Open Agenda

Health and Wellbeing Board

Tuesday 31 January 2017
2.00 pm
Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

APPENDICES

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Date: 23 January 2017

APPENDIX B

Agenda Item 7

Air Quality Strategy & Action Plan

December 2016

Contents

Foreword

Insert following approval

Councillor Maisie Anderson/other
Acting/Cabinet Member for Public Health, Parks and Leisure

In line with the requirements of the GLA London Local Air Quality Management Framework the following services endorse this document.

Insert signature following approval

Jin Lin
Interim Director of Public Health

Insert signature following approval

Simon Bevan
Director of Planning

1 - Introduction

As part of the UK National Air Quality Strategy, The Environment Act 1995 requires Local Authorities to have an Air Quality Strategy, to declare Air Quality Management Areas at locations where air quality does not meet the objective limits for certain pollutants, and, where an Air Quality Management Area has been declared, have a consulted and approved Air Quality Action Plan to reduce the relevant atmospheric pollutant/s within that area so that, at some point in the future, the area will meet the national air quality objective limits.

Since the publication of the 2002 Air Quality Strategy and Air Quality Action Plan there have been a number of changes in both national and regional policy, reflecting our improved understanding of the impact of air pollution. This document outlines the revised Air Quality Action Plan for Southwark, detailing a range of aims and objectives we seek to achieve in 2017 – 2022.

Sources of atmospheric pollution in Southwark Council

The main atmospheric pollutants of concern in Southwark are Nitrogen Dioxide (NO_2) and Particulates, both PM_{10} (breathable) & $PM_{2.5}$ (able to pass into blood stream). Locally the main source of both pollutants is road transport emissions, with large scale combustion plants and heating systems, construction site plant and domestic heating emissions also significantly contributing to poor air quality.

The Southwark Area is not currently meeting legal limits for all pollutants regulated by EU legislation. NO_2 remains a serious challenge as it often exceeds limits, especially along the road network. In 2013, 45% of population in the borough was exposed to over 40µg.m^{-3} NO_2 (LAEI, 2013). In regards to Particulate Matter, even if the limits are not exceeded, it is known that there is actually no safe limit and further reductions are necessary to protect human health.

Due to air quality objectives being exceeded for NO_2 in a large portion of the borough and Particulates in some key locations, Southwark has declared an Air Quality Management Area.

The following information can be found in Appendices 3 & 4 attached to this document:

- map of the current Air Quality Management Area,
- map of the modelled emissions of Nitrogen Dioxide
- map of the modelled emissions of Particulates (PM_{10} & $PM_{2.5}$), and
- the source apportionment (what is causing the air pollution)

The health impact of atmospheric pollution

Recent analysis by the Institute for Health Metrics & Evaluation estimates that air pollution is ranked as the 10th largest risk factor for mortality and ill-health in England. Recent studies have calculated that poor air quality affects the health outcomes of approximately 9,500 Londoners every year.

There is a strong body of evidence which shows that short term exposure to high levels of air pollution has a range of adverse health effects. These can range from exacerbation of respiratory conditions such as asthma and chronic respiratory disease, through to increases in emergency

admissions to hospital. Poor air quality disproportionately affects the health outcomes of the very young, the elderly, the ill and the poor.

While short term exposure to air pollution is known to adversely affect health, the relative risk associated with long term exposure is much greater, contributing along with other factors, in the initiation, progression and exacerbation of disease. It is estimated that the average reduction in life expectancy associated with air pollution is up to 6 months, through increasing deaths from cardiovascular and respiratory conditions, and from lung cancer. Public Health England suggest that 7% of adult deaths in Southwark may be attributable to human made particulate air pollution (measured as fine particulate matter $PM_{2.5}$) This equates to around 90 deaths per year in the borough.

The equalities impact of atmospheric pollution

All members of the community within Southwark's Air Quality Management Area are affected by poor air quality. A report by the Environment Agency found that areas of the worst exposure to poor air quality generally correlated with areas of deprivation. There are a number of localities within Southwark that fall within the Government's definition of being an area of deprivation. (Source - Official National Statistics)

In London there is a complex link between air quality and inequality. In general, more deprived areas are likely to experience higher levels of pollution but there is considerable local variation. The link between inequality and poor air quality is stronger in outer London than in inner London as in inner London there are high levels of atmospheric pollution across the board affecting affluent and deprived areas equally.

Fine particles (PM2.5) have the greatest impact on health as they reach the bloodstream via the lungs. Young children, those with compromised health and the elderly are the most susceptible to the negative health impacts.

The environmental impact of atmospheric pollution

Poor air quality has an impact on biodiversity and buildings. Sensitive plants, including commercial food plant species are unable to thrive and fish and insect populations, and the species that rely on them in the biosphere, dwindle. The external surfaces of buildings become soiled by particles and soot arebe unduly weathered by aggressive chemicals caused by pollutants dissolving in rainwater as it falls.

Studies have shown that local air quality can be impacted by climate change and conversely climate change can impact local air quality. Average temperatures are predicted to be higher, hotter, drier summers will increase pollution because some of the chemical reactions that lead to NO_2 formation require sunlight. Additionally, less rain will mean that less PM_{10} will be washed out of the atmosphere. Coupled with the fact that higher temperatures make people more sensitive to pollution, the relationship between air quality and climate change is likely to become more important in the future.

2 – Air Quality Strategy

The Air Quality Strategy

The Southwark Air Quality Strategy aims to:

1) Ensure compliance with the following legislation:-
   - EU Directives 1996/62/EC, 1999/30/EC, 2000/69/EC, 2002/3/EC, 2004/107/EC and 2008/50/EC
   - The Environment Act 1995
   - The Environmental Protection Act 1990
   - The Clean Air Act 1993
   - The Air Quality Standards Regulations 2010 & 2011

2) Comply with the GLA London Local Air Quality Management Framework by:-
   - Having a valid and relevant Air Quality Strategy
   - Regularly reviewing the area covered by our Air Quality Management Area
   - Having an Air Quality Action Plan containing actions on:-
     - ✓ Air quality management within Southwark
     - ✓ Reducing emissions from buildings
     - ✓ Increasing public awareness of local air quality & related public health issues
     - ✓ Reducing emissions from road traffic
     - ✓ Reducing carbon emissions that contribute to poor local air quality
     - ✓ Regulation within the borough using enforcement powers to protect local air quality
   - Delivering the Air Quality Action Plan
   - Monitoring local air quality by maintaining our monitoring network and improving it where and when resources permit
   - Providing an Annual Status Report giving the detail of the results of local air quality monitoring and our progress against the Air Quality Action Plan
   - Providing an Annual Status Summary Report to accompany the Annual Status Report

3) Support the GLA's air quality objectives by:-
   - Retaining Southwark's Cleaner Air Borough Status
   - Supporting, where possible and appropriate, the Mayor of London's air quality policies, objectives and actions
   - Working with the Mayor of London's office to promote good environmental awareness and practice to business, commerce, road users and the general public
   - Being mindful of the content of the London Plan and relevant Special Planning Guidance
   - Lobbying for equality of access to clean air for all Londoners

4) Support the local public health framework objectives by:-

- Maintaining local air quality as a local public health priority
- Bidding for funds from the Mayor's Air Quality Fund, Defra's Air Quality Fund and any other organisation offering relevant bidding opportunities to resource air quality improvement actions and projects within Southwark
- Ensuring a cohesive suite of policies by co-ordinating local air quality policy with other service areas in the production of relevant local policy documents, for example:-
  - ✓ Local Development Framework – The Southwark Plan & Core Strategy
  - ✓ Local planning policies and special planning guidance
  - ✓ Transport Plan
  - ✓ Kerbside Strategy
  - ✓ Sustainability Strategy
  - ✓ Carbon Reduction Action Plan
  - ✓ Housing & Modernisation programme
  - ✓ Tree Planting, Parks & Green Space Strategies

3 – Strategic Air Quality Action Plan

Strategic Aims	Objectives	Action number
Management of Air Quality	Monitor local air quality	1.1 - 1.3
	Comply with the requirements of the London Local Air Quality Management Framework	1.4 - 1.6
	Devise a communication plan for air quality	1.7
Reduce Emissions from Buildings	Provide technical guidance on air quality assessment & mitigation	2.1
	Use planning process to reduce emissions from new and refurbished developments and to implement the highest environmental standards for emissions to air	2.2
	Raise awareness regarding fuel economy	2.3
Public Health and Awareness	Encourage active travel including walking & cycling	3.1 - 3.4
	Publicise air-text air quality forecasts and cleaner routes for active travel	3.5
	Ensure web-based information and guidance on air quality is available and up to date	3.7
	Run communication campaigns on personal and business behaviour change to improve air quality	3.8
	Work with clinicians to ensure information on the health impact of air quality is passed to relevant patients e.g. those with COPD, asthma, heart conditions, at risk of stroke, etc.	3.9
Cleaner Transport	Promote the provision of electric and alternative fuels infrastructure	4.1
	Promote freight consolidation	4.2 - 4.6
	Encourage logistics fleets operation in the borough to get FORS scheme Silver accreditation	4.4
	Reduce emissions from Southwark vehicle fleets	4.7 & 4.8
	Ensure Southwark Council's travel plan is up to date	4.9 & 4.10
	Lobby to improve the public transport infrastructure in Southwark	4.11, 4.15 & 4.16
	Lobby to reduce emissions from buses & taxies	4.13 & 4. 14
	Support the extension of ULEZ to south circular	4.15
	Take part in anti-idling campaigns	4.17

Strategic Aims	Objectives	Action number
Reducing Carbon Emissions	Promote reduced fuel/energy consumption from buildings	5.1 - 5.7
	Improve the energy efficiency of Buildings managed by Southwark Council	5.8 - 5.12
	Install renewable energy technologies to Southwark Council buildings	5.13
	Use planning policy to reduce local atmospheric emissions	5.14 - 5.16
	Increase the no. of council homes using renewable energy from SELCHP	5.17
Regulation & Enforcement	Actively discourage & prevent the burning of unauthorised fuels in Southwark's Smoke Control Zone	6.1 & 6.2
	Ensure all Part B EPA'90 processes in the borough maintain compliance with their permits	6.3
	Ensure construction sites are regulated to the highest standard	6.4 - 6.6
	Discourage and prevent bonfires and open burning	6.8
Support the GLA Air Quality Aims	Take air quality improvement actions within designated GLA Air Quality Focus Areas	7.1
	Retain Southwark's Cleaner Air Borough status	7.2
	Support the extension of the ULEZ to the south circular	7.3
	Support the GLA's planning policy	7.4
	Support and lobby for cleaner air for all Londoners	7.6
Support the Public Health Framework Objectives	Include local air quality in Southwark's Joint Strategic Needs Assessment	8.1
	Retain local air quality as a public health priority	8.2
	Ensure local air quality is considered in all relevant policy documents	8.3
	Devise a local cascade for poor air quality alerts	8.4
	Bid for funds from the Mayor's Air Quality Action Fund and other sources to improve local air quality and thus public health	8.5

Appendix 1 – Air Quality Action Plan Workstreams

Section 1 – Management of Air Quality							
Action Number	**Theme / Aim**	**Objective**	**Action**	**Target**	**Expected emissions/ concentrations benefit**	**Directorate**	**Delivered by Lead Service Area / Team**
1 – 1	Monitoring Air Quality	Maintain the two continuous Air Quality Monitoring Stations in the Borough	Ensure that the Air Quality Monitoring Stations at the Elephant & Castle and the Old Kent Road are maintained, serviced and calibrated to current guidance	90 per cent data capture.	To inform air quality policy	Environment & Leisure	Environmental Protection
1 – 2		Maintain the Nitrogen Dioxide Diffusion Tube survey in the Borough	Ensure that the Nitrogen Dioxide Diffusion tube monitoring is maintained in accordance with current guidance	The collection and deployment of diffusion tubes is carried out on 100% of the dates set by Defra.	To inform air quality policy	Environment & Leisure	Environmental Protection
				100% of the tubes collected analysed. Results to be regularly displayed on the Southwark web pages	To inform air quality policy	Environment & Leisure	Environmental Protection

Section 1 – Management of Air Quality							
Action Number	**Theme / Aim**	**Objective**	**Action**	**Target**	**Expected emissions/ concentrations benefit**	**Directorate**	**Delivered by Lead Service Area / Team**
1 – 3	Monitoring Air Quality	Review the use of low - cost sensor technology to enable roadside monitoring in order to underpin the air quality modelling in the Borough	Use of low-cost sensors on area surveys for proposed road projects	Pilot 3 road projects to use low – cost sensor technology.	To inform air quality policy	Chief Executive	Transport Policy
1 – 4	London Local Air Quality Management Framework	Prepare and produce all London Local Air Quality Management Framework reports as required	Ensure that all reports required by the London Local Air Quality Management Framework are produced	Reports produced and submitted to Defra and GLA when required	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection
1 – 5		Respond to all appropriate air quality consultations	Review all air quality consultation requests and respond to them where appropriate.	100% of the appropriate air quality consultation reports are submitted by the consultation deadline	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection
1- 6		Ensure that the air quality action plan is current	Review the Authority's local air quality action plan to ensure it is clear and up to date.	Review Air Quality Action Plan annually	NO_2 & PM	Environment & Leisure	Environmental Protection
1 – 7		Have a communication plan for air quality	Devise a communication plan for air quality	Review the air quality communication every quarter	NO_2, PM & CO_2	Chief Executive	Environmental Protection & Comms

Section 2- Reduce Emissions							
Action Number	**Theme / Aim**	**Objective**	**Action**	**Target**	**Expected emissions/ concentrations benefit**	**Directorate**	**Delivered by Lead Service Area / Team**
2 – 1	Local Air Quality Assessments	Ensure that local air quality technical guidance provides the latest advice on air quality assessment and mitigation	Devise air quality technical guidance	Review technical guidance annually	NO_2 & PM	Environment & Leisure	Environmental Protection
2 – 2	Environmental Standards	Planning applications assessed to ensure that all applications will meet the aim of measure 2-1	Assessment of all relevant planning applications	100% of relevant planning applications assessed	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection
2 – 3	Increase the awareness of residents, businesses & visitors of need to reduce emissions to atmosphere	To promote the reduction of total emissions to ensure the protection of public health and the natural environment	Raise awareness to reduce emissions to the atmosphere to protect public health and the local environment	Initiate annual, season-relevant campaign on fuel type and fuel economy	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection & Comms

Section 3- Public Health Education and Awareness							
Action Number	**Theme / Aim**	**Objective**	**Action**	**Target**	**Expected emissions/ concentrations benefit**	**Directorate**	**Delivered by Lead Service Area / Team**
3 – 1	Encourage residents and those working in the borough to walk and cycle	Encourage children to walk or cycle to school	Promote School Travel Plans & increase the number of schools attaining Silver and Gold accreditation each year until 2020	Increase the number of schools with Silver accreditation each year	NO_2, PM & CO_2	Environment & Leisure	Sustainable Travel & Road Safety
				Increase the number of schools with Gold accreditation each year	NO_2, PM & CO_2	Environment & Leisure	Sustainable Travel & Road Safety
3 – 2		Encourage Southwark staff to walk or cycle in the Borough	Promote the Authority's Travel Plan encouraging staff to walk or cycle in the Borough & provide access to cycles for staff	Increase the number of staff walking or cycling each year	NO_2, PM & CO_2	Chief Executive	Facilities Management
3 – 3		Encourage employees of businesses in Southwark to commute by foot or cycle	Encourage employees of businesses in Southwark walk or cycle through the promotion of business specific Travel Plans	The result of the annual survey shows an increase in the number of people walking or cycling for their commute	NO_2, PM & CO_2	Chief Executive	Transport Policy
3 – 4		Encourage residents to walk or cycle in the Borough	Promote active travel through relevant public health work streams and services including physical activity and healthy weight	Measures to increase active travel included in all relevant new public health strategies, action plans and events	NO_2, PM & CO_2	Children and Adults Services	Public Health

Section 3- Public Health Education and Awareness							
Action Number	**Theme / Aim**	**Objective**	**Action**	**Target**	**Expected emissions/ concentrations benefit**	**Directorate**	**Delivered by Lead Service Area / Team**
3 – 5	Increase public awareness of air quality forecasting and avoidance of high levels of pollutants	Public aware of how to access airTEXT and Walk it apps	Promotion of availability of airTEXT and Walkit apps	Plan for awareness raising programme to be devised by April 2018	Protect individual health	Children and Adults Services	Public Health
3 – 6	Health Intelligence	Actions to reduce the health impact of poor air quality are evidence based and in line with national and regional policy	Public Health to provide expertise and intelligence relating to the health impacts of poor air quality in the Borough	Public Health involved in planning all air quality projects and initiatives.	Protect individual health	Children and Adults Services	Public Health
3 – 7	Web information on air quality	Southwark website has comprehensive information and appropriate guidance on air quality issues	Keep web-based information accurate and up to date	Annual review of air quality webpages content	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection & Public Health
3 – 8	Increase awareness of air quality issues	Public and businesses aware of the impact of their actions on air quality	Communication campaign on personal and business behaviour change to improve air quality	Initiate annual season-relevant campaign	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection, Public Health & Comms

Section 3- Public Health Education and Awareness							
Action Number	**Theme / Aim**	**Objective**	**Action**	**Target**	**Expected emissions/ concentrations benefit**	**Directorate**	**Delivered by Lead Service Area / Team**
3 – 9	Protect vulnerable groups from poor air quality	Ensure vulnerable persons get comprehensive advice on reducing personal exposure to atmospheric pollutants	Work with clinicians via Breathlessness Group of CCG to ensure GPs have access to appropriate prompts, advice and information for use in surgery	GPs have access to appropriate prompts, advice and information for use in surgery	Protect individual health	Environment & Leisure	Environmental Protection & Public Health

Section 4 – Cleaner Transport							
Action Number	**Theme / Aim**	**Objective**	**Action**	**Target**	**Expected emissions/ concentrations benefit**	**Directorate**	**Delivered by Lead Service Area / Team**
4 – 1	Promote the use of alternative fuels	Increase the use of the alternative fuel infrastructure	Provision of alternative fuel infrastructure information on Southwark web-pages	To provide information and review it annually	NO_2, PM & CO_2	Chief Executive	Transport Policy
4 – 2	Reducing Emissions from Delivery and Servicing	Develop a freight consolidation solution for Southwark	Carry out a joint feasibility study with Lambeth, Wandsworth and Croydon	Feasibility study to be completed by March 2017	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection
			Providing the feasibility study is positive, implement the preferred solution	Monitor the development of any preferred solution	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection
				Evaluate the preferred freight consolidation solution by March 2019	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection
4 – 3		All Southwark Council suppliers to use the proposed freight consolidation solution where possible	Ensure in-contract documentation that all Southwark Council suppliers are required to use any implemented consolidation solution	100% of suppliers, that can use the approved freight consolidation solution, using it	NO_2, PM & CO_2	Finance & Governance	Procurement

Section 4 – Cleaner Transport							
Action Number	**Theme / Aim**	**Objective**	**Action**	**Target**	**Expected emissions/ concentrations benefit**	**Directorate**	**Delivered by Lead Service Area / Team**
4 – 4	Reducing Emissions from Delivery and Servicing	All non consolidation solution suppliers to the authority with a large fleet to join the Fleet Operator Recognition Scheme (FORS) and obtain Silver accreditation as a minimum	Within the contract documentation that all suppliers of large fleet are required to be Silver accreditation of the Fleet Operator Recognition Scheme (FORS) to be achieved within six months of the contract being signed.	100% of all suppliers to the authority	NO_2, PM & CO_2	Finance & Governance	Procurement
4 – 5		To support sustainable logistical measures in the north of the Borough.	Work with TfL to promote the combination and rationalisation of deliveries using low & zero emission vehicles and local distribution hubs for final stage delivery in the Bankside, Borough and London Bridge areas	Reduced delivery mileage	NO_2, PM & CO_2	Chief Executive	Transport Policy
4 – 6		Virtual Loading bays and priority loading by ultra-low emission delivery vehicles	Explore if virtual loading bays can be implemented within the Borough	Produce a feasibility report identifying where virtual loading bays could work	NO_2, PM & CO_2	Chief Executive	Transport Policy
				Implement feasible virtual loading bays in the borough	NO_2, PM & CO_2	Chief Executive	Transport Policy

Section 4 – Cleaner Transport							
Action Number	**Theme / Aim**	**Objective**	**Action**	**Target**	**Expected emissions/ concentrations benefit**	**Directorate**	**Delivered by Lead Service Area / Team**
4 – 7	Reducing Emissions from Delivery and Servicing	Reduce Southwark fleet emissions by reducing total mileage	Undertake an annual survey of the mileage of the fleet	Reduction in business mileage year on year.	NO_2, PM & CO_2	Environment & Leisure	Fleet Services
			Produce mileage and efficiency guidance for services	Guidance to be produced by end of 2017	NO_2, PM & CO_2	Environment & Leisure	Fleet Services
		Introduction of telematics on commercial fleet	Install telematics on commercial fleet	Telematics installed on 100% of fleet by 2020	NO2, PM & CO2	Environment & Leisure	Fleet Services
4 – 8		Smarter Driver Training for drivers of all fleets used by the Authority	Introduce Smarter Driver training requirement for all fleet drivers	All current staff to undertake Smarter Driver training by December 2018	NO_2, PM & CO_2	Environment & Leisure	Fleet Services
				All new staff to receive the training within six months of commencement of their employment	PM & CO_2	Environment & Leisure	Fleet Services
4 – 9	Travel Planning	Maintain an up to date Council Travel Plan consistent with the aims of the air quality action plan	Undertake survey of staff travel arrangements	Undertake a staff survey in respect of the Authority's Travel Plan bi-annually	NO_2, PM & CO_2	Chief Executive	Transport Policy

Section 4 – Cleaner Transport							
Action Number	**Theme / Aim**	**Objective**	**Action**	**Target**	**Expected emissions/ concentrations benefit**	**Directorate**	**Delivered by Lead Service Area / Team**
4 – 10	Travel Planning	Maintain an up to date Council Travel Plan which is consistent with the aims of the air quality action plan	Review the Authority's Travel Plan	Undertake a bi-annual review of the Authority's Travel Plan	NO_2, PM & CO_2	Chief Executive	Transport Policy
4 – 11	Reducing emissions from Taxies & Private Hire Vehicles	Lobby TfL to promote Smarter Driver Training for drivers of all taxis and private hire vehicles.	Lobby the GLA and TfL to introduce a requirement that all PCO licences include an Smarter Driver training element	Smarter Driver Training element is introduced and GLA / TfL have produced a target for existing and new drivers to be trained.	NO_2, PM & CO_2	Chief Executive	Transport Policy
4 – 12	Reducing vehicle emissions	Work with TfL to reduce emissions from buses in the borough	Engage with TfL and GLA to promote the use of low emission buses on all routes in the Borough	Increase percentage of routes with low emission vehicles year on year	NO_2, PM & CO_2	Chief Executive	Transport Policy
4 – 13		Work with TfL and other London Boroughs to review the extension of the Ultra-Low Emission Zone to the South Circular	Engage with TfL and GLA on the potential air quality benefits of extending the ULEZ to the south circular	Annual review	NO_2, PM & CO_2	Chief Executive	Transport Policy

Section 4 – Cleaner Transport							
Action Number	**Theme / Aim**	**Objective**	**Action**	**Target**	**Expected emissions/ concentrations benefit**	**Directorate**	**Delivered by Lead Service Area / Team**
4 – 14	Reducing Vehicle Emissions	Work with the appropriate industries to reduce fine particle emissions from tyre, brake and clutch components	Engage with the appropriate universities and industries to reduce fine particle emissions from tyre, brake and clutch components	3 articles published in trade or academic press	PM	Environment & Leisure	Environmental Protection
4 – 15	Increase public transport facilities in the Borough	To increase public transport links in the Borough	Attendance at all relevant meetings with TfL, maintain record of discussions/minutes of meetings	Increased no. of buses, bus routes and under-ground stations. 100% of meeting minutes recorded	NO_2, PM & CO_2	Chief Executive	Transport Policy
4 – 16	Extension of the Bakerloo Line in the Borough	To extend Bakerloo line to Lewisham	Attendance at all relevant meetings with TfL, maintain record of discussions/minutes of meetings	Increased no. of underground stations. 100% of meeting minutes recorded	NO_2, PM & CO_2	Chief Executive	Transport Policy
4 – 17	Anti-idling campaign	Vehicle compliance with the Road Traffic Act anti idling provisions	Ensure all sectors of the population in the Borough have awareness of the anti-idling legislation	Annual campaign	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection & Comms
4 – 18	Emissions of vehicles	Enforcement of the provisions of the Road Traffic Act	Use of the vehicle idling powers	Train all JET officers in Road Traffic Act anti-idling enforcement	NO_2, PM & CO_2	Environment & Leisure	Joint Enforcement Teams

Section 5 – Reducing Carbon							
Action Number	**Theme / Aim**	**Objective**	**Action**	**Target**	**Expected emissions/ concentrations benefit**	**Directorate**	**Delivered by Lead Service Area / Team**
5 – 1	Reduction of carbon emissions	Require developers to contribute to reducing atmospheric emissions	Achieve minimum 35% regulated carbon emissions reduction on Part L of 2013 Building regulations on all new major developments	100% of relevant major planning applications meet policy target	PM & CO_2	Chief Executive	Development Management
5 – 2			Any of the 35% minimum CO_2 reduction not achieved on-site to be secured through S106 for the "Green Fund" (carbon off-setting projects) for the equivalent remaining regulated carbon emission savings	100% of major planning applications not meeting the 35% minimum CO2 reduction on-site to address remaining emissions through off-setting funds secured through S106	PM & CO_2	Chief Executive	Development Management
5 – 3			New homes on all major developments to be zero carbon as per London Plan policy 5.2, achieved either on-site or via financial contributions for off-setting	100% of money secured allocated to carbon off-setting projects	PM & CO_2	Chief Executive	Development Management
5 – 4			All major developments to achieve Air Quality Neutral Standards onsite	100% of major developments to achieve Air Quality Neutral standards	NO_2, PM & CO_2	Chief Executive	Development Management

Section 5 – Reducing Carbon							
Action Number	**Theme / Aim**	**Objective**	**Action**	**Target**	**Expected emissions/ concentrations benefit**	**Directorate**	**Delivered by Lead Service Area / Team**
5 – 5	Reduction of carbon emissions	Require developers to contribute to reducing atmospheric emissions	Where Air Quality Neutral standards not achieved on-site, off-setting funds secured through section 106 which meets the equivalent air quality neutral standard	100% of major planning applications not meeting the on-site Air Quality Neutral standard secure remaining requirement through off-setting funds through S106	NO_2, PM & CO_2	Chief Executive	Development Management
5 – 6			Commit and spend all offsetting funds on carbon offsetting projects	All monies secured for carbon off-setting purposes is monitored and reported	PM & CO_2	Chief Executive	Development Management
5 – 7	Improve the energy efficiency in Southwark homes	Promote reduced energy consumption and bills	Promote low cost energy efficiency measures	2 articles per year promoting energy reduction measures	NO_2, PM & CO_2	Housing	Major projects
5 – 8		Maximise funding streams available to improve energy efficiency	Bid for funding where funding will be beneficial to energy efficiency and fit in with the overall council objectives	Report on funding received and utilised	NO_2 & CO_2	Housing	Major Projects
5 – 9		Install ultra-low NO_x boilers in council & TMO housing	Install ultra-low NO_2 boilers when boilers are replaced in council and TMO housing	Install 1600 ultra-low NO_2 boilers/year	NO_2 & CO_2	Housing	Major Projects

Section 5 – Reducing Carbon							
Action Number	**Theme / Aim**	**Objective**	**Action**	**Target**	**Expected emissions/ concentrations benefit**	**Directorate**	**Delivered by Lead Service Area / Team**
5 – 10	Improve the energy efficiency in Southwark homes	Develop a strategy for communal boiler upgrades and renewals within council housing	Implement the strategy for communal boiler upgrades and renewals	Strategy approval and subsequent progress	NO_2 & CO_2	Housing	Major Projects
5 – 11		Monitor the effect of energy efficiency improvements in the Council's social housing planned renewal programme	Implement improvement programme in the social housing planned works programme	Baseline SAP score in 2017 /18 and monitor the changes through the investment programme annually	NO_2 & CO_2	Housing	Major Projects
5 – 12	Promoting the use of renewable energy and minimise the energy demand of Southwark estate	Reorganise the use of space in operational council buildings to reduce overall energy demand	Improve the use of Council buildings making them more sustainable, flexible, cost and space efficient	Baseline study in 2017 /18 and monitor the changes through the new Modernise Strategy annually	NO_2 & CO_2	Chief Executive	Facilities Management
5 – 13		Be aware of the energy used and generated by the Authority's operational buildings	Publish online information of the energy used and any generated by the Authority's operational buildings	Web based information available to public	N / A	Environment & Leisure	Service Development

Section 5 – Reducing Carbon							
Action Number	**Theme / Aim**	**Objective**	**Action**	**Target**	**Expected emissions/ concentrations benefit**	**Directorate**	**Delivered by Lead Service Area / Team**
5 – 14	Promote the use of renewable energy and minimise the energy demand of Southwark Housing	Explore the opportunity to install renewable energy technologies in Southwark housing (e.g. solar panels)	Through extra funding, explore the opportunity of installing renewable energy technologies and retrofitting insulation and energy efficiency measures	Explore all available opportunities	NO_2, PM & CO_2	Housing	Major Projects
5 – 15	Ensuring new developments minimise their impact on local air quality and climate change	Develop robust planning policies on air quality	Develop robust planning policies in the New Southwark Plan (NSP) and Old Kent Road Area Action Plan (OKR AAP)	Adopt policies on air quality in NSP and OKR AAP	NO_2, PM & CO_2	Chief Executive	Planning Policy
5 - 16		Highlight design guidance for best practice in reducing emissions to air	Develop a revised Sustainable Design and Construction SPD that includes up to date guidance on improving air quality	Revised Sustainable Design and Construction SPD is adopted	NO_2, PM & CO_2	Chief Executive	Planning Policy
5 - 16	Increase number of Southwark Council Homes using renewable energy	Increase no of Southwark Council Homes using renewable energy from SELCHP	Connect more dwellings to SELCHP	Increase no. of homes connected to SELCHP by 50%	NO_2, PM & CO_2	Housing	Major Projects

Section 6 – Regulation							
Action Number	**Theme / Aim**	**Objective**	**Action**	**Target**	**Expected emissions/ concentrations benefit**	**Directorate**	**Delivered by Lead Service Area / Team**
6 - 1	Emissions from developments and premises	Enforcement of the Clean Air Acts.	Ensure that all retail premises selling wood and coal are aware that the whole of the Borough is a Smoke Control Area	An annual enforcement campaign	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection
6 - 2	Smoke Control Zone	Discourage burning of logs and house coal in the Borough	A communication campaign during the Autumn to highlight pollution caused by using non - smokeless fuels	Campaign each year until 2022	PM & CO_2	Environment & Leisure	Environmental Protection & Comms
6 - 3	Emissions from industrial premises know to emit emissions to air	Regulation of EPA Part B processes	All IPPC premises in the Borough inspected in accordance with their risk assessment	Annual inspection of 100% of all relevant premises	NO_2, PM & CO_2	Environment & Leisure	Environment Protection
6 - 4	Emissions from development	Emissions from all construction work is minimised	Ensure that all strategic and major developments are aware of the Authority's Technical Guidance for Demolition & Construction	100% of all major & strategic planning applications made aware	NO_2 & PM	Environment & Leisure	Environmental Protection

Section 6 – Regulation							
Action Number	**Theme / Aim**	**Objective**	**Action**	**Target**	**Expected emissions/ concentrations benefit**	**Directorate**	**Delivered by Lead Service Area / Team**
6 - 5	Emissions from construction equipment	Ensure all Non Road Mobile Machinery complies with the GLA SPG construction criteria	Ensure that all strategic & major construction sites are on the on-line NRMM register	100% of all strategic and major construction sites on on-line NRMM register	NO_2 & PM	Environment & Leisure	Environmental Protection
6 - 6			All strategic and major construction sites are inspected for NRMM compliance	100% compliance of all major & strategic construction sites	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection
6 - 7	Emissions from developments and premises	Enforcement of the provisions of the Environment Protection and Clean Air Acts	Apply the provisions of Clean Air Act 1993 S.14 (chimney height.) to appropriate developments	100% of all relevant developments	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection
6 - 8			Investigate reports of bonfires & open burning.	90% of reports investigated	NO_2, PM & CO_2	Environment & Leisure	Noise & Nuisance
6 - 9			Ensure that there is public awareness that the Borough is a smoke control area	Annual communication campaign	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection & Comms

Section 7 – Support the GLA Air Quality Aims							
Action Number	**Theme / Aim**	**Objective**	**Action**	**Target**	**Expected emissions/ concentrations benefit**	**Directorate**	**Delivered by Lead Service Area / Team**
7 - 1	GLA Air Quality Focus Areas	Target the improvement of air quality in the GLA Air Quality Focus Areas	Ensure that local air quality in the GLA Air Quality Focus Areas is monitored	100% of the Focus Areas are monitored	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection
			Devise an air quality improvement project for each GLA Air Quality Focus Area	100% of the Focus Areas have an air quality improvement project	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection & Transport Policy
			Ensure that air quality projects in the GLA Air Quality Focus Areas are assessed	100% of projects are assessed	NO_2, PM & CO_2	Chief Executive	Transport Policy
			Ensure that local air quality projects in the GLA Air Quality Focus Areas are adequately evaluated.	100% of the projects produce evaluation reports	NO_2, PM & CO_2	Chief Executive	Transport Policy
7 - 2	Cleaner Air Borough	Retain Cleaner Air Borough Status	Take all actions required by GLA to retain Cleaner Air Borough	Cleaner Air Borough status retained	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection
7 - 3	The extension of the ULEZ	Support the GLA and TfL to extend the ULEZ to the South Circular	Respond to all consultations	100 % of responses made within consultation period	NO_2, PM & CO_2	Chief Executive	Transport Policy

Section 7 – Support the GLA Air Quality Aims							
Action Number	**Theme / Aim**	**Objective**	**Action**	**Target**	**Expected emissions/ concentrations benefit**	**Directorate**	**Delivered by Lead Service Area / Team**
7 - 4	Support GLA planning policy with regard to air quality	Ensure full consideration of GLA air quality planning policy changes	Ensure GLA air quality policy is considered in all planning decisions	100% of all applications	NO_2, PM & CO_2	Chief Executive	Development Management
7 - 5	Mayor's Air Quality Action Fund	Identify projects suitable for Mayor's Air Quality funding	Review the Mayor's Air Quality funding guidance	Maximise All funding opportunities to deliver projects to improve local air quality	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection
7 - 6	Clean air for Londoners	Work with the GLA & TfL and other organisations towards meeting the national air quality objectives	Review all external opportunities to participate in air quality improvement projects	All appropriate external opportunities are maximised	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection

Section 8 – Support Public Health Framework Objectives							
Action Number	**Theme / Aim**	**Objective**	**Action**	**Target**	**Expected emissions/ concentrations benefit**	**Directorate**	**Delivered by Lead Service Area / Team**
8 - 1	Joint Strategic Needs Assessment	The JSNA includes Air Quality and has up to date information on health impacts	Draft the air quality section of the JSNA	JSNA section is prepared by April 2017	NO_2, PM & CO_2	Children and Adults Services	Public Health
			Produce the air quality section of the JSNA	JSNA section is ratified by June 2017	NO_2, PM & CO_2	Children and Adults Services	Public Health
			Review the air quality section of the JSNA bi-annually	JSNA air quality section updated bi-annually	NO_2, PM & CO_2	Children and Adults Services	Public Health
8 - 2	Air Quality & Public Health	Retain local air quality as a public health priority	Provide up to date information in connection with air quality	Provide updates to the lead member and Health and Well-being board	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection
8 - 3	Embedding Air Quality Policy	Ensure that Air Quality is considered within all relevant complementary council policy developments	All relevant new policies to incorporate air quality aims	All new policies include relevant air quality aims	NO_2, PM & CO_2	Chief Executive	Relevant operational service areas
8 - 4	Air Quality Alerts	Provide air quality alert information to Southwark's vulnerable persons and those caring for them	Staff cascade for air quality alerts and advice	Implement by April 2017	NO_2 & PM	Environment & Leisure	Environmental Protection
8 - 5	Air Quality Projects in the Borough	To identify external funding and deliver projects to improve air quality in Borough	Review all external funding opportunities to fund air quality improvement projects	All appropriate external funding opportunities are maximised	NO_2, PM & CO_2	Environment & Leisure	Environmental Protection, Public Health & Transport Policy

Technical Appendices

The appendices are in a separate document accessible on the Southwark website at www.southwark.gov.uk/airquality . Below is the list of technical appendices available.

Appendix 1 – Air Quality Objectives

Appendix 2 – Health Impacts of Air Pollution

Appendix 3 – Air Quality Monitoring & Modelling Results

Appendix 4 – Emission Sources / Source Apportionment

Appendix 5 – Glossary

Contact	Environmental Protection Team Regulatory Services 3rd Floor, Hub 1 P.O. Box 64529 London SE1P 5LX
Telephone	020 7525 4261
Email	environmental.protection@southwark.gov.uk
Web	www.southwark.gov.uk/airquality
Revised	06/12/2016 15:35:06

APPENDIX C

Air Quality Action Plan

Technical Appendices

December 2016

Content of Appendices

Appendix 1 – National Air Quality Objectives

The air quality objectives applicable to London are set out in the Air Quality (England) Regulations 2000 (SI 928), The Air Quality (England) (Amendment) Regulations 2002 (SI 3043), and are shown in Table 1. This table shows the objectives in units of micrograms per cubic metre $\mu g.m^{-3}$ and for carbon monoxide in units of milligrams per cubic metre $mg.m^{-3}$). The number of exceedences in each year that are permitted are also listed where applicable).

Table 1 Air Quality Objectives included in Regulations for the purpose of London Local Air Quality Management in London

Pollutant	Air Quality Objective		Date to be achieved by
	Concentration	Measured as	
Benzene	16.25 $\mu g.m^{-3}$	Running annual mean	31.12.2003
	5.00 $\mu g.m^{-3}$	Annual mean	31.12.2010
1,3-Butadiene	2.25 $\mu g.m^{-3}$	Running annual mean	31.12.2003
Carbon monoxide	10 $mg.m^{-3}$	Running 8-hour mean	31.12.2003
Lead	0.50 $\mu g.m^{-3}$	Annual mean	31.12.2004
	0.25 $\mu g.m^{-3}$	Annual mean	31.12.2008
Nitrogen dioxide	200 $\mu g.m^{-3}$ not to be exceeded more than 18 times a year	1-hour mean	31.12.2005
	40 $\mu g.m^{-3}$	Annual mean	31.12.2005
Particulate Matter (PM_{10}) (gravimetric)	50 $\mu g.m^{-3}$, not to be exceeded more than 35 times a year	24-hour mean	31.12.2004
	40 $\mu g.m^{-3}$	Annual mean	31.12.2004
Sulphur dioxide	350 $\mu g.m^{-3}$, not to be exceeded more than 24 times a year	1-hour mean	31.12.2004
	125 $\mu g.m^{-3}$, not to be exceeded more than 3 times a year	24-hour mean	31.12.2004
	266 $\mu g.m^{-3}$, not to be exceeded more than 35 times a year	15-minute mean	31.12.2005

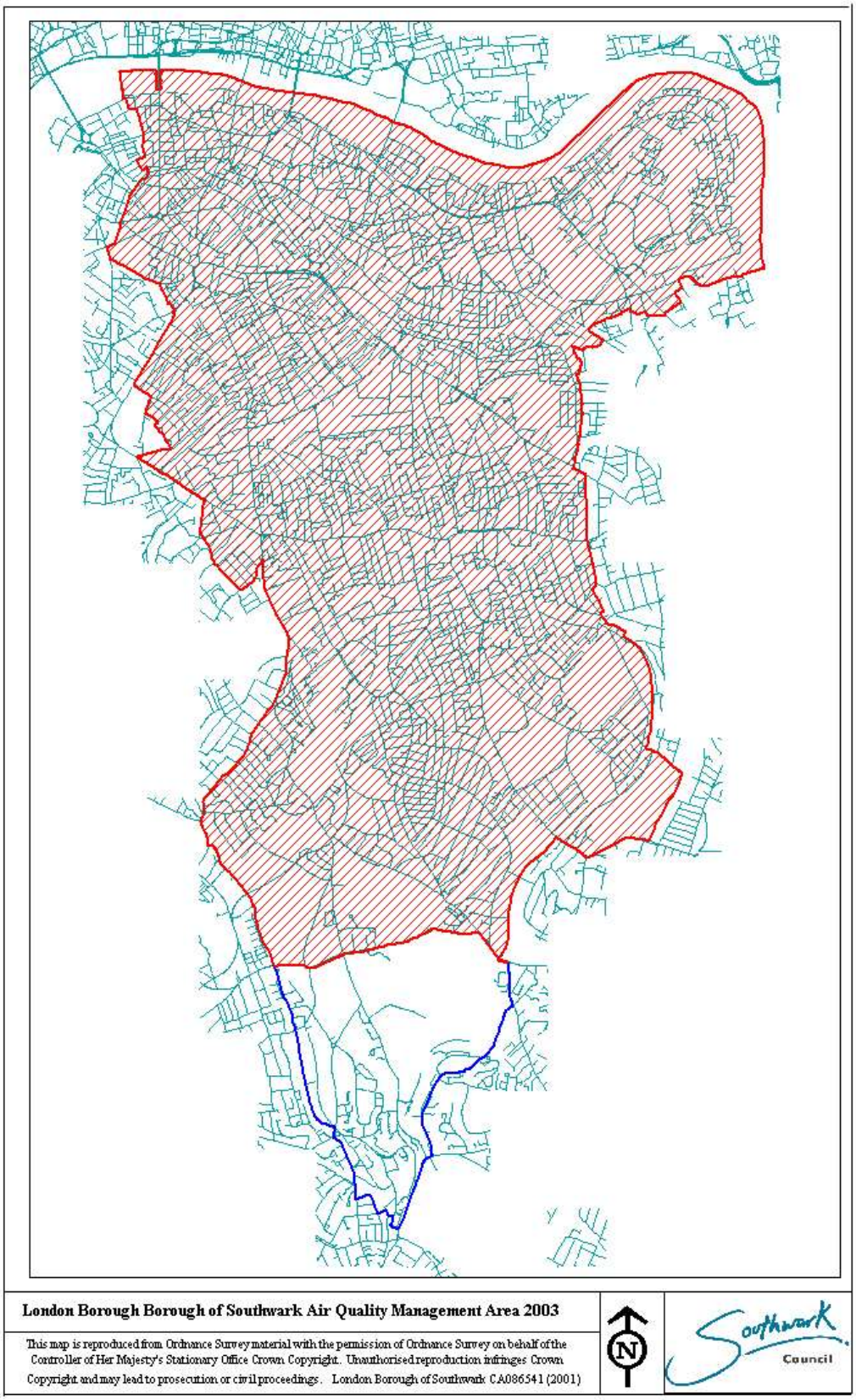


Figure 1 **Map of Air Quality Management Area in the L.B. Southwark**

Appendix 2 – Health Impacts of Air Pollution

Introduction

The health impacts of air pollution are varied, ranging from coughing, worsening of asthma, changes in lung function, increased hospital admissions for respiratory and cardiovascular disease and death.

Meta analysis of several studies provides the evidence of a statistically significant effect. This meta analysis also provides an estimate of the magnitude of the effect. The results are usually expressed as a proportional increase in effects for a $10\mu g.m^{-3}$ change in exposure. For an example, the overall increase in all-cause deaths from an increase in exposure to $PM_{2.5}$ is 6% per $10\mu g.m^{-3}$ change in the annual mean concentration.

In March 2015 the Committee on the Medical Effects of Air Pollutants concluded there is evidence of association of ambient concentrations of NO_2 with a range of effects on health. Studies have shown that to some extent, NO_2 acts as a marker for the effects of other traffic-related pollutants. The epidemiological and mechanistic evidence now suggests that it would be sensible to regard NO_2 as causing some of the health impact found to be associated with it in epidemiological studies.

In July 2015 King's College London calculated that the total mortality burden of long-term exposure to NO_2 is estimated to be up to 88,113 life-years lost, equivalent to 5,879 deaths at typical ages (assuming the WHO value of up to a 30% overlap between the effects of $PM_{2.5}$ and NO_2). Some of this effect may be due to other traffic pollutants. The total mortality burden of anthropogenic $PM_{2.5}$ for the year 2010 is estimated to be 52,630 life-years lost, equivalent to 3,537 deaths at typical ages. The total mortality burden in 2010 from $PM_{2.5}$ and NO_2 can be added to give a range from the 52,630 life-years lost, equivalent to 3,537 deaths at typical ages from $PM_{2.5}$ alone (if only including the most established effects) to as much as 140,743 life-years lost, equivalent to 9,416 deaths at typical ages (assuming a 30% overlap between the effects of $PM_{2.5}$ and NO_2 and comparing with a zero concentration of NO_2).

A study in East London[1] found that traffic-related air pollutants have adverse effects on respiratory and allergic symptoms in school children in the area. This study also demonstrated that was a reduction of lung Forced Vital Capacity with increased exposure to traffic derived pollutants.

[1] Wood HE, Marlin N, Mudway IS, Bremner SA, Cross L, Dundas L et al. (2015) Effects of air pollution and the Introduction of the Low Emission Zone on Prevalence of Respiratory and Allergic Symptoms in Schoolchildren in East London: A Sequential Cross-Sectional Study. Plos One 10(8): e0109121. Doi 10.1371/journal.pone.0109121

The table below shows the summary of the sources and impact of pollutants found in an urban area.

