organisation to organisation and often professionals were unaware of the next step in the referral process. For example one medical professional stated that once she made the referral to social services, it was unclear what would happen next and she did not know what to tell her patient. Some services we talked to were following safeguarding guidance from the Forced Marriage Unit and the Home Offices Multi agency guide; some services adopted a combination of their own processes with parts of the Home Office guidance and Pan London Child protection guidance.

Where no clear agreement between partners has been established, confusion still occurs about where an incident should be signposted to, what services clients may be entitled to and the best course of action to take. Local authorities and GPs are often the first point of contact and many of the women we talked to have had a negative experience and are not referred or sign-posted to relevant services and partners.

A number of the women shared examples of poor practice amongst statutory agencies (health professionals, police, the courts, job centres and council staff) which left them feeling dismissed, disbelieved, vulnerable and not informed about where to access support. Barriers encountered included lack of understanding about the issues affecting them, for example most of the women we talked to had no understanding of the concept of safeguarding. Other barriers included a lack of practical assistance and a few felt that they were being discriminated against. Some of the women were concerned about being stigmatized and having their children taken away from them. They felt that the barriers and attitudes they encountered had made them less likely they would report incidents and make it more likely that they remained in dangerous situations

Access to on-going face-to-face training on different forms of VAWG from the specialist VAWG sector would go some way to ensuring responses were more consistent and of a high quality. For women with immigration/asylum issues, access to support services including refuge accommodation is particularly difficult, and women face a higher risk of destitution. Therefore there is a need for more joint work with UK Boarder Agency and other partners to improve referral to specialist VAWG services and review existing practice and policies on VAWG.

IMKAAN[12]recently produced a report *Beyond the Labels* which explores the views and opinions of Women and girls who have been subjected to harmful practices. The report also examines the barriers preventing access to support and summarises recommendations made by these women and girls and how local authorities and other professionals can improve their response to harmful practices. Some of the recommendations include:

Local Authorities

- Local authority staff particularly to have a more consistent and better understanding and knowledge on how to respond to VAWG.

Health

- For GPs to be more informed and proactive about the appropriate care and referral pathways specifically where women require access to support from the VAWG sector.
- Professionals in the health sector e.g. GPs, health visitors etc. to be trained to ensure that they are able to respond better to women after they disclose violence.
- GPs to have a better understanding of their need for confidentiality when seeking support. For example, women and girls wanted more opportunities to be alone with the GP to disclose safely.

UK Border Agency (UKBA)

- The UKBA (Home Office) to implement a working culture which is more sensitive and appropriate on VAWG and one which starts from the premise of belief.

Criminal Justice System

- For the police to have a better and more consistent awareness and training on VAWG to prevent women from feeling that their experiences have been minimised or dismissed because of an emphasis on physical violence rather than psychological violence and coercive control.
- For the police to be more informed and provide better quality and more consistent advice and information to enable effective referral to specialist VAWG services.
- Regular communication between the police and women/girls so they feel more informed once they have made a formal report. This included being regularly updated on any actions taken against the perpetrator(s) as well as information on location which would impact on their safety.
- More consistent forms of protection to support women and girls to feel informed, equipped and safe before, during and after court proceedings.
- Improved knowledge and training on VAWG across all parts of the Criminal Justice System (CJS) and more specialist VAWG courts.

[12] Imkaan is a UK-based, black feminist organisation dedicated to addressing violence against women and girls.

"A call to end violence against women and girls (action plan 2013)" the Home Offices Commitment to tackling Violence against Women and girls identifies working in partnership as one if its main priorities. Partnership working - Guiding principle*: Work in partnership to obtain the best outcomes for victims and their families*. The action plan sets out the outcomes it hopes to achieve by 2015:

- Better support available for victims and their families with statutory, voluntary and community sectors working together to share information and agree practical action

- Improved the life chances of victims of violence against women and girls overseas, with this issue an international priority for the UK.

- Promote effective partnership working between police and schools where children are at risk of domestic violence (e.g. Operation Encompass on going to 2015).

- Continue to work in partnership across Government and with the third sector to ensure that the impact of Government reforms are fully understood and managed

- Provide clear information on violence against women and girls to commissioners in the changing commissioning landscape

- Support statutory and voluntary services in sharing information about the women and girls most at risk and agreeing clear referral and needs assessment arrangements

- Continue to demonstrate leadership internationally to address violence against women and girls, and ensure that the links are made between the women whom the UK is helping overseas and those who arrive in the UK seeking protection.

Key activity since 2012 on partnership working in England and Wales:

- Provided £100,000 to determine gaps in service provision at a local level, help local authorities better understand what services will best assist victims, and assist the voluntary sector in professionalising their dealings with statutory agencies;

- In response to the consultation "Getting it Right for Victims and Witnesses", set out the move to a new model for the provision of support services for victims of crime where the majority of services will be commissioned locally by Police and Crime Commissioners (while rape support services will continue to be funded centrally);

- Funded Against Violence & Abuse (AVA) and the Aya Project (managed by Women's Aid and IMKAAN) to build capacity within the women's sector and help them better understand Local Authority commissioning processes; and help Local Authority commissioners better understand the needs of violence against women and girls victims and measures to tackle perpetrators in their areas

The task group would like to ensure that a partnership strategy on harmful practices is developed within the context of the Violence against Women and Girls Strategy that would

facilitate a more coordinated approach between partners working on this issue and provide clear guidelines to key staff on referrals and services available. We would also recommend that all key staff undertake training to build a better understanding of the issues, enable them to identify those at risk and make referrals.

Recommendation 1
That tackling harmful practices becomes a high partnership priority within Brent and that a clear partnership strategy is developed within the context of the wider Violence against Women and Girls Strategy. The harmful practices strategy should include:

1.1. Developing services to protect women and girls at risk

1.2. Developing services to support women and girls subjected to harmful practices

1.3. Robust recording and better quality of data and sharing of data from all partners

1.4. Clear and consistent guidance for reporting risk, pathways for referrals and services

1.5. Provide clear guidance to all key staff and the public on how to report a crime against a women affected by these issues.

1.6. A single point of contact is established for those affected

1.7. The adoption of good practice from elsewhere, health service, local authorities, voluntary sector organisations and educational institutions.

Recommendation 2
That work in relation to the implementation of the Harmful Practices Strategy is the responsibility of:

- **The Children's Safeguarding Board**
- **The Health and Wellbeing Board**
- **Safer Brent Partnership**
- **The Assistant Chief Executive Department will take the overall lead responsibility**

8.4. Services and accessing available funding
To establish the extent of existing services available to those affected by harmful practices the task group met with key staff from within the council and its partners to discuss the current provision. Most council departments told us that for cases where there are children or vulnerable adults safeguarding concerns there was social services provision. All other cases, especially where there is no recourse to public funds, are referred to charities and the voluntary sector.

In the course of our work, members of the task group visited various charities and community groups to ask them what improvements they would like to see to current service provision. We also looked at the recommendations set out in the IMKAAN Report "*Beyond the Labels".*

The recommendations set out in the report mirrored the views of the Brent residents consulted. These were:

On future services for women and girls

- For refuge provision to be more accessible across London in order to prevent women from being housed in generic homelessness provision.

- Consistent and longer term investment in women-led women-only spaces and services that women and girl's value, and that make them feel safer, protected and understood.

- More consistent and longer term investment in BME women-led services which provide effective responses to differences in social identity and support women and girls to experience higher levels of social inclusion and belonging.

- To improve the availability of local women-only services which are specialist in their approach and respond to women and girls' individuality of experience and identity.

- More accessible services that offer different forms of expertise including responses to Female Genital Mutilation, Forced Marriage, sexual violence and exploitation, domestic violence, support in exiting prostitution.

- More accessible services to address additional vulnerabilities and support needs including drug and alcohol, disabilities, chronic health issues and mental health needs.

- Improved access to refuge provision for women with immigration/asylum related issues particularly where women lack the relevant documentation or access to any other means of financial or housing support.

- Increased investment in projects that provide longer term support e.g. life skills, training, employment, and programmes that support women and girls to recover and reduce isolation after they have left the violence.

- Increased access to longer term, flexible and specialist key-work support at points of crisis and where women are rebuilding lives after leaving violence. This was specifically important to women who experience a range of complexities and where there are gaps in existing service provision e.g. exiting prostitution, young women within a gang/group-based context and/or peer-based abuse, Female Genital Mutilation and Forced Marriage.

- Improved access to holistic support services that are young-women centred and tailored to address the specific needs and experiences of young women.

- Improved access to long-term VAWG counselling and therapeutic support services which are rooted in a VAWG approach, including BME specific provision.

Overall it is important for public sector commissioners to recognise the need for more consistent and longer term investment in a diverse range of women-only VAWG service models and approaches which respond to different forms of VAWG and social identity. Women affected by FGM spoke about the barriers around disclosure and the complexities of reporting family and community members, hence the importance of on-going case-work support through community-based support workers. There are also inadequate levels of targeted provision for young women in the context of different forms of VAWG. Equally significant is improving access to services that provide longer term and flexible arrangements for emotional support through counselling, group work, peer-learning programmes and activities for adults and children. These were considered as significant as access to safe housing.

The recent London Council funded ASCENT project which launched in November 2013 is a partnership within the London Violence against Women and Girls Consortium, delivering a range of services for survivors of domestic and sexual violence and abuse under six themes funded by London Councils. ASCENT improves service provision for those affected by sexual and domestic violence and abuse in London through the provision of front-line services as well as support to voluntary and statutory organisations. The London VAWG Consortium is made up of 22 organisations working in partnership to deliver comprehensive, cost effective, high quality services to all communities across London. This innovative partnership strengthens referral pathways across organisations and identifies trends and emerging need.

We would also like to highlight the work at Northwick Park Maternity Unit, particularly the African Well Women's Clinic as an example of good practice. They keep records and collect data of all women subjected to FGM, provide counselling and perform reversal surgery prior to birth.

In October members of the task group visited London Councils to discuss the new funding programmes for 2014-2020. The rights and Citizenship Programme 2014-2020 which holds a budget of €439 Million, has the general objective of contributing to the creation of an area where the rights of the person are promoted and protected. The programme will be centrally managed and funding will be allocated on a competitive basis. Transnational projects and multi-agency and multi-sector partnerships will be favoured. Call for proposals will happen in the second quarter of 2014 (early autumn).

Specific related Objectives include:

- Enhancing the exercise of rights deriving from citizenship of the European Union
- Implementing the principle of non-discrimination
- Enhancing the respect of the right of the child

Type of actions that will be funded:

- Raising awareness of harmful practices within practising communities
- Identifying good practice in running specialist support services for victims of Violence
- Training professionals who work with vulnerable children (e.g. children in residential care, in detention or separated children)

- Improving EU citizens' understanding of their rights and help them realise when these have been violated
- Developing mechanisms to collect and report hate crime or xenophobic incidences
- Encouraging the private sector to improve gender balance
- Exchanging good practice in promoting good pay

All public and private organisations, including international organisations legally established in one of the 28 EU members states are able to apply to the rights and Citizenship Programme 2014-2020 Fund.

The task group would urge partners to work together to access this funding.

Recommendation 10
That Brent Council in conjunction with its partners, particularly Council for Voluntary Services (CVS) Brent, pursue all avenues for available funding and support specialist charities and local voluntary organisations to bid for money from government agencies such as the Forced Marriage unit and the European Union fund.

Recommendation 12
That Brent Clinical Commissioning Group (CCG) should commission services for women and girls affected by the harmful practices of Female Genital Mutilation, Honour Based Violence and Forced Marriages.

9. Conclusion

The task group believes that this report provides a range of important recommendations which, when implemented, will lead to improved outcomes for the women and girls in Brent who have been, or are likely to be affected by FGM, Forced Marriage and Honour Based Violence. All of the women we talked to from affected communities were adamant that they did not want their daughters to suffer like they had. We hope that we can help them, by working with our local communities, the voluntary and community sector, specialist agencies and partners. We can raise awareness about these criminal activities and ensure that preventative interventions and services are in place to reduce the negative impacts that these harmful practices have. The individual members of the task group are passionate about these issues and will continue to highlight them at every possible opportunity.

Stakeholders:

1.	LB Brent	Council Officers: – Councillors (Members) Brent Community Safety Brent LSCB & Children Services Brent Education Welfare Brent Adult Safeguarding Brent Multiagency Safeguarding Hub Public Health Scrutiny Committees (Health, Partnership & Place and Children & Young People) Policy Teachers School Governors
2.	NHS & Clinical Commissioning Group (CCG)	Hospitals – Northwick Park and Central Middlesex School Nurses Midwives Health Visitors GPs Doctors/Surgeons
3.	Charities, Community Groups and Voluntary Sector	Parents & Parent Groups Young People and Youth Groups Charity Groups:- Forward Jan Trust Asian Women's Resource Centre Ashiana Network Iranian & Kurdish Women's Rights Organisation Somali Advice and Forum of Information Help Somalia Foundation Jazari Community Centre Women's Refugee's Daughters of Eve One Billion and Rising White Ribbon Charities Men's Charities
4.	Partners for Brent /Multi Agency Safeguarding Hub/Safer Brent Partnership	Police CVS
5.	Religious Groups	Multi Faith Forum Group Priests, Vicars, Imams and Clerics from all denominations in the borough
6.	Community	Residents and Resident Groups
7.	Government Agencies	Mayor of London VAWAG Dept.

		The Home Office The Forced Marriage Unit All Party Parliamentary Dept.
8.	Other Local Government Authorities	Bristol Islington Lambeth Southwark Harrow Ealing Birmingham City Council
9.	Other Interested Parties	Members of Parliament (MPs) Media

References:

The task group referred to a number of reports in the course of its work. Key documents include:

- Home Office, 2004-8, British Crime Survey Analysis of data comparing London rates with overall findings
- Crown Prosecution Service, 2009, Violence against women Crime Report 2008-2009
- Forward, 2007, A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales
- The Foreign and Commonwealth Office's Forced Marriage Unit (FMU) May 2012
- Female Genital Mutilation (FGM) in Islington: A Statistical Study 2012
- IMKAAN recently produced a *Beyond the Labels* report 2013
- The Home Office *A call to end violence against women and girls (action plan 2013)*
- Mayor of London's Violence against Women and Girls strategy "The Way Forward", (2009)
- "A Childhood Lost" A report on Child Marriage in the UK and Developing World from the UK All-Party Parliamentary Group on Population, Development and Reproductive Health (2012)
- "Postcode lottery" A report on research undertaken by the Iranian and Kurdish Women's Rights Organisation (IKWRO) on police records of 'honour' based violence (January 2014)

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Tackling Violence Against Women And Girls in Brent Task Group
Professional Discussion Group

Meeting 1 – Female Genital Mutilation (FGM)

Meeting:

Tackling VAWAG in Brent Task Group – Professional Discussion Group
Friday 8th November 2013,
Brent Civic Centre Room – 5M 003
10.00am – 12.00pm

Questions:

1. In your professional opinion and in your area of work, what methods:
   A) Have been successful?
   B) Have been unsuccessful?
   C) Would you recommend for good practice?

2. What has made the biggest impact on improving the work you do, tackling FGM?

3. Other than funding, what could we recommend to the Council and its partners that would help your work?

4. How has funding cuts impacted on your work? And how have you managed to maintain your services?

5. What do you feel we should say about the issues that affect you?

6. Where do you think best practice is taking place e.g. other boroughs, cities, countries?

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Tackling Violence Against Women And Girls in Brent Task Group
Professional Discussion Group

Meeting 2 – Forced Marriage & Honour Based Violence

Meeting:

Tackling VAWAG in Brent Task Group – Professional Discussion Group
Friday 6th December 2013,
Brent Civic Centre Room – 7M 003
10.00am – 13.00pm

Questions:

Discussion 1, Forced Marriage - FM

What is your opinion on the criminalisation of Forced Marriage?
(Continue with Q. 1-6)

Discussion 2, Honour Based Violence - HBV

Where is the notion of honour coming from and how do we begin to change mind set?
What are the sign leading up to HBV being inflected on an individual?
(Continue with Q. 1-6)

1. In your professional opinion and in your area of work, what methods:
   A) Have been successful?
   B) Have been unsuccessful?
   C) Would you recommend for good practice?

2. What has made the biggest impact on improving the work you do?

3. Other than funding, what could we recommend to the Council and its partners that would help your work?

4. How has funding cuts impacted on your work? And how have you managed to maintain your services?

5. What do you feel we should say about the issues that affect you?

6. Where do you think best practice is taking place e.g. other boroughs, cities, countries?

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Members Training, 21st November 2013

Tackling Violence against Women & Girls in Brent

Questionnaire

This Council Members Task Group was set up to review Violence against Women and Girls in Brent and will focus on:

Female Genital Mutilation (FGM)
Forced Marriages
Honour Based Violence

With the aim of bringing these highly illegal and violent crimes against women to the forefront of public awareness, the task group will be collecting and reviewing evidence from victims, partners and other professionals, in order to improve services and protect Women and Girls in Brent. The task group would like to you know your thoughts and ask if you could please complete this short questionnaire; part 1 before the start of the training, and part two once the sessions has finished.

Thank you in advance for your cooperation

Name of your Ward ……

Part 1

(To be completed before training session)

Please circle your answers

1. Are you aware of the particular offences that this task group is tackling?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

2. Are you aware of the law regarding these offences?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

3. Are you aware of the council's responsibility in protecting women and girls in Brent?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

4. Would you know what outside bodies to contact, either to get the information you need to cover these topics, or get direct support if needed? **Yes/No**
   (Please list outside bodies)……
   ……
   ……
   …

Part 2

(To be completed after training session)

Please circle your answers

1. Are you aware of the particular offences that this task group is tackling?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

2. Are you aware of the law regarding these offences?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

3. Are you aware of the council's responsibility in protecting women and girls in Brent?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

4. Would you know what outside bodies to contact, either to get the information you need to cover these topics, or get direct support if needed? **Yes/No**
   (Please list outside bodies)……
   ……
   ……

5. How do you ensure that vulnerable women and girls in your wards receive information about such sensitive subjects, particularly with regard to the dangers and existence of the offences previously mentioned?

   (Please Write in) ……

6. What kind of training and materials would you need in order to cover these topics in your wards?

   (Please write in)……

7. To your knowledge, is there any work currently being done in your wards to tackle the above offences? **Yes/No**

8. In your opinion, what would you like to see members do to protect women and girls against the above offences?

   (Please write in)……

9. What one thing have you learnt here today that you will take away and discuss with others?
   ……
   ……
   ……...

Annual Brent Governors Conference 2013

Tackling Violence against Women & Girls in Brent

Questionnaire

This Council Members Task Group was set up to review Violence against Women and Girls in Brent and will focus on:

Female Genital Mutilation (FGM)
Forced Marriages
Honour Based Violence

With the aim of bringing these highly illegal and violent crimes against women to the forefront of public awareness, the task group will be collecting and reviewing evidence from victims, partners and other professionals, in order to improve services and protect Women and Girls in Brent. The task group would like you know your thoughts and ask if you could complete this short questionnaire and return it to the Tackling Violence against Women & Girls in Brent display stall today.

Thank you in advance for your cooperation

Name of your school (Optional)…… …..... **Please circle your answers**

1. Are you aware of the particular offences that this task group is tackling?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

2. Are any of the above listed offences covered in your safeguarding training? **Yes/No**

3. Are Personal Health Sex Education (PSHE) lessons on your school's curriculum? **Yes/No**

4. If you answered yes to Q3, would you like to see these topics included in the PSHE lessons? **Yes/No**

5. How do you ensure that pupils in your school receive information about such sensitive subjects, particularly with regard to the dangers and existence of the offences previously mentioned?

   (Please Write in) ……

6. What kind of training and materials would your school need in order to cover these topics?

   (Please write in)……

7. To your knowledge, is there any work currently being done in your school to tackle the above offences? **Yes/No**

8. Does your school currently employ a school nurse? **Yes/No**

9. In your opinion, what would you like to see schools do to protect females against the above offences?

   (Please write in)……

10. Would you know what outside bodies to contact, either to get the information you need to cover these topics, or get direct support if needed? **Yes/No**
    (Please list outside bodies)……

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FORWARD

Safeguarding rights & dignity

A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales

Summary Report

Principal Investigators
Efua Dorkenoo BSc MSc RGN RSCN OBE
Linda Morison BSc MA CStat
Alison Macfarlane BA Dip Stat CStat FFPH

Foundation for Women's Health, Research and Development (FORWARD)
In collaboration with
The London School of Hygiene and Tropical Medicine and
The Department of Midwifery, City University

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MAPS

Chris Grundy

FOREWORD

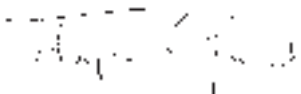
Female genital mutilation (FGM) is a grave human rights violation which is perpetuated by families in the name of culture, tradition and religion. The World Health Organisation estimates that globally from 100 to 140 million girls and women have undergone some type of FGM. It has been estimated that currently, about three million girls, most of them under 15 years of age, undergo the procedure every year. The majority of FGM takes place in 28 African countries but many immigrant communities continue the practice in Europe, North America, Australia and New Zealand.

The practice of FGM is an international problem. Numerous international human rights laws and conferences have highlighted the need to eliminate this practice. FGM violates the human rights of women and girls, causing them physical and psychological harm. It also denies them the enjoyment of the highest attainable level of sexual and reproductive health. Steps have been taken by the UK parliament to discourage FGM, for example, the government introduced a new Law on FGM in 2003 to demonstrate its commitment to preventing the occurrence of FGM in the UK, but to date there have been no convictions under this law.

More needs to be done to tackle FGM. The lack of data on FGM makes it difficult for policy makers and professionals to respond effectively to the needs of affected women and to protect girls from undergoing FGM. Within the UK, data used to support policy decisions have been at best estimates.

FORWARD's new collaborative work with the London School of Hygiene and Tropical Medicine and the City University is a welcome attempt to address this gap. "A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales: Summary Report", provides reliable data to inform and plan better maternity and gynaecological care and related support services for girls and women affected by FGM. This study suggests that over 20,000 girls under the age of 15 are potentially at risk of FGM in England and Wales. It also suggests that the practice is on the increase. It is hoped that the results of the study will support the planning and implementation of a comprehensive national strategy in the UK that will help to expedite efforts to end FGM within one generation.

Many sectors need to work collaboratively, including health, social, education, community and the police to integrate a better understanding of FGM into its policies and services to meet the needs of those affected and to eliminate this human rights violation. It is hoped that this study and its recommendations will provide the impetus to change.



Baroness Joyce Gould - FORWARD Patron

A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales: Summary Report

Foundation for Women's Health, Research and Development (FORWARD)
In collaboration with
London School of Hygiene and Tropical Medicine
Department of Midwifery, City University

FORWARD is an African Diaspora led non-profit organisation dedicated to improving the health and human rights of African girls and women in the UK and Africa. We focus on tackling harmful gender based discriminatory practices such as female genital mutilation and child and forced marriage through enabling our partners and key stakeholders including women and young people to help shape the health and rights of African girls and women. Through advocacy, training and advice, research and resource development we seek to influence government and other statutory bodies in the area of policy development and implementation. FORWARD is one of the leading advocates in the UK fighting to eliminate female genital mutilation.

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Contents

1. Introduction

The United Nations has recognised female genital mutilation (FGM) as a human rights violation. In the UK the practice is included in the UK Children Act and other legislation. There is recognition that it is practised in some minority communities in the UK. It has also been the focus of two and half decades of educational campaigns by voluntary groups in the communities concerned.

Despite this, there are no reliable data on the extent of FGM in the United Kingdom. Lack of data on FGM marginalises the issue. An urgent need for these data has been expressed at all levels, from grassroots organisations to parliament.

Data are needed for the planning and implementation of a comprehensive national strategy for the prevention and the elimination of FGM in the United Kingdom, to act as a baseline against which to measure the success of programmes to combat FGM and for targeted advocacy. Reliable data on FGM are also needed to inform maternity and gynaecological care as well as other support services that are needed for girls and women with complications of FGM.

These are the first systematic estimates for England and Wales. Although, as the report describes, there are some limitations in the methods used, they give some insight into the scale and the spread of FGM in England and Wales and support the view that action is needed to prevent FGM being passed on to the younger generation.

2. Background

Female genital mutilation (FGM) constitutes partial or total removal of the external female genitalia or injury to the external female genitals for non therapeutic reasons.[1] It is estimated that 100-140 million girls and women in Africa and Yemen have undergone FGM and that 3 million young girls undergo FGM every year.[2] FGM also occurs in some parts of the Middle and the Far East. Mainly due to migration, women with FGM are increasingly found in Europe, the United States, Canada, New Zealand and Australia.

Table 1: WHO 1995 classification of FGM types

Type	Description
I	Excision of the prepuce, with or without excision of part of the clitoris
II	Excision of the clitoris with partial or total removal of the labia minora
III	Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)
IV	Practices including piercing, pricking and incising of the clitoris and/or labia, cauterisation by burning of the clitoris and surrounding vaginal orifice (angurya cuts) or cutting of the vagina to cause bleeding or for the purposes of tightening or narrowing it.

Source: WHO, 1995[1]

The World Health Organisation has classified FGM into the four types shown in Table 1. FGM Type III accounts for approximately 15 per cent of all women with FGM in Africa, whilst FGM Type I and II account for approximately 80 per cent. Little is known about Type IV FGM, including types of FGM practised outside Africa.

2.1. Reasons given for practising FGM

The practice of FGM is embedded in ancient beliefs surrounding women's fertility and control of their sexual and reproductive capacity. The reasons given by communities who practise FGM vary widely but a common reason given for the practice is that it reduces the sexual desire of girls and women, promotes virginity and chastity, maintains fidelity in married women and is done for aesthetic reasons. FGM is practiced to enhance girls' marriage ability and to please their husbands. In some groups, FGM is central to girls' rite of passage into adulthood and is an integral part of society's definition of womanhood.

2.2. FGM as a human rights issue

FGM is a human rights violation in the absence of any perceived medical necessity. Among those rights that are violated are the right to the integrity of the person and the highest attainable level of physical and mental health.[3] FGM is recognised by the United Nations to be part of discrimination as well as a form of violence against girls and women.

Article 1 of the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) defines discrimination as "any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social cultural, civil or any other field, CEDAW art. 1, United Nations General Assembly Resolution 34/180 of 18 December, 1979.

Article 24 of the Convention on the Rights of the Child (1989) states:" States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health … " (Para 1) and "States Parties shall take all effective and appropriate measures with a view to abolishing traditional with a view to abolishing traditional practices prejudicial to the health of children … "(Para 3), UN General Assembly resolution 34/180 of 18 December 1979

The Declaration on the Elimination of Violence against Women expressly states in its article 2: "Violence against women shall be understood to encompass, but not limited to, the following:

(a) Physical, sexual and psychological violence occurring in the family, including … dowry related violence … female genital mutilation and other traditional practices harmful to women …" .UN General Assembly,A/RES/48/ 104, 85th plenary meeting, 20 December 1993.

The 2002 UN Special Session on Children, endorsed by 69 heads of states and governments, which include the United Kingdom, set a goal to end female genital mutilation by the year 2010.[4]

2.3. Health risks

The health risks associated with FGM are wide and some are severely disabling.[5] Despite this, there are few large series of case reports or quantitative community-based reports of the frequency and patterns of the consequences of FGM. Girls and women undergoing FGM Type III are particularly likely to suffer serious and long-term complications as the stitching of the labia majora to create a flap of skin covering the vaginal opening causes a direct mechanical barrier to urination, menstruation, sexual intercourse and to delivery.

A recent large scale WHO collaborative study in six African countries showed that women with FGM were at higher risk of caesarean section, post-partum haemorrhage, prolonged maternal hospitalisation, infant resuscitation and perinatal death among women with FGM than those without FGM; and that the risk increased with the severity of FGM.[6] Another study in the Gambia, where Type II FGM is commonly practised, found that women with FGM were more likely to have Bacterial Vaginosis and to have been infected with Herpes Simplex Virus-2. Both of these could have implications for increasing risk of HIV infection.[7]

There is little documentation on the psychosexual and the mental health consequences of FGM. One controlled study which was undertaken in Senegal, found that women who had been subjected to FGM were significantly more likely to suffer from post-traumatic stress disorder (PTSD) and other psychiatric syndromes when compared to women who had not been subjected to FGM.[8]

2.4. FGM practitioners

FGM is largely performed by traditional practitioners without anaesthetics but in urban centres and amongst the elite it may be performed by western trained health professionals with anaesthetics.

2.5. Age when FGM is performed

Amongst ethnic groups for whom FGM is a traditional practice, it is generally performed on young girls who are below the legal age of majority. The age at which the procedure is performed varies from one community to another. It can be carried out during infancy, on girls under ten years old or on adolescent girls and occasionally on adult women including pregnant women. Most experts agree that the age at which genital mutilation is performed is decreasing.

2.6. Evidence that FGM is a concern in the UK

The United Kingdom has had a long history of migration from its former colonies. FGM is known to be commonplace in some of these countries. More recently, increasing numbers of refugees from the Horn of Africa fleeing from civil unrest and war have sought asylum in the UK. A study involving case studies of 50 women attending an African well-woman clinic in London described 14 primigravid women with FGM Type III who required episiotomy for sustained perineal tears at the time of delivery.[9] Small scale academic studies and local authority casework interventions on girls deemed at risk of undergoing FGM, also show that FGM is a continued traditional practice in specific African communities in the UK.[10-13]

Because of the concern about FGM, the UK Prohibition of "Female Circumcision" Act came into force in 1985. The Act made it an offence to carry out or to aid, abet or procure the performance by another person, of any form of female genital mutilation, except for specific medical purposes. FGM was further recognised as a denial of the girl child's fundamental human rights to her physical integrity and natural sexuality and has been incorporated as a case for concern into 'Working Together to Safeguard Children', a guide to arrangements for inter-agency co-operation in the UK to protect children from abuse.[14]

Further legislation, the 'Female Genital Mutilation Act 2003', came into force in March 2004. It introduces the issue of extraterritoriality, which makes it an offence for FGM to be performed anywhere on UK nationals or UK permanent residents. This closes the loophole in the 1985 Act, which gave room for parents to get around the law by taking their girls abroad for FGM and then returning them to the UK. The 2003 legislation also increases the penalty for aiding, abetting or counselling to procure FGM to 14 years imprisonment or a fine or both. FGM is a hidden practice which is difficult to detect. To date, no prosecutions on FGM have been made under the UK legislation although two doctors have been found guilty of serious professional misconduct before the General Medical Council.[15] Although FGM is incorporated into child protection, at present no data are collected on the number or type of social work cases involving FGM in the UK.

In 2005, Scotland amended its legislation on female genital mutilation in line with the 'Female Genital Mutilation Act 2003' that applies to England, Wales and Northern Ireland. Although female genital mutilation is already illegal in Scotland, the amended Bill extends the provisions of the current legislation by giving them extra-territorial effect and increases the maximum penalty from 5 to 14 years imprisonment.

There are at least ten specialist clinics in the NHS which treat women and girls who have been mutilated. These clinics all have trained and culturally sensitive staff who offer a range of healthcare services for women and girls including reversal surgery. Services are confidential and in many instances interpreters are available. These clinics are open to women to attend without referral from their own doctor.

The Department of Health has also recently funded a well-received DVD for health professionals, which provides factual and clinical information on this subject. Female genital mutilation is also recognised as a form of domestic abuse highlighted in Responding to domestic abuse: A handbook for health professionals, published by the Department in January 2006.

3. Statement of the problem

3.1. Previous estimates of the prevalence of FGM in the UK

It has been estimated that there are from 3,000 to 4,000 new cases each year in the United Kingdom but no indication was given of the methods used to derive these figures.15 Other estimates suggest that 22,000 girls under the age of 16 years are at

risk of FGM and 279,500 women already resident in the UK have undergone FGM.[16] These estimates were derived by applying the WHO estimates of the prevalence of FGM figures in practising countries17 to estimates of numbers of women reporting six of these countries of origin in the 1999 Labour Force Survey.

In the United States, the Centers for Disease Control and Prevention derived estimates using 1990 census data and estimates of the prevalence of FGM in women's countries of origin.[18] The Population Reference Bureau updated these analyses using 2000 census data and more recent prevalence survey data. It concluded that the numbers of women with or at risk of FGM had risen by 35 per cent over the decade.[19] Similar methods have been used to derive estimates for Belgium and Spain.[20]

3.2. Limitations of previous estimates for the UK

Although the methods used so far to derive estimates of the number of women and girls affected by FGM in the UK have led to the best estimates available to date, there are obvious limitations with the reliability of these figures.

- The UK Labour Force Survey sample used to derive the estimates of females affected by FGM was not large enough to produce estimates about the size of the country of birth groups which were estimated to be fewer than 6,000 in number and the estimates were subject to sampling variability.
- It omitted the second generation of women, who were born in the UK but who may have undergone FGM.
- It assumed that the prevalence of FGM in practising migrant or refugee populations in the UK was the same as in their countries of origin. This assumption may not be valid but there are very few data on the effect of migration on the practice. One study suggested a lower prevalence of FGM among young Somalis in London than the population average in Somalia.11

In this report, we present estimates which overcome the first of these limitations by deriving numbers of women born in practising countries from the 2001 Census of Population. We have extended the number of countries of origin practising FGM from six to twenty nine. The improved estimates are still subject to limitations 2 and 3 so a survey will be needed to produce estimates which include second generation women and to allow for possible differences between the prevalence of FGM in women living in the UK and in their countries of origin. The process of producing the estimates presented here will provide the groundwork for designing such a survey as well as furthering future community based research.

4. Study objectives

To estimate for women and girls resident in England and Wales:

- The prevalence of FGM among women aged 15 and over.
- The number of registered maternities, that is, pregnancies ending in a registrable live or stillbirth, to women who have undergone FGM.
- The estimated numbers of girls aged below 15 at risk of FGM and the type of FGM.

The study was restricted to England and Wales. Although the proportions of births in Scotland and Northern Ireland to women born outside the UK in general and women from FGM practising countries has increased over the years since 2001 as a consequence of inward migration, the numbers of births to women from FGM practising countries were still relatively low.

5. Methods

The overall approach was to identify countries in which FGM is practised and from which there is significant migration to England and Wales, identify published data about the prevalence of FGM in those countries and apply them to Census and birth registration data for England and Wales obtained from the Office for National Statistics.

5.1. Identifying published data about the prevalence of FGM

Demographic and Health Surveys (DHS) implemented by Macro International for USAID (http://www.measuredhs.com) or the Multiple Cluster Indicator Surveys (MICS) implemented by national governments with technical assistance from UNICEF or other UN agencies. For countries where such estimates were not available published, bibliographic databases and reports from national and international bodies were searched.

5.2. Estimation of the number of women born in FGM practising countries and the number likely to have undergone FGM.

The method used for the calculation of prevalence was adapted and refined from FGM prevalence studies in the USA, Belgium and Spain.18,20 These also used census data.

The data items of relevance are women's ages, countries of birth, ethnicity and local authority of residence on census night. In discussion with the Office for National Statistics (ONS) Census Customer Services staff, tabulations using these variables already undertaken either as part of ONS own programme of publications or commissioned by others were reviewed. We obtained a table for England and Wales as a whole, M1000, which tabulated the numbers of women born in each of the countries in which FGM is practised, by age-group.

The number of women with FGM was estimated by multiplying the number of women in each age-group from each FGM practising country by the age-specific FGM prevalence for that country and then summing these numbers over all the FGM practising countries. The age-specific FGM prevalence in each country of origin was assumed to represent the probability that a woman from that country in that age group would have FGM.

It was planned to do further work that will repeat the above tabulation by ethnicity so that women with Asian and white ethnicity can be excluded from the figures and also to include tabulations by region in order to examine geographical spread, but this was not possible within the time and resources available.

5.3. Updating the 2001 estimates

Since the estimates calculated using methods described in 5.2 are now five years out of date, migration data were requested from ONS with the aim of updating estimates of numbers of women from practising countries. Because of disclosure control these were requested for groups of countries, according to the categorisation described in Table 2, rather than for all individual countries.

