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# Health and Wellbeing Board*

**Tuesday 17 July 2018 at 6.15 pm**
Members Suite - 4th Floor, Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ

## Membership:

| | |
|---|---|
| Councillor Farah (Chair) | Brent Council |
| Dr Ethie Kong (Vice-Chair) | Brent CCG |
| Councillor Hirani | Brent Council |
| Councillor Kansagra | Brent Council |
| Councillor McLennan | Brent Council |
| Councillor M Patel | Brent Council |
| Sheikh Auladin | Brent CCG |
| Dr Ketana Halai | Brent CCG |
| Julie Pal | Healthwatch Brent |
| Carolyn Downs | Brent Council - Non Voting |
| Phil Porter | Brent Council - Non Voting |
| Dr Melanie Smith | Brent Council - Non-Voting |
| Gail Tolley | Brent Council - Non-Voting |
| Simon Crawford | London North West Healthcare NHS Trust |
| Dr David Finch | NHS England |
| Claire Murdoch | Central and North West London NHS Foundation Trust |

**Substitute Members (Brent Councillors)**
Labour Councillors:

Agha, Miller, Krupa Sheth and Tatler

Conservative Councillors:

Maurice

* Please note that this agenda has been re-published on Tuesday 10 July 2018 to reflect the appointments made at the Full Council meeting on Monday 9 July 2018. It also includes reports which have been marked ‘to follow’ in the previous version.

**For further information contact:** Nikolay Manov, Governance Officer
Tel: 020 8937 1348; Email: nikolay.manov@brent.gov.uk

For electronic copies of minutes, reports and agendas, and to be alerted when the minutes of this meeting have been published visit:
**www.brent.gov.uk/committees**

## The press and public are welcome to attend this meeting.

**Notes for Members - Declarations of Interest:**

If a Member is aware they have a Disclosable Pecuniary Interest* in an item of business, they must declare its existence and nature at the start of the meeting or when it becomes apparent and must leave the room without participating in discussion of the item.

If a Member is aware they have a Personal Interest** in an item of business, they must declare its existence and nature at the start of the meeting or when it becomes apparent.

If the Personal Interest is also significant enough to affect your judgement of a public interest and either it affects a financial position or relates to a regulatory matter then after disclosing the interest to the meeting the Member must leave the room without participating in discussion of the item, except that they may first make representations, answer questions or give evidence relating to the matter, provided that the public are allowed to attend the meeting for those purposes.

***Disclosable Pecuniary Interests:**

(a) **Employment, etc. -** Any employment, office, trade, profession or vocation carried on for profit gain.

(b) **Sponsorship -** Any payment or other financial benefit in respect of expenses in carrying out duties as a member, or of election; including from a trade union.

(c) **Contracts -** Any current contract for goods, services or works, between the Councillors or their partner (or a body in which one has a beneficial interest) and the council.

(d) **Land -** Any beneficial interest in land which is within the council's area.

(e) **Licences-** Any licence to occupy land in the council's area for a month or longer.

(f) **Corporate tenancies -** Any tenancy between the council and a body in which the Councillor or their partner have a beneficial interest.

(g) **Securities -** Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

****Personal Interests:**

The business relates to or affects:

(a) Anybody of which you are a member or in a position of general control or management, and:

- To which you are appointed by the council;
- which exercises functions of a public nature;
- which is directed is to charitable purposes;
- whose principal purposes include the influence of public opinion or policy (including a political party of trade union).

(b) The interests a of a person from whom you have received gifts or hospitality of at least £50 as a member in the municipal year;

or

A decision in relation to that business might reasonably be regarded as affecting the well-being or financial position of:

- You yourself;
- a member of your family or your friend or any person with whom you have a close association or any person or body who is the subject of a registrable personal interest.

# Agenda

Introductions, if appropriate.

**Item** Page

**1 Apologies for absence and clarification of alternate members**

For Members of the Board to note any apologies for absence.

**2 Declarations of Interest**

Members are invited to declare at this stage of the meeting, the nature and existence of any relevant disclosable pecuniary or personal interests in the items on this agenda and to specify the item(s) to which they relate.

**3 Minutes of the previous meeting** 1 - 4

To approve as a correct record, the attached minutes of the previous meeting held on 27 March 2018.

**4 Matters Arising (If Any)**

To consider any matters arising from the minutes of the previous meeting.

**5 Knife Crime Prevention** 5 - 26

This report highlights current knife crime trends across London and the specific challenges faced in Brent. It also discusses the importance of a public health approach to knife crime, and provides an overview of a range of successful prevention interventions.

**6 Mental Wellbeing in Brent** 27 - 32

This report updates the Board on the local work undertaken to promote mental wellbeing in response to Thrive LDN.

**7 Children's Trust Update** 33 - 40

The Brent Children's Trust (BCT) provides the Brent Health and Wellbeing Board with an update paper every six months, with the previous report having been presented at the October 2017 meeting. This paper provides a broad summary of the BCT work programme and actions of the JCG from November 2017 to March 2018.

**8 Child Death Overview Panel Annual Report** 41 - 60

The Child Death Review Panel (CDOP) is a subcommittee of the Local Safeguarding Children Board (LSCB). Brent LSCB received the 2017/18 CDOP Annual Report at its June 2018 meeting. The report is presented to the Health and Wellbeing Board with an account of the LSCB

deliberations.

**9 Healthwatch Work Plan and Priorities** 61 - 66

The report updates the Health and Wellbeing Board on the progress of Healthwatch Brent and sets out the 2018/19 work programme and priorities for Healthwatch Brent.

**10 Any other urgent business**

Notice of items to be raised under this heading must be given in writing to the Head of Executive and Member Services or his representative before the meeting in accordance with Standing Order 60.

**11 Date of Next Meeting**

The next scheduled meeting of the Health and Wellbeing Board is on Tuesday 9 October 2018.

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

- The meeting room is accessible by lift and seats are provided for members of the public on a first come first served basis.

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Brent

Brent Clinical Commissioning Group

# MINUTES OF THE HEALTH AND WELLBEING BOARD
## Held on Tuesday 27 March 2018 at 7.00 pm

**MEMBERS PRESENT:**

Councillor Hirani (Chair), Sheikh Auladin (Chief Operating Officer, Brent Clinical Commissioning Group), Dr Sarah Basham (Vice Chair and Co-Clinical Director of Brent Clinical Commissioning Group), Carolyn Downs (Chief Executive, Brent Council), Councillor Farah, Julie Pal (Chief Executive, Healthwatch Brent), Councillor M Patel, Phil Porter (Strategic Director of Community Wellbeing, Brent Council), Dr Melanie Smith (Director of Public Health, Brent Council), Gail Tolley (Strategic Director of Children and Young People, Brent Council)

**Also Present:** Duncan Ambrose (Assistant Director, Brent Clinical Commissioning Group), Zac Arif (Director of Integration, Brent Council/Brent Clinical Commissioning Group), Simon Crawford (Director of Strategy, London North West Healthcare NHS Trust), Meenara Islam (Strategic Partnerships Manager, Brent Council), Helen Woodland (Operational Director of Social Care, Brent Council)

**In Attendance:** Councillor Perrin

1. **Apologies for Absence and Clarification of Substitute Members**

   Apologies for absence were received from:

   (i) Councillor McLennan, with Councillor Farah present as substitute;

   (ii) Councillor Butt;

   (iii) Councillor Colwill; and

   (iv) Dr Ethie Kong (Vice-Chair of the Health and Wellbeing Board; Chair and Co-Clinical Director, Brent Clinical Commissioning Group).

2. **Declarations of Interest**

   There were no declarations of interest.

3. **Minutes of the Previous Meeting**

   It was **RESOLVED** that the minutes of the previous meeting held on 24 January 2018 be approved as an accurate record of the meeting.

4. **Matters Arising**

   There were no matters arising.

5. **Deputations**

   There were no deputations.

6. **Health and Wellbeing Board Public Engagement Roadshow - Themes**

Zac Arif (Director of Integration, Brent Council/Brent Clinical Commissioning Group) introduced the report which provided Members with a summary of the three Health and Wellbeing Board roadshow events which had taken place in mid-March 2018.

Members heard that the events had followed on from a previous series of events in 2016, and had been a successful method of engagement with the public to reinforce the themes within the Brent Health and Care Plan and to also establish the current issues that residents felt strongly about. Zac Arif specified the key issues which had arisen through interaction with the public, which had centred on: how to achieve a balanced lifestyle; pre-diabetes; the difference between type one and type two diabetes; tackling social isolation; different ways to access services (such as through the 'Health Help Now' NHS app); and the role of Brent Healthwatch. Mr Arif thanked colleagues who had assisted the successful organisation and delivery of the events.

In the ensuing discussion, the Chair, having been present at all three events, outlined that the event held at Tesco Extra Supermarket in Brent Park had provided the best opportunity to speak to residents due to the high volume of footfall. Both he and Zac Arif also encouraged Board members to attend the Community Hub at Central Middlesex Hospital which was running into its second week at the time of the meeting, and praised the work of the hub thus far.

A member of the Board raised that Ramadan would take place in the near future and questioned what health and wellbeing advice was due to be given to Brent residents who observed Ramadan. The Chair outlined that the existing resources which provided information on fasting during Ramadan would likely be utilised, and that it would be useful to have partners' communications teams promote these accordingly as the month drew closer. Members felt that health and wellbeing guidance for those with diabetes who observed Ramadan would be particularly important.

It was **RESOLVED** that the report and emerging themes be noted.

7. **Inspection of Local Authority Children's Services (ILACS)**

Gail Tolley (Strategic Director of Children and Young People, Brent Council) introduced the report which provided the Board with an overview of the new framework for Inspection of Local Authority Children's Services (ILACS). The report also noted Brent's progress since the previous inspection and preparation for the new arrangements.

Gail Tolley stated that the provisions within the new framework had been scrupulously reviewed by key stakeholders at a number of different meetings, including the Brent Children's Trust. The Board heard that the new framework no longer included an inspection of the partnership working of local safeguarding boards and that there was a key focus on local authority social work services and the quality of professional practice. Gail Tolley explained that the report provided detail and assurance on partners being engaged and sighted on the changes. She

also mentioned that the key transition points between the Children and Young People and Community Wellbeing Departments at the Council were being discussed by Strategic and Operational Directors.

It was **RESOLVED** that the report be noted.

8. **Update on Frailty Workstream**

Helen Woodland (Operational Director of Social Care, Brent Council) introduced the report which provided the Board with a summary of progress on the delivery of the Frailty work stream within the Brent Health and Care Plan. She explained that the report highlighted the achievements in this area over the past year, and the learning from these which could be fed into the priorities for 2018-19. She provided a top-line overview of the different sections within the report, which were: Delivery of Home First; Step-Down Beds; Delayed Transfers of Care (DTOC); Acute Frailty Service (AFS); Integrated Rehab and Reablement Service (IRRS); and emerging issues.

Simon Crawford (Director of Strategy, London North West Healthcare NHS Trust) emphasised that, from an NHS Trust perspective, the interventions specified within the report had been very positive. He added that each initiative provided opportunities for additional learning and scope for further effectiveness, particularly on optimising care pathways and long-term approaches to staffing, but that the partnership working so far had been invaluable. Sheikh Auladin (Chief Operating Officer, Brent Clinical Commissioning Group) agreed that lessons could continue to be drawn from the work, such as improving Home First provisions to ensure a single point of access.

A question arose on the different versions of the Home First programme which ran out of Northwick Park Hospital (as referenced within paragraph 5.17 of the report), and whether this had resulted in a difference in service for residents across Brent, Harrow or Ealing. Simon Crawford acknowledged that staff working differently across sites had proved to be a challenge, which could manifest in delayed transfers of care, but that the service had been become more joined-up in its operation over the last year. Phil Porter (Strategic Director of Community Wellbeing, Brent Council) expanded on this and noted that work was underway to align social care discharges across the area. Sheikh Auladin added that there were multiple discharge pathways within the system as things stood and Hunter Healthcare had also undertaken work at Northwick Park Hospital to streamline these in order to make discharges easier for staff to coordinate.

It was also questioned how momentum could be maintained for the work stream in the future. Simon Crawford indicated that the continued support of partner organisations would be very important and that the schemes needed to continue to be monitored in order identify where further improvements could be made. He also noted that the financial implications and funding streams needed to be considered going forward. Members agreed that the desire remained to keep up the work particularly whilst funding could be accessed via the Improved Better Care Fund (iBCF), but it was acknowledged that the uncertainty of long-term funding remained an issue. On the whole, Members felt that progress had been positive over the past year and that the low re-admittance rates after discharge across the area reflected this.

It was **RESOLVED** that the report be noted.

9. **Publication of the Pharmaceutical Needs Assessment**

Dr Melanie Smith (Director of Public Health, Brent Council) introduced the report which provided the Health and Wellbeing with a progress update on the publication of Brent's Pharmaceutical Needs Assessment (PNA).

She explained that statutory regulations stipulated that Health and Wellbeing Boards were required to publish a revised assessment within three years, which for Brent was by 1 April 2018. She reminded the Board that at its June 2017 meeting it had been agreed to establish a PNA steering group to assist with the organisation, consultation and final publication of the revised assessment and that the report detailed this work. She concluded and drew the Board's attention to the recommendations which requested delegated authority for the decision as to whether a revision of the PNA was required or whether the publication of a Supplementary Statement would suffice.

It was **RESOLVED**:

(i) That the publication and consultation of the draft Brent PNA, be noted;

(ii) That the intention of the Brent PNA Steering Group to publish the final Brent PNA before 1 April 2018, be noted;

(iii) That the role of the NHS England, the Clinical Commissioning Group and Brent Council in maintaining the PNA, be noted;

(iv) That authority be delegated to the Director of Public Health ("DPH") or the DPH's nominee as to whether a revision of the PNA was required, or whether the publication of a Supplementary Statement would suffice.

10. **Date of Next Meeting**

It was noted that the date of the next Health and Wellbeing Board meeting would be confirmed upon the publication and agreement of the Council's municipal calendar for 2018/19 at the Council's Annual General Meeting on 14 May 2018.

11. **Any Other Urgent Business**

There was no other urgent business to transact.

Before the meeting was formally declared closed, the Chair placed on record the Board's thanks to Dr Sarah Basham (Vice Chair and Co-Clinical Director of Brent Clinical Commissioning Group) for all of her hard work as she was soon to leave her current role.

The meeting was declared closed at 7.39 pm

COUNCILLOR KRUPESH HIRANI
Chair

| | |
|---|---|
| Brent<br>NHS Brent Clinical Commissioning Group | **Health and Wellbeing Board**<br>17 July 2018 |
| | **Joint Report from Strategic Director of Regeneration and Environment, Strategic Director of Children and Young People and Director of Public Health** |

# Knife Crime Prevention – Review of Evidence and Recommendations

| | |
|---|---|
| **Wards Affected:** | All |
| **Key or Non-Key Decision:** | N/A |
| **Open or Part/Fully Exempt:**<br>(If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act) | Open |
| **No. of Appendices:** | N/A |
| **Background Papers:** | N/A |
| **Contact Officer(s):**<br>(Name, Title, Contact Details) | Miriam Shovel<br>National Management Trainee, Community Protection<br>Email: Miriam.Shovel@brent.gov.uk<br>Tel: 020 8937 2571<br><br>Karina Wane<br>Head of Community Protection<br>Email: Karina.Wane@brent.gov.uk<br>Tel: 020 8937 5067<br><br>Melanie Smith<br>Director of Public Health<br>Email: Melanie.Smith@brent.gov.uk<br>Tel: 020 8937 6227<br><br>Sue Gates<br>Head of Early Help<br>Email: Sue.Gates@brent.gov.uk<br>Tel: 020 8937 2710 |

## 1.0 Purpose of the Report

1.1 Brent Council is committed to tackling knife crime and working in partnership, both internally and externally, to enable a targeted response. This report will first highlight current knife crime trends across London and the specific challenges we face in Brent. It will then discuss the importance of a public health approach to knife crime, and provide an overview of a range of successful prevention interventions.

## 2.0 Recommendations

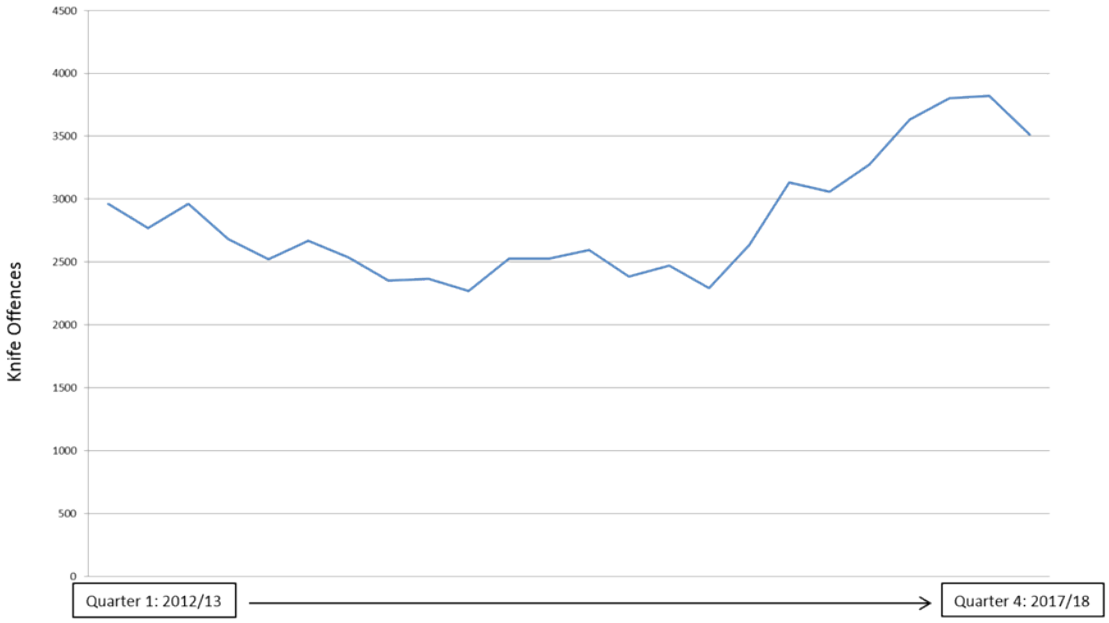
2.1 That the Board acknowledges knife crime as a public health issue and consider the need to work together as a partnership to strengthen knife crime prevention measures.