Pollutant	**Sources**	**Health effects**
Nitrogen dioxide	Road transport (especially diesel vehicles), domestic boilers, power stations and industry	Lung irritation and damage
Sulphur dioxide	Power stations, domestic boilers, industry	Coughing, irritation and narrowing of airways. Can make asthma and bronchitis worse
Fine Particulates (PM_{10} and $PM_{2.5}$)	Road transport (mainly diesel vehicles and tyre and brake wear), power stations, domestic boilers	Increased chances of respiratory disease, lung damage, cancer and premature death
Ozone	Produced when sunlight reacts with vehicle exhaust fumes	Irritation to eyes, nose and throat. Can damage lungs and airways

Appendix 3 – Air Monitoring & Modelling Results

Introduction

This section presents the historical and up to date data from the continuous monitoring stations within the Southwark area for Nitrogen Dioxide (NO_2) and Particulate Matter (PM_{10}). The Authority does not present monitor for $PM_{2.5}$ so the average data for all of the London sites has been presented.

After the monitoring data section, there are the modelled annual means for NO_2 , PM_{10} & $PM_{2.5}$ concentrations for the Greater London Area in 2013 maps. The following maps show the modelled annual mean concentrations for 2013 for the Borough.

The final part of this appendix outlines the GLA focus areas in the Greater London and in the Southwark and the areas which are on the border of the borough.

Nitrogen Dioxide

Site ID	Site type	Valid data capture for monitoring period % [a]	Valid data capture 2015 % [b]	Annual Mean Concentration (µg.m^{-3})						
				2009	2010	2011	2012	2013	2014	2015
SWK1[2]	Urban Background	N / A	N / A	**49** (44%)	N / A	N / A	N / A	N / A	N / A	N / A
SWK5	Roadside	69	69	N / A	N / A	**46** (73%)	**52** (80%)	**55** (>90%)	38 (32%)	**42** (69%)
SWK6	Urban Background	80	80	N / A	N / A	N / A	N / A	**42** (85%)	37 (84%)	**41**(80%)
CP1[3]	Roadside	N / A	N / A	**49** (93%)	**47** (56%)	N / A	N / A	N / A	N / A	N / A

Table 2 Annual Mean NO_2 Ratified and Bias-adjusted Monitoring Results (µg.m^{-3})

Notes: Exceedence of the NO_2 annual mean AQO of 40µgm^{-3} are shown in **bold**.
NO_2 annual means in excess of 60µg m^{-3}, indicating a potential exceedence of the NO_2 hourly mean AQS objective are shown in bold and underlined.

The above data shows that at both stations the annual mean concentration is exceeding the objective of 40µg.m^{-3} since 2011. The trends for the monitoring stations in the Southwark area can be seen in Figure 2 below.

[2] This air quality monitoring station was situated at Larcom Street, this station closed in June 2009, due to the council building being disposed off

[3] This air quality monitoring station was installed by a collaboration of Local Authorities (L.B. Bromley, L.B. Croydon L.B. Lambeth, L.B. Lewisham and L.B. Southwark). This station was closed in July 2010 due to reduction in resources to the Local Authorities.

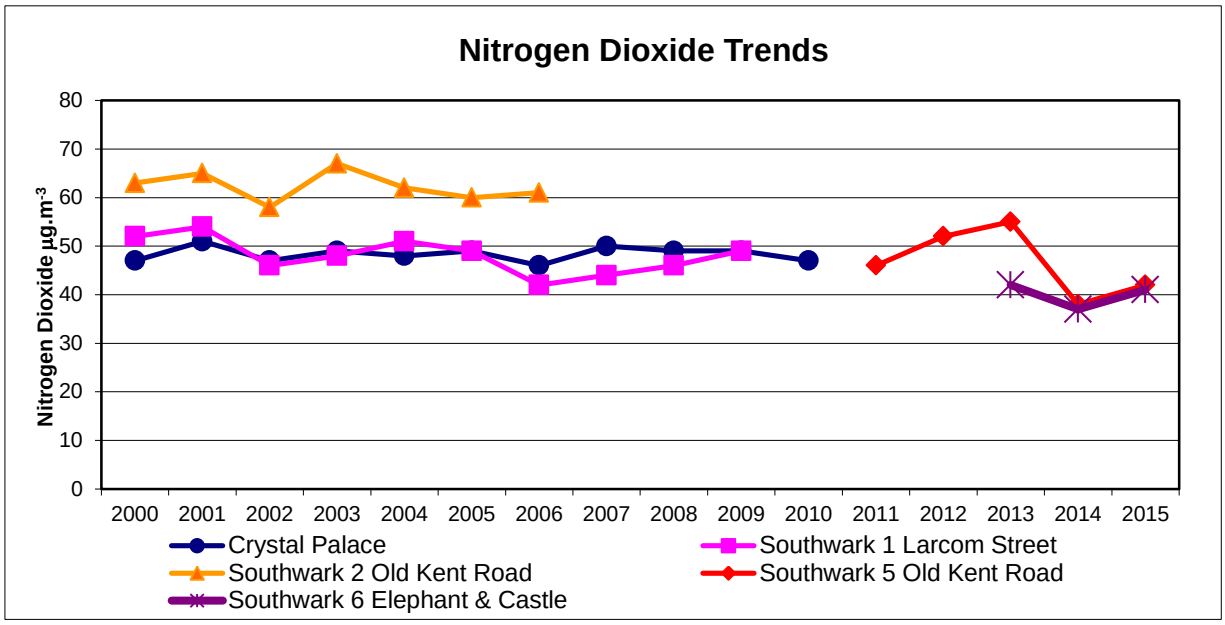


Figure 2 Trends in Annual Mean NO_2 Concentrations at the Borough's Automatic Monitoring Sites

Figure 3 below shows the mean results from all roadside and background monitoring stations within the London Air Quality Network[4]. This shows that the trend for the background sites is showing a gradual reduction to below the objective. However the roadside locations are not reducing and exceed the objective in the region of 7µg.m^{-3} to 20µg.m^{-3}.

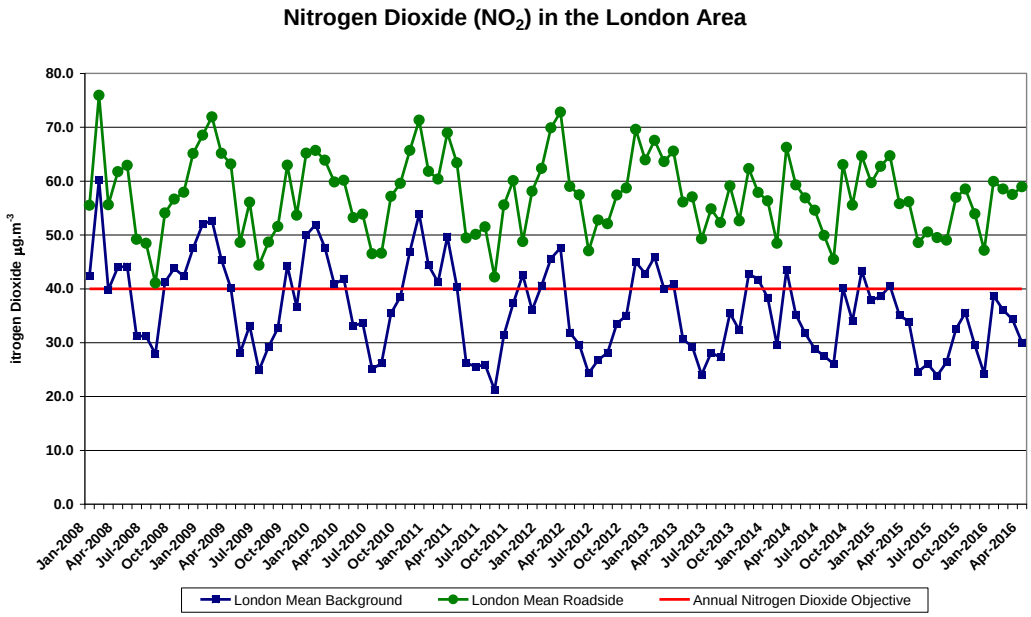


Figure 3 Trends of the monthly mean Nitrogen Dioxide concentrations at roadside and background sites in the London area

[4] London Datastore - London Average Air Quality Levels accessed at http://data.london.gov.uk/dataset/london-average-air-quality-levels

Particulate Matter (PM_{10})

Table 3 Annual Mean PM_{10} Automatic Monitoring Results (µg m^{-3})

Site ID	Valid data capture for monitoring period %	Valid data capture 2015 %	Annual Mean Concentration (µg.m^{-3})						
			2009	2010	2011	2012	2013	2014	2015
SWK1	N / A	N / A	22 (44%)	N / A	N / A	N / A	N / A	N / A	N / A
SWK5	60	60	N / A	29 (8%)	27 (80%)	25 (82%)	30 (85%)	23	21
SWK6	77	77	N / A	N / A	N / A	N / A	23 (80%)	19	20
CP1	N / A	N / A	24(80%)	23 (55%)	N / A	N / A	N / A	N / A	N / A

Notes: Exceedence of the PM_{10} annual mean AQO of 40µgm^{-3} are shown in **bold**.

The PM_{10} annual mean concentrations at the monitoring stations have met the national air quality objectives. The downward trend of the PM_{10} annual mean concentrations at the monitoring stations is shown in Figure 4. The trends for all the London Air Quality Network roadside and background monitoring stations can be seen in Figure 5, this shows that concentrations are generally below the objective level.

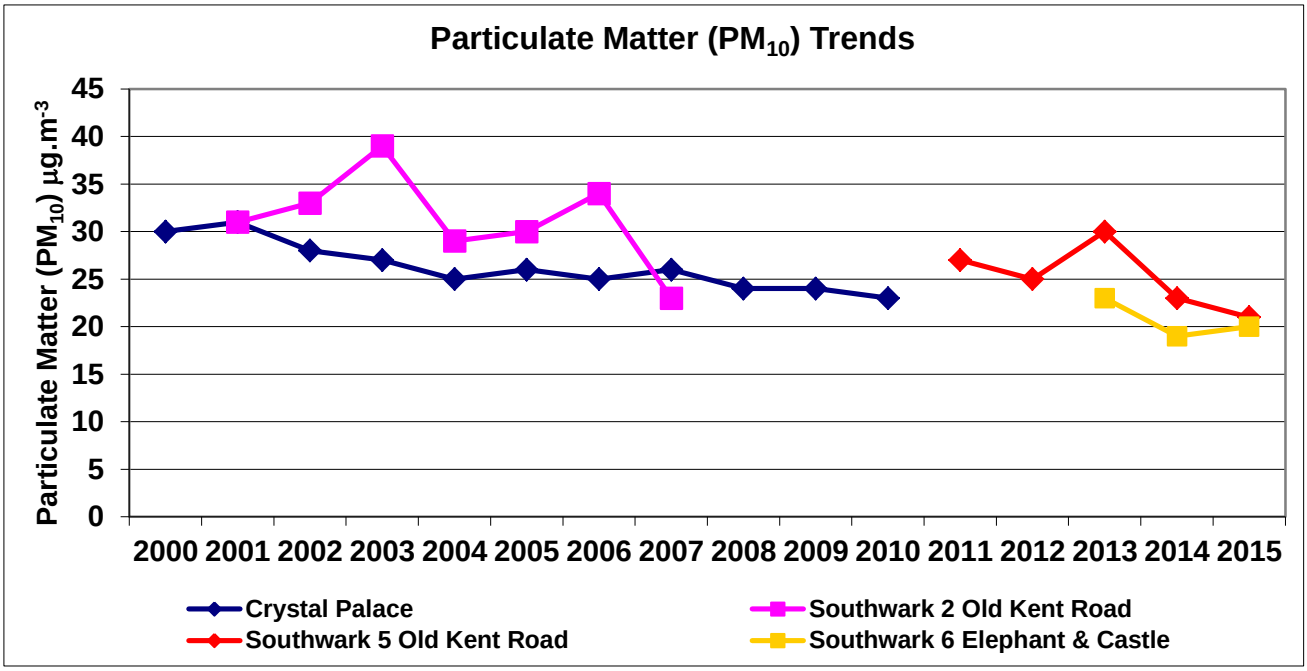


Figure 4 Trends in Annual Mean PM_{10} Concentrations of the Authority's PM_{10} monitoring stations

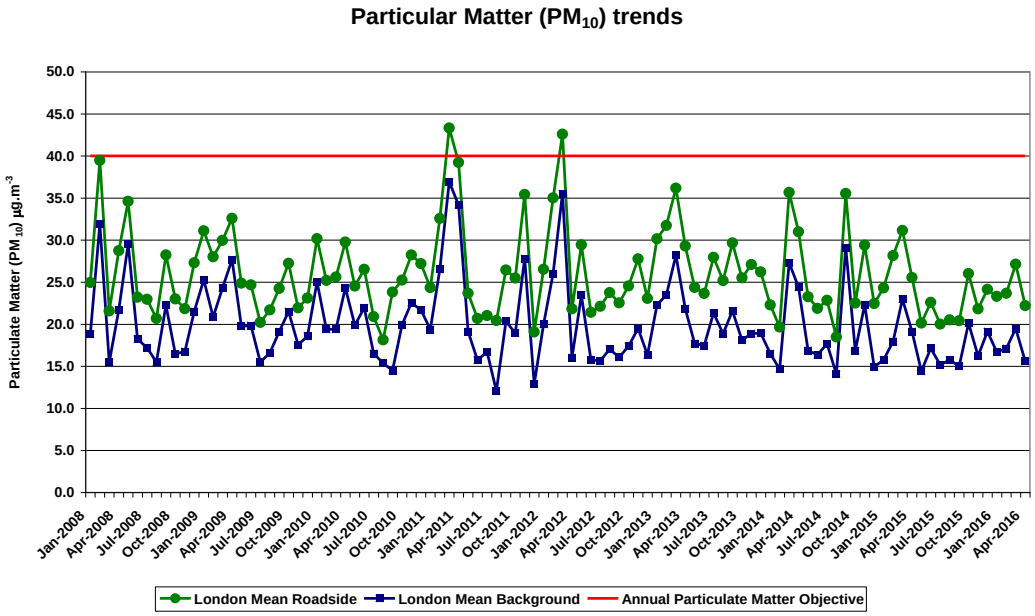


Figure 5 **Trends of the monthly mean Particulate Matter (PM10) concentrations at roadside and background sites in the London area.**

Particulate Matter ($PM_{2.5}$)

The London Borough of Southwark does not monitor for $PM_{2.5}$ in the Borough. Figure 6 shows the concentrations of all the $PM_{2.5}$ roadside and background monitors in the London Air Quality Network. There appears to be a downward trend in the measured concentrations.

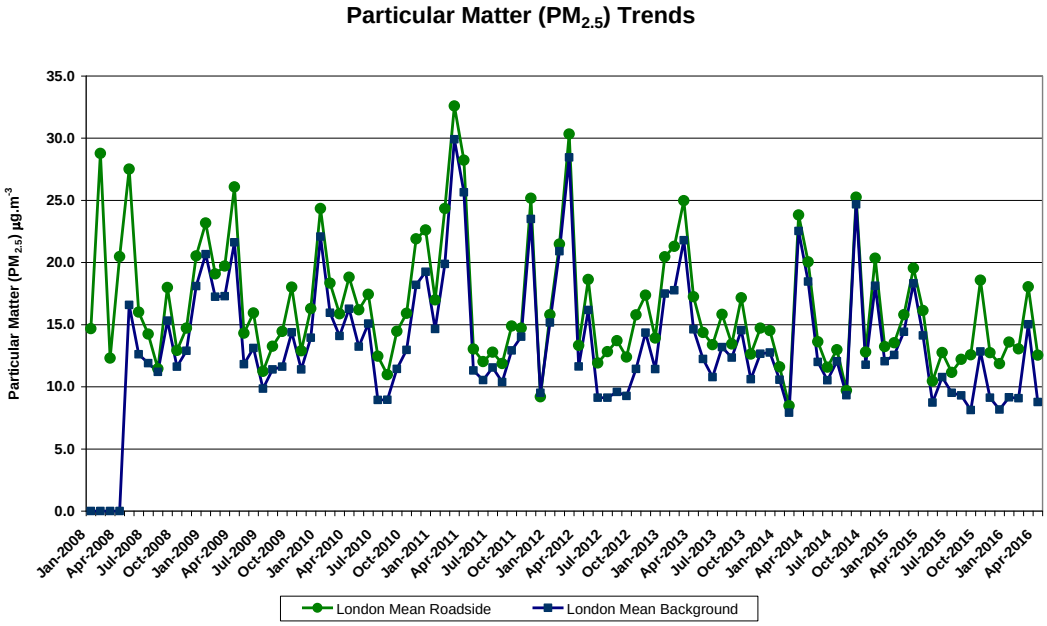
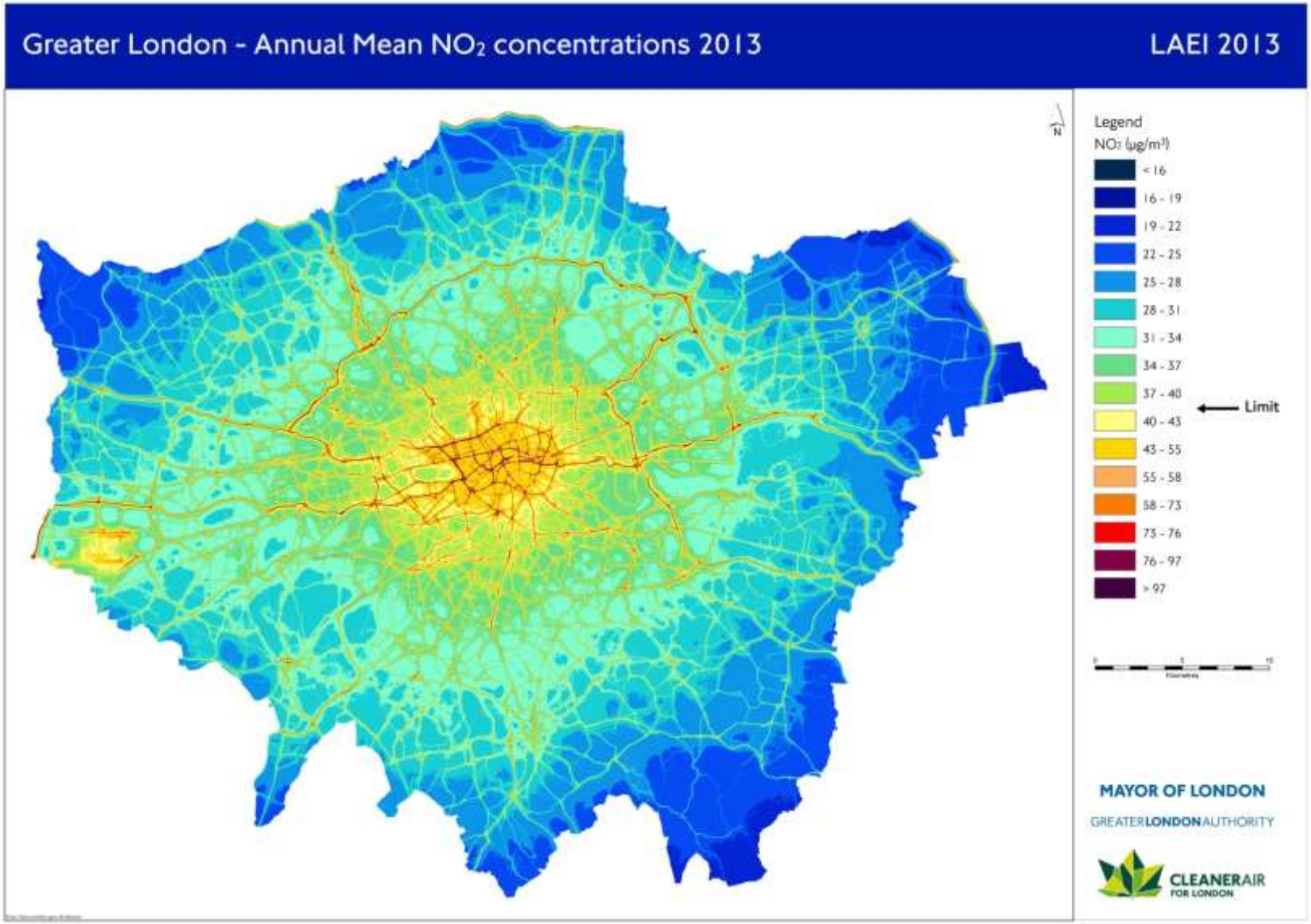
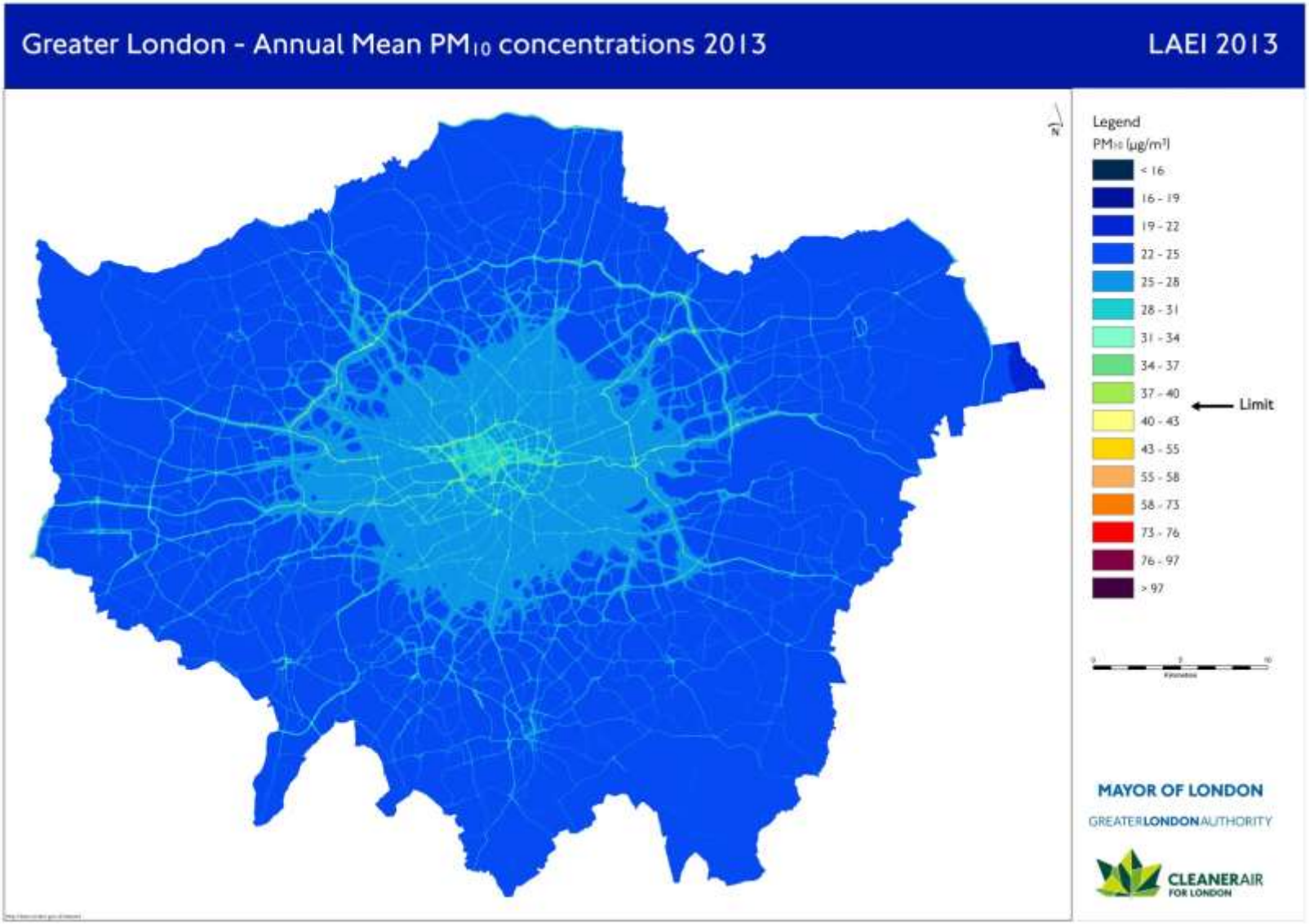


Figure 6 **Trends of the monthly mean Particulate Matter ($PM_{2.5}$) concentrations at roadside and background sites in the London area.**
Source GLA accessed at **http://data.london.gov.uk/dataset/london-average-air-quality-levels**


Greater London - Annual Mean NO2 concentrations 2013
LAEI 2013
Legend
NO2 (µg/m3)
< 16
16 - 19
19 - 22
22 - 25
25 - 28
28 - 31
31 - 34
34 - 37
37 - 40
40 - 43
43 - 55
55 - 58
58 - 73
73 - 76
76 - 97
> 97
Limit
MAYOR OF LONDON
GREATERLONDONAUTHORITY
CLEANERAIR FOR LONDON


Greater London - Annual Mean PM10 concentrations 2013
LAEI 2013
Legend
PM10 (µg/m³)
< 16
16 - 19
19 - 22
22 - 25
25 - 28
28 - 31
31 - 34
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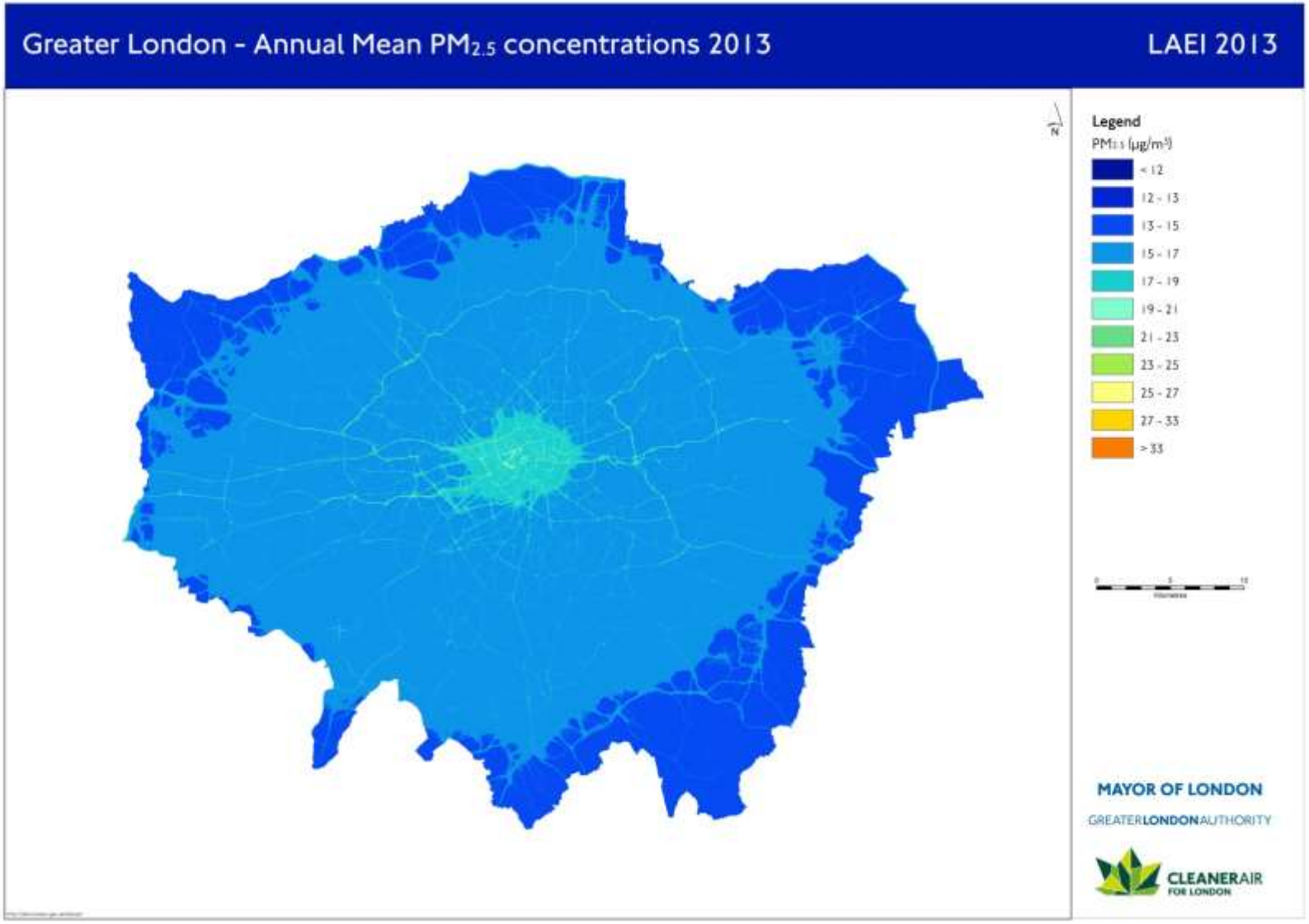
40 - 43
43 - 55
55 - 58
58 - 73
73 - 76
76 - 97
> 97
MAYOR OF LONDON
GREATERLONDONAUTHORITY
CLEANERAIR FOR LONDON


Greater London - Annual Mean PM2.5 concentrations 2013
LAEI 2013
Legend
PM2.5 (µg/m3)
< 12
12 - 13
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15 - 17
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MAYOR OF LONDON
GREATERLONDONAUTHORITY
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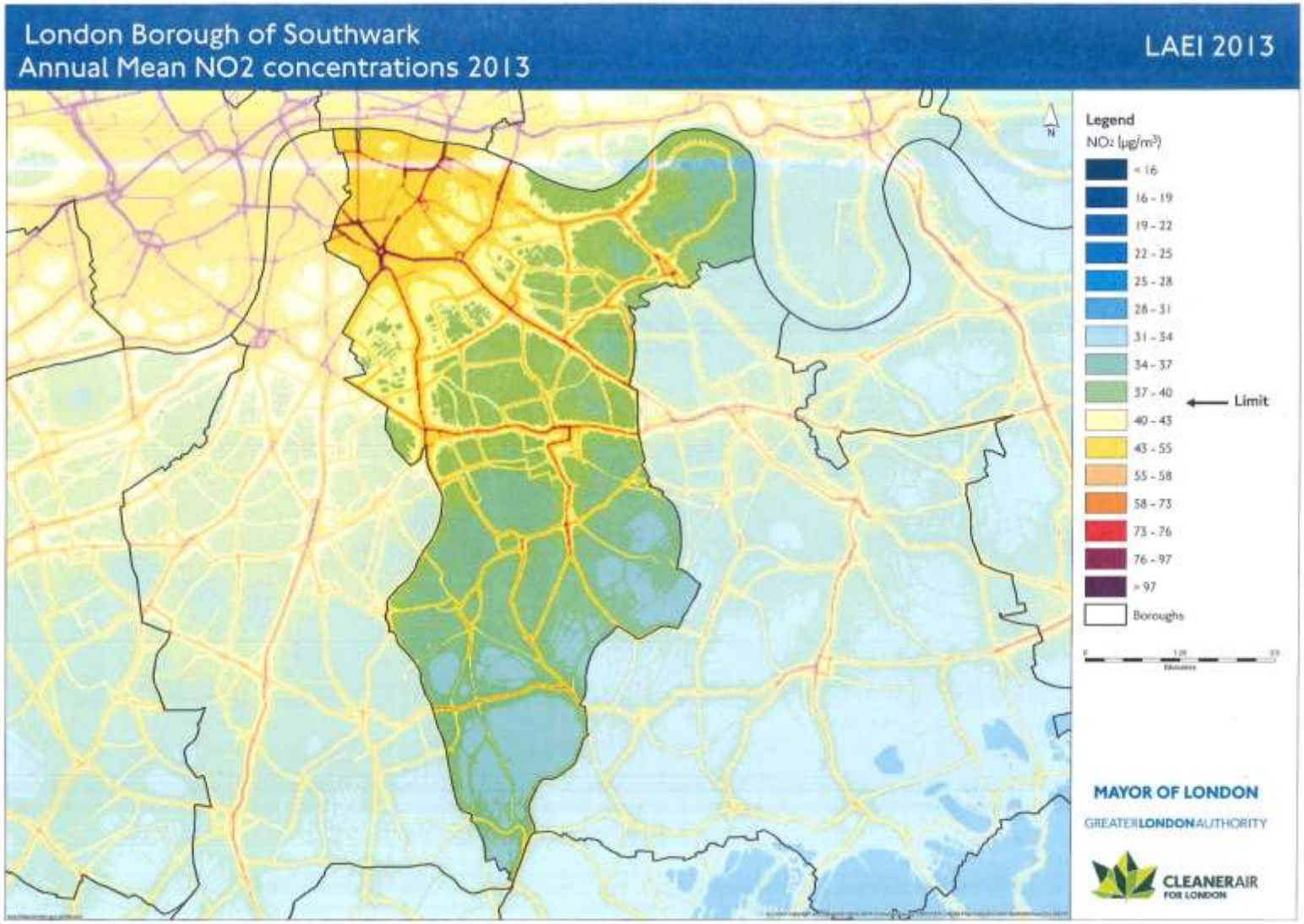
FOR LONDON


London Borough of Southwark
Annual Mean NO2 concentrations 2013
LAEI 2013
Legend
NO2 (µg/m3)
< 16
16 - 19
19 - 22
22 - 25
25 - 28
28 - 31
31 - 34
34 - 37
37 - 40
Limit
40 - 43
43 - 55
55 - 58
58 - 73
73 - 76
76 - 97
> 97
Boroughs
MAYOR OF LONDON
GREATERLONDONAUTHORITY
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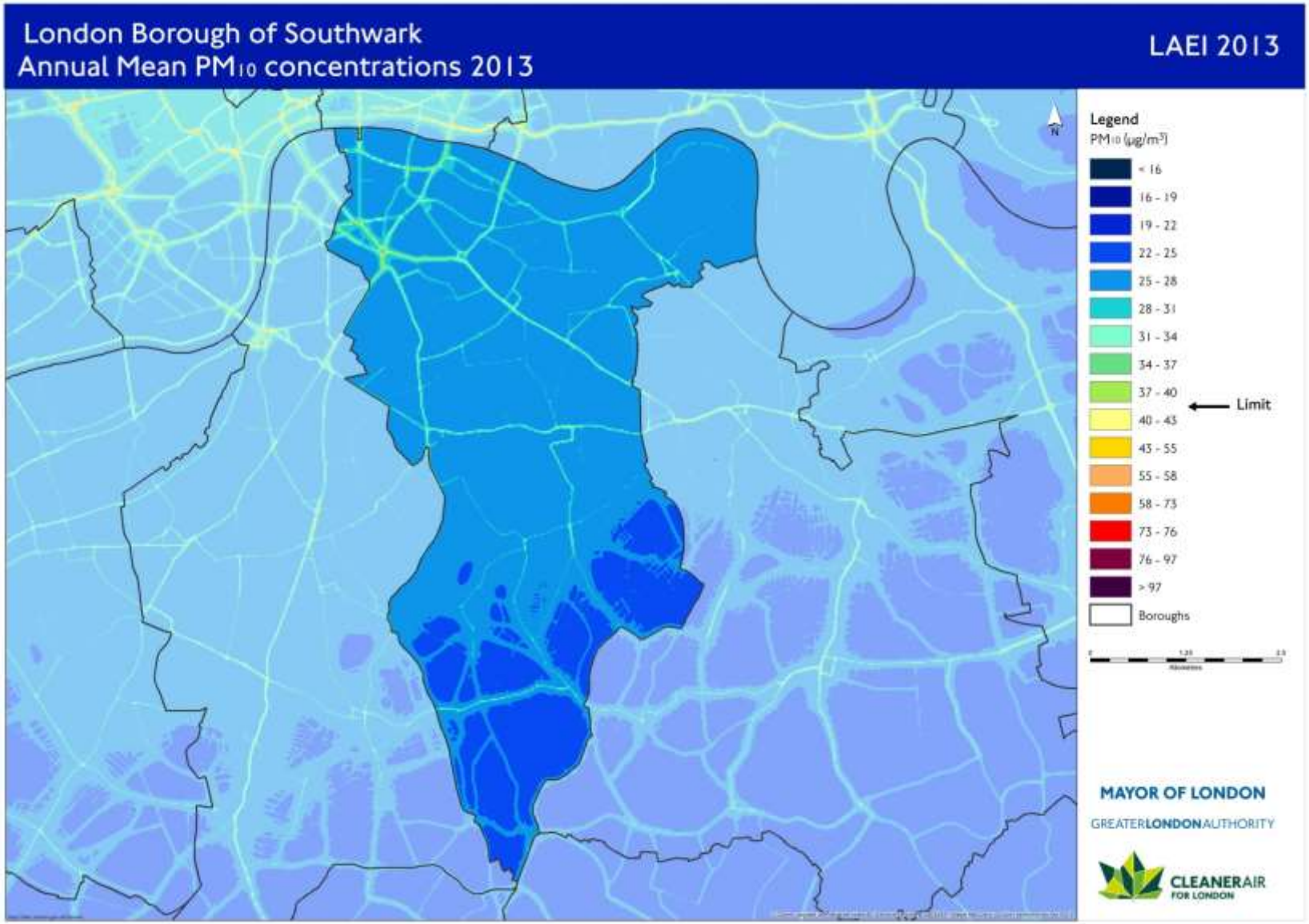
FOR LONDON


London Borough of Southwark
Annual Mean PM10 concentrations 2013
LAEI 2013
Legend
PM10 (µg/m3)
< 16
16 - 19
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22 - 25
25 - 28
28 - 31
31 - 34
34 - 37
37 - 40
40 - 43
43 - 55
55 - 58
58 - 73
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76 - 97
> 97
Limit
Boroughs
MAYOR OF LONDON
GREATERLONDONAUTHORITY
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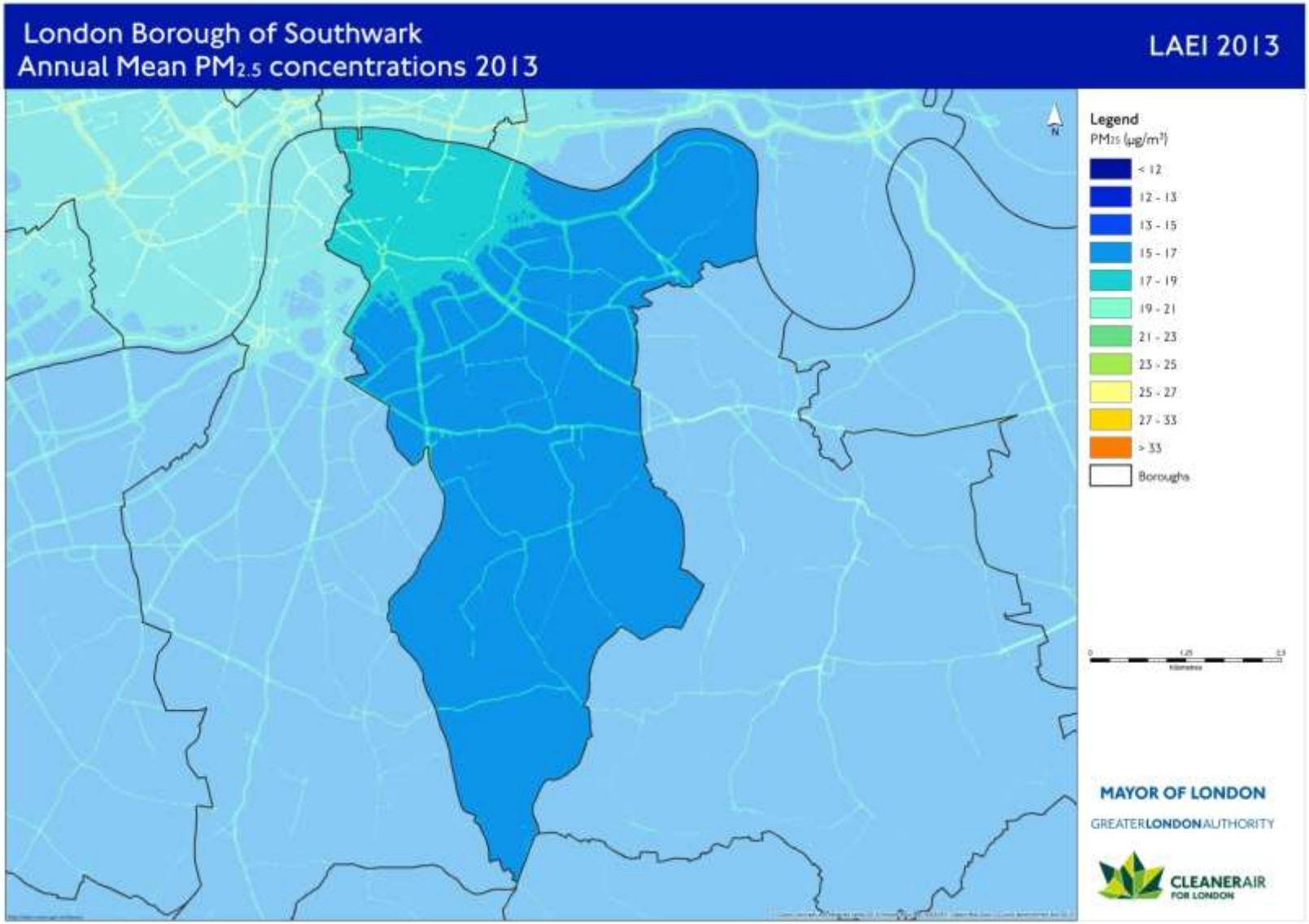
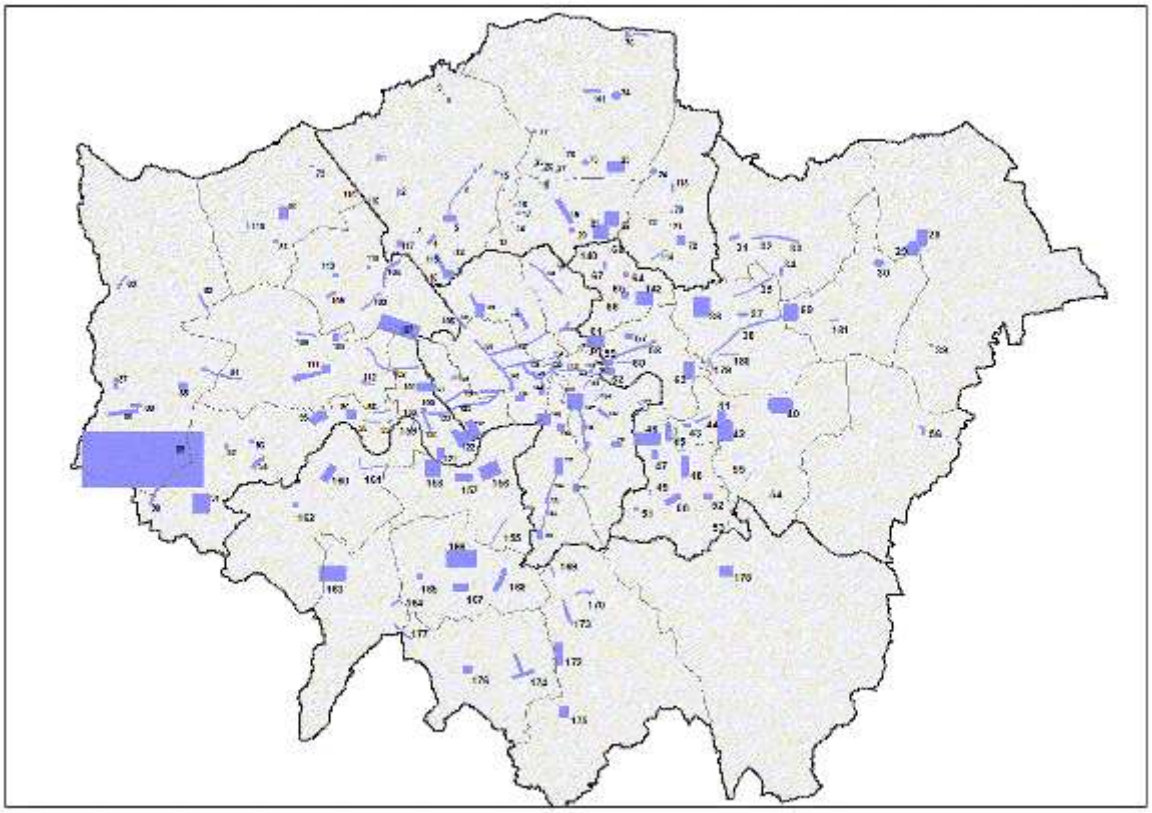

London Borough of Southwark
Annual Mean PM2.5 concentrations 2013
LAEI 2013
Legend
PM2.5 (µg/m³)
< 12
12 - 13
13 - 15
15 - 17
17 - 19
19 - 21
21 - 23
23 - 25
25 - 27
27 - 33
> 33
Boroughs
MAYOR OF LONDON
GREATERLONDONAUTHORITY
CLEANERAIR
FOR LONDON

GLA Air Quality Focus Areas for the Greater London Area.

The London Mayor has introduced a number of Air Quality Focus Areas[5] in the Greater London area**.** See map below.



The process of how the Mayor of London developed these focus areas can be found here

Within Southwark the following areas in have been designated Air Quality Focus Areas by the GLA.

ID	Description of the Air Quality Focus Area
1	London Bridge at Borough High Street
2	Elephant and Castle to St George's Circus
3	Walworth Road / Camberwell Road / Camberwell Green
4	Tower Bridge Road A100
5	A2 Old Kent Road from East Street to Trafalgar Avenue
6	Lower Road A200 Surrey Quays
7	Peckham High Street and Clayton Road

Table 4 Air Quality Focus Areas in the London Borough of Southwark

[5] GLA (2013) Air Quality focus areas data accessed at http://data.london.gov.uk/dataset/air-quality-focus-areas

Figure 7 is a map showing the GLA's Air Quality Focus Areas in Southwark with the Air Quality Focus Areas adjacent to the boundary of the Authority included. Table 4 and Table 5 give descriptions of the air quality focus areas in the borough and the air quality focus areas adjacent to borough's Boundary.