5.4. Estimating the number of maternities to women born in FGM practising countries by local authority.

Because of the emphasis on affected women, the analysis of birth registration data was conducted in terms of maternities, defined as pregnancies leading to one or more registrable live or stillbirths. In order to satisfy disclosure control procedures, tabulations of numbers of maternities by age and mother's country of birth for mothers born in the FGM practising countries for each year from 2001 to 2004 were held within ONS and not released to us. The study team provided age-specific FGM prevalences for each of the countries. Estimates of numbers of maternities to women with FGM in each local authority were calculated by ONS by multiplying the number of women delivering in each local authority area in each age-group and in each country where FGM is practised by the age-specific FGM prevalence estimate for that country. These numbers were then summed over all the countries where FGM is practised to estimate the total number of women with FGM overall in England and Wales and for each region.

5.5. Estimates of numbers of females younger than 15 years with FGM or at risk of FGM

Numbers of girls aged below 15 who had been born in FGM practising countries, were derived from the 2001 census. An additional tabulation of the birth registration data provided us with births of females to mothers from countries which practice FGM between 1993 and 2004. This gave a minimum estimate of numbers of girls under 15 residents in England and Wales at risk or having undergone FGM. To assess the magnitude of these risks, the FGM practising countries were categorised by level of risk of FGM.

5.6. Mapping

Two maps were created by Chris Grundy of the Public and Environmental Health Research Unit at the London School of Hygiene and Tropical Medicine.

5.7. Ethics

This study involved secondary analysis using FGM rates derived from publicly available survey data DHS and MICS as well as other published research data not requiring prior permission before use. Following an application to ONS' Microdata Release Panel, the birth registration statistics for England and Wales were made available as aggregated counts, not as individual records, to comply with ONS' disclosure control rules. According to the ONS, secondary analyses of census material which we will be working with can be used for research without prior permission. All analyses of ONS data in this report were checked by ONS to ensure that disclosure did not occur.

FORWARD was the institutional base for the study with collaboration from the London School of Hygiene and Tropical Medicine and City University.

6. Results

6.1 Prevalence of FGM in countries of birth

Countries in which FGM is reported to be a traditional practice were identified as:

North Africa and Yemen	Sub-Saharan Africa
Djibouti	Benin
Egypt	Burkina Faso
Eritrea	Cameroon
Ethiopia	Central African Republic
Somalia	Chad
Sudan	Cote D'Ivoire
Yemen	Democratic Republic of the Congo
	Gambia
	Ghana
	Guinea
	Guinea Bissau
	Kenya
	Liberia
	Mali
	Mauritania
	Niger
	Nigeria
	Senegal
	Sierra Leone
	Togo
	Uganda
	Tanzania

FGM has been reported in other countries or groups but little is known of the extent or type of practice. A form of FGM, probably Type I or IV, has been described in Muslim women in Malaysia[21] and Indonesia.[22] FGM has also been reported among some Kurdish groups, the Dowdi Bohra in India21 and Ethiopian Jews now resettled in Israel, although little information is available.

For 20 of the 29 countries in the above list, estimates of FGM prevalence by country among 15-49 year olds overall and for five year age-groups were obtained from rigorous national surveys notably the Demographic and Health Surveys (DHS) implemented by Macro International for USAID (http://www.measuredhs.com) or the Multiple Cluster Indicator Surveys (MICS) implemented by national governments with technical assistance from UNICEF or other UN agencies. For the nine countries where such estimates were not available published, bibliographic databases and reports from national and international bodies were searched for data on FGM prevalence.

International and national organisations with a possible interest in FGM known to work in these countries were also approached by the principal investigator for any information they could provide on FGM prevalence. Best estimates were then derived by pooling any published data found with local information. The results of this are shown in Table 2.

Countries were then classified according to the prevalence of FGM and the types of FGM found there, using the WHO 1995 classification of types of FGM. This method of grouping countries, shown in Table 2 is modified by us from that of UNICEF which was based only on prevalence.[2] The results of this are shown in Table 3, which shows the prevalences. These categories were then used in plotting Figure 1. FGM practices usually vary by ethnic group so the overall prevalence for a particular country tends to reflect the number and size of practising ethnic groups within it.

Table 2 Grouping of countries according to prevalence and type of FGM

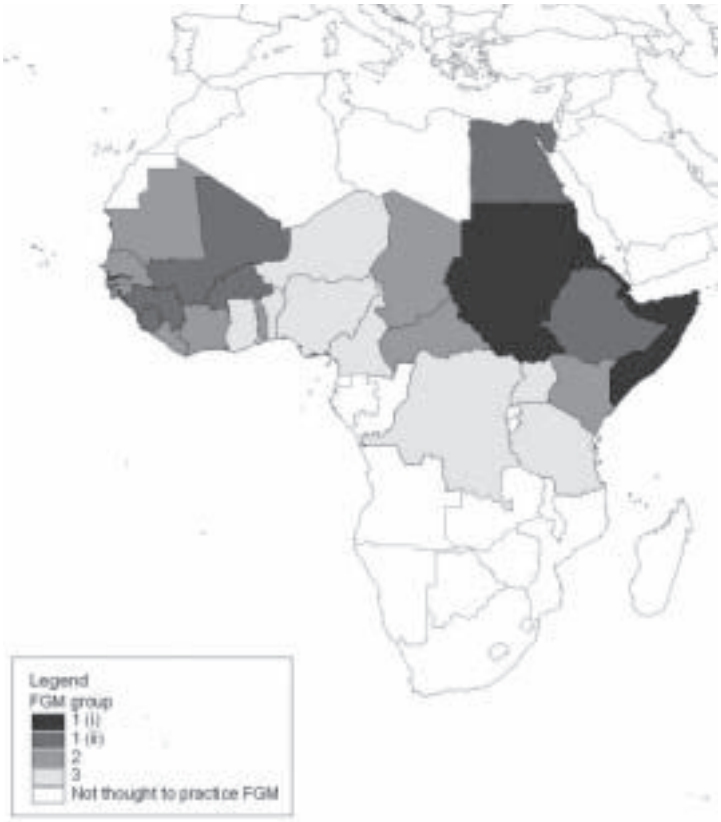
FGM category	Descriptive title of category	Definition
1(i)	Almost universal FGM and substantial WHO FGM Type III	Prevalence 85 per cent or higher and over 30 per cent of operations are type III
1(ii)	High prevalence WHO FGM Types I and II	Over 75 per cent prevalence and predominantly Types I and II
2	Moderate prevalence WHO FGM Types I and II	25 -74 per cent prevalence and predominantly Types I and II
3	Low prevalence WHO FGM Types I and II	Under 25 per cent prevalence and predominantly Types I and II

Adapted from UNICEF[2]

Table 3 shows FGM prevalence estimates overall and by age-group for the 29 practising countries identified. Because prevalence rates differed by age, being lower in younger age groups for some countries such as Kenya and Nigeria, we decided to use age-specific prevalences in the calculations for England and Wales, where available. The overall and age-specific prevalences were assumed to be probabilities that a woman from that country would have FGM. Table 3 also shows which countries were in each of the four risk groups specified in Table 2. These groupings were used where disclosure control did not allow categories as small as country to be used or where we had no information on probability of FGM, as was the case for females under 15 years old.

6.2. Estimates of the number of women likely to have FGM in England or Wales

Table 4 shows that 174,528 women resident in England or Wales in 2001 had been born in an FGM practising country. This figure seems likely to be an underestimate. Firstly, they did not include the 9,030 women who said they were born in Africa but did not state which country. Of these, 3,626 said they were born in East Africa, 276 in North Africa and 896 in West Africa. The second problem was low response to the census in inner city areas, particularly in Inner London. ONS took steps to compensate for this by imputing missing data, but this may not have fully compensated for any non-response by women born in the 29 countries considered here.



Countries in each FGM group shown in Table 2

1(i)	Almost universal FGM, over 30% FGM Type III	Sudan (north), Somalia, Eritrea, Djibouti.
1(ii)	High national prevalence FGM WHO Type I and II	Egypt, Ethiopia, Mali, Burkina Faso, Gambia, Guinea, Sierra Leone
2	*Moderate national prevalence of FGM WHO Type I and II	Central African Republic, Chad, Cote D'Ivoire, Guinea Bissau, Kenya, Liberia, Mauritania, , Senegal, Togo
3	*Low national prevalence of FGM WHO Type FGM I and II	Benin, Cameroon, Ghana ,Niger, Nigeria, Democratic Republic of Congo, United Republic of Tanzania, Uganda

*FGM prevalence is tied to ethnicity in these countries. Although national FGM prevalence's in these countries are moderate to low, FGM prevalence could be high amongst the specific ethnic groups who practice it.

Table 3 FGM prevalence by age group and grouping of country according to FGM risk

Country	Source of data	Year of survey	Overall	Age group							Group1
				15–19	20–24	25–29	30–34	35–39	40–44	45–49	
Benin	DHS	2001	16.8	12.1	13.4	16.9	18.4	18.3	25.1	23.7	3
Burkina Faso	DHS	2003	76.6	65.0	76.2	79.2	79.4	81.6	83.1	83.6	1(ii)
Cameroon	DHS	2004	1.4	0.4	2.5	1.6	1.1	1.2	1.8	2.4	3
Central African Republic	MICS	2000	35.9	27.2	33.8	35.6	39.9	43.3	41.5	41.9	2
Chad	MICS	2000	44.9	41.6	43.9	44.4	46.5	45.0	45.2	51.5	2
Côte d'Ivoire	DHS	1998–99	44.5	41.2	42.7	42.4	49.0	44.5	51.4	51.0	2
Democratic Republic of the Congo	WHO	1998	5.0								3
Djibouti	Union National des Femmes de Djibouti3	1991	98.0								1(i)
Egypt	DHS	2003	97.0	96.8	97.4	97.3	96.5	96.4	96.5	98.0	1(ii)
Eritrea	DHS	2001–02	88.7	78.3	87.9	90.8	93.4	92.6	94.1	95.0	1(i)
Ethiopia	DHS	2000	79.9	70.7	78.3	81.4	86.1	83.6	85.8	86.8	1(ii)
Gambia	Singhateh SK4	1985	79.0								1(ii)
Ghana	DHS	2003	5.4	3.3	3.8	6.4	6.3	6.7	5.5	7.9	3
Guinea	DHS	1999	98.6	96.6	98.5	99.1	99.1	99.1	99.3	99.5	1(ii)
Guinea Bissau	WHO	1998	50.0								2
Kenya	DHS	2003	32.2	20.3	24.8	33.0	38.1	39.7	47.5	47.7	2
Liberia	Marshall R5	1984	60.0								2
Mali	DHS	2001	91.6	91.2	91.3	91.9	92.1	92.3	91.2	91.0	1(ii)
Mauritania	DHS	2000–01	71.3	65.9	71.1	73.4	74.2	71.7	76.5	68.5	2
Niger	DHS	1998	4.5	5.0	4.8	4.3	5.3	3.8	3.3	3.3	3
Nigeria	DHS	2003	19.0	12.9	17.0	20.8	19.4	22.2	22.2	28.4	3
Senegal	DHS2	2005	28.2	24.8	28.0	28.4	30.1	30.5	30.3	30.6	2
Sierra Leone	Koso Thomas O6	1987	90.0								1(ii)
Somalia			97.0								1(i)
Sudan (north)	MICS	2000	90.0	85.5	88.6	89.3	89.8	91.5	91.6	92.9	1(I)
Togo	National Committee on Harmful Practices7	1993	50.0								2
Uganda	WHO8	1998	5.0								3
United Republic of Tanzania	DHS	1996	17.7	13.2	15.7	19.3	20.6	18.3	21.3	21.9	3
Yemen	DHS	1997	22.6	19.3	22.2	21.3	22.9	23.6	25.1	25.0	3

Footnotes

1. See Table 2 for definitions of groups
2. Data for Senegal (2005) are from preliminary report.
3. Anecdotal report from Union National des Femmes de Djibouti. Unpublished report.
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e. Indonesia: Pratiknya AW. Female circumcision in Indonesia:a synthesis profile for cultural,religious and health values. In: Female circumcision:strategies to bring about change
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The largest population groups from practising countries were from Ghana, Kenya, Nigeria, Somalia and Uganda. Table 4 also shows estimated numbers with FGM. The estimated number of women resident in England and Wales in 2001 who had been subjected to FGM was 65,790. The highest estimated numbers of women with FGM were from Kenya and Somalia.

Table 4 Number of women born in FGM practising countries and estimated number of women with FGM, residents in England and Wales enumerated in 2001 census

Country of birth	Enumerated number of women aged 15-49	Estimated number aged 15-49 with FGM
Benin	99	18
Burkina Faso	33	26
Cameroon	1,353	21
Central African Republic	163	64
Chad	44	20
Côte d'Ivoire	1,082	489
Democratic Republic of the Congo	1,199	60
Djibouti	93	91
Egypt	3,698	3,592
Eritrea	2,804	2,545
Ethiopia	3,421	2,807
Gambia	1,387	1,096
Ghana	22,116	1,340
Guinea	101	100
Guinea Bissau	155	78
Kenya	45,396	18,516
Liberia	555	333
Mali	41	38
Mauritania	13	9
Niger	39	2
Nigeria	33,485	6,925
Senegal	264	77
Sierra Leone	6,625	5,963
Somalia	15,744	15,272
Sudan	3,200	2,879
Togo	174	87
Uganda	19,640	982
United Republic of Tanzania	10,512	2,102
Yemen	1,092	262
Africa - East (not otherwise stated)	3,626	
Africa - North (not otherwise stated)	276	
Africa - West (not otherwise stated)	896	
Africa (not otherwise stated)	4,232	
Total ignoring not stated	**174,528**	**65,790**

ONS' Migration Statistics Unit provided data about inward and outward migration to update these estimates over the years 2001 to 2005. It was unable to subdivide estimated numbers of migrants by age as these estimates are based first on the International Passenger Survey, which has a relatively small sample and does not record informants' ages. In addition, asylum seeking statistics are not disaggregated by sex. The data provided do imply a net inflow of women migrants from countries practising FGM, however. Although the largest numbers came from the countries with low prevalence, it was estimated that there was a net inflow of about 3,000 women from the high prevalence countries.

6.3. Estimated number of maternities in England and Wales in women with FGM

Table 5 shows the number of maternities in England and Wales to women born in FGM practising countries, the estimated number of maternities to women with FGM and the total number of maternities for each of the four years 2001 to 2004. Over the four years, the estimated number of maternities to women with FGM increased by 44 per cent from 6,256 in 2001 to 9,032 in 2004. Figure 2 and Table 6 show the geographical spread of the maternities to women likely to have undergone FGM in 2001 and 2004. As expected, the geographical distribution was extremely uneven with the highest estimated percentages in London, but with prevalences of over two per cent in the cities of Cardiff in Wales and Manchester, Sheffield, Northampton, Birmingham, Oxford, Crawley, Reading, Slough, Milton Keynes and many London boroughs. In 2004, the prevalence was 6.3 per cent in Inner London and 4.6 per cent in Outer London.

Table 5 Maternities to women from FGM practising countries and estimated number and percentage of maternities to women with FGM, England and Wales, 2001 to 2004

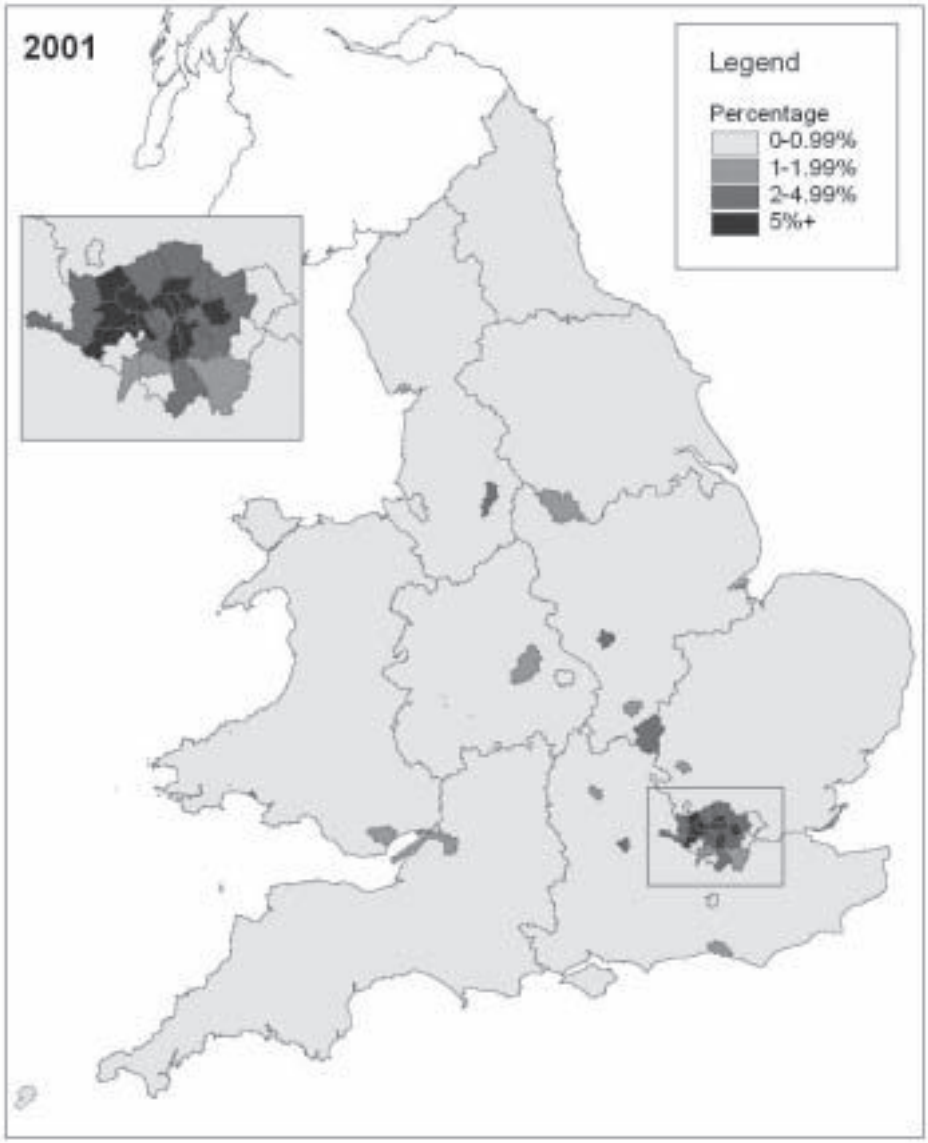
Year of birth	Number of maternities to			Percentage of maternities to women with FGM
	Women born in FGM practising countries	Women with FGM	All women	
2001	13,328	6,256	588,868	1.06
2002	14,666	7,109	590,453	1.20
2003	16,890	8,090	615,787	1.31
2004	19,356	9,032	633,651	1.43

Table 6 Estimated number of maternities to women with FGM and percentage of all maternities to women with FGM by region for local authorities where percentage exceeds one per cent, England and Wales, 2001-2004

Local authority	2001		2002		2003		2004		Total
or region of residence	Number	%	Number	%	Number	%	Number	%	Number
Non-residents	5	1.84	6	2.93	5	2.25	6	2.73	22
Cardiff / Caerdydd	70	1.97	96	2.72	90	2.45	103	2.81	360
Rest of Wales	18	0.07	18	0.07	29	0.11	28	0.10	95
Wales	88	0.29	114	0.38	119	0.38	131	0.41	455
NORTH EAST	31	0.12	40	0.15	36	0.13	39	0.14	152
Manchester	150	2.74	176	3.13	216	3.66	252	3.84	794
Liverpool	44	0.90	65	1.33	61	1.20	67	1.34	237
Rest of North West	62	0.10	63	0.10	87	0.13	120	0.17	338
NORTH WEST	256	0.34	304	0.41	364	0.47	439	0.55	1,369
Sheffield	69	1.22	105	1.92	126	2.15	130	2.14	430
Rest of Yorkshire and the Humber	55	0.11	86	0.17	97	0.19	158	0.29	396
YORKSHIRE AND THE HUMBER	124	0.22	191	0.35	223	0.39	288	0.48	826
Northampton	44	1.79	57	2.37	62	2.37	81	3.18	243
Leicester UA	116	2.92	181	4.41	212	4.85	226	4.98	735
Rest of East Midlands	61	0.16	69	0.18	81	0.20	93	0.23	307
EAST MIDLANDS	221	0.50	307	0.69	355	0.76	400	0.84	1,285
Birmingham	185	1.29	236	1.63	365	2.39	500	3.20	1,286
Coventry	23	0.64	27	0.76	50	1.33	63	1.60	164
Rest of West Midlands	61	0.14	80	0.19	86	0.19	135	0.30	366
WEST MIDLANDS	269	0.45	343	0.57	501	0.79	698	1.07	1,816
Watford	11	0.99	11	1.05	16	1.46	22	1.92	60
Luton UA	32	1.13	36	1.16	43	1.40	34	1.07	143
Rest of East	138	0.25	124	0.22	156	0.27	170	0.29	591
EAST	181	0.30	171	0.29	215	0.35	226	0.36	794
City of London	3	5.77	2	3.57	1	1.64	2	3.45	8
Camden	175	6.34	234	8.35	240	8.20	235	7.81	883
Hackney	209	5.15	233	5.77	249	5.87	231	5.32	921
Hammersmith and Fulham	144	6.19	181	7.10	192	7.60	194	7.48	711
Haringey	253	6.66	216	5.82	238	6.18	241	6.06	948
Islington	130	5.23	175	7.01	188	7.12	183	6.90	676
Kensington and Chelsea	92	4.39	104	4.90	103	4.69	101	4.64	400
Lambeth	289	6.64	308	7.09	373	7.87	394	8.35	1,364
Lewisham	152	4.12	172	4.52	188	4.80	213	5.28	726
Newham	331	6.90	339	6.87	367	7.19	345	6.70	1,381
Southwark	347	8.74	374	9.15	439	10.18	431	9.76	1,590
Tower Hamlets	105	2.90	119	3.12	139	3.52	166	4.08	528

Local authority or region of residence	2001 Number	%	2002 Number	%	2003 Number	%	2004 Number	%	Total Number
Wandsworth	131	3.19	138	3.43	157	3.65	174	4.05	600
Westminster	109	4.30	124	4.93	141	5.17	125	4.63	499
Inner London	2,470	5.53	2,719	6.00	3,015	6.35	3,035	6.30	11,235
Barking and Dagenham	82	3.42	100	4.15	122	4.74	167	6.08	471
Barnet	151	3.76	174	4.22	200	4.70	208	4.70	733
Bexley	25	0.96	29	1.16	36	1.38	53	1.99	143
Brent	356	9.13	382	9.27	403	9.28	422	9.83	1,563
Bromley	41	1.22	31	0.92	46	1.28	43	1.22	162
Croydon	106	2.43	121	2.79	132	2.91	148	3.08	506
Ealing	348	7.99	342	7.77	333	7.50	371	7.85	1,393
Enfield	122	3.28	165	4.18	196	4.85	247	5.91	730
Greenwich	158	4.96	195	5.85	202	5.88	230	6.22	785
Harrow	138	5.38	150	5.90	169	5.99	183	6.45	639
Havering	6	0.26	8	0.36	15	0.64	17	0.67	47
Hillingdon	126	3.94	121	3.70	145	4.37	177	5.12	569
Hounslow	161	5.18	184	5.73	184	5.61	222	6.17	752
Kingston upon Thames	19	1.08	15	0.84	21	1.14	19	0.95	74
Merton	40	1.52	39	1.55	41	1.51	58	2.07	179
Redbridge	103	3.33	114	3.56	125	3.73	156	4.51	498
Richmond upon Thames	16	0.68	8	0.33	16	0.64	18	0.71	58
Sutton	13	0.63	16	0.76	17	0.77	17	0.77	63
Waltham Forest	128	3.68	143	4.03	174	4.66	189	4.82	635
Outer London	2,139	3.66	2,337	3.94	2,577	4.16	2,945	4.57	10,000
LONDON	4,609	4.47	5,056	4.83	5,592	5.11	5,980	5.31	21,235
Oxford	23	1.53	24	1.54	18	1.10	38	2.24	103
Crawley	10	0.81	13	1.03	13	0.99	28	2.06	64
Reading UA	40	2.04	34	1.75	42	2.11	42	2.00	158
Slough UA	51	2.76	54	2.92	58	2.92	71	3.51	234
Milton Keynes UA	59	2.11	81	2.83	101	3.25	96	3.03	336
Brighton and Hove UA	29	1.04	29	1.07	28	0.93	26	0.91	112
Rest of South East	132	0.18	169	0.23	163	0.21	215	0.27	688
SOUTH EAST	344	0.39	404	0.46	423	0.47	516	0.56	1,695
Bristol, City of UA	78	1.68	115	2.47	180	3.62	239	4.58	612
Rest of South West	38	0.09	44	0.10	67	0.15	72	0.15	227
SOUTH WEST	116	0.24	159	0.33	247	0.48	311	0.60	839
England and Wales	6,256	1.06	7,109	1.20	8,090	1.31	9,032	1.43	30,487

Figure 2 Map showing estimated percentage of maternities to women with FGM in England and Wales, 2001 and 2004




2004

6.4 Estimates of the number of girls/women under 15 years of age who are at risk or have undergone FGM

Table 7 shows that at least 24,012 girls and women are at high risk or may have already undergone FGM, Type III and that 8,913 are at high risk or may have undergone FGM, Type II. In the countries where the prevalence of FGM is high the most common age for the FGM procedure is between 6 and 8 years. Adding the numbers aged four or under in 2001 to those born from 2002 to 2004 suggests that an estimated 15,710 girls were at high risk of Type III FGM and 5,573 were at high risk of Type II in 2005.

Table 7 Estimated numbers of girls at risk of or subject to FGM in England and Wales

	FGM Group of Country				
	1(i) High risk of FGM Type III	1(ii) High risk FGM Type I or II	2 Med risk FGM Type I or II	3 Low risk FGM Type I or II	Total
Born in FGM practising country and enumerated in 2001 census					
Aged **under 1 year** in 2001	191	71	35	171	468
Aged **1-4 years** in 2001	1201	359	348	1,082	2,990
Aged **5-9 years** in 2001	2177	610	811	2,279	5,877
Aged **10-14 years** in 2001	3231	932	1152	4,090	9,405
Total	6,800	1,972	2,346	7,622	18,740
Born in England or Wales 1993-2004 to mother who was born in an FGM practising country, derived from birth registration data					
Aged **under1 year** in 2001	1,861	643	964	3229	6,697
Aged **1-4 years** in 2001	5,084	2,049	4,243	12,710	24,086
Aged **5-8 years** in 2001	2,894	1,798	5,255	13,571	23,518
Born **2002-2004**	7,373	2,451	3,026	12,485	25,335
Total	**17,212**	**6,941**	**13,488**	**41,995**	**79,636**
Grand total	**24,012**	**8,913**	**15,834**	**49,617**	**98,376**

7. Discussion

The estimates presented in this report are subject to several limitations. For some countries where FGM, is practised, data on the prevalence of FGM are very sparse and this uncertainty in the prevalence will affect our estimates. Using Census data for England and Wales to estimate numbers of women born in countries where FGM is practised overcomes the problems due to the lack of estimates for small groups from the previous study based on the Labour Force Survey. The Census also produces more reliable estimates than a sample survey. Even so, Census data are still likely to underestimate numbers in some groups who may be reluctant to participate in the census because of concerns about residence status or who may not be living in a conventional or legal dwelling.

In addition our method underestimates numbers as the Census does not identify second generation women who may be subject to this traditional practice. Basing the probability of having FGM purely on the country of birth does not take account of the ways in which the practice might change with migration. There is some evidence that it declines with migration to the West.11 For these estimates, this is likely to affect only women who left their country of birth before the usual age of undergoing FGM.

An additional problem of basing the probability of having FGM on country of origin is that in many countries it is particular regions or specific ethnic groups who practise FGM. These groups may be more or less likely than others to migrate to the West. Data on changes in practice with migration are very sparse. Two studies of Somalis, one in London11 and one in Sweden,[23] suggest changes in attitudes against FGM although newspaper reports on two recent prosecutions on FGM in the Somali community in Sweden[24] suggest that the practice is hidden.

Although imprecise, the migration data suggested that there were was a net inflow from countries practising FGM. In particular, there is a net inflow from Somalia where FGM is nearly universal. Increasing numbers of maternities to women born in Somalia made a substantial increase to the rise in estimated proportions of maternities to women with FGM.

The results presented here are the most rigorous estimates to date. To obtain a clearer picture of actual prevalence among both migrant and second generation women, a survey of women giving birth in the UK would be needed, however. As well as being useful in their own right, the data presented here also provide a useful framework for designing such a survey.

8. Conclusions

The estimates derived through these analyses suggest that nearly 66,000 women with FGM were living in England and Wales in 2001 and their numbers are likely to have increased since then.

This is reflected in the increase in the estimated percentages of all maternities which were to women with FGM from 1.06 per cent in 2001 to 1.43 per cent in 2004.

There were nearly 16,000 girls aged 8 or younger at high risk of WHO Type III FGM and over 5,000 at high risk of WHO Type I or Type II. In addition over 8,000 girls aged 9 or more had a high probability of already having type III FGM and over 3,000 a high probability of having types I or II.

The estimates of FGM provided in this study highlight the need not only to enhance health care for girls and adult women who have already undergone FGM but calls for systematic actions to prevent FGM being passed on to the younger generation. Despite the limitations of these estimates, they suggest that the numbers of women living in England and Wales with FGM are substantial and increasing. Action is therefore needed to provide appropriate care to girls and women concerned and to prevent FGM being passed on to the younger generation.

Women with FGM are largely but not exclusively concentrated in particular areas, but there are many other areas of the country where there are smaller numbers of affected women. It is therefore important to ensure that services in all areas respond to their needs and the potential risks to their daughters.

9. Recommendations

Given that the estimates of FGM provided in this study suggest that the numbers of women living in England and Wales with FGM are substantial and are increasing.

Given that there are girls living with FGM; and given that over 20,000 under 15 year old girls are potentially at risk of FGM, the following are recommended for intensified action on FGM elimination and care for women and girls with complications due to FGM:

1. A survey should be undertaken to provide more reliable estimates of the prevalence of FGM in England and Wales. The data presented in this study provide a useful framework for designing such a survey
2. Further research on FGM is needed to increase knowledge in the following areas:

(a) Attitudes, perceptions and motivations of women and families from FGM practising countries, including those who have stopped practising it and are opposed to it, reasons for continuing the practice and factors precipitating change.

(b) Barriers to FGM prevention and care by health and social workers who frequently have to deal with attempted FGM and other groups who work to prevent FGM.

(c) The health complications particularly the psychological and the sexual aspects of FGM.

(d) How women with FGM perceive health services.

(e) Evaluation of approaches and programmes against FGM.

3. Data on FGM should be collected routinely by health and social services in order to inform the provision of better care and service provision for women and girls who have undergone FGM and for girls at risk of undergoing FGM. The Department of Health and the Department for Children, Schools and Families should provide the policy framework and guidance for documentation and the collection of data on FGM within clinical practice and within child protection.
4. Women with FGM are largely but not exclusively concentrated in particular areas, but there are many other areas of the country where there are smaller numbers of affected women. It is important to ensure that services in all areas respond to their needs and the potential risks to their daughters. All strategic health authorities, primary care trusts, acute trusts and foundation hospitals should ensure that services including commissioning of services in all areas respond to the health needs of women and girls with FGM.

5. As well as girls at risk of FGM there are substantial numbers of girls under15 likely to have undergone FGM. Girls with FGM Type III may have restricted mobility, in case the scar splits, difficulties in participating in sports, difficulties with urination and menstruation and they may need psychological support. In order to improve access to health care and support for affected young people, it is important that professionals in the health and education professionals are alert and respond to their needs.
6. FGM care and prevention should be mainstreamed into existing strategies that respond to the needs of women and girls with FGM and the potential risks to their daughters, for example through Child Health, Sexual Health and Maternity Improvement strategies working through Local Area Agreements and Local Strategic Partnerships.
7. There is a need for an understanding of FGM not just as a health issue but primarily as an issue of violence against women and an abuse of girl children. Thus FGM should be given equal status with other forms of child abuse and all Social Services, Health, Education and the Police Child Protection Units should update their child protection policy and procedures to include FGM.
8. All education and training programmes on child abuse, reproductive and sexual health care should incorporate FGM, but most importantly, because of the large turnover of staff in social services and health, FGM education should be incorporated into the core curricula of professionals in social, health, education and the police.
9. FGM prevention and care should be fully mainstreamed into the government child care provisions through the implementation of 'Every Child Matters' and into the National Service Framework for Children, Young People and Maternity Services.
10. FGM prevention should be integrated into the work of the joint Home Office and Foreign and Commonwealth Office Unit on Forced Marriages as FGM occurs in similar context. Messages to schools regarding forced marriage could easily and usefully incorporate information about FGM. New refugees, particularly from countries with high prevalence of FGM should be targeted with information on the illegality of FGM.
11. The voluntary sector and community groups' involvement is crucial to address issues of prevention as well as delivery of services that take FGM issues into account. Thus community action on FGM should be strengthened and promoted for all the FGM practising communities.

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FORWARD

Safeguarding rights & dignity

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Funded by the Department of Health

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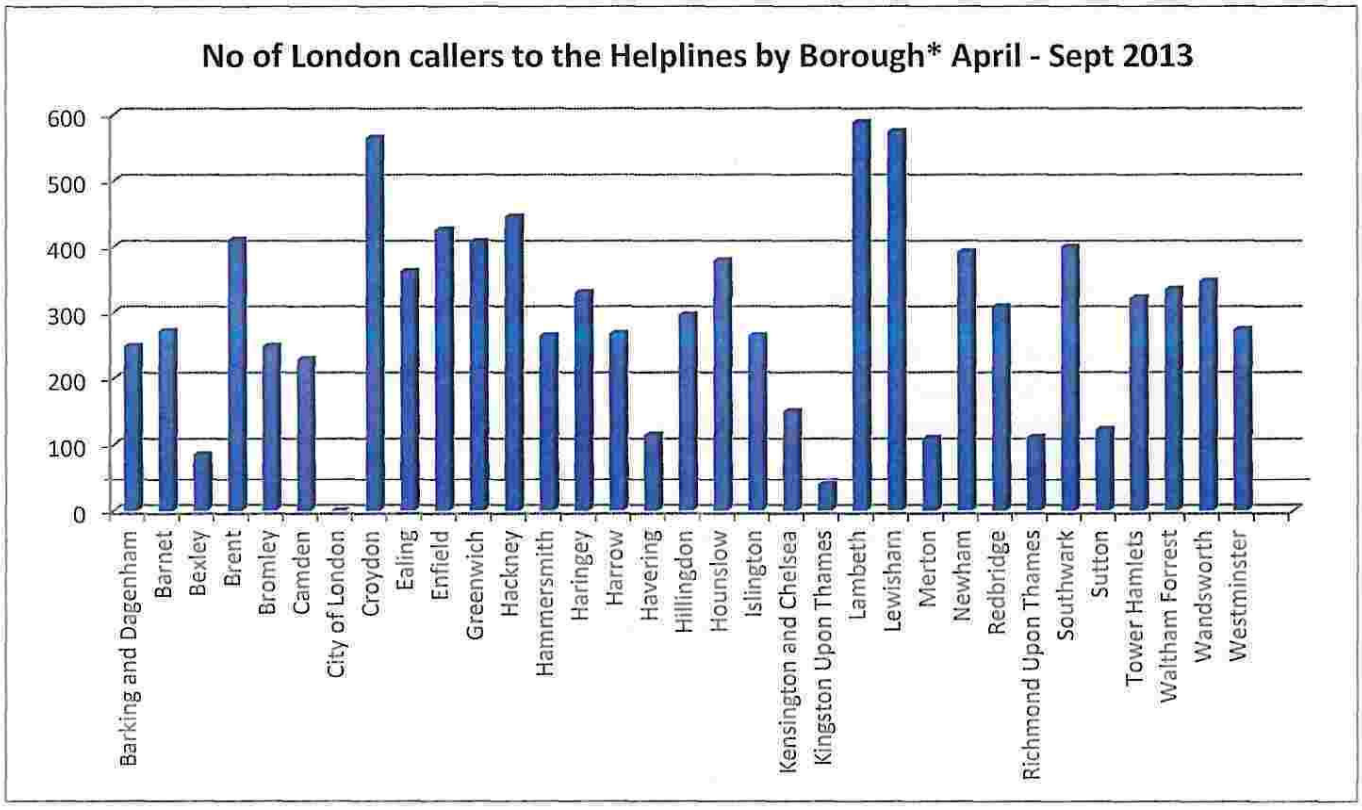
Update on impact: October 2013

In the 6 months from 1st April to 31st September 2013 the Domestic and Sexual Violence Helplines:

- Responded to **11,886** callers from London
- Referred 1,499 women in London to a refuge space
- Provided information on welfare benefits, immigration, medical, housing and/or legal rights to 4,291 callers in London
- Carried out online crisis and safety planning for 4,928 callers in London



*A further 2,187 calls were received from London where the Borough was unknown.