2.2 That the Board considers the proposals detailed in section 10, specifically with regard to how the proposals can best be taken forward by health organisations.

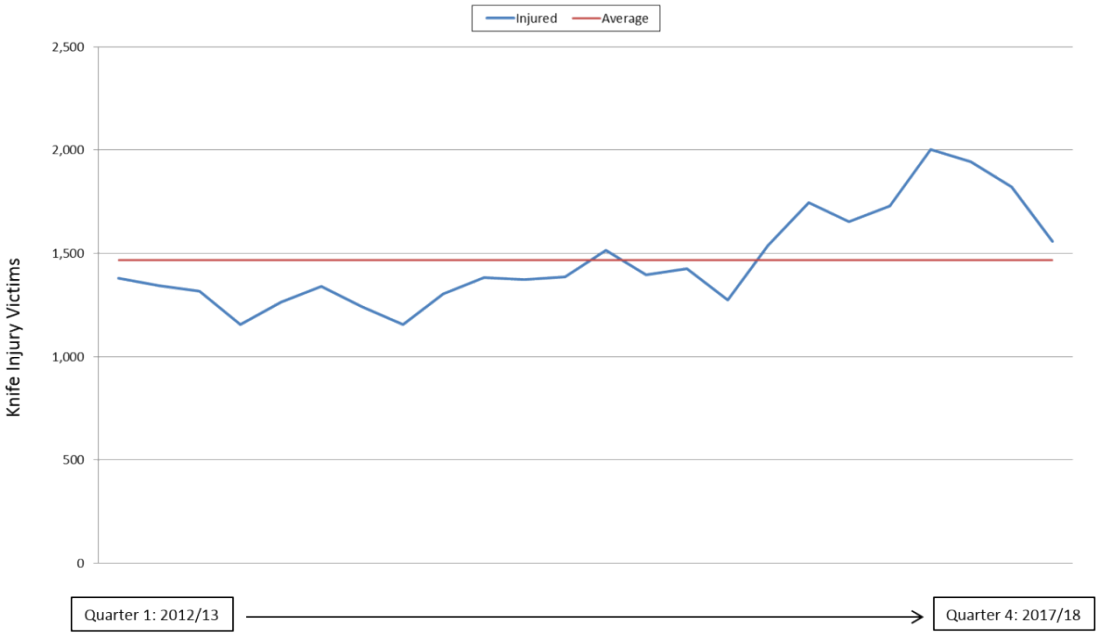
## 3.0 Knife Crime data and analysis – What Are the Problems?

### 3.1 The Pan-London Picture

3.1.1 Number of knife offences across London (Metropolitan Police Data, accessed May 2018):



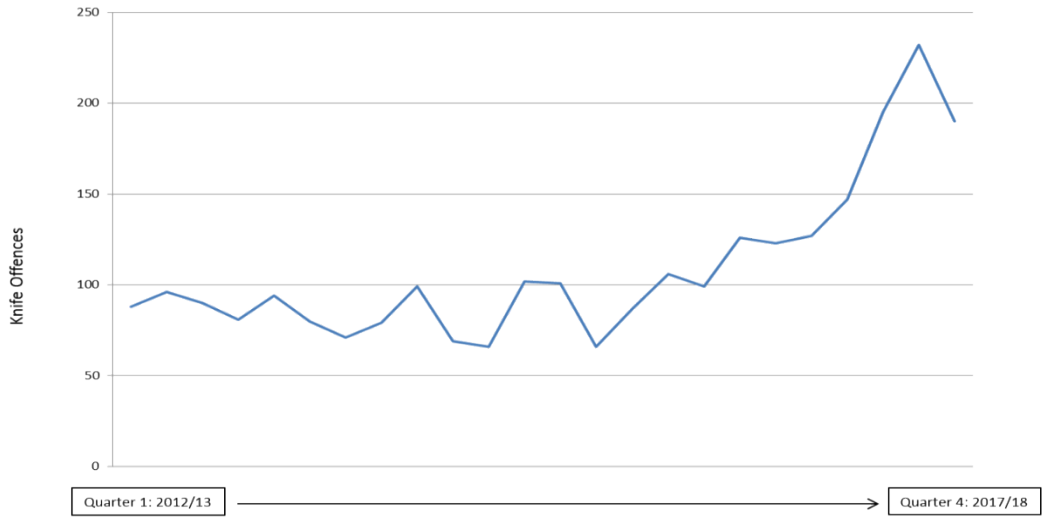
3.1.2 Number of London knife injury victims - non fatal (Metropolitan Police Data, accessed May 2018):



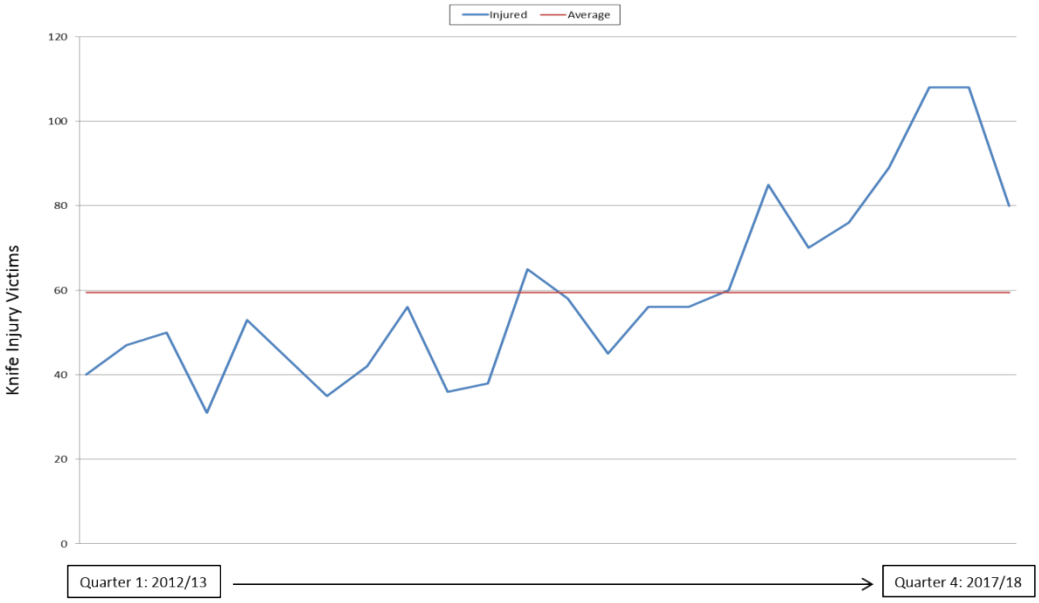

3.1.3 In 2017/18, the highest number of knife crime offences in London was recorded in **Southwark** (866 compared to 842 in 2016/17). The highest number of victims being injured as a result of a knife crime offence was also recorded in **Southwark** (453 compared to 409 in 2016/17). **Total number of offences involving knife crime has increased by 22% from 12,105 in 2016/17 to 14,768 in 2017/18**. Knife related murders in London increased by 86% from 59 (2016/17) to 110 (2017/18); this was a significant single year increase considering that London has averaged 56 knife related murders over the previous five years. The highest number of knife related murders in London was again recorded in **Southwark** (12 compared to 3 in 2016/17)
Source: Metropolitan Police June 2018.

## 3.2 The Brent Picture

3.2.1 Number of knife offences across Brent (Metropolitan Police Data, accessed May 2018):



3.2.2 Number of Brent knife injury victims - non fatal (Metropolitan Police Data, accessed May 2018):




3.2.3 In 2017/18, Brent had 764 knife crime offences, which is a **60% increase** on recorded offences on 2016/17 (475). This was the 4th highest increase in London and placed **Brent as having the 4th highest level of knife crime of the 32 London boroughs.**
In 2017/18, Brent also saw a **32% year on year increase in the number of victims being injured** as a result of knife crime offences. The 32% increase equated to an additional 92 victims injured by knives than in 2016/17. This was the 4th highest increase in London and placed **Brent as having the joint 2nd highest number of injured victims of knife crime of the 32 London boroughs.**
The number of knife related murders in Brent reduced from 4 in 2016/17 to 3 in 2017/18; this was below the London average.
Source: Metropolitan Police June 2018.

## 4.0 The Cost of Knife Crime to Health

4.1 Calculating the single agency cost of knife crime is complicated; many different agencies (central government, local government, police, health, and other agencies) are involved in preventing and responding to those affected. However, there is a clear cost to the health economy.

4.2 The Trauma Audit Research Network (TARN) at the University of Manchester conducted a comprehensive cost analysis of knife crime in terms of the cost to the health sector. The team looked at all penetrating trauma injuries that resulted in immediate admission to hospital for three or more days, or death within 93 days.

4.3 Stabbings accounted for almost three quarters of all penetrative injuries with an **average cost to the National Health Service (NHS) of £7,196 per victim**.

4.4 TARN research director Dr Fiona Lecky said "**Public health initiatives that aim to reduce the incidence and severity of penetrating trauma are therefore likely to produce significant savings in acute trauma care costs."**

4.5 Nationally, there were **4,434** finished consultant episodes (FCE) recorded in English hospitals in 2016/17 due to assault by a sharp object. Using the above estimate, the cost to NHS England was **£31,907,064 in 2016/17**. This is highly likely to be an underestimate due to the cost-based figures being ten years old, and therefore not reflecting inflation costs, as well as an unknown amount of general underreporting.

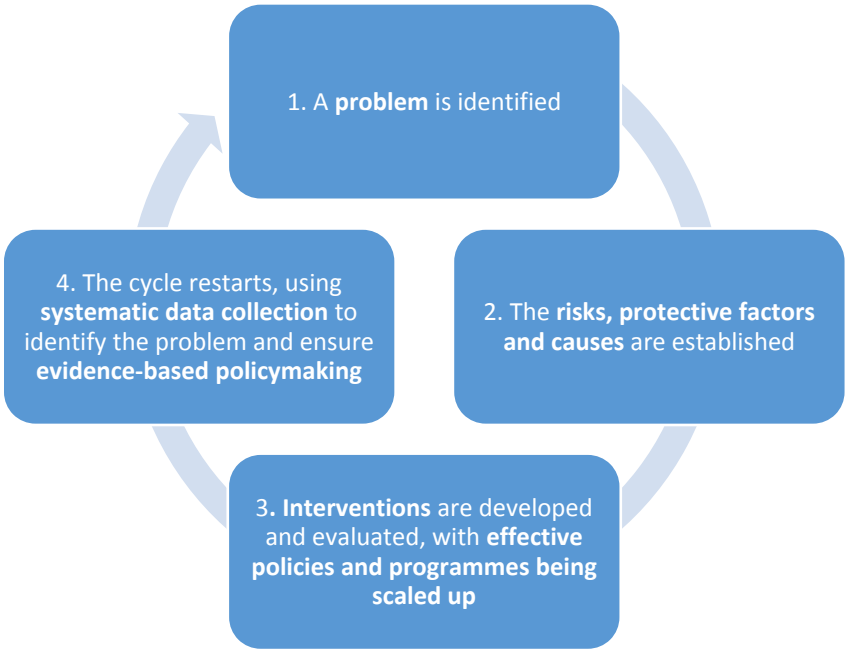
4.6 Locally, there were **385 knife injuries and 3 fatalities in Brent** recorded by the Metropolitan Police in 2017/18. This puts the estimated cost of Brent knife crime to NHS England at **£2,792,048 in 2017/18**. Again, this is highly likely to be an underestimate due to reasons given above. It is therefore clear that knife crime is a significant cost to the health economy as well as other public sector bodies.

## 5.0 Knife Crime – A Public Health Issue

5.1 *Why should the health sector be involved in violence prevention?* Violence negatively affects the health of victims as well as those who witness violence; it **acts like an epidemic disease**; and it can be effectively prevented using health methods. A significant number of scientific studies have conclusively shown that violence displays all of the characteristics of an epidemic disease: **Clustering, Spread, and Transmission**. For example, geographical data mapping has shown that there are clear crime hotspots. Furthermore, mental trauma from exposure to violence has been scientifically shown to increase a person's risk of adopting violent behaviour themselves, meaning that violent behaviour transmits and spreads based on exposure – just like an epidemic disease.

5.2 *What do we mean by a "Public Health Approach to Knife Crime"?* The public health approach to knife crime has been proven to be successful in areas where it has been employed to tackle the causes of violence. This approach essentially involves **treating violence as a preventable public health issue**, using **data and analysis to identify causes** and focusing on **prevention through multi-agency systemic approaches**. The public health approach to any problem is **interdisciplinary and science-based**, concerned with **long-term as well as short-term effects**, and draws upon many disciplines including: medicine, epidemiology, sociology, psychology, criminology, education and economics. The public health approach also emphasises **collective action**. Cooperative efforts from health, education, social services, justice and policy are necessary to solve knife crime. Each sector has an important role to play in addressing the problem and, collectively, the approaches taken by each have the potential to produce important reductions in violence. Public Health approaches focus on a population defined by a shared health risk (i.e. risk of violence) rather than individuals. Solutions must therefore involve co-production with communities.

5.3 The Public Health model requires **four steps**:




5.4 *Why is evidence-based policy making important?* Evidence-based policy making means using research findings to **inform new policies or improve effectiveness of existing programmes**, supporting data collection and analysis for research and management, developing policies that **incentivise the use of evidence**, and **evaluating current programmes to better inform future decisions**. This approach prioritises rigorous research findings, data, and analytics.

5.4.1 In an era of constrained public resources, evidence-based policy making helps maintain focus on the outcomes we want to achieve, for whom, and at what cost. It **encourages transparency and accountability** by clearly stating the goals of policies and programmes and then independently evaluating their results to see if those goals were achieved. By focusing on outcomes, an evidence-based framework **prioritises effectiveness of social interventions and efficiency** in use of resources. Evaluation also allows cost savings to be accurately calculated. This approach encourages a **virtuous cycle of knowledge building**. By evaluating policies and programs and by using data, we can learn how well programs are working. Ultimately, this information can be used to improve programs or to terminate consistently ineffective programs and find better approaches. From there, the cycle of learning and improving continues (see 4.3).

## 6.0 Knife Crime Prevention Research

6.1 The Early Intervention Foundation (EIF) conducted a 2015 **review of 67 relevant programmes** to understand what does and doesn't work, entitled 'What works to prevent gang involvement, youth violence and crime?'. The following factors were found in programmes that were effective in preventing gang involvement and serious youth violence, including knife crime:

6.1.1 **Creating positive change rather than focus on negatives of knife crime:** Effective programmes create positive changes in the lives of Children and

Young People (CYP) and their families, whilst reducing risk factors and preventing negative outcomes. The focus should be on programmes which **develop skillsets in CYP to equip them to make healthy life choices, and strengthen families' ability to tackle problems together**, rather than teaching about the negative effects of knife crime.

6.1.2 **School-based and family-focused**: Effective programmes often involve practicing skills, problem solving strategies, parent training, and/or therapy. School-based programmes should encourage indirect parental support for their children and practice at home. Effective programmes for high-risk CYP tended to be **interactive, family-focused and therapy-based**, reaching CYP in settings they normally interact in (e.g., at home/in school). Family-focused interventions take the influential power of the wider family/peer groups on the CYP's behaviour into account. Parent and family programmes should use content tailored to real-life problems; for example family-therapy programmes can be structured around key phases but still seek to strengthen each particular family by addressing their issues and needs.

6.1.3 **Trained facilitators**: Effective programmes often require or recommend trained facilitators, acting in their professional capacity, who have experience working with children and/or families. Training can help ensure facilitators understand what needs to be implemented and how, and therefore can play an important part in ensuring consistency and quality in delivery. Good facilitators tend to have a good level of education and experience of working with CYP and/or families, which may be key to skilfully and confidently treating their often complex problems.