ID	Local Authority	Description of the Air Quality Focus Area
8	Lewisham	New Cross Gate and New Cross
9	Lewisham	Honor Oak Park junction Brockley Road
10	Lewisham	Forest Hill and Perry Vale Junction
11	Lambeth	Herne Hill / Croxted Road / Half Moon Lane / Dulwich Rd / Norwood Rd
12	Lambeth	Kennington Oval and Camberwell New Road
13	Lambeth	Waterloo Road
14	City of London	Farringdon Road and New Bridge Street at Blackfriars
15	City of Westminster	Embankment Charing Cross to Tower Hill
16	Tower Hamlets	Tower Hill / Tower Gateway / Cable St / The Highway

Table 5 Air Quality Focus Areas in the adjacent boroughs

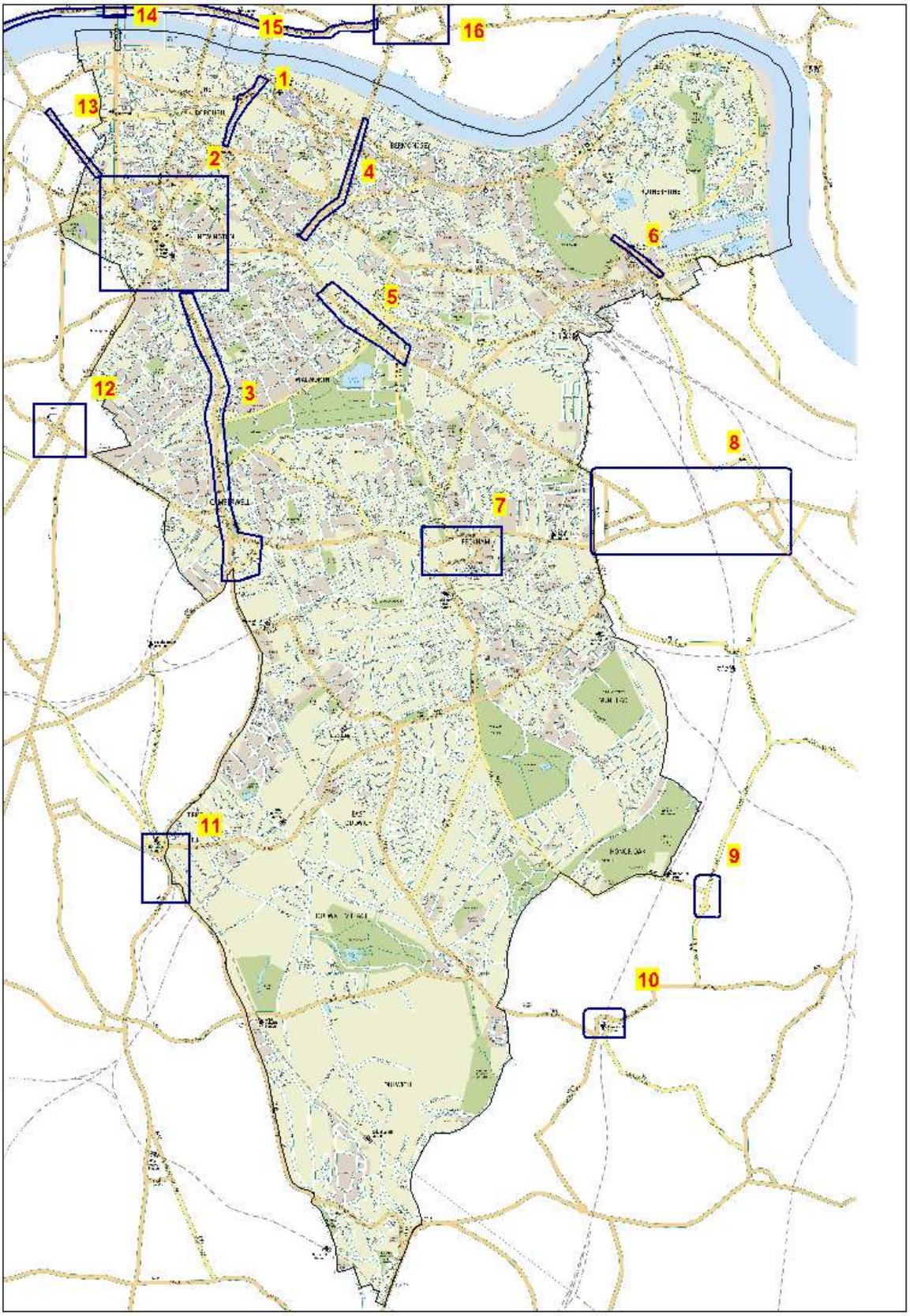


Figure 7 **London's Mayor Air Quality Focus Areas Map within and adjacent to the L.B. Southwark boundary**

Appendix 4 – Emission Sources

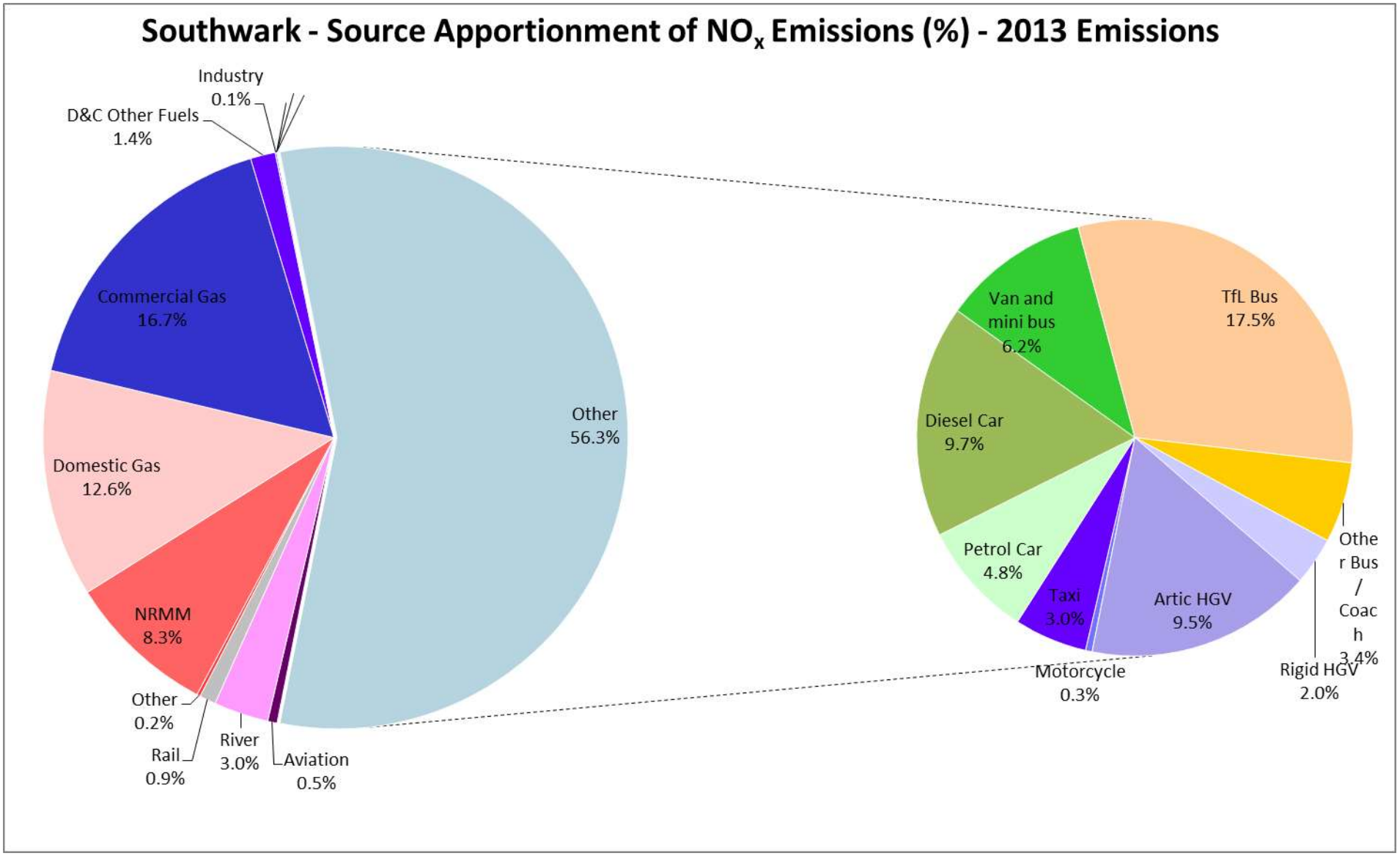
Introduction

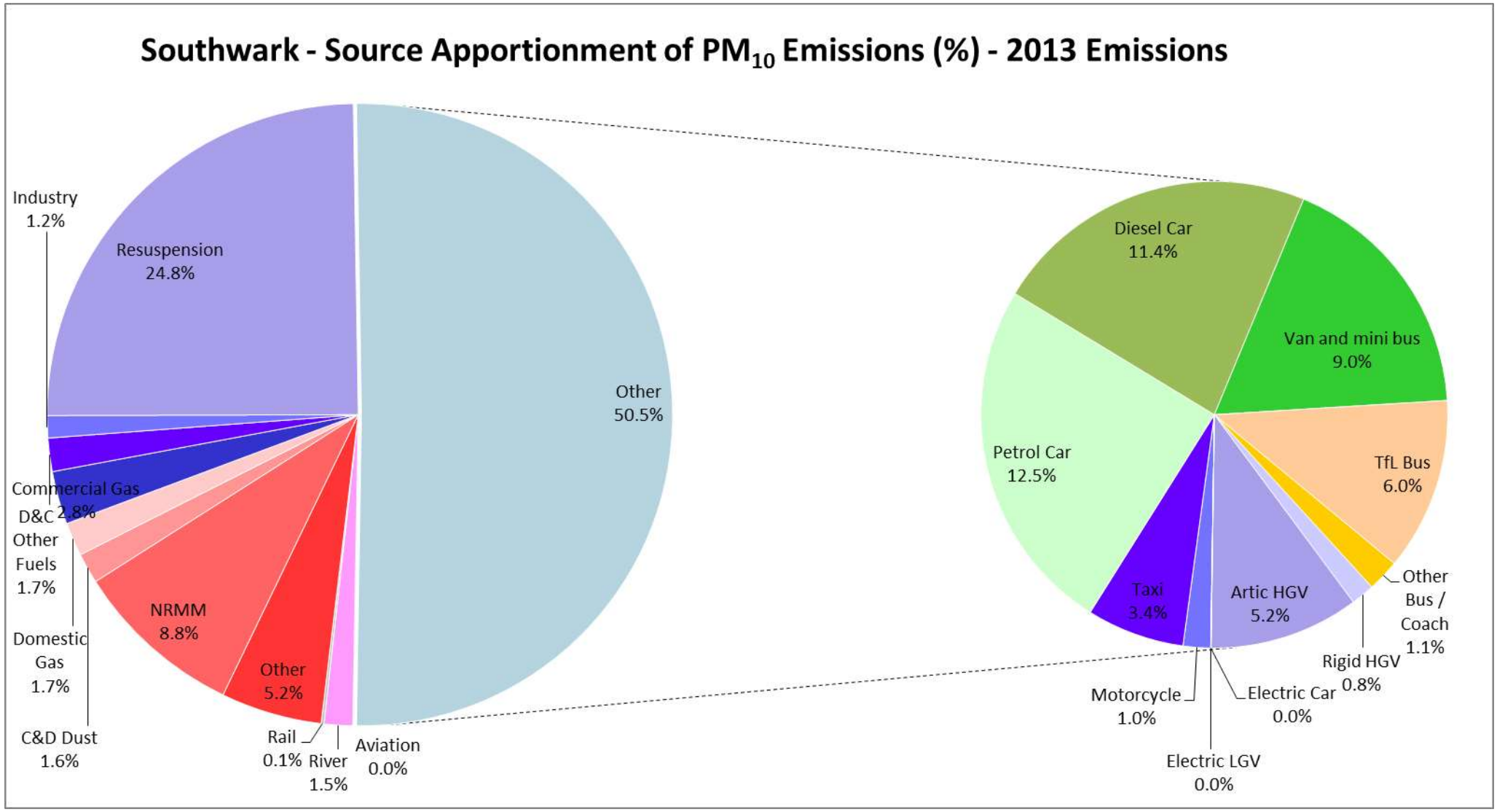
The GLA has produced the London Atmosphere Emissions Inventory (LAEI) for over a decade, the latest version was published in March 2016. The LAEI 2013 provides estimates in the Greater London area emissions for NO_2, PM_{10}, $PM_{2.5}$ & CO_2 for the base year 2013 and forward projections/predictions of pollutant levels for 2020, 2025 and 2030.

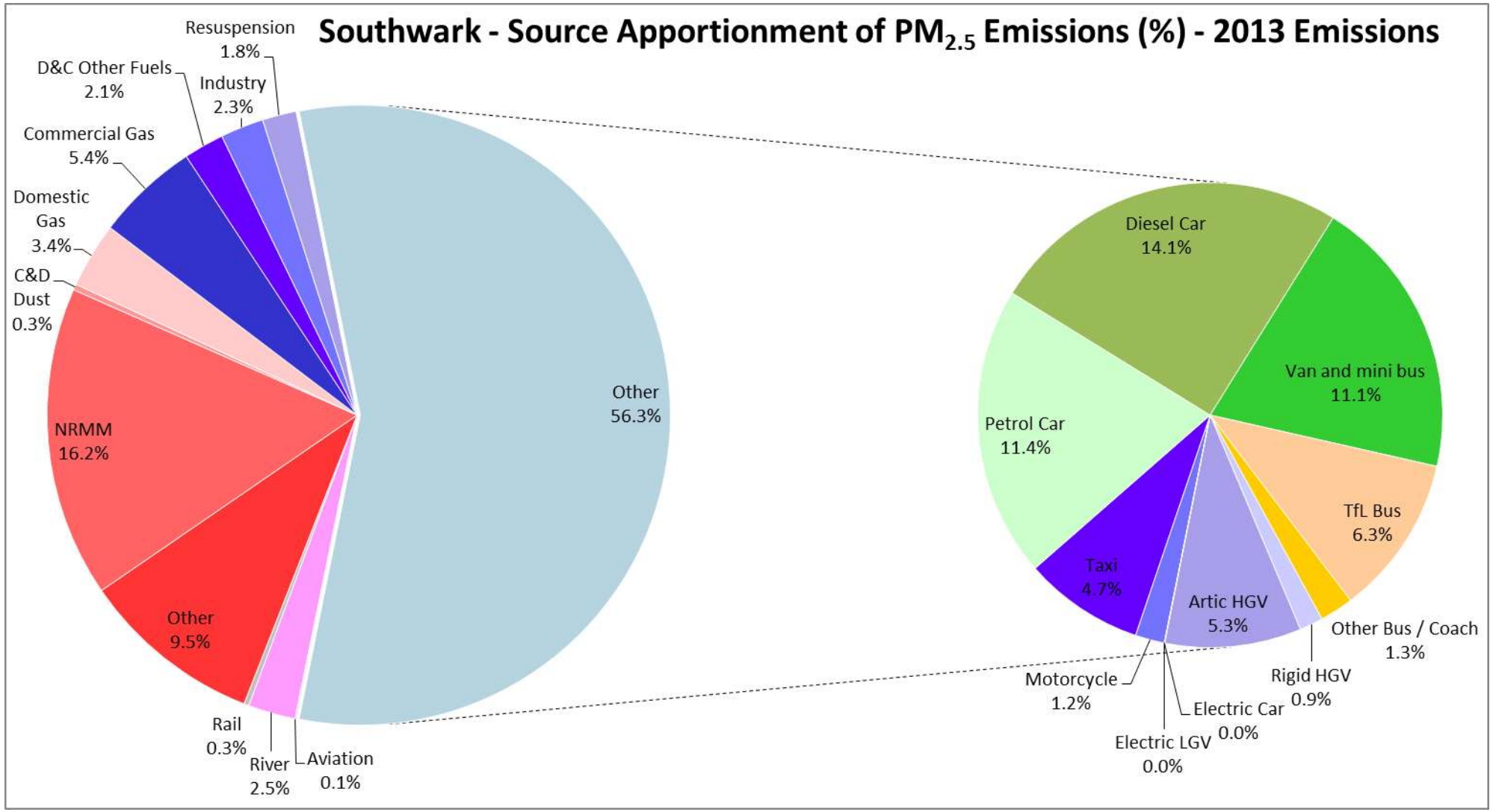
The LAEI can be downloaded from the GLA Datastore. The LAEI 2013 provides the following data.

- Supporting Information
- Grid Emissions Summary (in Excel. Mapinfo and Arc GISformat)
- Detailed Road Transport (in Excel. Mapinfo and Arc GISformat)
- Modelled Concentrations for the three pollutants for all the years
- Presentations Slides of the GLA LAEI 2013 Workshop on 14/04/2016

With the LAEI 2013 data the GLA has provided bespoke Borough by Borough information which utilises the information contained in the LAEI 2013. The information provides the concentration maps for 2013 and 2020 for NO_2, PM_{10} & $PM_{2.5}$ for all the London Boroughs and Excel Tools. The Excel Tools included a Source Apportionment Tool. The following pie charts show the source apportionment for NO_x, PM_{10} & $PM_{2.5}$ emissions in 2013 for the London Borough of Southwark. Within the source appointment tool, the emissions can be calculated for each 1km grid square within the borough.


Southwark - Source Apportionment of NOx Emissions (%) - 2013 Emissions
Industry 0.1%
D&C Other Fuels 1.4%
Commercial Gas 16.7%
Domestic Gas 12.6%
NRMM 8.3%
Other 0.2%
Rail 0.9%
River 3.0%
Aviation 0.5%
Other 56.3%
Van and mini bus 6.2%
TfL Bus 17.5%
Diesel Car 9.7%
Petrol Car 4.8%
Taxi 3.0%
Artic HGV 9.5%
Motorcycle 0.3%
Rigid HGV 2.0%
Other Bus / Coach 3.4%


Southwark - Source Apportionment of PM10 Emissions (%) - 2013 Emissions
Industry 1.2%
Resuspension 24.8%
Other 50.5%
Commercial Gas 2.8%
D&C
Other Fuels 1.7%
Domestic Gas 1.7%
C&D Dust 1.6%
NRMM 8.8%
Other 5.2%
Rail 0.1%
River 1.5%
Aviation 0.0%
Diesel Car 11.4%
Van and mini bus 9.0%
Petrol Car 12.5%
TfL Bus 6.0%
Taxi 3.4%
Artic HGV 5.2%
Other Bus / Coach 1.1%
Rigid HGV 0.8%
Motorcycle 1.0%
Electric Car 0.0%
Electric LGV 0.0%


Southwark - Source Apportionment of PM2.5 Emissions (%) - 2013 Emissions
Resuspension 1.8%
D&C Other Fuels 2.1%
Industry 2.3%
Commercial Gas 5.4%
Domestic Gas 3.4%
C&D Dust 0.3%
NRMM 16.2%
Other 9.5%
Rail 0.3%
River 2.5%
Aviation 0.1%
Other 56.3%
Diesel Car 14.1%
Van and mini bus 11.1%
TfL Bus 6.3%
Other Bus / Coach 1.3%
Rigid HGV 0.9%
Electric Car 0.0%
Electric LGV 0.0%
Motorcycle 1.2%
Artic HGV 5.3%
Taxi 4.7%
Petrol Car 11.4%

Appendix 5 - Glossary

AQAP	Air Quality Action Plan
AQMA	Air Quality Management Area
AQO	Air Quality Objective
BEB	Buildings Emission Benchmark
CAB	Cleaner Air Borough
CAZ	Central Activity Zone
GLA	Greater London Authority
LAEI	London Atmospheric Emissions Inventory
LAQM	Local Air Quality Management
LLAQM	London Local Air Quality Management
NRMM	Non-Road Mobile Machinery
PM_{10}	Particulate matter less than 10 micron in diameter
$PM_{2.5}$	Particulate matter less than 2.5 micron in diameter
TEB	Transport Emissions Benchmark
TfL	Transport for London

Agenda Item 12

APPENDIX 1

Southwark Council

NHS Southwark Clinical Commissioning Group

Southwark Children and Young People's Mental Health and Well-being Transformation Plan

2015-2020

October 2016 Refresh

Southwark Council

NHS Southwark Clinical Commissioning Group

1. Purpose

1.1. This transformation plan has been refreshed in line with *Implementing the Five year Forward View for Mental Health* (1) and achieving the objectives for children and young people's mental health, specifically that by 2020/21, there will be a significant expansion in access to high-quality health care for children and young people. There is an expectation that all local areas have expanded, refreshed and republished their Local Transformation Plan by 31 October 2016. This refreshed plan will therefore detail how Southwark as a local area will utilise the extra funds committed to support ambitions across the whole local system. This plan will be refreshed annually in line with business planning cycles. The transformation plan funding allocation in 2016-17 is £695,000; this includes uplift from the previous year of £106,000. Transformation funds are to be spent on both the prescribed and locally determined priorities for children and young people.

1.2. The overall purpose of this Transformation Plan is to bring a strong local focus to bear on improving mental health and wellbeing outcomes for children and young people in Southwark that are evidence-based, taking full account of *Future in Mind* (2)[1] and other key policy guidance (3, 4). It is intended to locate this Local Transformation Plan into the wider strategic development of the *Joint Southwark Children and Young People's Strategic Framework*, so that the transformative work arising from this Plan has coherence across Education, Health and Social Care, and works in partnership to support the wellbeing and achievement of children and young people.

1.3. In the year since the development of the Local Transformation Plan, the priority areas for action from our *Joint Southwark Children and Young People's Strategic Framework* have been identified for 2016/17and 2017/18 and are driven by our Children and Young People Commissioning Development Group (CYP CDG). The priority areas for commissioning that have been agreed by the CYP CDG are the following 3 population groups:

1. Children and young people with a long term condition
2. Healthy Children from pre-birth (- 12 months) to preschool (up to 5 years)
3. Looked After Children

1.4. In Southwark we are continuing to develop our joint commissioning arrangements with a clear focus on commissioning for outcomes. The new joint commissioning arrangements once established will take into consideration the impact of reductions in funding in social care and increasing demand for local services. Local commissioners across health and social care are seeking to ensure that existing services are maintained and are committed to reviewing the entire provision of services for children and young people. Commissioners will therefore start with reviewing the provision for early help and early intervention for children and young people and their families and the

[1] Numbers in Brackets in the text refer to References given in full at the end of this Plan.

work that is done with and in schools. This will impact on our Early Help CAMHS offer, Parental Mental Health team and Specialist Family Focus team and will be key examples of how we commission for outcomes.

1.5. We have also reviewed the existing service provision for Young People's health including sexual health, substance misuse, self-harm and reducing the impact of gang violence. We have identified service strengths and gaps, and opportunities to enhance services to improve the health and wellbeing of YP in Southwark.

Young people (YP) (aged 10 – 25 years) make up 21% of the population of Southwark (5) They are the age group in the UK that has experienced the least improvement in health status over the last 50 years and are the only age group in which morbidity and mortality are increasing (5). They are also twice as likely as other age groups to attend accident and emergency and walk in services, and local YP report difficult accessing primary care services (7)(8). Of the 10 major risk factors for adult disease, five are initiated or heavily shaped in adolescence (smoking, lack of physical activity, being overweight, unsafe sex and alcohol use), and it is a time of increased risk to health as a result of an increased tendency to exploratory risky behaviour (5)(6). They are therefore a key group for early intervention and prevention.

1.6. It is increasingly recognised that there is no health without mental health (9, 10). It is to everyone's benefit, and to the benefit of Southwark families and local communities, to understand what good mental health and emotional wellbeing consists of: how it can be promoted, protected and provide resilience; and how mental ill-health can be prevented and avoided. And in circumstances where mental illness cannot be avoided, how it is best treated and managed, with the young person and family supported onto recovery.

1.7. Our vision is for all Southwark children and young people to have healthy lives and to make a successful transition into adulthood. Education, Health and Children's Social Care will work together to support and empower children and young people to develop skills and use opportunities to become active, valued members of society. We will do this through co-producing outcomes with children, young people and their families. We will challenge stigma, discrimination and prejudice - so that no Southwark child or young person is disadvantaged or socially excluded because of their experience mental ill-health. Other forms of discrimination, including racism and discrimination on the basis of sexual identity also have an adverse impact on mental health and must also be challenged.

1.8. The link between childhood disorders and development of mental health problems in adulthood is well established. There are many reasons why there must be a change in focus (11) because it is associated with poorer educational attainment, poorer physical health, anti-social behaviour, offending, poorer lifetime mental health and social exclusion. This Local Transformation Plan combines with broader mental health developments across Southwark to reduce health and social care inequalities.

1.9. To date, mental health in England has not had parity with physical health. A key policy initiative is to achieve 'parity of esteem' with physical health (12). By working in partnership in Southwark using a Local Care Network approach, to support the achievement of children and young people, we will increasingly treat health as mind and body wellness together.

2. Intended Outcomes

2.1. Southwark children, young people and families are in good mental health, or are being helped to improve their health and increase their resilience; and their needs are identified.

2.2. Southwark children, young people and families know where to go for help and are clear about what information, support and services available and how to access them.

2.3. There is early access to assessment, early identification of mental health issues as these emerge, with evidence-based interventions taking place sooner to prevent the development of more complex difficulties when these can be averted.

2.4. Southwark has a competent and knowledgeable clinical and non-clinical workforce across Education, Health and Social Care who are confident to work together with children, young people and families on the co-production of health and wellbeing.

2.5. Non-mental health specialists recognise mental health needs and can consult mental health clinicians in a timely way. They have the skills to support children and young people experiencing mental health issues in many settings, including children centres, schools, families, foster care and youth offending services.

2.6. Children and Young People mental health provision is embedded in the geographical localities of Southwark with clear pathways for Primary and Secondary Schools, is available when it is needed and for as long as it is required, to support improvement in health.

2.7. There is an improvement in our combined response to Southwark vulnerable children and young people across Health, Education and Social Care and with our other key partners, including the voluntary sector, housing, police and criminal justice system, with strong signs of safety for children and young people across the system.

3. Local Context

3.1. Southwark is an inner London borough with a population of almost 300,000 that is comparatively young, mobile and ethnically diverse. There were 67,600 Children and Young People (age 0-19 years) in the Southwark population in 2013 (13). Around 300 languages are spoken in the borough and 79% of school children are from minority ethnic groups. The population is expected to grow by over 20% over the next decade. Southwark is densely populated and also a deprived population in relation to other London Boroughs and English authorities (14). Key Southwark Council priorities in relation to children and young people are set out in The Council Plan and Fairer Futures Promises (2014/15 - 2017/18) these are summarised in Appendix 1.

3.2. Most mental illness has its origin in childhood, and half of all mental disorder first emerges before the age of 14 years and three quarters by the age of 25 years (15).

3.3. Young people aged 12-25 years have the highest incidence and prevalence of mental illness across the lifespan (10). In contrast to physical health, which is at greatest risk at the start of life and in old age, mental illness vulnerability peaks at 18 years of age - just at the point where young people are moving into adulthood, and where, typically, service access arrangements change because of age boundaries and legal responsibilities.

3.4. Southwark has a mature CAMHS service, comprising the following multidisciplinary teams:

- Child and Family Service
- Adolescent Service
- Neurodevelopmental Service
- Carelink (for adopted and looked after children).

There are also Early Help CAMHS clinicians within Children's Social Care Locality teams and Families First Team located in Children's Services providing child and adolescent mental health interventions in community settings.

In addition, there is a Parental Mental Health Team and a joint service protocol to meet the needs of children whose parents/guardians have mental health problems (16). An area of focus in Southwark has been long waiting times to access first appointment. While these waits have reduced due to additional CCG investment in services, demand remains high. Transitioning to adult services is challenging for complex cases and or diagnoses. The Mental Health Trust provider (South London and Maudsley NHS Foundation Trust – SLaM) deliver both Children and Adolescent Mental Health Services (CAMHS) and Adult Mental Health services and are working with the CCG and Southwark Council to ensure transition protocols is fully embedded and this

will continue to be a focus of development for joint commissioning arrangements.

3.5. Another important element of local young people mental health services is Early Intervention in Psychosis, (EIP) because good evidence shows that early detection, diagnosis and treatment of psychosis improves lifetime health outcomes. The most recent service monitoring information about the Southwark team for Early Intervention in Psychosis (STEP) service (17) provides a very positive account especially in terms of achievement of the Early Intervention Waiting time standard. The family intervention rate is positive, which is very important in relation to wellness and recovery. The current all age service is working to achieve EIP Standards and is monitored monthly across the four boroughs that the provider delivers the service to in South East London. A flow chart of the process in Southwark can be seen in Appendix 2

3.6. NHS Southwark Clinical Commissioning Group (CCG) in partnership with Southwark Council developed a Joint Children and Young Peoples' Education, Health and Social Care Strategic Framework, which incorporates the emotional well-being and mental health of children and young people and sets out how services will be commissioned to improve outcomes.

The Southwark Joint Children and Young People's Strategic Framework sets out the following priorities:

- Early Years - with A Better Start for 0-5 year olds, including School readiness;
- Emotional Well-being and Mental Health of Children, Young People and Young Adults;
- Long-term conditions including diabetes, asthma, epilepsy, sickle cell and complex co-morbidity;
- The promotion and maintenance of wellness and early identification of needs;
- Improving health outcomes, with the aim of reducing emergency admission and the use of hospital and crisis services;
- Young People's health including sexual health, substance misuse, self-harm and reducing the impact of gang violence.

A particular focus on specific cohorts who are at greater risk of vulnerability and long-term poorer health outcomes*:*

- Young Carers
- Young Offenders
- Looked After Children (LAC) and Children in Need (CIN)
- Children and Young People at risk of violence, abuse or neglect;
- Children with Learning Disabilities, Special Educational Needs + Disability (SEND)
- Children and Young people who are obese - healthy eating, exercise and physical activity.

4. Local Priorities

4.1. As part of the wider transformation of Health and Social Care services, Southwark CCG and Southwark Council have agreed the following local strategic priorities for children, young people and families in June 2015:

- Commission to improve outcomes for children and young people across a range of domains, including physical health, mental health, social and emotional development
- Reduce health inequalities by working with Schools and Children's Centres, Colleges and other health and social care settings, including Youth Offending Services
- Jointly delivering an integrated local offer and establish Local Care Networks across health, local authority and voluntary sector services
- Increase integration of health, social care, housing, education and other partners over the course of implementing the Children and Young People Strategic Framework
- Commission for a culture of integrated support to enable Early Help and intervention to resolve issues as they emerge, to ensure every Southwark child is school ready, with support through childhood and into teenage years to become an independent, and resilient young adult
- Keep a focus on Safeguarding to prevent and reduce the impact of abuse and neglect and take into account new safeguarding priorities as these emerge (e.g., Female Genital Mutilation (FGM) and the Prevent Agenda)
- Work with children, young people, young adults and families as equal partners through co-production (18) to meet their needs in the most appropriate way

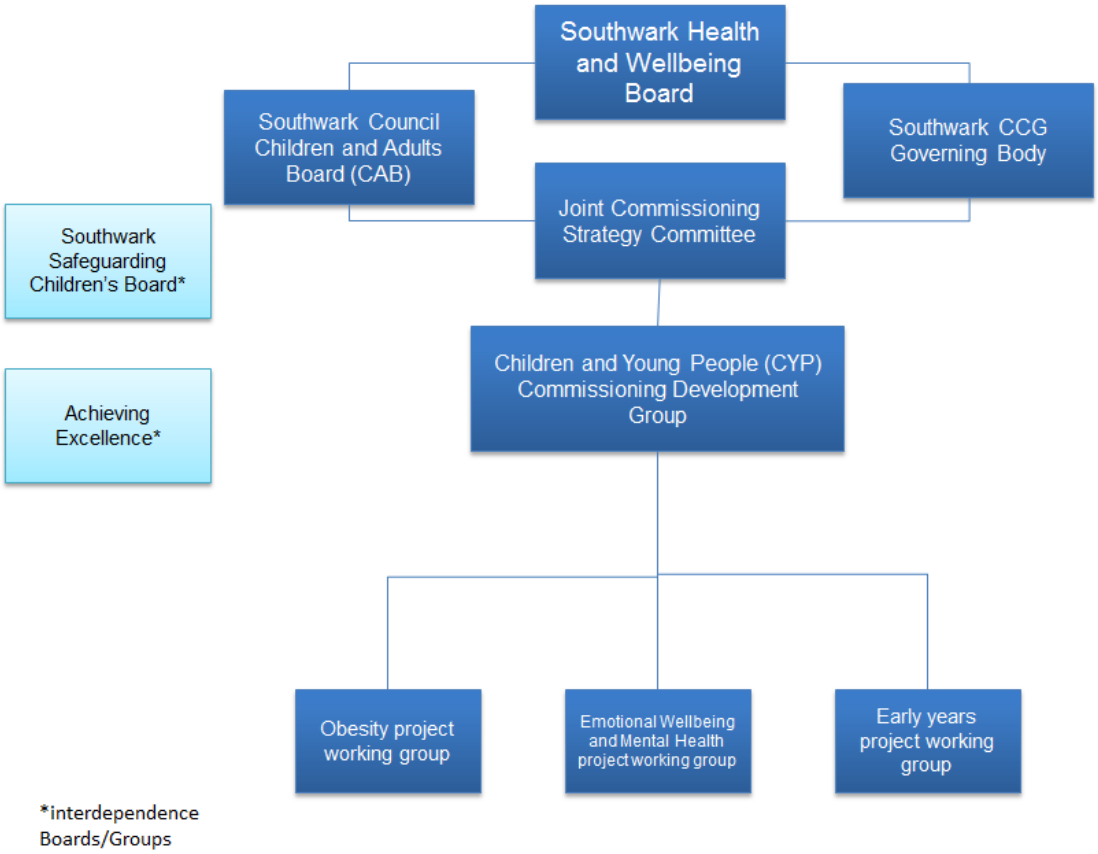
These priorities underpin the broader transformation work across NHS Southwark CCG and Southwark Council, including the improvement of Southwark children and young people's mental health and emotional well-being over the course of the next five years.

4.2. The transformation sought will be delivered through engagement with key stakeholders, including children and young people and their parents, commissioning, voluntary sector partners, as well as across a broader range of Education, Health and Children's Social Care Stakeholders.
We have stated in our commissioning intentions for 2017-19 that Southwark Council and CCG want to work with providers to develop an integrated pathway for the children of Southwark aged 0-19 years across health, education, community voluntary and social care services, including emotional

wellbeing and mental health for children and adults. Initially we will work on the pre-birth to starting school (5 years) pathway so that children have the best possible start into education. This pathway will look at innovative and alternative support for families and their children to reduce the impact of the public health grant reductions on the health visiting and school nurse services. The intended outcome of this pathway is to ensure that our children achieve the best start in life, achieve school readiness and health and developmental targets expected when entering primary school.

5. Governance, Engagement, Partnership and Collaboration

5.1. The Southwark Health & Wellbeing Board will sign off this Local Transformation Plan. Implementation of the plan will be overseen by the Southwark Joint Commissioning Strategy Committee via the Children and Young people Commissioning Development Group and the emotional wellbeing and mental health project working group. The project working group has been established to take forward the implementation of the transformation plan. Appendix 3 sets out transformation plan project working group stakeholders identified to date. NHS Southwark CCG and Southwark Council therefore have in place, agreed governance procedures for to deliver our strategic framework and commissioning for children and young people. See below for our governance arrangements.



NHS Southwark CCG and Southwark Council are committed to publishing and updating this Local Transformation Plan on their public websites.

5.2. The Children and Young People Strategic Framework and the first Transformation Plan was endorsed by Southwark Health and Well-being Board. Sign off of the refreshed plan has been agreed between the CCG and Council and locally with partners. Clinical and commissioning leadership for CYP mental health is now provided through the Children and Young People's Commissioning Development group which reports into the joint Southwark Commissioning Strategy Committee. Southwark has a good track record of joint working across the Borough as well as strong links to other Councils, NHS Trusts, Public Health, Southwark Healthwatch, Youth Justice, Education and Voluntary sector partners.

5.3. The Southwark Education and Children's Services Scrutiny Sub-Committee received the transformation plan and made a number of recommendations which will be considered by the implementation working group to ensure that the transformation plan areas of work and projects are embedded and contribute to achieving better mental health and wellbeing outcomes for children and young people. The recommendations made by the committee applies to the wider commissioning of mental health services for children and young people and will be a feature of joint commissioning arrangements that are being developed.

5.4. Southwark CCG and Social Council have undertaken extensive engagement with children, young people and families as part of its on-going work in developing children's and young people's services. Mental Health is a feature of regular public engagement and stakeholder events (for example: 19, 20) to introduce the development of the co-production process. We have also developed a questionnaire with the Southwark Youth Council for secondary schools and are seeking to test national findings locally with Healthwatch and local fora during the development of the Children and Young People's Health & Care Strategic Framework. The engagement undertaken so far has shaped our thinking around our priorities in respect of this implementation plan (Appendix 4).

5.5. In April 2016 we were able to successfully engage with 16-22 year olds using transformation plan funds to support the engagement event. The findings from this will inform the on-going development of transformation plan initiatives and help towards achieving the ambitions in our strategic framework and joint all age mental health strategy that is in development. . Initial feedback from the event was that it was successful in engaging 16-22 year olds on the health issues including mental health and wellbeing, relevant to them.

Young people told us:

- Teach young people about mental health
- Be creative and engaging.
- Teach teachers about mental health
- Reduce stigma; normalise talking about mental health.
- Can GPs help with mental health?
- Promote mental health support services.
- Support young people at school.
- Improve access to talking therapies.
- Encourage peer and mentor support
- Give clear information about confidentiality, and offer anonymous support
- Listen to young people.
- Make services friendly for young people.

The full report is due to be published on 31 October and can be found **here**

5.6. A CAMHS Joint Strategic Needs Assessment (JSNA) was completed in 2013 by Lambeth and Southwark Public Health and refreshed in 2015 to inform commissioning intentions and this Local Transformation Plan. A summary is provided at Appendix 5. The summary was reviewed and remains relevant one year on.

5.7. There is continuing collaboration with NHS England (NHSE) Specialised Commissioning, we have been involved in the review of NHS England Specialised CAMHS (Tier 4) in London as part of "Transforming Specialised Services in London" (TSSL) programme and as such the case for change to look at how we can improve the model of care to provide the right care, at the right time, and in the right place. We have also started the discussions locally and within the Sustainability and Transformation Plan (STP) area and NHSE about transforming care for CYP in the Justice system. We have signed the memoranda of understanding for recurrent and non- recurrent funding for the transformation programme for CYP in contact with the Justice System. Southwark commissioners have been directly involved in the Our Healthier South East London Partnership/ STP work and have regular discussions with NHSE specialised commissioning in regard to South East sector and borough specific work.

5.8. CAMHS services are provided across the spectrum of care settings with some of the most complex and/or high risk cases requiring admission to specialised (T4) inpatient care. There is the expectation that Local Transformation Plans lead to a significant reduction in demand for Specialised CAMHS services within the next 5 years. Community crisis care pathways that can provide robust and sustainable alternatives to inpatient care are under-developed particularly for children and young people with complex needs and behaviours related to learning disability (LD) and/or Autism and emerging personality disorders. The overall distribution of CAMHS inpatient capacity does not match Regional population needs and young people are being admitted far from their home, or to paediatric or adult beds; the NHS England National CAMHS Service Review aims to redress service deficits by

redistributing/realigning beds to meet local needs, the clear expectation is that by 2020 there will be no inappropriate admissions to adult or paediatric beds and patients will be treated in local care pathways.

5.9. There has been agreement for CCGs and STPs to focus on

- Commissioning of consistent out of hours services for young people particularly to manage crisis and prevent escalation with clear ambition to manage demand effectively at community level and reduce inpatient admissions as outlined in this Local transformation plan (LTP) refresh and our Transforming Care Partnership (TCP) plans.
- TCPs with engagement and support of NHS England to oversee consistent delivery of multi-agency pre-admission Care and Treatment Reviews for children and young people with LD, and/or autism to reduce inpatient admissions with ambition reflected in LTP refresh and TCP plans
- NHS England Specialised Commissioning Team to work collaboratively with the CCG and Local Authorities commissioners to design and commission effective community pathways with robust links to local acute inpatient services with ambition to reduce lengths of stay and inappropriate placements reflected in LTP and TCP
- NHS England Specialised Commissioning Team to continue to work local commissioners to reflect ambition in LTP/TCP and STP plans to
  - ensure Regional inpatient capacity meets requirements so out of region admissions become the exception
  - reduce variation by introducing standardised access and waiting times
  - adopt consistent models of care based on best practice that reduce the reliance on inpatient care
  - deliver seamless age-related service transitions
  - support the pilots within the New Care Models programme e.g. NWL

5.10. This Local Transformation Plan promotes equality and addresses health inequalities through a number of mechanisms including valuing mental health equally with physical health (parity of esteem); effective discharge of commissioning functions; and using the Equality Delivery System (EDS) as a toolkit to help NHS organisations drive improvements, strengthen the accountability of services to those using them, and bring about workplaces free from discrimination.

5.11. Our approach to advancing equality and tackling health inequalities is influenced by performance data and public health analytics as well as listening to, and learning from, service users, parents, families and the public. We are involving people and communities in designing services to meet their health and care needs, to ensure that we create services that work to improve user outcomes.

5.12. Improved integration across Health, Education and Children's Social Care is taking place at the same time as ensuring that services are commissioned around the needs of children, young people and families, rather than professional disciplines or services, incorporating learning from Making Every

Contact Count (21) to systematically incorporate prevention, protection and promotion of health and wellbeing.

5.13. The next key phase is continuing engagement with key stakeholders, including children and young people, parents/carers, schools, the voluntary / community sector and the wider children's services network around strategy development. This will test our current intentions and build consensus about the strategic direction. The opportunities for participation will be maximised through:

- Ensuring that children, young people and parents/carers have a central role in future service design and development
- Making the best use of existing findings from national, regional and local stakeholder engagement and consultation activity.

6. Current investment

6.1. The Tables below provide details of services currently commissioned with the block contract with South London & Maudsley NHS Foundation Trust, the main provider of mental health services for children and young people and specialised NHS England commissioned services (excluding Eating Disorder).

Jointly Commissioned CAMHS Core services (2014/15)	Cost to Commissioner	Workforce WTE	Referrals received	Referrals accepted	Waiting times (days)	DNA Rates
Carelink	£ 550,842	6.8	99	88	6	4%
Adolescent Service, includes Youth Offending service	£ 1,104,885	12.9	504	346	3	16%
Children and Family Team	£ 921,730	11.9	431	309	13	15%
Neurodevelopmental Team	£ 940,727	8.7	167	139	17	10%
Early Help CAMHS offer	£ 244,468	4	Not available	Not available		
Total	**£ 3,762,652**	44.3	1201	882	9.75	

Council Commissioned						
Functional Family Therapy	£ 341,345	5.8	25	25	7	7%
Parental MH Team	£ 396,616	6.4	120	111		10%
Total	**£737,961**	12.2	145	136		

Jointly Commissioned CAMHS Core services (2015/16)	Cost to Commissioner	Workforce WTE	Referrals received	Referrals accepted	Waiting times (days)	DNA Rates
Carelink	£ 504,650	6.7	122	120	4.9	7%
Adolescent Service, includes Youth Offending service	£ 989,381	15.9	539	326	3.3	13%
Children and Family Team	£ 923,609	12.8	342	248	8.1	12%
Neurodevelopmental Team	£ 875,778	9.5	234	203	9.3	9%
Early Help CAMHS offer	£ 292,320	7.0	Not available	Not available		
Total	**£ 3,585,738**	51.8	1251	910		

Council Commissioned						
Functional Family Therapy	£ 282,218	3.8	27	27		6
Parental MH Team	£ 412,320	6.4	107	88	7.9	13
Total	**£ 694,538**	12.2	134	115		

Public Health PSHE and Southwark Healthy Schools (3 years)	2014/15	2015/16
	£ 200,000	£ 200,000

NHSE Specialised Commissioning	Cost 2014/5 (£)	Activity (days) 2014/5
CAMHS Secure	282,536 (1 young person)	297
CAMHS T4	1,252,132 (7 young people)	1,940

NHSE Specialised Commissioning	Cost 15/16 (£)	Activity
CAMHS Secure	-	-
CAMHS T4	1,771,107	3,299

The differences in cost to commissioner above are not due to a reduction in workforce numbers but due to reductions in overhead from rebasing and from a cost improvement programme (CIP) savings. Transformation funds are part year effect in 15/16.

In addition to this investment, NHS Southwark CCG and Southwark Council commission other relevant services outside of these arrangements. For example the CCG commissions specialist outpatient services below:

CCG Specialist Outpatient CAMHS Services:	2015/16 SPEND £	No. of patients seen	2014/15 SPEND £	No. of patients seen
ABI	11,439	2	12,780	2
Anxiety and PTSD	38,139	13	50,124	16
CAFT	46,913	12	49,412	13
DBT	29,970	8	40,074	5
Eating Disorders	174,618	41	172,988	34
Eating Disorders MFG	11,620	5	22,761	4
Forensic Psychaitry	19,730	8	29,298	8
Forensic Psychology	15,082	1	28,928	2
LDT	1,395	2	11,090	4
Mood disorders	17,874	4	26,710	6
Neuropsychiatry	6,975	2	34,939	7
Neuropsychology	6,696	1	1,711	1
OCD	24,243	15	51,858	22
Paediatric Liaison	24,972	27	51,533	169
Total	**£429,666**	**141**	**£584,206**	**293**

The Council commission a range of Parenting programmes and the Families Matter strategy (see Appendix 6).

7. Analysis

An analysis was undertaken in relation to how the first and current phase of this Local Transformation Plan would bring greatest impact, taking account of recent progress in the development of a *Children and Young People's Strategic Framework*, the implementation of the *Families Matters Strategy*, the review of the CAMHS Joint Strategic Needs assessment by Public Health, and noting progress already made on PSHE across Southwark secondary schools. Key stakeholders from Health and Social Care Commissioning, Child Health Services, Children's Social Care, Youth Offending, Education and Public Health will continue to consider these matters at our transformation implementation and commissioning groups.

We are committed to working with neighbouring boroughs in South East London and already have established meetings in the sector. Our commissioning intentions for CAMHS have been aligned with the other south east boroughs who commission SLaM to ensure this approach continues. All of the borough's commissioning intentions include the high level intention of a 32-35% increase in access to CAMHS by 2020/21.

8. Key priorities and deliverables of the Local Transformation Plan

8.1. There are significant areas of work and good practice taking place in Southwark. The transformation plan funds can therefore be used to maintain and enhance current local offers to ensure more children and young people receive evidence based interventions. The transformation plan will allow us to bring together strategic plans for children's services and allow synergy across organisations through the joint strategic framework for maternity, children and young people.