The ASCENT Project

The partners delivering London domestic and sexual violence helpline services are doing so as part of the ASCENT project. ASCENT is a project of the London Violence against Women and Girls (VAWG) Consortium, delivering a range of services for survivors of domestic and sexual violence, under six themes, funded by London Councils.

For more information about this project, please do not hesitate to contact Nicki Norman, Director of Operations, Women's Aid - n.norman@womensaid.org.uk

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Counting the Somali Community In Brent

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September 2013

Counting the Somali community

Previous estimates of the Somali community have been based on Immigration, asylum claims, National Insurance, Languages spoken, country of birth and apportionment of national survey proportions to the local area.

These are all likely to underestimate the size of the community. The estimates are often based on old data and/or have wide margins of error.

The method we have used is based on matching two sources: The GP register and the School Census.

The GP register was from February 2013. The way the register is being compiled is changing. It used to be all people living in Brent wherever they are registered with a GP. It is changing to be a register of people who have a Brent GP, wherever they live. The list we used is a hybrid of the two. The register includes children with a Date of Birth up to the 26th February 2013. There are, of course some people who are not registered with a GP. However our experience of analysing many administrative datasets and census returns is that people are more likely to be registered with a GP than to appear in any other dataset.

The School Census is updated three times a year. We used the January 2013 Census. Potentially it gives us three ways to identify children as Somali: their national origins (Often described as 'Ethnicity'), the languages they speak and their names. We did not match the language field at the individual level in this case but at the aggregate level we identified that that only 50 Somali speaking children did not identify themselves as Somali. We also looked at an earlier Brent school Census database and identified that of 60 children who simply identified themselves as Black African only six said they spoke Somali and 37 said they spoke English. It is possible that some of these English speaking 'Black African' children are Somali but it is a very small number. Finally because we have done this exercise before (see over) we have a large database of distinctively Somali names. We can therefore identify as Somali people who may have lived in countries other than the UK or Somalia and children of Somali origin who do not speak Somali. A possible source of underestimation is that the school census does not include children at private schools. From what is known about the socio economic profile of the Somali community it is likely that the vast majority of Somali children are at state schools. Data from Free schools are not included.

GP Register

Based on 322k probable population of Brent our estimate of the Somali population is 10,375.

Compared to other boroughs:

Borough	Somali population	Year of data
Brent	10,375	2013
Newham	6,512	2011
Haringey	5,012	2012
Tower Hamlets	4,645	2010
Waltham Forest	3,804	2011
Greenwich	2, 877	2011
Hackney	2,013	2011
Waltham Forest	3,804	2011
Barking and Dagenham	592	2011

Outside London

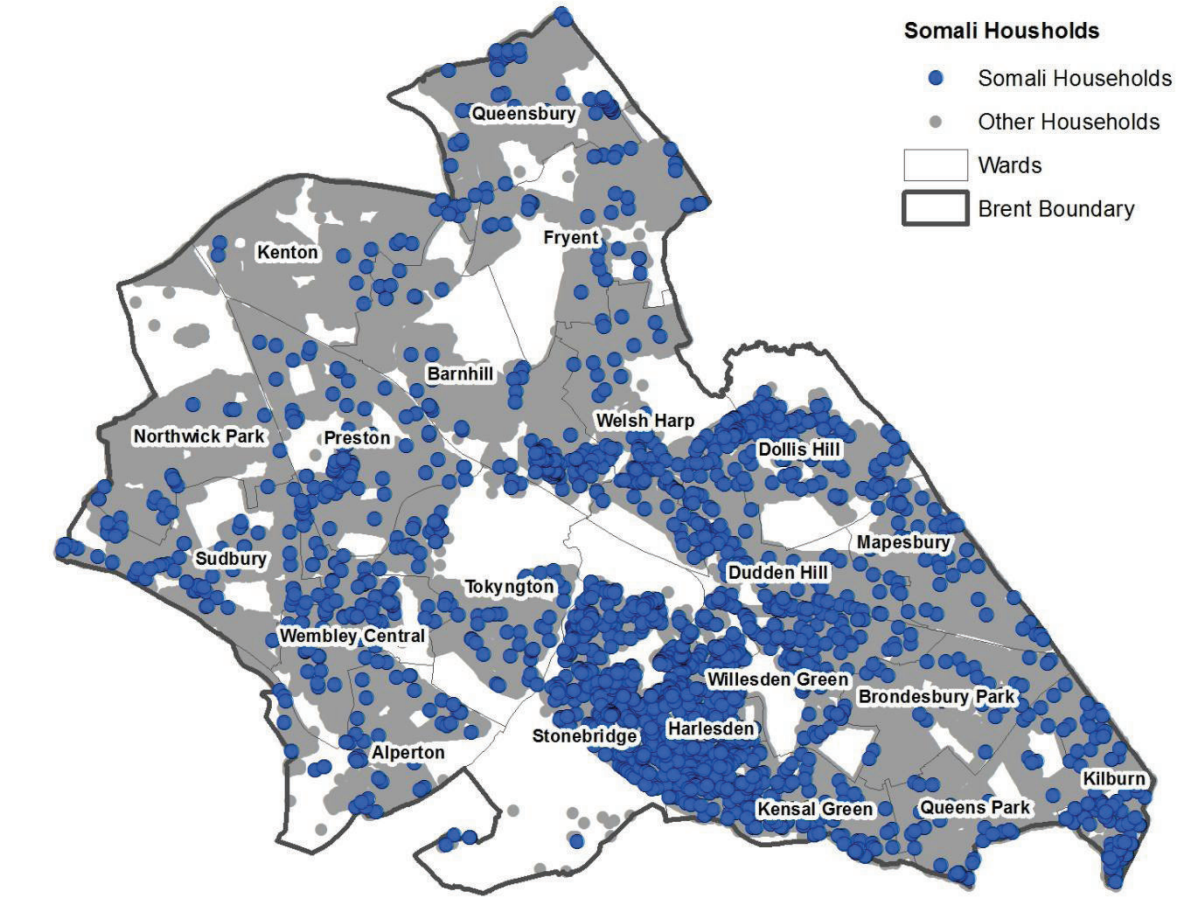
- Luton 1,360 (2010)

When we did the analysis of the 2008 school census Ealing had the largest Somali pupil population followed by Brent. We have no reason to think this has changed.

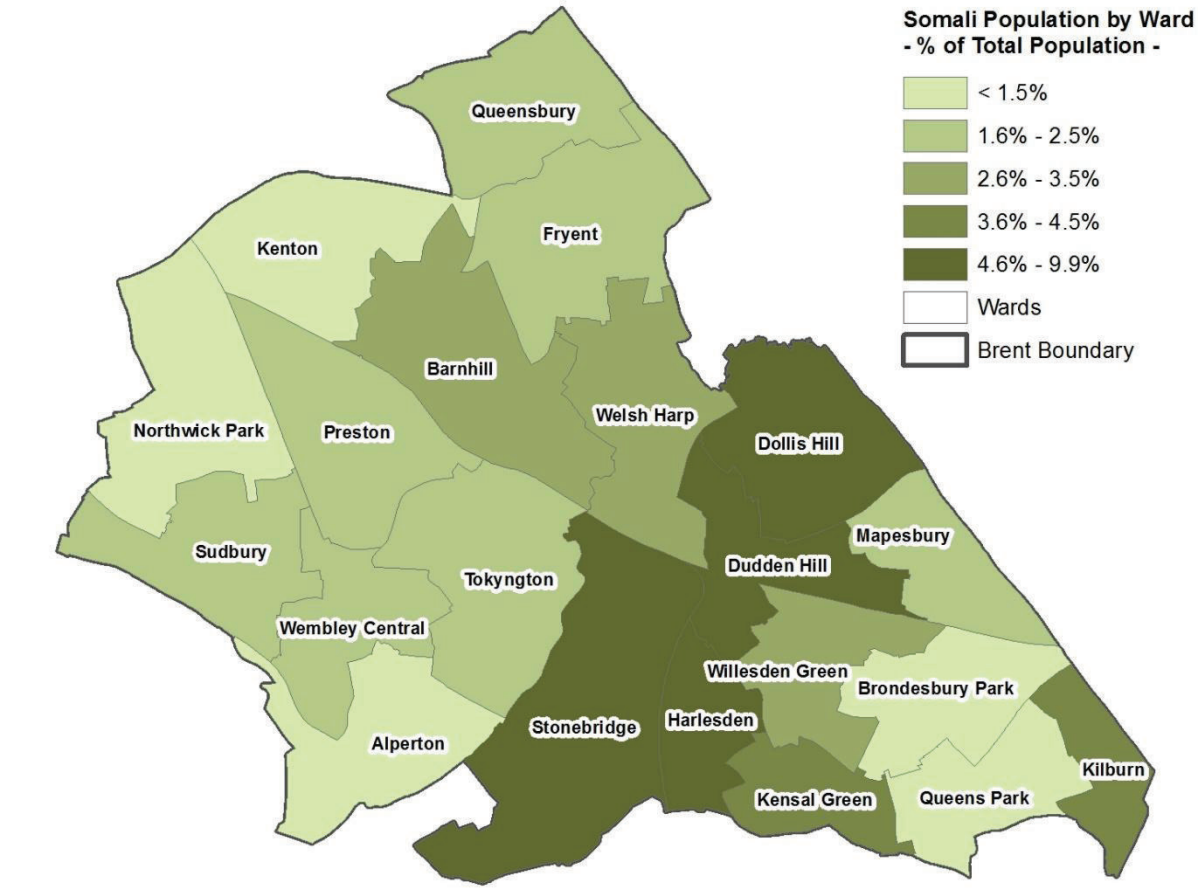
Age and Gender Population Distribution

Age	Somali Population				Total Brent Population	% Somali
	Female	Male	Unknown	Total		
<5	679	664	1	1344	22976	5.8
5-9	818	825	0	1644	19913	8.3
10-14	742	756	1	1500	17778	8.4
15-19	618	652	3	1273	17802	7.1
20-24	383	362	0	745	23050	3.2
25-29	350	306	1	657	34312	1.9
30-34	298	258	1	557	33631	1.7
35-39	284	274	0	558	26223	2.1
40-44	323	334	1	658	23478	2.8
45-49	222	272	0	494	21820	2.3
50-54	138	174	2	313	19617	1.6
55-59	71	114	2	186	15494	1.2
60-64	61	59	1	121	12313	1.0
65-69	60	39	1	99	9851	1.0
70-74	53	40	0	93	8283	1.1
75-79	46	24	0	70	6854	1.0
80-84	25	19	0	43	4683	0.9
85-89	10	3	0	13	2343	0.6
90+	5	2	0	7	1180	0.6
Total	*5185*	*5178*	*13*	***10375***	*321601*	*3.2*

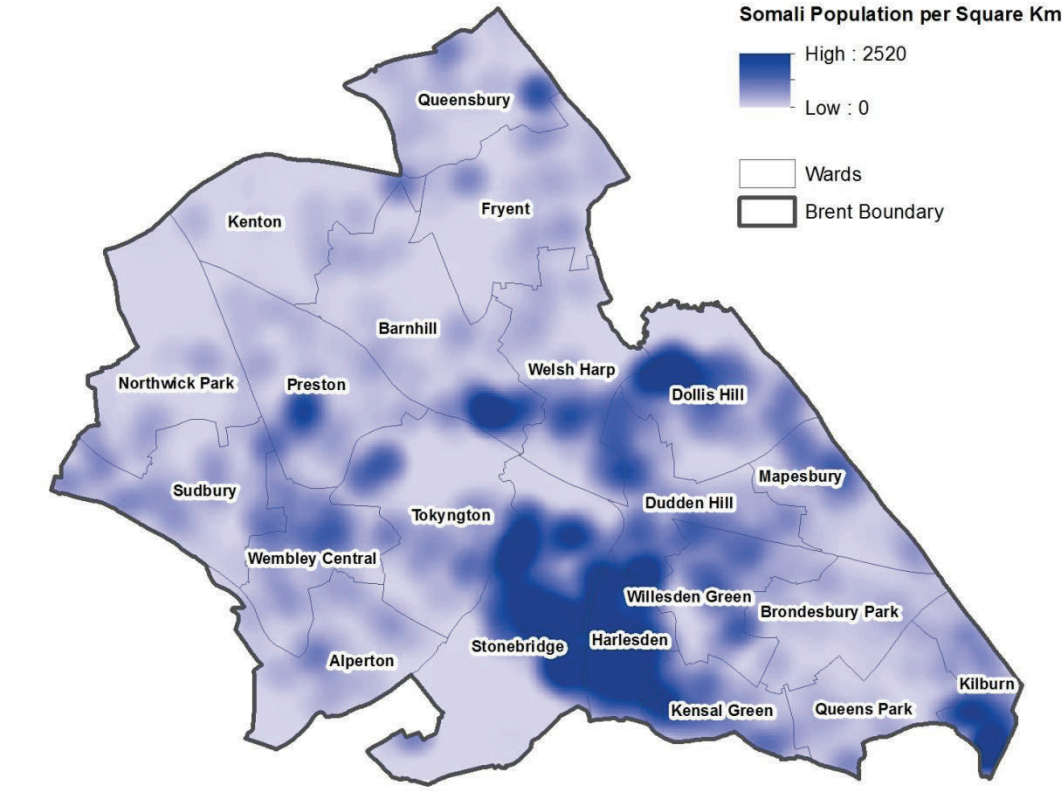
Location of Somali Households (A Somali Household in this instance is defined as a Household where at least half of the residents are Somali)

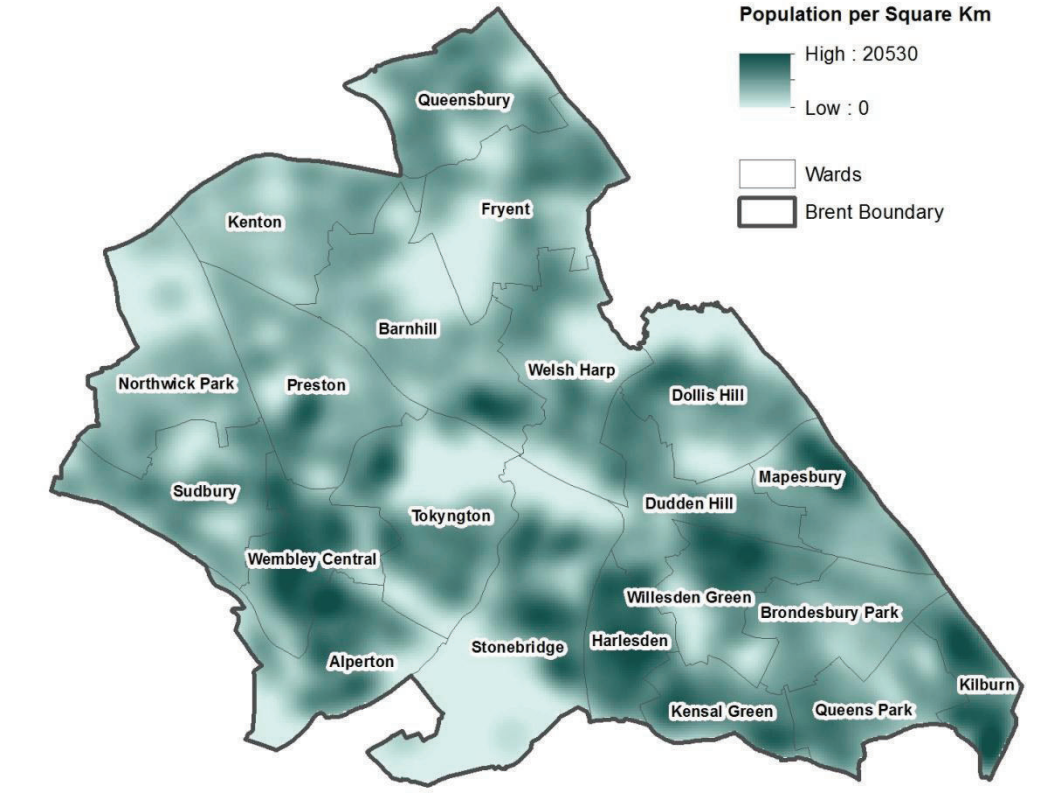


Somali Population by Ward



Somali Population Density (compared to general population density distribution below)





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STRICTLY EMBARGOED UNTIL: THURSDAY 00:01 6 FEBRUARY 2014

Postcode lottery: police recording of reported 'honour' based violence

Report on research undertaken by the Iranian and Kurdish Women's Rights Organisation (IKWRO) on police records of 'honour' based violence

January 2014

IKWRO
IRANIAN AND KURDISH
WOMEN'S RIGHTS ORGANISATION

FOREWORD

In undertaking the research for this report we, the Iranian and Kurdish women's rights Organisation (IKWRO), set out to ascertain the scale of reported 'honour' based violence (HBV) in the UK and to check that police forces are properly recording HBV cases.

Flagging (labelling) of HBV cases is essential to enable the safeguarding of victims and those at risk. It allows the scale of the reported problem to be understood, both locally and nationally, and helps prevent under-resourcing. Once an HBV case is properly flagged, it reduces the risk of other police officers failing to identify it as HBV, not acting appropriately and endangering the victim, for example by negotiating with their family or community. It is also crucial for risk profiling and risk management.

We submitted Freedom of Information Requests to every police force across England, Wales, Northern Ireland and Scotland. We were encouraged by the fact that we received a response from every police force. I would like to take this opportunity to thank each police force for their co-operation.

What became apparent from the responses, is that it is not possible to establish the full scale of reported HBV. This is because a significant proportion, 20% of police forces, failed to flag all HBV cases reported to them. This failure puts lives at risk.

In this report we have set out recommendations to help 'honour' based violence be tackled effectively. We hope that the government, the Association of Chief Police Officers, all police forces and Her Majesty's Inspectorate of Constabulary will commit to implementing these recommendations, to ensure the protection of those at risk of HBV.

I would like to thank Sara Browne, our Campaigns Officer for writing this report and to all staff at IKWRO who supported this project.

Diana Nammi
Executive Director, IKWRO

CONTENTS

1 BACKGROUND

1.1 THE IRANIAN & KURDISH WOMEN'S RIGHTS ORGANISATION

The Iranian and Kurdish Women's Rights Organisation (IKWRO) is a registered charity which was founded in 2002 in response to extremely poor understanding of and inadequate responses to 'honour' based violence by the police and other front-line agencies.

IKWRO provides advice, advocacy, support, referral and counselling services to Kurdish, Farsi, Arabic, Turkish, Pashtu, Dari and English speaking women and girls living in the UK who are facing 'honour' based violence, forced marriage, child marriage, female genital mutilation and domestic abuse. We provide support and advice to frontline professionals. We deliver training to professionals and women and give presentations in schools and colleges as well as campaigning for better laws, policies and implementation.

1.2 DEFINITION OF 'HONOUR' BASED VIOLENCE

The Association of Chief Police Officers' (ACPO) definition of 'honour' based violence (HBV) is as follows;

> ***'Honour based violence' is a crime or incident, which has or may have been committed to protect or defend the honour of the family and/or community'.***

In their national 'Honour Based Violence Strategy' (herein referred to as HBV Strategy) which was implemented on 30 September 2008 and remains current, ACPO stated that the term 'honour' based violence is used *'to include Forced Marriage (FM) (so often the driver for or context in which HBV is committed) and Female Genital Mutilation (FGM).'*

In this research, we requested figures for reported 'honour' based violence, however we were concerned to find that there is inconsistency in what the UK's police forces include under this category. For example, some police forces, such as the Metropolitan Police, flag forced marriage cases separately from, rather than under the term 'honour' based violence. We also understand that some police forces do not include female genital mutilation under the category 'honour' based violence.

IKWRO believes that some of this inconsistency may flow from the definition (above) which is too vague to underpin concerted action. We therefore propose this fuller and more explanatory definition which will help people understand and identify 'honour' based violence more easily.

> ***'Honour' based violence is normally a collective and planned crime or incident, mainly perpetrated against women and girls, by their family or their community, who act to defend their perceived honour, because they believe that the victim(s) have done something to bring shame to the family or the community.***
>
> ***It can take many forms including: 'honour' killing, forced marriage, rape, forced suicide, acid attacks, mutilation, imprisonment, beatings, death threats, blackmail, emotional abuse, surveillance, harassment, forced abortion and abduction.***

In addition to our concerns about inconsistency in how HBV cases are recorded, we are also concerned, that some police officers still do not have a proper understanding of HBV. This prevents them from properly investigating incidents and crimes, recording all pertinent information and acting appropriately

to protect victims. We believe that this fuller, more explanatory definition will help police understanding of HBV as will better, regular training and effective risk assessment and management tools.

1.3 THE ASSOCIATION OF CHIEF POLICE OFFICERS' POSITION ON THE FLAGGING (LABELLING) OF HONOUR BASED VIOLENCE CASES & WHY FLAGGING IS CRUCIAL

1.3.1 Identifying the scale of HBV & ensuring resources meet needs

The first of the ***'stated priorities for the police service'*** in the HBV Strategy (2008) is;

> ***'to identify the scale of HBV in all police services across the UK.'***

ACPO therefore made it clear in the HBV Strategy 2008 that there is a need for every police force to flag (label) HBV cases and to understand the prevalence of HBV reporting.

Provided every police force accurately flags every reported HBV case, each police force can easily identify the scale of reported HBV. This would also mean that ACPO would be in a position to obtain national figures for reported HBV and analyse the issue.

So what happens when a police force fails to flag HBV cases? To ascertain how many HBV cases have been reported to them, they have to manually check each file. Unfortunately, it appears that this is unlikely to happen, since it is prohibitively resource and time intensive. This prevents not only the local police force, but also ACPO from having the data that they need to be able to assess the prevalence of reported HBV.

ACPO states in their HBV Strategy 2008 that;

> ***'identifying the scale of the problem is essential if services are to be underpinned by an evidence base; are to be tailored to the needs of the communities being served; are to be sensitive and appropriate and are to be developed in line with identified and/or emerging trends and patterns. By identifying the scale of honour based violence, police services will be able to allocate resources appropriately, target interventions, deploy more effectively'.***

ACPO also state in their HBV Strategy 2008 that;

> ***'regular reports (every six months) will be required by the ACPO and Home Office Working Groups so that a more complete view of the scale of HBV is available.'***

It follows that without this data, these objectives cannot be achieved.

With the introduction of local commissioning, through Police Crime Commissioners (PCC's), it is now even more essential for every UK police force to accurately flag all reported HBV cases as this will help avoid under-resourcing where there is need. When assessing these figures PCC's must factor in underreporting;

a problem in all domestic abuse cases and in particular with HBV. Furthermore PCC's should appreciate that the figures may not reflect the true scale of reported HBV, as some police officers could fail to identify HBV, particularly if not all police officers are fully trained on the issue. All police officers, at every level, need effective, regular training to ensure that they understand, can identify and appropriately handle HBV cases.

1.3.2 Reducing risk of police officers failing to identify HBV cases & responding inappropriately

It is essential that all police officers handling an HBV case, including 999 and 101 telephone responders, understand from the outset that it is an HBV case. To ensure that anyone at risk is protected, and not further endangered, knowledge about HBV needs to be applied. There are important 'dos and don'ts' which must be followed.

Some examples of what the police must do:

> Recognise that any family member or community member of the person/ people at risk may be a perpetrator.
>
> Recognise that there may be many perpetrators, including people not known to the victim (such as bounty hunters and contract killers). This means the victim may be at risk even if far away from their family.

*Some examples of what the police must **not** do:*

> They must never inform the family or community about their involvement, or interview a victim in front of any family or community member, or attempt to mediate as doing so would put the person/ people who are at risk in greater danger.

If a police officer flags an HBV case, this reduces the risk of all other police officers, who may be involved at that stage, or a later time, failing to identify it as HBV. Therefore the risk of the police acting inappropriately and failing to protect the victim or endangering them further is reduced.

Sadly, there have been a number of cases which the police have failed to identify as HBV, where they have not acted appropriately to protect the victim, and have put the victim in greater danger.

> One example is the case of Banaz Mahmod. She was murdered in an 'Honour' Killing in 2006. Before her murder she reported HBV to the police five times. On the last of these occasions, on New Years Eve 2005, her father made her drink alcohol and then attempted to murder her. She managed to escape and the policewoman handling her case that night failed to understand the context, disbelieved Banaz and took the view that she was just a girl who had drunk too much. The police informed Banaz's father that she had raised a complaint and the police went to Banaz's family home to interview her in front of them. A few weeks later, in London

on 24 January 2006, Banaz was raped and murdered in by her family and her body was later found buried in a suitcase in Birmingham.

Flagging is essential to prevent multiple police failure to identify HBV and trigger the appropriate approach.

With HBV cases, there is a real likelihood that the case could be encountered by a number of different police officers, at different times and in different places.

It is probable that police officers could encounter an HBV case over a long time span. This is because the risk to those in danger never disappears, until the perpetrators are satisfied that they have regained their 'honour', by erasing the person/ people that they believe have brought shame to the family and community.

It is likely that police officers in different areas may encounter an HBV case because people at risk often move to try find safety, however there are likely to be a high number of potential perpetrators, who could be spread across the UK and abroad.

In a case that IKWRO was involved with, our client and her children had to be moved to 8 different refuges because she and her children were being pursued by her family and members of the community. Perpetrators went to refuges and shops in different areas with pictures of her to try to find her.

The greater the numbers of officers that are involved in a case, the more likely it is that one or more of them will fail to identify it as HBV, and as a result will not act appropriately to protect the victim, which could put them in greater danger.

Therefore every single police force must identify and flag all HBV cases and information about cases must be able to easily be safely shared between all police forces.

1.3.3 Risk profiling

Flagging HBV cases is important for effective risk profiling. In HBV cases there is a significant likelihood that other family members could already have experienced HBV. This is key intelligence which can help the police to safeguard all family members at risk. If all cases of HBV are flagged, this assists the police with their risk assessment and risk management.

In the case of Banaz Mahmod, her sister Bekhal was already under police protection, because their brother had tried to kill her in what a clear 'honour' based violence case. If the police had flagged Bekhal's case as being HBV, they would have

had a record of the Mahmod's being a family that took 'honour' very seriously, and when Banaz reported, it would have been noted that the Mahmod's were perpetrators of 'honour' based violence and her reporting is likely to have been taken more seriously.

1.3.4 Importance of flagging all HBV cases; incidents as well as crimes

Significantly, ACPO's definition of 'Honour' based violence, which is set out at 1.2 of this report above, includes not only crimes but also incidents. Importantly ACPO recommends;

'that each force puts in place the mechanism to record the number of HBV incidents reported.'

It is vital that as well as recording and flagging every HBV crime, that every reported HBV incident is also recorded and flagged.

HBV cases can escalate very quickly, from what someone without a proper understanding of HBV might interpret as a trivial incident, to extreme violence and 'honour' killing. To protect people at risk of HBV, all reported incidents must be taken seriously, investigated thoroughly and acted upon appropriately and sensitively. Furthermore the case must be fully recorded and flagged as HBV, so that all police officers involved from the start, and at any later stage, know to apply the appropriate approach.

We know from our work with women and girls at risk that eight years on from the murder of Banaz Mahmod, there are still cases where the police are failing to identify risk and are not taking steps to protect the person/ people reporting to them.

Recently a woman came to IKWRO who had just been turned away from a police station. The police had asked her if she had any bruises and she told them that she did not. They asked her if there was a history of violence against her and she told them there was not. They asked her if she was being forced into a marriage and she told them that no she was not. She explained to them that her family believed that she had brought them dishonor because she had fallen in love with a man who they had not chosen and she was scared that they would harm her. The police did not take a statement from her. They told her that no crime was committed and told her to go home. IKWRO undertook a risk assessment the same day and we found her to be at high risk of HBV. We accompanied her to the same police station and they then accepted that she was at high risk.

To ensure this does not happen, every police officer needs to be properly trained to understand and identify HBV and every HBV case must be flagged, to reduce the risk of their colleagues failing to identify the case and acting inappropriately.

Recording incidents, as well as crimes, gives a more accurate picture of reported HBV prevalence. Reported incidents must be flagged by every police force, so that they can easily understand the true scale of reported HBV locally. This is imperative if they are to respond to the issue effectively. It is also essential so that Police Crime Commissioners have accurate data to help ensure that the issue is not under-resourced.

Furthermore, unless each police force flags all reported HBV incidents, as well reported crimes, which would enable ACPO to easily identify the national scale of reported HBV, ACPO cannot effectively address the issue.

1.3.5 Need to flag HBV cases throughout the criminal justice process

But flagging HBV cases when they are reported and investigated is not enough. It is vital that every HBV case is flagged and remains flagged at every stage, including when a charge is pressed, and if it results in a conviction. This is essential, so that the case can be properly understood and dealt with appropriately by all who handle it.

Flagging at every stage is also crucial so that all police forces and ACPO can gather data on the scale of HBV at the different stages of the criminal justice system. This information is vital to enable effective planning to address HBV.

1.3.6 Importance of consistency

In their HBV Strategy, ACPO state that;

> ***'the ambition is to achieve consistency in terms of identifying an honour based violence incident, recording such incidents and the collation and analysis of this data.'***

This is vital so that HBV cases are not missed and so that accurate information can be obtained both locally by individual police forces and nationally by ACPO about the scale of HBV.

2. METHODOLOGY

In August 2013, IKWRO submitted requests under the Freedom of Information Act 2000 to every police force in; England, Wales and Northern Ireland (in total 44 forces). Each police force was asked the following:

For the full year of 2012, please can you confirm;

1. How many incidents of 'honour' based violence your police force recorded?

2. How many of these incidents led to criminal charges being pressed?

3. How many of the charges referred to in question 2 resulted in convictions?

For the full year of 2012 there were eight regional police forces in Scotland, which on 1 April 2013 were amalgamated into one force; Police Scotland.

In August 2013, under the Freedom of Information (Scotland) Act 2002, the following request was submitted to Police Scotland;

Separately, for each of the former regional police forces in Scotland, please can you confirm;

1. How many incidents of 'honour' based violence your police force recorded?

2. How many of these incidents led to criminal charges being pressed?

3. How many of the charges referred to in question 2 resulted in convictions?

3 FINDINGS

3.1 SUMMARY OF FINDINGS

More than one in five police forces in England, Wales, Northern Ireland and Scotland failed to flag and provide data for both HBV incidents and crimes reported in 2012. It was therefore not possible to establish the scale of HBV reported in 2012.

Please refer to the infographic at Appendix 1.

It should be noted that police figures must always be treated with caution; the police may fail to identify and/ or record a case as 'honour' based violence. It must also be remembered that reported HBV does not represent the prevelence of HBV within the UK as many HBV cases are never reported to the police.

3.2 SOME POLICE FORCES FAILED ENTIRELY TO FLAG HBV CASES

These forces (see 3.2.1 below) failed to flag all HBV cases including; incidents, crimes, cases where a charge had been pressed and convictions.

They were unable to provide any of the information that was requested. They stated that in order to gather the requested data they would need to manually search through each case. They claimed exemption under the relevant Act; the Freedom of Information Act 2000 and the Freedom of Information (Scotland) Act 2002.

3.2.1 England, Wales & Northern Ireland

Derbyshire Constabulary stated;

> ***'the Constabulary utilises a computerised crime recording system to log all reported crimes. Whilst the system has some search facilities it cannot search for 'honour' based violence crimes per se. Given that there is no central register for these crimes the only way to extract the data would be to open each crime and read notes to see whether or not it is relevant to this application.'***

Gloucestershire Constabulary stated;

> ***'unfortunately, there is no central register for the information you have requested. Due to there being no Home Office Crime Category for 'honour' based crimes, the reports would only be recorded on the Constabulary's system as an incident. Our incident recording system does not have a flag or marker for 'honour' based crime and therefore we would have to manually review all incidents for the year requested to see if they would fall under your request remit.'***

Staffordshire Police stated;

> ***'there is no specific system to easily retrieve the required data. There are thousands of incidents which would require a manual search of each crime to investigate whether it is 'honour' based violence'.***

3.2.2 Scotland

The response from Police Scotland regarding four of the former eight police forces, which existed prior to it's formation on 1 April 2013; Dumphries and Galloway, Northern, Fife and Strathclyde, was that;

> ***'there was no way of extracting this information from the incident and crime recording systems without examining each individual record, which would be a considerably time consuming task given the number of crimes reported in each legacy force every year.'***

IKWRO is however encouraged by the following statement from Police Scotland;

> ***'the Lead officer for the ACPOS HBV working group identified that there was both under-reporting and a lack of identifying and recording of HBV incidents throughout the eight different forces. She identified this gap and as a result a national recording mechanism was agreed and put in place from 6 December 2012.'***

IKWRO intends to carry out further research to investigate whether, since the formation of Police Scotland on 1 April 2013, lessons learned from the earlier failures are being addressed in practice.

3.3 SOME POLICE FORCES FLAGGED ONLY CRIMES & NOT INCIDENTS

These forces stated that the data they provided was specifically for crimes, not incidents;

Avon and Somerset Constabulary, Hampshire Constabulary, Police Service Northern Ireland, West Mercia Police and **Surrey Police.** The later stated;

> ***'Results are extracted from a live Crime Information System (CIS) which is subject to change over time…only notifiable crimes are included (those which police are required to notify formally to the Home Office)'.***

3.4 SOME POLICE FORCES FAILED TO FLAG HBV CASES IN WHICH A CHARGE WAS PRESSED

These forces are **Bedfordshire Police**, **Cleveland Police** and **Lancashire Constabulary.**

3.5 OTHER FINDINGS

3.5.1 There is significant variation in how 'honour' based violence is interpreted; some forces include Forced Marriage and others do not. For example, the Metropolitan Police record Forced Marriage under a separate category.

3.5.2 Some forces claimed exemption to providing data on the basis that disclosure could impede investigations.

4. SUMMARY

It is IKWRO's view that following some significant progress culminating in the publishing of ACPO's HBV strategy in 2008, that subsequently ACPO has neglected the issue of HBV. This is demonstrated by the fact that no HBV review or action plan has been published since the 2008 HBV Strategy, despite it clearly being stated in the strategy that it was due to be reviewed on 30 September 2010.

This neglect is further illustrated by the finding from this research that more than one in five UK police forces failed to flag all HBV incidents and crimes, despite it being clear in the ACPO HBV Strategy 2008 that this is essential.

5. RECOMMENDATIONS

The following recommendations are made on the basis of IKWRO's findings from this research, as well as IKWRO's expertise on HBV. Our expertise comes from over 11 years of campaigning on this issue and providing front-line services to women and girls at risk of HBV.