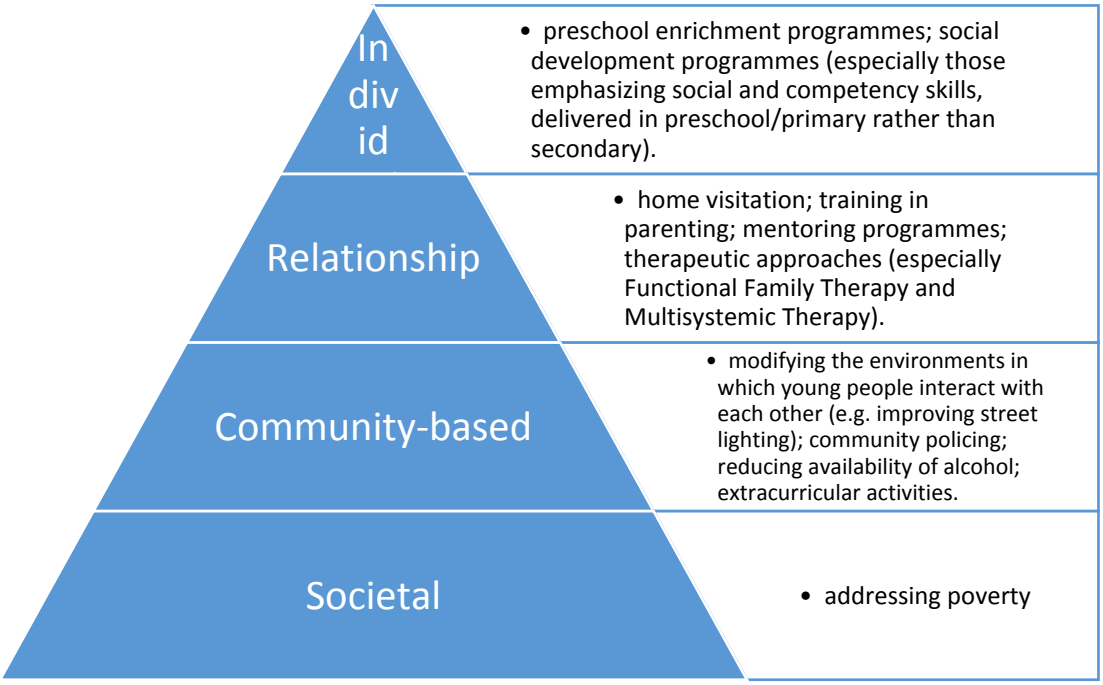
6.1.4 **Therapy**: a key feature of programmes targeting high-risk youths and/or families. CYP with greater levels of need and on the fringe of involvement/already involved in crime and violence may therefore require more specialised treatment. **Functional Family Therapy and Multisystemic Therapy** have a particularly strong evidence base for success.

6.1.5 **Implementation fidelity and evaluation**: Sticking to the original programme specification and ensuring good implementation quality are crucial in terms of ensuring and/or maximising effectiveness. The importance of implementing the programme as originally specified and intended has also been highlighted in the literature. A **process evaluation and adequate monitoring procedures** may help identify whether the programme was implemented correctly and consistently, whether participants received an adequate proportion of the programme, and any barriers to implementation that need to be addressed. **Effects of any adaptations, intentional, accidental, or otherwise, should be evaluated**. Practitioners replicating an evidence-based programme should still evaluate the outcomes.

6.1.6 **Avoid quasi-military programmes**: None of the effective programmes identified had a military element, which is often linked to deterrence and discipline-based approaches. The bulk of research evidence clearly favours non-military-style programmes that aim to foster positive changes through skill-building, parent training, and therapy, for example when working with people affected by knife crime.

6.2 ***World Health Organisation (WHO) approaches to preventing Serious Youth Violence***

The WHO reviewed successful evidence-based interventions from all over the world, and concluded that approaches to preventing youth violence can be broken down into individual, relationship, community-based, and societal. Overall, strategies which research has shown to be effective include:




6.2.1 Overall, it is clear that **prevention begins at birth**, and that longitudinal approaches such as these will not necessarily show a clear benefit for a number of years – these are long-term rather than quick-fix solutions. However, the **potential cost savings are enormous**, as risk factors for serious youth violence are similar to those for Child Sexual Exploitation, Substance Misuse, and Mental Health Problems, among others.

6.2.2 Brent is currently developing an early years and primary school prevention programme aimed at building self-regulation in young children and resilience in families. The programme is built on evidence-based research as promoted by the Early Intervention Foundation and there are plans for a pilot to be in place in summer 2018. The proposal will need Schools Forum agreement for Dedicated Schools Grant funding.

## 7.0 Real World Approaches Utilising a Public Health Approach

### 7.1 ***Scotland Violence Reduction Unit (VRU)***

7.1.1 The Scottish VRU is a national centre of expertise on violence. Part of Police Scotland, the VRU targets violence wherever it occurs, whether it's on the streets, in schools or in homes. Supported by the Scottish Government the unit has **adopted a public health approach, believing violence is preventable, not inevitable, and treating violence as an infection which can be cured.**

7.1.2 Influenced by the 2002 WHO report referenced in Section 6.2, the VRU is the only police member of the WHO's Violence Prevention Alliance, and the only

police force in the world to adopt a public health approach to violence. The VRU teamed up with agencies in the fields of health, education and social work to create **long-term attitudinal change in society rather than a quick fix**. The VRU also focused on enforcement seeking to contain and manage individuals who carry weapons or who were involved in violent behaviour.

7.1.3 In tackling gang crime the unit imported a successful anti-gang violence initiative spearheaded in Boston in the 1990s. The Community Initiative to Reduce Violence (CIRV) programme broke up Glasgow's long established gangs by **offering gang members an alternative** to the violent lives they were living. The VRU also successfully lobbied for increases in maximum sentences for carrying knives. With studies suggesting police under-recorded violence by as much as 50 to 70% the VRU's researchers have carried out **injury surveillance in A&E departments**, helping to fully define the scale of the problem facing Scotland. The VRU have a selection of different projects that support their initiative. These include:

- ***Injury surveillance*** which helps to create a fuller picture of violence, providing agencies with more accurate data to inform the development of prevention and intervention strategies.
- ***Navigator*** who work in emergency departments in Glasgow and Edinburgh to help stop the revolving door of violent injury in hospitals. The programme engages with patients at a moment when they may be open to breaking free from the challenges trapping them in a cycle of violence.
- ***Medics against Violence (MAV)*** were set up in 2008 by 3 surgeons who dealt every day with the awful consequences of violence. They aim to prevent violence through education and now run an award winning secondary school programme. MAV volunteers (all NHS professionals) work with local schools going into classrooms and speaking directly to children about how to avoid violent situations and stay safe. To date MAV have reached over 150,000 young people.

## 7.2 *The Cure Violence Model*

7.2.1 Cure Violence stops the spread of violence by using the methods and strategies associated with disease control – resulting in reductions in violence of up to 70%. This model (originally called Ceasefire) was developed in the USA to respond to high gun crime, but many elements can be adapted to focus on knife crime. **It focuses on three things**:

7.2.2 ***Detect and interrupt potentially violent conflicts***: Trained violence interrupters and outreach workers prevent stabbings by identifying and mediating potentially lethal conflicts in the community, and following up to ensure that the conflict does not reignite.

- **Prevent Retaliations**: Whenever a stabbing occurs, trained workers immediately work in the community and at the hospital to cool down emotions and prevent retaliations – working with the victims, friends/family, and anyone else connected with the event.
- **Mediate Ongoing Conflicts**: Workers identify ongoing conflicts by talking to key people in the community about ongoing disputes, recent arrests, recent prison releases, etc. and use mediation techniques to resolve them peacefully.
- **Keep Conflicts 'Cool'**: Workers follow up with conflicts for as long as needed, sometimes for months, to ensure that the conflict does not become violent.

7.2.3 ***Identify and treat highest risk***: Trained, culturally-appropriate outreach workers work with the highest risk, meeting them where they are at, talking to them about the costs of using violence, and helping them to obtain the social services they need e.g. job training and drug treatment.

- **Access Highest Risk:** Workers utilize their trust with high-risk individuals to establish contact, develop relationships, and work with those most likely to be involved in violence.
- **Change Behaviours**: Engage with high-risk individuals to convince them to reject the use of violence by discussing the cost and consequences of violence and teaching alternative responses to situations.
- **Provide Treatment**: Workers develop caseload who they work with intensively (meet several times a week) assisting with needs such as drug treatment, employment, leaving gangs.

7.2.4 ***Mobilise the community to change norms***: Workers engage leaders in the community as well as community residents, local business owners, faith leaders, service providers, and the high risk, conveying the message that the residents, groups, and the community do not support the use of violence.

- **Respond to Every Stabbing**: Whenever a stabbing occurs, workers organise a response where dozens of community members voice their objection to the stabbing.
- **Organise the Community**: Workers coordinate with existing and establish new block clubs, tenant councils, and neighbourhood associations to assist.
- **Spread Positive Norms**: Program distributes materials and hosts events to convey the message that violence is not acceptable.

**7.3** ***Redthread Youth Violence Intervention Programme & Hospital Interrupting Violence Exchange***

7.31 The Youth Violence Intervention Programme runs in **hospital emergency departments in partnership with the major trauma network**. Every year, thousands of young people aged 11-24 come through hospital doors as victims of assault and exploitation. It is at this **point of crisis** that the Redthread youth workers utilise their unique position embedded in the emergency departments alongside clinical staff to engage these young victims.

7.32 This moment of vulnerability (the **'Teachable Moment'**) when young people are out of their comfort zone, alienated from their peers, and often coming to terms with the effects of injury, is a time of change. Many are more able to question what behaviour and choices have led them to hospital and, with specialist youth worker support, pursue change they haven't felt able to before. Redthread focus on this moment, supporting and encouraging young people to make healthy choices and positive plans to disrupt the cruel cycle of violence that can too easily lead to re-attendance, re-injury, and devastated communities.

7.33 Redthread also founded and coordinate the **Hospital-based Interrupting Violence Exchange (HIVE)**, a national network designed to help existing and emerging hospital-based violence intervention programmes share ideas and insights. Regular teleconferences are hosted for practitioners from different projects and areas of the UK to talk through opportunities and challenges. There is also an annual symposium, where all those working on the model get together to discuss the latest developments.

### 7.4 ***StreetDoctors***

7.41 StreetDoctors give **young people at risk of experiencing violence the skills and confidence to deliver first aid**. Set up by medical students, they are a registered charity led by medical volunteers. Sessions are tailored to be directly relevant to young people at risk of violence, including what to do when someone is bleeding and/or unconscious. Sessions are interactive, giving participants the chance to **practise CPR, the recovery position and managing blood loss**.

7.42 They help dispel the myth that there are parts of the body where it is safe to stab someone by explaining how the body's organs work and what happens when someone loses blood. StreetDoctors volunteers are young people themselves, which helps create a **peer-to-peer** relationship with the young people.

7.43 StreetDoctors also deliver **StepWise**, a peer education programme over 3-6 months which empowers young people at risk of violence to learn, share and teach emergency lifesaving skills. Young people are provided with first aid accreditation, career guidance and co-facilitate sessions alongside medical volunteers. This programme therefore goes further by offering personal development through **peer education, career development and first-aid accreditation**.

## 8.0 Tackling Knife crime in Brent – What We Currently Do

### *8.1 Community Protection*

8.1.1 **Offender Management Programme (OMP)** - focuses on Reducing Reoffending for priority offenders. This enhanced programme includes a targeted and coordinated partnership intervention for a range of offenders, including Knife crime offenders and Habitual Knife Carriers, among others. Support includes offenders under 18 years old, and utilizes provision from commissioned services, such as Air Network and St Giles Trust (see below).

8.1.2 **Air Network** - provides a Mentoring, Sports and well-being programme supporting those on the Offender Management Programme, comprised of an extensive community-based mentoring, activity and personal development programme. This includes an under 18s worker, who focuses on providing support to those known to the Youth Offending Service (YOS) and other CYP services. Workers have prison access to provide support to cohort offenders prior to release, meet the targeted cohort at the prison gate when released, and escort to release appointments. The service has flexible working hours including an out-of-hours service. Workers provide assistance with appointments if needed (e.g. escort to probation appointments) and provide support around the nine pathways of re-offending (including housing support and assistance securing housing, education, training and employment, and support with drug and alcohol needs).

8.1.3 **St Giles Trust - Gangs Intervention Programme (2017-19)** aims to challenge and work with those involved in gangs to change their behaviour, while holding them to account to take responsibility for their actions. The programme encourages those involved in gangs to exit gang lifestyle and stop carrying knives. Early intervention is provided to those identified as being on the

periphery of gang offending. The Gang Mentors Education Programme provides two mentors, one for over 18s and one specialist young person's mentor. Each mentor engages and supports identified individuals involved in gangs that cause the most harm and risk in the borough to reduce their involvement in gangs and achieve positive outcomes. Educational programs are offered to all Brent schools to provide early intervention and prevention and increase awareness around the consequences of joining a gang. There is also a peer training project offered to those who have engaged significantly with the Gang Intervention programme and exited gang lifestyle, as well as gang awareness training for professionals who work with gang-affected people and/or families, to build awareness around the issues and how to best support those involved.

8.1.4 **Youth Gangs worker (2017-19/21**): Community Protection successfully bid for London Crime Prevention Fund (LCPF) funding to increase funding of interventions to tackle serious youth violence and gangs. This funds a youth gangs worker who provides specialist support for CYP engaged in statutory services on the periphery of gang involvement, integrated into the Youth Offending Service (YOS): half of cases are YOS nominals and half are allocated to Family Solutions and wider Children's Services referrals. The worker supports CYP to exit gangs, develop greater empathy, access mentoring provision and diversionary activities, and obtain formally accredited achievements. Work includes: victim awareness; joint enterprise; knife crime; consequences of the index offence/arrest; consequences of crime more generally; gangs lifestyle – strategies to avoid been drawn into gangs; county lines and drug dealing; home visits; goals and aspirations setting; supporting young people to develop positive interests – in sports/music/hobbies.

8.1.5 **The Partnership Tasking Team (PTT)** provide focused policing activities linked to the Safer Brent Partnership priorities and the MOPAC local priorities, including Violence with Injury – non DA. Fortnightly tasking enables the PTT officers to respond to local issues of high concern and this is mirrored and aligned to the work of the Police Safer Neighbourhood Officers and other Policing departments. Working together has increased policing capacity and we have successfully found illegal weapon stashes (knives and guns), removed street drug dealing in locations through the use of enforcement powers and techniques, safeguarded vulnerable CYP at risk of exploitation and prevented the escalation of ASB. Prolific individuals identified by the Partnership Tasking Team and Safer Neighbourhood teams will be referred to Brent's Local Joint Action Groups which meets monthly. Criminal Behaviour Order applications (CBOs) are sought on all individuals prosecuted for criminal offences who meet the threshold. CBOs are effective in prohibiting criminal groups from associating and even banning them from areas. Breach of these orders could lead to imprisonments and the PTT will also be central to monitoring and enforcing breaches through the courts. The PTT also undertake stop and search of known drug dealers and habitual knife carriers to help enhance deterrence mechanisms in hotspot locations.

8.1.6 **Identify, Quantify and Manage (IQM) Risk Tool** will employ Predictive Modelling, which uses a range of data sources from YOS, social care, schools, and gang area intelligence. The model draws upon risk indicators identified from extensive research for 'The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups'. The early identification of vulnerable CYP provided by the model will promote the use of

earlier cost-effective interventions, ensuring better decisions are made each time a young person engages with services. The model will introduce a quantifiable and objective risk assessment which can be managed across partner agencies. The dashboard can focus the current risk management partnership meetings already in place through providing instant intelligence and insight into priority cases, for example areas of high knife crime incidents. The tool is currently in development. The deployment of this model into a multi-agency environment will undoubtedly better safeguard the most vulnerable children through better risk management and early cohort specific interventions.

8.1.8 **Communication Campaign:** Community Safety are currently developing a hard-hitting honest media campaign focusing on the effects of Knife Crime. This includes working with Brent mortuary to educate the public on the dangers of knife wounds, taking a new perspective to raise awareness of the real impact on young people, their friends and family.

### *8.2 Children and Young People's Department*

8.2.1 **Early Help – The Youth Offending Service (YOS)**

- **Case manager supervision**: Statutory supervision sessions with young people offer needs-led individual support in line with assessed needs, such as anger management and resolving conflicts without the use of knives. A lot of offending behaviour sessions with young people focus upon consequential thinking so that they are better able to make safe decisions and take responsibility for their actions. All YOS caseworkers have been trained to provide Beyond The Blade training to young people.

- **Group work programmes**: The YOS delivers a rolling eight-week Weapons Awareness Programme (see below). Other programmes which have a clear violence with injury focus include Crime Prevention presentations jointly delivered with the police, and Victim Awareness Sessions delivered by the Brent Centre for Young People.

- **Weapons Awareness Programme:** Delivered in consultation with the police and other agencies to children and young people who have been known to be involved in, or identified as vulnerable to involvement in, weapon related violence. The programme looks at carrying weapons and the effects that this has on those who carry weapons and others. It covers various topics including attitudes to carrying knives, the law, social implications of knife crime, victim awareness, conflict management and physical and mental health consequences. Young people are encouraged to address their attitudes and develop skills that allow them to understand the consequences of this type of behaviour and how it impacts upon victims and the wider society. The programme includes a session with a victim's mother who talks about her experiences, and a session with a police officer about the law and issues surrounding stop and search. The young people's parents are invited in on the last session to discuss their children's learning. The programme is delivered and facilitated by YOS practitioners and also external providers, including **StreetDoctors** who provide sessions on the impact of knife crime.

- **YOS Risk Management Panel** is a multiagency group that provides regular oversight and coordination of provision for young people who have been

assessed as posing a high risk of harm to the public or themselves including where knife crime has been identified.