We considered the areas of work achievable in 2015/16 and those achievable from 2016/17 as listed in the priorities below. We are committed to ensuring that all opportunities are explored including mitigation against and planning for any unspent funds. For example, the use of digital mental health services for young people once usage is evaluated in Southwark; emerging themes from children and young people and families during the engagement working currently being undertaken in the borough and ideas from the Southwark PSHE, Emotional Health and Wellbeing implementation working group.

We are committed to ensuring that good quality information is provided to children and young people and in 2015/16 launched the Health Help Now App which covers South East London (SEL) boroughs. The focus has been on embedding this application locally and we are evaluating its reach in the borough. We know for example that usage has increased and that mental health is the topic search for. We plan to build on this during winter 2016/17 and make links were possible with national work being done in this area for e.g. the NHSgo app

Since the assurance of the transformation plan in December 2015, commissioners have been working with providers and stakeholders to implement the plan. We are keen to ensure that all providers contribute to the provision of data for the key national metrics in the MH Services data set. We are seeking to evaluate all new projects and share good practice locally in the borough and with boroughs in our STP area.

In Southwark we have been successful in implementing the projects funded using non-recurrent 15/16 funds as described below. The main challenge however has been in the recruitment of staff for those projects to enhance existing or new services. The implementation working group will therefore focus on the workforce challenges as a core agenda item.

Key priorities and outcomes to be delivered with transformation plan funding

8.2. **Develop evidence based Eating Disorder services for children and young people with capacity in general teams released to improve self-harm and crisis services.**

Evidence based Eating Disorder services are effectively provided locally and cited in the guidance. As the main provider of services in South East London, South London and Maudsley NHS Foundation Trust developed a seven borough proposal. This includes how local community eating disorders services will be enhanced in line with new guidance to meet waiting and access standards for Eating Disorder services for children and young people.

The cost of enhancements to eating disorders services in terms self-referral and increased activity is being developed for the South East London sector. We will support further development of the already established community-based Eating Disorder service, by enhancing existing provision and open the service to self- referrals and online resources for early assessment. Further investment will improve waiting times and access, reduce in-patient admissions as well as work with schools to embed training and education; Southwark will also utilise some of the eating disorder funding for self-harm and crisis as identified priority areas.

Objective	• Ensure CYP are screened and access an appropriate treatment plan within the National Waiting Times standard in relation to eating disorders • Improved access to service assessment and evidence based treatment • Reduced number of CYP accessing ED service
KPI	• 95% of CYP assessed as emergency, urgent and routine treatment have treatment plan within 24hrs, 1 week and 4wks respectively • Increase in number of referrals once first year baseline established • Programme to be in one school per term
Outcomes	Improved access and self-referral to services and improved outreach and crisis work especially for schools

Progress to date

The following was achieved for access and waiting time standards for CYP with Eating Disorders.

Increasing access to services

- A referrals telephone line was launched on 22 February
- Self-referrals information was published on website 17 May
- Website fully updated, including resource pages on 25 July
- Outreach work in schools.

Appendix 7 provides details on the implementation and performance of community eating disorder services across the SE Sector from April to September 2016.

8.3. **Crisis Care**

As outlined in our Crisis Care Concordat commitments we will continue to do the focused work to ensure that there are clear protocols around the crisis care pathway and that these work well for vulnerable groups of children and young people. There is a comprehensive well utilised Paediatric Liaison service and as such presentations at the emergency department (ED) are responded to appropriately. Work is underway to understand how urgent and emergency access to crisis care can be enhanced for example with the creation of ED-based or paediatric liaison supervised or supported youth worker roles for out of hours to work alongside existing out of ours services.

Review Crisis Care Pathway and further development of a Telephone Helpline resource may contribute to a reduction in presentations to Emergency Departments.

Objective	• Reduce in ED presentations and admissions • Pilot increased capacity and support for CYP in crisis out of hours in ED
KPI	• Reduction in ED presentations by 50% and reduction in admissions by 50% • Reduce presentations to 43 from 86 by 17/18 and reduce admissions to 14 from 28 by 17/18
Outcomes	Reduction in presentations to Emergency departments and admissions via ED. Provision of brief interventions and signposting Improved support out of hours (OOH) for CYP in crisis

Progress to date

Activity for a three year period has been analysed to identify the trends in demand for emergency mental health assessments for under 18 year olds presenting to the ED. The findings show that over the period July 2013 – June 2016, demand for U18s emergency mental health assessment significantly increased, with an increase of 45% in the 2015/16 period and an 82%

increase across the three years. Over the three year period however there have been significant changes to ED pathway for CYP. A paediatric short stay unit opened in 2014 and this has provided seamless short-stay psychosocial admission for significant numbers of children and young people, sometimes even 16 year olds. There are also clear emergency care pathways for under 18s presenting to the main emergency department with mental health issues.

Transformation plan funds were used to

1- Implement a CAMHS practitioner role into the new all age 24/7 Mental Health Support Line. The support line covers four boroughs and is able to receive calls from and relating to, children and young people and

2- Employ a youth worker as part of the extended under 18s mental health offer. The youth worker will be employed to work alongside children and young people presenting out of hours, and will advocate for, gather information from and alert ED and mental health staff to safeguarding issues they come across with the child or young person they are working with. A one year pilot will examine the impact on children and young people's experiences of being in the ED, which at present are frequently reported as poor out of hours. The pilot will also explore new models of co-working between youth services and emergency mental health services. The youth worker role is expected to be in place by December 2016.

Southwark Commissioners are committed to reviewing the trend data and to work with colleagues our STP to share good practice and provide effective crisis care for our children and young people.

8.4. Trauma Services

There is agreement to improve access to trauma focused work, including where there are presentations of Post-Traumatic Stress Disorder (PTSD) and self-harm.

Objective	• Improved reported outcomes measures using IAPT measures. • Increase in access to trauma focused interventions • Increased awareness and reporting by CYP of child sexual exploitation, gang related sexual violence and child sexual abuse
KPI	• Increase in the number of CYP seen in community and support the reduction in presentations to Emergency Departments by March 2018 (using baseline figures)
Outcomes	Reduction in self-harm and complex presentations of PTSD and admissions to inpatient beds

Progress to date

We were successful in appointing to a specialist trauma focused CAMHS practitioner with the local provision since September 2016. Local stakeholders have identified the need ensure links with this specialist worker and The

Havens specialist centres for CYP who have been raped or sexually assaulted and indeed all CAMHS teams.

Stakeholders have however identified gaps in service around;

1- Preventing tier 4 /specialised inpatient admissions by CYP who tend to not be able to have needs meet in the community.

2- The cohort of CYP who may still be experiencing trauma during engagement with services e.g. at the YOS.

These identified areas will be taken forward by the implementation working group.

8.5. **Bring education and local children and young people mental health services together around the needs of the individual child.**

Southwark's was one of the 87 proposals received by NHS England to participate in a mental health training pilot. Given the interest by Southwark schools (32 Schools) in the training pilot, the transformation implementation and service delivery group will continue to seek opportunities to support the work to develop the workforce and disseminate local good practice and have sought to build this element in to the CAMHS Early help offer outlined in the plan.

Objective	• Increase in brief interventions and support in the community and Southwark schools
KPI	• 150 staff across, CAMHS services, paediatric liaison, pastoral care and schools trained by March 2018 • Increase in Healthy Schools award year on year for emotional heath and wellbeing.
Outcomes	Staff will be trained to deliver the brief therapeutic interventions for CYP presenting in services. Increased number of whole school approaches

Progress to date

Southwark Schools were asked to bid for transformation funds to build emotional wellbeing and mental health capacity in schools. Thirty four (34) applications were received and 19 applications were funded. Primary and Secondary schools were asked to work in groups/clusters and as such the total reach of the 19 applications is to 65 schools.

Links will be made between schools and each of the Early Help Service teams so that there is good understanding of the interventions and projects being undertaken in schools by each locality team. Schools have been informed of the outcome of their bid and successful schools have agreed to develop evaluation plans to look at the impact and outcomes of various projects bid for. Commissioners will also ensure that the work in schools will used to support and guide the development of projects arising from charitable funding

received by the Children and Young People's Health Partnership (CHYHP) to support emotional health and wellbeing in Southwark schools. We have built in an evaluation process for the work in schools which will also contribute to schools achievement of the Healthy Schools Award.

8.6. **Developing the workforce**

Overall the main provider of CAMHS South London and Maudsley NHS Foundation Trust has developed a workforce strategy and plan to identify and meet its future staffing requirements. This includes a resourcing strategy and action plan to address the need for additional staff. The CAG's (Clinical Academic Group) succession plan and Education and Training meetings set out and agree interventions to develop our existing workforce to meet the service's future needs. At a Trust level, through its work on South East and South West London Sustainability and Transformation Plans (STPs), SLaM is collaborating with mental health providers from these areas in the development and delivery of integrated services across primary, secondary and social care services.

As part of this, SLaM is working with two Local Workforce Action Boards (LWABs) to identify future workforce requirements. In addition to the work with LWABs, the Trust is reaching out to schools with visits by former employees on working in healthcare. It also has future plans for intern programmes and being an apprenticeship placement and training provider.

There are plans to:

- Work with SLaM to understand the trajectory of presentations against workforce competency
- Develop plans with safeguarding, social care and education to develop allied professional competencies in relation to mental health
- Develop an IAPT workforce plan based on sector submissions to the IAPT Collaborative (and approvals)
- Work together in the SE London STP to develop a workforce strategy that will be published.

Opportunities for a skilled and confident workforce, including specialist foster carers, who can better manage mental health and behaviour issues to avoid placement breakdown is being scoped locally and Southwark schools have expressed an interest in mental health training, 32 out of 96 schools in Southwark expressed an interest in the schools pilot for mental health training, work includes;

- A Mental Health resilience in Children and Young People through a Whole School Approach and PSHE
- Better joint work around Key Transitions

Objective	• Identify specialist leaders in education (SLE) • Increase number of healthy schools prioritise Emotional wellbeing and MH as part of a whole school approach • Increase the number of CYP seen in Early Help Service • Increase brief interventions and support in community
KPI	• The projects selected will have a reach to 65 schools and the evaluation of impact will be shared via PSHE group and healthy schools programme Three projects identified will be evaluated for impact - Therapeutic Story writing, Mindfulness and Mentoring and mediation
Outcomes	Increased confidence and skills of local workforce in Southwark schools and services

Progress to date

Some of the bids received from schools were around developing the workforce in schools. Three areas were identified from bids received and these have been funded from transformation funds; this would increase the number of schools benefitting from transformation funds by 20-30 schools by providing;

1. Therapeutic Story writing
2. Mindfulness programmes
3. Mentoring and Mediation

These projects will be evaluated and good practice shared across Southwark schools.

8.7. **Transitions**

Further scoping will be undertaken on how to implement the recommendations in the 14-25 mental health and wellbeing report and CAMHS needs assessment. Transition is the process of moving from one position or stage to another. In health and social care it is commonly identified as the point at which young people, on reaching 18, move from children's services to adult care. There is recognition locally of the need for specific services supporting the transition from Children Services to Adult services (20).

Objective	• Improved quality of experience for young people and their families • Reduce presentation to emergency departments and local CAMHS services
KPI	• Developed process to manage transitions effectively
Outcomes	Improved arrangement and protocols to manage transitions

Progress to date

This is an area of work that has not been developed given changes planned within Council and CCG to develop joint commissioning arrangements. The implementation working group however have this as an area to be scoped by December 2016 and for implementation by the end of March 2017.

8.8. **Good accessible information**

Further development of information on good mental health and wellbeing and its dissemination through the Southwark Information and Advice Service (SIAS) and other local routes to reach Children, Young People and Families in line with Families Matters Strategy, for example use of MindEd – an educational resource on children and young people's mental health for adults.

Objective	• To provide visible information in primary care, schools and on CCG and Council websites
KPI	• Improve resources on CCG and Council websites including the Local Offer website
Outcomes	Improved accessible information and resources available in Southwark

Progress to date

Some of the funding allocated for this work was used to fund an engagement event for young people aged 16 to 22, to better understand needs. The findings from this event will be used by commissioners to inform the development of services or to implement recommendations in the report due to be published shortly. SIAS has commissioned a short animation and Fact Sheet Suite focusing on the journey as seen by a young person who is a bit worried about something. This links with specific conditions that young people may be stressed about or is exacerbated by stress.

The project will be co-produced across agencies involving health, education, CAMH's and safeguarding teams. The animation will be made by young people from special schools

8.9. **Early Help offer**

Agreement on continuing to focus on shifting towards an Early Help and Early Intervention approach and service improvement around supporting better transitions:

- Further deployment of CAMHS clinical practitioners in the four Southwark Children Social Care locality teams, including a Clinical Practitioner Lead, to enhance the Early Help offer in primary care, community care and local schools, including additional support to LAC, SEND and other vulnerable groups

- Review of Transitional arrangements and protocols between services and across organisations
- Contribute additional resources to early intervention in behavioural difficulties for children in Primary school

Objective	• Increase the number of CYP receiving evidence based interventions • Improve reported outcome measures used
KPI	• Increase in number of consultations and specialist CAMHS interventions in community and schools by March 2018
Outcomes	Increased use of evidence based interventions to meet high demand for service

Progress to date

Following the implementation of CAMHS practitioners into the Early Help Service offer in 2014, commissioners are reviewing the service model to ensure that CYP are able to access the most appropriate intervention based on need. There have also been some staffing issues around retention that have led to increased waiting times and reduced access to interventions. Commissioners will therefore address with the provider action plans required to reduce waiting times in quarter 3 and 4 while reviewing and developing a service specification and funding available for Early Help CAMHS service offer, parental mental health and functional family therapy.

8.10. **Youth Offending Service (YOS)**

Increase capacity to the local Southwark Youth Offending Service (YOS) to better respond to the demand for CAMHS clinical practitioner input. A key focus will be on screening, group work and interventions as well as providing earlier and timely consultation to YOS staff

Objective	• To screen and access all young people in the YOS to be for Trauma.
KPI	• 50% increase YP in YoS accessing service screened and assessed by March 2018
Outcomes	Improved assessment and early interventions, for YP

Progress to date

Despite on-going recruitment drive this role remains vacant. This role is one of several that the provider has been unable to fill. The implementation working group therefore have identified the recruitment of a sustainable workforce as an area of work for the group given the difficulties recruiting staff for some services. Discussions have therefore been started to consider;

i. How can we support recruitment or what can be done differently?

ii. The need to review models to consider where staff teams are located.
iii. Clear governance and embedding of services if located in schools and other community sites/bases.
iv. How schools use the pupil premium received for recognised evidence based interventions that work in school.

8.11. **Enhanced Prevention and Early intervention Community Service**

Increase capacity to the most vulnerable children and young people by establishing a Home Treatment Team to provide intensive community support, follow up and liaison, outreach support and home contact, with the objective of avoiding presentations to emergency departments, crisis hospital admissions and the breakdown of placements.

Objective	• Increase in the number of CYP receiving evidence based interventions • Improve quality of experience a young person and family with CAMHS under SLaM
KPI	• Increase in 7 day follow up CAMHS assessments required from outpatients CAMHS
Outcomes	Improved outreach support, professional expertise and home contact for children and young people and families

Progress to date

This scheme sought to increase staffing in this service to do more outreach and interventions in the home to prevent emergency department presentations. Of the three additional roles, one is in place and two are still being recruited to and as is another example of the difficulties recruiting good quality CAMHS staff.

8.12. **Child Sexual Assault Hub**

Contribute to the development of Child Sexual Assault Hub for the SE London to improve mental health response to Assault, Exploitation and Female Genital Mutilation (FGM).

Objective	• Demand and capacity mapping across the South East sector
KPI	• Clear recommendations to support development of CSA hub/house
Outcomes	Initial scoping and development of recommendations for CSA hub/house

Progress to date

Southwark along with Lambeth, Lewisham and Bromley utilised transformation funds to contract the NSPCC to undertake a piece of work to:

1. Revise and extend existing mapping of the current physical and mental health services provided for child and adolescent victims of Child Sexual Abuse (CSA), Child Sexual Exploitation (CSE)
2. Undertake a gap analysis of services and capacity in the area
3. Estimate the existing capacity in provider services
4. Estimate future demand for services to meet the CSA model and the Child House models

Commissioners will use these findings to development of a commissioning framework around CSA and the scoping for a Child House in South East London.

8.13. The increase in 2016/17 of the Transformation plan allocation from 2015/16 will be utilised to continue and enhance the work of our functional family therapy team. This increase in funding will allow the team to continue the work with complex children and young people and their families. In support of our plans to review our service delivery and model of early help and early intervention, we will work with providers and children and young people services to improve access to early intervention services which reduce the requirement for crisis and social care interventions for our children.

Key priorities and outcomes within the wider scope of the transformation plan

8.14. **Roll-out of the CYP Improving Access to Psychological Therapies (CYP-IAPT)**

Southwark was a Wave 1 CYP IAPT site and has worked to embed the collection of outcome measures routinely in practice. Southwark via South London and Maudsley NHS Foundation Trust (SLaM) are part of the CYP IAPT Collaborative as required. There were arrangements in place in 2015/16 for CAMHS staff to be trained to ensure routine practice around outcome measures (See Appendix 8). We are seeking to support staff from all agencies to participate in CYP IAPT training and salary support where required.

Progress to date

CYP IAPT outcome measures are reported quarterly by the provider. There will be changes in the training (delivery) as well as new modalities and we are discussing with the provider and SEL STP colleagues the type of staff needed and where they will best impact on waiting times as within the STP we are at different stages of development.

8.15. **Improve perinatal care**

Southwark commissions perinatal mental health services from SLaM and has a good foundation to enhance service provision. Southwark will work with Southwark Council and other local system stakeholders, including NHS England who commissions specialist mother and baby units, to identify the priority areas for development and future investment.

Our initial analysis suggests that care for pregnant women and new mothers with significant mental health needs are well developed locally. There are gaps within services that support people with mental health disorders and young parents/primary carers in primary care and community services. We prioritise access to IAPT services for women who experience mild to moderate common mental health problems.

Progress to date

A proposal was submitted to the NHS England Perinatal MH Community Services Development Fund by South London and Maudsley NHS Foundation Trust to develop perinatal services in Southwark, Lambeth and Lewisham for wave 1 funding and was successful.

8.16. **Transforming Care programme**

In Southwark we have made progress implementing the Transforming Care programme ensuring that CYP with learning disabilities and those with autistic spectrum disorder in and out of area are known and that our register is regularly updated to reflect changes e.g. admission, discharges and step down. A comprehensive plan is now in place to ensure Care and Treatment Reviews (CTRs) are undertaken as required prior to and during admission to deliver care in appropriate settings, prevent escalation and promote care closer to home.

Progress to date

We continue to make good progress in developing our risk registers and in undertaking CTRs as required. NHS England Specialised Commissioning is responsible for commissioning high secure, medium secure and low secure inpatient services for adults with Learning disabilities and/or autism and for commissioning specialised inpatient care for children and young people with Learning Disabilities and/or autism. Specialised Commissioning will therefore work closely with local commissioners within the Transforming Care Partnership to;

- deliver a robust approach to implementing the pre and post admission Care and Treatment Reviews to reduce the numbers of people particularly children and young people being admitted to inpatient care unnecessarily.
- support the design of appropriate community packages enabling timely discharges and reduced lengths of stay
- deliver care closer to home by commissioning appropriate inpatient capacity for: medium and low secure services for adults and specialised inpatient care for CAMHS.

Southwark Council

NHS Southwark Clinical Commissioning Group

Transformation Plan - Commissioning intentions - priority areas for action - Total allocation 16/17 - £695,000

Eating Disorders, £168,000 CYP MH £527,000

Priority Area	Commissioning Intentions	Allocation and spend 15/16	Allocation 16/17	Recurrent or non-recurrent	Projected spend 16/17
Eating Disorder services for children (Working with other SE London Boroughs)	ED funding will be used to enhance existing provision: 1. Access time to service and opening service to self-referrals 2. Further development of on-line resources 3. Development of Parents' Buddy network system with parents of young people treated in the service 4. Dedicated paediatric bed at King's College Hospital 5. Outreach work in schools 6. Development of the treatment for young people with comorbid eating disorder and self-harm and other comorbidities. 7. Collaboration with Crisis Services	£2,625	£10,500	Recurrent	£10,500
Specialist ED Service in primary care	To provide additional support to general practice within local care networks		£28,173	Recurrent	£28,173
Crisis Care	Enhance 24 hour crisis line to include children and young people.	£10,635	£64,977	Recurrent	£64,977
Trauma Services	Trauma Focused work across child and family and adolescent service, focus on PTSD, Self-harm, Sexual Assault and exploitation and FGM, and support work of Red Thread, the Haven and Solace		£64,977	Recurrent	£64,977
Therapeutic assessment training	Therapeutic assessment training for paediatric liaison staff, adolescent team and workers in ED and crisis services e.g. Red Thread	£20,000		**Non recurrent from 15/16**	
ED Crisis support	Building capacity in crisis/ED as in Crisis care concordat.- supervised/supported youth worker/advocate roles for OOH	£118,577		**Non-recurrent from 15/16**	
Total		**£168,082**	**£168,082**	**£29,505**	**£168,082**

Priority Area	Commissioning Intentions	Allocation and spend 15/16	Allocation 16/17	Recurrent or non-recurrent	Projected Spend 16/17
Bringing education and local children and young people mental health services together around the needs of the individual child.	High level of interest in Southwark primary and secondary schools, opportunities to support the workforce and whole school approaches to be developed and linked with Early Help Service. 1. Identification and development of a programme to support a universal offer / support for school age children for: a) emotional resilience / resourcefulness of school age children b) early identification of emotional wellbeing / mental health issues e.g. ADHD, eating disorders	£200,000		**Non-recurrent**	On track, full allocation spent
Developing the workforce	Opportunities for a skilled and confident workforce in schools including specialist foster carers, who can better manage mental health and behaviour issues to avoid placement breakdown. 1. Training and advice for foster carers to understand and cope with challenging behaviour and underlying issues 2. Reviewing and implementing rapid access to specialist advice and support when in crisis	£72,513		**Non-recurrent**	On track to spend full allocation
Transition	Review of Transitional arrangements and protocols between services and across organisations and further work to scope how transition is implemented and embedded across local mental health teams including the transitions team working with young disabled people Investigate needs of our young people transitioning to adult services. Scope and test models of transition working with providers, service users and their carers and families. Project manager support to co-produce pathway, including workshops	£45,000		**Non-recurrent**	On track to spend full allocation

Good accessible information	Further development of information on good mental health and wellbeing and its dissemination through Family Information Service and other local routes to reach Children, Young People and Families in line with Families Matters Strategy	£10,000		**Non-recurrent**	On track to spend full allocation
Early Help - Families Matter and Functional Family Therapy	Further deployment of CAMHS clinical practitioners across the Southwark Children Social Care locality teams, including a Clinical Practitioner Lead, to enhance the Early Help offer in primary care, community care and local schools; Contribute additional resources to early intervention in behavioural difficulties for children in Primary school; work with targeted vulnerable groups including LAC, Care Leavers and those on CP Plans.	£41,933	£300,197	Recurrent	£194,197 £106,000 uplift in 2016-17 On track to spend uplift funds
Youth Offending Service	Increase capacity to the local Southwark Youth Offending Service (YOS) to better respond to the demand for CAMHS clinical practitioner input. A key focus will be on screening, group work and interventions such as ADHD community and primary care assessment and treatment, as well as providing earlier and timely consultation to YOS staff;	£12,630	£50,517	Recurrent	£50,517
Enhanced Prevention and Early Intervention Community Service – Home Treatment Team	Increase capacity to the most vulnerable children and young people by establishing a Home Treatment Team to provide intensive community support, follow up and liaison, outreach support and home contact, with the objective of avoiding presentations to emergency departments, crisis hospital admissions and the breakdown of placements; and transitions	£36,090	£166,011	Recurrent	£166,011
CSA hub in SE Sector	Child Sexual Assault and exploitation and FGM	£2,499	£10,000	Recurrent	£10,000
Total		**£420,666**	**£526,725**		**£526,725**

	Key priorities within the wider scope of the transformation plan				
Roll-out of the CYP Improving Access to Psychological Therapies (CYP-IAPT)	Currently being embedded in CAMHS services across the borough.				**Funded by CYP-IAPT programme**
Improve perinatal care	Southwark commissions perinatal mental health services and will work with the local stakeholders, including NHS England to identify the priority areas for development and future investment.				**Funding awarded following bid submitted September 2016**
Transforming Care programme	Implemented. Care and Treatment Reviews (CTRs) are undertaken as required and routinely, prior to and during admission to deliver care in appropriate settings, prevent escalation and promote care closer to home.				**Funded and managed by CCG**

9. Summary

The Transformation plan funding received while significant contributes to the wider body of work being done in Southwark to improve mental health and wellbeing outcomes for children and young people. The additional investment enhances the local mental health and wellbeing offer to Southwark children, young people and their families. The plan is seen within the all age mental health strategy that is in development and the Southwark Children's and Young People Mental Health and Wellbeing Strategic Framework.

New resources will be invested to enhance and maintain existing services and we will work to ensure that the areas of work within the wider scope of the transformation plan are included. On-going stakeholder engagement is planned to ensure the development of the plan is co-produced and strongly linked to outcome based commissioning and what children and young people have told us they want.

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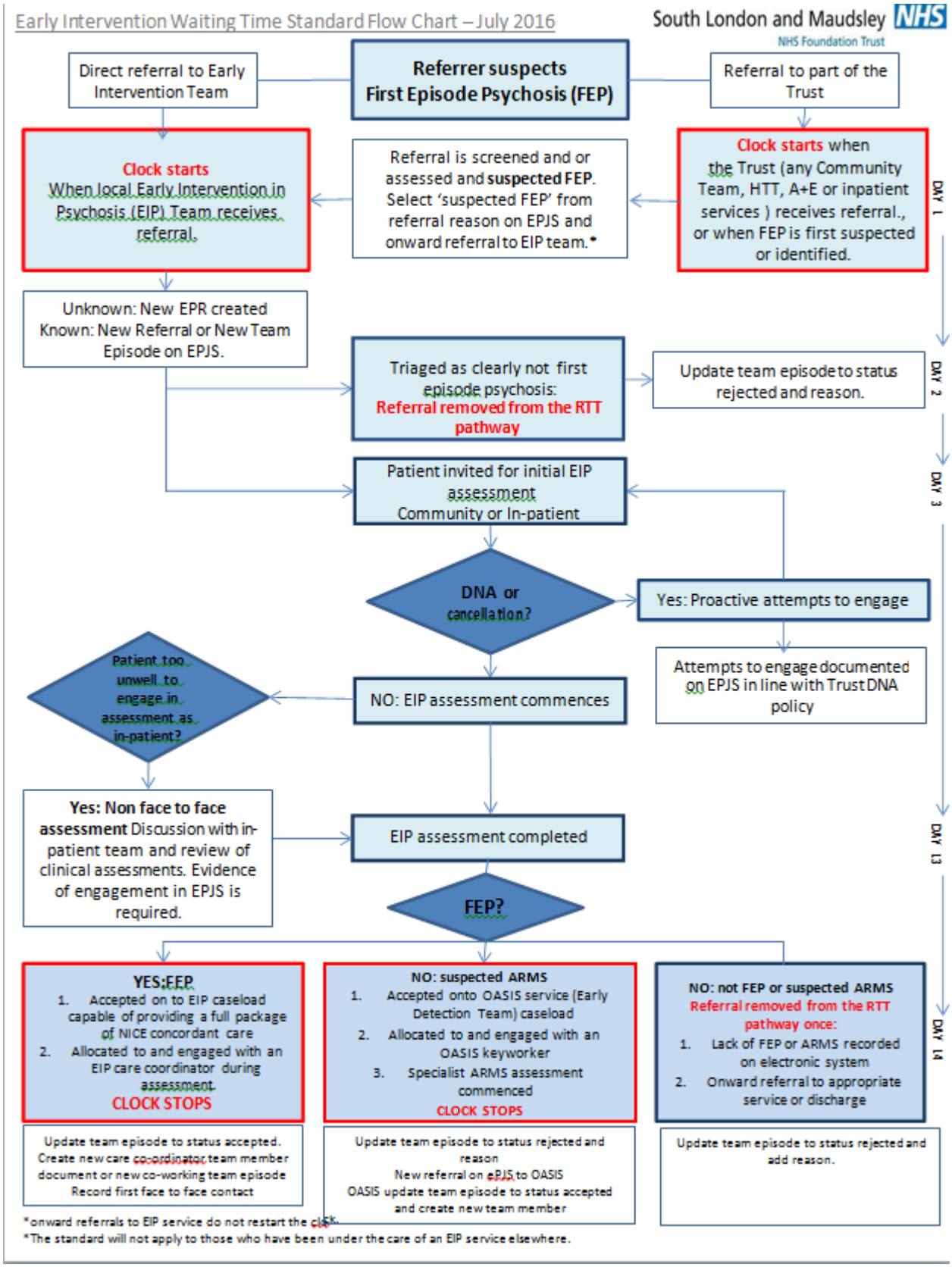
Appendix 1:

Council Plan and Fairer Futures Promises (2014/15 to 2017/18)

The key priorities and themes which run across Council strategies are set out in the table below - along with suggested opportunities for joint commissioning activity going forward:

Priorities	**Themes**	**Commissioning Intentions**
Giving Children and Young People the Best Start in Life	1.1 Right Support, Right Time	Early Help / Families Matter SEND and EHC Plans/ Local offer (SIAS)
	1.2 Stable and Loving Homes	Fostering Offer Alternatives to Residential Provision 16+ Re-commissioning
	1.3 Improving educational standards for all.	Multi-agency response to supporting educational attainment. Link to 2.3
Improve children's Health and Wellbeing	2.1 Improve maternal and infant health	0-5 Health and Maternal Health, Early Help, Children's Centres
	2.2 Reduce obesity in children	Health checks / Health promotion/ GP / SW/ PSHE
	2.3 Improve resilience and build positive mental health	CAMHS / IAPT/ Support to LAC/ Support for Schools/ PSHE. Joint approaches to prevent and tackle self- harm, bullying, gang violence etc.
*****Underpinned by Hearing and Acting on the Voice of the Child*****		

Appendix 2:


Early Intervention Waiting Time Standard Flow Chart – July 2016
South London and Maudsley NHS
NHS Foundation Trust
Direct referral to Early Intervention Team
Referrer suspects First Episode Psychosis (FEP)
Referral to part of the Trust
Clock starts When local Early Intervention in Psychosis (EIP) Team receives referral.
Referral is screened and or assessed and suspected FEP. Select 'suspected FEP' from referral reason on EPJS and onward referral to EIP team.*
Clock starts when the Trust (any Community Team, HTT, A+E or inpatient services) receives referral., or when FEP is first suspected or identified.
DAY 1
Unknown: New EPR created
Known: New Referral or New Team Episode on EPJS.
Triaged as clearly not first episode psychosis: Referral removed from the RTT pathway
Update team episode to status rejected and reason.
DAY 2
Patient invited for initial EIP assessment Community or In-patient
DAY 3
DNA or cancellation?
Yes: Proactive attempts to engage
Attempts to engage documented on EPJS in line with Trust DNA policy
Patient too unwell to engage in assessment as in-patient?
NO: EIP assessment commences
Yes: Non face to face assessment Discussion with in-patient team and review of clinical assessments. Evidence of engagement in EPJS is required.
EIP assessment completed
DAY 13
FEP?
YES:FEP
1. Accepted on to EIP caseload capable of providing a full package of NICE concordant care
2. Allocated to and engaged with an EIP care coordinator during assessment.
CLOCK STOPS
NO: suspected ARMS
1. Accepted onto OASIS service (Early Detection Team) caseload
2. Allocated to and engaged with an OASIS keyworker
3. Specialist ARMS assessment commenced
CLOCK STOPS
NO: not FEP or suspected ARMS
Referral removed from the RTT pathway once:
1. Lack of FEP or ARMS recorded on electronic system
2. Onward referral to appropriate service or discharge
DAY 14
Update team episode to status accepted. Create new care coordinator team member document or new co-working team episode Record first face to face contact
Update team episode to status rejected and reason
New referral on ePJS to OASIS
OASIS update team episode to status accepted and create new team member
Update team episode to status rejected and add reason.
*onward referrals to EIP service do not restart the clock.
*The standard will not apply to those who have been under the care of an EIP service elsewhere.

Appendix 3: Stakeholders for Transformation Plan Implementation Updated

Organisation	Job Title	Role in plan
Southwark CCG	Senior Mental Health Commissioner	Lead author
Southwark CCG	Head of Mental Health	Strategic Mental Health Lead
Southwark CCG	Head Primary, Community and Children's Commissioning	Maternity, Children and Young People's Strategic Framework Lead
Southwark CCG	GP Clinical Lead for Mental Health	
Southwark CCG	GP Clinical Lead for Children and Young People	
Southwark Council Public Health	Public Health Consultant	Joint Strategic Needs assessment
Southwark Council Public Health	Mental health and wellbeing	Pre October 2015
Southwark Council	Head of YOS	
Southwark Council	Head of Early Help	
Southwark Council	C&YP commissioner for substance misuse	
Southwark Council	Principal Strategy Officer/s	
Southwark council	Head of Troubled Families	
NHS England Specialist MH Commissioning	Case Manager	Collaborate on plans Sign-off when assured
South London & Maudsley NHS Foundation Trust (SLaM)	Clinical Director Service Director Clinical Lead Service Manager	Clinical Pathway Development
Service user and parents groups	Youth Advisor, parent/carer rep	Engagement and development of Plan
Voluntary sector	Community Action Southwark(CAS) rep	
Schools	Head Teachers Forum	Contribution to the plan
Southwark Healthwatch	Healthwatch	Engagement and development of Plan

Key stakeholders on CYP Commissioning Development Group

Southwark CCG	Director of Integrated Commissioning	CCG Lead
Southwark Council	Public Health Consultant	Joint Strategic Needs assessment
Southwark Council	Director of Commissioning Adults and Children	Strategic Lead Local Authority
Southwark Council	Director of Children's Social Care –inc children looked after	
Southwark Council	Director of Education PSHE and Healthy Schools	

Appendix 4

Southwark Children and Young Peoples' Strategic Framework Engagement Mapping

Engagement undertaken and lead	Key findings	Gaps identified and planned engagement	Contacts for engagement
1 - Early years, better start and school readiness			
1000 Journeys – Southwark Council – 2013	Make it easier to use local services such as antenatal services, childcare or services in children's centres. More children having their health and education checks and immunisations, and more having better health and taking up free education places. Fewer young people missing school or being involved in crime. More families achieving permanent positive changes more quickly following support from specialist services	Test key findings with parents, children and young people.	Early Years Quality Improvement Officers Public Health Specialist: Children & Young People PSHE and Healthy Schools Lead in Southwark
1000 Lives- Southwark Council, Healthwatch and Health and Wellbeing Board – 2014	**Parent stories** Mothers contributed stories about the importance of good advice through pregnancy, choice and control of their own childbirth experience, support with breastfeeding and on-going support through their child's early years. Stories about post-natal depression and		

	stories from parents whose children have health problems, meaning that they need help from a range of services were collected. There was special praise for midwives, health visitors and our children centre workers. But there was also a desire to receive clearer, more consistent information. We were reminded of the essential role families play in providing support and the importance of enhancing community based support from professionals and voluntary and community groups especially for people who are isolated, vulnerable and without close relatives. **Young people's stories** Young people's own stories focus on their desire to be active and healthy, building their self - esteem and helping them to become confident and resilient young adults. Young people particularly valued leisure services, swimming and gyms and organized activities such as football clubs.		

Engagement undertaken and lead	Key findings	Gaps identified and planned engagement	Contacts for engagement
2 - Emotional wellbeing and mental health			
1000 Lives- Southwark Council, Healthwatch and Health and Wellbeing Board – 2014	The impact of bullying on wellbeing and the responsibility of being a young carer were mentioned by several young people.	Gaps identified: LGBT – mental health and wellbeing Planned engagement: 1) Quality review (outcomes and patient experience) of commissioned services 2) Workshops – Test key findings	One Big Community to run workshops on mental health/ wellbeing Somali Integration – Saturday School – 60 CYP Challenge Network – Campaign Metro Centre – Service for LGBT youth Public Health Lead for emotional health and wellbeing (all ages)
SLAM			
CCG Case study – Alika's story Alika shares his story on film about his experience of suffering a mental health breakdown and subsequently spending four months in a SLaM intervention unit.	First contact with professionals during mental health episode was with the police (taken to hospital). Refused care and was left to leave hospital without follow up plans – one month later had "full breakdown" Again taken to hospital, cuffed by the police. Had no idea what was going on. Spent 4 months in SLaM early intervention unit – has excellent experience- felt "at peace" highlights the importance of staff who cared during recovery. Highlights the importance of holistic activities – not just medicine – music, art, exercise, cooking, games, socialising felt like a "kids retreat".		

	Areas for improvement – constantly having to repeat story to professionals, overload of information.		
CCG Head teachers' meeting Southwark CCG Chair – Jonty Heaversedge attended the Southwark Head Teachers meeting	We don't currently adequately include schools in the development of our strategic plans for service development for children, young people and their families. There is no voice for schools on the H&WB. Teachers see obesity very much as a symptom not a cause. Their overwhelming view is that we are massively neglecting the mental health and wellbeing needs of our children, and importantly their parents. They have noticed an 'explosion' in the number of children suffering with MH problems. Emotional resilience should be a key ambition in any early intervention work that we do. Schools are having to increasingly provide a range of support to meet the medical needs of children - physical, social and emotional. They would appreciate support and training to be able to do this – have HCPs embedded in schools.		

Health Huts – X 15 huts across Southwark Currently working with young people between the ages of 7 to 24yrs within youth clubs, schools, youth offending, colleges and universities and voluntary organisations that work or provide services for young people (across a range of health issues)	Wordles on what young people value most to stay emotionally healthy		
Youth Council meeting 5th October 2015	CAMHS counselling an essential service for CYP. There is a lot of stress experienced by school children – competitive environment – very focussed on grades and university, other life stresses such as bullying increase stress levels. Need to be provided support for this at school.		Youth Council members
Community Action Southwark (engagement sessions pre-2014)	Take a holistic approach to the treatment of Mental Health Issues Develop integrated mental health services with schools to tackle school related issues such as bullying Focus on at risk groups Provide information and guidance on services in the community so that people are aware of	Mental Health services in schools Public education CAMHS - > Adult Services Self-harm & eating disorder focus	

	what is available Ensure service continuity during the transition from CAMHS to adult services – currently is a large gap Take a whole family approach to the treatment of CYP mental health issues Focus on self-harm in CYP, and specifically early identification and intervention Focus on eating disorders Raise the public's awareness of mental health issues.		
Engagement undertaken and lead	Key findings	Gaps identified and planned engagement	Contacts for engagement
3 - Long term physical conditions including diabetes, asthma, epilepsy, sickle cell and complex co-morbidity			
Children and Young People's Health Partnership (CYPHP) - Partnership between Lambeth and Southwark LA's, CCGs, Evelina Children's Hospital, King's, SLAM, KCL) Focus groups facilitated jointly with London Citizens	Primary Care: Most parents described finding it difficult to get a GP appointment immediately. Difficulties cause many parents routinely to rely on A&E. Where other professionals are involved, the GP is often bypassed, as in the case of children with moderate - severe asthma who	Quality review (outcomes and patient experience) of commissioned services	Quality Team at CCG

and Stockwell Partnership, which informed programme plans. The groups included: Mumspace; Notre Dame Girls school (predominantly Latin-American students); Cherry Tree Special Needs School; Youth Futures; and Evelina Asthma. Parent and Carer panel - two events held to date - experiences of accessing primary care with their child. Plus one group of Spanish-speaking mothers from Latin American backgrounds in Southwark (mostly based in the Camberwell area).	described only receiving care from the specialist nurse and going to A&E when they need nebulisers. Young people were particularly sensitive to the interaction with the GP. Inadequate support in the community –leads to A&E visit Secondary Care: Many of the parents of children with complex health needs felt that the hospital environment was distressing for their children, especially when having to wait for outpatient appointments. A lack of coordination - negatively affecting experience of health services, often resulting in frequent health service use and time off school. Networks: Patients tended to feel that they were experts by experience - first-hand experience of the condition/ close relationships with other people with the same condition, generally family members, friends or those at school. Poor professional communication around complex needs results in parents having to act as advocates and coordinators of their children's care.		

	Inadequate support at school to manage their conditions – variable across schools – need more health promotion in schools. Information: Young people felt that they had insufficient information about where to go for their physical and emotional health concerns.		
Engagement undertaken and lead	Key findings	Gaps identified and planned engagement	Contacts for engagement
4 -Emergency admission avoidance			
CYPHP	See above		
Engagement undertaken and lead	Key findings	Gaps identified and planned engagement	Contacts for engagement
5 - Young People's Health 10-25 including sexual health, drugs misuse, self-harm and gang violence			
Healthwatch Southwark – Sexual Health workshops Public forum workshop	Sex education: Better sex education in schools. Sex education to begin in Primary school Non heterosexual relationships Consent	Lambeth Southwark and Lewisham Sexual Health Strategy – Stakeholder engagement event planned for 25 August 2015	

	Service improvement: Waiting rooms should be more relaxed. Separate service for male and females. More places to get free contraception. C Card to be used at all pharmacies not just local one Communication: Age matters when it comes to the person you are talking to. Supportive staff who don't judge. Staff who are open. More focus on emotional relationships.		
YACnCAY – Youth violence/ crime/ anti - social behaviour engagement event with Somali community. Saturday 25 July- Large outreach/ engagement event	Waiting for report		
Health Huts	"The main gripes young people have is that they are rarely consulted by professionals e.g. clinic times, locations, how they are pre-judged and one of the biggest is confidentiality."		

Youth Council meeting 5th October 2015	Self-harming was raised as an issue by councillor. Caused by stress, more competition within schools, the pressures in terms of doing well at school for university, and through bullying from other students – more emotional bullying than physical (this is picked up easier than emotional). Need to identify the channels now used by students to bully others – social media is used a lot. Sexual health education is necessary at schools, along with support for teenage mums.		
Community Action Southwark (engagement sessions pre-2014)	Focus on self-harm – early identification and intervention Focus on eating disorders – early identification and intervention		
Engagement undertaken and lead	Key findings	Gaps identified and planned engagement	Contacts for engagement
6 - Vulnerable children and young people including: Young carers, young offenders, LAC/CIN, CYP at risk of violence, abuse or neglect, SEND			
1000 Journeys – Southwark Council	More effective help for parents struggling to care for their children. More children and young people living in a permanent and stable home. More foster carers and children being adopted.		

	Vulnerable children and young people succeeding better at school.		
Healthwatch Public Forum March 2015– Eight young people (carers) took part in a discussion. Public Forum June 2015 - Five young people aged 8-12 came from Southwark Young Carers and took part in a discussion	Issues • There are many professional available to help young carers, it is hard to know where there support starts, ends and who then picks up that support • Funding constraints can limit the activities offered at Southwark Young Carers • Sometimes the professionals supporting young carers are not appropriately trained Solutions • Help with their homework • Support with driving lessons. • More training for people that are in contact with people with mental health problems and substance misuse • Better public facilities such as local activities, parks and youth clubs • Better and more social activities and trips. • A range of services in schools: *Speech and language therapy* *Child and Adolescent Mental Health Service (CAMHS)* *Social Worker* *School council to say what we want in the school* *After schools sports club* *Mentors*		

	• Appropriate training for staff in schools, hospitals, community services to understand the complexities of issues faced by young carers and support them in their role accordingly • Awareness raising work with children and young people to understand some of the issues faced by young carers		
7 - Children and young people who are obese			
Community Participation Team – Southwark Council Review to gather ideas, opinions and beliefs about the problem of child obesity locally Focus groups - Local residents, Children and Young People – 10 focus groups Conversations with families at events Community researchers doing surveys – 343 surveys collected- (Most respondents from hotspot areas for child obesity)	Why do you think children are becoming overweight and obese in Southwark? • Unhealthy food (Takeaways, convenient and everywhere) • Low income leading to unhealthy food choices • Lack of time/long working hours leading to unhealthy lifestyle choices re food and PA • Families no interest in healthier lifestyle • Parents lacking awareness and education • Not enough affordable supervised physical activity options • Children lack interest in physical activity and enjoy sedentary activities (PS3, Computer, TV) • Overweight teenagers not being picked up • Obese pregnant women don't always get referral to dietician • Some lack of consistency of message • Lack of time for HVs and MWs to	1) Test key findings	Work with tackling physical inactivity in younger children

	support weight loss post birth Solutions: • Provide healthy food at school • Increase PE and PA after school • Educate children about HE and PA • Involve and educate parents • Raise awareness of risks • Raise awareness and promote healthy lifestyle • Projects in community • Free or low cost activities (attractive and supervised) - more facilities and places • Restricting access to unhealthy food (takeaways) • Monitoring and health checks of children • Important to look at cultural dimensions • Support from; community networks/community centres, schools, faith groups, sport and leisure centres, groups and clubs, libraries/food businesses/health, professionals/government/media, colleges, • Parents/Teachers can be barriers to doing more fun physical activity • Need to introduce more behaviour change skills		
Community Action Southwark	Focus on eating disorders.		

Appendix 5:

Summary of Southwark Children & Young People Mental Health Needs

Almost 10% of Southwark children and young people are estimated to have a diagnosable mental health disorder. One in five is estimated to have more than one mental disorder (i.e. 1.9% of all children). The most common combinations are conduct and emotional disorders and conduct and hyperkinetic disorders (0.7% of children).

However, far more children and young people are likely to benefit from emotional and mental health and wellbeing interventions and services, including building resilience and early help. 10-15% (17, 18 of children are considered to be likely to benefit from access to Early Help services not necessarily provided through traditional CAMHS services.

In Southwark, about 23% of children and young people with estimated mental health needs are seen by CAMHS, compared to international estimates of 25% of children and UK estimates of around 30%.

Pre school age children

ChiMat estimates suggest **3,190** Southwark 2-5 year olds may have a mental health disorder (estimated prevalence 19.6%). There are different opinions about the validity of diagnosing children below the age of 5. Years. This figure is likely to include behavioural issues, developmental disorders and conduct disorder. However, it is important to address needs early and to ensure that as many children as possible are ready for school. In 2013-14 a higher percentage of Southwark children achieved the required standard for school readiness at the end of reception than the England average.