1. **Adopt fuller more explanatory definition:** The government, police and all statutory and voluntary organisations should adopt this fuller more explanatory definition;

   'Honour' based violence is normally a collective and planned crime or incident, mainly perpetrated against women and girls by their family or their community, who act to defend their perceived honour, because they believe that the victim(s) have done something to bring shame to the family or the community.

   It can take many forms including: 'honour' killing, forced marriage, rape, forced suicide, acid attacks, mutilation, imprisonment, beatings, death threats, blackmail, emotional

abuse, surveillance, harassment, forced abortion and abduction.

2. **An inspection of current police handling of HBV:** Her Majesty's Inspectorate of Constabulary (HMIC) should carry out an inspection into the handling of HBV by UK police forces and ACPO. This should include an examination of training provided on HBV for all levels of police officer, including telephone responders (101 and 999) and the response to, recording, analysis and monitoring of HBV.

3. **Greater Transparency:** ACPO and Police Scotland should operate with much greater transparency with regards to HBV strategy.

4. **Greater partnership working to keep women and girls safe:** ACPO should work much more closely with, and meet regularly with HBV stakeholders, including charity organisations with expertise in HBV, such as IKWRO, to ensure shared learning and progress in tackling HBV.

5. Police recording and flagging of HBV should be made a statutory requirement.

6. **Every police force should flag HBV at every stage:** ACPO must ensure that every police force in England, Wales and Northern Ireland has a system in place to flag all cases of reported 'honour' based violence, including both incidents and crimes, as well as cases in which a charge is pressed. ACPO should set and publicise a date by which all police forces must demonstrate that this system is operational. If any police force fails to comply, ACPO should publicise their failure and take all steps in their power to ensure timely compliance.

7. **Scotland:** Police Scotland must ensure that it learns from the mistakes of the former Scottish police forces, highlighted by the former Association of Chief Police Officer's Scotland and that it flags all cases of reported 'honour' based violence, including both incidents and crimes, as well as cases in which a charge is pressed.

8. **Regular reporting essential:** In line with ACPO's HBV Strategy 2008; ACPO should collect ***'regular reports (every six months)'*** on HBV from each police force. ACPO should carefully analyse this data and produce reports on their findings, which they should publish. ACPO should learn from their findings and demonstrate this in subsequent reports. Police Scotland should so the same.

9. **Training for police officers:** ACPO and Police Scotland must ensure that every police officer, including telephone responders (101 and 999), is sufficiently and regularly trained to ensure that they properly understand and can identify HBV cases. ACPO and Police Scotland should publicise details about training on HBV for all levels of police officers.

10. **Home Office Crime Category for HBV** should be set up and implemented by all police forces.

11. **National recording system of all non-crimed incidents:** should be put in place and implemented by all police forces.

12. **ACPO HBV network needed:** ACPO should set up a network of named HBV leads for each police force. For the larger police forces such, as the Metropolitan Police, each borough/ area should also have a named HBV lead. Police Scotland should do the same. The contact details of these named leads should be made publically available so that they are easily accessible to all police, agencies, charities and individuals who may need to contact them. Should the individual leave their post, they should immediately be replaced and the contact list should be updated.

13. **Clearer responsibilities:** Each named HBV lead, referred to at Recommendation 12, should keep an updated list of, and be familiar with, every HBV case reported within their area. They should be in a position to easily be able to safely share information about each HBV case, as appropriate.

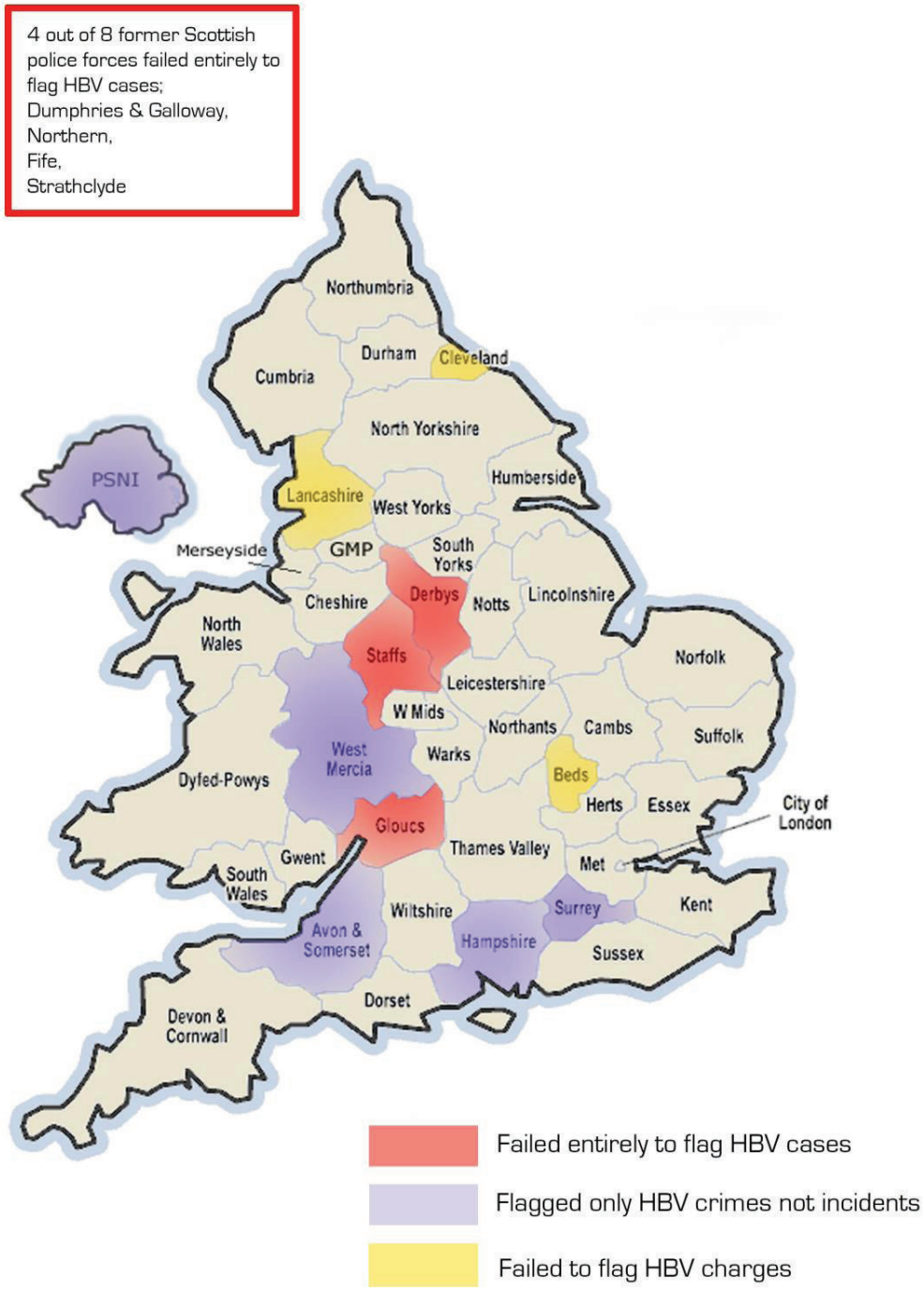
14. **Ensure effective implementation in each police force:** The HBV leads network, referred to at Recommendation 12, should have responsibility for ensuring that regular, effective HBV training is implemented at all levels within their area and that all reported HBV incidents, crimes and cases in which charges are pressed, are flagged and reported to ACPO in accordance with Recommendations 6 and 8.

15. **Access to help on the ground:** We understand from discussions with police that currently when a police officer is called out to a domestic abuse incident, they should take a booklet with them which includes a D.A.S.H. risk assessment which they must apply. We recommend that the standard risk assessment must include questions to ascertain whether the person or people at the scene are at risk of HBV. The risk assessment must always be carried out in full and there should be penalties for police officers who fail to do this. The booklet should include the referral details of support organisations with specialist knowledge of HBV, such as IKWRO, as well as the definition at recommendation 1 and the key do's and don'ts for HBV cases.

16. Child protection policy for all front-line agencies must ensure that HBV is thoroughly addressed including requiring regular, effective training of all staff.

Appendix 1

Police recording of 'Honour' Based Violence (HBV) 2012



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Brent Harmful Practice Case Studies

Case Study 1 - Female Genital Mutilation

FORWARD was contacted by social services from the London Borough of Brent regarding a case involving several children believed to be at risk of FGM. FORWARD provided support, advice and guidance for the family and local social services. One-to-one support sessions and emotional support were delivered to the mother who was also provided with information about FGM in a culturally sensitive way, information about the law. As a woman who had undergone FGM, she was also signposted to FGM specialist services for medical care and counselling.

FORWARD delivered group sessions with for the young girls, providing them with FGM information in an age appropriate format. The girls were also provided with emotional support and advice to guide them through the challenging situation. The young girls were provided with information about services and options for where to go if they or their peers felt at risk.

- FORWARD also worked with other family members including the father to ensure that children were supported and safeguarded.
- FORWARD provided social services with a report as well advice on best practice and cultural sensitivity.
- FORWARD believes that the HP Strand will be able to ensure that more women and young women are supported and protected

Case Study 2 - Forced Marriage Case Study

A young Asian young woman was referred to the AWRC by her teacher at college. The young woman was being forced to marry one of her cousins in Pakistan, by her parents. They had found out that she had a boyfriend from a different cultural background, which they did not approve of. As a result they beat her and attempted to strangle her. The parents had further threatened to break her legs, arms and kill her if she did not do what they said. The parents had accused her for becoming too “westernised” by developing relationships before marriage, deviating from her culture and for bringing shame on the family. The young women feared for her safety and did not want to return home.

The AWRC provided the following support:

- Risk assessment /Safety planning advice.
- MARAC referral
- IDVA referral
- Reported the threat of honour based violence to the police (worker accompanied her).
- Reported violence to the GP – (worker accompanied her).
- Provided emotional support
- Made referral to a refuge, provided her with taxi fare to travel.
- Provided follow up support

Case Study 3 – Honour Based Violence Case Study

A young Asian Women started dating a young Asian man who seemed like a nice man at first. After a while it became clear that the relationship was not working and she decided she wanted to end it. The young man was aware all along that our relationship was a secret, and due to his controlling behaviour, began to use this against her. He threatened to tell her family about their relationship, which was absolutely, terrified her. The thought of what her parents would do if they found out petrified her. Honour was embedded in her family

"I've never known any different. Having a relationship with a man would bring dishonour to the family. It's not just my mother and father that I had to worry about."

The young women continued to see the young man for fear of her finding out – this was effectively against her will, again she tried to end the relationship and the threats continued.

"I thought about them all the time. The anxiety was always there, it's not a nice feeling to have. I kept on blaming myself for getting into the position I found myself in. Eventually I decided enough was enough, I could not go on living my life in this way."

The young women lived with the threats for a year before she contacted the AWRC,

The AWRC provided the following support:

- Risk assessment /Safety planning advice
- Reported the threat of honour based violence to the police (worker accompanied her).
- Provided emotional support
- Provided follow up support

ISLINGTON

Female Genital Mutilation (FGM) in Islington: A Statistical Study

Contents

Executive Summary

The purpose of this study is to establish a more detailed picture of Female Genital Mutilation (FGM) in Islington. The study adapted the method used by the Foundation for Women's Health, Research and Development (FORWARD; 2007) which used UK census data and national and regional FGM prevalence data to estimate the number of women and girls in the UK who were likely to have undergone FGM. This study combined FGM prevalence data with language and ethnicity data for Islington to produce a similar estimate. There are several key findings:

There are 1,812 girls aged 0 – 18 in Islington who are at risk of (or who may have already undergone) FGM, and this is undoubtedly an underestimate.

This number represents 10.2% of the 0-18 female population in Islington.

There are 1289 girls in the highest risk category for FGM; they are from backgrounds where FGM is effectively universal in their country of origin.

This number represents 7.3% of the 0-18 female population.

A significant proportion of girls in the two highest risk categories are aged 0-7 (47% in category 1 and 63% in category 2)

The data presented here is based on self reporting of language and ethnicity therefore this is very likely to be an underestimate. Whilst the conclusion of this study is not that every one of these girls will undergo, or will have already undergone FGM, cultural background is the most important risk factor and there are a number of countries in the world where FGM is practiced on a universal scale. Therefore, it is vital that we are fully aware of the level of risk to girls and young women in Islington from all backgrounds and that we do not assume that living in the UK where FGM is illegal, is enough to eradicate the practice.

This study is a starting point, designed to help us estimate the likely level of risk around this practice, and to help us ensure we are protecting all Islington residents. FGM is one of the serious violent crime types within the Violence Against Women and Girls (VAWG) agenda, and Islington Council's VAWG Strategy 2011-15 outlines the Council's aims and objectives around VAWG over the next four years. Conducting this study was part of the work plan that underpins Islington's *Violence Against Women and Girls Strategy 2011-15 and t*he recommendations at the end of this report will feed into the Council's work plan around FGM and VAWG.

1. Introduction

1.1. The purpose of this study is two-fold. Firstly, it will provide some background to the practice of female genital mutilation (FGM); the procedure itself, its causes and impacts, and the profile of those most at risk. Secondly, this report will draw together information we have locally to establish an estimation of the level of risk to girls and young women in Islington.

1.2. This study uses a methodology similar to that used in the 2007 report by the Foundation for Women's Health, Research and Development (FORWARD; 2007); combining country and regional statistics on FGM prevalence with local data to estimate the numbers of girls and young women likely to be at risk of FGM. Islington is the first local authority in the UK to use this method to assess the risk of FGM in the local area.

2. Background and context

Definition

2.1. The World Health Organisation (WHO) defines FGM as comprising all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons, and has categorised FGM into four major types:

i) **Clitoridectomy**: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

ii) **Excision**: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).

iii) **Infibulation**: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.

iv) **Other**: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

Reasons Given for the Practice

2.2. There are a number of different reasons given for FGM by different communities, most of which stem from traditional beliefs about the importance of controlling a woman's sexuality, preserving virginity and promoting fidelity. FGM is sometimes also practised for aesthetic reasons.

2.3. In many communities FGM is seen as an important rite of passage for girls entering adulthood, it is continued both to maintain a traditional custom but also because it is widely believed to be beneficial to women; many believe it is more hygienic, that it makes women cleaner, and some even mistakenly believe it may make childbirth safer.

Health Implications

2.4. FGM has no health benefits and is associated with a range of long and short term harmful health and welfare consequences. The following are just some of the potential physical consequences of FGM, but the list is by no means exhaustive:

- Severe pain
- Wound infections
- Chronic vaginal, pelvic and urine infections
- Difficulties with menstruation and passing urine
- Renal impairment and possible failure
- Complications in pregnancy
- pain during sex and lack of pleasurable sensation
- Damage to the reproductive system, including infertility
- Increased risk of HIV and other STIs
- Death in childbirth

2.5. It is widely acknowledged that there are also a number of psychological and psychosexual consequences associated with FGM, including:

- low libido
- depression
- anxiety and sexual dysfunction
- flashbacks during pregnancy and childbirth
- substance misuse and/or self-harm

2.6. There is also an increasing body of research demonstrating the link between FGM and a number of psychological syndromes and anxiety disorders. A study undertaken in Senegal in 2003 found that women who had suffered FGM in childhood showed a significantly higher prevalence of Post Traumatic Stress Disorder (PTSD).

Prevalence Worldwide

2.7. Internationally FGM is recognised as a human rights violation. Yet the World Health Organisation (WHO) estimates that between 100 and 140 million women and girls worldwide have undergone the procedure and that in Africa alone around 3 million girls undergo the procedure every year.

2.8. There are 28 African countries where FGM is known to be practiced, and although less statistical information is accessible the practice has also been

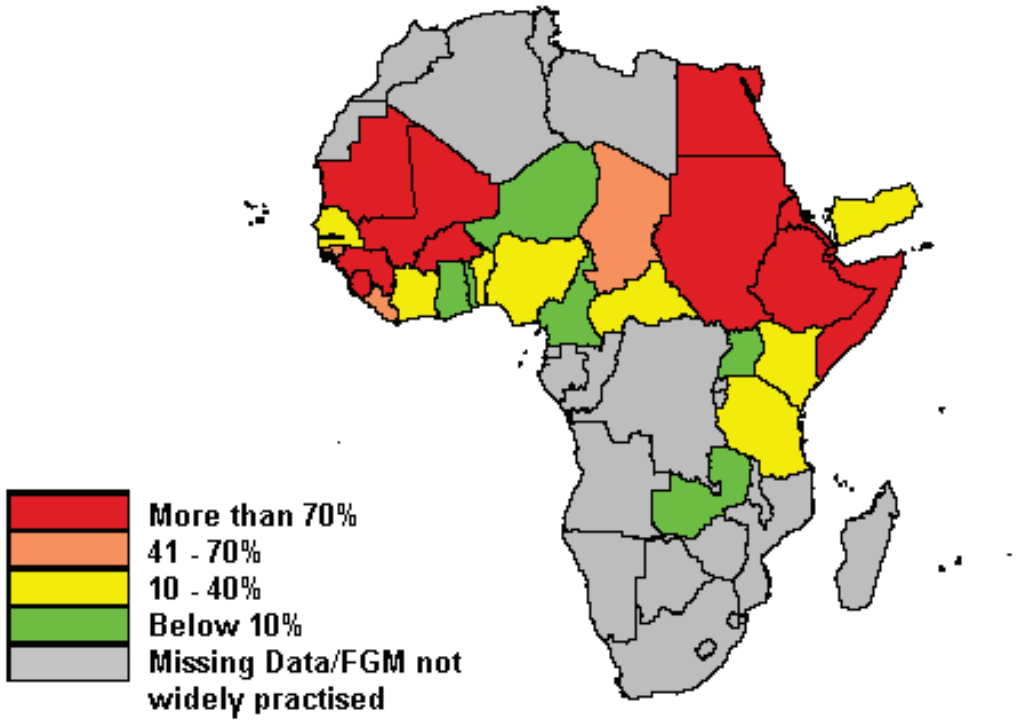
documented in Iraq, Israel, Oman, the United Arab Emirates, the Occupied Palestinian Territories, India, Indonesia, Malaysia and Pakistan.

2.9. A 2010 study by WADI, Association for Crisis Assistance and Development Co-operation used a mixture of questionnaires and interviews to establish an estimate of the prevalence of FGM in the Kurdish Autonomous Region of northern Iraq. The result of the study was that the overall FGM prevalence rate in this region was 72.7%.

2.10. In addition to this, a WADI press release from 9th April 2012 announced that a new study conducted by WADI and a local women's rights organisation investigated the prevalence of FGM in Kirkuk (outside of the Iraqi Kurdistan region) and found a prevalence rate of 65.4% among Kurdish women living in Kirkuk and 25.7% among Arab women in Kirkuk.

2.11. The map below shows estimated rates of FGM across Africa.

Source: HM Government (Feb 2011), *Multi-Agency Practice Guidelines: Female Genital Mutilation*, p. 5



Risk Factors

2.12. The highest risk of FGM is obviously among girls and young women from FGM practising communities and within this there are further characteristics that obviously increase the risk level:

- Level of integration of a family into society
- Girls born to mothers who have undergone FGM

- Girls whose sisters have already undergone FGM

2.13. The age at which girls are likely to undergo FGM varies across different communities. The highest risk period is believed to be between the ages of 5 and 9, although it is important to note that there have been reports of FGM being performed on newborns, in childhood, adolescence or before marriage.

FGM in the UK

2.14. In the UK FGM is illegal under the Female Genital Mutilation Act 2003. Despite this, a study into UK prevalence by FORWARD based on 2001 census data estimated that over 20,000 girls under the age of 15 could be at high risk of FGM in England and Wales each year; and nearly 66,000 women are living with the consequences of FGM.

2.15. In February 2011 the Government published the Multi-Agency Practice Guidelines on FGM, which aimed to provide support to all front line professionals who have responsibility for safeguarding children and adults from the abuses associated with FGM.

2.16. The UK Government estimates that the prevalence of FGM in the UK is not evenly distributed and that higher prevalence is likely to be found in areas with larger populations from practicing countries, and London is listed as an area where rates of FGM are likely to be high.

2.17. It is believed that FGM is carried out on British girls both in the UK and overseas, often in the family's country of origin. As a result girls are at particular risk during school holidays, especially the long summer holiday, when they can be taken overseas and have a significant period of time to recover before returning to school.

2.18. Islington has a very diverse community with populations from all over the world. There are a number of community groups and projects in the borough that do work with communities to raise awareness about the harmful health and welfare consequences of FGM, and support women and girls who have undergone the procedure.

2.19. Female Genital Mutilation is one of the serious violent crime types within the Violence Against Women and Girls (VAWG) agenda. Islington Council has a VAWG strategy that outlines the Council's aims and objectives over the next four years. The VAWG Strategy is delivered through a number of working sub-groups with responsibility for different areas and FGM comes under the Harmful Traditional Practices (HTP) sub-group.

2.20. Part of the work plan of the HTP VAWG sub-group was to use local data and information to provide an estimate of the risk profile of girls and young women in Islington.

3. Methodology

3.1. Following a similar method to that used by FORWARD in their 2007 report on the UK prevalence of FGM, the purpose of the study was to establish an estimate of the level of risk to girls in Islington using country prevalence data from international sources, and local data on language and ethnicity from our own databases (where FORWARD used census data for a national estimate).

3.2. The first stage was to identify the country and regional prevalence rates of FGM in countries around the world. This was done using estimates available through the World Health Organisation (WHO), and a number of regional or country based Demographic and Health Surveys (DHS). For prevalence rates among Kurdish women this was done using the study by WADI as the WHO doesn't have prevalence data specifically for the Kurdistan region.

3.3. After a list of countries had been established, a full list of all ethnicities and languages associated with those countries was produced. These ethnicities and languages were used to run a search through the database of Islington children. This Data Warehouse is a central collection of records that draws together a number of databases and reporting systems used in the borough including council tax, housing, schools and others.

3.4. Due to the variety of ages at which FGM can be performed it was decided to focus on girls aged 0 -18, so the Data Warehouse was used to establish the numbers of female 0-18 year olds in Islington whose ethnicity or language indicated they were from an FGM practising community.

3.5. The information that came back from the Data Warehouse was carefully cleaned and checked to make the count as accurate as possible.

3.6. Language and ethnicity were looked at for each individual and it was decided that language would be used as the basic measure for this study as the language records were more detailed and could be most easily associated with particular countries. Ethnicity was still considered where language information alone was not sufficient to establish whether the individual belonged to a practising community. Age was also included in the profiles and the results are published below.

3.7. All the data analysed was anonymous, the records viewed showed only certain characteristics, with all information that would have allowed personal identification removed.

Advantages

3.8. The fact that the Data Warehouse is a central collection of a number of different databases meant that we were able to access as wide a range of

information as possible, and that we could identify siblings and children living in the same household to further increase the accuracy of results.

3.9. The use of language as well as ethnicity allowed a more accurate estimate to be drawn from the data since there were a number of individuals for whom only one was listed, and often for children we have information on language and not on ethnicity, so it enabled us to identify more of those potentially at risk.

3.10. The use of language also allowed greater accuracy as it meant the estimates did not have to rely on national prevalence estimates only. For example, in a country such as Nigeria, the overall country prevalence rate is comparatively low (29.6%), but there are significant regional variations in the prevalence rate revealed through the 2003 DHS. The survey revealed that in Nigeria prevalence was found to be as low as 0.4% in some areas and as high as 56.9% in others. The use of language data in this study allowed a more accurate appraisal of the risk level as it was possible to identify the prevalence rate associated with individual languages.

3.11. Previous estimates on FGM prevalence, including the 2007 estimate by FORWARD, have used country of birth and ethnicity as the proxies from which to estimate FGM prevalence or risk. This method has the limitation that it does not include those of a second generation who may have been born in the UK but whose background would still indicate that they are at high risk of FGM. Including language data in this estimate enables us to identify those from FGM practising communities regardless of their country of birth.

3.12. These estimates are based on live data, which means that they are likely to be more up to date than those that were, for example, based on a particular population survey such as the 2001 census, which is now over ten years out of date.

Limitations

3.13. The limitation identified by FORWARD, that there is insufficient research on the impact of migration on FGM practice, also applies to this study. The dearth of research in this area means that this study uses country of origin prevalence to reach estimates, and we cannot know how different prevalence in migrant communities is likely to be from those in country of origin.

3.14. The study by Morison et al (2004) conducted a survey with a sample of young Somali men and women living in London. The sample consisted of 80 Somali men and 94 Somali women all aged 16 – 22. In this study 70% of the women reported having undergone FGM, and two thirds of those had undergone type iii. The study also found that there was a significant difference in the prevalence of FGM between girls who had arrived in the UK before age 6 (42%) and those who had arrived when aged 11 or older

(91%). Whilst this study provides some insight, there is a need for more research to fully understand the impact of migration to the UK in terms of FGM practice.

3.15. The evidence is limited by the fact that we only have information on those 0 -18 year olds or their siblings about whom we have at one point collected ethnicity or language data. The fact that this relies on self reporting means that it is this is very likely to be an underestimate.

3.16. Where an individual's language is one that is extremely widely spoken, such as Arabic, they will have not been counted in this study unless additional information was available on their ethnicity or nationality. This is because there are some Arabic speaking countries associated with a high prevalence of FGM and others with a very low, or no evidence of FGM at all. Since it cannot be assumed that all speakers of the language are from countries where FGM is practiced, they have been excluded. This inevitably means there has been some under-counting.

4. Results

4.1. The full list of languages which existed within the Data Warehouse and were counted in this study are shown in Table 1 below.

Table 1 – List of Identified Languages	
Afar-Saho	Krio
Akan/Twi-Fante	Kurdish
Amharic	Lingala
Arabic (Egypt)	Nigerian (Language not known)*
Arabic (Iraq)	Nzema
Arabic (Sudan)	Oromo
Arabic (Yemen)	Pashto/Pakhto
Bambara	Somali
Berber (Tamashek)	Swahili/Kiswahili
Ebira	Temne
Edo/Bini	Tigre
Efik-Ibibio	Tigrinya
Esan/Ishan	Urdu
Ewe	Urhobo-Isoko
Hausa	Wolof
Igbo	Yoruba
*This category was used to describe those whose ethnicity was listed as Nigerian but for whom there was no language data available.	

4.2. Each of these languages is associated with a country or region where FGM is known to be practiced. Where languages are associated with more than one country, the ethnicity was examined and this often indicated the country of origin. Where there was no clear country of origin the country selected was the one most associated with the language.

4.3. The list of languages with countries (or regions) and associated prevalence rates (where available) is shown in Table 2 below.

Table 2 – List of Languages and Associated Prevalence Rates

Language	Country/Region	Prevalence Rate (%)
Afar-Saho	Djibouti	93.1
Akan/Twi-Fante	Ghana	3.8
Amharic	Ethiopia	74.3
Arabic (Egypt)	Egypt	91.1
Arabic (Iraq)	Iraq	N
Arabic (Sudan)	Sudan	90
Arabic (Yemen)	Yemen	38.2
Bambara	Mali	85.2
Berber (Tamashek)	Sierra Leone	94
Ebira	Kwara state, Nigeria	9.6
Edo/Bini	Edo state, Nigeria	34.7
Efik-Ibibio	Akwa Ibom State and Cross River State, Nigeria	34.7
Esan/Ishan	Edo state, Nigeria	34.7
Ewe	Ghana	3.8
Hausa	Northern Nigeria	0.4
Igbo	SE Nigeria	40.8
Krio	Sierra Leone	94
Kurdish	Turkey/Iran/Iraq	72.7
Lingala	CAR	25.7
Nigerian (Language not known)	Nigeria	29.6
Nzema	Ghana	3.8
Oromo	Ethiopia	74.3
Pashto/Pakhto	Afghanistan/Pakistan	N
Somali	Somalia	97.9
Swahili/Kiswahili	Congo*	5
Temne	Sierra Leone	94
Tigre	Northern Sudan	90
Tigrinya	Eritrea	88.7
Urdu	Pakistan	N

Urhobo-Isoko	Delta State, Nigeria	34.7
Wolof	Senegal	28.2
Yoruba	SW Nigeria	56.9
N = Not Known (countries where FGM has been documented but where there is little or no data available) *From listed ethnicity		

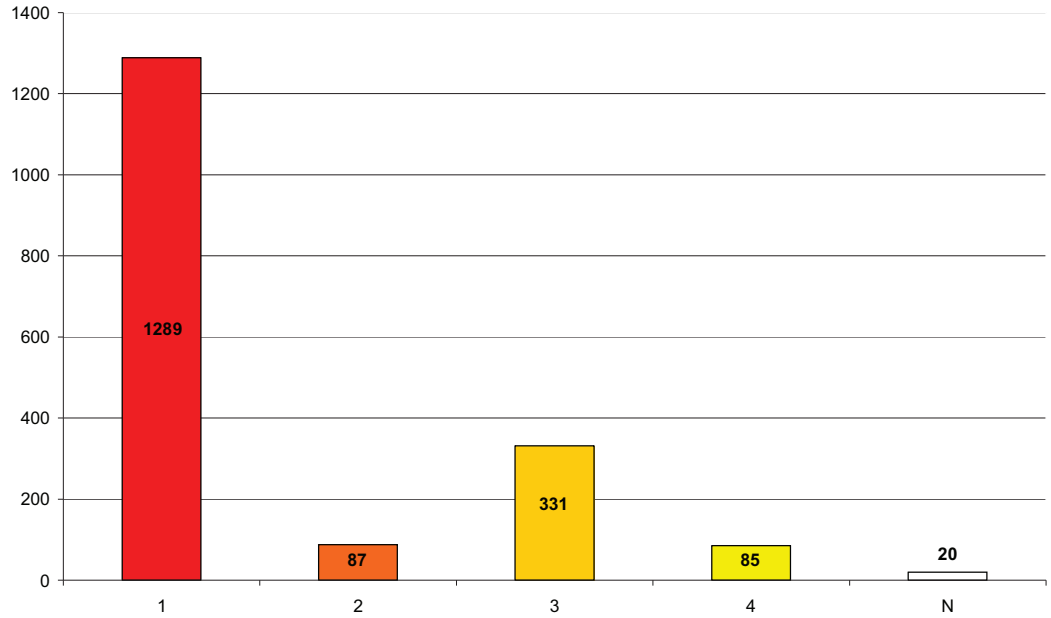
4.4. The total count for girls aged 0-17 whose language or ethnicity or both indicated that they could be at risk of FGM was 1,812. The numbers of girls listed as speaking the 32 languages above is shown in Table 3 below:

Table 3 – Numbers of Girls Speaking Each Language			
Language	**No. of Girls**	**Language**	**No. of Girls**
Afar-Saho	3	Krio	6
Akan/Twi-Fante	69	Kurdish	104
Amharic	85	Lingala	3
Arabic (Egypt)	19	Nigerian (lang not known)	30
Arabic (Iraq)	16	Nzema	1
Arabic (Sudan)	40	Oromo	2
Arabic (Yemen)	6	Pashto/Pakhto	2
Bambara	2	Somali	1092
Berber (Tamashek)	3	Swahili/Kiswahili	3
Ebira	5	Temne	1
Edo/Bini	8	Tigre	11
Efik-Ibibio	1	Tigrinya	112
Esan/Ishan	5	Urdu	2
Ewe	4	Urhobo-Isoko	4
Hausa	3	Wolof	1
Igbo	28	Yoruba	141
Grand Total			**1812**

4.5. By adapting the categories used in UNICEF's 2005 report, and FORWARD's 2007 report, this study designated 4 categories of FGM prevalence. Table 4 shows the four categories and Chart A below shows the number of girls in Islington by Category, established using their language:

Table 4 – Categories of FGM Prevalence	
Category	**Description**
1 (Universal Prevalence)	85 – 100%
2 (High Prevalence)	75 – 84%
3 (Medium Prevalence)	25 – 74%
4 (Low Prevalence)	Under 25%

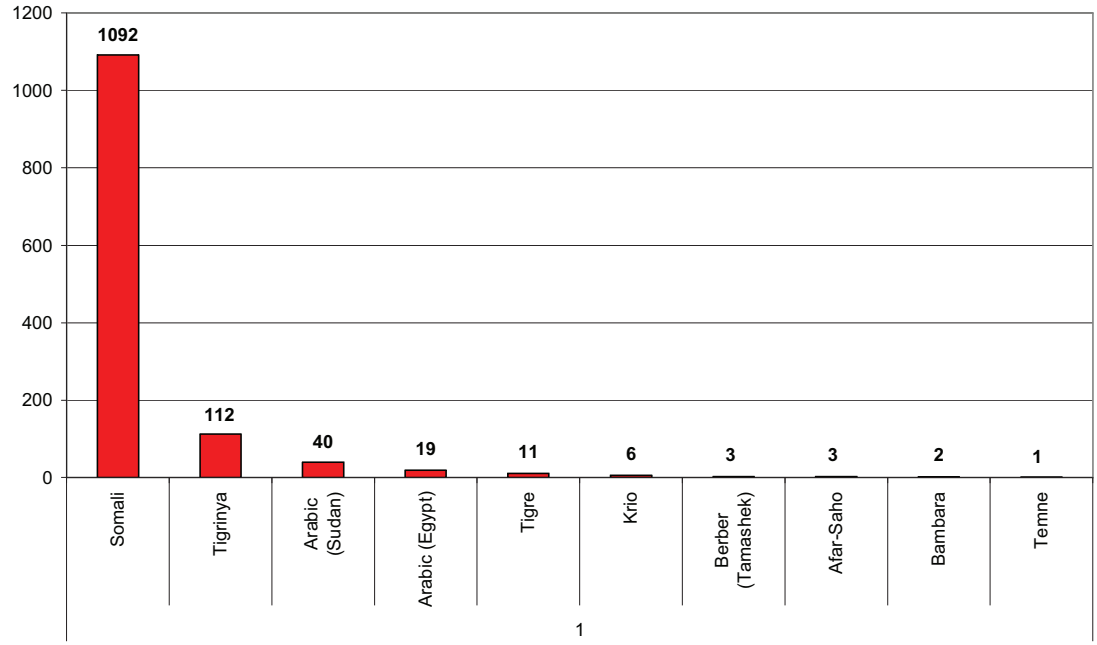
Chart A – Number of Girls by FGM Prevalence Category



4.6. As Chart A illustrates, the highest number of girls are in the highest risk categories; they are from FGM practising communities where there is a universal prevalence rate in countries of origin. 'N' represents the number of girls whose language indicates they are from a practising community but where prevalence is not known.

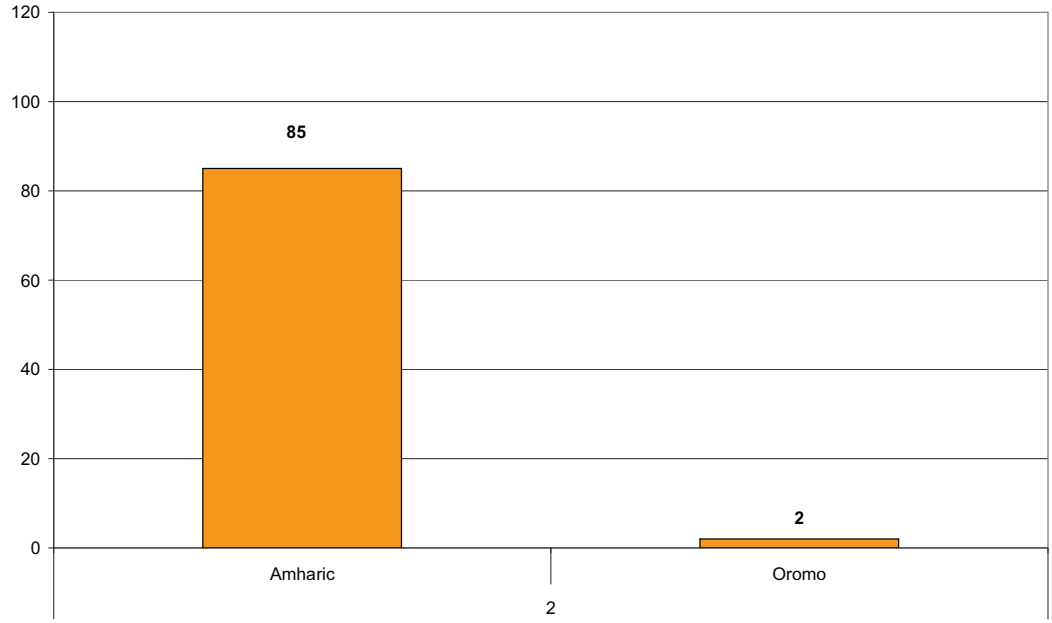
4.7. Charts B – F show a breakdown of the languages in each FGM prevalence category.