- **Adoption of the Trauma Informed Approach**: All YOS case managers and managers have been trained in the Trauma-Informed Approach which offers a wider understanding of the issues relating to the pattern and behaviour of offending and improves YOS's ability to tackle knife crime by providing a psychology-led approach to multi-agency case formulation and intervention planning. This, in turn, will enable youth justice staff to tailor and sequence interventions more effectively according to the developmental and mental health needs of individual young people; Helping YOS staff to manage the impact upon themselves of trauma in their work with young people.

- **Partnership working**: with a range of key services within the Council such as Family Solutions, social work services and Inclusion and externally with CAMHS, Police, Brent River College (PRU), Employment Training and Education providers and schools to provide a joined up approach to reducing risk of harm to CYP and the communities they live, socialise and learn in.

8.2.2 **Early Help – the Family Solutions Team** contribute towards prevention of knife crime in a number of ways:

- **Troubled Families Programme**: Supporting especially vulnerable families that have been 'stepped down' from statutory children's social care or are at likely risk of escalating problems. Intensive family support that aims to promote resilience and reduce the risk of escalation.
- **Early Help offer**: families at the greatest risk of escalating problems have access to a 'team around the family' model of integrated and intensive family support to ensure families have tailored support when children in need/child protection plans have been discharged. This is available for families with children and young people aged 0-19 years old and is responsive to family needs. The families that benefit from early help have needs which fit within Levels 2 and 3 of Brent's 4 levels of need. Early Help teams are based within Children's Centres.

8.2.3 **Inclusion – Youth Provision**: There is one Council Youth Centre in the borough (Roundwood Youth Centre), with facilities including a Café, IT suite, multi-use games area, media area, performance area, and dance studio. Brent Connexions Service provides 6 targeted support workers for young people at risk of/who are Not in Education, Employment or Training (NEET), or are at risk of becoming NEET, by signposting to various services including SEND, YOS and CAMHS. The workers act as personal advisors, supporting young people through the journey back into education/work and enabling them to make informed choices about their future.

8.2.4 **Setting and School Effectiveness – Schools** receive an **educational programme in primary schools** within Brent to provide early intervention and prevention by increasing awareness of the consequences of joining a gang, covering different themes including knife crime. This is provided by St Giles and funded by the Brent Safer Neighbourhoods Board. For secondary schools and Pupil Referral Units (PRU's), **Your Life You Choose (YLYC)** delivers a one-day multi-agency presentation to educate young people about the consequences of crime, not only for the offender but their family and friends,

victims and the wider community. The project is led by magistrates in the North West London Justice Area. YLYC Brent brings together magistrates, police – safer schools officers & trident officers, prison officers, inclusion officers, Directions project – ex offenders, paramedics, education consultation in cyberbullying & sexting.

### *8.3 Public Health*

8.3.1 **Maternal Early Childhood Sustained Home visiting (MECSH)** is a new model for the delivery of effective sustained home visiting. MECSH is not an added programme: it is an evidence-based programme that is delivered by health visitors to the families in their caseload in need of additional support: those in the universal plus and partnership plus, and also for some families requiring an intensive multi-agency care package.

8.3.2 MECSH has developed as a manualized home visiting programme that, uniquely, is fully integrated within public health and community services and achieves both individual family and whole population improvement. It provides support during those critical sensitive periods in child development, and curriculum that promotes children's health and development in all areas: it particularly focusses on emotional control, habitual ways of responding, symbol, language and social skills.

8.3.3 Brent Public Health has recently commissioned the **New Beginnings Service from Westminster Drugs Project (WDP)**, the integrated treatment recovery and wellbeing service for substance misuse in Brent which includes a focused young people's service. The New Beginnings service will continue to support a range of strategic initiatives across the workstreams of the Safer Brent Partnership as well as the continued work to support drug misuse offenders across the criminal justice system including the local probation office, Willesden Magistrates and the London prison estate. The young people's service will be relaunched and will target those young people impacted or directly affected by substance misuse, as well as issues that impact on their wider environment such as gang and knife crime. It will include a co-located post with the Youth Offending Service.

8.3.4 Many of those who access the services provided through New Beginnings have been directly or indirectly involved as either perpetrators or victims of knife-related crime. The precise number and scale needs to be mapped. Knife crime and its aftermath directly impacts on those accessing the specialist young people's service. A key area for the New Beginnings Service is to ensure that people engaging in treatment and recovery services are no longer engaged with local drugs markets with all staff trained to deliver brief interventions targeting the carrying of knives. The services at Cobbold Road and Willesden Centre for Health and Care have a zero tolerance policy to the carrying of weapons both in and around service buildings and threats to staff inferring that people are carrying weapons.

8.3.5 The young people's service will be relaunched, re-focused and will target working with those young people directly or indirectly affected by substance misuse and issues that impact on their wider environment such as gang and knife crime as well as including a co-located post with the Youth Offending Service. The service will offer a range of interventions including group work,

one to one support, outreach and drama workshops as well as wider interventions around bullying and resilience.

### *8.4 Health*

8.4.1 **Redthread** (discussed above in point 6.3) are based in St Marys Hospital to provide support to young people who enter the hospital suffering from a violent injury.

### *8.5 Wider Services*

8.5.1 **Outcome Based Reviews** – Council wide reviews into Gangs, Domestic Abuse and Children at the Edge of Care include key partners and community members. Findings due to be shared in the summer with new initiatives and programmes being developed.

8.5.2 **Brent Council Communications team** have delivered a number of local campaigns and events including 'It's Time to Talk' campaign focused on working with and empowering residents and community leaders to tackle issues such as hate crime, gangs, child sexual exploitation, domestic abuse and extremism. This work involved partnering with The Beat London 103.6 FM to hold a series of panel discussions on the issues. The team also promotes the message from the Mayor of London's Anti-Knife Crime Campaign through Brent's communications channels, including social media, Your Brent (our fortnightly newsletter) and The Brent Magazine.

8.5.3 **Local Safeguarding Children Board (LSCB):** Contextual Safeguarding. Following two fatal stabbings of young people in Brent in 2017, the Board commissioned a learning event to discuss serious youth violence in January 2018 where Dr Carlene Firmin, Principal Research Fellow at the University of Bedfordshire, presented on contextual safeguarding. This concept promotes the idea that young people's behaviours, levels of vulnerability, and resilience are all informed by the social/public, as well as private, contexts in which young people spend their time. When spending time in extra-familial contexts, young people may be exposed to healthy norms which promote pro-social relationships or they may encounter harmful norms that are conducive to abusive and exploitative relationships. Redthread was also represented at this learning event.

Robust and cohesive partnership working is needed across our diverse sectors and professions to influence the environments in which abuse and harm can occur to effectively safeguard children and young people in Brent.

At the April 2018 LSCB Board meeting it was agreed to reduce the number of priorities from four to the following three: Domestic Abuse; Neglect; and Child Exploitation. An agreement was also made to widen the child sexual exploitation priority to child exploitation to focus on issues such as missing children, gangs and knives as well as sexual exploitation.

8.5.4 **Brent Safeguarding Adult Board (BSAB)** expects safeguarding assessments, and assessments for care and support, to include a focus on keeping safe, and in some circumstances this might include a focus on prevention of, or protection from knife crime. They also expect strong co-operation across agencies, for example in the sharing of relevant information to help prevent and detect crime. The Board itself does seek to raise awareness

of different forms of abuse and neglect and works closely with other Boards and partnerships when focusing on prevention and protection.

8.5.5 **Police**

- **Emergency Response** via 999/101.
- **Proactive work in hotspot areas** using Stop and Search powers, plus dispersal and Sec 60 legislation when available to identify, deal with and deter knife and weapon carriers. Body-worn video provides support and accountability to interactions.
- Dealing with **outstanding wanted offenders** linked to violence and knife crime.
- **Safer Neighbourhoods**: Carry out weapons sweeps in conjunction with local community ranging from youth groups to local residents. Patrols aimed at dealing with ASB and criminality associated with street-drinking in hotspot areas. Work in conjunction with partners through the Local Joint Action Boards to address locations and addresses where criminality occurs or is based, e.g. crack house closure work leading to a decrease in drugs use and associated acquisitive and violent crime in the area. Dealing with outstanding wanted offenders linked to violence and knife crime. Participating in **Operation Sceptre** activity aimed at identifying and dealing with habitual knife carriers and linked offending. Execution of drugs warrants resulting in crime and ASB reduction in the immediate area.
- **Schools Officers**: Provide talks in assembly and with groups around knife carrying. Weapons arch in association with schools. Liaise with Pupil Referral Units to identify and divert young people from crime and violence. Provide summer school work to divert young persons from gang activity.
- **Licensing**: Proactive and reactive work to deal with issues connected with licensed premises, reviews where required and assistance rendered to licensees to run safe venues. Proactive work done on Wembley event days to ensure licensed premises operate in a safe manner with a view to reducing criminality, violence and offences committed by those attending events especially football.
- **Crime Wing**: Reactive response to violent crime – secondary investigation, detailed suspect handling and ongoing victim support with use of Family liaison Officers where required. Dealing with outstanding wanted offenders linked to violence and knife crime. Dealing reactively with domestic abuse matters, ensuring victim supported, victimless prosecutions used if required
- **Gangs Unit and Crime Squad**: Targeted work at persons involved in crime on Brent and borders. Participation in operations such as Operation Viper aimed at offenders involved in gang crime, knife, weapons and violent criminality. Participating in Operation Sceptre activity aimed at identifying and dealing with habitual knife carriers and linked offending.

## 9.0 Gaps

### *9.1 Prevention*

9.1.1 There is a **gap of support for vulnerable adults and young people who do not meet the threshold for our Offender Management Programme or YOS services**. The OMP only works with those who have been arrested, and YOS only works with those who have been given triage, a caution, or have been sentenced. While efforts have been made to work with young people at an earlier stage (i.e. after their first offence) we could provide more services for youths who are high risk but yet to offend. This could be supported by the

Troubled Families agenda and also by an on-street based intervention, with a peer network targeting known hotspot locations with earlier identification and engagement of potentially vulnerable young people as is being suggested from the Outcome Based Reviews.

9.1.2 There is a **gap of provision for young people to access to divert them off the streets**. Although there are community-led youth activities, many of these involve a financial cost which excludes some higher-risk CYP including an increased number linked to the Young Brent Foundation. Free youth activities could therefore be increased in the borough, as could extra-curricular school activities and on street positive/peer support. The Young Brent Foundation could strengthen our partnership with other youth clubs – the Council already works with The Unity Centre but could strengthen partnership with the OK Club, South Kilburn. Research suggests that youth clubs need to provide structured activities (such as sport, art or drama) in order to improve youth outcomes. Youth activities that take place regularly, in a group setting, with a clear hierarchy and well defined aims help children to develop better social and emotional skills, and can offer structure to children who lack it at home.

9.1.3 There is a **gap in terms of mapping and tracking vulnerable children from birth and assessing their risk**. While a predictive model is being developed within Community Safety, there is currently no resource around mapping potentially vulnerable peer groups and deploying prevention measures.

9.1.4 There is a **gap around providing social development programmes in nursery/infant/primary schools**. These programmes reduce antisocial and aggressive behaviour in children, and consequently reduce violence among adolescents. They adopt a variety of strategies, typically focusing on one or more of the following: managing anger; modifying behaviour; adopting a social perspective; moral development; building social skills; solving social problems; resolving conflicts. Evidence suggests these programmes can be effective in reducing youth violence and improving social skills. Programmes emphasizing social and competency skills are among the most effective youth violence prevention strategies (see section 6.2.2 above).

### *9.2 De-escalation*

9.2.1 There is a **gap around providing immediate rapid response on-street disruption of knife-related incidents**. A core facet of the Cure Violence model is violence interrupters, who intervene in conflicts as they occur, using mediation techniques to de-escalate incidents and prevent retaliation. Brent currently has no similar service.

9.2.2 There is a **themed gap around wider street presence of outreach workers on the streets of Brent**. As well as providing services to keep young people off the streets (see section 9.1.2) it is important to have outreach workers who regularly walk the neighbourhood. This helps disrupt knife crime, as well as the perception of crime in an area, by providing visible and active outreach in the community. Outreach workers hold caseloads of high-risk clients and provide mentoring and positive activities similar to that currently provided by St Giles and Air Network. However, our outreach workers do not currently engage with young people who are not already known to services on the street. Aligning with Community Safety's focus on hotspot areas, we need to ensure that we have offers of support in areas of high risk and vulnerability, targeting more location

based support. For example, the Local Joint Action Groups (LJAGs) could share information about low-level offending of CYP with the YOS to ensure that any anti-social behaviour is known to YOS workers and breaches are quickly and effectively addressed; as well as offering preventative outreach to those not known to YOS.

### *9.3 Rehabilitation*

9.3.1 There is a **gap around providing employment opportunities for those who are attempting to leave criminality behind**, especially those with a criminal record. While Air Network does encourage clients to work towards qualifications (e.g. as a lifeguard), more could be done to partner with local businesses and establish apprenticeships for ex-offenders. More could also be done to identify appropriate employment opportunities within the council for ex-offenders, and encourage those with a criminal record to apply to such jobs.

9.3.2 There is a **gap around providing through-the-gate provisions for offenders nearing release to ensure a smooth transition back into the community**. This requires working in partnership with Young Offenders Institutions (YOIs) to ensure that the necessary support in place (we have begun to do this by commissioning Air Network to work within prisons, but more could be done).

## 10.0 Proposed Solutions

The proposals outlined below are recommended based on the research discussed in section 6, the successful programmes highlighted in section 7, and the gaps in Brent's provision identified in section 9. Funding for these proposals would need to be sought and only then could proposals be given more detail and definitive next steps around public health contributions be established.

### *10.1 Prevention*

- Work with young people at an earlier stage, providing support for Children and Young People (CYP) who are both low and high risk but yet to offend, targeting support at an early stage, and supporting those on the periphery of offending. This could be done by recruiting outreach workers specifically for high risk youths who are yet to offend. These workers would have a visible presence in the community, walking streets in high-risk areas to engage with CYP on-street to build their client base, as well as holding caseloads and providing 1-1 and/or group mentoring.

- More extra-curricular activities for young people. Both in schools and youth centres. Community groups/voluntary sector organisations could take the lead on this.

- Adapt the predictive model to focus on serious youth violence, in order to alert frontline workers to high risk CYP before they have offended. This is particularly important given that the type of first time offenses perpetrated by CYP are increasing in severity.

- Develop an early intervention predictive analytics tool to enable identification for additional support to families with children from age 2-3.

- Social development programmes for CYP.

- Follow up all siblings of individuals who come to our attention for a knife-related incident.

- Employ StreetDoctors to provide presentations in all Brent primary and secondary schools.

- Develop preventative programmes to be delivered in Early Years settings and primary schools.

### *10.2 De-escalation*

- Employ Violence Interrupters for the borough. Violence Interrupters were first employed in the Cure Violence model (see point 7.2). Their role is to mediate conflicts as they occur and to prevent retaliatory stabbings.

- Increase the number of outreach workers working outside of core working hours (at weekends and in the evenings) and offer on-street peer support to young people from low-high risk.

### *10.3 Rehabilitation*

- Develop a programme encouraging ex-offenders to apply for council jobs.

- Working with local businesses to develop apprenticeships for at-risk young people.

- Prioritise habitual knife carriers/knife-related offenders when referring to St Giles/Air Network.

- Targeted programme for knife-related robbery (In response to the news that 60% of Brent knife crime is robbery-related).

### *10.4 Training for Professionals*

- Regular training for frontline workers (including health professionals) to ensure they know what is available and make accurate referrals.

- Regular training for school-based staff about the signs/implications of knife carrying and gang involvement.

- Clear guidance on referral pathways for primary school (and younger) children who are displaying early risk factors but fall below statutory thresholds.

- Expand Beyond The Blade training to all frontline staff.

- Train all frontline staff in the Trauma Informed Approach.

- Contextual Safeguarding training.

- Training for social workers by ex-gang members. Previously this has been delivered by St Giles and those who attended said ‘it was very useful as it

- helped staff know what questions to ask CYP and how to interact with high-risk CYP'.

## 11.0 Financial Implications

11.1 The proposals stated in section 10 of this report are to be delivered by external health partners and will be financed by the delivering organisation. The only impact on the Council's budgets will be by way of officer time used to support organisations to secure funding and integrating any commissioned programs into existing delivery. The cost of officer time will be contained within existing approved staffing budgets.

## 12.0 Legal Implications

12.1 There are no direct specific legal implications arising from the recommendations in section 2 of this report and the proposed solutions in section 10 of this report.

## 13.0 Equality Implications

13.1 Under section 149 of the Equality Act 2010, the council has a duty when exercising its functions to have "due regard" to the need to eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act and advance equality of opportunity and foster good relations between persons who share a protected characteristic and persons who do not. This is the public sector equality duty.

13.2 The protected characteristic is defined in the Act as: Age, Disability, Gender reassignment, Pregnancy and maternity, Race (including ethnic or national origins, colour or nationality), Religion or belief, Sex and Sexual orientation. Marriage and civil partnership are also a protected characteristic for the purposes of the duty to eliminate discrimination. The previous public sector equalities duties only covered race, disability and gender.