School age children

ChiMat estimates suggest that there will be around **3,640** young people aged between 5 to16 years in Southwark with common mental health disorders (emotional disorders, hyperkinetic disorders and conduct disorders).

Young People aged 16-25 years

As the Children and Young People Mental Health Transformation Plan will address the needs of young people as young adults, particularly those with disabilities or Leaving Care (up to the age of 25 years) it is important to consider\the needs of young people over the age of 16. In Southwark, **1,675** young people 16-19 are estimated to have a neurotic disorder, for example, mixed anxiety and depression.

The estimates in Table 1 are based on national prevalence rates, and do not take into account any differences between Southwark and England in levels of risk factors for poor mental health such looked after children, young offenders, children with learning disabilities children of parents with poor mental health, substance misuse problems, domestic violence, learning difficulties; children experiencing trauma and violence. Deprivation is also a risk factor for poor mental health.

Table 1 Estimates of mental disorders in 16-24 year olds, Adult Psychiatric Morbidity in England Survey, 2007, ONS

Condition	Estimated Prevalence			Estimated local numbers (population x prevalence)		
	Male	Female	Both	Male	Female	Total
Adult ADHD Self Report Scale 4 items	*14%*	*14%*	*14%*	2,521	2,916	5,437
Adult ADHD Self Report Scale 6 items	*1.3%*	*0.8%*	*1%*	239	168	407
PTSD	*5%*	*4%*	*5%*	938	881	1,820
Common Mental Disorder (Neurotic disorders)	*12%*	*21%*	*16%*	2,189	4,406	6,595
Psychotic Disorder (schizophrenia and affective psychosis)	*0%*	*0.4%*	*0%*	0	84	84
Eating Disorder prevalence (see table 5 for incidence)	*6%*	*20%*	*13%*	1,122	4,259	5,381
Suicidal thoughts (in last year)	*5.4%*	*8.5%*		993	1,783	2,777
Suicide attempts (in last year)*	*1%*	*2.4%*		184	504	688
Self- harm (lifetime)	*6.3%*	*17%*		1,159	3,567	4,726
Anti-social personality disorder	*1.5%*	*0.4%*		276	84	360
Borderline personality disorder	*0.3%*	*1.4%*		55	294	349
Alcohol dependence (moderate or severe)	*1%*	*0.3%*		184	63	247
Drug dependence – cannabis only	*8.1%*	*2.9%*		1,490	608	2,099
Drug dependence – not cannabis	*3.1%*	*0.8%*		570	168	738

Autistic Spectrum Disorder (ASD)

Estimates of the prevalence of autism and autistic spectrum disorder vary by country and over time. Boys are more likely to have ASD or autism than girls.
Estimates for the Southwark 0-19 years population suggests there will be between **756 -1,031** children and young people with autism locally. Local data shows there are **1,100** children aged 0-19 in Southwark known to services as having autism, although not all will be Southwark residents. Around **610** school age children in Southwark have a Statement of SEN with autism given as the primary reason for the statement, whilst **210** school age children are identified as having autism but no SEN.

Eating Disorders

Between 2000 and 2009 there was an increased incidence of eating disorders according to a review of the general practice research database. Rates of eating disorders are different for males and females (Table 2). Eating disorder not otherwise specified was the most frequently recorded eating disorder, following by anorexia and bulimia.

Table 1: Estimated incidence of new cases per year) of eating disorders for children and young people in Southwark

Age group (years)	Gender	Incidence per 100,000	Population	Estimated number of new cases per year
10–14	female	63.5	6,855	4
	male	17.5	7,132	1
15–19	female	164.5	7,311	12
	male	17.4	7, 500	1
Total				**18**

Self-harm and suicide

Self-harm is an issue which local schools have become more concerned in recent years, including some incidences at Primary School. Statistics show that 94 young people from Southwark aged 10-24 years old were admitted to hospital due to self-harm in 2013-14. This is equivalent to 172 per 100,000 - significantly lower than the England average rate of 412 per 100,000. But self-harming which is not severe enough to require hospital admission has not been captured here.

Young people who complete suicide are less likely to have been in contact with mental health services in the year prior to their death, compared with adults (14% vs 26%). Young men are more likely to commit suicide than young women. Young Lesbian, Gay, Bi-sexual, Transgender and Questioning (LGBTQ) young people are also at higher risk of suicide. If Southwark had the same rate as England (6.6 per 100,000 population aged 15-24 years), then this would account for 2-3 suicides per year.

Some groups of children and young people are much more vulnerable to mental health disorders and services need to particularly address the needs of this group who often suffer multiple disadvantages.

Children and young people with learning disabilities

36% of children and young people with a learning disability are estimated to have a mental health problem compared to 9.6% of the general child and young person population. Southwark has 932 children with learning disabilities known to schools, which suggests that there are **336** children and young people with learning difficulties and mental health needs.

Looked After Children and Children In Need

45% of children in care are estimated to have a diagnosable mental health condition – around **248** looked after children in Southwark need to access CAMHS. Children leaving care are also at high risk of mental illness and services should be planned to ensure continuity of support as they move to independence.

Vulnerable groups and access to mental health services

33% of Looked After Children who were estimated to have mental health needs were seen by CAMHS according to the 2013 Needs Assessment. In 2014-15 Carelink saw around 88 looked after children (compared to 248 with estimated need). It was not possible to report on the proportion of Young Offenders seen by CAMHS as there is not a dedicated service for this group

of young people. 46% of Children with Learning Disabilities were seen by the Neuro-developmental team.

Young Offenders

31% of young offenders are estimated to have a mental health disorder. This equates to around **140** young people in Southwark.

Homelessness and rough sleeping

Mental illness is estimated to affect 67% of young people sleeping rough. CHIMAT estimate that there will be 15 homeless young people in Southwark with mental health needs.

Parental mental health disorders

Children of parents with mental health disorders are at higher risk of mental health problems, however locally there is no mechanism for recording how many adults using mental health services have children who might be affected.

Parental substance misuse and domestic violence

Children whose parents misuse drugs or alcohol, or who suffer domestic violence are at higher risk of mental health problems. Local substance misuse services routinely ask clients about their family, and provide services for any children or young people identified as being at risk. In the quarter ended June 2015 **568 adults** known to substance misuse services in Southwark lived with children under 18 years old.

Transition

Transition to Adult services from Children and Young People Mental Health Services, and between services, remains inadequate. This is particularly true for young people requiring a range of health and social care services during their transitioning. Transfers from CAMHS, whether to Adult Mental Health Services (AMHS) or to other services, including discharge back to primary care, are single point events in the entire transition process. Young people may be subject to serial and sequential transfers within and across different healthcare organisations and specialist teams.

Young people who do not meet the threshold for Adult Mental Health Services may be best supported by primary care, other agencies such as Youth Counselling Services, or may be discharged with a clear plan which tells them and their families what to do if they become unwell. Currently many young people and families receive no such plan and are left to re-contact primary care services if further advice, treatment or care is required.

No detailed work has yet been done on other key transitions, such as the transition from Primary to Secondary school, and the CAMHS needs assessment steering group recommended that this key transition needs consideration.

Stakeholder Views

Stakeholders interviews during the 2013 Needs Assessment were concerned about the impact of disruptive home environments, eating disorders, self-harm, overly sexualised behaviour, gangs, Autism Spectrum Disorder and the effects of cannabis, particularly skunk, on the mental health and wellbeing of children and young people in Southwark.

More recent views from a Stakeholder event as part of the development of this Local Transformation Plan and the 2014 events identified the following issues:

- Need to keep an open dialogue between agencies when discussing residential needs and treatment to ensure effective solution for whole family;

- Improve open access to services to respond to community need;

- Promoting Resilience through better resources for parents, including community parenting champions and better use of online resources;

- Enhance PSHE training for teachers and its use in Southwark schools to support development of Resilience.

Since the time of the 2013 CAMHS Needs Assessment, stakeholders have also identified very obese children, LGBTQ (Lesbian, Gay, Bisexual, Questioning) group, and girls at risk of, or experiencing, Female Genital Mutilation as being at higher risk of mental health disorders.

Appendix 6: Families Matter

Families Matter is Southwark's approach to ensure we have the right local pathways to provide effective, accessible universal services from 0-19 years by strengthening links with providers across early years learning, primary and secondary education, health services, Youth Services and Children's Centres to enhance resilience and develop protective factors in children, young people, young adults and families.

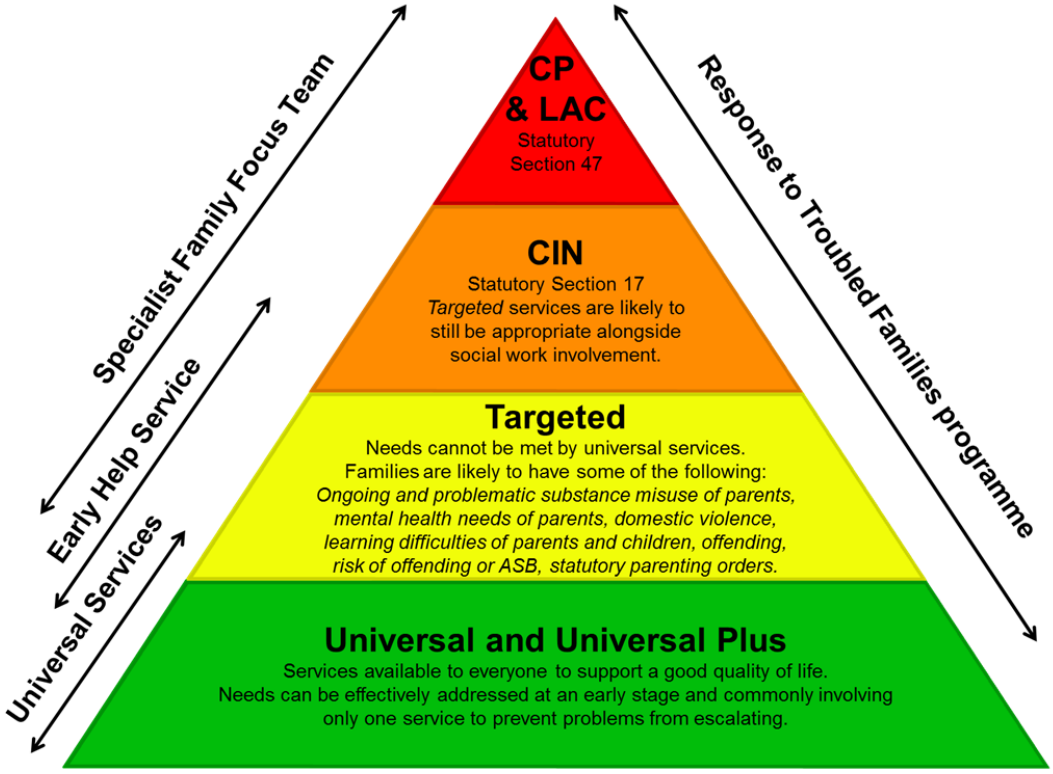
Families Matter deploys a 4-tier approach with a range of support and services available at every tier of support.

There is a focus on ensuring that Universal and Universal Plus services are delivered, the universal level reflecting our commitment to deliver high quality services for all residents of Southwark regardless of their level of need.

Targeted Support (Early Help Service and Specialist Family Focus Team) is deployed when a child, young person or family faces a number of different problems at the same time and requires more support to resolve them.

Services at the Children in Need level of delivery focuses upon providing more enhanced services for children, young people and their families where risks are greater and require longer term support.

The Child Protection and Looked After Children level encompasses statutory Child Protection, and services for children looked after by the local authority. The pyramid below outlines the Families Matter service delivery strategy.



From: Families Matter Strategy - 2015

Appendix 7 NEW Appendix

Update on SLAM Child and Adolescent Eating Disorder Service: Q1 and Q2 2016

Recruitment and workforce development matters

Since April we have advertised and recruited into the service one consultant psychiatrist who is due to start on 7/11/2016.

Two members of staff left the service in October 2016 for their own professional development and promotion. We have replaced them with two clinical psychologists and recruited two additional clinical psychologists and one family therapist. We have also recruited an additional Band 4 research assistant to help us with collecting outcome data and analysing outcomes.

Participation of patients/residents in the design of services

PPI Leads in CAEDS meet approximately once a month to ensure that PPI activity in the team is ongoing and meaningful. We regularly recruit parents and patients to be on a PPI register which is then used to invite interested individuals to attend for either Focus Group meetings for specific topics or “advice panels” on various issues including feedback about service developments, research activity, etc.

Dr Simic is currently developing Mind-ED modules for the Department of Health with the support of expert parents recruited through the PPI register. This will be readily available for patients, carers and parents early next year.

Engagement and communications with GPs; schools; families and other key partners

We regularly offer consultation to GPs through the self-referral telephone line. The line has been offered since 22/2/2016. The line has been used by families, schools, counsellors and other professionals working with children as well as GPs and other CAMH services.

We have also secured funding from Guys and St Thomas’ charity to trial an outreach programme for Bulimia Nervosa in schools in SLAM and OXLEAS as with this money will recruit a Band 6 CAMHS practitioner and part time Band 4 research assistant to evaluate the impact of the programme (please see Appendix 2).

We continue to run the Happy Being Me programme in schools. The following table provides an update on activity in schools. We are now running an evaluation of the impact of the programme on young people, comparing key outcomes for those who do and those who do not receive the programme. The demand for this programme is such that we are developing in collaboration with local schools a programme to train teachers in its delivery which will be measured in order to assess whether the impact is comparable to when delivered by clinicians. This will enable a larger number of young people to receive the programme.

Governance of the programme

The joint heads of the service have regular meetings with Clinical and Medical directors of CAMHS to review developments, challenges and problem solve. There are regular meetings of the senior service staff (Psychiatry, Family therapy, Psychology and Nursing) to plan and review service delivery. Regular audits of service outcomes are conducted and service performance is discussed monthly in team business and research meetings. In addition, the service leads (Simic and Eisler), service manager (Ellis) and consultant psychologist (Hunt) are members of the expert reference group for the development of community services. We have also applied to NHS England to provide nationwide training for eating disorder teams in a joint bid with GOSH. The service leads (Simic and Eisler) and team manager (Ellis) are members of the expert reference group for review of inpatient services for eating disorders.

An update on the on-line services

Website: http://www.national.slam.nhs.uk/services/camhs/camhs-eatingdisorders/
The website has been updated and now includes screening questions and information about the referral line. It also has resources including the team treatment manual.
Dr Simic is developing three modules on eating disorders with Mind-Ed, in collaboration with service users, and these will be accessible via the website.

Programme activity and any outcomes achieved against the standards

Our Child and Adolescent Eating Disorder Service has a current case load of 228 patients.

Improvement against the goal based measures set

The following data is for the 80 young people referred to the service in Q1 and Q2 2016/7, who have been assessed to date.

Breakdown of presentation and diagnosis at time of assessment

	N	%
Anorexia Nervosa	**42**	**52.5**
Bulimia Nervosa	**5**	**6.25**
EDNOS R	**12**	**15..0**
EDNOS BP	**3**	**3.75**
Binge Eating Disorder	**1**	**1.25**
Avoidant/Restrictive Food Intake Disorder	**1**	**1.25**
Feeding disorder in infancy	**1**	**1.25**
Other Non-ED Diagnoses or feeding difficulties associated with other disorders	**5**	**6.25**
No Diagnosis	**8**	**10.0**
DNA/cancel	**2**	**2.5**

Sixty-five have been accepted for treatment of whom nine have been discharged (two prior to three months of treatment and five between three and six months).
Data is reported for change between assessment and three months of treatment.

Key outcomes: The key outcomes for the first months of treatment are eating disorder symptomatology (measured by the Eating Disorder Examination Questionnaire, EDEQ) and increase in weight for young people with Anorexia Nervosa or EDNOS (restrictive subtype). The EDEQ is a self-report questionnaire of eating disorder symptoms, including restriction, binge, purge and concerns about weight and shape (Fairburn and Beglin, 1994).

Weight gain (AN/EDNOS-R)

Weight data is available for all young people at assessment and 21 young people at three months. There has been a significant increase in percentage median BMI over this time period.
Mean %mBMI over treatment young people with AN or EDNOS-R

	N	Mean %mBMI	SD
Assessment	**54**	**84.62**	**8.31**
3 months	**21**	**85.77**	**21.03**

t(20)=0.68, p = 0.05

Eating Disorder Symptomatology: EDEQ

Review of the EDEQ data reveals a decrease in Dietary Restraint and Global Eating Disorder scores over the first three months of treatment. However, At three months 5/25 young people completed the EDEQ. Only three young people did not complete the EDEQ at assessment. Invitations to complete further assessment at three months were sent via email approximately a week before they were due. If questionnaires were not completed within two weeks' time a reminder email was sent out and/or phone call made to the family.
Recruitment of a Band 4 research assistant will support collection of outcome measures and the process by which they are collected is under review to ensure more effective measurement of change in treatment.

Summary

Under the transformation plans, CAEDS is a much more accessible service and this has resulted in a significant increase in referrals, including direct GP referrals and self-referrals. Our duty clinicians also provide telephone advice and consultation to GPs, schools, primary care and other health and mental health services.

As referrals have increased we have responded by increasing the number of new patient assessments in a week from three to five. On average the total number of assessment per month has increased from 11 to 20, and the case load of the service has increased from around 140 to currently 230. For urgent assessments we are meeting targets in 63.6% and for normal cases we are reaching the 28-day standard in 37% of cases; there

has been a small improvement in Q2. However, as the referrals received have increased from 150 per year to currently predicted 230 per year (an increase in activity of 53%), we are not meeting the target for normal assessments on average in more than 20% of cases.
Our outcome measures show a significant increase in patient's weight for anorexia nervosa cases in the first three months, however as treatment of an eating disorder usually lasts between nine months and a year, we will continue to monitor outcomes.
We have also provided information for the number of discharges that which highlight that the majority of young people are discharged back to their GP after the treatment with us.

Currently, all members of CAEDS are over capacity and two team members have left the service (promotions) in the last month. This month (October) we have three new members of staff are joining our team (all band 7 Clinical Psychologists), a new Consultant Psychiatrist will join us on 7 November and a new family therapist will be starting with CAEDs in December. In this context, it is worth noting that the process of new staff recruitment has taken six months.
While we are not currently in a position to fully meet access and waiting times standards, we anticipate that with the benefit of new staff we will be able to meet Access and Waiting Time Standards in 60% of normal cases by the end of 2016 will result in a significant improvement in achieving these standards in the next three months.

DR MIMA SIMIC
Consultant Child & Adolescent Psychiatrist
Joint Head of Child & Adolescent Eating Disorder Service

Numbers of children and young people referred via the telephone helpline and source

Appendix 1: **Period: 22 FEBRUARY to 6 OCTOBER 2016**

SOUTHWARK		report covers: 22 February to 6 October 2016 (7.5months)	
No. patients referred:	**11**	**NOT accepted**	**2**
***of which* self-referrals**	**5**	**DNA/assessment**	**1**
		Family did not want assessment	0
		Withdrew/canx/assessment	0
URGENT referrals (within 7 days):	**2**	**Met target** **1**	**Missed target:** **1 (+ 5 days)**
ROUTINE referrals (within 28 days):	**7**	**Met target** **2**	**Missed target:** **5**
		exceeding target – range:(1-—36 days) ***36 days – earlier date offered/ family on holiday**	

NEW REFERRALS BY MONTH

Period: 22 FEBRUARY to 6 OCTOBER 2016

2016	SOUTHWARK	LAMBETH	LEWISHAM	CROYDON	BEXLEY	BROMLEY	GREENWICH	Total referrals
FEB	1	1	0	4	0	6	0	10
MAR	1	1	4	3	2	5	3	21
APR	3	0	2	3	2	8	4	23
MAY	1	3	3	4	3	4	2	19
JUNE	1	4	5	2	4	1	0	16
JULY	2	2	0	1	1	11	2	18
AUG	1	2	3	5	2	6	4	24
SEPT	0	5	4	1	2	8	1	21
1-6/OCT	1	1	0	1	0	0	1	4
total	11	19	21	24	16	49	17	
Self-referral	5	4	2	4	1	2	4	

27 September 2016

Telephone: 020 3228 2545

SLaM switchboard: 020 3228 6000

Website: www.camhs.slam.nhs.uk

Email (admin) Louise.Proust@slam.nhs.uk

Extract from SLAM e-news

CAMHS bulimia service wins Guy's & St Thomas' Charity grant award

Guy's and St Thomas' Charity are backing SLaM to create a new outreach service to help prevent and fight a prevalent and aggressive eating disorder.

The charity has provided a grant of **£118,495** to our CAMHS **to raise awareness of the symptoms of bulimia.** Through the new service, a full-time mental health outreach practitioner will build relationships with GPs, schools, community groups, youth clubs and other local services across the boroughs, and provide accessible information to young people and professionals in contact with them via lessons, posters, assemblies and more.

The service will make referrals and self-referrals easier and promote access to existing treatment pathways, with a special focus on young people from ethnic minority groups.

It will test new practices which, if successful, could be applied across the country.

By the end of the project, we expect to treat 35-45 young people who have symptoms of bulimia per year. By strengthening prevention and improving access to treatment, the new service also hopes to benefit over 470 local teenagers who may otherwise have developed the condition to chronic levels.

Dr Catherine Stewart, who leads the project, said: "Young people have very clearly told us that we need to be more visible and provide more information for those experiencing symptoms of bulimia nervosa so they can seek treatment earlier. Discussions with teachers from local schools have revealed that staff have great concern about anorexia, which can be a very visible problem, but that they are largely unaware of the difficulties experienced by an equal number of young people with bulimia. This project will ease access for young people with symptoms of bulimia nervosa to existing but currently

under-utilised pathways, before the disorder becomes chronic and harder to treat."

Appendix 8 – CYP IAPT programme

Children and Young People Improving Access to Psychological Therapy (IAPT)

SLAM CAMHS CYP IAPT:
Evidence to support existing IAPT services

The following information has been provided by South London & Maudsley NHS Foundation Trust (for Southwark Council areas) to evidence the CYP-IAPT evolution:

a) Current number of staff who have completed training, who are currently training and how many are projected to start training as a result of the Memorandum of Understanding (MOU).

b) Skill mix of staff trained, currently training and planned to be trained.

c) Financial value of the Memorandum of Understanding (MOU).

d) Current number of staff who have completed training, who are currently training and how many are projected to start training as a result of the MOU.

The tables below evidence the number of staff who have completed and will be completing IAPT training in Southwark. It also details clinicians who are already trained in evidence based therapies but have done so through another academic channel, for example through Clinical Psychology. These therapies are also being delivered to young people and families by staff who were not trained through the CYP-IAPT training course.

Southwark CAMHS IAPT Team

The table below represents skill mix across the teams:

Team	Psychological Therapy	Role	Skill mix
Southwark Child and Family Service	Family Therapy	Supervisor	CAMHS Practitioner
Southwark Child and Family Service	Family Therapy	Trainee Therapist	CAMHS Practitioner
Southwark Adolescent Team	CBT	Therapist	CAMHS Practitioner
Southwark Adolescent Team	CBT	N/A	CAMHS Practitioner
Southwark Carelink	CBT	N/A	CAMHS Practitioner
Southwark Carelink	Family Therapy	Therapist	CAMHS Practitioner
Southwark Carelink	CBT	Therapist	Clinical Psychologist
Southwark Adolescent Team	CBT	Therapist	Clinical Psychologist
Southwark Adolescent Team	Family Therapy (Systemic)	Therapist	CAMHS Clinical Specialist
Southwark Adolescent Team	CBT Family Therapy (Systemic)	Therapist	Clinical Psychologist
Southwark Neurodevelopmental Team	CBT	Therapist	Clinical Specialist
Southwark Neurodevelopmental Team	CBT/Family therapy	Therapist	Clinical Psychologist
Southwark Neurodevelopmental Team	CBT/Family therapy	Therapist	Clinical Psychologist.

The financial value of the Memorandum of Understanding (MOU) is **£26,000.**

a) The Current CYP- IAPT model

Project Plan for CY IAPT May 2014/16		Updated		
Area	**Task**	**Owner**	**Deadline**	**RAG**
Project governance	Disseminate routine outcome measure usage within pilot site schemes	TL/SW/HK	complete	Green
	Increase PPI within teams in both boroughs Data collection	TL/SW/HK	Complete	Green
	Increase/sustain use of evidence practice	TL/SW/HK	Complete	Green
Phase 1 - Set up	How to disseminate CY IAPT model of working to multiple teams across the boroughs	TL/SW/HK/LM/IR	Complete	Green
	How to make best use of CYP/IAPT training and resources teams across the boroughs		Complete	Green
	Clinical Governance days in the boroughs to orientate teams		Complete	Green
	Informal discussions with Colleagues		Complete	Green
	Formal discussions within Team Meetings, steering Group and senior management meetings		Complete	Green
	What training in teams may be required			Green
Reporting/ data planning	Data admin and Assistant Psychologist employed	TL/JR/MB/JL/DP	Complete	Green
	Set up spreadsheet for tracking new cases		Complete	Green
	Prepare Questionnaire packs according to age of child and young person		Complete	Green
	Liaise with Clinicians in teams to handover packs of questionnaires		Complete	Green
	Liaise with clinicians to collect and score questionnaires, enter data and give clinicians graphs and scores		Complete	Green
	Circulate monthly report to Pilot Project Board		Complete	Green
Phase 2	Hub and spoke model		Complete	Green
	Comprising CP IAPT workers from the two boroughs		Complete	Green
	To meet regularly to share good practice		Complete	Green
	Attend team meetings, work with individuals clinicians to ensure ROM are utilised and CBT (through consultation and supervision, carry a case load)		Complete	Green
	Supervision CBT groups to be organised in each borough	JR/MB/DP	Complete	Green
	Training workshop events in both boroughs. Duncan Law coming to Lambeth Clinical governance day on the 17th June		completed	Green
	Southwark does not currently have a facilitator to run the parenting group with Lambeth. The group is at risk of only having Lambeth families	TL/RC/PB	To organise	N/A
	Clinical Leads to attend IAPT SLAM IAPT meetings	RC/PB	To organise	Amber
	Audit on clinical views on using measures	FM/JR/TL	To organise	Amber

Phase 3 - Sustainability	ROMS on EPJS	TL/MB/ RC/PB/J R/JL/JR	completed	green
	Graphs		completed	green
	Contextual Factors		completed	green
	Roll out of Tablets for all staff that are completing measures		Ongoing Dec 2014	Amber
	Clinicians to ask C YP to complete questionnaires on tablets		Ongoing Dec 2014	Amber
	Scoring and graphs automatically generated on EPJS to be shared with C YP and family/guardian		completed	green
	Monthly update meetings to ensure targets are met		completed	green
	Team Leaders to get reports from Insight about data % and feedback to staff		Ongoing Dec 2014	Amber
	Making it second nature to use outcome measures in every day practice			Amber
	Data continuously at 90%		Ongoing Dec 2014	Amber
Monitoring and Evaluation	Meeting to review results of measures identify lessons learned and develop recommendations		completed	green
	CBT supervision groups to be run in Lambeth and Southwark, training courses within the trust to be attended		to be completed	amber
	clinical governance days e.g. Jan in Southwark, December in Lambeth		to be completed	amber
	young people to discuss experience of measures		to be completed	amber

Number of young persons who have been through the CYP IAPT model and the outcomes (if known) of the young person's having accessed the CYP IAPT delivered service.

The table below illustrates the number of young persons who have been who have given consent to take part in CYP-IAPT from September 2012- September 2015 is at least **1723**. This is an estimate derived from Lambeth and Southwark's database.

Southwark CAMHS Services	Consented YES to CYP-IAPT
Southwark Adolescent Services	340
Southwark CAMHS FFT	12
Southwark CAMHS Neuro Developmental	235
Southwark Carelink	66
Southwark Child and Family Service	271
Grand Total	**924**

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APPENDIX 1

healthwatch Southwark

Healthwatch Southwark

Young voices on mental health

November 2016

Contents

Background and what we did

What is Healthwatch?

Healthwatch is an independent health and social care champion for local people. This means we represent your views, to ensure services are shaped around your experiences and designed around your needs. We are the 'critical friend' to people who plan, provide and fund care.

We are part of a wider network of local Healthwatch across the country, as well as a national body, Healthwatch England.

Why speak to young people?

We want everyone's voices to count towards improving services. Young people often do not get an opportunity to share their experiences so we wanted to engage specifically with them. We wanted to understand the challenges they face so that we can inform commissioners and providers about how to improve access and the experience of young people using services.

Why talk about mental health?

Mental health care is one of our priorities. We have undertaken a number of engagement activities to hear from adults who access these services. We have also been informed that people experience long waits to access child and adolescent mental health services (CAMHS). We therefore wanted to understand the experiences of young people when accessing mental health information, education, support, services and advice.

How we reached young people

Workshops

We connected with community and voluntary sector organisations that offer services for young people, and visited groups. This enabled us to reach young people with a variety of backgrounds and ages, and because some of the young people were already familiar with each other they might feel more able to open up.

We ran six workshops where we asked young people to respond to statements by showing cards or moving about in the space. Whilst we noted how many agreed with each statement, our main aim was to provoke discussion and explore themes which were important to the young people in a semi-structured way. We have recorded where views were shared by many young people, or lone voices. It was clear that the makeup and experiences of certain groups created distinct dynamics and we have also tried to reflect this in the report.

Whilst we reached fewer young people through the workshops than via online surveys and a survey at Walworth Academy (see below), we found that the

Background and what we did

discussions held in this format yielded much more detailed, qualitative insights.

Online

A parallel survey containing mostly the same questions was put online so that we could promote it via our website, Twitter and e-newsletter. We encouraged partner organisation to distribute the survey through their networks.

Survey

We sent paper copies of the survey to Walworth Academy (a Southwark secondary school), with which we had a relationship. We gave the school one week to distribute the surveys on the last week before summer break.

While findings from the workshops and online survey are grouped together, findings from the Walworth Academy survey are presented **separately in green boxes** because we are aware that a large number of responses from students at a single school might well skew overall findings.

In total, 114 young people participated in this project:

We do not claim that this report fully represents the views and experiences of all Southwark's young people - indeed, no report could.

However, we believe it is important to spend time building a dialogue with young people and hearing their views in depth, rather than simply focusing on large-scale capture of often more simplistic quantitative data.

Every voice counts and even if only a minority of people, or a particular group of people, report a problem in the health and social care system, this should be addressed wherever possible.

The recommendations presented in this report were suggested by young people themselves. They are broad areas and we welcome any opportunities to discuss how they can be translated into concrete actions for different agencies working together, and what resources would be needed to accomplish this.

Demographics

Please see Appendix 2 for detailed demographic data.

School

- 77 young people had been or were currently students at 11 Southwark schools and colleges.
- We also spoke to 15 students of 11 other South East London schools.
- 9 were students in 7 North London schools.
- 13 did not state their school.

Borough of residence

- 20/54 of our online and workshop participants and 43/60 Walworth Academy participants were Southwark residents - in total 69% of respondents whose home borough we know.
- 19 participants lived in other South East London boroughs
- 8 lived in in North London.
- 23 did not know or gave no response.

Age

- Ages ranged from 12 to 23 years.
- There were clusters at age 14 (Walworth Academy survey), and age 16 (Healthwatch hosting young volunteers through the HeadStart post-GCSE programme).

Gender

- Ratio of female to male respondents - 53:41.
- 2 participants were gender non-binary or 'other'.
- 18 did not specify their gender.

Gender status

- 4 were transgender and 1 did not know if they were.
- 91 were cisgender (identified with the gender they were given at birth).
- 18 gave no response.

Sexuality

- 85 were straight/ heterosexual.
- 4 were bisexual.
- 1 was asexual.
- 2 gave their sexuality as 'other'
- Only 1 said they were lesbian/gay/homosexual, highlighting a gap for future engagement work.
- 21 people did not state their sexuality.

Ethnicity (self-described)

White British (4), White European/other/unspecified (5), Black British (11), Black African/African British (24), Black Caribbean/Caribbean British (11), Black other (3), Asian, South Asian, Bangladeshi, Bengali, Pakistani or Indian [British] (10), Turkish [British] (3), Mixed (13), Other or insufficient detail (10), not specified (20).

Length of time in UK

- 72 participants said they had lived in the UK all their life.
- 7 had been here over 10 years, 6 between 6 and 10 years, 4 between 2 and 5 years, and 2 less than 18 months.

Demographics

At least 5 were refugees or asylum seekers.
- 23 did not answer this question.

Religion

Christian (45), Muslim (18), Sikh (1), Jewish (1), pagan (1), atheist (2), and no faith (11). 3 had not decided and 23 gave no answer.

Disability

- Only 5 respondents said that they had a disability (including autism and stutter) – this highlights another gap for future engagement work.
- 88 did not have a disability.
- 21 gave no answer.

Looked after

At least 11 respondents were or had been looked after (in care).

Caring for someone

27 people said they 'cared for someone else who had a disability or illness' – it is unclear whether all of these people were carers in the practical sense.

Perceptions and knowledge of mental health

What does the term mental health mean to young people?

We asked young people what the term 'mental health' brought to mind for them. Only one person in the workshops, and two online, offered a positive take on the term - ***"strength"***, ***"healthy thinking."***

A few people described mental health in a neutral way (e.g. ***"state of mind and emotions"***) but a majority interpreted the term negatively:

"Mental health is when someone has an illness rooted from how the brain works"

"Instability"

"Being stressed, unwell and needing help"

"Sick"

"People that have difficulty in putting their thoughts together"

One person told us that while they had had education about mental health in school, ***"I didn't really listen to her because I don't think that I will be affected by it."*** Others in the group disagreed with this view, ***"I think everyone is affected by mental health."***

What students at Walworth Academy told us

4 students gave positive interpretations of the term mental health, for example, ***"something that allows you to take control of your emotions and how you feel"***. 18 students gave a neutral explanation.

The majority (25 students) gave a negative interpretation of the term, ***"something wrong in your head"***, ***"difficulties in learning"***, ***"I think mental health is life threatening"***.

Which is more important - physical health or mental health?

Individuals in four of the workshops, and four online respondents, said that mental and physical health were equally important, with one explaining, ***"both can mean you're not looking after yourself."*** Some also noted the impact of mental health on physical health. People talked about the seriousness of some mental illness, with one describing family members as ***"damaged, never the same again. People really change."***

Two participants from workshops and three people online felt that mental health can be even more important than physical, ***"Though it cannot be seen, issues with mental health are sometimes in my opinion even more***

traumatic than physical conditions. I think that it is very important to feel comfortable with your inner self."

Awareness of symptoms of mental illness

We asked two workshops, where people were struggling to describe what mental health meant, to elaborate on what symptoms they associated with poor mental health.

One workshop listed depression, mood swings, being nervous, irritated or angry, and struggling to look after oneself. In one workshop where they had very negative interpretations of the term mental health mentioned suicidal thoughts, ***"crazy people in Camberwell shouting on the bus"***, lack of control and awareness, and anger. We prompted participants to think about subtler symptoms, and they listed confusion, 'self-medicating', crying, and isolating oneself away from the world.

In another workshop we discussed how they would know if somebody needed help. This included people being 'closed off' or a change in character, ***"If you know someone for a long time, you notice change if they are having problems."*** However, one person pointed out that ***"it is not always obvious - they can mask their sadness and happiness."***

Getting information

Ease of finding information

"It's easy for young people to get information and advice about mental health"

What young people told us from workshops and the online survey...

14 people agreed with this statement

24 people disagreed with this statement

15 people weren't sure if they agreed or disagreed

We wanted to find out whether young people are provided with information and education about mental health (which might help them recognise problems, understand others, and know how to seek help).

Some who disagreed that it was easy to get information elaborated on this:

- ***"Physical health is much more talked about"***
- ***"People aren't open"***
- ***"People aren't educated enough. If they have symptoms they might not know what that means"***

Several people agreed that there might be information available but people did not always see it, ***"You have to look for it yourself."***

In five of the six workshops, talking about information led naturally into discussions about the internet, with all five groups including people who were sceptical about going online for this purpose (see below).

People in three of the six workshops raised discussion about provision in schools, though two did so in the context of it being absent or inadequate.

A few people mentioned other sources of information, such as a teacher with responsibility for pastoral care or a key worker. One person said that they would use 'Dummies' guides' to conditions from libraries, although several did not want to use books. Several young people in one workshop said (unusually) that they thought information about mental health was well-publicised on social media, in music and on public advertising around Southwark.

The internet

Some said that to find information they would simply ***"Go on Google!"***, and that the internet is helpful because they use it every day.

One person said that they liked to use YouTube as it was easy and quick (preferring it to 'books on prescription' which they had been offered by their GP) – though they accepted that ***"you***

Getting information

don't know what you're going to get." Another said that they had seen links to useful articles on Snapchat.

However, many did not feel that the internet was a good source of information and one even said, ***"Access to the internet can make it difficult to get information."*** Reasons given included:

- not everyone having internet access
- some information not being reliable or accurate (not being able to trust everything)
- some information applying to different areas of the country
- not knowing what to search for
- risk of self-diagnosing (wrongly)
- being put off by scary descriptions of one's illness.

Even some who did not generally trust the internet for information on mental health saw the NHS website as a reliable option. ChildLine was also well known because it was advertised on social media and had been publicised in schools.

What students at Walworth Academy told us...

26 people
agreed with this statement

16 people
disagreed with this statement

14 people
weren't sure if they agreed or disagreed

Three people who agreed said that even though it may be easy to get information, it may be hard for young people to ask for help, ***"they might panic and not say anything to anyone."***

One student who said it was not easy for young people to get information about mental health commented, ***"this [Healthwatch survey] is the first time I've had information about this."***

Getting information

Education and information in schools

"My school or college provides (or provided) good information and education about mental health"

What young people told us in workshops and the online survey...

While a couple of people were satisfied with information provided via, for example, assemblies, large numbers of young people in all of the workshops said that they had not received any education in school about mental health, even when PSHE and general health and wellbeing education were provided. Some schools try to provide extra support around exam time such as ***"holding a meeting about the importance of sleep"***, but this was not seen as enough.

Where schools did provide information, it was often inadequate. People said that teachers were not trained in the subject and were too vague, ***"they talked about sleeping and how we were feeling and then moved onto another topic."*** One person said that teachers had only mentioned depression and anxiety, whereas ***"there's a lot more to it than that."***

Even when schools had provided support at exam time it was not very effective, ***"They do try at difficult times but I feel it is tick-boxing…it's really important stuff and should be discussed. Exams make people really stressed…in a maths exam people were crying. Teachers offered advice but they are not professionals. They are trying but it's not perfect."***

Some noted that information needs to be engaging, saying that PSHE makes the topic ***"boring and repetitive"*** and ***"it's hard to engage 15/16 year olds on this topic."***

In a few schools a potentially more effective approach had been taken, with external educators coming in. Two pupils had found it helpful when people with mental health conditions came to speak about their experience. Another person mentioned organisations like Mind and Rethink giving tailor-made courses (and this person had then found support via those groups).

Getting information

What students at Walworth Academy told us...

19 people
agreed with this statement

27 people
disagreed with this statement

9 people
weren't sure if they agreed or disagreed

Of those who disagreed, 5 students explicitly said that education on this topic was not given by Walworth Academy, ***"In my three years here I have not seen anyone receiving this."***

One person explained their answer by saying, ***"I don't know who to go to or where to go."***

Where young people go for support

What would young people do if someone needed help?

To find out about awareness of the seriousness of mental health problems and of sources of support, we asked the young people what they would do if someone told them that they might have a problem with their mental health, or if they noticed that someone was showing worrying symptoms.

Five people in workshops and seven online said that they would ask for or suggest getting the support of an adult, sometimes after talking to their friend to find out more, ***"I would encourage someone to go somewhere; if I was really worried I'd try to help more - seek professional advice like from a psychologist or the internet to help them make a choice."***

One of these respondents specified that if the person was in school, they would tell a school mentor or the head of sixth form – ***"someone in authority"***. Four specified that if the problem was serious they would advise seeing the GP or other mental health professional. Another said they would tell their friend's parents.

Two participants also emphasised the importance of being sensitive when talking to a friend about their problems, ***"Try not to be judgemental - it might stop them telling you the truth."***

Two people said that they would not know what to do for a person with a possible mental health issue:

- ***"I would try and talk to them but not sure what sure of what to do next or where to go."***
- ***"I'm not sure where I would go, if we were to seek something out like that people might think we were weak or crazy."***

Finally, two people said they would not do anything – ***"everyone has their own problems"*** – though one would intervene by taking the person to hospital if they were cutting themselves.

What would young people do if they were concerned about their own mental health?

We also asked young people what they would do if they were worried about their own mental health.

Seven people in workshops and seven online said that they would talk to someone if they had a mental health problem, with suggestions including ***"the person I am closest with"***, parents, the school counsellor, friends, a doctor, social worker, and Mind.

One explained, ***"sometimes while you're talking you realise the solution and the logic behind it and it makes more sense; you get epiphanies; speaking helps you be rational."***

Where young people go for support

One online respondent said they would ***'Go on Google'.***

However, five people said they would not talk to anyone:

- ***"'I wouldn't go to a doctor; I wouldn't take it seriously."***
- ***"In the situation I am not actually sure you would speak to someone even though you say now you would, but would you actually? You'd worry what people thought - if you were weak - or they might judge."***
- A person with experience of depression said they would not do much – ***"I'd just withdraw and accept that I will be like that for a while, and then I will get better naturally."***

Support from those close to a young person

Talking to friends

"I would feel able to talk to my friends about my emotional wellbeing or mental health if I needed support"

What young people told us in the workshops and the online survey...

27 people agreed with this statement

9 people disagreed with this statement

9 people weren't sure if they agreed or disagreed

To find out about levels of openness and whether young people feel they have somewhere to turn, we asked first about whether people can talk to their friends about their mental wellbeing.

Naturally, many people stressed that who they would talk to depended on their individual relationship. Some were confident that close friends would ***'offer me support and advice'***. Some noted that sometimes it is difficult to know who to trust, which makes it harder to talk to anyone.

Two people also said that while they would talk to friends about minor issues, if something was ***"really bad"*** they might not, ***"I'd just go and get help."***

Some people shared why they would be unable to talk to their friends:

- not having a time or place to talk about private issues while at school
- wanting to talk only about positive topics when with friends, feeling that ***"everyone has their own problems"***
- fearing that something serious might get ***"brushed off as no big deal"***
- fear of being judged
- thinking the other person might feel awkward ***"because they don't know what to say, so they stop talking to you."***
- not having many friends due to being a recent immigrant.

In one workshop made up almost entirely of young men, there was an interesting discussion about gender. Most present felt that young women are much more likely to open up to their friends, ***"Guys don't lie on the bed together chatting like girls do with their best friends".*** Many males in the group were initially surprised to hear that the suicide rate for men is higher than for women, but then exclaimed, ***"That figures, because men don't talk."***

Support from those close to a young person

What students at Walworth Academy told us...

32 people
agreed with this statement

12 people
disagreed with this statement

7 people
weren't sure if they agreed or disagreed

Some mentioned they do not like to talk to people about anything personal or that they didn't have any friends to talk to.

Talking to parents

"I would be able to talk to my parents about my emotional wellbeing or mental health if I needed support"

What young people told us in workshops and the online survey...

20 people
agreed with this statement

17 people
disagreed with this statement

15 people
weren't sure if they agreed or disagreed

Several of the young people we spoke to felt close to at least one of their parents, and were confident that they would support them with mental health issues, for example saying, ***"My family have been there from the beginning and can offer 24/7 support."***

However, many people felt that their parents would not understand issues around mental health, with several saying this had a cultural component, though it manifested in different ways:

- ***"My family would joke about, they laugh it off, they think it will help but it doesn't help - it's a Jamaican thing. So I'd be too embarrassed - no wonder men commit suicide!"***
- ***"African parents overreact - they want to take me to the hospital if I get angry!"***

One person said that family members would focus on practical issues, and

Support from those close to a young person

another added that this was sometimes unhelpful, ***"If you go to them saying, 'Mum, I feel really down, I have no job', well she'd just say, 'Get a job then!'"***

People in one workshop noted that even if parents were understanding, they might not know how to help, ***"It's hard for parents. They don't always know what to do - parents need training in how to talk about these things with us. And professional services could put themselves out there more."***

Finding support can be particularly difficult for some young people who are already under pressure. Two participants whose parents themselves had health problems (at least one of whom was a young carer) said poignantly that they did not want to burden their family, ***"I could talk to them but… I wouldn't want to put them through it, because I know it can be hard to know about someone else's mental health troubles"; "I wouldn't want to bother them because they have their own problems."***

Several people added that they were likely to talk to their siblings or cousins about emotional concerns, ***"I've spoken to my brother - he said he felt the same sometimes, which helped."***

Finally, some people simply said they would prefer to talk to a professional than to their parents. Two said this was because professionals ***"can actually help"*** and would not judge; another, ***"I find it hard to open up to other people. I can tell my therapist everything because she is neutral."***

One person commented that some people find it scary to talk to anybody at all.

What students at Walworth Academy told us...

35 people
agreed with this statement

12 people
disagreed with this statement

5 people
weren't sure if they agreed or disagreed

Of those that agreed they'd be able to talk to their parents, some students acknowledged that they might not be able to talk about really personal feelings, ***"I think I would be able to talk to my mum but not about everything."***

Of those that disagreed, one student said that they liked to keep things private

Support from professionals

Support in schools for those facing problems

The workshop participants were mainly critical regarding support provided by schools to pupils actually experiencing mental wellbeing difficulties. When asked who they would go to for support, one person stated emphatically, ***"Definitely not schools or any teachers!"***

Noone had any particularly positive comments about school nurses:

- ***"They will tell you to come at lunchtime, but that's lunchtime! I think we need a full time school nurse."***
- ***"I didn't know I had a school nurse until I was in year 9."***

A few of the young people mentioned that being given a lot of leaflets was not helpful, ***"I had to talk to someone about my behaviour, they gave me some leaflets; they gave me so much but I didn't get through them."***

Some young people were aware of mentors or counsellors in their school. One said, ***"I have a mentor but it's hard to get a counsellor."*** One thought there was a counsellor, but had never seen them. Another had been told they would have a chance to talk to someone, but seemed to fall off the radar. One young person said that the school had arranged for someone to take them to activities to address their poor attendance, ***"but they don't talk to you."*** However, another participant had drama therapy for anger issues which they found helpful.