Chart B – Language Breakdown in Category 1



4.8. Chart B illustrates that Somali speakers make up a very large majority of those in the highest risk category where the FGM prevalence rate in country of origin is classed as universal.

Chart C – Language Breakdown in Category 2



4.9. Chart C shows just two languages; Amharic and Oromo, both primarily spoken in Ethiopia, a country with an FGM prevalence rate of just over 74%.

Chart D – Language Breakdown in Category 3

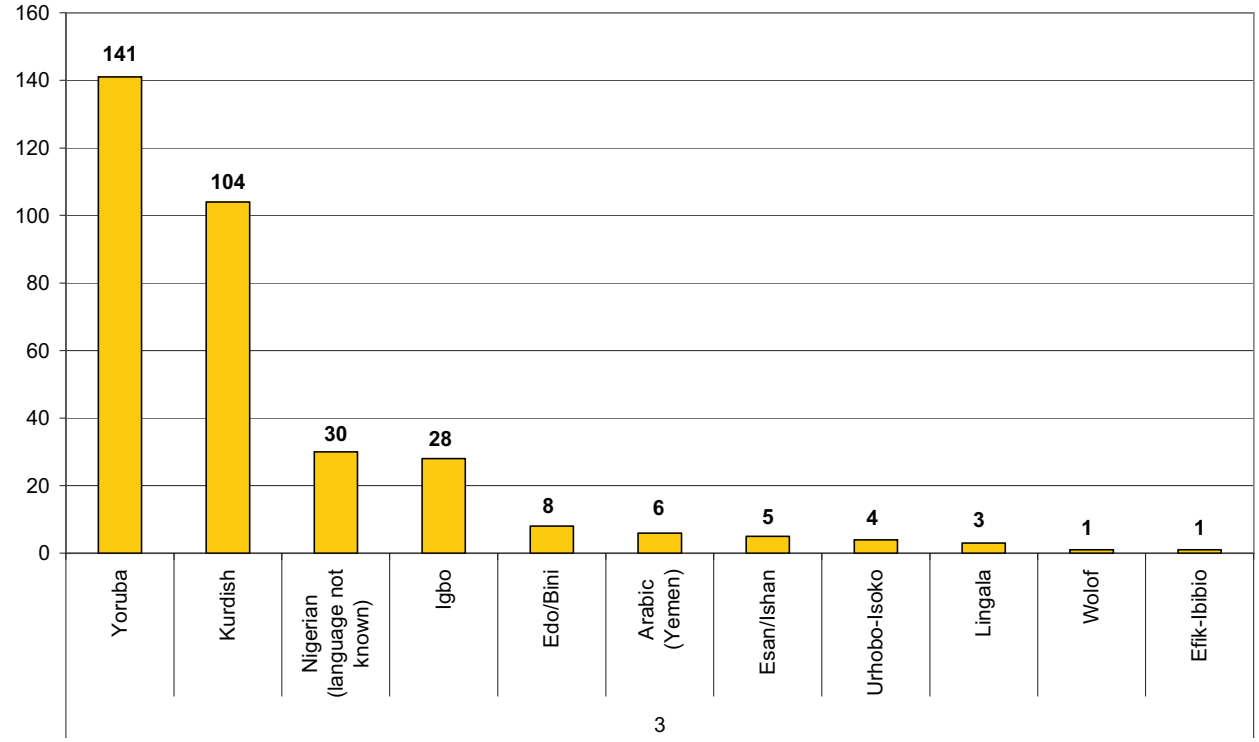
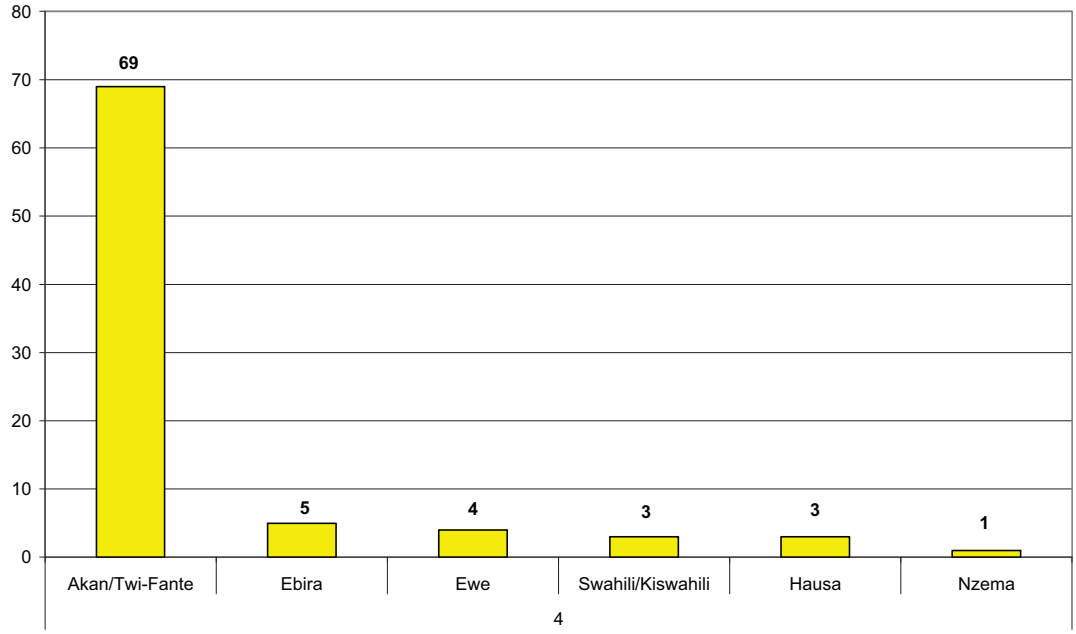


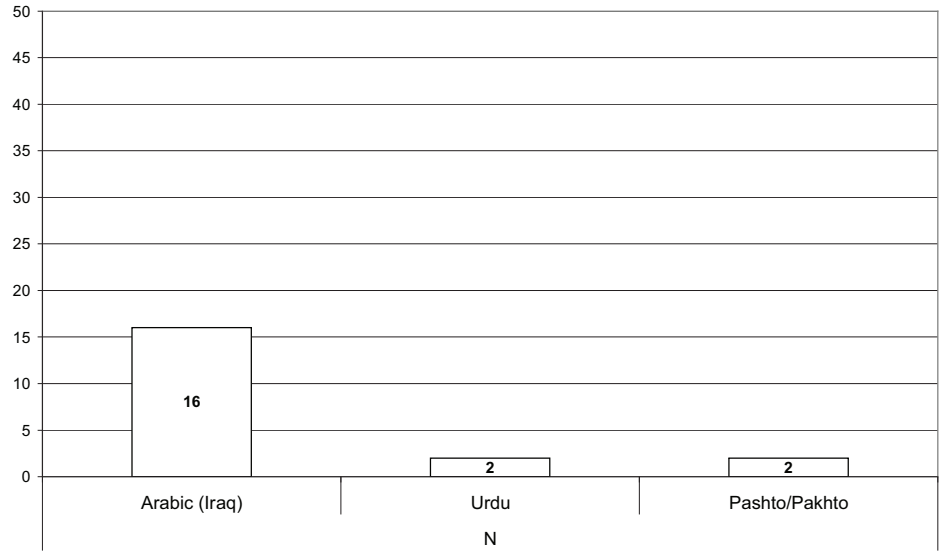
Chart E – Language Breakdown in Category 4



4.10. Charts D and E show the spread of languages across the medium and low prevalence categories. The most common being West African languages spoken in Nigeria (in Chart D) and Ghana (in Chart E), as well as Kurdish (Chart D).

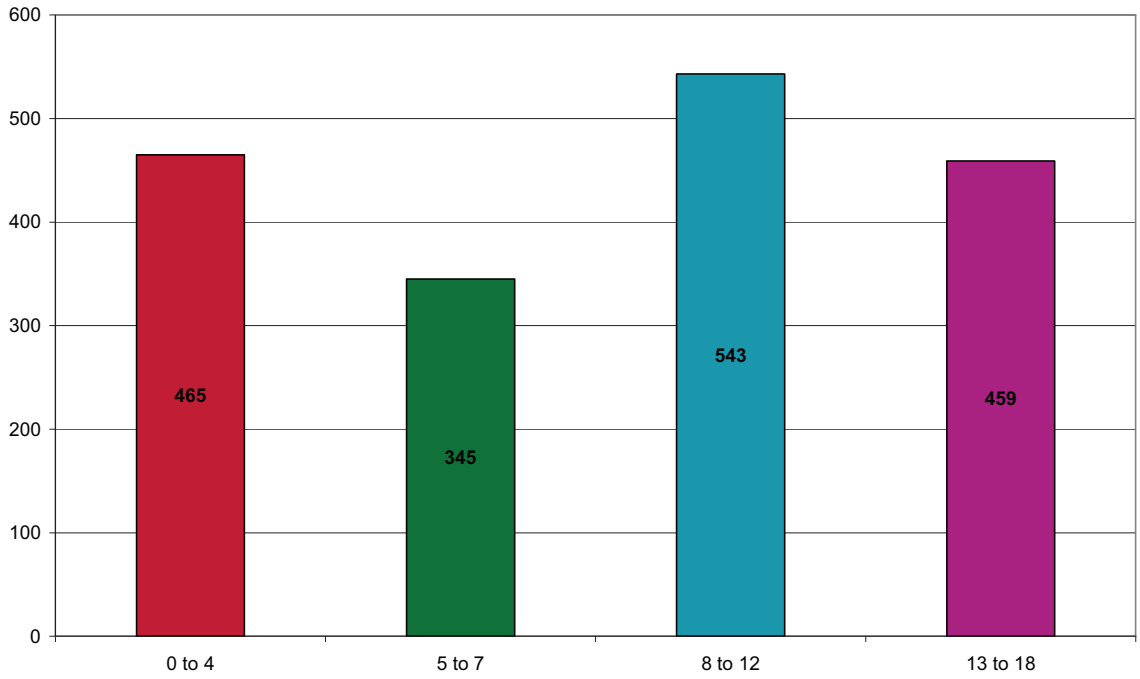
4.11. Chart F shows the number of girls speaking languages from communities where there is not enough information available to estimate prevalence rates. The numbers in this category are very low overall. Arabic speakers from Iraq are the majority, and although there has been one study looking at prevalence rates among Arab women in Kirkuk in Iraq, there is not enough evidence to estimate a prevalence rate for Arab speakers across Iraq.

Chart F – Language Breakdown where Prevalence is Not Known (N)



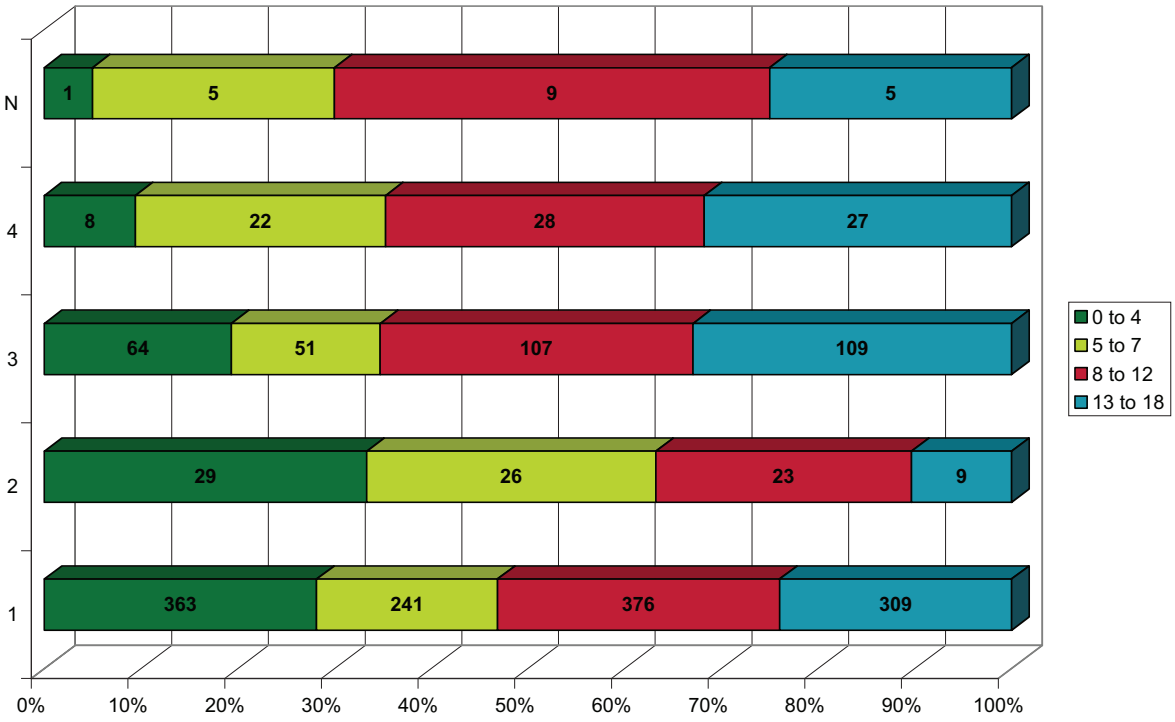
4.12. The ages of the girls identified are shown below in Chart G in four categories: 0-4, 5-7, 8-12 and 13-18. As the chart shows, there is reasonably even distribution across all the age groups.

Chart G – Age of Girls Identified



4.13. Chart H shows the percentage age breakdown for each FGM prevalence category.

Chart H – Age Breakdown by FGM Prevalence Category



4.14. The chart illustrates that the higher risk categories, 1 and 2 see a relatively even distribution across the age groups. Category 3 has a relatively high number of 13 – 18 year olds and Category 4 has a relatively low number of 0 – 4 year olds.

4.15. Categories 1 and 2 both have a significantly higher proportion of girls in the 0-7 group than categories 3 and 4 (47% and 63% as against 34% and 35%).

5. Discussion

5.1. The overall count indicates that we have 1,812 girls aged 0 – 18 in Islington who are potentially at risk of, or who will already have undergone, FGM. As discussed above, this is likely to be an underestimate as the data is reliant upon self reporting of language and ethnicity.

5.2. The Office for National Statistics mid year population estimates for 2010 estimate the 0 – 18 female population in Islington to be 17, 696. Therefore the numbers of girls identified in this study represent 10.2% of the 0-18 female population in Islington.

5.3. The study identified 1289 girls in the highest risk category for FGM; that is they come from backgrounds where the prevalence rate is effectively universal in their country of origin. This constitutes 7.3% of the 0-18 female population.

5.4. Even bearing in mind that there has been insufficient research into the impact of migration on the continuation of FGM, the extremely high prevalence rates in countries of origin should still be cause for concern.

5.5. Somali speakers constituted the highest number in the study, with 1092 girls identified. The most recent estimate of FGM prevalence in Somalia is 97.9%, the highest in the world. These girls are at the highest risk.

5.6. The finding in the study by Morison et al (2004) that 91% of young Somali women surveyed who had come to the UK older than age 11 had undergone FGM, perhaps suggests that age at time of migration could be considered as another risk factor in future research.

5.7. There were 20 girls identified as belonging to communities where FGM has been documented but where there is insufficient evidence to estimate prevalence. It is important that these communities are not overlooked when considering risks around FGM locally.

5.8. The age breakdown revealed that a significant proportion of the girls in the two highest risk categories were 7 and under. This has implications for what support or interventions are most appropriate when we consider that the most likely age when FGM will be performed is 5 – 9.

6. Conclusions and Recommendations

6.1. The conclusion of this research is that there is a risk to girls in Islington around FGM. 1 in 10 girls aged 0-18 in Islington come from a background where FGM is practiced, and over 70% of these are girls from backgrounds where levels of FGM practice are near universal.

6.2. There are pockets of good practice in Islington, including a number of community groups that provide support and advocacy in relation to FGM, and a specialist midwife at the Whittington hospital who has expertise in FGM and in conducting the necessary operation to reverse type iii.

6.3. This work forms a crucial part of the response to FGM locally, but there is currently no co-ordinated response to FGM across the borough. The nature of the issue requires that there be a joined up response from health (including mental health), education, social care (because FGM is a safeguarding issue), the police, the local authority and the voluntary and community sector.

6.4. The basis for this multi-agency response can be found in the Government's *Multi-Agency Practice Guidelines: Female Genital Mutilation* (2011) published last year. Below are some recommendations for action we can take around FGM locally. More detail on the implementation of these recommendations can be found in the agency-specific chapters of the Guidelines.

6.5. Further research could focus on identifying whether there are particular locations in the borough where there are concentrations of populations with high FGM prevalence to allow targeting of resources.

6.6. This study has focused on 0 – 18 year old girls but further statistical analysis could try and identify numbers of adult women from FGM practising communities who may require support around FGM. The publication of data from the 2011 Census may assist with this.

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July 2012

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STONEBRIDGE SCHOOL

SAFE GUARDING POLICY

January 2014

SAFEGUARDING POLICY

STONEBRIDGE SCHOOL 2014

Agreed by Governors: January 2014
Agreed by Staff: January 2014

The policy is to be reviewed: SPRING 2017

INTRODUCTION

The governors and staff of Stonebridge School fully recognise the contribution they make to the safeguarding of children. We recognise that all staff, teaching and non-teaching, including volunteers, have a full and active part to play in protecting our pupils from harm[1].

All staff and Governors believe that our school should provide a caring, positive, safe and stimulating environment which promotes the social, physical, emotional and moral development of the individual child.

The aims of this policy are:

- To support the child's development in ways that will foster security, confidence and independence
- To raise the awareness of both teaching and non-teaching staff of the need to safeguard children and of their responsibilities in identifying and reporting possible cases of abuse.
- To provide a systematic means of monitoring children known or thought to be at risk of harm.
- To emphasise the need for good levels of communication between all members of staff.
- To develop a structured procedure within the school to be followed by all members of the school community in cases of suspected abuse.
- To develop and promote effective working relationships with other agencies, especially Social Services and the police.
- To ensure that all adults who work within the school environment have carried out a full and current DBS check in order that their suitability is checked.
- To ensure all members of the school community are treated with dignity and respect.

[1] HARM should be read with reference to any kind of physical, sexual, emotional abuse or any kind of neglect.

PROCEDURES

Our school procedures for safeguarding children will be in line with LA and LSCB procedures (Local Safeguarding Children's Board). We will ensure that:

- The HT and Assistant Head Teacher with responsibility for Inclusion, will act as the Designated Teachers for Child Protection at Stonebridge School. They will both undertake regular training.

- There is a senior member of staff who will act in the designated teachers' absence, the Deputy Head, who will also receive appropriate training.

- The Designated Teachers for Child Protection will be the first person to be approached in the light of any concerns, allegations or disclosures.

- Both DTCP will update the Child Protection record and share information. Cases will be allocated for one DTCP to take a lead on but regular meetings will take place to review progress and to offer supervision to each other.

- The DTCP will meet each term to monitor the update of the Child Protection record for the school to ensure it is an accurate and up to date record. Cases at this point may also be reallocated.

- All members of staff are familiar with the categories and definitions used when referring to Child Protection. (See Appendix 1 - 4)

- All members of staff develop their understanding of the signs and indicators of abuse. (See Appendix 1 - 4)

- All members of staff know how to respond to a pupil who discloses abuse. They will ensure that time is given to the child in order that they can fully concentrate on the child's disclosure and that this time is found as a matter of urgency. This information will then be passed on via the Child Protection Report form (see Appendix 5) and / or by speaking to a Designated Teacher for Child Protection – forms will be given to the Head Teacher PA.

- The Designated Teachers for Child Protection will ensure that the correct Child Protection forms for monitoring, recording and reporting to formal settings are made available to staff. Staff will ensure that these forms are kept confidentially, kept up to date and completed in line with deadlines. (See Appendix 5 -9 for copies of these forms)

- Safeguarding and Child Protection will be included in all staff handbooks and group training and professional meetings throughout the academic year.

- All parents/carers are made aware of the responsibilities of staff members with regard to child protection procedures. A Child Protection statement will be included in all school parent hand books.

- Our procedures will be regularly reviewed and up-dated following a three year cycle outlined at the end of this policy.

- All new members of staff will be given a copy of our Safeguarding Policy as part of their induction into the school.

- Training undertaken by the designated teachers for child protection and staff will be documented and filed.

CHILD PROTECTION & SUPPORTING CHILDREN

We recognise that the school has a role to play in supporting children who are experiencing great challenges in their lives. We also recognise that these challenges may be of a child protection nature. We acknowledge that the school may provide the only stability in the lives of children who have been abused or who are at risk of harm. We recognise that the school should fully understand how being a victim of abuse can manifest itself in numerous ways. We recognise that the school must endeavour to put in place systems and training in order that all members of staff can act appropriately. Children will always be given time and privacy to talk to a member of staff in order to discuss issues that are affecting them or worrying them.

We appreciate that a child who is abused or witnesses violence may find it difficult to develop and maintain a sense of self worth. We understand that a child in these circumstances may feel helpless, humiliated and may feel self blame.

We accept that research shows that the behaviour of a child in these circumstances may range from that which is perceived to be normal to aggressive or withdrawn.

Our school will therefore support all pupils by:

- Encouraging self-esteem and self-assertiveness whilst not condoning aggression or bullying – PSHE , Circle Time, Comments Box, Article 12, Inclusion officer support, Lunchtime Clubs, Art Therapists and Place 2 Be (where appropriate)
- Promoting a caring, safe and positive environment within the school – Class Rights and Responsibilities, School Core Values, Year Group assemblies, and School Collective Worship, PSHE, Circle Time
- Offering the support of Place 2 Be counsellors at the school and by working closely with the School Project Manager.
- Holding regular Inclusion meetings with key school based professionals – every half a term.
- Liaising and working together with all other support services and those agencies involved in the safeguarding of children.
- Notifying Social Services as soon as there is a significant concern.
- Providing continuing support to a pupil about whom there have been concerns when moving from one class teacher to another or who leaves the school by ensuring that appropriate information is forwarded under confidential cover.
- Ensuring that children who are at risk are closely monitored.
- Ensuring that monitoring procedures are up to date and regularly reviewed.
- Children will be given time & privacy should they wish to talk to an adult.

RESPONSIBILITIES

The designated teacher for child protection is responsible for:

- Adhering to the LSCB (Local Safeguarding Children Board), LA and school procedures with regard to referring a child if there are concerns about possible abuse.

- Keeping written records of concerns about a child even if there is no need to make an immediate referral.

- Ensuring that ongoing monitoring of children is kept up to date.

- Ensuring that action points agreed at Child Protection Conferences, Child Protection Reviews and Core Group Meetings are carried out. (see record sheet Appendix 10)

- Ensuring that accurate and up to date information about individual children is presented at Child Protection Conferences.

- Ensuring that all such records are kept confidentially and securely and are separate from pupil records.

- Ensuring that an indication of further record-keeping is marked on the pupil's general records and that all records are passed on to their next school.

- Ensuring that any pupil currently with a Child Protection plan who is absent without explanation for two days is referred to their key worker at Social Services and that the attendance of children with a Child in Need Plan (CIN) is monitored closely and any concerns referred to their key social worker.

TYPES OF ABUSE (See appendix 1 – 6) for definitions and signs.

There are four main types of abuse and these are:

- Physical abuse including FGM (Female Genital Mutilation)
- Emotional abuse including domestic violence
- Sexual abuse
- Neglect

Physical Abuse

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes ill health to a child whom they are looking after. This situation is commonly described using terms such as factitious illness by proxy or Uncaused syndrome by proxy and cutting (including female genitalia).

Physical Abuse Continued - Female Genital Mutilation (FGM)

FGM involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health

consequences, both at the time when the mutilation is carried out and in later life. It is acknowledged that some FGM practising families do not see it as an act of abuse, however it is illegal in the UK and suspicions of FGM having already taken place or knowledge of girls at risk must be reported. It is also against the law to groom or prepare a girl to have any type of FGM. FGM is known by a number of names, including 'female genital cutting', 'the cut', 'circumcision' or 'initiation'. The age at which girls undergo FGM varies enormously according to the community. **The procedure may be carried out when the girl is new-born, during childhood or adolescence, just before marriage or during the first pregnancy.** However, the majority of cases of FGM are thought to take place between the ages of 5 and 8 years old and therefore girls within that age bracket are at a higher risk. FGM is a deeply rooted tradition, widely practised mainly among specific ethnic populations in Africa and parts of the Middle East and Asia. FGM has also been documented in communities in **Iraq, Israel, Oman, the United Arab Emirates, the Occupied Palestinian Territories, India, Indonesia, Malaysia and Pakistan**.

Emotional abuse

Emotional abuse is the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. It may involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of ill-treatment of a child, though it may occur alone. Emotional abuse also happens when a child is subjected to witnessing domestic abuse between both or one of his/her parents.

Domestic Abuse - Emotional abuse continued

Domestic abuse is any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. A child who is subjected to domestic abuse either through directly observing it or is exposed to its effects is emotionally scarred and is under a lot of stress. Domestic Abuse chips away at feelings of self-worth and independence. Domestic abuse can also include *verbal abuse* such as yelling, name-calling, blaming, and shaming. It can also include controlling behaviours like financial control, Isolation and intimidation, these are all aspects of emotional abuse. The physical, psychological and emotional effects of domestic abuse on children can be severe and long-lasting. Some children become withdrawn and find it difficult to communicate, others may act out the violence or aggression they have witnessed, or blame themselves for the abuse. All children living with abuse are under a great deal of stress and need support.

Sexual abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

Neglect
Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

CONFIDENTIALITY

- We recognise that all matters relating to Child Protection are of a Confidential nature and should be treated as such.

- The Designated Teachers will disclose information about a pupil to the key member of staff on a Need to know basis only. This information will only be passed on to relevant members of staff by the Key member if and when it is required.

- All staff must be aware that they have a professional responsibility to share information with other agencies in order to safeguard children.

- All staff must be aware that they cannot and must not promise a child to keep a secret.

SUPPORTING STAFF

We recognise that staff working in the school who have become involved with a child who has suffered harm, or appears to be likely to suffer harm may find the situation stressful and upsetting. We will support such staff by providing an opportunity to talk through their anxieties with a designated teacher and to seek further support as appropriate. The Designated Teachers for CP act as each other's supervision support. All members of staff can approach Place to Be for this support if required.

ALLEGATIONS AGAINST STAFF

We understand that a pupil may make an allegation against a member of staff.
If such an allegation is made the following action will be taken:

- The member of staff receiving the allegation will immediately inform the Head Teacher / Deputy Head Teacher and not enter into a dialogue.
- The head teacher on all such occasions will discuss the content of the allegation with the LA Lead Officer for Child Protection (LADO).
- If the allegation made to a member of staff concerns the Head teacher, the designated teacher / deputy will immediately inform the Chair of Governors who will consult with the LAs Lead Officer for Child Protection (LADO).
- The school will follow the LEA procedures for managing allegations against staff, a copy of which will be readily available in the school.

WHISTLE BLOWING

We recognise that children cannot be expected to raise concerns in an environment where the staff fail to do so. All staff should be aware of their duty to raise concerns, where they exist, about the attitude or actions of colleagues. These concerns should be brought to the attention of the Head Teacher or Deputy Head Teacher.

PHYSICAL INTERVENTION

We acknowledge that staff must only ever use physical intervention as a last resort and at all times be the minimal force necessary to prevent injury to another person. We understand that physical intervention of a nature which causes injury or distress to a child may very well be considered under child protection or disciplinary procedures. The school follows the LSCB guidelines on the use of restraint and is covered in the school Restraint Policy.

SAFEGUARDING CHILDREN

BULLYING

Our policy on bullying is set out in our school Anti – Bullying Policy and Behaviour Policy. We acknowledge that to allow or condone bullying may lead to consideration under child protection procedures.

RACIST INCIDENTS

Our policy on racist incidents is set out in a separate policy. It acknowledges that a single serious incident, repeated racist incidents or to allow or condone racism may lead to consideration under child protection procedures.

PREVENTION

We recognise that the school plays a significant part in the prevention of harm to our pupils by providing pupils with good lines of communication with trusted adults, supportive friends and an ethos of protection.

The school community will therefore:

- Establish and maintain an ethos where children feel secure, are encouraged to talk and are always listened to – Article 12 Group, Circle Time, Lunchtime Clubs, Art Therapy Support and Place to Be.
- Ensure that all children know there is an adult in the school whom they can approach if they are worried or in difficulty.
- Include in the curriculum opportunities for PSHE which equip children with the skills they need to stay safe from harm and to know to whom they should turn for help – Curriculum Map for PSHE across the school.
- The school also has an E-safety policy which emphasises how children can be safe when using the Internet. Staff are trained and themes of e-safety are looked at through the curriculum and assemblies throughout the year.
- The school monitors attendance and punctuality rigorously and any concerns are followed up with an initial letter from the head teacher and

persistent absences are referred to the Educational Welfare Officer (EWO).

Outside agencies – working in partnership

- The school works very closely with outside agencies to support children and families. This includes health services, speech and language therapist, social care and the Educational Welfare Officer (EWO).

Safer Recruitment

- The school is committed to safer recruitment and ensures that members of staff have DBS and this is updated every 4 years as agreed by governors.
- The school holds a single Central Record with relevant data for all members of staff.

HEALTH AND SAFETY

Our Health & Safety policy and our Educational Visits Policy is set out in separate documents. They reflect the consideration we give to the protection of our children both within the school environment and when undertaking school trips and visits away from the school environment.

Accidents and Welfare

- If an accident occurs, the child/ren are sent to the medical room. The Welfare officer then judges whether any medical attention is required. In cases when children are medically attended to, a letter is sent home to the parents and a copy of a HSL is kept on file. There is also a list of children who visit the medical room. The welfare officer is first aid trained as well as a number of other adults in various classes in the school. Where a child requires medication regularly, a meeting is held with the welfare officer and parent/carer and a plan is set out, outlining the frequency of the medication and dosage. The parent also signs a letter to consent that the welfare officer can administer the medication.

Intimate Care

- Intimate care is any care which involves carrying out an invasive procedure (such as cleaning up a pupil after they have soiled themselves) to intimate personal areas. The school is committed to ensuring that all staff responsible for intimate care of children will undertake their duties in a professional manner at all times. Please see Intimate Care Policy for more details.

Site Safeguarding

- The school safe guards the site in a variety of ways. All entrances to the school building are secure. Access to the school site is via the main office and all visitors are expected to sign in and wear a visitor's badge. All members of the school have a fob and an identification badge which has their name and role. A weekly survey is carried out by the site manager and the fire alarm is tested on a weekly basis as well. On-going issues are raised by staff and these are put on the school's intranet for the site staff to deal with. These are monitored regularly and actions and outcomes are written in response to issues.

Fire Drills

- Fire drills are carried out half termly and the findings are reported to the governors and actions are written and followed up by site staff.

Inappropriate Behaviour

- The school expects all the school community to adhere to the schools core values of Consideration, Positive Attitude and Respect. Where any visitor is causing harassment, anxiety and distress, (HAD) the school will record such incidents and further action such as a ban from the school premises may be enforced.

APPENDICES

- **APPENDIX 1 – Definition & Signs – Physical Abuse (including FGM)**
- **APPENDIX 2 – Definition & Signs – Emotional Abuse (including Domestic abuse)**
- **APPENDIX 3 – Definition & Signs – Sexual Abuse**
- **APPENDIX 4 – Definition & Signs – Neglect**
- **APPENDIX 5 – Child Protection Report Form**
- **APPENDIX 6 – Every Child Matters (ECM) Summary of Needs**
- **APPENDIX 7 – Individual Child Protection Record Sheet**
- **APPENDIX 8 – Stonebridge Welfare Check/Core Group Record Sheet**
- **APPENDIX 9 – Confidential Incident Record Sheet**
- **APPENDIX 10 – Confidential Meeting Record Sheet**
- **APPENDIX 11 – Record of CP Meeting & Action Form**

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF ABUSE?

PHYSICAL ABUSE

DEFINITION:

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes ill health to a child whom they are looking after. This situation is commonly described using terms such as factitious illness by proxy or Uncaused syndrome by proxy.

SIGNS:

- Marks and Bruises
- Suspicious stories about how marks made
- Frequent bumps etc
- Broken Bones
- Frightened / nervous at simple movements / jumpy
- Jumping when adult raises voice
- Introverted, shy or withdrawn
- Tearful
- Poor behaviour / Bullying others
- Repeating inappropriate behaviour/ bullying
- Violent outbursts
- Hair missing
- Scratches / burns
- Stories include violent descriptions / pictures depict regularly violent scenarios
- Hitting or aggressive to other children
- Sleeping in class
- Self conscious when changing for PE
- Restless and fidgety
- Wetting / soiling them self
- Mood swings
- Little contact with other children
- Poor attendance
- Use of bad language
- Physically threatening behaviour
- Shouting

(STONEBRIDGE CPD 16/12/13)

Additional signs:

CONSTANT INJURIES THAT CAN ALWAYS BE EXPLAINED / CHANGE OF MOOD / WITHDRAWN OR AGGRESSIVE / CHANGE OF CHARACTER OR BEHAVIOUR / SELF COMFORT / VERBAL ABUSE / NON-COOPERATION / POOR HEALTH / UNKEPT / FEAR OF ADULTS / ABSENCES / STRANGE BEHAVIOUR AFTER WEEKENDS OR HOLIDAYS / FORGOTTEN PE KIT / FLINCHING IN RESPONSE TO SUDDEN MOVEMENTS / FREQUENT MEDICAL APPOINTMENTS / DO NOT WANT TO GO HOME AT THE END OF THE DAY / UNABLE TO FORM RELATIONSHIPS WITH ADULTS / SELF PROTECTION / GUARDING / LACK OF EYE CONTACT / CONSTANTLY ILL WITH NO REAL SYMPTOMS / FEARFUL OF ADULTS

FEMALE GENITAL MUTILATION (FGM) IS PHYSICAL ABUSE

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF FGM?

DEFINITION:

FGM involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life. FGM is against the law except when performed by a registered medical profession on medical or mental health grounds. It is also illegal for someone to arrange for a child to go abroad with the intention of having her circumcised.

SIGNS

- Difficulty walking, sitting or standing
- Spending longer than normal in the bathroom or toilet due to difficulties urinating.
- Fracture or dislocation of legs/arms as a result of restraint
- Spend long periods of time away from a classroom during the day with bladder or menstrual problems
- Severe pain in groin area
- Haemorrhage
- Being withdrawn - emotional and psychological shock (exacerbated by having to reconcile being subjected to the trauma by loving parents, extended family and friends);
- Urinary infections
- Detached / isolated
- Change in physical appearance/dress & body language
- Withdrawn aggressive
- Unable to form relationships with adults
- Changes in attitude, personality or behaviour
- Changes in interaction with others
- Feelings shown through writing or art work
- Peer group problems
- Extremes of emotion
- Underachieving

(STONEBRIDGE CPD 16/12/13)

Any suspicions of a child at risk of having or having had FGM must be reported immediately to the Head teacher or Designated teacher for Safe guarding. Girls aged 5 to 8 years are most risk.

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF ABUSE?

EMOTIONAL ABUSE

DEFINITION:

Emotional abuse is the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. It may involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of ill-treatment of a child, though it may occur alone. Children witnessing domestic abuse between the parents or carers is also emotional abuse.