13.3 All commissioned services collate data relating to equality as part of the programme of work including gender, disability, sexuality, ethnicity, and age (with particular interest in young victims and perpetrators). The commissioned services are monitored on their ability to deliver effective services to specialist BME cohorts, and to link in with other local specialist partners to facilitate this.

## 14.0 Consultation with Ward Members and Stakeholders

14.1 There has been several consultation meetings with stakeholders, community members and lead members around the issues related to knife crime in recent months.

## 15.0 Human Resources/Property Implications (if appropriate)

15.1 None.

***Report sign off:***

***Amar Dave***
Strategic Director of Regeneration and Environment

***Gail Tolley***
Strategic Director of Children and Young People

***Melanie Smith***
Director of Public Health

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| Brent<br>NHS Brent Clinical Commissioning Group | **Health and Wellbeing Board**<br>17 July 2018 |
| | **Report from the Director of Public Health** |

# Mental Wellbeing in Brent - Update

| | |
|---|---|
| **Wards Affected:** | All |
| **Key or Non-Key Decision:** | N/A |
| **Open or Part/Fully Exempt:**<br>(If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act) | Open |
| **No. of Appendices:** | N/A |
| **Background Papers:** | N/A |
| **Contact Officer(s):**<br>(Name, Title, Contact Details) | Sangeetha Ilanko<br>National Management Trainee, Public Health<br>Email: Sangeetha.ilanko@brent.gov.uk<br>Tel: 020 8937 2575 |

## 1.0 Purpose of the Report

1.1 This report updates the Board on the local work undertaken to promote mental wellbeing in response to Thrive LDN.

## 2.0 Recommendations

2.1 The Board is asked to:

- endorse Thrive LDN's principles
- note the Thrive LDN campaign and consider how it is relevant to the local context
- consider how the public event in the autumn can best be promoted locally
- note the development of the mental health and employment OBR, and its link with the work around mental wellbeing.

## 3.0 Detail

3.1 In 2017, the Mayor of London and the London Health Board launched Thrive LDN - a city-wide movement aspiring to promote mental wellbeing, prevent illness and eliminate suicide in London. The initiative was launched to help overcome the challenges that exist around mental wellbeing. In the UK, the poor mental wellbeing of the population is reflected by the prevalence of common mental health problems (this includes depression, generalised

anxiety, obsessive compulsive disorder and post-traumatic stress disorder). Over the course of a week, one in six people report experiencing a common mental health problem in the UK[1]. Other challenges include low mood levels, stigma and discrimination around mental illness, inequalities in the workplace and high suicide rates. In Brent, 16.7% of the population self-reported high levels of anxiety last year, whilst 17% self-reported feeling low levels of life satisfaction[2].

3.2 Thrive LDN has 6 aspirations:

1) A city where individuals and communities take the lead
2) A city free from mental health stigma and discrimination
3) A city that maximises the potential of children and young people
4) Develop a healthy, happy and productive workforce
5) A city with services that are there when and where needed
6) A zero suicide city
    - Reduce the suicide rate in the general population
    - Provide better support for those affected/bereaved by suicide

3.3 In January 2018, the Health and Wellbeing Board supported a community workshop run by Thrive LDN and the Mental Health Foundation. Over 60 individuals attended including; residents, councillors, council officers, NHS providers, commissioners, and representatives from community and voluntary sector organisations. There was general support for the six aspirations of Thrive LDN, however representatives also recognised the particular strengths and challenges of Brent.

3.4 Following the workshop, the CCG, Public Health, CNWL, HealthWatch and voluntary organisations have been working on a local action plan using 4 of the 6 Thrive LDN principles as a framework:

A) A borough where individuals and communities take the lead
B) A borough free from mental health stigma and discrimination
C) Develop a healthy, happy and productive workforce
D) Suicide prevention

Other existing groups are focusing on principle 3 (children and young people's mental wellbeing) and principle 5 (mental health services).

3.5 The evidence base which recognises what promotes mental wellbeing and resilience is growing. The evidenced factors are often referred to as the '5 ways to wellbeing'[3] (akin to the 5-a-day message on physical health). These are:

- Connect.
    - Connect with family, friends and neighbours- this could be in the local community, at home, work and/or school. Public Health England estimate the impact of social isolation on health to be equivalent to 15 cigarettes a day[4].

[1] Adult Psychiatric Morbidity Survey (APMS, 2014)
[2] Public Health Outcomes Framework (Public Health England, 2017)
[3] Five Ways to Wellbeing. New Economics Foundation 2010
[4] Holt-Lunstad J, Smith TB, Layton JB (2010) Social Relationships and Mortality Risk: A Meta-analytic Review.

- Be active.
  - Physical activity is beneficial to both mental and physical health.

- Take notice.
  - Savouring the moment and taking notice of the world around oneself.

- Keep learning
  - Continued learning enhances self-esteem, social interaction and a more active lifestyle.

- Give
  - This does not necessarily imply formal volunteering- it could simply entail doing something nice for someone else.

3.6 In Brent, there are a wealth of opportunities and organisations providing potential ways to wellbeing. However, these are not always seen as a means to improve and maintain emotional wellbeing, and they do not always connect to people or to one another. Simultaneously, individuals and organisations may wish to get involved in the promotion of mental wellbeing, but feel ill-equipped to do so.

3.7 For these reasons, it is suggested that a campaign be explored with the aims of working with local organisations, communities and residents to:

- better equip provider organisations and groups to confidently promote mental wellbeing to residents
- raise awareness of the support that exists locally for good mental health
- raise awareness of the ways to wellbeing and showcase the potential for recovery and resilience (through capturing and sharing residents' experiences and stories)

3.8 This will 'piggyback' on and help frame the planned engagement over the summer by the local Increasing Access to Psychological Therapies (IAPT) service. Brent Talking Therapies already engage with the community with the purpose of identifying individuals with feelings of low mood, anxiety, particular fears, and/or problems coping with daily life and relationships. IAPT are looking to expand their engagement through various new avenues.

3.9 Thrive LDN are about to launch a summer awareness-raising campaign following on from last year's Are we OK London? campaign. This summer, the focus will be on inequalities in mental health. Public health, communications and the CCG will work together to explore how Thrive LDN's materials can be used locally in order to start conversations with local people and groups.

3.10 These conversations will lead up to an event in the Civic Centre in the autumn time. The event will be designed alongside local people and community organisations and will:

- share the five ways to wellbeing message
- improve residents' awareness of what exists in Brent to support each of the five ways to wellbeing
- raise awareness of providers in Brent and

- share stories of resilience, recovery and prevention

By attending the event, residents will:

- be better informed about how to cope with mental distress
- learn how to maintain positive wellbeing through the five ways
- learn what practical steps can be taken to implement the five ways to wellbeing in Brent (how to make use of local facilities, community groups, events and activities)
- instil hope in residents that maintaining positive wellbeing is possible by hearing stories of recovery and prevention

**Planned Outcome Based Review on mental health and employment**

3.11 One of Thrive's aspirations is a city with a happy, healthy and productive workforce. This encompasses all employers making mental health and wellbeing central to the workplace, as well as assisting people who experience poorer mental health gain and maintain good work opportunities. This second aspect of the aspiration is a particular priority in Brent where there is a 59.5% gap in the employment rate between those in contact with secondary mental health services and the overall population rate5.

3.12 Adult Social Care undertook a mapping exercise to examine the provision of employment support for individuals with mental illness in Brent. The research identified:

- Numerous pathways and a lack of cohesion
- Misinformation between organisations and inappropriate referrals
- Gaps in provision
- Some potential areas of over capacity

These findings lead to the establishment of an Outcome Based Review (OBR) on mental health and employment. This workstream will work towards increasing the number of people with mental illness who find, retain and thrive in work. The OBR will assess the effectiveness of current arrangements and identify where and how outcomes can be improved. A scoping exercise for the OBR has been completed and has been approved by the CMT.

3.13 Outcome based reviews are established in the Council as a means of addressing complex problems using a clear methodology. The next step will entail initial engagement with key stakeholders during the discovery (research) phase. The OBR will build on what we have already learnt about the issues and challenges around work experienced by people with mental health conditions. This work will be delivered in the following phases:

[5] Public Health Outcomes Framework (Public Health England, 2017)

| Phase | Activities | Milestones |
|---|---|---|
| Phase 1 **DISCOVER** | ▪ Data collection and needs analysis<br>▪ Service mapping, focus groups and professional interviews<br>▪ Horizon scanning | ▪ Profile of need<br>▪ Service maps |
| Phase 2 **DEFINE** | ▪ Stakeholder event | ▪ Stakeholder event held<br>▪ Priorities / ideas agreed |
| Phase 3 **DEVELOP** | ▪ Development of shared commissioning approach | ▪ Draft commissioning approach |
| Phase 4 **DELIVER** | ▪ Roll out of approach | ▪ Approach implemented |

The OBR will involve the local Thrive workstream and draw upon the work of Thrive LDN.

## 4.0 Financial Implications

4.1 There are no direct financial implications as a result of this work

## 5.0 Legal Implications

5.1 There are no legal implications of this work

## 6.0 Equality Implications

6.1 The Thrive LDN summer campaign will highlight equality concerns in mental health.

## 7.0 Consultation with Ward Members and Stakeholders

7.1 Councillors and Stakeholders were included in the original workshop and will be invited to the follow up event.

***Report sign off:***

**Melanie Smith**
Director of Public Health

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| Brent / NHS Brent Clinical Commissioning Group | **Health and Wellbeing Board**<br>June 2018 |
| | **Report from the Chair of Brent Children's Trust** |

# Brent Children's Trust Update November 2017 - March 2018

| | |
|---|---|
| **Wards Affected:** | All |
| **Key or Non-Key Decision:** | N/A |
| **Open or Part/Fully Exempt:**<br>(If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act) | Open |
| **No. of Appendices:** | One:<br>• Updated Governance Structure of the BCT, JCG and five Transformation Groups |
| **Background Papers:** | N/A |
| **Contact Officer(s):**<br>(Name, Title, Contact Details) | Gail Tolley<br>Strategic Director Children and Young People<br>Email: gail.tolley@brent.gov.uk<br>Tel: 020 8937 6422<br><br>Wendy Proctor<br>Strategic Partnerships Lead<br>Email: wendy.proctor@brent.gov.uk<br>Tel: 020 8937 4237 |

## 1.0 Purpose of the Report

1.1. The Brent Children's Trust (BCT) is a strategic partnership body made up of commissioners and key partners. The primary functions of the BCT include commissioning, joint planning and collaborative working to ensure that resources are allocated and utilised to deliver maximum benefits for children and young people.

1.2. The BCT reports to the Brent Health and Wellbeing Board (HWB) and has a strong relationship with Brent Local Safeguarding Children Board (LSCB). Through its Joint Commissioning Group (JCG), the BCT oversees five groups tasked with implementing specific priorities operationally across the partnership.

1.3. The BCT provides the Brent Health and Wellbeing Board with an update paper every six months, with the previous report having been presented at the October 2017 meeting. This paper provides a broad summary of the BCT work programme and actions of the JCG from November 2017 to March 2018.

## 2.0 Recommendations

2.1. The Health and Wellbeing Board is asked to:

- note the work of the Brent Children's Trust for the period November 2017 to March 2018
- champion the protection of CAMHS service funding from 2019/2020

## 3.0 Detail

2.2. The BCT meets six times a year to review progress of its work programme and address emerging issues locally and nationally. Between November 2017 and March 2018 the BCT met three times on 14 November 2017, 23 January 2018 and 13 March 2018.

2.3. The BCT, JCG and transformation groups have consistent attendance with representation from Brent Council and Brent CCG.

2.4. The JCG also meets every two months to progress the Joint Commissioning Framework and consists of the Chairs of the five Transformation Groups, Brent CCG Children's Commissioner, Brent Council Children's Commissioner, and other key stakeholders. Three school head teachers have also been active standing members of the JCG since September 2017.

2.5. In November 2017 the BCT agreed a proposal to replace the Maternity and Children Under Five Transformation Group with the Working with Families Strategic Board in order to strengthen the focus on early help.

2.6. The diagram in Appendix A provides an overview of the updated governance structure of the BCT, JCG and five Transformation Groups.

2.7. Between October 2017 and March 2018 the BCT examined three main strategic themes:

2.7.1. **Special Educational Needs and Disabilities SEND Inspection follow up**

- Following the joint Ofsted and CQC SEND Inspection carried out in Brent in May 2017, a Written Statement of Action (WSoA) was produced and approved by Ofsted in November 2017.
- The BCT continues to have oversight of the implementation of the WSoA monitoring programme.
- The BCT recognises that progress has been made with several achievements to date including:
  - the establishment of a joint commissioning work stream to develop joint specifications for paediatric therapy services
  - the appointment of an interim joint CCG and Local Authority post - Joint Children's Commissioner
  - the development of a draft agreement to formalise the occupational therapy arrangements between the CCG and Local Authority
- The BCT provided direction and support to the development of a draft SEND strategy which also included engagement from the Inclusion Strategic Board and Brent Parent/Carer Forum.
- The BCT agreed the focus of the monitoring programme would be on evidencing impact.

2.7.2. **The Inspection of Local Authority Children's Services (ILACS)**

- The BCT reviewed the new Ofsted framework for the Inspection of Local Authority Children's Services (ILACS), Brent's progress since the previous inspection in 2015 and preparation for an inspection in 2018 under the new arrangements.
- It is likely that Brent Council will be inspected during 2018 as inspections are to be carried out within six months of the three-year anniversary of the previous inspection (Brent's previous Ofsted inspection took place in September 2015).

2.7.3. **Childhood Obesity**

- The BCT acknowledge childhood obesity is an issue in Brent and support the activity being undertaken to address this through the joint partnership work of the STP Prevention DA1 Board.
- The BCT recognises that the levels of childhood obesity in Brent exceed those of similar boroughs and the challenges with what is considered normal with regard to weight, balanced diets and exercising habits in Brent.
- The BCT contributed to the development of the briefing paper on Childhood Obesity submitted to the Community and Wellbeing Scrutiny Committee in February 2018. It noted that parents, schools and education settings and young people (e.g. Brent Youth Parliament) should be consulted and involved in work undertaken to address this.
- The BCT supports the range of measures being undertaken including:
  - the council and partners signing up to the Declaration on Sugar Reduction and Healthier Food commitment
  - the inclusion of the healthy high streets approach in Brent's Local Plan
  - encouraging schools to implement the 'Daily Mile/Marathon Kids' for their pupils
  - further development of the under-fives activities offer

2.8. The BCT's work programme also covered the following areas:

2.8.1. **Brent LSCB's 2016/17 Annual Report**

- The BCT continues to work collaboratively with the Brent LSCB. The LSCB Chair is a standing member of the Children's Trust and shares the LSCB annual report with the BCT.
- The Brent LSCB 2016/17 Annual Report was presented to Brent Children's Trust in November 2017.
- The LSCB Chair highlighted the significant legislative changes introduced through the Children and Social Work Act 2017 to replace Local Safeguarding Children Boards (LSCBs) with locally determined safeguarding arrangements to be developed, agreed and delivered by three statutory safeguarding partners, local authorities, CCGs and police.
- Until the three Brent Safeguarding Partners have agreed the new safeguarding oversight arrangements and have set out a timetable for transition, the LSCB continues to be the strategic safeguarding oversight board for Brent.

2.8.2. **Signs of Safety England Innovation Project 2 (EIP 2)**

- Following Brent's successful engagement in the first Signs of Safety England Innovation Project (EIP 1) which ended in 2016, Brent was successful in securing funding through phase two of Signs of Safety England Innovations project (SoS EIP 2). This phase is a two year project that will run through to September 2019.
- The BCT contributed to the development of the Brent Council Signs of Safety Implementation plan and supports the actions set out in the plan to develop partnership engagement in the implementation of Signs of Safety across Brent.

2.8.3. **Children and Young People's Mental Health and Wellbeing Local Transformation Plan**

- The BCT continues to be a key forum to share, discuss and inform the development of the shared vision to reshape services supporting children and young people's mental health and emotional wellbeing in Brent.
- As a result of the recognition that insufficient progress had been made in delivering the local transformation plan, an accelerated pace of work was instigated in January 2018 supported by the new Joint Children's Commissioning Manager who developed an updated implementation plan.
- While the BCT recognised that access to specialist CAMHS services has significantly improved and appointment targets are being met, some consideration should be given to evidencing the positive impact this work has had on children and young people in Brent.
- The Local Authority is working with the CCG to explore how the Whole Systems Integrated Care Dashboard can be utilised in order to provide better communication and sharing of relevant information across the health and social care system.
- It is anticipated that funding from NHSE for CAMHS transformation will cease in 2019/2020. While some of the redeveloped services are no longer reliant on transformation funding there is concern that other services would be vulnerable to the reduction of funding.

2.8.4. **Looked After Children (LAC) and Care Leavers**

- Focused work has been undertaken to improve LAC health outcomes and the strong partnership monitoring between the Local Authority, CCG and other health providers has improved the quality of LAC health assessments.

- The BCT contributed to the development of the Brent Care Leavers Charter which was approved by the Corporate Parenting Committee in February 2018.
- The BCT welcomed the results of the Bright Spots 2017 survey which found that LAC and care leavers were broadly happy with foster carers, teachers and social workers, however, they wanted more contact with their family and siblings.
- The BCT supports the identified action for the Local Authority to review all LAC family contact arrangements in response to the survey results.