Three further issues were raised as obstacles to young people getting support through their schools.

One was the fact, raised in a couple of workshops, that getting support was often predicated on the young person having academic problems or behaving badly, ***"If you misbehave, that is when they will come to you to talk about how you are."*** There was a strong perception in one workshop (made up entirely of black and mixed black/Asian girls) that racial stereotypes affected how this played out. They felt that if a white pupil was 'acting out' they would get help faster, whereas black pupils had to show more extreme behaviour before being offered support. There was a feeling of distrust towards school authorities among many of this group which made them unlikely to seek support through school.

Another worrying issue was the fact that many young people were keenly aware that there would be serious consequences from discussing certain issues, even in a mental health context, due to safeguarding rules. Discussing a difficult home life might result in interventions, ***"I had a teacher that would say to come and speak to her but we heard about people getting taken away so no one would go to her***

Support from professionals

after that." In one workshop several described extreme discipline from their parents which many would consider child abuse, but said that it was part of their culture. They were aware that this would concern professionals, and thus felt it would be hard for some young people to engage with support.

Finally, one person said that they felt they lost control when seeking support through school, ***"School just refer you. They tell you to go to them but they just pass on your details without telling you and you don't know what's going on"***, with different agencies then turning up to be involved.

Support from GPs

"I would be able to talk to my GP about my emotional wellbeing or mental health if I needed support"

What young people told us in workshops and the online surveys...

11 people agreed with this statement

38 people disagreed with this statement

4 people weren't sure if they agreed or disagreed

We wanted to find out how young people felt about GPs as a potential first port of call for medical help around mental health.

Whilst most of the young people in all workshops said they were unlikely to feel able to talk to their GP about mental health, a couple were more confident about this. Another said that they had gone but with support from a youth worker to explain their problem. Several online respondents were confident that the GP could help, saying ***"They're professional"***, ***"They have the knowledge"***, ***"They know the stuff"***.

Individuals in three different workshops were surprised to hear that they could approach their GP about mental health issues at all, ***"I really didn't know GPs were anything to do with mental health. They need to promote this."***

Individuals in two groups said it was hard to get GP appointments. Another two people mentioned lack of continuity as they see a different GP each time; two did not know who their GP was.

For several people, their personal relationship with their GP was not good enough to allow them to open up, ***"There's a lack of relationship - all my doctor says when I get in the room is, 'What's the problem?' in a grumpy voice and then writes a prescription. They're not interested in you as a person and it doesn't make you want to talk about your problems - how are***

Support from professionals

you supposed to get the help you need like this?"

One person felt they might be judged by the GP, ***"they'd look at me differently and treat me differently"***. Trust issues were connected to fears about confidentiality, particularly for one person whose mother was friends with their GP - ***"I don't have faith that they would keep to patient confidentiality."*** On a related note, one person did not want mental health issues to be on their notes as they felt it might damage their future career in the health sector.

One young person felt that because their depression was not as serious as their parent's mental illness, they did not need to see a GP. They were also afraid of being ***"stuck with"*** a diagnosis.

Do young people have confidence that GPs can help in the right way?

Some expressed scepticism that GPs would be expert enough to help with mental health, ***"GPs don't know what they are talking about."*** One online respondent feared that a GP might give the wrong diagnosis. A young person with mental illness in their family said, ***"I've lost trust in GPs because of seeing people suffer around me."***

However, one young person had had a good experience with their GP, despite having heard off-putting stories – ***"When I went to my GP about my gender, I told her I feel ashamed and anxious and she referred me to CAMHS… [The letter] came in a week and I had the appointment in the following week."***

There were contrasting ideas about what a GP would do for a mental health problem. Some young people in two workshops said that GPs would only give drugs, which they did not like, ***"they just give pills, they don't want to talk. Pills have side effects and don't work."*** An online respondent felt that ***"they can offer advice and help, but could give me medication that could enhance the mental issues or make me rely on it."*** Some had an extreme impression, saying that the GP would ***"try to give me drugs, injections, or lock me up in the Maudsley!"***

In contrast, a couple of young people in one workshop were not sure they would be able to access mental health medication, ***"medicine is less accessible for mental health than it is for physical health - you can't get antidepressants in this country."*** Others contradicted this, but all in the workshop agreed that they would rather talk to somebody than be given medicines, and were not sure the GP would offer this. Some people felt the GP might not do anything, or ***"would just refer you on so what's the point."*** One person told, us, ***"the GP referred me to someone and that messed me up even more."***

Support from professionals

What students at Walworth Academy told us...

24 people
agreed with this statement

20 people
disagreed with this statement

9 people
weren't sure if they agreed or disagreed

Students indicated that it depended on whether they felt comfortable or trusted their GP, ***"I don't feel close to them so I wouldn't talk about it."***

Some students felt that they could get help from their GP about anything, but others disagreed, ***"not everything you can explain to your GP."***

Embarrassment and stigma

"If people knew I had asked for support around my emotional wellbeing or mental health, I would feel embarrassed"

What young people told us in workshops and the online surveys...

8 people agreed with this statement

24 people disagreed with this statement

5 people weren't sure if they agreed or disagreed

Interestingly, several people said that they would not feel embarrassed about seeking support with their mental health – it was simply that this was not the type of conversation they had had. Many said that people knowing would feel like an invasion of privacy, ***"It's a personal emotion; I don't need everyone to be in my business."***

A few were however put off by stigma surrounding mental ill-health, ***"In my mind I know I shouldn't be [embarrassed], but the way it's seen in society, I would."*** Some said that if people judged them, they were not real friends – but equally that being judged by a supposed friend would hurt more. Discussions about societal attitudes ensued: ***"Society thinks that people with mental health [problems] are crazy people. They won't trust you."*** One person also referred to stigma as a barrier to seeking information.

People in two workshops said that television played ***"a big part of building stereotypes."*** This could also deter people from seeking help, because of extreme depictions of treatment or of illness, ***"My friend wants to go to GP to talk about mental health. Our school showed a documentary about obsessions. Now my friend doesn't want to go because she says she is not that crazy!"***

Cultural perceptions also contributed to stigma, ***"My home country is very different to the UK. [Mental health] is a taboo. There is some prejudice that only crazy people go to therapy… People I know from immigrant backgrounds - there is stigma. I was raised on the idea that that talking about this is very weak, and if these stereotypes were broken down, people might use services more."***

At one workshop, when discussing the definition of mental health, said that in some cultures mental illness was still seen as being possessed, ***"Yes, my mum would say 'you've a devil inside'*** -

Embarrassment and stigma

and… it's the same idea among some older traditional people."

What students at Walworth Academy told us...

23 people
agreed with this statement

15 people
disagreed with this statement

14 people
weren't sure if they agreed or disagreed

Students who agreed said ***"it is personal"*** and ***"I wouldn't want the wrong people to know"***. One who was unsure was concerned ***"Because mental health is a worrying thing."***

However, another explained ***"There's nothing to be embarrassed about as it's natural in life in my opinion."***

Recommendations

We asked young people what advice they would give to those who plan and run mental health services when they look at improving information and support for young people, and reducing embarrassment about seeking help.

Teach young people about mental health.

There was a large consensus that young people simply need to be taught more about mental health. Suggested methods included workshops, assemblies, discussions, performances and day sessions, and several people suggested having medical professionals or external organisations come in, partly so that young people are more aware of sources of support. Posters in school describing mental illness symptoms were suggested. People wanted to see a range of information formats, from films to leaflets. Social media could also be used, for example through creation of a hashtag or app.

> ***"Get mental health organisations into schools to provide information to young people and promote the services available to young people. This will help to normalise talking about mental health."***

Individuals also said that education on related issues like relationships and cyber-bullying would support good mental health.

Based on our discussions, we would recommend that information include:

- positive definitions of 'mental health' as well as discussion of illness
- awareness-raising about less extreme treatment-worthy mental health problems
- types of treatment on offer
- a range of illnesses and symptoms
- signposting to reliable websites organisations and support that are applicable locally.

Be creative and engaging.

Young people want to be educated about mental health, particularly in school, in a way which is sensitive, stimulating and appropriate.

> ***"They should try to adapt the way they give out information to the young people and shouldn't try to scare them with the information given."***

> ***"Give preventative advice - for example some people don't realise that smoking cannabis can really affect their mental health. Teach skills and share personal experiences."***

Recommendations

> *"Make it more project and group based, to talk in focus groups rather than big groups, [so as not] to intimidate individual feelings."*

Teach teachers about mental health.

Young people felt strongly that schools need to be better at talking about mental health. They felt that teachers aren't equipped to do this, and need training to support young peoples' wellbeing.

> *"Teachers can't help because they don't know how."*

We would also suggest education and awareness-raising for parents to help them support their children and dispel myths.

Reduce stigma; normalise talking about mental health.

Young people felt that the NHS, campaigners, media and schools should help raise awareness and reduce the stigma surrounding mental illness. This was felt to be a barrier for people seeking help. They felt this was a societal, cultural issue that needs to be challenged. Professionals also need to emphasise to individuals that seeking help is nothing to be embarrassed by.

> *"Mental health being discussed with reassurance & taught at an early stage in life - year 5 & 6. So kids grow up knowing about mental health and they have more of an understanding about it."*

> *"Change or normalise the terms. Talk about emotional wellbeing instead of mental health, to make it less frightening."*

> *"They should teach that people with illness and disabilities can't control them and we shouldn't judge. They are just like us and they should be treated as equals."*

Can GPs help with mental health?

Young people suggested that the NHS needs to promote the fact that young people can see GPs about mental health, as not all were aware of this. Although some didn't feel confident that GPs would offer non-judgemental advice and support. Two people suggested that GPs should ***"check up on mental health"*** or ***"do regular check/catch ups"*** to offer support.

Recommendations

Promote mental health support services.

Young people felt services need to raise awareness about what they can offer around mental health support and information, and about the fact that they can be effective.

> *"Publicise case studies of how counselling/online services have helped people – to show that you aren't alone and it's normal."*

Support young people at school.

Several people gave different suggestions about how schools could be well-positioned to offer support for those who are struggling, particularly at stressful times:

> *"Have a health hub at school where pupils can drop in with all sorts of issues, and make it clear that this includes mental health."*

> *"Very ambitious people take getting good grades seriously and are stressed. During exam times there should be counselling."*

Given that some were unaware of their school nurse or unable to see them in the hours offered, this service should also be publicised and made as flexible and accessible as possible.

Improve access to talking therapies.

Young people said that more talking therapies/psychology should be offered, and feared going to a GP would just lead to being prescribed medication. Some also suggested other forms of non-drug treatment:

> *"Use different ways for them to overcome it like going on trips."*

> *"We want to stop being prescribed drugs – they just make things worse, and the long list of side effects is really scary. We want more talking therapies."*

Encourage peer and mentor support.

Many young people suggested that a peer support system would help them to deal with emotional and mental health issues. Several also wanted semi-formal mentoring systems to provide regular one-to-one support and develop a nurturing relationship. Someone close to the young person's own age might be a good mentor. On a connected note, a few people wanted younger mental health advocates, particularly those with experience of illness, to educate them.

Recommendations

"Make young people who have overcome/been through the same thing give advice/counsel others."

Give clear information about confidentiality, and offer anonymous support.

Confidentiality was seen as very important and mentioned by several people. Health professionals and teachers should be clear with the young person about what referrals are being made, keep them informed of what to expect, and ask their permission.

"Build trust. People are more likely to open up to you."

A few young people suggested that anonymous services are needed in order for some people to seek information and support, particularly if there are issues which give them concerns about confidentiality.

Listen to young people.

It is important for young people that they felt understood and people were empathetic about their situation. GPs need to be understanding, impartial and non-judgemental. Listening to and empowering young person is crucial.

"Focus on the needs of young people as they say it is, rather than the assumptions/perceptions of the people working on behalf of them."

"Ensure you understand the young person's predicament - try to put yourself in their shoes."

Make services friendly for young people.

Young people felt strongly that health professionals need to know how to talk to young people, and see them in a non-threatening environment. It's important that young people feel comfortable and trust the services they seek help from.

"You need a comfortable environment. Don't make it look *like therapy."*

"Don't have a pad and pen making notes, it feels clinical."

"Make the services young-people-friendly and build rapport"

Appendix 1: Survey questions

These are the questions used for the online survey. Very similar questions were used for workshops, though these took a more semi-structured approach.

1. How would you describe 'mental health'?

2. If someone told you they might have a problem with their mental health, or they were showing symptoms you were worried about, what would you do?

3. It's easy for young people to get information and advice about mental health: *Strongly Agree, Agree a bit, Disagree a bit, Strongly disagree, Don't know*

4. My school or college provides (or provided) good information and education about mental health: *Strongly Agree, Agree a bit, Disagree a bit, Strongly disagree, Don't know*

5. I would feel able to talk to my friends about my emotional wellbeing or mental health if I needed support: *Strongly Agree, Agree a bit, Disagree a bit, Strongly disagree, Don't know*

6. I would be able to talk to my parents about my emotional wellbeing or mental health if I needed support: *Strongly Agree, Agree a bit, Disagree a bit, Strongly disagree, Don't know*

7. I would be able to talk to my GP about my emotional wellbeing or mental health if I needed support: *Strongly Agree, Agree a bit, Disagree a bit, Strongly disagree, Don't know*

8. Is there anyone else you would speak to about your mental health?

9. If people knew I had asked for support around my emotional wellbeing or mental health, I would feel embarrassed: *Strongly Agree, Agree a bit, Disagree a bit, Strongly disagree, Don't know*

10. What advice would you give to the people who plan and run mental health services when they look at improving information and support for young people?

Appendix 2: Detailed demography

The table below outlines detailed demographics for the 114 young people that participated in this project; they are separated in columns according to the mode of participation.

Current or last school or college attended:

	Workshops (47)	Online survey (7)	Walworth Academy survey (60)
Southwark schools (77 pupils at 11 schools)			
Walworth Academy (Southwark)	1		60
St Saviour's and St Olave's - for girls, CofE (Southwark)	3		
The Charter School (Southwark)	3		
St Thomas the Apostle College - for boys, RC (Southwark)	1		
St Michael's Catholic College (Southwark)	1		
Notre Dame RC Secondary Girls' School (Southwark)	1		
Sacred Heart School - RC (Southwark)	1		
Harris Girls' Academy East Dulwich (Southwark)	1		
Harris Girls' Academy Bermondsey (Southwark)	1		
Bacon's College (Southwark)	3		
Ark Globe Academy (Southwark)		1	
Other South East London schools (15 pupils at 11 schools)			
Sydenham School - for girls (Lewisham)	2	1	
Forest Hill School - for boys (Lewisham)	2		
Platanos College (Lambeth)		1	
La Retraite RC Girls School (Lambeth)	2		
Lambeth Academy	1		
The Elmgreen School (Lambeth)	1		
Ravensbourne School (Bromley)	1		
The John Roan School (Greenwich)	1		
St Ursula's Convent School (Catholic Girls) (Greenwich)	1		
Crown Woods (Greenwich)	1		
Norbury Manor Business and Enterprise College for Girls (Croydon)	1		
Schools in North London (7 schools)	**8**	**1**	
No answer	**10**	**3**	

Appendix 2: Detailed demography

Borough of residence:

	Workshops (47)	Online survey (7)	Walworth Academy survey (60)	Total (114)
Southwark	18	2	43	63
Lambeth	7	2	2	11
Lewisham	3	1		4
Greenwich	2			2
Bromley	1			1
Croydon	1			1
Hackney	4			4
Islington	1			1
Waltham Forest	1			1
Newham	1			1
Tower Hamlets		1		1
Don't know			2	2
No answer	8		13	21

Age:

	Workshops (47)	Online survey (7)	Walworth Academy survey (60)	Total (114)
12 years	1			1
13 years	3		3	6
14 years	2		42	44
15 years	5	2	2	9
16 years	17	3		20
17 years	3			3
18 years	1			1
19 years	1			1
20 years	1			1
21 years	2	1		3
22 years	2			2
23 years	1	1		2
No answer	8		13	21

Appendix 2: Detailed demography

Gender:

	Workshops (47)	Online survey (7)	Walworth Academy survey (60)	Total (114)
Female	27	6	20	53
Male	10	1	30	41
Non-binary	1			1
Other	1			1
No answer	8		10	18

Gender status:

	Workshops (47)	Online survey (7)	Walworth Academy survey (60)	Total (114)
Cisgender	37	7	47	91
Transgender	2		2	4
Don't know			1	1
No answer	8		10	18

Sexuality:

	Workshops (47)	Online survey (7)	Walworth Academy survey (60)	Total (114)
Straight/heterosexual	33	7	45	85
Lesbian/gay/homosexual			1	1
Bisexual	3		1	4
Asexual	1			1
Other	1		1	2
No answer	9		12	21

Length of time in UK:

	Workshops (47)	Online survey (7)	Walworth Academy survey (60)	Total (114)
Whole life	32	3	37	72
Less than 18 months			2	2
2-5 years			4	4
6-10 years	1	1	4	6
More than 10 years	3	3	1	7
No answer or unclear	11		12	23

Appendix 2: Detailed demography

Ethnicity:

	Workshops (47)	Online survey (7)	Walworth Academy survey (60)	Total (114)
British unspecified	1		2	3
White British	1		3	4
White European	1		1	2
White unspecified			2	2
White other			1	1
Black [British]	3	1	7	11
Black African [British]	8	2	14	24
Black Caribbean [British]	9	1	1	11
Black other	1		2	3
Asian, South Asian, Bangladeshi, Bengali, Pakistani or Indian [British]	4	2	4	10
Turkish [British]	1		2	3
Mixed White/Black	4		1	5
Mixed Black/Asian	1			1
Mixed - White British/Irish	1			1
Mixed unspecified	1		2	3
Mixed other	2		1	3
Other or insufficient detail		1	6	7
No answer	9		11	20

Refugee status:

	Workshops (47)	Online survey (7)	Walworth Academy survey (60)	Total (114)
Not a refugee/asylum seeker	35	6	36	77
Refugee or asylum seeker		1	4	5
No answer	12		20	32

Appendix 2: Detailed demography

Religion:

	Workshops (47)	Online survey (7)	Walworth Academy survey (60)	Total (114)
Christian	22	4	19	45
Muslim	4	2	12	18
Sikh	1			1
Pagan	1			1
Jewish			1	1
Atheist	2			2
None	4	1	6	11
Christian/Muslim (haven't decided)			2	2
Don't know	1			1
No answer	12		11	23

Disability:

	Workshops (47)	Online survey (7)	Walworth Academy survey (60)	Total (114)
Not disabled	34	7	47	88
Disabled	3		2	5
No answer	10		11	21

Being looked after:

	Workshops (47)	Online survey (7)	Walworth Academy survey (60)	Total (114)
Have not been looked after (in care)	31	6	42	79
Are of have been looked after (in care)	4		7	11
No answer	12	1	11	24

'Do you care for somebody else who has an illness or disability?'

	Workshops (47)	Online survey (7)	Walworth Academy survey (60)	Total (114)
No	25	7	28	60
Yes	11		16	27
No answer	11		16	27

APPENDIX 2

healthwatch Southwark

Healthwatch Southwark

Young voices on sexual health

November 2016

Contents

Background and what we did

What is Healthwatch?

Healthwatch is an independent health and social care champion for local people. This means we represent your views to ensure services are shaped around your experiences and designed around your needs. We are the 'critical friend' to people who plan, provide and fund care.

We are part of a wider network of local Healthwatch across the country, as well as a national body, Healthwatch England.

Why speak to young people?

We want everyone's voices to count towards improving services. Young people often do not get an opportunity to share their experiences so we wanted to engage specifically with them. We wanted to understand the challenges they face so that we can inform commissioners and providers who offer services for young people what they can do to improve the experience and access of young people using their services.

Why talk about sexual health?

Sexual health care is one of our priorities. Sexual health continues to be a challenge in Southwark and services are under pressure. According to the Lambeth, Southwark and Lewisham (LSL) Sexual Health Strategy 2014-2017:

- Sexually Transmitted Infection (STI) rates across Lambeth, Southwark and Lewisham have continued to rise locally.
- In Lambeth, Southwark and Lewisham, diagnoses of gonorrhoea continue to be high.
- Lambeth and Southwark have the highest prevalences of HIV in the UK.
- Lambeth, Southwark and Lewisham have high teenage conception rates relative to London and England.
- All three boroughs have high abortion rates relative to England and London, and high rates of repeat termination.

We also know that there are plans to change provision of sexual health services. We therefore wanted to understand the experiences of young people when accessing sexual health information, education, support, services and advice.

How we reached young people

Workshops

We connected with community and voluntary sector organisations that offer services for young people, and visited groups. This enabled us to reach young people from a variety of backgrounds and ages in spaces they are familiar and comfortable with. We also felt that because some of the young people were already familiar with each other in the

Background and what we did

workshop they might feel more able to open up.

We ran six workshops where we asked young people to respond to statements by showing cards or moving about in the space. Whilst we noted how many agreed with each statement, our main aim was to provoke discussion and explore themes which were important to the young people in a semi-structured way. We have recorded where views were shared by many young people, or lone voices; sometimes a view was expressed by a handful of people but others were not probed as to their reaction. It was clear that the makeup and experiences of certain groups created distinct dynamics and we have also tried to reflect this in the report.

Whilst we reached fewer young people through the workshops than via online surveys and a survey at Walworth Academy (see below), we found that the discussions held in this format yielded much more detailed, qualitative insights.

Online

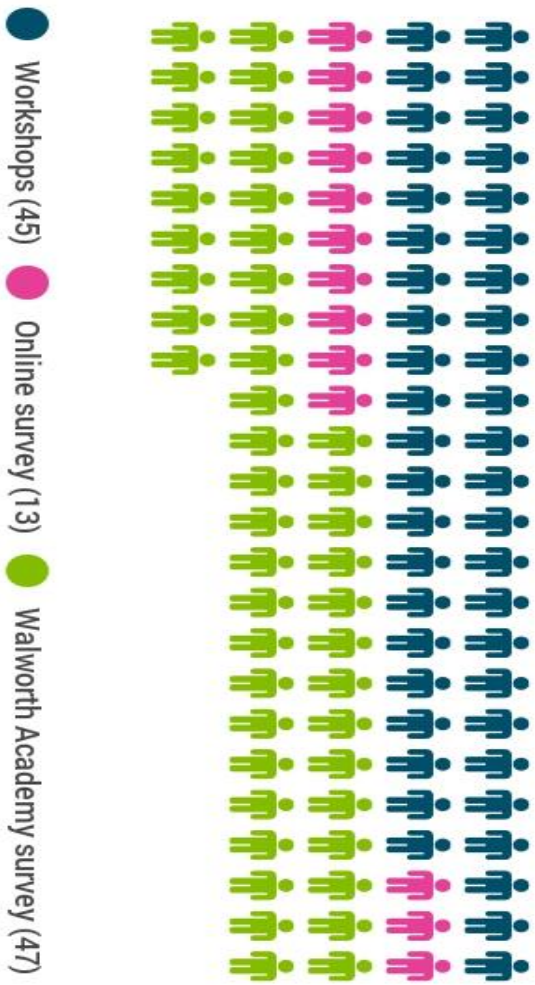
A parallel survey containing mostly the same questions was put online so that we could promote and distribute it via our website, twitter and e-newsletter. We encouraged partner organisations to cascade the survey through their networks to reach a wider audience.

Survey

We sent paper copies of the survey to Walworth Academy (a Southwark secondary school), with which we had a relationship. We gave the school one week to distribute the surveys on the last week before summer break.

While findings from the workshops and online survey are grouped together, findings from the Walworth Academy survey are presented **separately in green boxes** because we are aware that a large number of responses from students at a single school might well skew overall findings.

In total, 105 young people participated in this project:



Background and what we did

We do not claim that this report fully represents the views and experiences of all Southwark's young people – indeed, no report could.

However, we believe it is important to spend time building a dialogue with young people and hearing their views in depth, rather than simply focusing on large-scale capture of often more simplistic quantitative data.

Every voice counts and even if only a minority of people, or a particular group of people, report a problem in the health and social care system, this should be addressed wherever possible.

The recommendations presented in this report were suggested by young people themselves. They are broad areas and we welcome any opportunities to discuss how they can be translated into concrete actions for different agencies working together, and what resources would be needed to accomplish this.

Demographics

Please see Appendix 2 for detailed demographic data.

School

- 54 young people had been or were currently students at 5 Southwark schools and colleges.
- 20 young people had been students at 15 other South East London schools.
- 9 students at 6 North London schools.
- 7 people educated abroad.
- 15 people did not tell us.

Borough of residence

- 12/58 of our online and workshop responses and 37/47 of our Walworth Academy student respondents were Southwark residents – in total 58% of those whose home borough we know.
- 24 were from other South East London boroughs.
- 11 were residents of North London.
- 21 people did not tell us / didn't know.

Age

- Range from 13 to 25 years.
- Clusters at 14 years old (Walworth Academy survey) and 16 years old (Healthwatch hosting young volunteers through the HeadStart post-GCSE programme).

Gender

- Ratio of female to male participants - 56:34.
- 1 person was gender non-binary.
- 14 did not specify.

Gender status

- 4 people were transgender and 1 did not know if they were.
- 85 were cisgender (identified with the gender they were given at birth).
- 15 did not respond.

Sexuality

- 79 were straight/ heterosexual.
- 7 were bisexual.
- Only 1 said they were gay/lesbian/homosexual, highlighting an area for future engagement.
- 11 people did not state their sexuality.

Ethnicity (self-described)

White British (4), White European/other (5), Black British (15), Black African/African British (20), Black Caribbean/Caribbean British (6), Black other (2), Asian, Bangladeshi, Bengali, Pakistani or Indian [British] (7), Middle Eastern or Turkish [British] (4), Latin American (7), Mixed (9), Other or insufficient detail (11), Not specified (15).

Length of time in UK

Demographics

- 60 people said they had lived in the UK all their lives.
- 7 had been here over 10 years, 5 between 6 and 10 years, 6 between 2 and 5 years, and 10 less than 18 months. At least 4 were refugees or asylum seekers.
- 17 gave no answer.

Religion

Christian (41), Muslim (16), Sikh (1), Jewish (1), pagan (1), spiritual (2) and atheist (2), and no faith (11). 1 had not decided and 29 gave no answer.

Disability

- Only 3 respondents said they had a disability (including academic challenge and autism) - this highlights another gap for future engagement.
- 86 said they had no disability.
- 16 did not specify.

Looked after

At least 11 respondents were or had been 'looked after' ('in care').

Care for someone

24 people said they 'cared for someone else who had a disability or illness.' It is unclear whether all of these people were 'young carers' in the practical sense.

Knowledge of sexual health

Do young people know how to protect themselves?

"I feel confident that I know how to protect myself from sexually transmitted infections (STIs) or unwanted pregnancy"

What young people told us from workshops and the online survey...

- 49 people agreed with this statement
- 2 people disagreed with this statement
- 6 people weren't sure whether they agreed or disagreed

We wanted to find out how confident young people were in the information they had been given about sexual health, and then to test how extensive and accurate their knowledge was.

Interestingly only two people outright disagreed that they knew how to protect themselves, and they had both been educated at first abroad and were both Trans. They told us young people get different messages - ***"the Church says no sex until you're married"*** - and that sex education at school was too basic and covered only condoms and the Pill. The other five workshops managed to list, between their participants, a range of methods of protection, as did the thirteen online survey respondents.

All of the workshops and twelve online respondents mentioned condoms. One workshop mentioned male and female versions. A few workshops mentioned coils/IUDs, patches, injections and the Pill. Individual participants mentioned the vaginal ring, cap, and morning after pill.

Two workshops and one survey respondent suggested abstinence, ***"self-control"; "Wait until you're married to have sex so you know them better and have trust."***

One workshop remarked that they were aware they could get free contraception from the GP or their college. However in another workshop, only one person of five had heard of C-cards (a scheme for 13-24 year olds to access free condoms), and others responded, ***"We just haven't been educated enough."***

In one workshop there was emphasis on limiting the number of partners, possibly relying on this rather than condoms in some cases. There was some implication that there are certain 'types' of people to be avoided, though several young women wanted evidence of their

Knowledge of sexual health

partner's sexual health test results, ***"When I meet a partner, I go and check before anything. I am very cautious."*** One male said he would rather see the girl take a pill each day than use a condom.

Some people told us they had limited knowledge - ***"condoms - and that's pretty much it."*** One online survey respondent also listed the ineffective 'pull-out method'.

There were mixed views on whether in practice people protect themselves, with one saying - ***"There is a difference between knowing and doing."*** Past experiences might play a role - ***"I've been clapped [had gonorrhoea] twice, it was really scary, now I'm much more picky about who I go with."***

What students at Walworth Academy told us...

22 people
agreed with this statement

7 people
disagreed with this statement

4 people
weren't sure whether they agreed or disagreed

Influences on sexual behaviour

Social media and technology

"Social media and new technology influence how young people behave sexually"

What young people told us from workshops and the online surveys...

- 38 people agreed with this statement
- 1 people disagreed with this statement
- 8 people weren't sure whether they agreed or disagreed

Before discussing education, we wanted the participants to consider various influences and the ideas about sex which are presented to them.

Many young people noted how easy it was to post or find sexual content on social media:

- ***"On Snapchat it is easy to post nude photos"***
- ***"Twitter don't block porn"***
- ***"Tumblr is anonymous and you can easily see some porn on there"***

People also mentioned the media content they might see, ***"Music videos are so explicit"***.

The vast majority of people agreed that social media influences young people in their sexual behaviour, with some saying ***"100% agree!"*** or ***"110%!"***

Some felt ***"not everyone is the same"*** - with vulnerable people more likely to be influenced. People in three workshops said younger teens were more impressionable and also exposed to more media: ***"Younger people are affected more by societal pressures. If you are older, 18 to 19, you know who you are more."*** One also pointed out ***"Maybe if social media doesn't affect you it can affect people around you, which then affects you."***

Most of the described impacts of social media on sexual behaviour were negative. It was agreed by most that pornography can be hard to avoid. Several were unhappy about this - ***"even on Twitter it is easy to stumble across some stuff that's not necessarily illegal but you didn't want to see."***

Some participants thought that most young people got their knowledge of sex through porn. They felt porn could change people's expectations of sex - ***"they see it and want to make it happen in real life."*** People in two workshops (one of which was all-female) felt that porn had a negative effect on gender expectations:

Influences on sexual behaviour

- ***"Boys praise porn where boys are dominant - like pulling the girl's head by the hair and holding it back"***
- ***"Boys… watch videos and they think that is how you do it. It makes it look as though the girl gets pleasure [from that]."***

One person also felt that porn could affect sexual health, ***"It might encourage people to do things and they don't know how to do them safely."***

Some even more worrying elements of pornography were also mentioned - revenge porn and the mobile app Periscope, ***"It's dangerous, it's live filming. I heard someone streaming a film of kids having sex."***

One person felt the ease of connecting with people could be a risk, ***"Boys love to peer pressure girls - older boys take younger girls and call them their 'young tings' and you know what they want from them when they say that. They talk to them via social media, and boys may choose these girls based on their Instagram pictures - some look much older than they really are."***

The false images presented on social media were also mentioned in three other workshops – ***"This is the selfie generation. Social media is image-focused. It puts a fake image in people's heads."*** People felt this could make young people insecure. Several online survey respondents also commented on the combination of personal image and overt sexuality on social media, ***"Young girls twerking online. It's a shame that most role models like Kim Kardashian portray sexual images."***

Finally, people commented on unrealistic or narrow depictions of relationships:

- ***"Music videos portray heteronormative relationships"***
- ***"On social media…they show drama, in relationships that aren't really realistic."***

What students at Walworth Academy told us...

One person agreeing said that ***"Peer pressure, adults, have a strong influence"*** and another gave the example of twerking. However, another felt, ***"Noone can tell you what to do."***

Influences on sexual behaviour

Other influences on sexual behaviour

Three workshops talked about cultural and religious norms. One person compared the UK to their previous home in West Africa, ***"In the UK you're much freer to be and do what you want. In [country], people have to keep to themselves, so they don't talk so much and are not aware of the consequences or side effects."***

In another workshop several people expressed the feeling that sex was largely accepted, even expected, nowadays – ***"As we get more liberal, more young people do hook-up type relationships."*** People in one group told us that whilst many young people locally belong to religions which disapprove of sex outside marriage, this advice was often ignored – ***"Sex is just an expectation. No matter if you are religious."*** However, people also noted that it can be difficult to find approval - ***"You have to balance between being a slut and being a prude – it's tough."*** This tension was also evident in another workshop where people discussed sexual 'reputations'.

Drugs and alcohol were mentioned as an influence by people in two workshops – ***"People at my school…have access to alcohol and drugs and make silly decisions."*** One person connected this to the influence of friends – ***"people can have friends that are partying and taking drugs."***

Other influences on sexual behaviour were mentioned:

- Peers and friends
- Family/parents
- Magazines
- Music and music videos
- TV (such as reality shows) and movies – ***"there is uncensored stuff, it looks realistic"***
- Celebrities (such as rappers)
- Parties
- One's image in the mirror
- The opposite sex.

Getting information

At what age should young people be educated about sexual health?

We asked the participants to tell us, bearing in mind all the influences already discussed, at what age they thought children and young people need to be educated about sexual health.

Some felt that early sex education was important:

- ***"Some people start puberty early on, they get curious"***
- ***"People get pregnant at stupid ages so you need to have sex education in primary school...just not go into full-on detail."***

Others felt strongly that they had been taught too young, and found it uncomfortable:

- ***"It was just too much"***
- ***"We got shown condoms, and some teachers gave a lot of detail, in primary school. I was a bit traumatised!"***
- ***"If you know about stuff you then become more curious. Primary school is too young."***

Suggestions for an appropriate age for sex education made in the workshops ranged from year 6 (age 10/11) to year 8 (age 12/13). Online suggestions ranged from age 7 to age 14.

One workshop participant explained their reasoning for suggesting age 11/12 - ***"Some people realise at 10. I read a report that said in the UK most kids have seen porn by the time they are 12. And there is the influence of Facebook and Twitter - these do influence people and they can stumble on stuff about sex."***

People in all workshops felt that sex education should be taught in stages:

- ***"My own child is in year 5 (age 9/10), they come home talking about kissing and love, I tell them about some things, bit by bit"***
- ***"At year 4 (age 8/9) they should start at boys liking girls and girls liking boys and then build up".***
- ***"These shouldn't be a one-off, we need refreshers."***

One participant felt that parents are the best judges of when an individual is ready for sex education, ***"some are ready for it in year 6 (age 10/11) but it's individual and their parents might disagree."***

In two workshops, several people stressed that the emotional/social aspects of relationships should come first:

- ***"Consent should be taught very early on"***
- ***"They should start with good relationships, it's the wrong way round now - you get the sex stuff early but not relationships, which you get in year 11 [age 15/16], and by year 11 people have been beaten, had abortions, had their hearts broken!"***

Getting information

Ease of finding information and advice about sexual health

"It is easy for young people to get information and advice about sexual health"

What young people told us from workshops and the online surveys...

- 38 people agreed with this statement
- 5 people disagreed with this statement
- 15 people weren't sure whether they agreed or disagreed

We asked participants whether they thought young people can get information and advice about sexual health. We then discussed where they get information.

While most people said it was easy to get information, some felt that they had not even had the basics, ***"All I want to know is how to be safe, I don't think I have been taught."***

Several felt that information was available only to those who actively sought it out:

- ***"There are still misconceptions about a lot of things. It's only there if you look"***
- ***"People might know where to go but might feel uncomfortable or scared."***

People in four workshops mentioned school as a source of information, with mixed views. Some for example said school was the best way of getting information and easier than talking to parents, whereas others had not found their school's sex education programmes effective or detailed enough (see below).

Three of the eight online respondents who said it was easy to get information mentioned school, the school nurse, or assemblies, one writing, ***"this makes it easy because everyone is receiving the same information at the same time so it's not embarrassing."***

Individuals in two workshops mentioned leaflets, with one saying ***"they teach in a friendly way"***, but another said that ***"leaflets are overdone and people don't get time to sit down and read it."***

Another person mentioned TV publicity, but in a negative way, ***"Adverts on TV are uncomfortable when watching with parents."*** One person online suggested books.

Getting information

People in one workshop talked about family and friends as a source of information, with mixed views about whether they could talk to their parents (again see below). Of the eight online respondents who said finding information was easy, two mentioned asking friends, one ***"dad"***, and one ***"boyfriends."***

Three groups discussed **sexual health services** as a source of information, all positively. This merged into discussions about where young people would seek support if they had an actual sexual health concern – see pages 21-23 for detail.

The internet

Four of the workshops mentioned online information. In one workshop, participants said they would use the NHS website. In another, one person named the website 'Sexperience'.

In the online survey, when asked what websites they would go to, respondents mentioned NHS, Google, and with one saying - ***"To legit websites that I have heard have great advice."***

However, in one workshop, no one was positive about information available online, with some being afraid they would find porn and others sceptical about information - ***"Online, things are mis-portrayed. You might get some info but you might get trash, you don't know."*** In the online survey, one person said that it is hard to get information - ***"as the popular source that is not embarrassing to go to is the internet, which has many opinions and a few false facts about sexual health if someone doesn't go to a right website."***

What students at Walworth Academy told us...

People who agreed with the statement said:

- ***"There are GPs and information everywhere."***
- ***"By asking your mum or carer."***
- ***"We have workshops in school."***
- ***"There are places to go."***

Sexual health education in schools

"My school or college provides/provided good information and education about sexual health"

Getting information

What young people told us from workshops and the online survey...

27 people agreed with this statement

22 people disagreed with this statement

5 people weren't sure whether they agreed or disagreed

We asked young people whether their school or college provided them with good sex education. Overall, there was a lot of variation in how much sex education different schools had provided.

A couple had covered only puberty and gave little else. Others had focused on avoiding teenage pregnancy - ***"they emphasised 'don't get pregnant'… it was really basic. I was really surprised, I was expecting something a bit deeper."*** This person would have liked detail on types of infections (STIs) and how they are transmitted, and where to go for help.

However, some covered sex education a lot – ***"Our school was always talking about sex - on four out of our five PSHE days. It kind of felt like they were promoting you to have sex!"*** One person said they had benefitted from a sexual advisor coming in, and another had received a good information pack.

Among online survey respondents, examples of information provision in schools were sex education lessons, presentations, assemblies, ***"several talks"***, and ***"getting people from outside of school to come and talk about it."***

Participants in at least three workshops attributed their schools' reluctance to provide sex education to religion or culture:

- ***"Our school was scared - it was a church school - they didn't want to promote it so just touched on it"***
- ***"In some cultures it's shameful to have sex, so schools are worried about talking about it."***
- ***"The only time we touched on sex was in RE [Religious Education], about sex being wrong outside marriage."***
- ***"I went to a Catholic school [possibly abroad]. There was one lesson on sex and it was…tragic! Someone in the class said you couldn't research information about sex before you're married or it'd make you gay, and the person who came in to give the talk nodded. It discouraged me from listening to them any further."***
- ***"It was more 'don't do that', rather than education."***

Getting information

What students at Walworth Academy told us...

Some who agreed with the statement mentioned workshops and ***"classes on SRE* [sex and relationship education] *which help a lot"***, whereas someone who disagreed wrote, ***"They skim through these topics."***

Quality of discussions in schools

Teachers' discomfort with the topic of sex was mentioned in a few workshops:

- ***"He didn't want to talk about it and kept using euphemisms."***
- ***"He felt uncomfortable which made us feel uncomfortable."***
- ***"Our teacher was all [trying to be cool] 'let's talk about sex!' I didn't like it, I'd rather read about it".***
- ***"One teacher phrased it as 'when a man has intercourse with a woman' - that's not how people talk about it!"***
- Girls in a workshop said that having a male teacher had been unhelpful - ***"he didn't really understand the female perspective, and school didn't make an effort to get a woman in."***

The one online survey respondent who disagreed that their school had provided good education said it had been limited and repetitive, ***"we were taught about the same topics by different visitors instead of learning new things."***

Among one workshop group there was a strong sense that sex education should be the responsibility of parents, and that they would not want schools teaching their younger relatives about sex. This view was connected to poor experiences of sex education among the group:

- ***"Teachers don't teach it well - I'd rather do it myself at home"***
- ***"You can't trust teachers, they say the wrong thing"***
- ***"Schools sometimes mislead you. We never got taught properly."***

However, one person had seen the Channel 4 programme *Sex in Class* about a Belgian educator's controversial approach, and said that if schools in the UK could deliver education like this, they would be in favour. Everyone also agreed that healthy relationships and basic biology should be taught.

Education about healthy relationships and gender roles

Getting information

In most of the workshops we also discussed whether young people were educated about healthy relationships. People from four different schools said that they were, though this was not always adequate – ***"They did mention healthy and unhealthy relationships but didn't go into what that meant"***. One of the schools had covered domestic violence in preference to comprehensive sex education. Another had covered the topic, but in year 11, which was seen as too late. One person had received more, ***"I had a lesson on consent - yes means yes, and no means no. Also had a session on porn and addictions."***

Other schools did not cover this topic – one person said - ***"Young people should be taught the signs to spot relationship abuse, not just physical."*** Another said that schools should help address 'rape culture' – ***"the victim tends to be a girl and she gets blamed for what she wears or for drinking. There's a lot of pressure on girls."***

Some Latin American young women said that they felt they had been taught more about consent back home than in England. They felt schools should cover healthy relationships (trust, communication, respect, consent) in mixed-sex classes - ***"teach boys how to treat girls. They let boys do what they want."*** Two individuals said they thought schools placed unfair pressure on girls to take responsibility around preventing teenage pregnancy.

Of the twelve online respondents who answered this question, seven said that they do get information on healthy relationships, with one specifying ***"in PSE and citizenship"***. A further three said they get some information, ***"in school sometimes"*** and ***"a little"***. However, two had had no information or ***"not as much information as I would like to have."***

Education about sexual orientation

Thought we did not have time to ask about this in all groups, we asked Trans/bisexual young people whether schools had provided education about non-heteronormative relationships. Both participants said that they had not, and agreed with each other that teachers are not very educated about sexuality and identity and tend to assume all pupils are straight. They agreed when their youth worker said that even good sex education does not usually cover asexuality. However, one person in another group said, ***"Our school talked about sexuality more than sex in general - they showed the same video over and over."***

Support from those close to a young person

Talking to friends

"I would feel comfortable speaking to my friends if I needed to talk to someone about my sexual health"

What young people told us from workshops and the online survey...

34 people agreed with this statement

11 people disagreed with this statement

9 people weren't sure whether they agreed or disagreed

We asked young people whether they felt able to speak to their friends about their sexual health. While the majority felt they were able to talk to friends about sexual health, some were adamant that sex was private and not to be discussed outside the relationship - ***"It's not their business, it's for me to look after myself"***.

A few even said that their friends' reactions might be negative:

- ***"You could ask them a serious question but they could joke about it"***
- ***"My friends destroy my thoughts about sexuality. They talk about sex in lots of detail and are very open so if you don't have the same mentality you can get scared."***
- ***"Some people can be judgemental. What if they didn't want to be your friend anymore?"***
- ***"If it was something bad they might tell someone."***
- One young Trans person said, ***"I couldn't really - I still feel shame."***

However, in one workshop, while one individual said, ***"It's intimate. If someone asked me I wouldn't lie, but sex is personal to me"***, many of the others in this workshop were very surprised, even sceptical, about this view. Their views included:

- ***"It's not a big thing any more like it was back in the day. People are like, 'oh yeah you had sex, did you enjoy?!'"***
- ***"Everyone's doing it no one's going to get called slutty."***
- ***"Once you're age 15+, people see it as acceptable."***
- ***"My friend turned 16, we gave her condoms and a thong."***

Another individual said that if they got pregnant they would want advice from friends about how to tell their parents. Reasons given online for talking to friends included ***"they give advice"***, and friends being trustworthy, reliable, and good to

Support from those close to a young person

confide in - ***"certain friends who I trust, I can tell anything."***

Individuals in two groups did point out that asking friends for actual information might not be helpful, ***"I don't think many would understand [i.e. have knowledge] - they're all in the same boat."***

What students from Walworth Academy told us...

- 23 people agreed with this statement
- 16 people disagreed with this statement
- 7 people weren't sure whether they agreed or disagreed

Talking to parents

"I would feel comfortable speaking to my parents if I needed to talk to someone about my sexual health"

What young people told us from workshops and the online surveys...

- 18 people agreed with this statement
- 22 people disagreed with this statement
- 15 people weren't sure whether they agreed or disagreed

We asked young people whether they felt able to speak to their parents about their sexual health. We received mixed responses.

Fewer people felt comfortable talking to parents about sex than to friends. Reasons given included feeling uncomfortable or embarrassed or that it was not appropriate:

- ***"If I was pregnant I would have to tell them. But if I was having sex I just wouldn't feel comfortable"***
- ***"I don't have trust or that connection to talk to my parents"***
- ***"[I'm a] very private person"***
- ***"My parents aren't open about that stuff."***

Several people recognised that ***"Parents find conversation difficult. They were not exposed to sex as much as we are. My mum tried to talk about it but just laughed as she was embarrassed."***

Support from those close to a young person

Some parents were unwilling to discuss sex at all:

- ***"When I was younger my mum made up a story of how babies were born instead of telling me the truth"***
- ***"I had a 'military' upbringing at home, never talked about it - got pregnant, kicked out of school, became an adult."***
- Several (aged 15/16) said their parents saw them as too young - ***"They think I'm too young to talk about stuff like that...they have a mentality of back in the day."***

In several cases parental opposition to sex, as well as to talking about sex, was connected to culture:

- ***"My parents are [South American nationality]. We don't talk about stuff like that. We don't have that connection. It's a taboo."***
- ***"Having Bengali and Muslim parents, sex or relationships is a big no. If I did I would be out of the house."***
- ***"Not in my house. The word sex doesn't exist. My parents are traditional African - I can't tell them if I have a boyfriend."***
- ***"My parents make jokes like 'you gonna marry a Ghanaian and cook for him', but I know if the real thing happened they'd be like, 'get out!' My dad would go on a mad one."***

Some parents were seen as prying too much, ***"I wouldn't tell, but my mum finds stuff out… I can't hide stuff from her. I don't like this… She'll search my dustbin!"*** An online respondent felt that though they could talk to parents about anything, ***"they may get a little too nosey".***

However, one person said that they appreciated their parents' concern - ***"if I have a boyfriend, I'll tell [Mum], and every week she'll ask if I'm sexually active/pregnant. She's not too hard or too soft on me, and she's quite young, so I'd feel I can tell her. It's a bit annoying but I know why she's asking."*** Another person responded, ***"I wish they did [check in with me]!"***

A few others would also feel able to talk to their parents, with one saying they could always talk to their mother, another that their parents ***"always used to talk about it from a very young age"***, and another ***"I would just say "Mum I got a problem!'*** One person explained, ***"My mum tells me. She's cool. She had me very young. When she talked to me about periods she told me about sexual health."*** One online respondent said, ***"My parents can give me the best advice and are there for support."***

One group made up entirely of girls, several of whom said they were from traditional African families, discussed differences in how parents deal with the sexuality of daughters versus sons. Many thought that boys were given more freedom:

- ***"It's a double standard - they accept boys bringing girls home. She's a slut, he's a boss."***

Support from those close to a young person

- *"If my female cousin brings a boy home she gets cussed, but for her brother, my auntie just told him firmly 'no means no' [about consent] and that's it."*
- *"Some boys I know have sex in their parents' house if their parents are away; they talk more freely with their parents. Parents just say, 'be careful, don't get her pregnant.'"*

What students at Walworth Academy told us...