SIGNS:

- Low self esteem
- Withdrawn / frightened / shy
- Secretive
- Makes little eye contact
- Emotionally finds it difficult to maintain relationships with peers and adults
- Jumpy or stuttering during conversations with adults
- Cries a lot / very sensitive
- A Loner
- Pictures use mainly dark colours
- Stealing
- Mood swings
- Lack of concentration
- Very quiet, speaks little
- Poor social skills
- Bullies others
- Very unsettled
- Anti-social behaviour
- Lack of confidence

(STONEBRIDGE CPD 16/12/13)

Additional signs:

WETTING / SOILING / SELF HARM / SELF COMFORT / ROCKING / CHANGE IN APPETITIE / UNDEACHIEVEMENT / TIMID / TEARFUL / ANOREXIC / BULIMIC / DO NOT WANT TO GO HOME AT THE END OF THE DAY / ATTENTION SEEKING / CHANGES IN STANDARD OF WORK / DEPRESSION / INTROVERTED / WITHDRAWN / CHANGES IN RELATIONSHIPS / NO FRIENDS / HARD TO MAKE FRIENDS / NEEDY / CLINGY / CHANGE IN PHYSICAL APPEARANCE/DRESS & BODY LANGUAGE / WITHDRAWN AGGRESSIVE / CHANGES IN ATTITUDE, PERSONALITY OR BEHAVIOUR / CHANGES IN INTERACTION WITH OTHERS / PEER GROUP PROBLEMS / EXTREEMS OF EMOTION / ALIEN TO PRAISE

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF DOMESTIC ABUSE?

DOMESTIC ABUSE IS EMOTIONAL ABUSE

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF DOMESTIC ABUSE?

DEFINITION: Domestic abuse is any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. A child who is subjected to domestic abuse either through directly observing it or is exposed to its effects is affected emotionally and is under a lot of stress.

SIGNS

- Disproportionate reactions (overly apprehensive, tearful, angry or fearful)
- Withdrawn or quiet
- Negative relationships with opposite sex (children and peers)
- Aggression or bullying
- Tantrums
- Vandalism
- Problems in school, truancy,
- Difficulty with speech problems that were not there before
- Difficulties with learning
- Attention needing
- Struggle to make or keep friendships
- Reluctance to come to school
- Reluctance to go home with parents
- Aggressive comments or language (sometimes not expected for that age)
- Self-harming
- Nightmares or insomnia
- Bed-wetting
- Anxiety, depression, fear of abandonment
- Feelings of inferiority
- Constant colds, headaches, mouth ulcers, asthma, eczema
- Seem afraid or anxious to please
- Need for constant acceptance
- Be possessive over friends or belongings

(STONEBRIDGE CPD 16/12/13)

Additional signs:

CHANGE OF MOOD / WITHDRAWN OR AGGRESSIVE / CHANGE OF CHARACTER OR BEHAVIOUR / SELF COMFORT / VERBAL ABUSE / NON-COOPERATION / / UNKEPT / FEAR OF ADULTS / ABSENCES / STRANGE BEHAVIOUR AFTER WEEKENDS OR HOLIDAYS /EXTREME RESONSES TO CORRECTION/ FLINCHING IN RESPONSE TO SUDDEN MOVEMENTS / FREQUENT MEDICAL APPOINTMENTS / DO NOT WANT TO GO HOME AT THE END OF THE DAY / UNABLE TO FORM RELATIONSHIPS WITH ADULTS / SELF PROTECTION / GUARDING / LACK OF EYE CONTACT / CONSTANTLY ILL WITH NO REAL SYMPTOMS / FEARFUL OF ADULTS

APPENDIX 3

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF ABUSE?

SEXUAL ABUSE

DEFINITION:

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

SIGNS:

- Hides under clothes / baggy clothes
- Inappropriate physical contact with other chn
- Withdrawn / shy
- Aggressive to chn of the opposite sex
- Scared of others
- Don't like being touched
- Touch themselves or others
- Won't change for PE
- Very quiet or loud
- Use of sexual language
- Stories or drawings include sexual connotations
- Exposing self
- Hesitate when wanting to talk to teacher
- Soiling/ wetting / stains on underwear
- Repeated Urine problems
- Re-enacting sexualised behaviour as part of play
- Bruising
- Sexually specific behaviour or / and language
- Abusive to other chn
- Little physical contact, finds hugs touches difficult will move away.

(STONEBRIDGE CPD 16/12/13)

Additional signs:

SEXUAL PLAY – HOME CORNER / PLAYGROUND / INAPPROPRIATE / PROVOCATIVE SEXUAL LANGAUGE / MEDICAL DIFFICULTIES / CHANGE OF MOOD / WITHDRAWN OR AGGRESSIVE / CHANGE OF CHARACTER OR BEHAVIOUR / MASTERBATION / ANOREXIC / BULIMIC / SELF HARMING / DO NOT WANT TO GO HOME AT THE END OF THE DAY / SECRETIVE / WITHDRAWN / CHANGE IN PHYSICAL APPEARANCE/DRESS & BODY LANGUAGE / UNABLE TO FORM RELATIONSHIPS WITH ADULTS

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF NEGLECT?

NEGLECT

DEFINITION:

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

SIGNS:

- Child smells, clothes are dirty, hair un brushed
- Appears unhealthy but is always in school when unwell
- Low attendance – EWO involvement
- No Breakfast
- Is unfamiliar with basic routines of feeding self and toileting etc
- Always hungry
- Late before and after school
- Attention seeking / needs praise to feel confident
- Poor hygiene, does not know how to use toilet properly
- Angry
- Parents have little contact with school. Do not attend parents evening
- Homework not completed / PE kit repeatedly forgotten
- Correct clothes not worn to school i.e. not warm enough in winter, not cool enough in summer
- Steal things
- Come to school on their own when they are too young
- Lying
- Older siblings care for younger chn and take on the parent role.
- Cries a lot
- Makes slow progress
- Packed lunch does not provide child with a balanced diet
- Over eats at lunchtime
- Untidy / unkempt
- Parents do not follow up medical requests form school i.e. need for eyes to be tested.
- Instability in family, different carers/ boyfriends
- Sleeps in class / Goes to sleep late little routine at home

(STONEBRIDGE CPD 16/12/13)

Additional signs:

INADEQUATE PACKED LUNCH / UNKEMPT / CRUFFY / SLEEPING DURING LESSONS / OVERLY TIRED / REPEATED HEALTH PROBLEMS THAT GO UNCHEACKED OR ARE NOT DEALT WITH / HEADLICS / RINGWORM NOT DEALT WITH AND CONSTANTLY REOCCUR /DISORGANISED / ATTENDANCE / PUNCTUALITY (END & BEGINNING OF DAY) / DO NOT WANT TO GO HOME AT THE END OF THE DAY / OVERWEIGHT / UNABLE TO FORM RELATIONSHIPS WITH ADULT / CONTENT OF WRITING OR DRAWING / UNDERACHIEVING

APPENDIX 5

CHILD PROTECTION REPORT FORM

NAME OF CHILD			
CLASS			
NAME OF PERSON PROVIDING INFORMATION			
DATE		LOCATION	
TIME		THOSE PRESENT	
NOTES OF CONCERNS			
TICK APPROPRIATE LEVEL OF URGENCY BELOW			

INFORMATION		QUITE URGENT		URGENT	

CHILD PROTECTION REPORT FORM

NAME OF CHILD			
CLASS			
NAME OF PERSON PROVIDING INFORMATION			
DATE		LOCATION	
TIME		THOSE PRESENT	
NOTES OF CONCERNS			
TICK APPROPRIATE LEVEL OF URGENCY BELOW			

INFORMATION		QUITE URGENT		URGENT	

APPENDIX 6

EVERY CHILD MATTERS SUMMARY OF NEEDS	
Name of Child:	
Year Group:	Date:
Purpose of Summary:	
BE HEALTHY	
STAY SAFE	
ENJOY & ACHIEVE	
MAKE A POSITIVE CONTRIBUTION	
ECONOMIC WELLBEING	
Signature and Role of Person filling in form:	

APPENDIX 7

CHILD PROTECTION RECORD – CLASS TEACHER NAME OF CHILD : START DATE :	
DATE	**COMMENT / OBSERVATION**

APPENDIX 8

STONEBRIDGE SCHOOL
Shakespeare Avenue
Harlesden
London NW10 8NG
Tel: 020 8965 6965

Fax: 020 8838 0784

STONEBRIDGE SCHOOL WELFARE CHECK / CORE GROUP			
NAME OF CHILD			
DATE OF BIRTH		YEAR GROUP	
ADDRESS			
INFORMATION REQUESTED BY			
DATE			
ACADEMIC PROGRESS AND ACHIEVEMENT			
BEHAVIOUR AND SOCIAL RELATIONSHIPS			
ATTENDANCE & PUNCTUALITY			
CONTACT WITH PARENTS / CARERS			
ANY SPECIFIC INCIDENTS OR MATTERS OF CONCERN			
ADDITIONAL INFORMATION REQUIRED			
CLASS TEACHER SIGNATURE		DATE	
DTCP SIGNATURE		DATE	

APPENDIX 9

CONFIDENTIAL

Incident Sheet

Name of Child _____ Date of Birth _____

Chronology of incidents and concerns

Date	Time	Location	Those Present

Notes of incidents / allegations or observation giving rise to concern.

Name _____

Designation _____

Signature _____

Date _____

Date received by designated teacher for inclusion in the Child Protection File _____

APPENDIX 10

CONFIDENTIAL

Meeting Record Sheet

Present: _____ Date _____

Name of Child _____ Date of Birth _____

General outline of Concerns

Issues discussed and action agreed:

Name _____

Designation _____

Signature _____

Date _____

Date received by designated teacher for inclusion in the Child Protection File _____

APPENDIX 11

RECORD OF CHILD PROTECTION MEETING & ACTION	
Name of Child:	
Year Group:	Date:
Purpose of Meeting:	
Those present:	
NOTES	
ACTION & BY WHOM	WHEN COMPLETED
Signature and Role of Person filling in form:	

Brent	**Health Partnerships Overview and Scrutiny Committee** 18th March 2014 **Report from the Assistant Chief Executive**
For Action	Wards Affected: ALL

Future of Central Middlesex Hospital and Willesden Centre for Health

1.0 Summary

1.1 Members of the committee will be aware that under the "Shaping a Healthier Future" reconfiguration of hospital services in North West London, there was some doubt as to the exact plans for Central Middlesex Hospital (CMH). This report outlines the proposals for the future services to be delivered at CMH. These proposals form the basis for the Strategic Outline Case which was approved by the SaHF Implementation Board on 27th February.

1.2 Under the SaHF plans, CMH will be a local and elective hospital. The site has been underutilised for some time and currently operates at around £11m a year loss. Part of the plans to address this include relocation of rehabilitation beds from Willesden Centre for Health, which would have an impact on the centre, effectively transferring vacant space from CMH to Willesden. Measures to mitigate these costs in conjunction with the other CCGs in North West London are still in discussion.

1.3 The key additional services now being proposed for CMH are:

- "Hub Plus" for primary care and community care services for Brent (including the relocation of rehabilitation beds from the Willesden Centre).
- Elective Orthopaedic Centre;
- Brent Mental Health Services: Transferred from Park Royal Centre for Mental Health;

- Regional Genetics Services: relocated from Northwick Park Hospital.

2.0 Recommendations

2.1 The committee is recommended to question officers on the viability of its plans and the timescale for their implementation, as well as on what contingency plans are in place in case any of the proposals (particularly the proposed transfers of services from other sites) do not go ahead.

2.2 The committee is further recommended to question officers on the options being discussed with other CCGs in NW London to mitigate the costs to Brent CCG of transferring patients from Willesden Centre to CMH.

Contact Officers
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Assistant Chief Executive
ben.spinks@brent.gov.uk

Mark Burgin
Policy and Performance Officer
mark.burgin@brent.gov.uk

Shaping a Healthier Future and Central Middlesex Hospital
Report for Brent HOSC on 18 March 2014

Executive Summary

This report provides Brent HOSC with a further update (previous written update of 28 January 2014) on the work taking place to review opportunities to resolve the future of Central Middlesex Hospital, to provide a sustainable long term solution.

1. Introduction

Shaping a Healthier Future (SaHF) set out a vision for the future of how services are delivered across North West London (NWL). This vision has been consulted upon, a recommendation has been approved and these proposals are now being implemented. However, this strategy was not intended to and has not resolved all the issues in NWL. An ongoing issue is Central Middlesex Hospital (CMH), which was an underutilised site before SaHF and remains so now, and will produce a financial deficit indefinitely if steps are not taken to resolve this. Work has now commenced to build upon the SaHF plans for Central Middlesex Hospital to be a local and elective hospital. As a local and elective hospital the services delivered at CMH are planned to include a 24/7 Urgent Care Centre (UCC), outpatients services, diagnostics, elective services and primary care. The proposed closure of the A&E department at CMH will mean that as a local and elective hospital, CMH will be supported by a level 2 intensive care unit and associated high dependency beds. Maximising utilisation of the CMH site has implications for the utilisation of sites in Brent, including Willesden Centre for Health, which is also included in the report and requires resolution.

2. The proposals & impact to patients

The intention is that a range of additional services will be provided at the CMH site to fully utilise this facility for the benefit of Brent and the NWL wide population, ensuring the long term clinically viable and financially sustainable future of CMH. A Strategic Outline Case (SOC) has been developed during January and February with a stakeholder workshop on 14 January to support the case for a range of additional services at the CMH site, a public engagement meeting on 19 February and Future of CMH Partnership Board on 25 February 2014. The plans provide Brent residents with additional and improved healthcare services as well as the relocation of some services already provided at other sites in Brent including the Willesden Centre for Health. Work is therefore also taking place to scope a range of additional services that can go into the Willesden Centre for Health as this is also an underutilised site in Brent and will become further underutilised if the rehabilitation beds and outpatient services at Willesden Centre for Health are moved to CMH.

Travel analysis on affected patient/carer journeys has been undertaken on the range of services affected and there are no significant impacts that would prevent the inclusion of the range of services being considered for CMH. Similarly, equalities impact consideration has highlighted no significant impacts that would prevent the range of services being progressed.

3. Decision making process and patient engagement

Following approval by the SaHF Implementation Programme Board on 27 February the SOC will be considered by the affected statutory organisations and providers during February and March with a view to agreeing to proceeding to Outline Business Case stage. The intention is to have the additional services in place on 6 March, 2015. See slide 7 for further detail on the decision making process.

A Brent stakeholder engagement session was carried out on 12 December and the feedback was very positive. A further public engagement meeting was held on 19 February. There was broad support for plans to put additional services onto the CMH site and to use the Willesden site to the full. A write up of 19 February event will be shared with HOSC in advance of the HOSC meeting.

The range of services being proposed now require focused patient and public engagement alongside further clinical and financial evaluation and we would like your views on how this should be approached. Any proposals developed into an Outline Business Case will be progressed subject to any necessary or appropriate consultation.

4. Importance of decisions

Financial evaluation and identification of the risk of the options including Willesden will be included in the paper to go to Brent CCG's Governing Body on 26 March 2014. The SOC is not yet available for inclusion in this paper. These papers will go into the public domain on Brent CCG's website on 19 March 2014. The potential cost to Brent CCG of increasing empty space at Willesden and the requirement to subsidise rental costs for new services at both CMH and Willesden is high. The CMH site currently runs at an annual loss of £10.8M and the impact of moving services from Willesden increases the underutilised space on that site. Brent CCG is pursing a number of initiatives to mitigate these potential increased costs to Brent, in partnership with NWL CCGs and providers as we expect the pressure to be absorbed across a number of organisations. Nonetheless the future decisions on CMH and Willesden have major service and financial considerations for Brent CCG and residents for many years to come.

5. Next Steps

The SOC will go through a formal approvals process through the affected statutory organisations during March. For Brent CCG the SOC will be presented to the Governing Body on 26 March (see slide 21 for SOC approvals process) and the papers will go into the public domain on Brent CCG's website on 19 March 2014.. If the SOC is supported by Brent CCG and the other statutory organisations support the SOC, then this work will proceed to Outline Business Case (OBC) stage. Each stage of the process (SOC, OBC, Full Business Case) will require formal approval and support through the statutory organisations (with assurance of the process as appropriate).

Throughout the process Brent CCG will engage with stakeholders and patients and public representatives to ensure that plans for services are tailored to the local population and an

effective outcome for patients is achieved. We would welcome views of Brent HOSC on the options and support and advice on engagement in this process.

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SaHF, Central Middlesex Hospital and Willesden Centre for Health

Update for Brent HOSC

18 March 2014

Introduction

- Provide an update on Shaping a Healthier Future (SaHF)
- Explain where we are in the process
- Outline proposals for Central Middlesex Hospital (CMH) – more services at CMH
- Highlight implications for Willesden Centre for Health and Care
- Hear views on our proposals
- Agree how to further engage during the development of this work

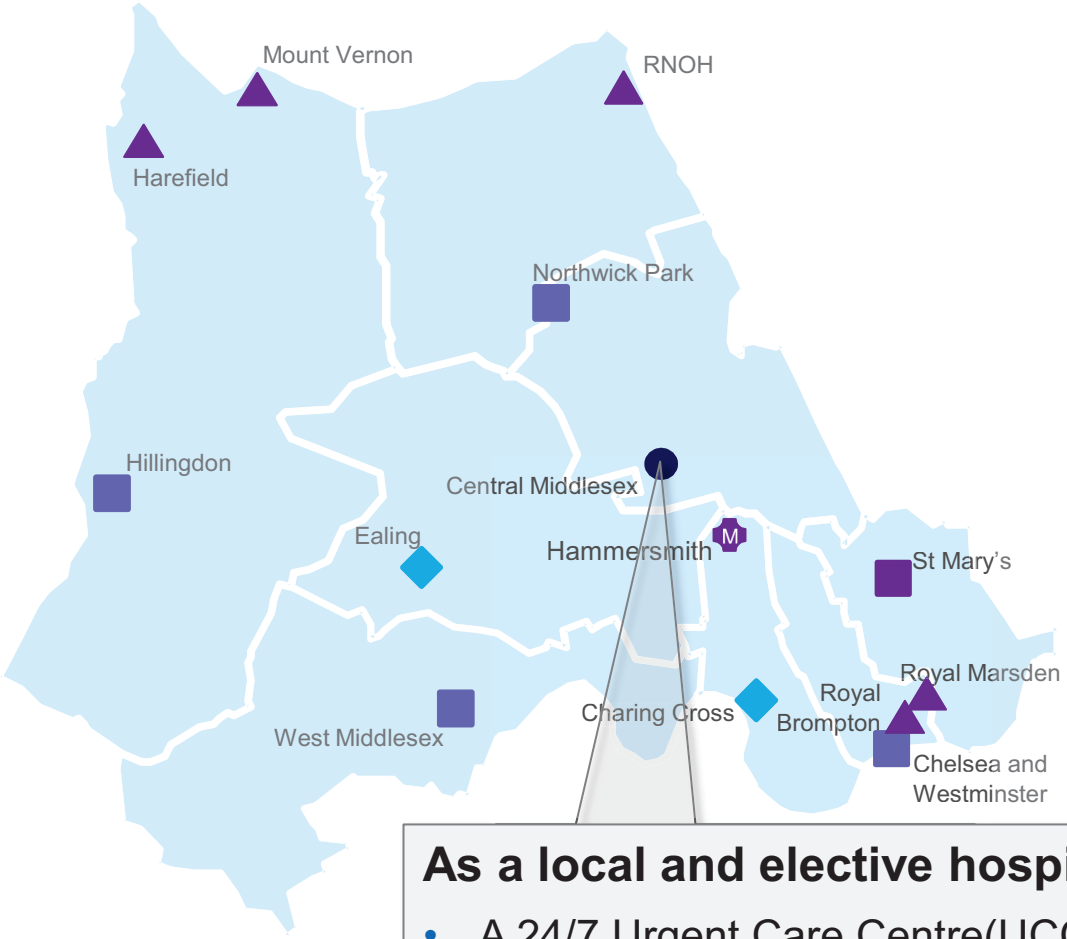
Shaping a healthier future – brief summary to date

- SaHF is a clinician led programme which set out to develop a vision for how we want health services to be developed and improved in NW London.
- Increasing care delivered closer to home will better coordinate services and improve quality. Concentrating major emergency services onto fewer sites, allowing consistent senior clinical support.
- Local services are being co-designed by clinicians and local residents around the specific needs of the population.
- A full public consultation ran from July to October 2012 where the team ran over 200 meetings, sent 73,000 consultation documents and received 17,000 responses
- In February 2013 the Joint Committee of Primary Care Trusts (PCTs) agreed the programme recommendations.
- The programme has also been successful in both a JR process and following a review by the IRP. In October 2013 the Secretary of State endorsed the IRP. This means we must proceed at pace to deliver better care for the 2 million people in NW London.

"***Changes to A&E at Central Middlesex*** *and Hammersmith hospitals should be implemented as soon as practicable*"

- Work is currently being progressed to plan service changes to ensure a safe transition of services for patients
- This includes consideration of:
  - *Ensuring neighbouring A&Es ready for transition*
  - *Central Middlesex and Hammersmith Urgent Care Centres operating to agreed North West London wide specifications*
  - *Emerging Emergency Service Review by Sir Bruce Keogh and Prof Willietts*
- We need to make these changes as soon as practicably possible, in line with the Secretary of State's decision
- Details of the changes to A&E services will be communicated appropriately with affected residents in advance of any change

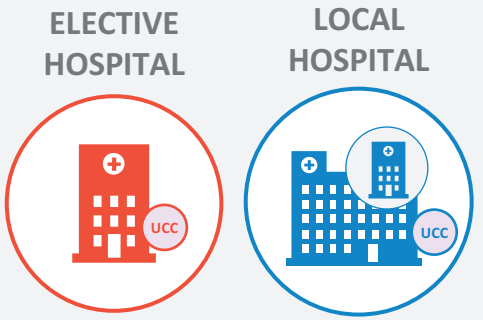
We are working to deliver changes to health



- Specialist hospital
- Local and Specialist hospital with obstetric-led maternity unit and UCC
- Local and Elective hospital with UCC
- Local and Major hospital with A&E and UCC
- Local and Major hospital and specialist eye hospital and Hyper Acute Stroke Unit with A&E and UCC
- Local hospital with A&E

As a local and elective hospital, CMH would have:

- A 24/7 Urgent Care Centre(UCC)
- Outpatients services
- Diagnostics
- Elective services
- Primary Care



Shaping a healthier future

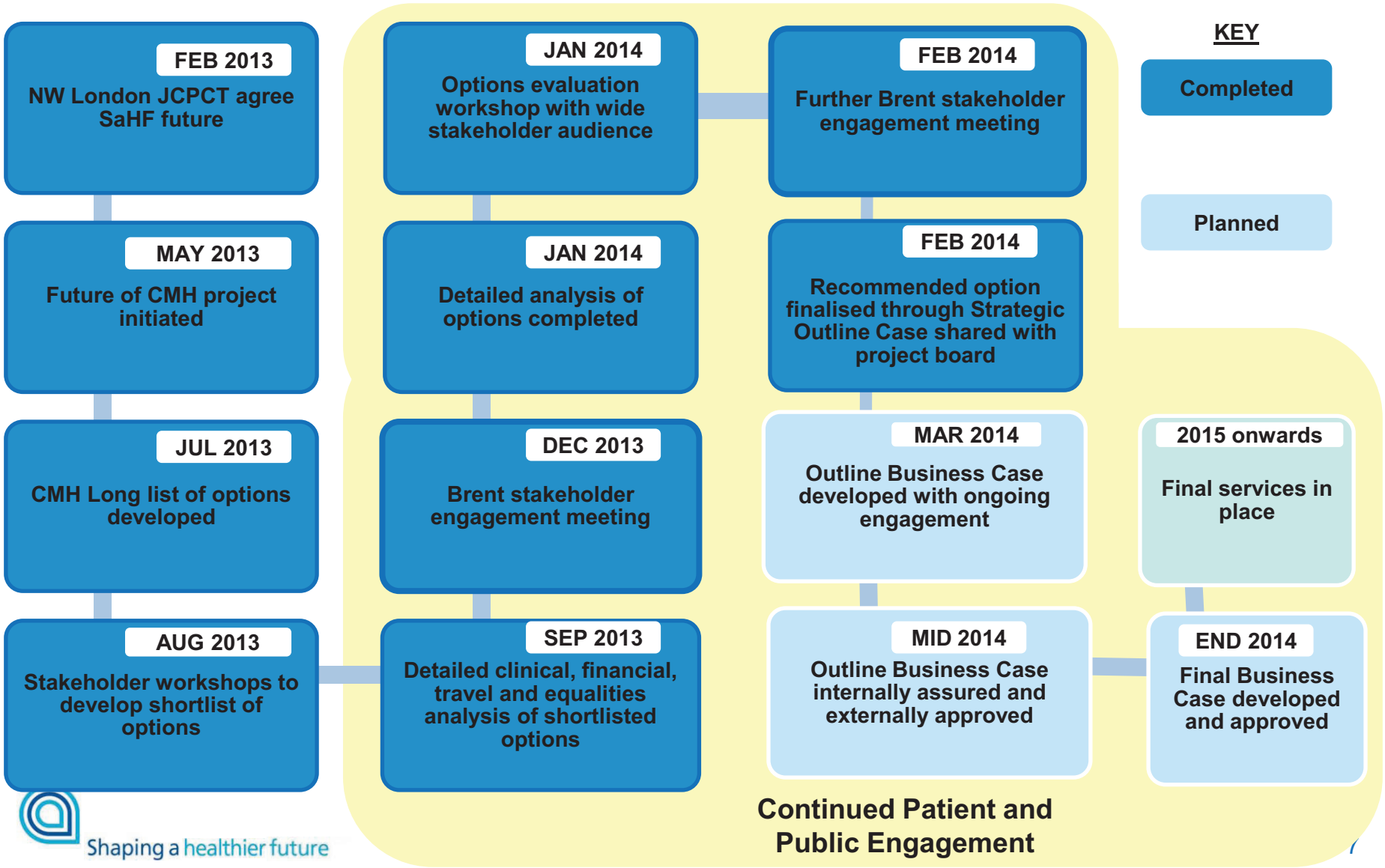
Future options for additional services at Central Middlesex

- *Good, but expensive premises, underused (usage circa 35%)*. Project set up to further develop local and regional services.
- The project has considered four key areas to allow evaluation of different services:

1. **Clinical evaluation** – quality of care, deliverability, research and education
2. **Estates and Finance Analysis** – affordability and value for money
3. **Transport Analysis** – access to care and impact of changed patient journeys
4. **Equalities Analysis** – any impact on protected patient groups

- We have also undertaken provider engagement across NWL to establish who would like to provide potential services on site.
- We are at the stage of being able to engage with the wider community to hear your feedback and input to these proposals.

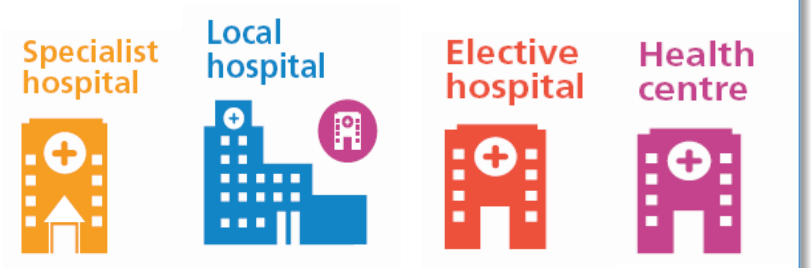
Process for developing a clinically viable and financially sustainable future for CMH



Three overall options have been considered for CMH

Option 1 — ***DMBC base case "no change" option**

Option 2 — **Bundle of additional Services from multiple providers on CMH site**

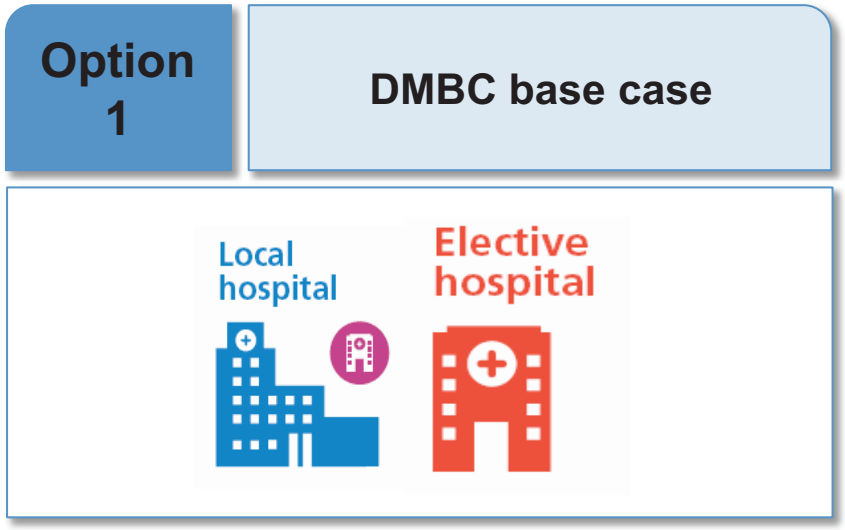


Option 3 — **Close and transfer services to other sites**

- Closure of the CMH site is considered to provide a comparator for the other options

*DMBC – decision making business case

Option 1 was insufficient in itself as it didn't fully utilise CMH

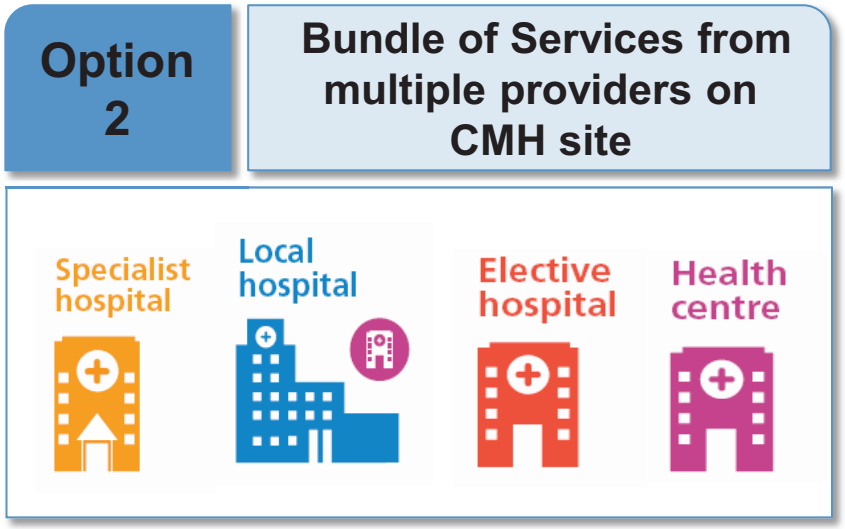


- Option 1 is the base case described in the DMBC.
- **Services would include:**
  - 24/7 Urgent Care Centre
  - Diagnostics
  - Acute and community outpatients
  - Elective inpatients and level 2 ITU
  - Hub facility for primary and community services

- only 35% of the site is utilised leaving the site running at an £11million recurring deficit
- Closure of the CMH site was considered to provide a comparator for quality as well as money

For these reasons Brent CCG have built on Option 1, as agreed by the JCPCT, to develop a sustainable option for the future

Option 2 considered a ‘long list’ of all the potential additional services that could be safely and practically provided at CMH



‘Bundle’ of services could include:

1. **Hub Plus for Brent** – using CMH as a major hub for primary and community services including 24/7 Urgent Care Centre.
2. **Elective Orthopaedic Centre** – a joint venture for local providers.
3. **Specialist Rehabilitation Services** moving from NPH.
4. **Rehousing Mental Health Services** from Park Royal Centre for Mental Health.
5. **Relocating some or all of St Marks Hospital**.

We clinically evaluated each of these options

1 Hub Plus for Brent

- CMH becomes a larger hub for primary and community care services, including General Practice, Urgent Care Centre, outpatients, diagnostics and intermediate care.
- This option has a sub-option of Hub 'Plus Plus' which includes Willesden rehabilitation beds
- The Hub ++ option has a greater impact as it uses more of the CMH estate and potentially increases quality more than Hub + and provides better support to inpatient rehab beds and allows the development of larger teams to support, orthopaedics, rehab and community services
- This option has an impact on the viability of Willesden Hospital and this will need greater assessment.

Evaluation Domain		Sub - domain	Estimate	Key reasoning
1	**Clinical Quality**	Clinical Quality	+	Rehab beds co-located with a wider range of services and support
		Patient Experience		
4	**Deliverability**	Workforce	+	Building larger team of AHPs on one site.
		Expected Time to Deliver	-	Reconfiguration at CMH cf. continued use of Willesden
		Wider Co-Dependencies	-	Creates vacancy at Willesden Site
5	**Research and Education**	Education and Research		

2 Elective centre for NW London

- After discussion it has been recommended that an orthopaedic centre similar to the South West London Elective Orthopaedic Centre (SWLEOC) be developed as a joint venture between Northwick Park, Ealing, St Mary's and Charing Cross (Imperial).
- Alongside the orthopaedic work SaHF includes current CMH elective activity and a proportion of the elective work that will move from Ealing Hospital. To reduce risk of infection this general surgical work should be separated from the orthopaedic work.
- The Orthopaedic centre should learn from and adopt the service delivery model from SWLEOC, requiring 24/7 consultant led HDU to enable rapid recovery, reduced complications and reduced LOS.

Evaluation Domain		Sub - domain	Estimate	Key reasoning
1	**Clinical Quality**	Clinical Quality	++	Dedicated elective care, with improved LoS, low infection and complication rate
		Patient Experience	++	Very high satisfaction of SWLEOC model
4	**Deliverability**	Workforce		Challenges of joint venture model
		Expected Time to Deliver	o*	Reconfiguration at CMH for EOC requires some rebuild
		Wider Co-Dependencies	+	Helps support NWL/EHT merger
5	**Research and Education**	Education and Research	+	SWLEOC undertakes considerable research and training

* The expected time to deliver was scored as o as it had already been considered in the DMBC and all scoring has been against those original proposals

3 Specialist Rehabilitation Services

- The Regional Rehab Unit (RRU) at Northwick Park is constrained by space and there are patients in more distant units and waits for admission. The unit is commissioned by Specialised Commissioning at NHS England. It is the only level 1 hyper-acute rehabilitation unit in London.
- The patients have complex needs. The National Guidelines for these services recommend they be located an acute hospital site. An audit of activity at the RRU showed a very wide range of inputs from diagnostics and specialists from the acute services at NPH.

Evaluation Domain		Sub - domain	Estimate	Key reasoning
1	**Clinical Quality**	Clinical Quality	--	The service needs substantial support from the acute hospital services
		Patient Experience	+	Greater space at NPH could reduce waits to enter the service
4	**Deliverability**	Workforce	-	Changes to this specialist unit would be likely to disruption to the workforce
		Expected Time to Deliver	-	Reconfiguration at CMH cf. continued use of NPH
		Wider Co-Dependencies	--	This would be in contradiction to the National Service Specification
5	**Research and Education**	Education and Research	-	The current unit is active in E&R

Because of the negative clinical evaluation the clinical review recommended that further evaluation of this option should not be pursued.

4 Mental Health Service transfer from Park Royal

- The Park Royal Hospital is almost adjacent to the CMH site, provided by CNWL FT. It contains a range of services and office facilities including a mother and baby unit, an acute assessment service and treatment wards. It has a small number of beds for low-security patients. Current accommodation does not comply with modern facility specifications.
- Re-locating services into CMH on the ground floor may be a cost effective option.
- CNWL are also considering developing a single pharmacy service for their range of services. If this were to be based at CMH then this service could also support the other services at the site.