2.8.5. **Working with Families (Troubled Families)**

- The Working with Families (WwF) Strategic Board now directly reports to the BCT following agreement in November 2017 for it to be a formal transformation group.

- This update to the governance structure will strengthen the BCT's oversight of the five year 'expanded' Troubled Families Programme which aims to ensure alignment of the whole family approach to working with families in Brent across partners.
- In addition to the work with families, the other purpose of the programme is to transform the way that public services work with families with multiple problems to take an integrated whole family approach and to help reduce demand for reactive services. As part of the service transformation all agencies are required to work in this way.
- The Troubled Families Programme aims to transform the lives of an additional 400,000 families across England, of which Brent has a target of 3210 families by 2020. The programme continues to be funded through a payment by results method of rewarding outcomes.

2.8.6. **Early Help Framework**

- The Early Help Framework was refreshed and ratified by the BCT in November 2017.
- The main objective of the Framework is to mainstream the Troubled Families approach and achieve service transformation by creating a sustainable model of early help interventions.
- The BCT has oversight of the delivery plan to implement the framework across the Children's Trust partnership through the Working with Families Strategic Board.
- The BCT support the action to link the framework implementation work with the latest phase of Brent Council's Outcome Based Reviews (Edge of Care, Domestic Abuse and Gangs) to create joined up services that result in a better experience and outcomes for the community, children, young people and families.

2.8.7. **Young Carers**

- Young Carers remain a priority area for the BCT and it continues to be sighted on the work led by the Brent Early Help service to raise awareness of Young Carers across Brent.
- The BCT maintains oversight of the ongoing awareness raising programme of Young Carers across the partnership which includes:
  - attending partner team meetings
  - promoting the identification of Young Carers champions within schools
  - the promotion of Young Carers Awareness Day (25 January)
  - the promotion of the Young Carers in Schools Award
- The BCT advocates the inclusion of young carers within the refreshed Brent Carers Strategy to ensure that there is a coherent approach to supporting Young Carers and their families.
- The BCT continues to support the links made with the LSCB to ensure that Young Carers' training is built into the multi-agency training offer.
- The BCT recognises the need to recommission the Young Carers service and supports the development of joint commissioning arrangements with Adult Social Care to align commissioning arrangements for carers' support services.

## 4.0 Financial Implications

4.1 There are no financial implications as a result of this report.

## 5.0 Legal Implications

5.1 There are no legal implications as a result of this report.

## 6.0 Equality Implications

6.1 There are no equality implications as a result of this report.

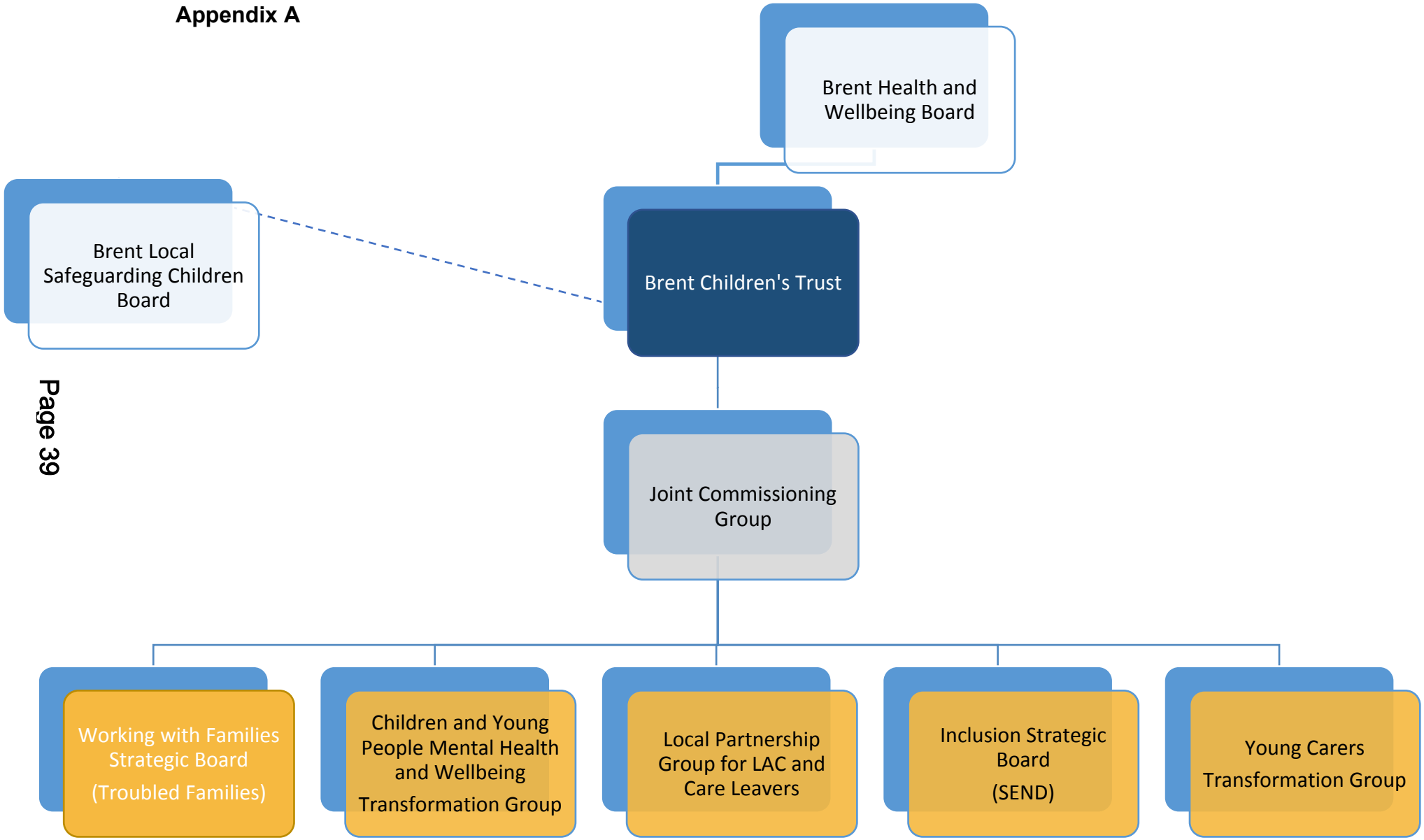
## 7.0 Consultation with Ward Members and Stakeholders

7.1 Brent Council and Brent CCG are members of the BCT and the transformation groups. All members have all contributed to this report.

***Report sign off:***

***Gail Tolley***
Strategic Director Children and Young People

**Appendix A**


Brent Health and Wellbeing Board
Brent Local Safeguarding Children Board
Brent Children's Trust
Joint Commissioning Group
Working with Families Strategic Board (Troubled Families)
Children and Young People Mental Health and Wellbeing Transformation Group
Local Partnership Group for LAC and Care Leavers
Inclusion Strategic Board (SEND)
Young Carers Transformation Group

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| Brent<br>NHS Brent Clinical Commissioning Group | **Health and Wellbeing Board**<br>17 July 2018 |
| | **Report from the Director of Public Health and the Designated Doctor for Unexpected Child Death** |

# Child Death Overview Panel (CDOP) Annual Report 2017/18

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|---|---|
| **Wards Affected:** | All |
| **Key or Non-Key Decision:** | N/A |
| **Open or Part/Fully Exempt:**<br>(If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act) | Open |
| **No. of Appendices:** | N/A |
| **Background Papers:** | N/A |
| **Contact Officer(s):**<br>(Name, Title, Contact Details) | Melanie Smith<br>Director of Public Health<br>Email: Melanie.Smith@brent.gov.uk<br>Tel: 020 8937 6227 |

## 1.0 Purpose of the Report

1.1 The Child Death Review Panel (CDOP) is a subcommittee of the Local Safeguarding Children Board (LSCB). Brent LSCB received the 2017/18 CDOP Annual Report at its June 2018 meeting. The report is presented to the Health and Wellbeing Board with an account of the LSCB deliberations.

## 2.0 Recommendation

2.1 The Board note the CDOP 2017/18 Annual Report

## 3.0 Detail

3.1 The child death review process is a statutory process. There is a rapid response process for unexpected deaths of children resident in Brent, irrespective of place of death. In addition all deaths of children, both expected and unexpected, are reviewed by a multi-professional panel, CDOP. Child deaths may also result in a serious case review, a serious incident being declared by health services or a Coroner's investigation or inquest.

3.2 The specific purpose of the CDOP process is to consider whether there were modifiable factors associated with the death. Modifiable factors are those which may have contributed to the death and which, by locally or nationally achievable interventions could be modified to reduce the risk of future child deaths.

3.3 The LSCB in receiving the report noted that CDOP identifies factors which are associated with a death, it cannot determine whether such factors are causative. A determination that modifiable factors were present does not imply blame on any individual party nor does it mean that that particular death was preventable. It simply means that there is the potential for an intervention to prevent future deaths.

3.4 The LSCB considered the CDOP report in the light of rates of infant (under 1 year) and child mortality which are declining.

3.5 In 2017/18, CDOP reviewed 27 deaths of which 5 were unexpected. Lessons may be learnt from expected as well as unexpected deaths, for example CDOP has emphasised the importance of end of life care plans being put in place.

3.6 In 2017/18, there were no serious case reviews. Four deaths were treated as serious incidents by health services. The LSCB were concerned that CDOP should receive timely and full information from SI reviews as this provides useful potential for learning. CDOP is particularly concerned that learning from SIs is acted upon.

3.6 Some deaths are associated with factors beyond health care; a number of expected deaths occur due to congenital abnormalities where there are consanguineous parents. The LSCB discussed this issue. Brent CDOP does not regard these deaths as preventable but is concerned to ensure that parents receive appropriate antenatal and genetic counselling and are able to make informed choices.

3.7 The report outlines lessons learnt during 2017/18. In 2017/18 learning was presented and discussed at a Paediatric Grand Round which is a very welcome development. There are a number of lessons specifically for health care professionals including the advice given to parents and the recording thereof, the particular risks of maternal obesity. A new sepsis pathway has been introduced as a result of lessons learnt.

## 4.0 Financial Implications

4.1 The CDOP office and co-ordinator are funded by Brent CCG.

## 5.0 Legal Implications

5.1 The CDOP is a subgroup of the Local Safeguarding Children Board (LSCB) as set out in Regulation 6 (SI No 2006/90) of the Children Act 2004. The child death process is a statutory process covered by Chapter 5 of Working Together to Safeguard Children 2015.

## 6.0 Equality Implications

6.1 None.

## 7.0 Consultation with Ward Members and Stakeholders

7.1 Not applicable.

***Report sign off:***

**Melanie Smith**
Director of Public Health

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Keeping children safe is everyone's responsibility

# CHILD DEATH OVERVIEW PANEL

# ANNUAL REPORT

# 1 APRIL 2017 – 31 MARCH 2018

**Dr Melanie Smith -– Director of Public Health**
**Dr Arlene Boroda -– Designated Doctor for Unexpected Child Deaths**

**Brent Local Safeguarding Children Board**
**Child Death Overview Panel**
**Annual Report for 1 April 2017 – 31 March 2018**

## 1. OVERVIEW

This annual report is provided by the Child Death Overview Panel (CDOP) for the Brent Local Safeguarding Children Board (LSCB). The CDOP is a subgroup of Brent LSCB as set out in Regulation 6 (SI No 2006/90) of the Children Act 2004. The Child Death review process is a statutory requirement as outlined in Chapter 5 of the Working Together to Safeguard Children 2015, (previously Chapter 7 of Working Together to Safeguard Children 2006, reviewed in March 2010 and March 2013).

The process for management for unexpected child deaths is revised regularly and uploaded on the LSCB website.

The CDOP are notified of all deaths of children who are resident within the London Borough of Brent and continue the child review process for these deaths.

The total number of reported deaths for the year 01/04/2017 – 31/03/2018 is **26.**

Deaths reported in the previous years:

- 38 deaths in 2008 – 2009 (this was the year in which CDOPs were established).
- 26 in 2009 – 2010
- 38 in 2010 – 2011
- 41 in 2011 – 2012
- 43 in 2012 – 2013
- 30 in 2013 – 2014
- 24 in 2014 – 2015
- 23 in 2015 – 2016
- 26 in 2016 – 2017
- 26 in 2017 – 2018

**Table 1: Total Number of Reported Child Deaths in Brent - 01/04/2008 31/03/2018**

| Deaths | 2008-09 | 2009-10 | 2010-11 | 2011-12 | 2012-13 | 2013-14 | 2014-15 | 2015-16 | 2016-17 | 2017-18 |
|---|---|---|---|---|---|---|---|---|---|---|
| Expected | 21 | 15 | 28 | 26 | 30 | 14 | 18 | 13 | 20 | 19 |
| Unexpected | 17 | 9 | 10 | 15 | 13 | 16 | 6[1] | 10 | 6 | 7 |
| **Total** | **38** | **26** | **38** | **41** | **43** | **30** | **24** | **23** | **26** | **26** |

**Table 2: Age range of child deaths reported for the year 2016-2017**

[1] One of these deaths initially classified as 'unexpected' was later determined by the CDOP paediatrician to be 'expected'

| Age range of deaths | Unexpected | Expected | TOTAL |
|---|---|---|---|
| Neonatal deaths (<4wks) | 1 | 10 | **11** |
| Infant death (4wks – 1yr) | 2 | 4 | **6** |
| Children between 1-4 years of age | 2 | 1 | **3** |
| Children between 5-9 years of age | - | 2 | **2** |
| Children between 10– 14 years of age | 2 | 2 | **4** |
| Young people between 15 – 18 years of age | - | - | **-** |
| **Total** | **7** | **19** | **26** |

**2. STAFFING**

The Chair is the Director of Public Health from the Brent Local Authority and the Vice Chair is the Designated Paediatrician for Unexpected Deaths in Childhood.

The child death co-ordinator commenced in May 2009 as a fixed term, part time post-holder, taking over from a locum independent consultant. The post became permanent part–time in 2012 and is managed by the Designated Doctor (see structure chart - Appendix A).

The Designated Paediatrician for Unexpected Deaths in Childhood is also the Designated Doctor for Safeguarding Children. The Designated Doctor can provide the Rapid Response home visits for unexpected child deaths.

**3. OFFICE ACCOMMODATION**

The Designated Single Point of Contact (SPOC), who is also the Child Death Overview Panel (CDOP) coordinator, is based at Wembley Centre for Health and Care in NHS Brent CCG. This arrangement provides good access to specialist health advice and access to the Safeguarding Children Team (who undertake the rapid response).

**4. CDOP PANEL MEETINGS**

There have been regular meetings to discuss and review the Child Death cases. There has been good attendance from key partner agencies. All CDOP panel meetings have taken place at the Wembley Centre for Health and Care. Attendance for 2017/18 has been summarised in Appendix B. The Child Death Overview Panel meets quarterly, or more often, depending on the number of child death cases that are ready for review.

Meetings were held on the:

- 10/05/2017- 4
- 19/07/2017- 6
- 04/10/2017- 6
- 06/12/2017- 5
- 21/02/2017- 6

The CDOP reviewed 27 child deaths cases in the year 2017- 2018.

**5. RAPID RESPONSE**

The current arrangements for the on call rota in NHS Brent are in line with Working Together to Safeguard Children 2015, covering 9am–5pm, Monday to Friday, weekends and bank holidays. Three health professionals have completed the Warwickshire University Advanced Child Death training programme and also nurses and social workers.

Of the 7 **unexpected child deaths**, there were 5 rapid response meetings which were attended by a number of professionals. These meetings are to agree what processes will be followed to ascertain the cause of the child's death.
Rapid response meetings were not held in 2 cases – causes not discussed as due to low numbers details may identify cases.
The rapid response meetings facilitated good information at the outset.

## 6. ANALYSIS

Child Deaths are categorised into four groups:

- **Neonatal –** under 28 days old in hospital
- **SUDI –** sudden unexpected death of an infant under 2 years
- **Unexpected –** death of a child under 18 years (**not expected** in the previous 24 hours)
- **Expected -** death of a child under 18 years **(natural causes)**

The panel reviews every death of a child irrespective of the category it falls under, to ensure the appropriate involvement and response from the statutory agencies. The Panel considers the time period before, at and following the child's death and may include the antenatal period.

In some of the cases the reviews were delayed until all the information was made available from the Coroners' investigations which took extended time.

## 7. SUMMARY OF FINDINGS

Between1st April 2017 and 31st March 2018, **26** child deaths were notified to the CDOP for children who were **resident** within the Brent LSCB area at the time of their deaths.
This number is not the same as the **number of deaths reviewed.** There can be a delay in obtaining information particularly when inquests need to be completed so cases may not be considered for review in the same year as they are notified.

The number of Brent child deaths reported from 01/03/2008 – 31/03/2018 is outlined in table 1.

The range in number of deaths each month over 2017 – 2018 **has varied** from **1 to 4 and is illustrated below.** A monthly comparison of the last two years, figures demonstrates that there is no emerging pattern in the number of deaths, or when they occur.