Support from professionals

Talking to professionals

"I would feel comfortable speaking to a health professional if I needed to talk to someone about my sexual health"

What young people told us in workshops and the online surveys...

34 people agreed with this statement

6 people disagreed with this statement

14 people weren't sure whether they agreed or disagreed

The majority of people said they would feel comfortable speaking to a health professional. Some explained that they trusted professionals' advice:

- ***"They are more experienced"***
- ***"They have the knowledge"***
- ***"They know what advice to give."***

Others explained why they did not feel too embarrassed:

- ***"The doctor is there for advice, it's not personal so they won't care"***
- ***"That's their job, to make you feel comfortable - though some do judge"***
- ***"If they are experienced they make you feel comfortable."***

However, some others would not find this so easy, with one even saying, ***"Unless I was really worried or dying I wouldn't go to a doctor. I don't want to be judged"***. A young Trans person also said, ***"I'm not sure. I think I'd have issues with that. I still feel ashamed."***

One person suggested, ***"Boys don't like to get tested - they think they'll stick something in [their urethra]. But I don't think that's true!"***

Three people mentioned concerns about confidentiality – ***"The doctor I go to has a big mouth so my parents would find out."*** Another said they would not see their school nurse – ***"they're not trustworthy. A sexual health nurse is more professional."*** There was confusion about whether a school nurse could or would break confidentiality.

Some Latin American young people found language a barrier - ***"The only boundary is the English. I would feel more comfortable if the doctor could speak the same language, rather than use a translator."***

Support from professionals

What students at Walworth Academy told us...

24 people agreed with this statement

16 people disagreed with this statement

6 people weren't sure whether they agreed or disagreed

People who felt they would be able to talk to professionals said, ***"They can help"*** and ***"Yes, 'cause they got advice."*** However, who disagreed said they were ***"not close to them."***

Choice of services

Online respondents were asked to specify which professionals (out of GP, practice nurse and sexual health clinic) they would prefer to go to if they needed to talk to someone about their sexual health. Seven chose clinic staff, one adding ***"they know their stuff"***. Three people said they would go to the GP and two said the practice nurse.

This was discussed more broadly in workshops. When asked whether they would talk to a professional, people in two workshops said spontaneously that they would go to a sexual health clinic, and many had good awareness of these. One person said ***"I would ask the doctor, not sure if I would ask the pharmacy."*** Few participants were aware of pharmacies offering sexual health services.

One workshop also discussed whether they would rather go to the GP or a clinic. They agreed that waiting times for GP appointments were too long - ***"it takes a month, and you aren't going to wait a month to have sex!"***

However, if this were different, a couple of people would choose their GP - reasons given were:

- ***"They know you, it's easier, more personal, you feel more comfortable"***
- ***"At the clinic everyone just stares and looks shy, you all sit in there together"***
- ***"In a clinic it is obvious what you are there for."***

Others would prefer the clinic because:

- ***"It's straightforward - you just go in and out"***
- ***"It's an effort to go to the GP, and when you are there they don't know what they are doing."***

How well the young people knew the health professional would influence where they would seek help. A couple of participants specified that they preferred to see a professional with whom they had no long-term relationship, ***"If it's a doctor I have seen for months and we have a***

Support from professionals

relationship then I wouldn't feel comfortable to talk to them". However, another would prefer someone they knew, ***"If it was the same GP all the time then maybe, but this isn't likely."***

Some groups discussed their personal interactions with different professionals. One felt, ***"I wouldn't talk to the GP - they're not nice. But people in the sexual health clinic at least some of them are nice - some are rude but some are nice."*** Another person from this same workshop shared a poor experience at the sexual health clinic, feeling judged, ***"When you're young, they're really nice to you… but when you're our age [19] then they're like, why are you here? They're disrespectful...After a certain age they make it harder to get help. The older you get they expect you to come less. When I come and need help, don't scare me and judge!"***

Sexual health clinics

Some practical considerations at different sexual health clinics were discussed by one of the groups.

One said, ***"Going to Brook is the easiest way to get information."*** One participant said of Brook, ***"I only found out last month that it was a sexual health clinic - but that makes it less embarrassing [because it's discrete]."*** Another agreed, ***"Yes, if it's too hidden people won't get checked out but if it's too obvious, they're scared. Brooks gets it about right."***

The Camberwell clinic, in contrast, was seen by some as less private – ***"it's a busy area with loads of buses and near Nando's. There's a sign saying free condoms. You have to walk past a few times before going in, to check no-one is going to see you!"***

The young people mentioned a clinic where there was a young people's drop-in on Wednesdays and liked this – ***"It's good there's a young people session because I went [to another clinic] with my friend, both in school uniform, and everyone was looking down on you [for being young]."***

Two people mentioned queues and opening hours, saying, ***"When I went seven months ago the queues were long."***

Embarrassment and stigma

Embarrassment and stigma

"If people knew I had asked for support around my sexual health, I would feel embarrassed"

What young people told us in workshops and the online surveys...

- 15 people agreed with this statement
- 16 people disagreed with this statement
- 11 people weren't sure whether they agreed or disagreed

We asked young people whether they'd feel embarrassed if people knew they had asked for support on their sexual health. We received mixed responses.

A few people were afraid of word spreading about them seeking help, and of judgement:

- ***"If they knew they might tell other people"***
- ***"If you go people assume things."***

Reasons given online for feeling embarrassed included - ***"that is private information, no one should know about it"***, and ***"they would jump to conclusions"***. Reasons connected to social judgments were ***"they would feel you are too sexually active"*** and ***"having problems, especially sexual health, connotes having slept around and contracting STIs."***

Some were less worried:

- ***"Hell no, I don't care what people think!"***
- ***"It's human nature, you can't beat yourself up."***
- One person pointed out that going to the clinic was responsible, ***"when you go you set a good example to other people"***.
- Another online respondent agreed, ***"I shouldn't feel embarrassment for wanting to know if my sexual health is ideal. It's my body and I need to take care of it."***

Several people felt that embarrassment levels were down to personality, and sometimes age – one felt ***"the older you are the less embarrassed"***, but another ***"no, then you understand more so people talk."***

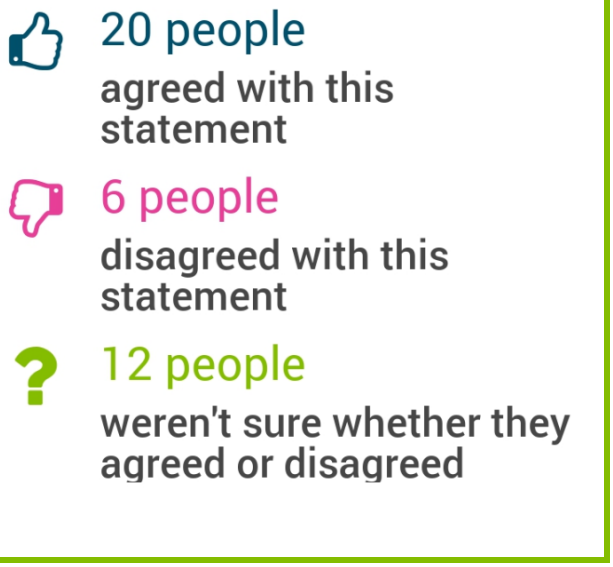
One young Trans person had mentioned shame as a reason for not talking to friends or medical professionals about sexual health. We discussed this further - ***"Maybe that has something to do with my home country - there is a lot of stigma around being Trans. People think Trans people are perverts - and***

Embarrassment and stigma

if they have sex, they're even more perverts. So maybe I feel like a pervert myself."

Another young person agreed about the impact of growing up in a different country, *"In [home country] you couldn't talk about not being straight. There'd be serious punishments…. I think you do become more comfortable after a while [being in this country]. After my first few sexual experiences I did feel really bad, I thought God was going to send me to hell. It takes a while to feel comfortable in your body."*

What students at Walworth Academy told us...



Recommendations

We asked young people what advice they would give to those who plan and run sexual health services when they look at improving information and support for young people, and reducing embarrassment about seeking help.

Bring experts in to schools to deliver sex education.

The expertise and skills of the person delivering education are crucial. The large majority of the young people we spoke to wanted external experts to come into schools to talk to them, because they felt this was more comfortable and because the speakers would be better informed and prepared to deal with the topic.

"I'd prefer professionals to come in because you can't ask a leaflet questions."

"They should come into schools to talk about their service and run activities and workshops to make young people aware."

"Nurses know what they are talking about."

Be creative and engaging with sex education.

While some young people felt that it was simply a case of more sex education being needed, most focused more on the quality of education in schools, saying it needed to be more engaging, interactive and effective. Ideas included asking young people about their pre-existing knowledge, much more discursive sessions and multimedia approaches.

"Sex ed should be a discussion not a lesson."

"Make their visits more intriguing, show us a film, get icons to visit the school and teach about sex (e.g. rappers, actors)."

"They should have ads on buses. Like when they did the anti-smoking campaigns and you could see the decay inside the lungs - people need to see the disease, photos of the symptoms. Shock tactics!"

Recommendations

More sustained/refreshed education is needed.

There were mixed opinions about when sex education should start in schools – some saying it should start young, and some saying that it shouldn't be taught too young.

However, what young people did agree with was that sex education shouldn't be a one-off; it should be built up gradually according to the age/maturity of the students. Some also wanted refreshers as they got older.

> ***"[It would be better] if they continued it into more than one year of secondary school."***

What about the social aspects of sex?

Young people want education in schools to cover emotional aspects of sex as well as looking at the different experiences of people of different genders and sexualities.

> ***"Give more information on the emotional side"***

> ***"They should try harder to normalise asexual/homosexual relationships."***

> ***"Teach us about healthy relationships."***

Based on our discussions we recommend that information given in schools should cover:

- Healthy relationships
- Consent
- Abuse – physical and emotional
- Impact and influences (e.g. social media)
- Gender roles
- Sexuality

Deal with stigma and taboos.

While many young people themselves might be quite open about sex, some still felt embarrassed at the idea of seeking professional help and many mentioned cultural restrictions on what they could discuss with family or learn at school.

Several people agreed that general social attitudes need to change in order for people to talk about sexual health, and to encourage people to seek out services. This should be encouraged by schools and the media as well as when professionals interact with young people.

> ***"Talk to [young people] about what they feel embarrassed about so that [professionals] can help them to feel more confident."***

Recommendations

"Adverts that stop people from being embarrassed about getting tested, and send a message that it is responsible. I saw one for Durex where they had a focus group of boys and girls, and girls asked [how the boys felt] about girls bringing condoms."

"Talk about sexuality, morals, shouldn't be a taboo. Encourage open discussions."

"Sexual health experts telling them seriously that there is no point hiding their sexual health concerns if [they] need to tell someone."

Promote sexual health services.

Several participants said that better publicity is needed about the sexual health services available to young people. This includes having health professionals coming in to schools to talk with young people, and promoting their services so they can access them in the way they want at a time they need to.

"Be on social media to reach out to a larger base of youths."

"Use more engaging ways to attract people and to let them know that there are services available to help them."

Offer anonymous help.

While this may be a difficult request to fulfil, services need to be aware that many young people would find it much easier and more likely to access help and at least information if it was anonymous, e.g. online discussion.

"It'd be a lot easier to reveal yourself… they're more likely to talk about things they wouldn't normally."

"Anonymous forums would make it easier to reveal yourself and to be open about sexuality."

"Respect that some people value anonymity."

Make services friendly for young people.

Participants were clear that medical professionals who help them must be able to interact in a comfortable,

Recommendations

respectful, non-judgemental way with young people, especially around a sensitive topic like sexual health.

They must also give information clearly and allow young people to ask questions at the appointment and following the appointment if any information was unclear.

"They should try and make it as least embarrassing as possible and welcoming so people don't feel too embarrassed."

"Talk to people calmly and speak about the positive."

"Have empathy; listen carefully to them."

Other characteristics of a good service mentioned were:

"Help them with everything not just what's easy."

"Confidentiality"

"Allow people to see the same health professional each time"

Accessible services

Young people discussed the differences between GPs and sexual health clinics, and accessibility was an important element. They suggested:

"Shorter queues"

"More local clinics"

"Quick accessible service"

Appendix 1: Survey questions

These are the questions used for the online survey. Very similar questions were used for workshops, though these took a more semi-structured approach.

1. I feel confident that I know how to protect myself from sexually transmitted infections (STIs) or unwanted pregnancy: *Strongly agree, agree a bit, disagree a bit, strongly disagree, don't know.*

2. Can you describe some ways people can protect themselves?

3. Social media and new technology influence how young people behave sexually: *Strongly agree, agree a bit, disagree a bit, strongly disagree, don't know.*

4. What are the other things that influence young people in their sexual behaviour?

5. Bearing in mind these influences, at what age do you think children and young people need to be educated about sexual health?

6. It is easy for young people to get information and advice about sexual health: *Strongly agree, agree a bit, disagree a bit, strongly disagree, don't know.*

7. [Those who agreed to Q6] Where do you get information? What makes this easy for you?

8. Do you get information about safe, healthy relationships as well as the physical aspects of sexual health?

9. Where would you best like to get information and advice about sexual health? In what format?

10. My school/college provides/ provided good information and education about sexual health: *Strongly agree, agree a bit, disagree a bit, strongly disagree, don't know.*

11. What would make schools/colleges better at giving information and education about sexual health?

12. I would feel comfortable speaking to my friends if I needed to talk to someone about my sexual health: *Strongly agree, agree a bit, disagree a bit, strongly disagree, don't know.*

13. I would feel comfortable speaking to my parents/guardians if I needed to talk to someone about my sexual health: *Strongly agree, agree a bit, disagree a bit, strongly disagree, don't know.*

14. Have you ever talked with your parents about sex and sexual health? Have they raised it with you?

Appendix 1: Survey questions

15. I would feel comfortable speaking to a health professional if I needed to talk to someone about my sexual health: *Strongly agree, agree a bit, disagree a bit, strongly disagree, don't know.*

16. Which health professional would you be most likely to go to? *GP, practice nurse, Someone at a sexual health clinic, Other?*

17. What could medical professionals do better to support young people?

18. We have mentioned parents, friends, school staff, and health professionals. Is there anybody else you would speak to about your sexual health?

19. Would you go online for information or support, and if so where? Please explain why.

20. If people knew I had asked for support around my sexual health, I would feel embarrassed: *Strongly agree, agree a bit, disagree a bit, strongly disagree, don't know.*

21. What do you think would help people to stop feeling embarrassed about asking for support?

22. Finally, what advice would you give to the people who plan and run sexual health services when they look at improving information and support for young people?

Appendix 2: Detailed demography

These are the more detailed demographic details for the 105 young participants in this project, separated according to the mode of participation.

Current or last school or college attended:

	Workshops (45)	Online survey (13)	Walworth Academy survey (47)
Southwark schools (54 pupils at 5 schools)			
Walworth Academy			47
St Saviour's and St Olave's - for girls, CofE	3		
St Michael's Catholic College	1		
The Charter School	2		
LESOCO	1		
Other South London schools (20 pupils at 15 schools)			
Sydenham School - for girls (Lewisham)	1	4	
Trinity Lewisham - CofE		1	
Forest Hill School - for boys (Lewisham)	1		
Platanos College (Lambeth)		1	
La Retraite RC Girls School (Lambeth)	2		
Kids Company (Lambeth)	1		
Lambeth Academy	1		
Lambeth College	1		
Charles Edwards Brooks (now called St Gabriel's College) - CofE (Lambeth)	1		
Norwood Girls' School (Lambeth)	1		
The John Roan School (Greenwich)	1		
St Ursula's Convent School (Catholic Girls) (Greenwich)	1		
Crown Woods (Greenwich)	1		
Woolwich Polytechnic - for boys (Greenwich)		1	
Norbury Manor Business and Enterprise College for Girls (Croydon)	1		
Schools in north London (6 schools)	**9**		
Schools abroad	**7**		
No answer	**9**	**6**	

Appendix 2: Detailed demography

Borough of residence:

	Workshops (45)	Online survey (13)	Walworth Academy survey (47)	Total (105)
Southwark	11	1	37	49
Lambeth	6	2	2	10
Lewisham	4	4		8
Greenwich	2	1		3
Croydon	1			1
Bromley	1	1		2
Camden	1			1
Hackney	4			4
Haringey	3			3
Newham	1			1
Waltham Forest	1			1
Ealing	1			1
Don't know			2	2
No answer	9	4	6	19

Age:

	Workshops (45)	Online survey (13)	Walworth Academy survey (47)	Total (105)
13 years	0	0	2	2
14 years	2	0	39	41
15 years	1	3	2	6
16 years	17	6	0	23
17 years	4	0	0	4
18 years	4	0	0	4
19 years	3	0	0	3
20 years	0	0	0	0
21 years	3	0	0	3
22 years	0	0	0	0
23 years	2	0	0	2
24 years	1	0	0	1
25 years	1	0	0	1
No answer	7	4	4	15

Appendix 2: Detailed demography

Gender:

	Workshops (45)	Online survey (13)	Walworth Academy survey (47)	Total (105)
Female	31	7	18	56
Male	6	2	26	34
Non-binary	1	0	0	1
No answer	7	4	3	14

Gender status:

	Workshops (45)	Online survey (13)	Walworth Academy survey (47)	Total (105)
Cisgender	35	9	41	85
Transgender	2		2	4
Don't know	0		1	1
No answer	8	4	3	15

Sexuality:

	Workshops (45)	Online survey (13)	Walworth Academy survey (47)	Total (105)
Straight/heterosexual	30	9	40	79
Gay/lesbian/homosexual	0	0	1	1
Bisexual	6		1	7
No answer	9	4	5	18

Disability:

	Workshops (45)	Online survey (13)	Walworth Academy survey (47)	Total (105)
Not disabled	35	9	42	86
Disabled	2	0	1	3
No answer	8	4	4	16

Appendix 2: Detailed demography

Ethnicity:

	Workshops (45)	Online survey (13)	Walworth Academy survey (47)	Total (105)
British unspecified	1	0	2	3
White British	1	0	3	4
White European	1	0	1	2
White unspecified	0	0	2	2
White other	0	0	1	1
Black [British]	5	3	7	15
Black African [British]	5	3	12	20
Black Caribbean [British]	4	1	1	6
Black other	1	0	1	2
Asian, South Asian, Bangladeshi, Bengali, Pakistani or Indian [British]	3	1	3	7
Middle Eastern or Turkish [British]	1	1	2	4
Latin American (including Brazilian, Columbian, Mestizo, and Afroamerican)	7	0	0	7
Mixed White/Black	2	0	1	3
Mixed Black/Asian	1	0	0	1
Mixed unspecified	0	0	2	2
Mixed other	2	0	1	3
Other or insufficient detail	4	0	4	8
No answer	7	4	4	15

Length of time in UK:

	Workshops (45)	Online survey (13)	Walworth Academy survey (47)	Total (105)
Whole life	23	4	33	60
Less than 2 years	8	0	2	10
2-5 years	2	0	4	6
6-10 years	1	1	3	5
More than ten years	2	4	1	7
No answer/unclear	9	4	4	17

Appendix 2: Detailed demography

Refugee status:

	Workshops (45)	Online survey (13)	Walworth Academy survey (47)	Total (105)
Not a refugee/asylum seeker	37	8	32	77
Refugee or asylum seeker	0	1	3	4
No answer	8	4	12	24

Being looked after:

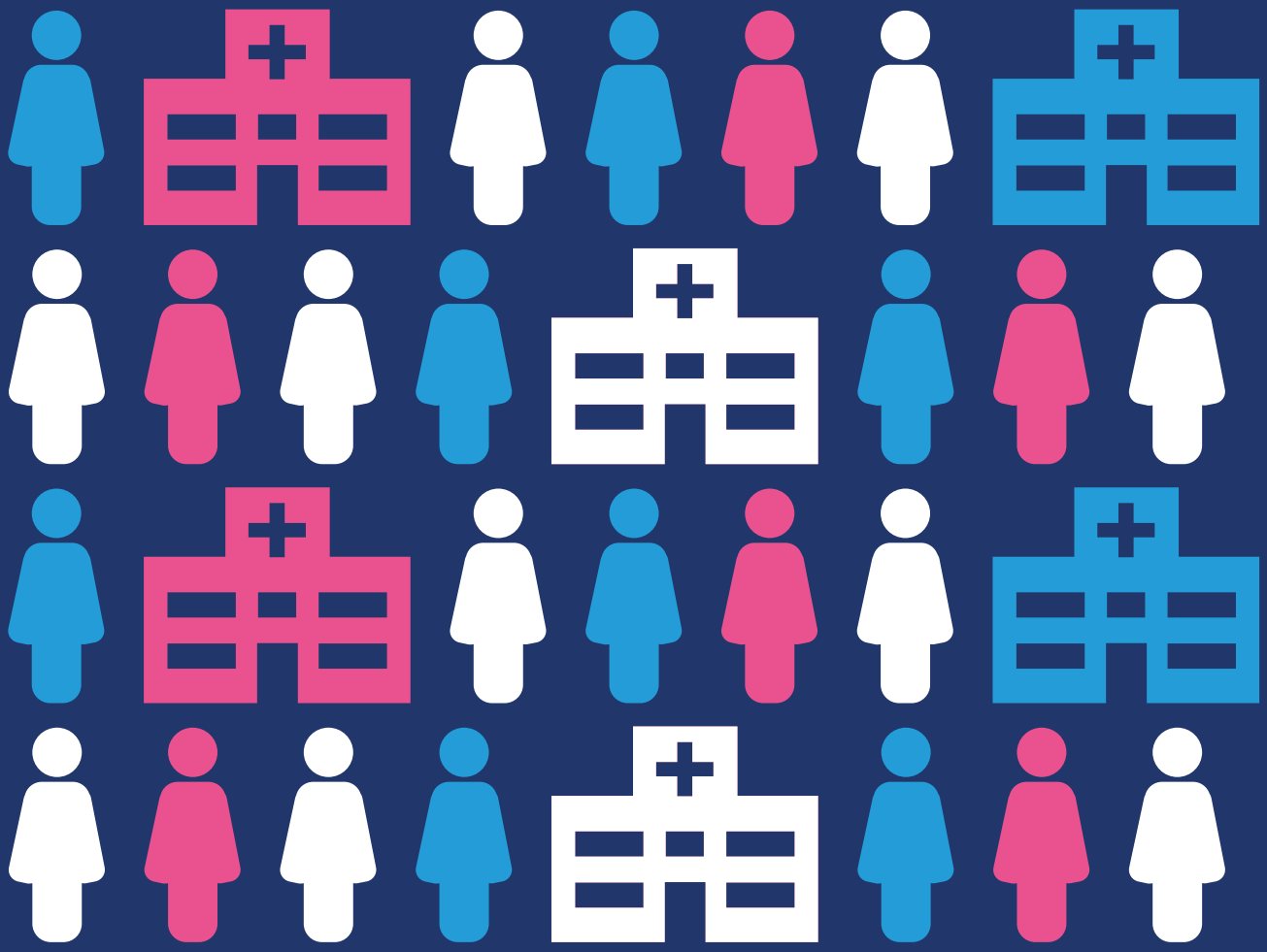
	Workshops (45)	Online survey (13)	Walworth Academy survey (47)	Total (105)
Have not been looked after (in care)	33	9	37	79
Are or have been looked after (in care)	5	0	6	11
No answer	7	4	4	15

'Do you care for somebody else who has an illness or disability?'

	Workshops (45)	Online survey (13)	Walworth Academy survey (47)	Total (105)
No	31	6	25	62
Yes	7	3	14	24
No answer	7	4	8	19

A Cry for Health

Why we must invest in domestic abuse services in hospitals



SafeLives

Ending domestic abuse

A Cry for Health

Why we must invest in domestic abuse services in hospitals

About SafeLives

SafeLives is a national charity dedicated to ending domestic abuse, for good.

We combine data, research and insight from services and survivors to find out what really works to make vulnerable people safe and well. Every year, over two million people experience domestic abuse; it is not acceptable or inevitable, and together we can make it stop.

Agencies must work together to provide people with wraparound and tailored support. Those at high risk of murder or serious injury should be given a dedicated Independent Domestic Abuse Advisor (Idva) who works on their behalf and is there at every step of the way.

We know that the safety of a victim and the safety and wellbeing of their children are inextricably linked; we need a 'whole-picture' approach to vulnerability.

People should not have to wait until they're in crisis before we pay attention.

We want long-term solutions, not short-term fixes. There needs to be a change in behaviour and culture, not just in structures and processes. The simple existence of a response to abuse is not enough.

Support for vulnerable people must be early, effective and consistent – wherever you live, whoever you are.

What we do

- Use our data, research and frontline expertise to help local services improve and to influence policy-makers, locally and nationally.
- Create a platform for victims, survivors and their families to be heard and to demand change.
- Offer support, knowledge and tools to frontline workers and commissioners.
- Provide accredited, quality assured training across the UK.
- Test innovative projects and approaches that make more families and individuals safe and happy.

How we work

- We focus on the practical: we believe in showing people what they can do, not telling them what they should do.
- We are independent.
- We are informed by evidence of what works; we gather evidence from data, frontline expertise and people with lived experience.
- We problem-solve.
- We learn from local provision and respect local circumstances, but show how national replication can be achieved.
- We work across organisational boundaries.

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- Professor Sandra Eldridge – Professor of Biostatistics, Joint Centre Lead for Centre of Primary Care and Public Health, Queen Mary University London
- Professor Louise Howard – Professor of Women's Mental Health, King's College, London
- Lizzie Magnusson – Policy and Research Officer, Women's Aid
- Dr Amanda Robinson – Reader in Criminology, Cardiff Centre for Crime, Law and Justice, Cardiff University
- Clare Rutterford – Statistician, Queen Mary University London
- Dr Ravi Thiara – Principal Research Fellow (diversity and qualitative methods), Warwick University

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Without the support of our funders, this project would not have been possible.

Contents

Domestic abuse in numbers

The cost of domestic abuse to health services

£1.73bn

With mental health costs estimated at an additional

£176m

Each year an estimated

2.1 million people

in the UK suffer some form of domestic abuse

Each year more than

100,000

British adults are at high and imminent risk of being murdered or seriously injured as a result of domestic abuse

Over

130,000

children live in these homes

51%

of hospital victims have children in their households

According to research by Sylvia Walby, an estimated 1 in 8 of all suicides and suicide attempts by women in the UK are due to domestic abuse. This equates to just under

200 women

a year dying from suicide and nearly

10,000

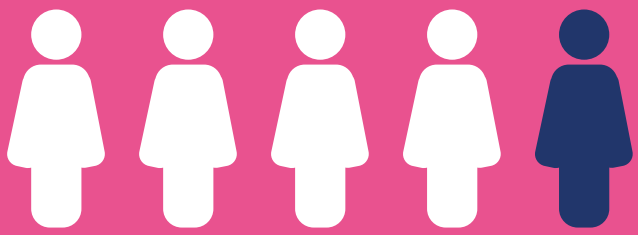
attempting suicide each year because of domestic abuse

1 year

85%

of victims sought help five times on average from professionals in the year before they got effective help to stop the abuse

The British Crime Survey found that 4 in 5 victims of domestic abuse don't tell the police

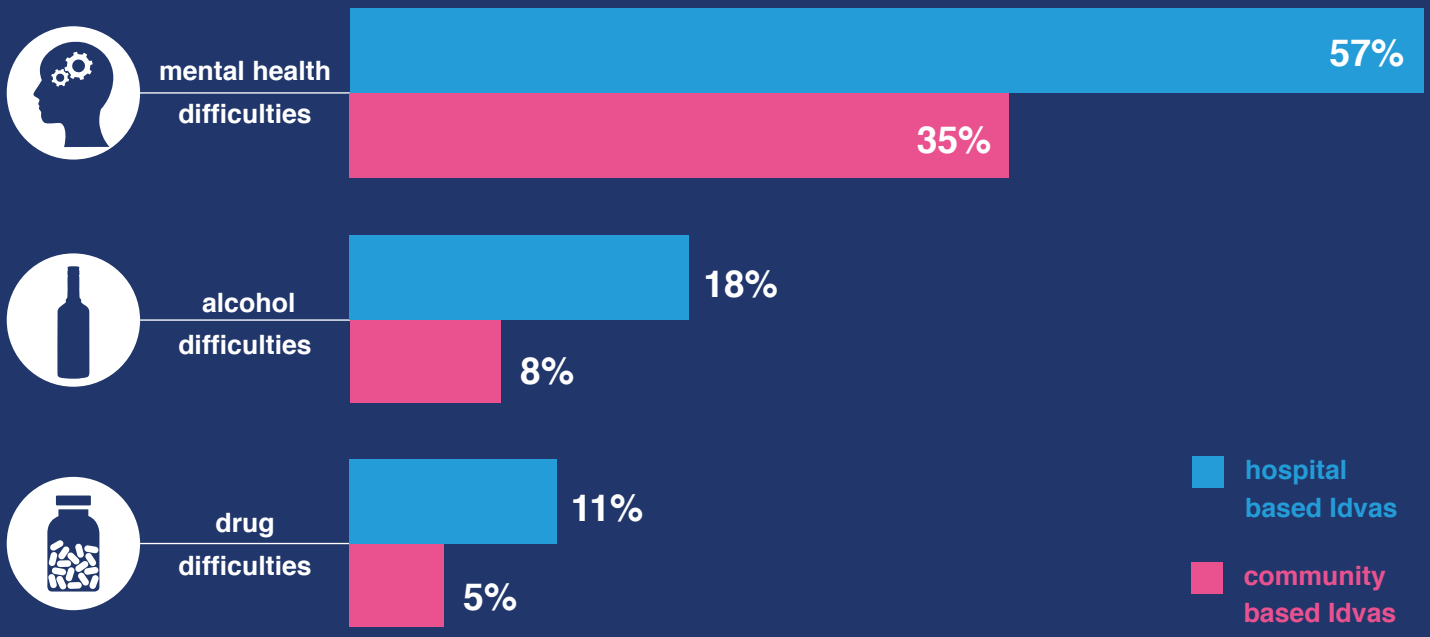


The Crime Survey for England and Wales reports that

486,720

victims experiencing partner abuse in the past year sought medical assistance

Idvas help victims disclose other difficulties



51,355

NHS staff are likely to have experienced domestic abuse in the past 12 months

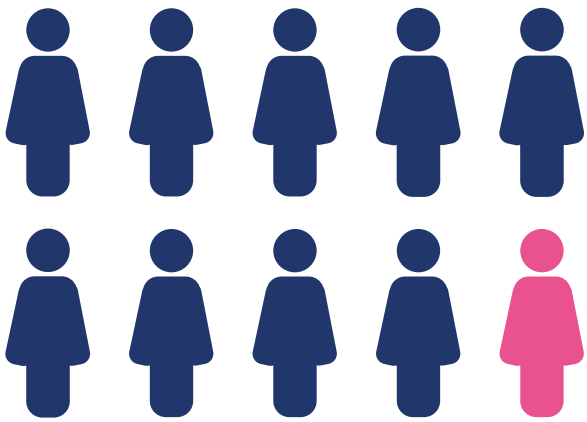
This breaks down as 44,825 women and 6,530 men

£15.7m

the cost of securing a team of specialist Idvas for every NHS acute provider in England

9 out of 10

victims reported improvements in safety following an intervention by a hospital Idva



Executive summary

Domestic abuse has a devastating effect on the health and wellbeing of victims and families, and is a national public health epidemic.

The UK Government defines domestic violence and abuse as:

Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members, regardless of gender or sexuality. The abuse can encompass, but is not limited to, psychological, physical, sexual, financial and emotional.

An estimated 2.1 million people in the UK suffer some form of domestic abuse each year – around 1.4 million women (8.5% of the population) and 700,000 men (4.5% of the population).[1] In the 12 months to March 2015, the police service in England and Wales received more than 900,000 calls about domestic abuse – an average of over 100 calls an hour. Domestic abuse victims and their children are among the most vulnerable in society; domestic abuse accounts for 10% of all recorded crime.[2]

Women are much more likely than men to be the victims of high-risk or severe domestic abuse:[3] 95% of victims referred to a Multi-Agency Risk Assessment Conference (Marac) or accessing an Independent Domestic Abuse Advisor (Idva) are women.[4]

Each year, more than 100,000 British adults are at high and imminent risk of being murdered or seriously injured as a result of domestic abuse.[5] Over 130,000 children live in these homes.[6]

Through its extensive national dataset, Insights, SafeLives has found that on average, adults at high risk live with domestic abuse for 2.6 years before getting help,[7] and that an estimated 85% of victims sought help from professionals an average of five times in the year before they got effective help to stop the abuse.[8] Domestic abuse has a severe influence on a child's physical and mental wellbeing, with 62% living with domestic abuse also being directly harmed themselves. SafeLives' Children's Insights national dataset[9] identified that high proportions (47%) are not known to children's services, and would not receive support following the abuse; 80% were known to at least one public agency.

Domestic abuse is so prevalent in our society that NHS staff will be in contact with adult and child victims (and perpetrators) across the full range of health services. The NHS spends more time dealing with the impact of violence against women and children than almost any other agency, and is often the first point of contact for women who have experienced violence.[10]

The cost of domestic abuse to health services has been calculated at £1.73 billion (with mental health costs estimated at an additional £176 million) so there is a pressing need to find cost effective ways of supporting victims.[11] Both adult and children's outcomes improve significantly across all key measures after support from specialist services.

About Themis

In November 2012, Themis was launched as the first research project of its kind in the UK. It set out to explore the impact of co-locating Idva services in hospitals. We wanted to develop the evidence base to highlight the benefits of stronger links between the health sector and domestic abuse services through innovative models.

This report builds on the findings of SafeLives' report, *Safety in Numbers*,[12] which recommended that the health response to domestic abuse needed to be strengthened. The report summarised extensive research into the negative impact of domestic abuse on the physical and mental health of women with both short- and long-term health consequences.

In SafeLives' report, *Getting it Right First Time,*[13] nearly a quarter (23%) of victims at high risk of harm and 1 in 10 victims at medium-risk went to Accident and Emergency (A&E) because of acute physical injuries. In the most extreme cases, victims reported that they attended A&E 15 times. If domestic abuse were to be responded to effectively when identified in hospital, wider and more detrimental costs could be minimised and harm to victims and children avoided. In the current climate of budget cuts, the value of researching, smarter and more cost-effective interventions for domestic abuse is obvious. Evidence from research studies exploring the effectiveness of health professionals asking about domestic abuse shows that without a service to which they can immediately refer, such as a hospital-based Idva service, the opportunity to intervene will be ignored or ineffective.[14]

SafeLives initiated the Themis research across four geographical areas, examining five English hospitals that had adopted the approach of locating specialist domestic abuse services within their A&E and Maternity units. In each of the four areas, a comparison group of domestic abuse victims from a community domestic abuse service was also recruited. We interviewed: hospital staff, hospital-based Idvas, Idva Service Managers and Commissioners at all sites to understand how the service works in practice, and establish learning points in relation to the effectiveness of the model.

This report presents the first multi-site evaluation of hospital-based specialist domestic abuse services conducted in the UK.[15] The project reached a total of 692 hospital victims and 3,544 community victims in the three years we were collecting data.

About hospital-based Idvas

The job of an Independent Domestic Violence Advisor can be varied, depending on who comes through the hospital doors that day. The core training and ethos of an Idva (or Isva, Independent Sexual Violence Advisor), which puts risk assessment at the heart of creating individual safety plans, is still the focus of an Idva in hospital. However it is a job based in a very fast-paced, medical environment. **These are the core responsibilities:**

- Day-to-day tasks could involve moving a victim of domestic abuse into a refuge, making applications to the local authority for safe, emergency accommodation, and supporting liaison with the police and other agencies.
- All high-risk cases are sent to Marac for further discussion, and will be supported by an Idva for 4 to 6 weeks (or the time agreed in the commissioning contract).
- Safeguarding adults and children through close links with Adult Safeguarding and Child Protection teams within the Trust.
- Liasing with other Trust practitioners, for example drugs liaison/ alcohol liaison nurses, psychiatry liaisons, learning difficulties nurses, to ensure a collaborative care pathway for patients.
- Going to court to request injunctions, and to support victims during trial, if Idvas have the capacity.
- Training and education such as raising awareness about domestic abuse among hospital staff, supporting practitioners to ‘ask the question’ in a safe, open environment. Helping staff understand risk in violent and abusive relationships.

Overview of key findings

SafeLives' Themis research found that co-locating Idva services within a hospital setting can significantly improve health and wellbeing outcomes for victims of domestic abuse.

The cost of securing a team of specialist Idvas for every NHS acute provider in England would be £15.7 million. These specialists help to train hospital staff to better identify victims who come through their door every day and ensure they receive the support they deserve. It makes neither human nor financial sense to ignore the needs of victims and their children – and without this provision, we will continue to fail people who most need help.

Our research found that:

1. We can support the most vulnerable victims

Our evaluation revealed that hospital Idvas were more likely to engage victims who disclosed high levels of complex or multiple needs related to mental health, drugs and alcohol, compared with community domestic abuse services:

	Hospital	Community
Victims with mental health needs	57%	35%
Victims with alcohol related issues	18%	8%
Victims with drug related issues	11%	5%

The high disclosure of complex needs is likely to be predominantly due to the healthcare setting, which is seen by victims to be confidential and focused on wellbeing, rather than on criminal justice issues, which victims may not see as a priority, or as being accessible.

As might be expected because of their location, hospital Idvas were more likely to engage with victims who were pregnant (17% in hospital setting compared to 6% in community setting).

> *"I think [victims in hospital] have higher needs because they come in with overdose, attempted suicides and injuries due to alcohol-related issues"*
> **Senior Idva**

Hospital victims were also more likely to have been suicidal or to have self-harmed, and many were referred to the Idva after taking an overdose linked

to the abuse they were facing. Just under half (49%) of hospital victims screened positive for post-traumatic stress disorder (PTSD), eight times as many as in an inner-city community sample (6%). One in six hospital victims (16%) had been to A&E for an overdose in the six months before seeing a hospital Idva, compared to 1 in 38 (3%) before seeing a community Idva.

Nearly twice as many hospital victims had self-harmed or planned/attempted suicide than victims in a community setting (43% compared to 23%).

According to research by Sylvia Walby, an estimated one in eight of all suicides and suicide attempts by women in the UK are due to domestic abuse. This equates to just under 200 women dying and nearly 10,000 attempting suicide each year because of domestic abuse.[16]

2. We can support those victims who frequently face barriers to getting help

Victims engaging with hospital Idvas seemed to be accessing effective support at an earlier point. Hospital Idva victims had experienced abuse for an average of six months less than victims engaged with a community service.

Hospital victims have been abused for an average of 30 months, compared to an average of 36 months for community victims.[17]

Consistent with this finding, hospital Idvas were more likely to be engaged with victims who were still in a current relationship with the abuser, living with the abuser, and experiencing more severe abuse. Hospital services also identified more victims who were experiencing abuse from multiple perpetrators.

	Hospital	Community
Living with perpetrator	41%	26%
Still in the relationship	53%	31%
Severity of physical (high) abuse	46%	41%
Severity of sexual (high) abuse	14%	10%

We know that some groups of victims may be less visible to services or be given less priority:[18]

	Hospital	Community
Older victims 55+	10%	7%
Victims from higher income £36,400+ p.a.	9%	4%

"We found people we were identifying through A&E were not known by other services"
Commissioner

"I think we are meeting people who are hidden from society"
Senior hospital Idva

3. There is a golden window of opportunity to identify victims

After the introduction of a hospital-based Idva service, the referrals of victims significantly increased. In one of the hospitals, there were 11 Marac referrals in the 11 months before the introduction of the Idva service; this increased to 70 in referrals in the 11 months following the start of the Idva service. Another hospital said they had no referrals of patients to domestic abuse services in the year prior to the start of the Idva service, while another said they had only referred five patients in five years.

There are a number of reasons why hospital Idvas may be reporting earlier engagement with a different profile of victim compared with community services:

- The 'crisis' element of the victims' situation may make the root cause harder to hide.
- The disclosure of complex needs, vulnerabilities and unrecognised abuse in the hospital victim population may be higher than the victim population accessing community services, since victims are attending hospital primarily for urgent health issues which may or may not be related to the domestic abuse experienced.
- They are accessing a group of victims who have previously not accessed help elsewhere, including those still in a relationship.
- Victims may be more likely to disclose domestic abuse because of the setting: it is considered by them to be a more benign, confidential and caring environment, free of the potential onward implications of involvement with criminal justice or other statutory services, particularly in relation to children.

"I think patients may seek referral here because they feel it is a safe place they can come. They come [saying] 'I know you have a service'. I don't think there are many other places… Coming to hospital equals [a] place of safety and expected confidentiality"
A&E Doctor

The hospital Idva has a golden window of opportunity to support victims because of their setting; for the reasons why the victim has accessed the health service, and because they feel more comfortable disclosing in a health environment. Idvas can help victims to understand, often for the

first time, that what they are experiencing is domestic abuse. While victims may not accept support initially, they leave hospital with knowledge of the support they could receive, should they choose to engage later on.

> *"I don't think I would have admitted it was a domestic abuse situation. I just felt my ex was just a nasty man. Then hospital Idva went through one of her questionnaires and I was on the border of being high-risk. Quite shocking"*
> **Victim**

4. We can help health services to meet their domestic abuse obligations

The National Institute for Health and Care Excellence (NICE) recommends that "people presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion".[19]

Recommendation 12 of NICE's guidance on domestic violence and abuse in 2014 recommends that health and social care commissioners, health and wellbeing boards, and practitioners in specialist domestic and sexual violence services should provide all those currently (or recently) affected by domestic violence and abuse with advocacy and advice services tailored to their level of risk and specific needs.[20]

Our findings support this recommendation: in the year before the hospital Idva service started, 56% of hospital victims had accessed A&E because of the abuse, compared with only 16% of victims who accessed a community service. These represent missed opportunities to intervene, which is particularly important for victims who do not have any contact with other agencies.

56% of hospital victims had accessed A&E in the year before getting effective help, compared to 16% of victims who accessed a community service.

Health professionals interviewed as part of the research told us that being able to refer patients to the hospital Idva made it more likely that they would ask patients about domestic abuse in line with NICE recommendations. They also had greater confidence that identification would result in a meaningful outcome for the victim.

> *"If we didn't have the service, people would just stop screening. There is no point asking the question if we're not going to do something about it. It's like opening a nasty cut and not doing anything about it"*
> **Nurse**

5. We can help improve victim safety and health by increasing referrals and access to wider services

Basing domestic abuse services in hospitals is part of a continuum of support for victims of abuse. It can provide a gateway for the provision of support to make victims safer and address their significant physical and mental health needs. For example, some domestic abuse service providers, such as the Arch service in Staffordshire, run the hospital-based Idva provision as well as the community and refuge provision for the local area. Being based in a healthcare setting makes it easier for domestic abuse professionals to make quick links with services for mental health, abuse, and sexual violence.

Nine out of 10 victims in our evaluation reported improvements in safety following an intervention by a hospital Idva. Hospital Idvas reported that this improvement was significant in 37% of cases (both of these figures are similar to victims in community services).

Victim-reported improvement in safety	Hospital	Community
Much safer	57%	51%
Slightly safer	34%	40%
No change	8%	9%
Less safe	0%	0%

The more intensive the Idva intervention, the more likely it became that victim safety would be sustainably improved. For example, more contact with the victim, a higher number of interventions, and longer periods of casework all improved safety.

Victims reported feeling more confident accessing support as well as more empowered to make significant and meaningful changes to their life as a direct result of hospital Idva support.

> *"Up until this point, I was trying so hard to get help – but now I have so much support and I know it's there all the time. It has been wonderful, absolutely wonderful… My confidence is coming back. I feel like now I can be there for the children, and my mum. It has gone right round the family. I have seven children and grandchildren. It has touched the entire family. You have no idea what a mess you have been in and how it's affecting the entire family. I don't know what would have happened without that support. I think we would have seen somebody die"*
> **Victim, commenting on the value of the hospital Idva**

Domestic abuse services can also provide support for members of hospital staff who are victims of abuse. By looking at the incidence of domestic

abuse in the general population, we extrapolated and found that a potential 2,065 members of staff across the five hospital sites were likely to be victims of domestic abuse.[21]

The total number of NHS staff likely to have experienced abuse in the past 12 months is 51,355 (male and female). This breaks down as 44,825 women and 6,530 men.

We know that four out of five victims don't tell the police about their abuse,[22] which means that a key route into accessing specialist domestic abuse services may remain closed to victims if they don't know how to, or don't want to, self-refer. Our findings show that locating Idvas in hospital settings can give support to victims who have not contacted the police – only 58% of victims in hospital had contacted the police in the year before receiving support, in comparison to 77% of community victims.