Evaluation Domain		Sub - domain	Estimate	Key reasoning
1	**Clinical Quality**	Clinical Quality	+	Providing services in facilities that reach best standards will reduce risk and optimise care
		Patient Experience	+	Rebuilt mother+baby unit and modern pharmacy services
4	**Deliverability**	Workforce		
		Expected Time to Deliver	+	Reconfiguration at CMH would be quicker than a decant and rebuild at the current Park Royal site.
		Wider Co-Dependencies		
5	**Research and Education**	Education and Research		

5 Moving all or part of St Marks

- St Marks is a specialist gastroenterology hospital co-located with Northwick Park. It provides regional specialist diagnostics and services for inflammatory bowel disease, familial polyposis coli, and the full range of GI conditions. It also provides colorectal screening services.
- The service is currently constrained at the NPH site which limits the necessary expansion of the colorectal screening services for example.
- The surgical and medical teams provide clinical support to the general hospital (for example emergency endoscopy).

Evaluation Domain	Sub - domain	Estimate	Key reasoning
1 **Clinical Quality**	Clinical Quality	--	Co-dependencies with NPH acute service. Effective single MDT team with screening service. Acute GI admissions denied St Marks skills.
	Patient Experience		Specialist site hospitals typically score highly. Disruption of combined MDT will lower experience
4 **Deliverability**	Workforce	-	Duplication of key staff at both CMH and NPH
	Expected Time to Deliver	-	Reconfiguration at CMH cf. continued use of NPH
	Wider Co-Dependencies	+	Moving Screening services would allow expansion
5 **Research and Education**	Education and Research	-	St Marks research and teaching would be disrupted

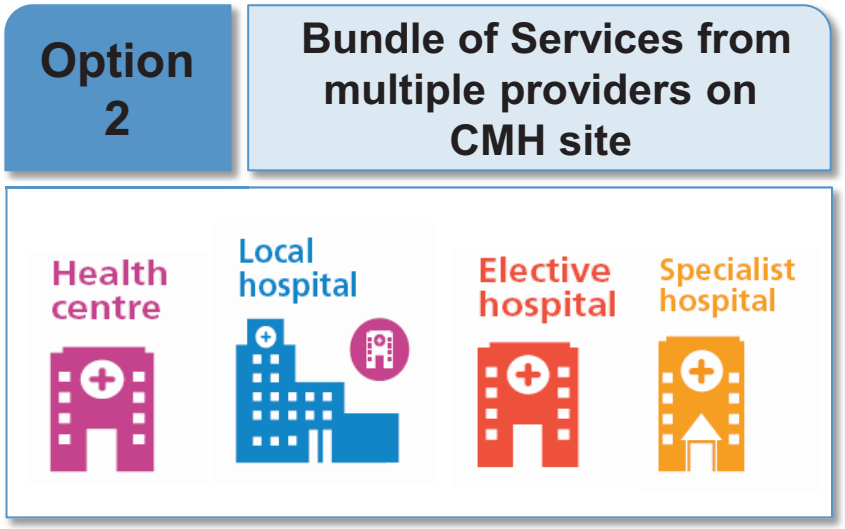
Because of the negative clinical evaluation the clinical review recommended that further evaluation of this option should not be pursued.

5b Relocation of Regional Genetics service from NPH to CMH

- This is a specialised service that provides outreach services across North West London and surrounding counties. It is supported by two laboratories which analyse samples from wide range of units. The labs are not interdependent with the general labs for NPH, which are provided by a private provider.
- The service needs a new IT infrastructure. This is not interdependent with other IT services at NPH.
- No co-dependencies with the acute service at NPH were identified.
- Moving the service from NPH would allow service lines to be developed at NPH.

Evaluation Domain		Sub - domain	Estimate	Key reasoning
1	**Clinical Quality**	Clinical Quality	+	Moving from NPH could allow other services to develop at that site
		Patient Experience		This is an outpatient service, mostly at distant sites.
4	**Deliverability**	Workforce		
		Expected Time to Deliver	-	Reconfiguration at CMH cf. continued use of NPH
		Wider Co-Dependencies		
5	**Research and Education**	Education and Research	+	New IT and labs would facilitate research.

The clinical evaluation resulted in an optimised proposed list of additional services that will make full use of CMH



- Together this uses CMH space and offers good local services.
- Needs significant investment, which is being detailed in the estates and finance workstream.

Hub Plus for Brent – major hub for primary care and community services including additional out-patient clinics and relocation and expansion of community rehabilitation beds from Willesden

+

Elective Orthopaedic Centre – a joint venture for local providers delivering modern elective orthopaedic services

+

Brent's Mental Health Services from Park Royal Centre for Mental Health

+

Regional genetics service relocated from Northwick Park Hospital

Shaping a healthier future

Impact of potential additional services at CMH

Hub Plus

- ✓ Improved quality – rehabilitation beds co-located with wider range of services and support
- ✓ More primary care and community services available on site
- ✓ Diagnostics services – improved direct access
- ✓ More out-patients clinics provided on site
- ✓ Co-located services support integration
- x Implication for Willesden Health Centre

Rehousing Mental Health Services

- ✓ Modern mental health facilities to ensure best practice care
- ✓ Improved mother and baby unit
- ✓ Shared pharmacy facilities between community acute and mental health

Elective Orthopaedic

- ✓ Dedicated planned/elective care with reduced length of stay and low infection and complication rate
- ✓ Proven model of care – SWLEOC receiving high patient satisfaction

Relocating regional genetics

- ✓ Moving lab services allows Northwick Park to expand major hospital services

Enhancing services on the CMH site has an effect on Willesden

- Willesden, as part of Brent CCG's out of hospital strategy is a hub, providing extended community services for South Brent.
- Under suggested proposals rehabilitation beds move to CMH, Willesden continues to offer
  - 2 GP practices (as today)
  - Locality hub for extended services including outpatients and diagnostics
- This creates opportunities for other services to move into the building – options currently being considered are:
  - Mental Health - consolidate Child and Adolescent Mental Health Services into a single (new) hub
  - Kilburn Square - community services relocation (mainly office space)
  - Static Breast Screening Unit - replacement of existing mobile service
  - Relocating some GP practices within a 1 mile radius (discussions underway with practices)
  - Non-traditional NHS services including voluntary sector
  - Commercial services

Evaluation agreement at Workshop 14th January 2014

1a. CMH full use & Willesden full use	**PREFERENCE 1**
1b. CMH full use & Willesden disposal	**REJECTED**
1c. CMH full use & Willesden partial use and partial disposal	**PREFERENCE 2**
2. CMH disposal	**REJECTED**

- The rank order was contingent on Willesden being able to be fully utilised
- Brent Clinical Commissioning Group will consider its preferred option for Willesden at a meeting of its Governing Body in March

Engagement with stakeholders

- GP Forum meeting 30th October 2013
- Equality, Diversity and Engagement Committee (EDEN) 27th November 2013
- Joint Health Overview Scrutiny Committee 3rd December 2013
- Brent Health Overview Scrutiny Committee 4th December 2013
- Brent stakeholder focus meeting 12th December 2013
- Brent Clinical Directors and Clinical Leads meeting 8th January 2014
- CMH Workshop 14th January 2014 – well attended by patient representatives
- Brent Health Overview Scrutiny Committee 28th January 2014 (Chairman deferred item to next meeting)
- Equality, Diversity and Engagement Committee (EDEN) 29th January 2014
- **Brent public engagement meeting *19th February 2014 - TODAY***
- Joint Health Overview Scrutiny Committee 20th February 2014
- Brent Health Overview Scrutiny Committee 18th March 2014
- ***Further events to be organised***

Feedback from 12th December stakeholder meeting

- Supportive of plans
- CMH offers good transport
- With this project having a tight timescale we need to ensure that it is delivered on time and avoid service quality being compromised
- Mental health treatment and care should be a key consideration for future CMH development
- The STARRS service provides excellent home based care

Feedback from 9th January meeting with Brent CCG Clinical Leaders

- Broad support for the proposals
- For many patients going to CMH and Willesden this would result in very little change from now, noting that many patients would choose to go to Wembley/Sudbury, CMH and Willesden for their outpatients and diagnostics appointments if the provider of choice was present on the sites
- Achievable if transport links could be improved for those patients closest to Barnet, NPH and Imperial
- Outpatients and diagnostics centre at CMH and other hubs would be successful if supported by effective Choose and Book, ie details of all services were available and waiting times were short
- Preference order of options for Willesden were:

  1. Maximise full use of site, if possible

  2. Fill site, as far as possible, and then partial dispose of part of site, if possible, so there is limited call on CCG funds to increase the cost of funding empty space at Willesden

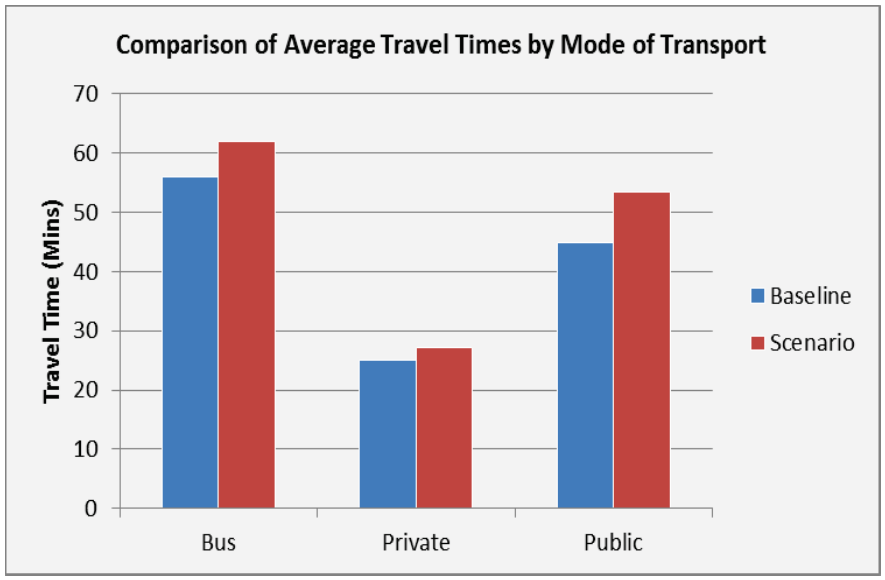
  3. Only in extremis to consider option of buying out the PFI site only if partial disposal is not possible and we cannot secure any new tenants to replace the wards. 2 primary care practices would need to be relocated in Willesden

Travel Considerations

Travel Conclusions:

- Only three options involve major shifts of treatment location
- A thorough analysis of journeys for the **Elective Orthopaedic Centre** option shows only small changes in journey times which, in our judgement, do not constitute a significant diminution of patient access
- Analysis of the major inpatient and outpatient flows in **Closure** option suggests that the average travel time is marginally improved which strongly suggests there are no new barriers to access in this option
- Analysis of the major flows relating to the **Brent Hub Plus** suggest that it also marginally improves the average patient journey time so cannot be considered to create significant access issues. A separate analysis may be required for routine GP activity based at Willesden and this is likely to require analysis of patient preferences not just activity.
- No other options require travel analysis

The changes in average travel times for those orthopaedic patients moving to CMH are not large

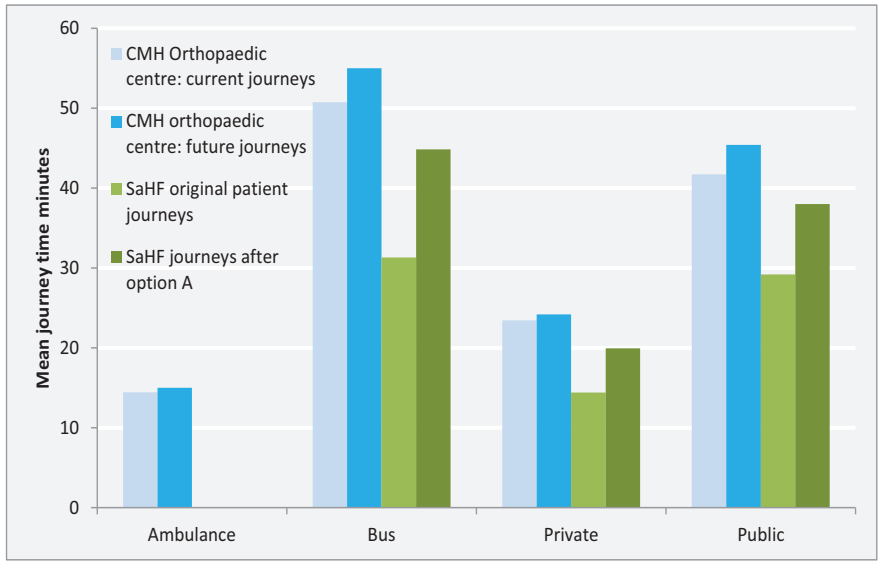


Our worst-case analysis takes the journey times of the patients to their current provider and compares it to the journey times to CMH. We test times for 3 key modes of transport, though in reality a mix of methods will be used (this has the advantage of being a worst-case for travel time).

Note that in some options for the Orthopaedic Centre at CMH, patient transport is provided by the centre so this analysis is irrelevant and there are no relevant issues potentially reducing patient access.

These are small changes in travel time and do not show significant affects on patient access.

Comparisons of orthopaedic centre option with the effect of SaHF changes shows the incremental change is much smaller



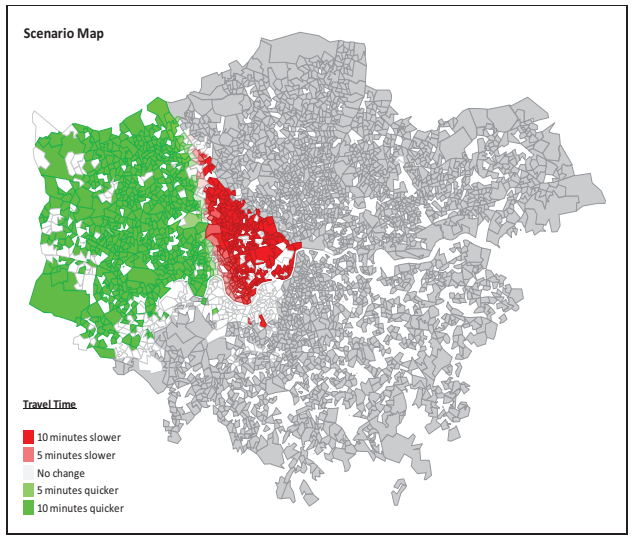
The changes of treatment location as a result of the original SaHF plans were not regarded as creating significant problems for patient access. We show here a comparison of the incremental changes in average journey times for the CMH orthopaedic option compared to the equivalent analysis for SaHF.

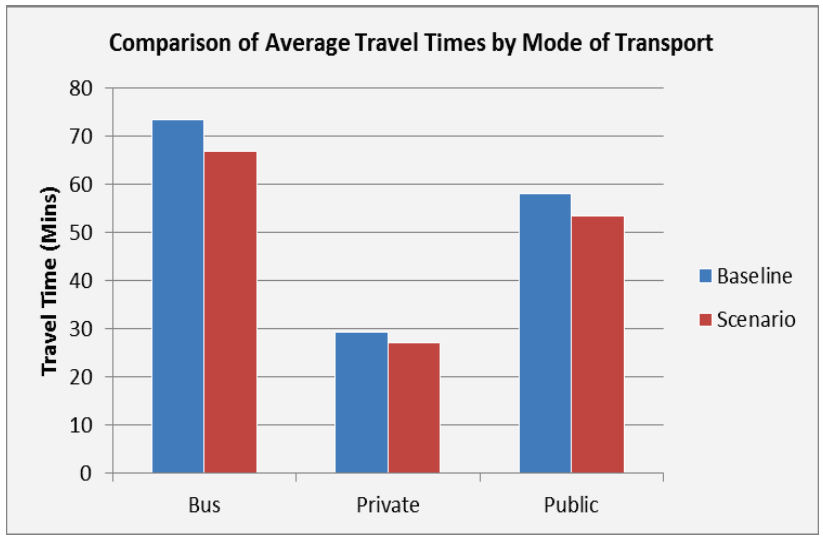
The average impacts can be seen to be much lower than the previous results which were themselves not though to be a significant barrier to access.

NB the SaHF results are not significant in the context of the average patient journey times before the changes. Calculations are not directly comparable and involve different locations and casemixes.

CMH primary care hub: travel times relating to significant activity *improve* with this option

Average travel times for most NWL population improve slightly and this is reflected in analysis of patient journeys

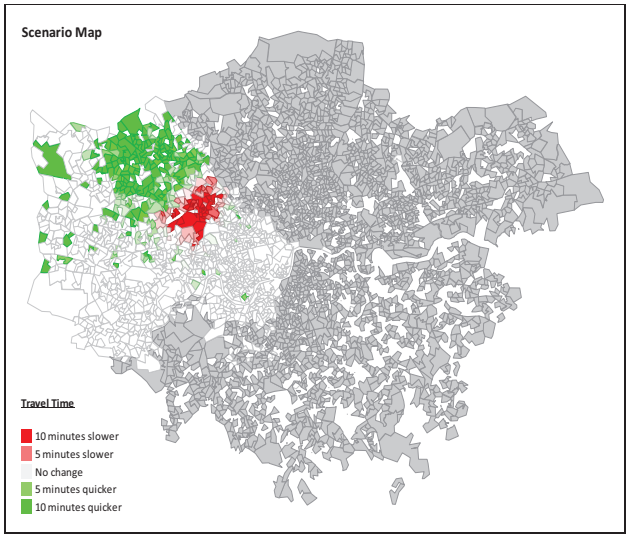


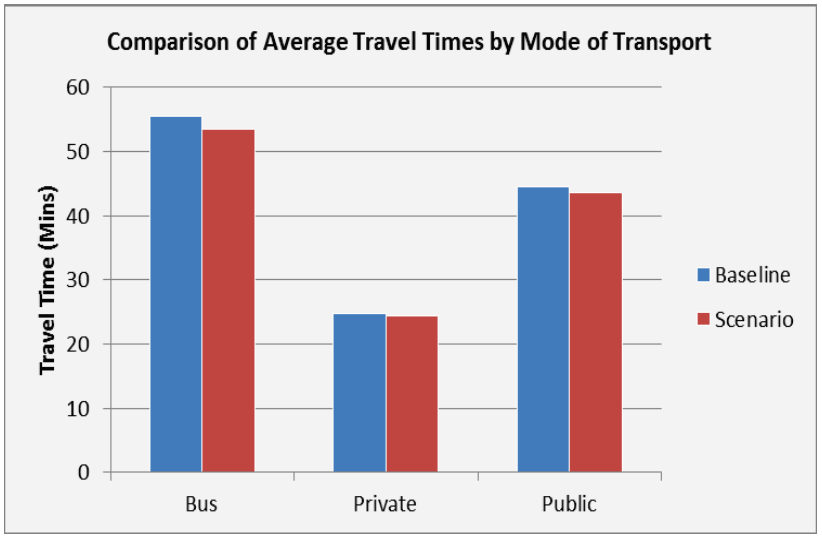


Simple interpretation of this shows that anyone who was closer to Willesden than CMH is now worse off but the vast majority would benefit from the shift.

Closure – Travel time change is marginally positive suggesting no new barriers to access are created by this option

The overall impact of closure option is small on average travel times and is marginally positive as, on balance, the locations of treatment are now closer to the resident location:





Detailed analysis shows that some patients living close to CMH have longer journeys but this is not a significant impact overall. Many individuals who live closer to Northwick Park but would have previously been sent to CMH could benefit if they are treated closer to home.

Next Steps

- No decisions made yet
- Identified potential solutions – strategic outline case (SOC)
- No firm decisions until Outline Business Case stage
- At outline business case stage further work will be undertaken to ensure any necessary or appropriate consultation and an equalities impact assessment
- Approval through statutory (responsible) organisations and the organisations potentially involved in delivering the services on the CMH site
- Further engagement will be planned and undertaken

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Brent	**Health Partnerships Overview and Scrutiny Committee** 18th March 2014 **Report from the Assistant Chief Executive**
For Action	Wards Affected: ALL

Redesign and Investment in Diabetes Services in Brent

1.0 Summary

1.1 Members will remember that, at the last committee meeting in January, it received a report that outlined the range of diabetes services provided in Brent. The committee requested that a follow up report be provided to this meeting with more details on the planned changes to the way diabetes services are delivered that were mentioned in the original report.

1.2 In response to the committee's request, this report outlines the rationale for changes in services. The redesigned services will focus on providing integrated care in a community setting in line with national and local guidance and priorities.

1.3 A subsidiary report is also attached, which provides an update on the Diabetes Task Group recommendations which were reported to (and approved by) the committee in February 2013.

2.0 Recommendations

2.1 The committee is recommended to consider the redesign of diabetes services in Brent and question officers on whether the measures proposed will be sufficient to address current needs and to address the continued increase in demands on diabetes services that is expected in the future.

2.2 The committee is further recommended to question officers on the progress that has been made in implementing the Diabetes Task Group recommendations.

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Report to HOSC on Proposed Redesign & Investment into Brent Diabetes Services Feb 2014

1.0 Purpose of the report

This report provides an update to Brent HOSC on proposed diabetes service redesign and focuses on the case for change in current services for people with diabetes in Brent and details the plan for the service redesign. The report also provides information on the Local Enhanced Service (LES) for provision of insulin initiation for Type 2 diabetes and covers the actual spend, the number of patients initiated and the number of practices providing this service.

2.0 Background

2.1 Case for change – National and Local Guidance

The residents of Brent have changing health needs, as people live longer and live with more chronic and lifestyle diseases, this places greater demand on primary and community care. Local acute providers continue to see an increase in demand for outpatient care which is putting pressure on services and increasing waiting times.

The objective of the community diabetes services is to ensure that resources are managed in a more co-ordinated way to deliver care which is timely and effective and available closer to home. This means optimising the role of general practice in delivering planned care and ensuring that specialist advice and input is used to good effect to support local clinicians in delivering the best outcomes for patients.

By supporting and enabling primary, secondary and community providers to work together more effectively there is an opportunity to avoid more ad hoc and reactive demand management of diabetes which risk storing up demand through short term initiatives to manage waiting times

2.2 Diabetes Prevalence in Brent

The table below sets out diabetes prevalence as the sum of diabetes mellitus (diabetes) Register (ages 17+) and represents actual GP recorded number of diagnosed diabetic patients. The recorded prevalence for Brent is 8.1 which is both higher than the national and London rate.

However Diabetes UK in October 2013 reported the prevalence of diabetes in Brent to be 10.5% the highest in the UK compared to a national rate of 7.4%. These figures take into account an estimate of undiagnosed diabetes in the population. The number of undiagnosed patients is currently being addressed by the NHS Health Check Programme for people 40yrs -74 years to identify those at risk.

Table 1: Prevalence of Diabetes for 2012-13

Population	No of diabetics register ages 17+	Prevalence
National (UK)	2,703,044	6.0%
London	418,346	5.8%
Newham	20,645	7.1%
Brent	22,097	8.1%

HSCIC (Health and Social Care Information Centre) QOF 2012-13 data

Table 2 - Distribution of Diabetes Registered Patients across Brent

Locality	Registered population age 17+	No of diabetics register age 17+	Prevalence
Harness	64,643	5,458	8.4%
Kilburn	63,072	3,861	6.1%
Willesden	41,100	3,020	7.3%
Wembley	42,732	3,899	9.1%
Kingsbury	61,313	5,859	9.6%
Totals	272,859	22,097	8.1%

HSCIC (Health and Social Care Information Centre) QOF 2012-13 data

2.3 Current Diabetic Specialist Nurse Staff Profile

Table 3 sets out a comparison of Brent and Newham Diabetic Specialist Nurses for the community integrated service teams.

Table 3: Current Diabetic Specialist Nurse Profiles

Location	Diabetic Specialist Nurses (DSN)
UK	587 DSNs – Diabetes UK Survey 2010
London	Information not available
Brent	1 WTE Consultant Diabetic Nurse 2 WTE DSNs 1 WTE Paediatric DSN (funding provided to NWLH)
Newham	0.8 WTE Adolescent and young adult DSN(16 -25 years) 5.2 WTE Adults>25 years old 1 WTE Paediatric DSN 0.5 WTE Team leader

2.4 Brent & Newham Comparison of Care Processes

The National Diabetes Audit (NDA) 2011-12 presents key findings for CCGs on achievements of the 8 National Institute for Health and Care Excellence (NICE) key care processes of diabetes care. The recommended care processes are annual checks for the effectiveness of diabetes treatment for HbA1c control, cardiovascular risks and detection of emergence of early complications. Tables 4 and 5 set out the completion rates for Brent and Newham as our statistical neighbour.

Table 4: Percentage of patients in NHS Brent CCG & England and Wales receiving NICE recommended care process, diabetes type and audit year

		All diabetes[a]			Type 1			Type 2		
		2009-2010	2010-2011	2011-2012	2009-2010	2010-2011	2011-2012	2009-2010	2010-2011	2011-2012
HbA1c[b]	CCG/LHB	91.6%	91.3%	90.6%	85.7%	84.1%	83.6%	92.5%	92.2%	91.4%
	England & Wales	92.1%	92.5%	90.3%	85.7%	86.0%	83.0%	93.2%	93.5%	91.3%
Blood pressure	CCG/LHB	94.8%	94.7%	94.5%	89.6%	90.8%	89.5%	95.3%	95.1%	94.9%
	England & Wales	95.2%	95.0%	95.0%	88.9%	88.7%	88.4%	96.1%	95.9%	95.8%
Cholesterol	CCG/LHB	91.7%	91.1%	90.1%	82.9%	82.3%	80.8%	92.4%	91.8%	90.8%
	England & Wales	91.7%	91.6%	90.9%	79.1%	78.8%	77.8%	93.2%	93.1%	92.4%
Serum creatinine	CCG/LHB	92.5%	91.9%	91.5%	84.4%	83.2%	82.3%	93.2%	92.6%	92.2%
	England & Wales	92.5%	92.5%	92.5%	81.0%	81.2%	81.1%	93.9%	93.8%	93.8%
Urine albumin[c]	CCG/LHB	81.5%	81.0%	80.3%	69.9%	69.5%	68.5%	82.9%	82.3%	81.4%
	England & Wales	72.3%	75.1%	76.0%	56.2%	58.4%	59.2%	74.3%	77.1%	77.9%
Foot surveillance	CCG/LHB	85.3%	84.7%	86.2%	77.5%	76.8%	78.1%	86.5%	85.9%	87.2%
	England & Wales	84.1%	84.3%	85.3%	71.7%	71.5%	72.8%	85.9%	86.1%	87.0%
BMI	CCG/LHB	87.9%	89.5%	90.2%	83.3%	84.7%	86.1%	88.5%	90.2%	90.8%
	England & Wales	90.1%	89.9%	90.3%	83.6%	83.4%	83.7%	91.1%	90.8%	91.3%
Smoking	CCG/LHB	84.8%	82.6%	81.6%	78.7%	75.8%	77.6%	85.3%	83.2%	82.0%
	England & Wales	86.9%	84.8%	85.1%	80.8%	78.6%	79.0%	87.7%	85.7%	85.9%
Eight care processes[d]	CCG/LHB	65.6%	65.1%	64.0%	53.7%	50.9%	51.1%	67.0%	66.6%	65.1%
	England & Wales	59.4%	60.6%	60.5%	42.4%	43.3%	43.2%	61.6%	62.8%	62.6%

[a] All diabetes includes maturity onset diabetes of the young (MODY), other specified diabetes and not specified diabetes.

[b] For patients under 12 years of age, 'all care processes' is defined as HbA1c only as other care processes are not recommended in the NICE guidelines for this age group.

[c] There is a 'health warning' regarding the screening test for early kidney disease (Urine Albumin Creatinine Ratio, UACR) but we believe that this does not concern NHS Brent CCG.

[d] The eye screening care process has been removed from this table; therefore 'eight care processes' comprises the eight care

Source: National Diabetes Audit 2011-2012 Report 1: Care Processes and Treatment Targets – NHS Brent CCG

Findings

- In 2011-12 Brent achieved > 90% in 5 of the key processes for diabetes Type 2 patients
- In 2011-12 Brent achieved 70% - 90% for 3 of the key processes for diabetes Type 2 patients
- In 2011 -12, urine albumin was the most poorly recorded care process in Brent at 81% however this is higher than the rate of 78% for England & Wales
- For the 8 care processes combined Brent achieved 65%

Table 5: Percentage of patients in NHS Newham CCG & England and Wales receiving NICE recommended care process, diabetes type and audit year

		All diabetes[a]			Type 1			Type 2		
		2009-2010	2010-2011	2011-2012	2009-2010	2010-2011	2011-2012	2009-2010	2010-2011	2011-2012
HbA1c[b]	CCG/LHB	91.9%	92.2%	91.7%	82.2%	79.8%	78.8%	92.6%	93.1%	92.4%
	England & Wales	92.1%	92.5%	90.3%	85.7%	86.0%	83.0%	93.2%	93.5%	91.3%
Blood pressure	CCG/LHB	96.2%	95.6%	95.2%	89.5%	88.8%	89.7%	96.6%	96.1%	95.5%
	England & Wales	95.2%	95.0%	95.0%	88.9%	88.7%	88.4%	96.1%	95.9%	95.8%
Cholesterol	CCG/LHB	92.3%	91.5%	91.0%	73.1%	69.1%	67.9%	93.2%	92.7%	92.0%
	England & Wales	91.7%	91.6%	90.9%	79.1%	78.8%	77.8%	93.2%	93.1%	92.4%
Serum creatinine	CCG/LHB	92.9%	92.4%	92.3%	76.1%	74.0%	73.1%	93.8%	93.4%	93.2%
	England & Wales	92.5%	92.5%	92.5%	81.0%	81.2%	81.1%	93.9%	93.8%	93.8%
Urine albumin[c]	CCG/LHB	82.2%	82.5%	82.3%	58.7%	59.3%	56.0%	83.5%	83.9%	83.6%
	England & Wales	72.3%	75.1%	76.0%	56.2%	58.4%	59.2%	74.3%	77.1%	77.9%
Foot surveillance	CCG/LHB	88.9%	88.9%	89.1%	72.5%	74.4%	71.3%	89.9%	90.0%	90.1%
	England & Wales	84.1%	84.3%	85.3%	71.7%	71.5%	72.8%	85.9%	86.1%	87.0%
BMI	CCG/LHB	93.7%	93.2%	93.7%	88.7%	87.7%	87.4%	94.1%	93.7%	94.1%
	England & Wales	90.1%	89.9%	90.3%	83.6%	83.4%	83.7%	91.1%	90.8%	91.3%
Smoking	CCG/LHB	92.3%	92.1%	92.1%	86.3%	82.6%	82.6%	92.7%	92.7%	92.6%
	England & Wales	86.9%	84.8%	85.1%	80.8%	78.6%	79.0%	87.7%	85.7%	85.9%
Eight care processes[d]	CCG/LHB	74.3%	75.7%	73.7%	49.4%	47.7%	45.0%	75.8%	77.3%	75.1%
	England & Wales	59.4%	60.6%	60.5%	42.4%	43.3%	43.2%	61.6%	62.8%	62.6%

[a] All diabetes includes maturity onset diabetes of the young (MODY), other specified diabetes and not specified diabetes.

[b] For patients under 12 years of age, 'all care processes' is defined as HbA1c only as other care processes are not recommended in the NICE guidelines for this age group.

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[d] The eye screening care process has been removed from this table; therefore 'eight care processes' comprises the eight care processes that are listed above.

Findings

- In 2011-12 Newham achieved > 90% in 7 of the key processes for diabetes Type 2 patients
- For the 8 care processes combined Newham achieved 75%

Overall Brent is behind Newham by 10% for the 8 care processes combined the highest differences being; smoking, foot surveillance and Body Mass Index (BMI). In consideration of the variation in Brent for each of the 8 care processes it is recommended that an action plan to improve one or two of the poorer care processes be undertaken.

2.4 Prevalence of Complications

Table 6 provides a comparison of additional risk of diabetic complications, comparing Brent against England and Newham.

Table 6: Benchmark of prevalence of complications

Clinical complication	England (%)	Newham (%)	Brent (%)
Angina	76	59	59
Myocardial Infarction	55	42	36
Heart Failure	74	60	57
Stroke	34	10	30
Renal Replacement Treatment	164	103	133
Minor amputations	337	189	113
Major amputation	222	100	41
Mortality rates	38	6	19

Source: National diabetes audit 2011/12
http://www.yhpho.org.uk/diabetescommunityhealthprofiles/default.aspx

The data shows the following key points:

- Brent compared to England has better outcomes for all 8 key additional risk of diabetic complications.
- Brent compared to Newham performs better in 4 out of 7 key risk areas of diabetic complications
- Brent compared to Newham has poorer outcomes in 3 out of 7 risk areas and have the same additional risk for angina

The redesigned pathway in Brent aims to improve all the areas of additional risk of complications and will drive up performance in areas where we compare unfavourably with Newham as our statistical neighbour.

3.0 Planned Changes to Brent Diabetes Services

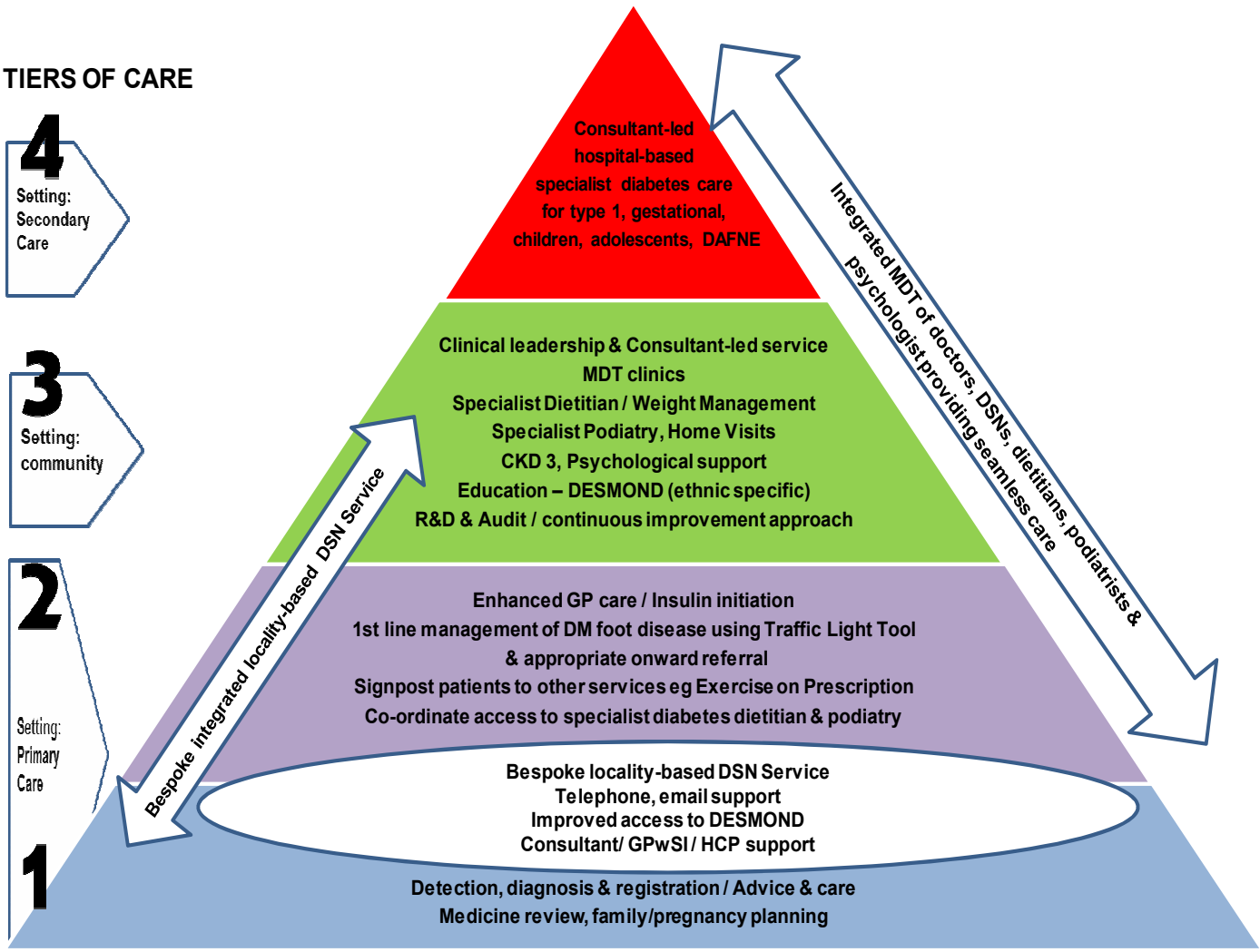
The model is proposed as a sustainable way of delivering high quality care integrated diabetic care in community settings for patients with type 2 diabetes except for those with very complex needs. DSNs will be located in the localities and in addition to holding a caseload will also provide greater clinical support to practices in terms of providing education to GPs, practice staff, patients, carers and nursing homes.