**Table 3: Monthly figures of child deaths 2014 - 2015, 2015 – 2016, 2016-2017 and 2017-2018**

| | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017-2018 | **0** | **1** | **4** | **2** | **3** | **3** | **2** | **1** | **3** | **3** | **1** | **3** |
| 2016-2017 | **0** | **1** (+1**) | **0** | **3** | **4** | **3** | **4** | **0** | **1** | **5** | **2** | **3** |
| 2015-2016 | **3** | **0** | **0** | **4** (+1**) | **3** | **1** | **1** | **3** | **2** | **1** | **3** | **2** |
| 2014-2015 | **2** | **2** | **3** | **3** | **3** | **4** | **0** | **0** | **2** | **4** | **0** | **1** |

**Gender**
The 26 deaths (2017-2018) comprised a total of 17 males and 8 females, 1 indeterminate

## Table 4: Gender of child deaths reported

| **Males** | **Females** | **Indeterminate** |
|---|---|---|
| 17 | 8 | 1 |

**Child Deaths by Locality**

| | |
|---|---|
| Willesden | 11 |
| Kingsbury | 1 |
| Harlesden | 3 |
| Kilburn | 3 |
| Wembley | 8 |

**Postcode of family home at time of child death**

## Table 5: Postcode of family home of child deaths

| **Area** | NW2 | NW6 | NW9 | NW10 | HA0 | HA3 | HA9 |
|---|---|---|---|---|---|---|---|
| **Number** | 6 | 2 | 1 | 9 | 3 | 2 | 3 |

**Place of Death**

The child deaths in hospital were recorded at one of nine hospitals. The number of deaths in each hospital ranged from 1 to 5.
22 of the deaths occurred in a hospital setting and 3 at home. One in a public space – following a road traffic collision.

The locations of the recorded deaths are as follows:
Northwick Park Hospital **4** deaths, St. Mary's Hospital **4** deaths, Chelsea and Westminster Hospital **2**, Queen Charlotte Hospital **5,** UCLH **3** and Kingston Hospital **1**, Birmingham Children Hospital **1**, St Georges Hospital **1**, Royal London PICU **1**.
**Three** deaths were recorded in the home (on end of life care plans).
The one road traffic collision victim was certified at the scene.

## Table 6: Hospitals/ Locations of Child deaths

| Northwick Park Hospital | St. Mary's Hospital | Chelsea and Westminster Hospital | Q.C.C.H. | St Georges Hospital | Birmingham Children Hospital | UCLH | Royal London PICU | Home/ Public Place | Kingston Hospital |
|---|---|---|---|---|---|---|---|---|---|
| 4 | 4 | 2 | 5 | 1 | 1 | 3 | 1 | 3 +1 | 1 |

**Ethnicity**

Ethnicity data is collected for all child deaths and linked into research about Child Deaths not only within London but nationwide. This provides valuable information especially within Brent due to its ethnically diverse population

## Table 7: Ethnicity of child deaths from 1st April 2016 – 31st March 2017.

| Ethnicity | Number |
|---|---|
| British- Asian/Pakistani | 2 |
| Black- British | 1 |
| Black- African | 2 |
| British Asian | 4 |
| British Afro Caribbean | 1 |
| British Asian/Indian | 5 |
| British/Black/Other/Asian/Other | 1 |
| British/Filipino | 1 |
| British/Pakistani | 1 |
| British/Portuguese/Black Caribbean | 1 |
| Mixed-White/Japan | 1 |
| White-British/Polish | 1 |
| White-Other (Southern & Other European | 1 |
| White British | 3 |
| White Other - Bulgaria | 1 |
| **Total** | **26** |

## REVIEWS:

### 8. CHILD DEATH OVERVIEW PANEL MEETINGS APRIL 2016 – MARCH 2017.

The panel completed reviews on a total of **27** child deaths during 2017 - 2018.
1 – for the year 2015-2016,
6 – for the year 2016 – 2017 and
20 – for the year 2017 – 2018

The table below shows the time span in which the child death cases were brought to panel and completed (from date of death to the date the review was completed).

**Table 8: Time span of Child Death review**

| No. of deaths reviewed within the following time periods. | Deaths reviewed with Modifiable Factors | Deaths reviewed with No Modifiable Factors |
|---|---|---|
| Under 6 months | 4 | 17 |
| 6 - 7 months | 3 | - |
| 8 - 9 months | 1 | - |
| 10 - 11 months | - | - |
| 12 months | - | - |
| Over 12 months | 1 | 1 |
| **Total** | **9** | **18** |

## 9. DEMOGRAPHICS

**Table 9. Age ranges for child deaths reviewed for April 2017 - March 2018.**

| Age range of deaths | Unexpected | Expected | TOTAL |
|---|---|---|---|
| Neonatal deaths (<4wks) | 1 | 11 | **12** |
| Infant death (4wks – 1yr) | 3 | 5 | **8** |
| Children between 1-4 years of age | 1 | 2 | **3** |
| Children between 5-9 years of age | - | - | **-** |
| Children between 10– 14 years of age | - | - | **-** |
| Young people between 15 – 18 years of age | 1 | 3 | **4** |
| **Total** | 6 | 21 | **27** |

**Gender of Reviewed cases.**
From the **27** children reviewed at panel**,** 1 April 2017 – 31 March 2018**,** their gender was as per table

**Table 10: Gender of reviewed cases in 2017-2018**

| Males | Females | Indeterminate |
|---|---|---|
| 16 | 10 | 1 |

## Table 11: Ethnicity of 16 child deaths reviewed from 1st April 2017 – 31st March 2018

| | |
|---|---|
| White: English/Welsh/Scottish/Northern Irish/British | 2 |
| White- British/Polish | 1 |
| White: Other European | 1 |
| Mixed: White- Japan | 1 |
| British Asian: Indian | 11 |
| British: Asian- other | 1 |
| Asian or Asian British: Pakistani | 3 |
| Black: British | 2 |
| Black: Caribbean/Portuguese | 1 |
| Black: British- African | 1 |
| Black: African | 1 |
| British – Filipino | 2 |
| **TOTAL** | **27** |

### 10. CATEGORIES OF DEATH

The panel reviews cases and agrees with the category the death should be classified within. There are two categories into which each death is classified:
Modifiable Factors (Preventable) and No Modifiable Factors (Not Preventable)

| | |
|---|---|
| **Modifiable Factors Identified** | The panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths |
| **No Modifiable Factors Identified** | The panel have not identified any potentially modifiable factors in relation to this death. |

It is important to recognise that this categorisation is to inform efforts to reduce childhood deaths, it does not in itself carry any implication of blame on any individual party, but simply acknowledges where factors are identified which, had they been different, may have resulted in the death being prevented.

## Table 12: Breakdown of categories for the 27 deaths reviewed 2017- 2018:

| | |
|---|---|
| **Expected death** from natural causes:<br>• Chromosomal, genetic and congenital anomalies 7<br>• Perinatal/neonatal event - category 8<br>• Malignancy - category 4<br>• Infection – category 9 | <br>9<br>8<br>4<br>1 |
| **Unexpected deaths** – these include<br>• SUDI / SIDS - category 10<br>• Perinatal/neonatal event - category 8<br>• Deliberate Inflicted Injury – Homicide- category 1 | <br>1<br>3<br>1 |
| **Total** | **27** |

**There were 2 SUDIs reviewed**.

- In one case the baby was placed in the parental bed.
  Recommendations are to promote safer sleep awareness for parents and carers of babies.
- One of the babies was a sudden postnatal collapse.

**Deliberate Inflicted Injury – Homicide.**

- One young person died from a knife incident in a public place.
- The case was reviewed following the criminal trial.
- A lessons learnt session convened by Brent LSCB focused on contextual safeguarding which also included tackling knife crime

## 11. THE CHILD DEATH REVIEW PROCESS

The process for the review of child deaths has followed the London Child Protection procedures and Working Together to Safeguard Children 2015. Notifications of deaths to the SPOC have improved as London-wide partner agencies are now more aware of the need to ensure effective communication. The professionals working in this field are increasingly aware of the need to ensure effective, timely and comprehensive referrals.

## 12. SERIOUS CASE REVIEWS (SCR) AND LSCB.

The CDOP also identifies other issues and links with other processes such as serious case reviews (SCR) and significant incidences (SI).

a) Serious Case Reviews SCRs
   There were no cases declared as SCRs.

b) Significant Incident reviews and NHS.
   CDOP links with the NHS Significant incident processes. Reports are reviewed by the Designated Professionals for safeguarding children and key messages highlighted at the CDOP case reviews.

Cases reviewed covered four SI reviews.

## 13. LINKING UP WITH LONDON CDOP

The Paediatrician for Child Deaths has attended the London Safeguarding Children Board CDOP Chairs network meetings. The Chair and the Paediatrician attended a London Workshop to review the roles and data processes for CDOP.

*Healthy London Partnership work:*
The following Programme Workshops were attended by panel members of Brent CDOP-

- Understanding and Tackling Neonatal Deaths- 25th May 2017
- Bereavement Support - 29th June 2017

The London Chairs meetings were attended by CDOP members to link with the wider network.

Brent CDOP and Brent LSCB has promoted the work of the Lullaby Trust and supported their safer sleep week. Safer Sleep Week is The Lullaby Trust's national awareness campaign targeting anyone looking after a young baby. From the 19-23 March 2018 The Lullaby Trust and partners aim to make sure parents in the UK know the importance of safer sleep and are aware of how to reduce the chance of Sudden Infant Death Syndrome (SIDS).

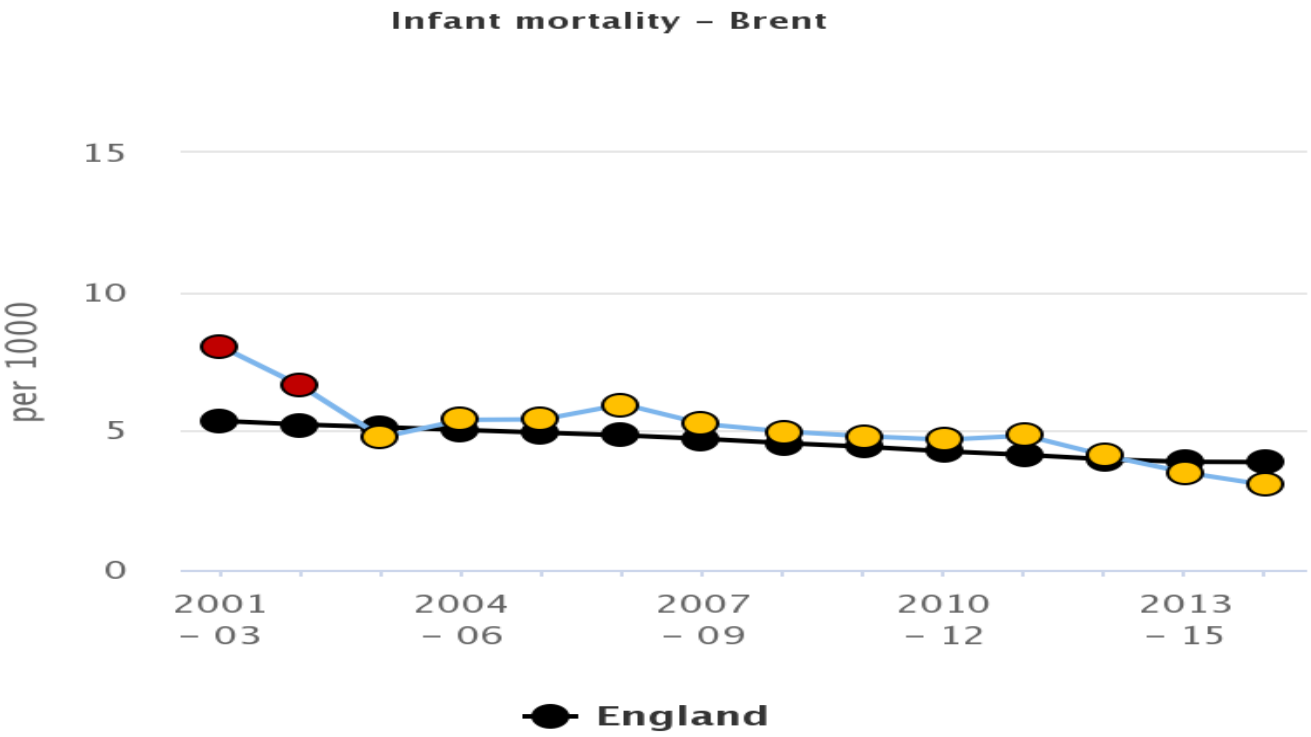
Brent LSCB promotes their work via links on the LSCB website, e-mailing messages across the partners and staff, placing poster displays in health settings

**14. INFANT MORTALITY RATES IN BRENT**

Data from Public Health England allows the numbers of child deaths in Brent to be considered as rates per 1000 live births and provide comparison with national and London rates:

Infant mortality is the rate if deaths under one year per 1000 live births. Because of the small numbers in any single year, three year rolling averages are used to compare areas. Examining historical data shows a downward trend for Brent and nationally, with rates in Brent now similar to those nationally.

Figure 1. Infant mortality rates over time



## Table 13: Infant mortality rates

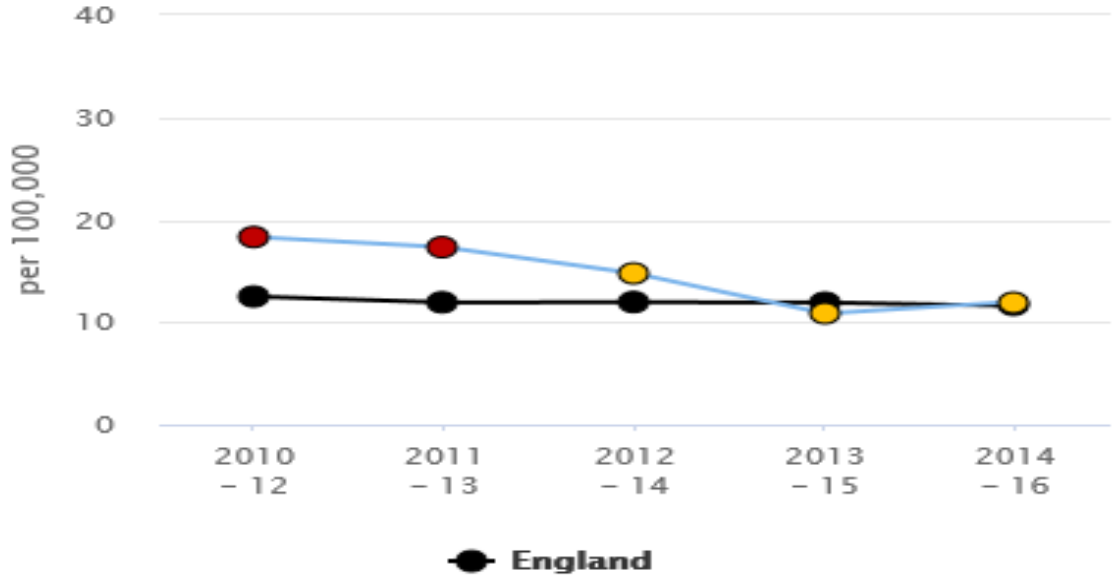
| Period | Brent | London | England |
|---|---|---|---|
| 2001 - 03 | 8.0 | 5.7 | 5.4 |
| 2002 - 04 | 6.6 | 5.4 | 5.2 |
| 2003 - 05 | 4.8 | 5.2 | 5.1 |
| 2004 - 06 | 5.4 | 5.0 | 5.0 |
| 2005 - 07 | 5.4 | 4.8 | 4.9 |
| 2006 - 08 | 6.0 | 4.6 | 4.8 |
| 2007 - 09 | 5.2 | 4.4 | 4.7 |
| 2008 - 10 | 5.0 | 4.5 | 4.6 |
| 2009 - 11 | 4.8 | 4.4 | 4.4 |
| 2010 - 12 | 4.7 | 4.2 | 4.3 |
| 2011 - 13 | 4.8 | 3.9 | 4.1 |
| 2012 - 14 | 4.1 | 3.6 | 4.0 |
| 2013 - 15 | 3.5 | 3.4 | 3.9 |
| 2014 - 16 | 3.0 | 3.2 | 3.9 |

*Source: Office for National Statistics (ONS)*

Child mortality rates

The child mortality rate is calculated as the directly standardized rate of deaths of children aged 1 to 17 years. Direct standardization allows for the age distribution of the child population and allows comparisons between different areas with different age distributions. Historical data show a downward trend in the child mortality rate for Brent with rates now similar to England.

Figure 2: Child mortality rates over time - Brent




## Table 14 Child Mortality rates

| Period | Brent | London | England |
|---|---|---|---|
| 2010 - 12 | 18.3 | 13.7 | 12.5 |
| 2011 - 13 | 17.3 | 12.2 | 11.9 |
| 2012 - 14 | 14.8 | 12.0 | 12.0 |
| 2013 - 15 | 10.8 | 11.5 | 11.9 |
| 2014 - 16 | 12.0 | 11.6 | 11.6 |

*Source: Office for National Statistics (ONS)*

## 15. ISSUES

Child deaths have been reviewed by the Coroner before coming to the CDOP. In some cases there are inherent delays due to further investigations and information required at the Coroner's inquest hearing or police investigation.
Communication with the Coroners' offices is via Coroners officers.
Accessing information from health providers remains difficult in some cases.

Information about the Child Death Review process and other relevant information including bereavement care and counselling is shared with parents at the hospitals.
A representative from the charity The Lullaby Trust (formerly FSID) attends the CDOP meeting and is a representative of the parents.

The panel communicates the final CDOP decisions with the parents and universal staff including GPs that had contact with the children.

## 16. LESSONS LEARNT

- Safer sleep advice should be promoted by front line professionals who have contact with parents of newborns and babies
- The need to improve the recognition of foetal distress by clinical staff and appropriate action to optimise outcome for babies.
- Increased surgical expertise is required for a Caesarean section for an overweight pregnant mother
- Increased maternal BMI is linked to babies being born with congenital abnormalities
- Professionals seeing expectant mothers for antenatal care should advise on what to do if they have reduced foetal movements
- Mothers who have sought advice for but not proceeded to termination should be encouraged to have antenatal care as babies born extremely prematurely are being offered neonatal care.
- A number of deaths due to congenital abnormalities have occurred with consanguineous parents. Brent CDOP does not regard these deaths as preventable but is concerned that parents receive appropriate antenatal counselling and genetic counselling where appropriate to ensure parental choice
- Professionals attending meetings do so as part of an organisation, not as individuals and have a responsibility to record decisions and deliver on agreed actions
- Knife crime and youth violence is a cause of preventable deaths
- End of life care plans in chronically ill babies / children avoid unnecessary distress when these children die
- Clinicians should all be aware of reporting of unexpected deaths in under 2s as part of Project Indigo Procedures
- Clinicians should understand SI reporting
- Maternity Units should review the recording of telephonic advice given to parents by their birthing centre
- Sepsis pathway is being implemented by the local Trust

A talk titled 'learning lessons from CDOP and preventing deaths in Brent' was the theme of a paediatric Grand Round at NPH in November 2017, attended by over 60 clinicians. Talks delivered by the Lullaby Trust and the CDOP paediatrician shared the proposed changes to CDOP across London. Feedback was that the session was well received.

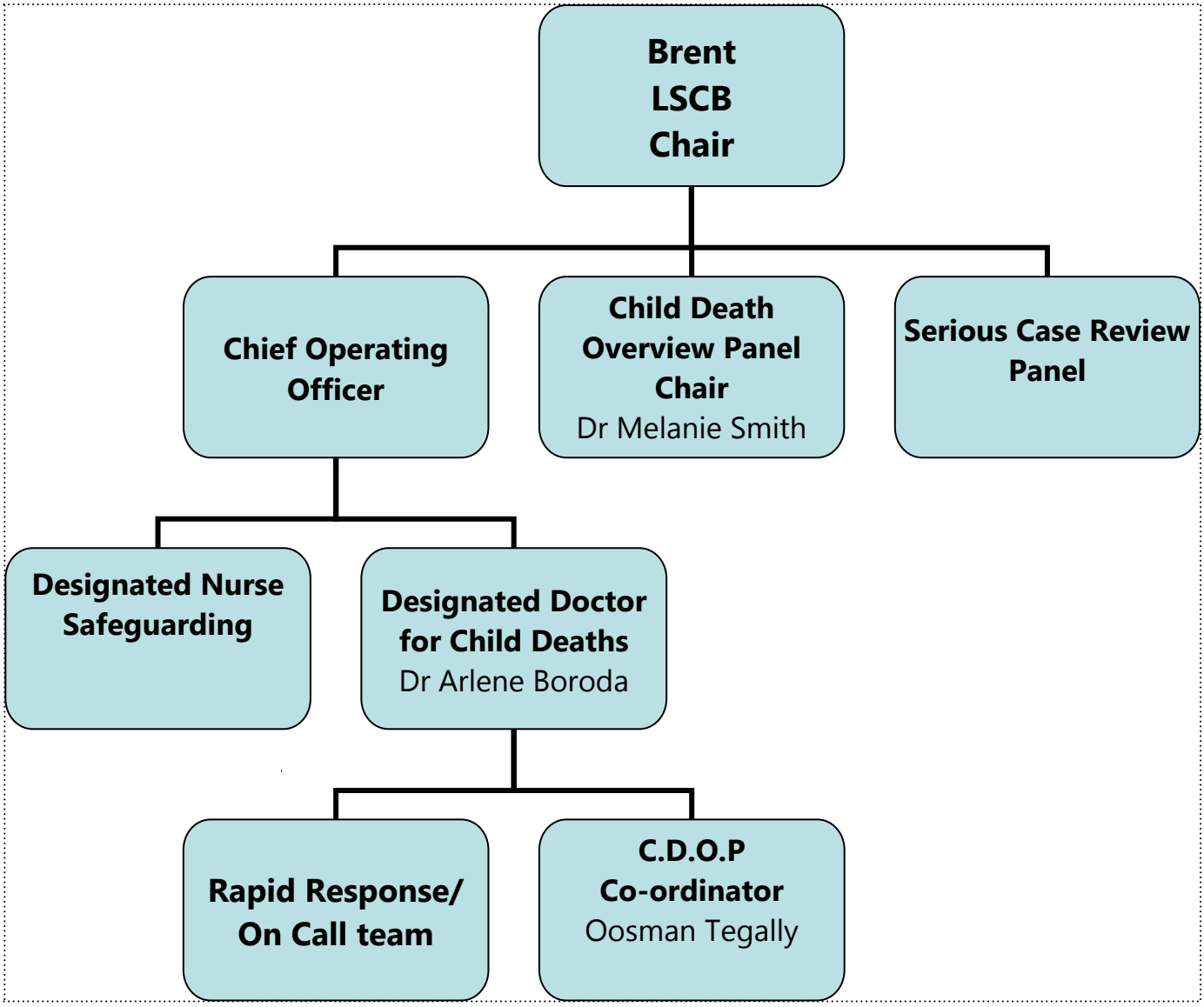
**17. ENGAGING PARENTS IN CDOP PROCESSES:**

An information leaflet about the Brent CDOP review process has been sent out to bereaved parents since March 2016 inviting them to contact CDOP to share any information which may help the review processes. So far four families have linked with the CDOP. This has facilitated the communication parents' views with service providers to the children.

**Appendix A**

**Post Holders**

Executive Lead for Safeguarding Children- Chief Operating Officer Brent CCG
Public Health Consultant – Dr Melanie Smith
Designated Doctor for Unexpected Child Deaths - Dr Arlene Boroda
CDOP Co-ordinator- Oosman Tegally (until end of January 2018)
Designated Nurse for Safeguarding Children NHS Brent CCG- post holder
Rapid response on call – Dr Arlene Boroda
Head of Safeguarding (Brent Children and Young People) – Sonya Kalyniak or a representative
Brent and Harrow Metropolitan Police CAIT – DI Jason Dawson



**Appendix B:**

**CHILD DEATH OVERVIEW PANEL MEMBERSHIP ATTENDANCE 2017-2018**

| | **10/05/2017** | **19/07/2017** | **04/10/2017** | **06/12/2017** | **21/02/2018** |
|---|---|---|---|---|---|
| **Public Health Consultant** | Present - Chair | Present - Chair | Present - Chair | Present - Chair | Present Chair |
| **Designated Doctor for Child Deaths for NHS Brent CCG** | Present | Present | Present | Present | Present |
| **CDOP Co-ordinator** | Present | Present | Present | Present | Present |
| **Designated Nurse for Safeguarding Children NHS Brent CCG** | Apologies | Present | Apologies | vacant | vacant |
| **Police/CAIT** | Present | Present | Present | Present | Present |
| **Brent Children and Young People - Head of Safeguarding Children** | Represented | Represented | Represented | Represented | Represented |
| **LNWH Trust** | Represented | Nil | Represented | Apologies | Represented |
| **CLCH- health visiting and school nursing** | Not invited | Represented | Represented | Represented | Represented |
| **The Lullaby Trust (FSID) - parents** | Apologies | Represented | Present | Present | Present |

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| | |
|---|---|
| Brent<br>NHS Brent Clinical Commissioning Group | **Health and Wellbeing Board**<br>17 July 2018 |
| | **Report from Healthwatch Brent** |

# Healthwatch Brent - Update Report

| | |
|---|---|
| Wards Affected: | All |
| Key or Non-Key Decision: | N/A |
| Open or Part/Fully Exempt:<br>(If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act) | Open |
| No. of Appendices: | N/A |
| Background Papers: | N/A |
| Contact Officer(s):<br>(Name, Title, Contact Details) | Julie Pal<br>Chief Executive Officer CommUNITY Barnet<br>Email: Julie.Pal@communitybarnet.org.uk<br>Tel: 020 8912 5831(general enquiries)<br><br>Ian Niven<br>Healthwatch Brent Manager<br>Email: ian.niven@healthwatchbrent.co.uk<br>Tel: 020 8912 5831(general enquiries)<br><br>Selina Rodrigues<br>Head of Healthwatch, CommUNITY Barnet<br>Email: selina.rodrigues@communitybarnet.org.uk<br>Tel: 020 8364 8400 (ext. 219) |

## 1.0 Purpose of the Report

1.1 This report updates the Health and Wellbeing Board on the progress of Healthwatch Brent.

1.2 This report sets out the 2018/19 work programme and priorities for Healthwatch Brent.

## 2.0 Recommendation

2.1 The Health and Wellbeing Board is asked to note the Healthwatch Brent 2018/19 priorities.

## 3.0 Detail

3.0 CommUNITY Barnet has been commissioned to deliver the local Healthwatch contract in Brent from 1 April 2018.

3.1 Healthwatch Brent works with 11 of Brent's charity, voluntary and community organisations.

3.2 Healthwatch Brent is delivered by a Brent-based central core team, a partnership of Brent based voluntary and community organisations and a team of volunteers.

3.3 The work programme of Healthwatch Brent aligns to all five priorities of the Brent Health and Wellbeing board namely:

- Giving every child the best start in life
- Helping vulnerable families
- Empowering communities to take better care of themselves
- Improving mental wellbeing throughout life
- Working together to support the most vulnerable adults in the community

3.4 Healthwatch Brent is delivered on a Hub and Spoke model. The Hub is the first point of public access and delivered by the core team located in Wembley. The Spokes consist of two groups – the Healthwatch Brent Advisory Board whose role it is to support the core team and shape the work programme around the needs of Brent residents. Membership of the Healthwatch Brent Advisory Board includes Age UK Brent, Brent User Group, Mosaic LGBT Young People's Group; Ashford Place, Brent CVS; Brent Carers' Centre; Brent Mencap, Jewish Care; Brent Multi-faith Forum; Young Brent Foundation and Help Somalia Foundation.

3.5 The Promotion and Reach Partners with their strong and vibrant networks are able to cascade messages from Healthwatch Brent to local residents. The partners include: Ashford Place, Brent Carers' Centre, Jewish Care, Brent Mencap, Young Brent Foundation and Brent CVS. A fuller list is captured in 6.3.

Our strategic priorities for Healthwatch Brent are to:

- Encourage greater participation in health and social care
- Collecting evidence of increasing engagement with those residents from under-represented communities
- Demonstrate that Brent residents feel more able to express their views and to report they are listened to
- Demonstrate how Healthwatch Brent has been able to make a constructive contribution to support and enable informed decision making through the representation of the authentic voice
- Demonstrate Healthwatch Brent offers value for money, through our reach, production of reports, participation in strategic meetings and volunteer activity
- That Healthwatch Brent service offers added value by:
    - Establishing collaborative, open and cooperative partnership with existing providers;

- Drawing upon the experience of partnership members by bringing together their combined expertise, knowledge and experience
- Providing strong project management and coordination of a high quality service
- Delivering cost-savings on engagement activities through using our existing channels;
- Adding value of specialist knowledge provided by the Healthwatch Brent Network;
- Adding value of local knowledge from trusted organisations who know Brent residents;
- Capability of reaching Brent households through newsletters, contacts and social media platforms delivered through HWB and the CVS Brent newsletter;
- Pulling together partners who are skilled and successful fundraisers and will be able to draw on independent sources of funding to supplement the budget envelope for the contract o

3.7 Key achievements over the past financial year included:

- Increasing the number of twitter followers from 1200 to over 5000
- Reaching almost 12000 residents through our consortium of charity partners
- Speaking directly with over 1200 residents
- Presenting over 1200 views to statutory partners
- Presenting reports to a combination of the Health and Wellbeing Board (From Words to Action – October 2017), Brent Clinical Commissioning Board Management Board on Urgent Care Use and the Children's Trust on the experience of registering Under 5s with Brent dentists
- Our Community Chest was used to resource a number of community research projects including the implementation of Accessible Information Standards in Brent GP practices
- Capturing the resident experience of registering with a dentist
- Reviewing young Brent people's experience and attitude towards using the NHS Go app and other online services
- Understanding the personal and systemic barriers to healthy eating and exercise of communities with a greater risk to developing Type 2 diabetes
- Listening to different caring communities
- Our Enter and View visits explored Adult Safeguarding awareness and experiences in care homes
- Identifying the support pathways for men at risk or living with prostate cancer.

3.8 Our operational priorities for Brent for 2018/19 are informed by the Joint Strategic Needs Assessment (JSNA) 2016, the Improving Health and Care in Brent priorities, annual reports by the Director of Public Health and the Better Care Fund. We believe that by combining this evidence with the views gathered from health and social care users resident in Brent will provide a richer insight into both the needs and potential responses that both commissioners and providers can develop together.

3.9 Healthwatch Brent identified the following as key issues in Brent for 2018/19:

- Completing the communication feedback loop on health and social care engagement
- How is good mental health promoted – encouraging prevention

- Understanding the hospital discharge experience of older residents
- De-mystifying the social care assessment pathway
- Reviewing the experience of care delivered in people's homes
- Capturing the experience of residents with sensory impairments to access adult social care services
- Engaging with young people to better understand their preferred ways of accessing sexual health services.

## 4.0 Financial Implications

4.1 There are no financial implications as all costs are within the current agreed contract.

## 5.0 Legal Implications

5.1 Healthwatch Brent was established through the Health and Social Care Act 2012 to give users of health and social care a powerful voice both locally and nationally and formally launched in 2013 as an independent charity.

5.2 From 1 July 2015 its services have been delivered as an arms-length department of Community Barnet (CB) a charity and company limited by guarantee.

5.3 Financial and contract accountability remains with CommUNITY Barnet's Board of Trustees and delegated through the Chief Executive Officer to the Head of Healthwatch and the Healthwatch Brent Manager.

5.4 The current contract is a two-year contract issued to CommUNITY Barnet from 1 April 2018 – 31 March 2020. An option to extend until 31 March 2021 is optional.

## 6.0 Equality Implications

6.1 CommUNITY Barnet is committed to supporting Brent Council to meet its Public Sector Equality Duty as defined under the Equality Act 2010.

6.2 As part of the quarterly performance monitoring, data relating to reaching Brent's protected groups is captured.

6.3 We have and will continue to be committed to giving a voice to under-represented communities. The Healthwatch Brent Network has organisations which reflect Brent's diverse communities and we have used it to give a voice to these communities and support them to re-shape public services.
The table below summarises our network and the communities they reach and have engaged in health and social care:

6.4 All staff and volunteers receive equalities training. We are acutely aware of the role of local Healthwatch to amplify the voice of all local communities, with a special remit to hear from less often heard groups. We have been supplying equality monitoring data to Brent Council over the last 3 years, including that of our membership/friends. The list below summarises our network and the communities they reach and have engaged in health and social care.

| Protected groups | Type of organisation | Name of organisation | Role within HB |
|---|---|---|---|
| Mental Health | User group | Brent User Group | Advisory Board<br><br>Community Chest recipient |
| Disability | Learning disability | Brent Mencap | Advisory Board,<br><br>Promotion and Reach<br><br>Community Chest recipient |
| Disability | Physical disability advocacy | Brent Advocacy Concerns | Community Chest recipient |
| Age/ Carers | Carers - all ages, all groups | Brent Carers Centre | Community Chest recipient |
| Age | Homeless, alcohol, dementia | Ashford Place | Advisory Board<br><br>Promotion and Reach |
| Age | Older people | Elders Voice | Advisory Board |
| Faith | All faiths | Brent Multi-Faith Forum | Advisory Board |
| Age | Young people Infrastructure support organisation | Young Brent Foundation | Advisory Board |
| Ethnicity | Support and advice | Help Somalia Foundation | Advisory Board<br><br>Community Chest recipient |
| Ethnicity | Support and advice | Iraqi Welfare Association | Community Chest recipient |
| Faith, older people | Charity | Jewish Care | Advisory Board |
| A wide range of groups | Voluntary sector support | CVS Brent | Advisory Board |
| LGBT | A range of support and services | MOSAIC LGBT Youth | Promotion and Reach |
| Women, faith | Improving health outcomes for women in a culturally sensitive manner | Al Bahdja | Community Chest recipient |

6.5 We believe Brent's communities are represented within our reports as far as possible, but we constantly strive to reach more communities. For example, we have met with Irish Travellers living in Lynton Close to hear about accessing public services; our Urgent Care report cut across the spectrum of Brent's communities, and that the South Kilburn Ladies group used Community Chest

fund to promote health awareness and gentle exercise to South Asian women at risk of diabetes.

## 7.0 Consultation with Ward Members and Stakeholders

7.1 Healthwatch Brent has set up an Advisory Board with membership drawn from Brent-based charities which supports the delivery of the contract.

## 8.0 Human Resources/Property Implications

8.1 All human resources/property implications are considered within the parameters of the contract between London Borough of Brent and CommUNITY Barnet.

***Report sign off:***

***PHIL PORTER***
Strategic Director, Community Wellbeing