This model of care builds on the current model, in which the majority adult patients, both newly diagnosed and those requiring long term monitoring, are seen and treated in the community. Some complex patients, for example those seen in joint

specialty clinics such as gestational diabetes will continue to be seen in hospital settings.
The redesigned service will be based on the following principles:

- Early detection and identification
- Individuals with diabetes at the centre of their care and treatment
- Patients involved in the decisions around personalised care planning
- Develop patient knowledge, skills and confidence for better self-management
- Integration of care
- Quality assurance, evaluation and monitoring
- Targeting high risk populations
- Tiers of care relating to primary, intermediate and secondary provisions
- Prevention and diagnosis of patient groups with particularly complex needs
- Robust monitoring, evaluation, audit and satisfaction surveys to assess clinical effectiveness and improved patient experience

Table 7: Brent Diabetes New Integrated Pathway Service Model



The diabetes service for Brent aims to achieve and deliver the strategic objectives set out in NHS Brent's CSP and QIPP Plans. The new model of service will ensure that:

- Improved clinical outcomes as a result of timely access and better coordination of care around the patient
- Primary care clinicians have a framework for providing Tier 1 and 2 services
- Brent CCG have robust data to monitor the performance of providers to improve health outcomes for patients with diabetes and reduce the variation in care across primary care localities
- The level of expertise across primary care is increased which will enable a reduction in services duplicated across primary care, community and secondary care
- Primary care services are incorporated within a locality clinical network to improve access and outcomes
- Patients will be offered dedicated diabetes education packages to help them to understand and manage their condition.

3.1 Interventions

All patients (22,097) receive their basic care in tier (tier 1) in primary care and many patients requiring tier 2 care are also managed in primary care. Patients step up and down through the tiers according to clinical needs. Table 5 below describes the interventions in the various settings of care. All care settings contribute to collaborative care planning and will be evaluated to ensure improved outcomes.

Table: 8 Pathway Interventions

Brent Community Services Diabetes Care - Interventions			
Tier 1	Tier 2	Tier 3	Tier 4
GP Essential Care Managed at GP Practice	GP Enhanced Care Managed at GP Practice	Ealing ICO Community Services Managed in Intermediary Care	Specialist Care Managed in Secondary Care
Supports and develops essential care, including: • Detection, diagnosis, register maintenance; • Patient education programmes e.g DESMOND • Dietary advice • Personal care planning; • Medicines review • Complications screening; • Patient and carer advice/education • Family planning and initial pregnancy planning advice • Where necessary co-ordinate access to: specialist diabetes dietetics & podiatry; • Telephone and email support. Retinal Screening Refer NEW patients to Brent Screening Programme	**Deliver and co-ordinate**: • Patient education programmes (DESMOND); • Access to insulin initiation and new therapies if appropriate; • Or Insulin initiation • Joint clinics; • Specialist diabetes dietetics • Psychological support; • Podiatry. • • Access to specialist opinion when needed. • Telephone and email support.	**Deliver and co-ordinate**: • Multidisciplinary clinics; • Consultant-level support; • Access to specialist diabetes dieticians, • podiatrists or other specialists; • Patient education; (DESMOND) • Insulin titration; • Family planning and pregnancy planning advice. • Psychological support; • Research and development, and training; • Professional training & education • House bound for Home visit by DSN * poor glycaemic control & related co-morbidities Referral to Tier 4 At discharge all patients will have: • Care plan modified / updated. • Insulin Titration formulated	**Deliver and co-ordinate:** • Joint clinics; • Foot/Kidney services; • Children and Adolescent services; • Care and Education for people with Type 1 diabetes; • Insulin titration • Patient education; (DAFNE) • Patients with complex multiple co-morbidities • Research, Development, and training; • In-patient management. • Adolescent/ Transition into adult services Antenatal • Complex multiple co-morbidities • Podiatry –Grade 3

3.2 Service Model

The service shall offer multi-disciplinary community clinics which will comply with best practice outline in the Healthcare for London Standardised Diabetes Care Model. The service redesign incorporates the following key elements:

3.2.1 Service Description

The Service shall support each CCG Locality to establish Tier 2 diabetic clinics in the GP practice and locality-based Diabetes Network – primarily by providing DSN and GP with Special Interest (GPwSI) advice and support. Each locality shall have a named DSN providing this support. In addition the service shall support each Locality to develop NICE compliant care plans for all diabetics with a time line to review and update individual Care Plans

3.2.2 Joint Consultation Clinics

The Provider shall initiate monthly Joint Consultation Clinics which will be done through identified need and planned sessions within each locality. Practice patients with diabetes will simultaneously consult a primary care clinician and a service clinician as defined by the practice. Increasingly this will be the vehicle through which most patients with complex diabetic presentations are managed.

3.2.3 The Link Clinician Service

The Service shall allocate a named DSN – the 'link clinician' to each GP practice in the CCG. There is a requirement that each locality DSN attends a monthly meeting with the locality Diabetes lead for support and advice. The Link Clinician shall offer joint case note reviews for all patients on the practice's diabetic patient list and subsequently offer advice on a management plan.

3.2.4 Home Visits

The Service shall offer a clinically equivalent service to housebound patients including the following cohort of patient:

- Patients receiving end of life care
- Patients with very complex needs who requires an assessment visit to their home
- Patients with poor engagement in diabetes care and poorly controlled diabetes.
- Patients who may require short term case management to improve control and improve patient compliance.

3.2.5 Self-Care, Patient and Carer Information and Patient Education

The Service shall adhere to the principles of empowering self-care and collaborative care planning and will be reflected in the written care plans, which will be expressed in a form the patient can engage with and use.

Letters will be addressed to patients and copied to GPs after each significant engagement with any clinician from the Service; to inform them of the outcomes, along with their test results.

The provider shall make information available in various formats such as audio, Braille and in suitable other languages.

The Service shall deliver DESMOND programmes at suitable locations around Brent, reflecting the prevalence in each locality. Inclusion of pre-conceptual and Pregnancy advice in the DESMOND educational programmes

4.0 Increased workforce Capacity of Proposed Model

In order to deliver an integrated care pathway resulting in improved outcomes the proposal is to increase clinical capacity and capability which requires a significant investment sum of £638,993 on top of the existing costs of £391,095.

Table 9: Outline of Diabetes Pathway Costing

POST	BAND	CONTRACTED WTE	NEW COST	EXISTING
PAY				
Consultant Physician	Diabetologist/Endocrinologist	0.50	£68,000	£56,112
Diabetes Nurse Consultant	AfC Band 8c	1.00	£79,898	£74,682
Operational Manager	AfC Band 8a	1.00	£64,868	£1,812
Clinical Psychologist	AfC Band 8a	0.50	£32,434	
Diabetes Nurse Practitioners	AfC Band 7	4.00	£226,563	£106,171
Diabetes Nurse - DESMOND	AfC Band 6	1.00	£49,045	
Dietician - DESMOND	AfC Band 6	1.00	£49,045	
Administrator	AfC Band 3	1.00	£28,622	
Lead Administrator	AfC Band 4	1.00	£30,574	£30,574
Nutrition and Dietetics	AfC Band 7	1.00	£56,640	
Podiatrist	AfC Band 7	1.00	£56,640	
GPwSI Support to the Pathway				
Pharmacist				
TOTAL PAY			**£742,329**	**£269,351**
TOTAL NON-PAY			**£89,000**	**£16,327**
Pay and non-pay total		**13.00**	**£831,329**	**£285,678**
TOTAL ESTATES & OVERHEADS			**£198,759**	**£105,417**
GRAND TOTAL			**£1,030,088**	**£391,095**

5.0 Key Measurable Outcomes

Delivery of the service will continue be measured via a system of Key Performance Indicators (KPI) and includes the following measures:

- Improved Clinical Outcomes for e.g. Better HbA1c control
- Reduction in hypoglycaemic episodes
- Reduction in hospital admissions and A&E attendances
- Improved Self Care
- Increased engagement with Primary Care
- Improved capability within Primary Care
- Improved access to Podiatry
- Improved patient experience
- Reduce the complications of diabetes
- Increase the management of more complex patients across primary care
- Reduce demand on secondary care

- Deliver psychological support to support compliance to treatment and self-care#
- Reduction in avoidable admissions
- To improve self-management a 100% of newly diagnosed diabetic patients to be offered DESMOND and a maximum wait for patients of 4 weeks.
- Increased uptake of annual diabetes Health Check and Patient Satisfaction Survey

6.0 Diabetes Insulin Local Enhanced Services (LES)

The Diabetic Insulin Local Enhanced scheme (LES) was rolled out across Brent in April 2012 and supports integrated diabetic care delivered in primary care. With 22,000 + diabetic patients in Brent it is crucial that practices are skilled in initiating insulin therapy. This is in line with the CCG vision to provide care as close to patients as possible and increase the role of primary care in both the management and self-management of people with chronic diseases.

Traditionally insulin conversion has been undertaken in hospitals. However, with both diabetes and other chronic conditions, there is a move to provide care as close to patients as possible and therefore increasing the role for primary care in the management of diabetes.

Across Brent there is variation in practices providing tier 1, tier 2 and tier 3 services and there are also differences in practices use of intermediate and secondary care diabetic services. One way of improving care across all practices is by education and further training for staff in the delivery of insulin initiation.

For poorly controlled diabetics on tablets insulin or other injectables would be the next step in treatment. With the increasing prevalence of diabetes, the numbers requiring insulin will also increase. To address this there is a need for primary care to retain and develop expertise in insulin initiation. This is accepted as good practice and fairly well implemented across the country.

Insulin initiation is complex and there are a number of steps involved. Patients are started on a low dose and this is built up slowly requiring close monitoring and intense patient education. Insulin dose titration is a skill that can be developed by experience and education in primary care.

6.1 Injectable Treatments for Diabetes

Injectable treatments such as Insulin, Exenatide, Liraglutide are increasingly being used to improve diabetes control to prevent diabetes long term complications therefore ideally many more patients should convert to injectable treatments. For 2012, it was projected that approximately 15,000 diabetics may require injectable management the majority of which will require insulin.

6.2 Brent Insulin Initiation Activity and Spend

Currently GP practices receive a payment of £100 per patient initiated, £30 per follow up appointment – up to a maximum of 7 appointments. Practices delivering the service (host) on behalf of non- participating practices receive a payment of £200 for insulin initiation or £50 if the patient is referred but does not require insulin to cover costs.

Table 10: Activity and Spend 2012/13

Quarter's	Claim	Number of Practices	Number of Start 'ups'	Number of follow 'ups'	Hosted not initiated
Q1 Apr – June	£6,470	12	27	109	10
Q2 July - Sept	£6,610	12	28	92	21
Q 3 Oct - Dec	£210	1	0	7	0
Q 4 Jan – Mar	£9,750	15	42	150	21
Total	**£23,040**	**40**	**97**	**358**	**52**

Findings:

- For 2012/13 - £23,040 was claimed by practices
- The number of practices claiming per quarter ranged from 12 – 15
- There is a disparity between the number of practices (41) who report they are providing the service to the number actually claiming for initiation each quarter

Table 11: Activity and Spend 2013/14 up to Q3

Quarter's	Claim	Number of Practices	Number of 'insulin start ups'	Number of follow ups	Hosted not initiated
Q1 Apr – June	£6,980	12	23	131	15
Q2 July - Sept	£4,760	9	15	92	10
Q3 Oct - Dec	£6,450	11	26	120	5
Totals	**£18,190**	**32**	**64**	**343**	**30**

Findings:

- Up to Q3 - £18,190 was claimed by practices
- The number of practices claiming per quarter ranged from 9-12

- There continues to be a disparity between the numbers of practices who report they are providing the service to the number actually claiming for initiation each quarter. An audit will be undertaken with recommendations to improve activity across Brent.

Table 12: Insulin initiation by locality & practice 2012 -2014

Locality	QTR 1 – Apr – June 2012
Harness	Oxgate Gardens Wembley Park Medical Centre Church End Medical Centre Brentfield Medical Centre The Surgery The Stonebridge Medical Centre Acton Lane Surgery Hilltop
Kilburn	The Law Medical Centre Lonsdale Medical Centre Kilburn Park M.C. Chamberlyne Road Surgery Staverton Windmill
Kingsbury	Chalkhill Medical Centre Premier Medical Centre Fryent Medical Centre Willow Tree Family Doctors Stag Lane Medical Centre Forty Willows Primary Care Kenton
Wembley	Preston Medical Centre
Willesden	Burnley Road Practice Gladstone Medical Centre St Georges Medical Centre St Andrews Medical Centre Neasden Medical centre

The above table gives a list of practices across Brent who have submitted claims for insulin initiation and does not necessarily represent actual activity as some practices may not have claimed.

7.0 Local Target For Identification of Chronic Kidney Disease (CKD)

According to the East Midlands Public Health Observatory (EMPHO) on behalf of NHS Kidney Care; in England in 2008/09 there were 1,739,443 people aged 18 and over who were registered with CKD (stages 3-5). This represents an overall crude (not adjusted for age) proportion of 4.1% in the 18 and over age group. The QOF prevalence only represents the people who have been detected and registered as having CKD, the actual prevalence will be higher.

The prevalence of kidney disease in diabetics is high and for Brent CKD prevalence as measured in Quality Outcomes Framework (QOF) is lower than expected at 2.2%.. Brent CCG has identified this as a local target for improvement and practices will be encouraged to improve detection rates to 2.7% for micro- albuminuria in

diabetics, improve rates of CKD stage 3 and above and treating these patient with the relevant drugs as appropriate.

8.0 Conclusions

There are changing health needs and demands in the population of Brent. We have seen an upward trend over the last four years in the number of recorded diagnosed diabetics and as highlighted by Diabetes UK's estimated prevalence (10.5%) there is a significant number of undiagnosed diabetic patients.

The increase in diabetes is being fuelled by: the ageing of the population, increasing rates of obesity and the high proportion of black and Asian ethnic groups in the borough who are more susceptible to diabetes.

Given that the prevalence of diabetes in Brent is projected to rise even higher Brent, CCG recognises that there is increasing demand on services and there is a need for additional investment in improving services in the community. The investment is intended to increase clinical capacity to improve the health outcomes for people with diabetes. This will enable early diagnosis, improved access to education programmes; deliver integrated care and reduce variation in care across Brent.

The reported risk of diabetic complications (National Diabetes audit) shows that Brent compares favourably to England. When compared to Newham, Brent performs better in 4 of the key risk areas of diabetic complications. Brent has 3 identified risk areas that are higher than Newham in particular stroke and this may need further investigation in terms of triangulation with the demographic differences as a cause.

Brent compares less well with Newham on the National Diabetes Audit (NDA) 2011-12 presents key findings for CCGs on achievements of the 8 National Institute for Health and Care Excellence (NICE) key care processes of diabetes care. Overall Brent is behind Newham by 10% for the 8 care processes combined the highest differences being; smoking, foot surveillance and Body Mass Index (BMI). In consideration of the variation in Brent for each of the 8 care processes it is recommended that an action plan to improve one or two of the poorer care processes be undertaken.

A task group was set to look at the issues and implications of diabetes in the borough of Brent. The groups findings and recommendations are set out in the report 'Tackling Diabetes in Brent '(November 2012), the recommendations fell into three key areas; joint services, education and prevention and healthier lifestyles

We are also working closely with Brent Council to reduce the prevalence of diabetes, and improve outcomes for patients with diabetes through several public health measures, including strategies to reduce obesity in children, encouraging physical activity and promoting healthy eating all of which are specific objectives in the Health and Wellbeing Strategy for Brent.

The CCG is working closely with Brent Council to continue with the NHS health checks program, which was initiated by Brent CCG with the public health department. Last year's 2012/13 performance was good with 9672 completed

checks and 161 newly diagnosed diabetics identified through this programme. Both the CCG and the Brent Council are working together to address performance during this year which has been lower with 3416 checks completed by the third quarter.

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Update on the response to the OSC Task Group on Diabetes

A Brent HOSC Task Group addressed "Tackling Diabetes in Brent", reporting in January 2013, with the Executive receiving the recommendations in April 2013. The Executive agreed to consider the Task Group's recommendations in the allocation of the public health budget and the work programme of the Healthy Lifestyles Team.

The Healthy Lifestyles Team has included diabetes awareness raising and prevention within their work programme and the Council and the CCG have invested in improved diabetes services, including prevention. This report provides an update on progress against the Task Force's recommendations.

Recommendation 1

The task group recommend that an educational film should be made in partnership with the Brent Clinical Commissioning Group to educate residents and patients about diabetes. Voluntary support groups and patient expert groups should be invited to advise how to get the message across to the people that need it the most. Heart of Gold - Heart Disease patient expert group are a very active group and should be considered for this. Patients who were referred to the Intensive Lifestyle Intervention programme and who have successfully reversed their prediabetic condition should also be considered. The allocation for Public Health has not yet been confirmed but there is potential for funding from the allocation for health promotion and this should be explored once the allocation and programme has been confirmed.

The film can be used to address the following key areas:

- Engaging with high risk communities that do not understand the problems associated with the disease
- Explanation of what happens when nothing is done
- Support patients and show examples of how they can take care of themselves and how to address the changes in lifestyle and diet in order to live a healthier lifestyle
- Explain benefits of prevention of the condition
- Signposting patients and providing a better understanding of where and how to find support and advice
- Tools and advice on how to support someone who has been diagnosed with diabetes
- Engaging with children at school - Copies of the film should be provided to school governors and nurses so that it can be used as a source of discussion – Primary schools are an ideal forum for engaging with parents about healthy eating

This recommendation is considered with recommendation 5, as both relate to increasing awareness of diabetes.

Recommendation 5

The task group recommends that there should be dedicated pages on the council's
website to provide advice and information relating to health improvement and more specifically diabetes. 'Maslaha' is a dedicated website that was introduced by Tower Hamlets council and was delivered in conjunction with The Young Foundation. Although the Maslaha site is specifically targeted at Muslims due to the demographics of Tower Hamlets, the Brent pages should

be targeted at all high risk communities. The group recommend that this work should be led by Brent Public Health in conjunction with the council's Communications Team and should link to nationally available information. The pages should be promoted at the various networking forums that take place in the borough to reinforce the message around how healthier lifestyles and healthy eating can help prevent diabetes.

The production of an educational film has not been progressed. However reactive and proactive communications and media activity has been undertaken to increase public awareness of the issue of diabetes in Brent, the services on offer and to signpost to authoritative sources of advice for example those of Diabetes UK.

Information on diabetes is being incorporated into the redesign of the Council website.

As an additional awareness raising and preventive effort the Healthy Lifestyles Team are in the process of procuring a Diabetes Community Champion programme, training and supporting community volunteers. The Team are also exploring the potential for Diabetes Roadshows which in addition to awareness raising and health promotion would offer risk assessments to members of the public.

Recommendation 2

The task group recommends that the NHS Health Checks Programme be fully implemented equally across the borough as this will help enable early detection of diabetes. The creation of Clinical Commissioning Groups promises to create a unified and systematic approach by integrating services that are currently fragmented. The group support this approach to stream line services in order to create a more holistic approach. Commissioning for health checks from April 2013 will be a mandatory function under the council's Public Health responsibilities and the health checks will be included in the work programme, however the promise of quicker and more coordinated health care has to be followed through.

Responsibility for the NHS Health Checks Programme has successfully transferred from the NHS to the Council. Brent GPs are offering health checks to their patients with Council funding. In the first three quarters of 2013/4, 9171 invitations to health checks have been issued with 3416 checks completed. Council public health staff and the CCG are working to increase both the number of offers and the percentage which are taken up. Referrals from Health Checks to lifestyle support including exercise referral and moving away from pre-diabetes (also known as the intensive lifestyle intervention) are being supported by Council public health staff.

Recommendation 3

The task group recommends that the pilot intensive lifestyle intervention for people with impaired glucose tolerance be developed into a local programme and rolled out across the borough. Brent Public Health are exploring further options with the current providers, Community Services, Brent Nutrition & Dietetics Service, for how intensive support can be provided in a more sustainable form.

Commissioning of the intensive lifestyle support service has been successfully transferred to the Council and contracts are being extended to 2014/5. The latest results (November 2012 to December 2013) for 112 patients that completed the intensive 6 month intervention, showed that 66% of those retested (70 patients) are no longer pre diabetic.

Recommendation 4
The task group recommends that the Desmond Programme should be rolled out across the borough so that all diagnosed patients can have access to education about diabetes. The programme is a key resource to raising awareness about diabetes and how to make the beneficial lifestyle changes. There is currently no funding structure in place which is a real concern. The Ealing Hospital Trust that services the community in Brent will review the programme and also consider alternative programmes that best meet the needs of the diverse community as this programme currently comes under the remit of NHS. There is also an opportunity to seek funding from the Public Health allocation once this has been confirmed to see if there is scope for the council to contribute.

The CCG are commissioning the DESMOND programme and an expansion of the programme is included in the plans for redesign and investment in diabetes services, which are detailed in a separate report to HOSC.

Recommendation 6
The task group recommends that more work should be done with schools to raise awareness about diabetes. Schools should be encouraged to provide children with more information about diabetes and maintaining a healthier lifestyle. Diabetes in children is on the increase and with so many fast food establishments opening up near to schools, highlighting the impacts of this disease is so important.
The group recommends that obesity management for the prevention of diabetes start in the early years and continues throughout the lifespan. One of the four strategic pillars in the Brent Obesity Strategy focuses on children, young people and infant feeding. There are currently two programmes in Brent which focus on children and young people (both are ending in March 2013). The Early Years Healthy Settings Programme involves nutrition training and one to one setting feedback for nursery staff and child minders. School age children are targeted through the Fit4Health programme, which offers those identified as above a healthy weight support in the form of a 1:1 or afterschool

The Health and Wellbeing Strategy contains the two objectives: too expand partnership working with schools, nurseries, playgroups and other early years settings to improve the wellbeing of children; and review our approach to childhood obesity and agree a revised strategy.

The Council public health team have supported the Healthy Schools Programme, with 35 schools registering with the London scheme (against a target of 30). Schools identify their own health priorities but are encouraged to consider healthy eating and

physical activity. The team are also supporting 20 child-minders, 21 nurseries and 5 children centre localities who are working towards the Brent HEY (Healthy Early Years) award. The HEY awards require settings to address 7 areas including nutrition and physical activity.

Recommendation 7
The task group recommends that as part of the council's commitment to staff in relation to their health and well being to include diabetes as part of their health and well being events. With 61% of the current staff at Brent coming from a BME background and with statistics confirming that this is the group at the highest risk it makes perfect sense to address the issue about diabetes at these events.

An offer of diabetes risk assessment has been incorporated into Brent Council Staff and Wellbeing Events.

Recommendation 8
The task group recommends that a form of commitment to support the Diabetes
Support Group be made to ensure the group can carry on the good work. This support should come in the form of information of how to contact GP surgeries and work with them to engage with diabetic patients and to seek out a source of funding. The group needs to be promoted and patients need to be made aware of what the aim of the group is and how it will benefit them. Through the work of the Healthy Lifestyles Team, information should be shared and support could be provided to such groups.

CCG and Council staff are in discussion with the Diabetes Support Groups about how best their work can be integrated into the development of diabetes services locally. It is hoped that the Diabetes Community Champions project can contribute to this

Recommendation 9
The task group recommends that a group be set up to work in partnership with the NHS, to work with establishments in the borough which sell food, i.e. fast food outlets, ethnic food shops and restaurants to establish links and educate owners about how to change practices to improve food quality and offer their customers a choice and option to purchase healthier food. A possible award scheme should be considered whereby 1 Dashboard monthly tracker, establishments that cooperate have an article written about them in the Brent magazine for example, to attract more customers. Also, having an endorsement by the local authority will boost their reputation. The Obesity Strategy group currently address this in their work and the council when reviewing such groups ahead of the public health transfer should consider retaining the group and extending their programme.

The Healthy Lifestyles team are exploring with Environmental Health whether the Healthy Catering Commitment could be introduced into Brent. This voluntary

accreditation scheme supports caterers, including fast food outlets, to provide and promote healthier choices on their menus.

The Council planning function is considering restricting the opening of fast food outlets within 400m of secondary schools in the borough.

> Recommendation 10
> The task group recommends that the outdoor gyms be introduced in all parks
> throughout the borough so that all residents can have easy access to one and everyone can benefit from them. This is something to consider once the Public Health allocation has been confirmed to scope out the possibility of funding, although it should be noted that previous funding for outdoor gyms has been non recurrent and at present they are not budgeted for in the public health allocation.

In the summer of 2013, six outdoor gyms were installed in parks in Brent. Whilst the numbers of outdoor gyms are increasing across the UK, there is little evidence of evaluation of their effectiveness. Therefore the healthy lifestyles team led on an initial 3 month post implementation evaluation of the scheme. This evaluation will be repeated in 2014, to determine if use is maintained, increased or decreased since the initial installation, and whether or not these have been an effective tool in increasing physical activity in residents.

The initial evaluation showed gym users were very positive about the gyms and 41% of gym users had increased their activity levels since the gyms had been installed. However use varied significantly between sites, with three of the six sites accounting for 82% of use. The evaluation suggested a need for better promotion of the gyms and this is being planned.

Melanie Smith
Director of Public Health
Brent Council

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Brent	**Health Partnerships Overview and Scrutiny Committee** 18th March 2014 **Report from the Assistant Chief Executive**
For Action	Wards Affected: ALL

18 Weeks Referral To Treatment Incident and Urology Serious Incident

1.0 Summary

1.1 Members of the committee will be aware that North West London Hospitals discovered in February 2013 that 60% of patients on North West London Hospital Trust (NWLHT) waiting lists did not have an open care pathway and that as a result a large number of patients had been waiting longer than 18 weeks for treatment. They will also be aware of a more recently identified incident that has occurred in urology, where patients booked on a planned waiting list for diagnostic/cystoscopy procedures had not been offered an appointment. The committee asked NWLHT to return to this meeting with a further update and, in particular, to provide more information on the impact on, and risks to, patient safety.

1.2 All deaths among patients waiting longer than 18 weeks in the last two years have been reviewed as have all patients waiting longer than 18 weeks for planned urology treatment. The trust has concluded that there has been no significant harm identified to individual patients, but there was an increased level of risk to patients who had waited an excessive length of time for treatment. A patient level review of risk is currently being instigated by the trust.

1.3 The committee will already be aware of the measures being taken to address the backlog of patients. The report provides a progress update and the number of patients who have been waiting for more than 18 weeks has now reduced to around 600.

2.0 Recommendations

2.1 The committee is recommended to question officers from NWLHT on the contents of the report and in particular on the review into patient safety and the assessment that no patients had suffered significant harm.

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To: Brent Overview and Scrutiny Committee

From: Tina Benson, Director of Operations, NWLH Trust

Date: 28th February 2014

Subject: Update on 18 Week RTT Clinical Review Process and Capacity

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Background:

The Trust undertook an internal and external review process, in agreement with the CSU/CCGs to provide assurance as well as clinical review in order to determine whether there had been a risk of harm for patients who had been waiting longer than 18 weeks for their respective procedure. The review primarily focussed on patients who had waited more than 18 weeks due to unnecessary delay rather than due to clinical or social reasons for delay e.g. patient choice or planned procedures.

Reporting process

Both the internal and external review findings, as well as additional information from the Urology incident are being formulated into a report that is due to be presented to the NWLH Trust Board in March 2014.

Interim update on 18 weeks

- All deaths amongst patients waiting longer than 18 weeks, for the last two years have been reviewed Patients waiting longer than 18 weeks on the Planned Urology list were also investigated. A consultant review process was instigated for the 196 patients identified. Four deaths are under clinical review.
- It was concluded that there had been no significant harm identified in relation to individual patients, but there existed an elevated level of risk exist for all those patients who have waited too long.
- The Trust is in the process of setting up a patient level review of risk which will be led by the Medical Director.

18 WEEK CAPACITY UPDATE

1.0 Background

The Trust has implemented plans as previously described to increase the internal capacity for a number of key specialities. In addition the Trust has worked in collaboration with CCGs/CSU to implement outsourcing to support the reduction in the waiting list size to reach sustainable levels.

As previously reported the Trust had 4400 patients on the admitted waiting list and this number needs to be nearer 2000 to reach a sustainable balance. The Trust also had 801 patients currently waiting over 18 weeks on the 3rd November 2013.

2.0 Trust Internal capacity

The Trust is implementing 33% (45 patients per month) of the planned capacity increase (136 patients per month) in February 2014. There are recruitment plans to achieve the remaining increase by April 2014. Recruitment however remains the highest risk against delivery with theatre nursing staff group being the most difficult to recruit to. Heads of Nursing are leading Trust wide

recruitment campaigns that will directly support critical care. Specialities where lists are affected are Orthopaedics, ENT, Gen Surgery, OMFS.

3.0 Outsource Process

To support the Trust, the CCGs have agreed to fund additional capacity through an outsourcing process. The following providers were chosen with the support of the CSU and CCGs. These are:

- BMI Healthcare group (BMI)
- The Hillingdon Hospitals Trust (THH)
- The Royal National Throat Nose and Ear Hospital. (RNTNEH)

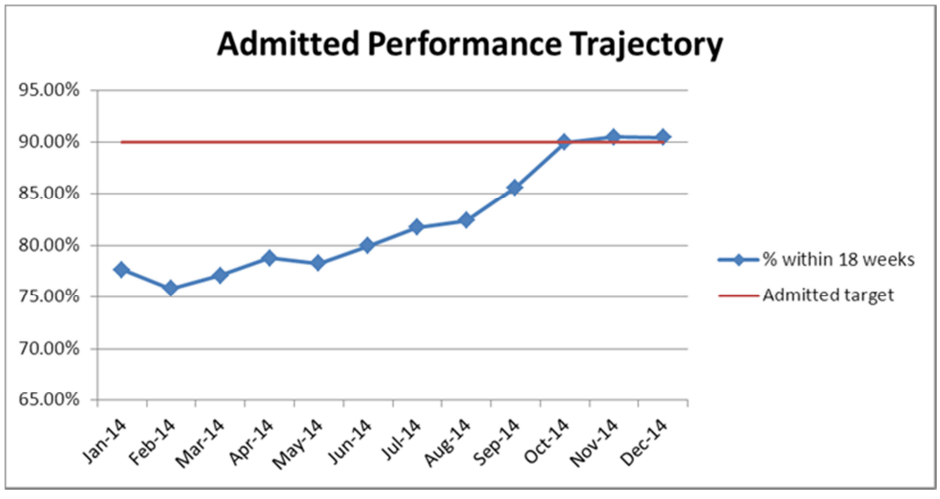
The outsourcing process started in November 2013 and the table below outlines the position as of 5th February 2014.

SUMMARY	Volume
Total Number on trackers	903
Number treated, surgery complete	223
Number in process to treatment	416
Number discharged, no treatment	143
referred back to Trust	66
Other a/w update	55

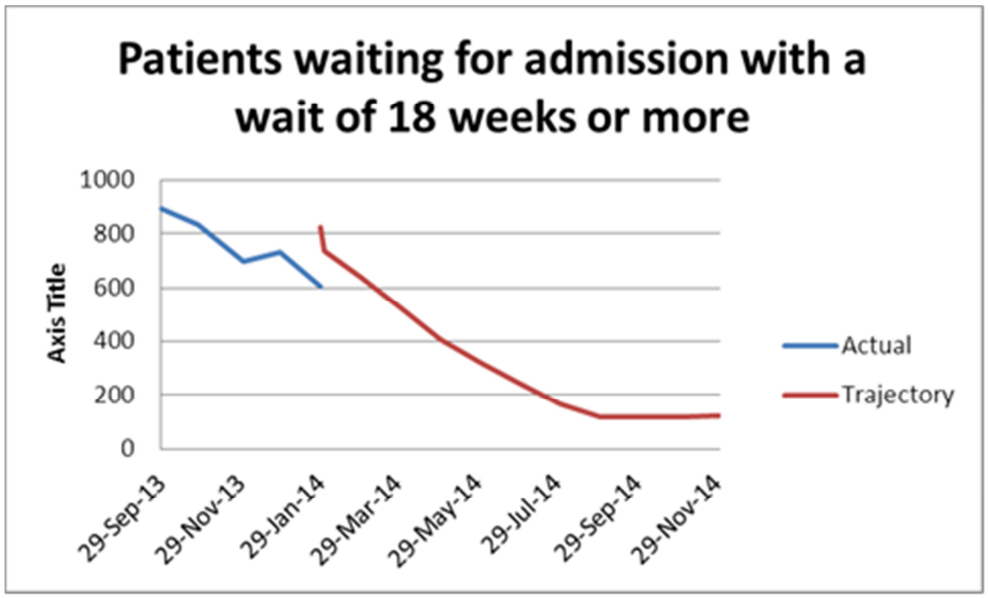
The Trust wrote to a total of 1253 patients, informing them that they had identified through the agreed process. This has resulted in 903, 72% of patients being moved across to the providers above. The table indicates that the majority of these patients have either been treated or are in the process of receiving their treatment. A small number of patients have returned to the Trust as either the patient wished to return or was too complex for other providers to treat.

4.0 Trajectories

The Trajectories have been updated to reflect the delay in internal capacity at the Trust and we have now mapped our current backlog (>18 week) patients onto our plan to reduce the number of patients waiting over 18 weeks. The graph below demonstrates the current trajectory plan for admitted performance..



The following graph shows current numbers of patients waiting over 18 weeks. January 2014 shows that the Trust is over achieving on its plan.



The Trust currently has fewer than 3800 patients on the waiting list, with fewer than 600 patients waiting over 18 weeks.

Conclusion

The Trust has reduced its overall waiting list size as well as the number of patients waiting over 18 weeks.

Outsourcing will be prioritised to ensure that the reduction in backlog is maintained and where possible accelerated as this may represent patient groups in which there may be elevated risks due to the length of wait for their treatment.

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Health Partnerships OSC

Work Programme 2013-14

Meeting Date	Item	Issue
March 2014	Plans for Central Middlesex	Following decisions taken at, and after, the stakeholder meeting: an update on the plans for services at Central Middlesex Hospital.
March 2014	Violence against Women Task Group	Report from the Violence Against Women Task Group with the group's findings recommendations.
March 2014	Mental Health services	Full report on current services provided by: CNWL, CCG, Social Care (council).
First meeting in 2014/15	Sexual Health	• Teenage pregnancy and the services offered; • Abortion services in Brent including a report on repeat abortions and what is being to done to combat this; • HIV services.
Ongoing	CCG: Wave 2 Commissioning	Update on Wave 2 Commissioning including the Service Specification.
TBC	Maternity Services	Maternity care in Brent, including proposed changes proposed under Shaping a Healthier Future
Recurring	Emergency Services	Current issues around emergency services/A&E at North West London Hospitals and immediate, mid and long term plans to address current problems and improve services.
TBC	NWLHT and EHT Merger	Update on the merger between North West London Hospitals Trust and Ealing Hospitals Trust and on current progress against financial targets.

TBC	Public Health	Report on the progress of transition of and integration of Public Health into the council.
TBC	Out of hospital care strategy	As part of the Shaping a Healthier Future work, Brent will be preparing an Out of Hospital Care Strategy. The committee will consider the strategy and respond to the consultation.
TBC	Diabetes Task Group	Update on progress of the Diabetes Task Group recommendations.