6. We can help safeguard unborn babies, infants and young children

Around 30% of domestic abuse begins during pregnancy, while 40–60% of women experiencing domestic abuse are abused during pregnancy.[23] The hospital Idva services that had developed strong links with maternity services were likely to support more pregnant women than community services. NHS staff are under a duty to safeguard children at risk of harm through the provisions of the Children Act (1989/2004),[24] and a hospital Idva service is well placed to help with identification, referrals and support, to enable hospitals to fulfil their duties, not least by ensuring mothers at risk are identified early on.

It was found the 51% of hospital victims had children in their household.

Although having links with maternity services is key for identifying pregnant women experiencing domestic abuse, for hospital-based Idva services to work most effectively, they should have strong links with all hospital departments.

7. Hospital Idvas could reduce future health costs

The cost of domestic abuse to health services has been calculated at £1.73 billion (with mental health costs estimated at an additional £176 million) annually, which highlights the pressing need to find cost-effective ways of supporting victims.[25] An earlier study by Walby estimated that around 3% of NHS expenditure is due to the physical injuries associated with domestic violence.[26]

Our evaluation included an analysis of the potential cost savings a hospital Idva service could produce, although the sample size was small.

Before accessing the Idva service, hospital victims cost on average £4,500 each year in their use of hospital, community and mental health services, whereas community Idva victims cost £1,066 per year for the same services.

An annual saving to the public purse of £2,050 per victim in health service use was estimated.

This consisted of savings of £2,184 in reduced hospital use by victims after they had been referred to the Idva service, and £200 in reduced ambulance use, balanced against rises of £196 in mental health service use, £64 in local surgery use, and £74 in alcohol/drug service use.[27] The increased use of these services is likely to be beneficial to the victims, particularly if they have complex needs which have remained unaddressed up until this point.

An increased annual cost of £282 in children's social care use was also calculated. Often it was the Idva service that identified victims who were parents and made referrals to children's social care for additional support. Referrals were made to safeguard children, so the cost associated can be seen as an investment in the child's future emotional health, which has the potential to reduce public spend in the longer term.

Hospital staff recognised that the expertise of the Idvas saved them time, which made them economically worthwhile to the organistion.

> *"We do leave a lot of work to them… They do so much more with patients than we could ever dream of doing because of time. Their role is so important. I don't know what we would do without them"*
> **A&E Consultant**

> *"It is really helpful to have input from an Idva… One of my nurses spent a whole day and I spent a whole afternoon trying to find one refuge"*
> **Consultant Psychiatrist**

8. Specialist domestic abuse services in hospitals are effective

Specialist domestic abuse services were most effective when they were:

- embedded in the hospital;
- highly visible to health professionals working in different hospital departments;
- regularly involved in training staff about domestic abuse;
- linked to community specialist domestic abuse providers;
- supported in a team (rather than lone working); and
- adequately and sustainably funded.

In practice, this means:

- establishing clear referral routes;
- Idvas being based in a central office and having a daily presence within the hospital;
- the Idva service operates across shift patterns; and
- systematic involvement in the delivery of training of all hospital staff.

> *"For something that's quite a complex and emotive subject, it is really nice to have a person available when we know we have concerns… Sometimes we have a hunch and we have somebody to say 'Can I just run it past you?'"*
> **Hospital Midwife**

> *"They [Idvas] have lunch in the staff room. They socialise with the team. That is where the success really comes from. They are not seen as a separate and aloof service that we just refer to"*
> **A&E Nurse**

The provision of clinical supervision for hospital Idvas should also be given priority so that Idvas feel well supported in a complex hospital work environment.

Recommendations

For national policy-makers

- **National leaders should prioritise domestic abuse as a health issue.** There is the opportunity for NHS England and the Department of Health to play a greater role in showing leadership in tackling what has traditionally been seen as a criminal justice issue. The cost of domestic abuse to health services needs to be taken seriously by all parts of the NHS to ensure that victims aren't passing through a 'revolving door' – returning time and time again without the cause being identified and addressed.

- **All hospital settings (particularly those with A&E, maternity and sexual health departments) should host an Idva (and Isva) service.** There are 157 registered acute NHS providers in England.[28] A minimum complement of two Idvas is required to ensure staff are not lone working across a seven-day service (particularly one which extends across busy evening periods), equating to a spend of £100,000 per NHS provider, or £15.7 million in total.

- **Increase provision for victims and children of domestic abuse.** In order to safeguard children, there must be effective referral pathways into services, particularly for pregnant victims of abuse given the potential impact on the unborn child.

- **NICE guidelines for asking every individual presenting with indicators of domestic abuse should be applied comprehensively.** The presence of Idva services makes this much more likely to happen in practice. We recommend that further research is undertaken to ascertain the extent to which NICE guidelines are being followed in the NHS.

- **A wider study on the cost-effectiveness of Idva services based in hospitals should be conducted** to evaluate whether our initial findings are replicated with a larger sample.

- **Continued study should be undertaken into basing specialist domestic abuse services within other health settings where there is not yet an evidence base,** for example, in mental health and sexual health services. In primary care, IRIS (Identification and Referral to Improve Safety) is an effective and proven model, which should be rolled out nationally alongside hospital-based domestic abuse services.

- **The Department of Health and the Home Office should investigate ways of incentivising and monitoring the development of Idva services within hospitals.**

For Commissioners[29]

- **Commissioning strategies should include Idva services within hospital settings,** as they have the potential to reduce future health service use by victims of domestic abuse through more robust pathways.
- **Ensure commissioning of a health-based Idva service is sustainable;** sustainable funding is necessary in order to attract confident, high-calibre Idvas, who can network and train all levels of staff. Health-based Idva services should form part of a wider commissioning strategy, rather than being standalone posts, and should not detract from wider provision of Idva services within community settings.
- **Embed hospital-based Idva services within local referral pathways** to ensure victims receive ongoing support from other services once they have exited the Idva service.

For hospital Idva services and hospitals

- **Embed the service within the hospital setting** by developing strong referral routes, IT access, a daily presence, a central office base, service coverage across shifts, and support from senior clinical staff.
- **Ensure the service is visible across all departments of the hospital.**
- **Ensure staff are implementing NICE guidance** by identifying victims early and ensuring they get the right support for their safety, and their health and wellbeing. An audit could be conducted within the hospital to ensure the guidance is effectively followed and referrals could be dip-sampled to ensure consistency.
- **Involve the hospital Idva in delivering domestic abuse training to all hospital staff** in a systematic way that ensures it is regular, and can cope with high staff turnover.
- **Ensure hospital Idvas are given additional training in how to respond to victims with complex needs** (for example, mental health, and alcohol or substance misuse); hidden and very vulnerable victims (for example, older victims, pregnant victims, and victims with poor health) and training on how to respond to victims at crisis point in a medical setting.
- **Make strong links with community specialist domestic abuse services** to ensure effective onward referral pathways for victims and children, and consider opportunities for shared training and opportunities to train each other (unless the hospital Idva service provider is the same as in the community).

- **Create a feedback loop between the hospital-based Idva service and clinicians.** Ensure you feedback to hospital referrers (where appropriate) about cases, so that they feel involved in the outcomes for the victim and can learn from cases.

- **Ensure that Idva staff have adequate clinical supervision to feel well supported in the complex hospital work environment.**

For hospital staff

- **All hospital staff should be trained in referral pathways through the hospital Idva.** If you have a hospital Idva service, ensure you know how to make a referral and share information appropriately – including for staff who are victims. If you do not have a hospital Idva service, ensure you know how to make a referral to the community domestic abuse service.

- **Ensure that you ask patients about domestic abuse, as recommended by NICE.** This should include making a referral if a victim of domestic abuse is identified.

- **Implement a domestic abuse awareness raising campaign and appoint champions in each ward.** Hospital screening for domestic abuse and hospital Idva engagement may be the first time victims recognise their experience as domestic abuse.

For non-hospital-based (or community-based) Idva services

- **Seek funding to extend your existing service** into the hospital, building on your expertise and helping to provide a seamless service to victims and their children.

- **Develop referral pathways with your local hospital.** If the hospital(s) in your area do not have an Idva service, make sure referral routes are established and known to health professionals across hospital departments.

- **Develop cross-training opportunities with hospitals and local health services.** Through making links with the local hospital service, domestic abuse services can maximise shared training opportunities as well as opportunities to train each other and increase knowledge.

Chapter 1 – The role of the Themis project

The primary objective of the Themis project was to evaluate the effectiveness of domestic abuse services in hospitals. This research evaluated Idva services operating in several different hospital sites and departmental settings, and using different models of service delivery. The World Health Organisation (WHO) acknowledges domestic abuse against women and children as an "urgent public health priority".[30]

In the UK, the Department of Health included the need to address domestic abuse within their strategic goals, producing an action plan to improve services for women and child victims of violence. The strategy recommended in particular that "Primary Care Trusts (PCTs) and NHS Trusts should work together with other agencies to ensure that appropriate services are available to all victims of violence and abuse".[31] Furthermore, the change in the commissioning of services within the sector requires robust evidence regarding the effectiveness and cost-effectiveness (in both financial and human terms) of health-based domestic abuse interventions, which Themis aims to provide.

This makes the Themis project timely and beneficial to both the health sector, due to the recent priority of addressing domestic abuse within health, and victims of domestic abuse. The hypothesis underpinning the research was that hospital-based Idva services would reach a different demographic of victim that might not access help via any other route. We also intended to explore whether hospital-based Idva services were a point of earlier intervention, thus potentially reducing the amount of time a victim suffered abuse before seeking help. This could reduce the impact of the many health consequences associated with domestic abuse.

In order to evidence this, we gathered data regarding the abuse experienced, demographics and the physical and mental health of victims before and after intervention. Ultimately, we hope that the findings from this research will feed into commissioning guidance through providing evidence of best practice in hospital-based Idva provision. We also hope that demonstrating the effectiveness of hospital-based Idva services will lead to more similar services being commissioned across the UK, to add to the small number (around 20) that currently exist.

Design of the Themis project

The aim of this study was to evaluate the model of domestic abuse intervention that bases Idvas in hospitals. This multi-site study included Idvas in five hospitals across England, operating different models of service delivery.

An Idva is a named professional case worker for victims of domestic abuse who works to address the safety of victims at high risk and their children. They assess the level of risk, discuss a range of suitable options and develop co-ordinated safety plans. These can include referral to the Multi-Agency Risk Assessment Conference (Marac), as well as sanctions and remedies available through the criminal and civil courts, housing options, and services available through other organisations. In some cases, hospital Idvas are Idsvas – Independent Domestic and Sexual Violence Advisors – but for brevity, all are referred to as Idvas in this report.

The key questions addressed by this research were:

1. Who are the victims accessing help through hospital-based services compared to domestic abuse services based in the local community?
2. What do hospital-based Idvas do (compared to those based in the local community)?
3. What impact on victims' risk, safety, and health and wellbeing do hospital Idvas have (compared to Idvas based in the local community)?
4. What are the facilitators/barriers to basing domestic abuse services in hospitals?

Idvas based in five English hospitals (one in a large city, one in a medium-sized city, and three in smaller towns in more rural areas) recruited victims aged 16 and over, with capacity to consent, who were judged safe to take part in the study. In each of the four geographical areas (with two hospitals being in one area), a comparison group of community Idva victims was also recruited. Community Idvas work with victims at high risk referred to them by the police, the local Marac and other agencies, and self-referred victims.

Telephone interviews were conducted with victims, with their consent, at the start and end of the Idva intervention, and three, six and nine months afterwards, where possible. These included standard measures of physical and mental health and questions about health service use. Initial interviews were conducted with 76 hospital Idva victims and 38 community Idva victims. Face-to-face interviews were also conducted with 15 victims (with their consent) after the intervention, to discover their views of the hospital-based Idva service and find out about their help-seeking journey.

Details of client demographics, complex health needs, levels of abuse and previous help-seeking, collected through SafeLives' anonymised Insights data monitoring service, were analysed for all participating sites. In addition, 692 intake forms from hospital Idva services between April 2012 and November 2015 were used for the data analysis, compared with 3,544 intake forms from the same period from community Idva services.

A total of 64 hospital staff, Idvas, Idva Service Managers and Commissioners at all sites were interviewed about how the service works in practice, and what factors hinder and facilitate its effectiveness.

At all times, victims' safety was paramount. Only those judged by Idvas as safe to take part were recruited. After the interviews, and with consent, any concerns about victims' safety and relationship with the abuser were referred to the Idva, and concerns about their mental health were referred to their GP for help and support.[32]

Analysis

Insights data for all sites from 2012–2015 were analysed descriptively and differences between hospital and Idva victims were ascertained using appropriate tests – chi-squared for categorical variables, and Mann-Whitney U for non-parametric variables. Factors relating to successful client outcomes were identified through logistic regression.

Victims' health and health service use journeys (pre- and post-Idva intervention) were assessed using Wilcoxon's repeated measure non-parametric test.

A health economist carried out the cost analysis, comparing hospital and community Idva victims' mean health service use in the six months before the intervention, and comparing hospital victims' mean health service use pre- and post-Idva intervention. (The 95% confidence intervals (CI) were estimated using the bootstrapping methods in Excel, where the initial cohort was resampled 1,000 times.)

Qualitative semi-structured interviews with Idva victims were audio-recorded and analysed by the interviewer, while those with hospital staff, Idvas and Commissioners were shorthand-noted and transcribed by the interviewer, and analysed by two other researchers. These interviews were analysed using codes related to the research questions, which were then incorporated into sub-themes using thematic maps to aid the generation of final themes as suggested by Braun and Clarke (2006).

Fifteen hospital Idva victims across three sites (large city, medium city and small town in rural area) were interviewed after they had exited the Idva service: 14 were female, one male. Thirteen had received support because of partner abuse, one had been abused by an adult daughter, and another had been raped by an acquaintance.

Victims described a range of abusive behaviours perpetrated against them, including physical abuse (some injuries requiring medical attention), psychological abuse, controlling behaviours, harassment, threats, sexual abuse, property damage and financial abuse. For many, who had not sought or needed medical treatment for injuries, the impact of the abuse had been such that they were self-harming, having anxiety attacks, or it had triggered physical health problems, which prompted the visit to the hospital A&E.

Chapter 2 – Domestic abuse victims and health services: The policy context

Introduction

In our groundbreaking 2009 report, *Safety in Numbers*,[33] SafeLives highlighted that physical and mental health problems are documented with greater frequency among victims of domestic abuse compared to those who are not abused. The research also highlighted gaps in service provision and concluded that there was a need to strengthen links between generic and specialist health services, especially since studies had shown that the delivery of integrated services to address domestic abuse in tandem with health-related issues (for example, mental health or substance misuse) facilitates improved outcomes for victims.

Use of health services by domestic abuse victims

Compelling data captured by SafeLives' measurement tool, Insights, has subsequently affirmed these findings. Among a suite of other measures, Insights is the largest database of domestic abuse cases nationally (over 50,000), and tracks the use of public services by victims, drawing on data from over 50 domestic abuse services in England and Wales annually. The dataset is populated with cases from Idvas and outreach workers. This year's Insights dataset (2015/16)[34] included 77% of victims at high risk, who had experienced abuse for three years on average. It indicated that nearly half of the victims (46%) had visited their GP in the 12 months prior to seeking support from an Idva service, and had done so 4.6 times on average. Furthermore, in 17% of cases, victims in the Idva dataset reported having attended A&E 1.3 times on average as a result of the abuse. In our 2013/14 Idva and outreach datasets, in the most extreme cases, victims reported that they attended A&E 15 times during the preceding 12-month period before receiving support from a domestic abuse service.

The SafeLives Insights dataset for outreach cases[35] included 23% of victims at high risk who had experienced abuse for four years on average. It found that 55% of victims visited their GP an average of 4.9 times. A smaller percentage of victims in the outreach dataset reported that they had attended A&E as a result of the abuse (12%), but they had done so 1.5 times on average. Both the Idva and outreach datasets had missing data on these questions for up to a quarter of victims, and were based on self-report, meaning that individuals might over- or under-report the number of times visits were made over a 12-month period.

The Crime Survey for England and Wales reports that 32% of victims in England and Wales experiencing partner abuse in the last year aged 16–59 sought medical assistance due to the abuse, equating to 486,720 victims.[36] Of those, 13% (or 63,000 victims) sought medical assistance in a hospital or A&E.

Help-seeking for domestic abuse victims in a health setting

The high proportion of victims found to be accessing the NHS illustrates the potential opportunities for healthcare professionals to be recognising and responding to domestic abuse. Despite this, a fear of not being believed or validated; a fear of social services involvement; feelings of shame or embarrassment; and a lack of interest, time and domestic abuse awareness among health professionals mean that healthcare settings often fail to be recognised as opportunities to disclose or access relevant support.[37] Over 70% of victims in one study did not know how to get help locally, and many women may not recognise healthcare services as potential providers of support.[38] Another common reason for not seeking formal help is the victims' belief that the abuse wasn't serious enough to warrant support.[39]

The British Crime Survey found that four in five victims of domestic abuse don't tell the police.[40] Therefore, as SafeLives' policy report *Getting it Right First Time* highlighted, considerable opportunities for victims to access support continue to be missed across the NHS and other health and public services.[41]

Citizen's Advice research in 2015[42] highlighted that friends and family are more likely to be aware of abuse than anyone else. The British Crime Survey of victims found more than two-thirds (71%) of individuals who experienced domestic abuse last year told someone close to them. The report argued that, since informal networks directly report abuse to specialists (in almost a fifth of cases which were reported to police, the information came from a third party), there ought to be "clear and accessible pathways to specialist support". Health-based domestic abuse services could provide a good way for friends and family to hear about the availability of services and learn about how to refer victims of domestic abuse.

Cost of domestic abuse to health services

Domestic abuse costs the NHS £1.73 billion (with mental health costs, estimated at an additional £176 million) according to research conducted by Sylvia Walby.[43] If domestic abuse were to be responded to before the point of crisis, wider and more detrimental costs later on could be minimised. In the current climate of cuts to budgets, the value of researching not only safer but smarter, more cost-effective interventions for domestic abuse is obvious.

According to a NICE[44] report on the costs of self-harm to the NHS, the cost of someone attending A&E is £110, while ambulance call-outs cost on average £246 each. This increases to £2,200 for a patient who needs treatment for poisoning with major complications, while treatment for other wounds or injuries with major complications costs £4,231.

Identifying and supporting victims in healthcare settings

Research in 2002 found that without a service to immediately refer on to, such as a hospital-based Idva service, the effectiveness of health professionals asking about domestic abuse is likely to be limited.[45] Since then, there have been a number of positive developments in healthcare settings to identify and support more victims sooner. In a hospital setting, research published in 2016 looked at domestic abuse screening and provision at the Royal Free Foundation Trust in London. It found that “having an in-house hospital screening service results in high numbers of referrals to the hospital-based Idsva, and that people referred from the hospital are more likely to take up the referral than people referred to domestic violence services from elsewhere”. [46] However, the research was unable to collect data on pregnancies, children or types of abuse, all of which Themis has included. Other findings raised by this research have also been highlighted over the course of the Themis project, including: the need for regular training of health staff; ensuring there is private space without the abusive partner present; and clear, integrated referral pathways to support services. Interestingly, the lack of long-term funding for the Idsva service presented a challenge to embedding the service successfully within the hospital which suggests an important learning point for Commissioners.[47]

Another evaluation of Idva services at Saint Mary's Hospital, Manchester in 2010 found that the number of referrals to the Idva service increased after an Idva was seconded for two years to work five days a week in the maternity unit.[48] The study also found that the time frame in which referrals are made was an important factor in improving safety for women and their children – 82 of the women in the study were seen and assessed within hours, and 16 within minutes. The research also confirmed that the midwives involved with the study felt more confident in routinely asking patients about domestic abuse because of the presence of the Idva. Institutional advocacy was also improved through training provided to staff by the Idva. One of the main recommendations from the review was that specialist Idvas should work with more patient groups, not just in maternity.

In 2000, the Department of Health endorsed a routine antenatal enquiry for domestic violence, which was also endorsed by the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, and NICE, who in 2001 recommended that all pregnant women should be asked routinely about domestic violence as part of their social history. A follow-up study into the routine asking of pregnant women by midwives about domestic abuse in the Bristol Pregnancy Domestic Violence Programme (BPDVP) has found that improvements in antenatal enquiry for domestic violence and abuse, developed through the 2004/05 BPDVP, have grown over time, with the support of mandatory training. Nevertheless, barriers continue to exist which include presence of a male partner and lack of face-to-face interpreting services. Both these obstacles need to be addressed if all women and, in particular, those who are most at risk of abuse, are to be identified and supported.[49] Research by the same authors in 2011 into the views of pregnant women themselves found that routine enquiry by midwives into domestic violence "is a positive move forward".[50] More recently, the Royal College of Nursing has called for mandatory domestic abuse training.[51]

In a primary care setting, the Identification and Referral to Improve Safety (IRIS)[52] model has recently been implemented in 33 GP practices across England. The IRIS model is a training, support and referral programme to support GPs in asking about, and responding to, domestic abuse disclosures. It locates a lead Advocate Educator (AE) in a community specialist domestic abuse service, working in partnership with a local clinical lead to co-deliver training and education across practices supported by the programme (up to 25 practices can be supported by a single AE). GPs are trained to ask, respond, refer and record – with identification helped by a pop-up list of symptoms (known as the HARKS checklist)[53] on patient records. AEs add capacity and help develop local pathways for victims and perpetrators. The project has found that women in participating practices were 22 times more likely to discuss referral to a domestic abuse service compared to controls, and actual referrals were six times higher.

The RESPONDS study aimed to bridge the knowledge and practice gap between domestic violence and child safeguarding.[54] The study found that after RESPONDS training, primary care clinicians were more confident in knowing how to proceed in a consultation when it was disclosed, (or if they suspected), that children were exposed to domestic violence and abuse, and the appropriate next steps to take. They had a greater awareness of current relevant service provision and referral routes. Training participants also reported increased willingness to engage directly with children and to discuss this appropriately with their non-abusive parent. REPROVIDE is the latest research programme into health impacts and practitioner responses to domestic abuse, which is funded from 2016 to 2021.[55] This research plans to improve how healthcare professionals respond to all adult patients and their children who experience or perpetrate domestic abuse.

In addition to this, Public Health England commissioned the charity, Against Violence and Abuse (AVA), to refresh their free e-learning modules to align with the NICE guidelines on domestic violence and NHS professionals, and provide free access to Level 1 and Level 2 training. Other programmes to assess and improve professionals' responses to domestic abuse within specialist healthcare settings include the Spotting the Signs toolkit in sexual health clinics, and the Promoting Recovery in Mental Health (PRIMH)[56] project in the domain of mental healthcare. Psychological Advocacy Towards Healing (PATH) is a randomised controlled trial to determine the effectiveness and cost-effectiveness of a psychological intervention delivered by domestic violence advocates.[57] The aim of this study is to assess the efficacy and cost-effectiveness of a novel psychological intervention specifically tailored for survivors of domestic violence and delivered by domestic violence advocates based in third sector organisations. Standing Together, a charity which brings communities together to end domestic abuse, was awarded funding in March 2016 from the 'Tampon Tax' by the UK Government to establish a Health Alliance for Domestic Abuse, to bring together those working across domestic abuse and health. This shows the increasing interest from senior policy-makers in how healthcare settings can provide a better response to domestic abuse victims.

Existing research has indicated that the mechanisms currently in place for early disclosure of domestic abuse in healthcare settings are particularly effective for reducing risk and improving victims' safety following support.[58] Certain barriers have, however, been highlighted, such as the presence of partners (or others) when seeking support, language barriers, and general time constraints.[59] These are among the factors found in healthcare settings which prevent successful identification of victims of abuse. It is evident that with these barriers in mind, further research – such as that undertaken by Themis – is necessary for identifying ways in which formerly missed opportunities can be learned from to ensure an earlier, quicker, and safer response to victims of domestic abuse.

Impact of domestic abuse on victims' health

Domestic abuse has detrimental implications for victims' health. The physical – and often more obvious – implications can be short-lived, or long-lasting. These can include: broken bones; sprains; cuts; bruises; digestive issues; eating problems; pain of the back, neck, abdomen, stomach or genital area; headaches; fainting; seizures; hypertension; urinary tract or vaginal infections; sexually transmitted diseases; and sexual dysfunction.[60] Although often less obvious, psychological implications of domestic abuse can pose an equally harmful threat to victims' health. A targeted sample of 260 women who had sought help from domestic abuse services within England and Wales completed baseline questionnaires as part of an intervention study.[61] According to the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM), which is used in counselling services as a screening tool, over 70% of these women reported clinical levels of psychological distress. Their mean score (18) was almost four times higher than that of the general population.[62] The study also indicated more than three-quarters of the women (77%) had been suffering post-traumatic stress disorder (PTSD), in addition to high levels of depression and anxiety – of which the severity was positively correlated to the severity of abuse experienced.

Agenda's *Hidden Hurt*[63] report on violence, abuse and other disadvantages in the lives of women, similarly evidences the overwhelming association between domestic abuse and mental health issues. The report illustrated that over half of women (54%) experiencing sexual and physical abuse – and a third (36%) experiencing extensive physical violence – meet the diagnostic criteria for at least one common mental disorder. Findings in earlier research of a strong bi-directional relationship between violent and abusive relationships and mental health issues highlight a need for interventions to address these issues together.[64] A recent research study suggested that the high prevalence of PTSD in their sample identified a need for interventions that target the trauma of domestic abuse to be available in health services. It also recommended that healthcare professionals should identify mental health difficulties or PTSD symptoms as potential indicators of domestic abuse.[65]

Impact of domestic abuse on children

Studies have shown that violence can begin or escalate during or shortly after pregnancy.[66] A study published in 2001 found that 30% of domestic abuse begins in pregnancy while 40–60% of women experiencing domestic abuse are abused during pregnancy.[67] An estimated 130,000 children in the UK live in households with high-risk domestic abuse; that is, where there is a significant risk of harm or death.[68] Furthermore, 6% of all children are estimated to be exposed to severe domestic abuse between adults in their homes at some point in childhood.[69] Thousands more live with domestic abuse every single day – two studies reported that a quarter of young people had witnessed at least one episode of domestic abuse.[70] Research studies show a link between domestic abuse and child maltreatment,[71] and domestic abuse has been shown to be a factor in the family background in two thirds of Serious Case Reviews.[72] The Children and Family Court Advisory and Support Service (CAFCASS) reports that domestic abuse was present in 60% of cases that led to care applications in a 2011 sample.[73]

Children's development can be affected by both direct and indirect exposure to abuse, and the impact of domestic abuse on victims' mental health is particularly relevant given the negative association between parental depression and children's cognitive and language development.[74] The term 'toxic trio' has been used to describe the interaction between domestic abuse, mental ill-health and substance misuse, which have been identified as common features in cases of child maltreatment.[75] SafeLives' analysis of our Children's Insights database found that exposure to domestic abuse causes serious physical and psychological harm to children. As measured by the children's caseworkers, at intake, 52% had behavioural problems, 60% felt responsible for the negative events, 52% had problems with social development and relationships, and 39% had difficulties adjusting at school.[76]

In the same study, we found that only half (54%) of the children who were or had been exposed to domestic abuse, and only two-thirds (63%) of those exposed to severe domestic abuse, were known to children's social care prior to intake to the specialist children's service. This is concerning given the evidence that two-thirds were also directly harmed; 91% by the same perpetrator. Therefore, other statutory services – including health – have a role to play in ensuring children exposed to domestic abuse are being appropriately identified and referred for support.

UK Government policy

The first Government taskforce looking at the relationship between health and domestic abuse was launched in 2010, chaired by Professor Sir George Alberti. It concluded that "the NHS has a vital role to play in dealing with violence and abuse and its consequences, both short- and long-term."[77] It recommended that NHS Commissioners should assess local needs and local services for victims of sexual abuse and ensure that appropriate commissioning arrangements were in place. The taskforce also recommended that Commissioners should ensure that "appropriately funded and staffed services" were put in place along locally agreed pathways. It is regrettable that more of the recommendations have not been seen through.

Early in 2016, the UK Government launched the second of two strategic ambitions, to End Violence Against Women and Girls (VAWG) (2016–2020). In line with SafeLives' earlier research, the 2016–2020 VAWG strategy advocates an earlier, quicker and safer response to domestic abuse. Victims are to be identified *before* the point of crisis, securing their own (and their children's) safety at the earliest possible stage.

Unlike previous governmental policy, the current 2016–2020 VAWG strategy recognises the importance of integrating domestic abuse within healthcare settings in particular. It acknowledges that "GPs, midwives, health visitors, mental health, drug and alcohol services, sexual health and Accident and Emergency staff are well placed to identify abuse". Their ability to intervene early and direct victims towards appropriate statutory and non-statutory services is highlighted. Supporting the governmental VAWG strategy, this year's NHS Mandate recognises the vital role of the NHS in tackling domestic abuse. This sets expectations upon NHS England o ensure the NHS helps to identify abuse early and provides or identifies the relevant support.[78]

Over the past three years, the Public Health Outcomes Framework (PHOF) 2013–2016 has contributed to developing practices to integrate domestic abuse with healthcare. This is a framework aimed at reforming the public health system as a whole, situating public health within local government. Identifying domestic abuse as a key determinant of health, the PHOF administers responsibility to local authorities and local healthcare entities (GPs, A&E departments and hospitals) to recognise domestic abuse as a major public health issue, and protect those who are vulnerable.

The framework has this year been supported by the National Institute for Health and Care Excellence (NICE). NICE has developed a specific domestic violence and abuse Quality Standard, whereby the broader visions of the PHOF are expressed through four 'quality statements' designed to drive measurable improvements. These are: people

presenting to frontline staff with indicators of possible domestic abuse are asked about their experiences in a private discussion; people experiencing domestic abuse receive a response from trained staff; people experiencing domestic abuse are offered referral to specialist support services; and people who disclose that they are perpetrating domestic abuse are offered referral to specialist services.[79] The four practice-focused 'quality statements' closely reflect the earlier recommendations made by SafeLives' 2009 *Safety in Numbers* report, as well as the wider governmental VAWG strategy for integrating domestic abuse support within the realm of healthcare.

Conclusion

As stated by the WHO, domestic abuse is a public health emergency. From the terrible impact of domestic abuse on the immediate health of victims and their children, to the long-term implications of surviving or witnessing abuse, it is clear that the leadership of the NHS cannot afford to stand by. There are strong cost arguments for swift action too. The cost of drug abuse to the NHS is calculated at £488 million;[80] less than that of domestic abuse, yet the impact is recognised by decision-makers. At a time when the Government and health leaders are starting to increase the role that health can play in tackling domestic abuse, it makes sense for there to be strong leadership outside the traditional prism of criminal justice and local domestic abuse service provision.

There is a convincing case for the use of healthcare-based settings to identify and refer victims of domestic abuse, but more importantly, the evidence suggests that simply training staff to recognise signs of abuse and providing a referral pathway does not lead to effective identification and referral. As the IRIS model, Royal Free Foundation Trust and Saint Mary's Hospital, Manchester research suggests, locating specialist domestic abuse services within healthcare settings is proving to be much more effective at increasing referral rates. The Themis research provides a crucial piece in this puzzle, examining the effectiveness of the intervention itself in terms of safety and health of victims, as well as what makes a service work in practice.

Chapter 3 – Who are the victims accessing help through hospital-based domestic abuse services?

Victims with unmet needs – complex needs

Hospital Idvas were more likely to reach victims who had strikingly more complex needs than community Idva victims, though this is likely to be as a result of a greater likelihood of disclosure rather than prevalence.

Need disclosed to Idva	Hospital	Community
Mental health difficulties	57%	35%
Alcohol misuse	18%	8%
Drug misuse	11%	5%
Financial difficulties	40%	30%
Additional vulnerability (physical disability including hearing and sight or learning difficulty)	12%	8%
'Toxic trio' (domestic abuse, mental health difficulties, alcohol/drug misuse)	20%	7%

Nearly twice as many hospital victims had self-harmed or planned/attempted suicide than victims in a community setting (43% compared to 23%).

By reaching victims with complex needs in the hospital setting, it is more likely that Idvas will be able to provide a more holistic service which enables victims to access support for their needs as well as their safety. Women who experience domestic violence have twice the level of usage of general medical services and between three and eight times the level of usage of mental health services. This was borne out by our findings which showed overall, at the start of the Idva intervention, hospital victims had slightly poorer physical health than the national population, and much worse mental health. Their anxiety score was twice the national average and their depression score 2.5 times worse. Overall quality of life was only three-quarters of the national average (0.6 compared to 0.8). Just under half (49%) screened positive for PTSD, this is eight times as many as in an inner-city community sample (6%).

If we look at the figures which compared victims in hospital with those in local community services, (at the point of Idva intake), hospital and community victims had similar rates of anxiety and PTSD. However, hospital victims had poorer physical health than community victims and were significantly more depressed, although these differences were not statistically significant. One in six hospital victims (16%) had been to A&E for an overdose in the six months before seeing the hospital Idva, compared to 1 in 38 (3%) before seeing the community Idva.

The identification of victims who had self-harmed or planned/attempted suicide is important because according to research by Sylvia Walby's research, an estimated one in eight of all suicides and suicide attempts by women in the UK is due to domestic abuse. This equates to just under 200 women dying from suicide each year and nearly 10,000 attempting suicide each year because of domestic abuse.[81]

We are more likely to hear that two women a week are killed by a current or ex-partner in England and Wales, but it is estimated many more take their own lives as a result of domestic abuse: every day almost 30 women attempt suicide as a result of experiencing domestic abuse, and every week three women take their own lives.[82] By ensuring that domestic abuse is identified in a healthcare setting, specialist domestic abuse workers can help to make the victim safer, while health professionals are better able to understand the underlying causes of their ill-health.

Victims not visible to services

Hospital Idva victims at the five hospital sites were also more likely to be:

	Hospital	Community
Pregnant	17%	6%
Aged 55+	10%	7%
High-income households (£36,400+ per annum)	9%	4%

The increased prevalence of pregnant victims reflects the fact that some hospital Idvas had close links with maternity units. Given that the evidence shows domestic abuse of women increases during pregnancy, it is important that these victims are identified at the earliest opportunity within maternity services to prevent adverse birth outcomes, ranging from foetal loss, to early onset of labour, to an increase in maternal stress, which can lead to delayed foetal growth.[83]

Half of hospital victims (51%) also had children living with them. We know that research studies show a link between domestic abuse and child maltreatment,[84] and domestic abuse has been shown to be a factor in the family background in two-thirds of Serious Case Reviews.[85]

SafeLives' research[86] shows that 80% of older people (55+) who live with abuse are not visible to services, and of those who are, a quarter have lived with abuse for over 20 years. Given that older people are more likely to be users of NHS hospital services,[87] the fact that hospital Idva victims were

nearly 50% more likely to be aged over 55 suggests that this provides a setting in which we can increase services' ability to identify older victims.

Hospital Idvas also help more than twice as many victims from high-income households than community Idvas; reaching another demographic that is likely to be hidden from statutory services.[88]

Reaching victims earlier and reaching those still in relationships

Our data showed that hospital victims' abusers were more likely:

	Hospital	Community
To be with their current partner	53%	31%
To be living with their partner, sometimes or all the time	48%	29%

We know that many victims do not want to contact statutory services about their abuse, so it is significant that the hospital victims we see in the research are more likely to still be with their partners. Our national Insights dataset shows that a majority of victims engaging with community-based Idva services have left or are leaving their relationship, which means there need to be more options provided for those who aren't yet ready to leave or for whom leaving is not an option (for example, familial abuse or child to parent abuse).

Hospital victims had also been abused for a shorter time (median 30 months) than community Idva victims (median 36 months), which shows that victims engaging with hospital Idvas were accessing support around six months earlier than those in community settings. This is important because we know that victims need help before they reach crisis point, which is when they call the police, for example. This is borne out by the data which show fewer hospital victims had called the police (58% compared to 77% of community Idva victims). This means that for too many families, the response to abuse remains an emergency one, focused on criminal justice action rather than becoming safe from abuse. As discussed on page 31, we know that four out of five victims don't tell the police about their abuse,[89] which means that a key route to accessing specialist domestic abuse services may remain closed to victims if they don't know how to, or don't want to, self-refer.

The data also showed that victims identified in hospital were more likely to disclose severe physical and sexual abuse in the three months prior to contact with the Idva service, and were more likely to have experienced abuse from multiple perpetrators than community Idva victims:

Abuse disclosed by victim	Hospital	Community
Severe physical abuse in three months before Idva intake	46%	41%
Severe sexual abuse in three months before Idva intake	14%	10%
Multiple perpetrators	14%	8%

However, more hospital Idva cases did not have a planned closure, meaning contact with the Idva stopped before casework was complete (13% for community victims, compared to 5% for hospital victims). This might reflect the earlier stage of change many hospital victims were at, often still living with their abuser, and sometimes only just beginning to realise that the partner's behaviour was abusive.

Abuser characteristics

The profile of abusers of hospital victims suggests that they are more likely to have been abusive to others (79% hospital, 67% community Idva victims), but that they are less likely to have a criminal record for domestic abuse[90] (36% hospital, 45% community Idva victims).

This perhaps suggests that the perpetrators who are being identified through the hospital-based Idva service are more likely to be serial offenders, and therefore a risk to victims, but less likely to have been identified already by criminal justice services.

Why might hospital-based Idva services be identifying hidden victims or unmet needs?

It is suggested that the hospital location also provides an opportunity to identify pregnant victims and safeguard children sooner, or to identify victims with children who are not receiving help.

> *"Sometimes repeat attenders at labour wards come in every week with non-specific things. Labour ward is for anyone after 22 weeks. Before that potentially [they] go to A&E"*
> **Community Midwife Manager**

> *"We try and encourage them [healthcare workers] to ask if there is a child at home. These children are hidden children… there is often a child behind the adult"*
> **Named Nurse, Safeguarding Children**

> *"This is the one [service] that is reaching people younger and earlier… safeguarding children more quickly. Sometimes in the case of a pregnant mum, even before they are born"*
> **CEO DVA Organisation**

Hospital staff highlighted how victims were more likely to seek out the service knowing it is easily accessible and can provide protection. Comments from Idvas concur with this, and further indicate that these victims are distinct from those seen in the community.

> *"I think patients may seek referral here because they feel it is a safe place they can come. They come [saying] 'I know you have a service'. I don't think there are many other places… Coming to hospital equals place of safety and expect confidentiality"*
> **A&E Doctor**

> *"We found people we were identifying through A&E were not known by other services"*
> **Commissioner**

> *"I think we are meeting people who are hidden from society"*
> **Senior Hospital Idva**

The red flags of domestic abuse

Hospital staff noted the signs that alert them to possible domestic abuse. These include subtle or hidden symptoms that can be signs of ill-treatment, such as functional disorders[91] or pseudo-seizures,[92] where the link has not been made. Idvas confirm that many victims they see in the hospital setting have complex issues and higher needs.

"Frequent attenders present with chronic pain, psychiatric presentations, overdoses, or almost fictitious disorders… they are a passport to see the doctor... very rarely do women turn up missing a couple of teeth or with a big black eye"
A&E Consultant

"Often injuries or aches and pains that don't necessarily correlate with complaints of the patient… What's important is to explore underlying problems"
Senior House Officer

"You think 'Mm'… from 'my partner hates me' to 'I can't get any money for the taxi home because my partner has got my cash card'. Could be completely innocent or controlled"
Clinical Nurse Specialist

"A lot have mental health problems. A lot have personality disorders"
Hospital Idva

"Hospital victims – I think their needs are higher because [they] either come in with overdoses, attempted suicide, injuries or alcohol-related issues"
Senior Idva

Challenging the status quo

Both hospital staff and domestic abuse professionals drew attention to individuals who may not obviously be considered victims – those from a high-income background, for example, who were primarily identified in the hospital setting. This highlights the need to consider the possibility of domestic abuse in all individuals.

"Not always the partner that is the perpetrator… it can be [the] parent or child"
Clinical Nurse Specialist

"People need to remember that men can be victims of domestic violence as well… it can be more difficult for them to seek help or even acknowledge what's going on because of the whole gender thing… There might be less awareness in the hospital regarding men"
Clinical Nurse Specialist

"Not forgetting [the] elderly population in this, [it's] not just young people in classic situations. A number of elderly women don't want to go home. Husbands don't help them at home, [they are] not managing and [they] shout at them and they are frightened"
Practice Development Nurse

"Saw a lot of very wealthy middle-class women who suffered terrible domestic abuse from their husbands. One lady had hammer mark on forehead. Didn't press charges [said] 'No, I love him'"
A&E Matron

"[We see] different kinds of victims, for example, people with addictions, people who don't speak English, transgender…"
Hospital Idva

"And much older women who might end up at A&E in their 60s/70s and for the first time ever someone will ask her that question. Because very, very often those victims have never been anywhere near the police"
CEO, DVA Organisation

Chapter 4 – The role of a hospital-based Independent Domestic Violence Advisor

Idvas are a crucial part of community domestic abuse provision. They represent the voice of victims at the highest risk and are a single point of contact for them, addressing their needs and ensuring that statutory agencies act quickly to make them safe.

Hospital Idvas are domestic abuse workers who have an Idva (Independent Domestic Violence Advisor) qualification (Open College Level 3) and take referrals mainly from hospitals.

- Hospital-based Idvas (and Independent Domestic and Sexual Violence Advisors, Idsvas) can either be seconded into the hospital from an established community-based Idva service, or they can be part of a specific hospital-only commissioned service.
- On top of the Idvas' normal range of skills such as knowledge and empathy, they need to be confident in the hospital setting, good at networking with all levels of hospital staff, and skilled and flexible trainers.
- A background in mental health or other complex needs is helpful.
- The exact role of the Idva will depend on the agreement with the hospital but, in general, staff will fill out a referral form after they have gained consent from the patient, which will be passed on to the Idva, or staff may phone the Idva with the necessary details. The Idva can then respond accordingly.
- The Idva will complete a Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment and refer to Marac as usual if the victim is at high risk. If the victim has left the hospital, the Idva will arrange to meet them, either at the hospital, at the victim's home (if safe to do so), or in another private place (for example, a GP surgery).
- If a victim is assessed as being at standard or medium risk, the Idva will signpost them to other specialist domestic abuse services in the community.
- If the victim is identified out-of-hours and is at high risk, they may be kept in overnight so that the Idva can support them in the morning.
- Even if there is no disclosure or consent, if staff are concerned for the safety of the patient, they can notify the Idva, who can carry out checks on the hospital register or contact the Multi-Agency Safeguarding Hub (MASH) or Public Protection Unit (PPU).

Where were Idvas based and for how long?

Site 1 – One part-time Idva (four hours a week during weekdays in office hours) not based on hospital premises.

Site 2 – One part-time Idva (two days a week), not known how much time was spent on hospital premises or which days.

Site 3 – Two full-time Idvas based in the hospital with seven-day cover mostly during office hours.

Site 4 – One full-time Idva based in the hospital working weekdays mostly during office hours.

Site 5 – No specialised hospital Idvas at time of the study. Referrals from hospitals were made and then allotted to different Idvas.

In some other hospitals, another model is used – domestic abuse workers handle most cases referred by hospital staff, who refer high-risk cases to the qualified Idvas.

Coverage depended partly on the size of the hospital (Site 3 was substantially bigger than Site 4), but also on operational factors – for example, the extent of funding for the Idva service, commitment of the hospital to the Idva service, and whether a suitable office was provided in the hospital.

A day in the life of a hospital-based Idva

8.30am Listened to messages on phone. Four referrals in A&E. One overdose transferred to Medical Assessment Unit (MAU). Will still be in on Monday for me to visit. Also one patient kept in A&E overnight for me to see first thing.

9.00am Picked up referrals from A&E. Two inpatients: one home awaiting my call; one positive disclosure, no consent given for support. Staff very upset by this as was "a nasty assault". Clarified no children or not a vulnerable adult. Support given to that member of staff. Telephone to MAU to let them know I'm aware of victim, please hold until I get there. They are also waiting for the psychiatric ward, but have no free beds, so patient shouldn't be there if no medical need. Bleeped psychiatric ward to let them know I haven't accessed patient yet, but if they get there before me please ask domestic violence questions.

9.45am Took patient in A&E from cubicles into private room, made comfortable. Female victim, physical assault from partner, sustained head injury, facial lacerations, fractured jaw, bruising to torso, and broken ribs. During our interview, disclosed regular attempted strangulation. Victim has two children who are with maternal grandparents. Victim agreed to refuge with children. Her parents able to take them.

10.50am Bleep from Maternity ward delivery suite – one of my ladies has arrived by ambulance and is asking for me. Said I'll get there as soon as I can.

Talked to doctor about case with disclosure of repeated strangulation; more tests ordered due to this. Identified appropriate refuge space, unfortunately out of county. Victim agreed for short term, while other safety procedures can be put in place. Victim agreed to make a statement after meeting our in-house police officer and understanding the process.

Wrote up notes, completed children safeguarding forms and Marac referral.

11.20am Telephone call to MAU. Psychiatrist with patient, asked for them to call me when finished.

11.35am Visited Maternity ward delivery suite, met with my lady who is very anxious that ex-partner is going to turn up. Reassurance given by myself and midwife. Ward is locked, password system is in place. Patient's anxiety is having an impact on labour. Agreed to visit later. Patient has no birthing partner.

12.00pm Coffee. Psychiatrist called. Patient took overdose following argument with partner, described them as “very controlling and makes threats of physical violence”. Has experienced two previous abusive relationships and traumatic childhood. Has consented to speak with me. Psychiatrist referring to self-harm counsellor but nothing else as mental health reactionary to abuse. Patient expecting my call this week.

Completed ward round for delivery suite and Maternity ward. Recognised a name on the board, looked at notes. Partner is a well-known perpetrator in our service. Telephone call to Domestic Abuse Unit. Confirmed that partner is a domestic abuse serial and serious perpetrator (DASSP), and that he had been to Marac four months ago with an ex-partner as the victim. Telephone call to community midwife. They were never able to ask about domestic abuse within the relationship as he was always there. Telephone call to social care. They weren’t aware of the pregnancy. They have worked with the victim previously with her other child. Safeguarding children referral form completed. Wrote up notes.

12.30pm Child protection conference for existing client. Sandwich in car.

2.00pm Visit for existing client.

3.30pm Bleeped by A&E. 78-year-old admitted with head injury. Disclosed he had been hit by his daughter (carer) with his walking stick as he was being too slow. After further questioning, disclosed other physical, emotional and financial abuse. A&E will find him a bed somewhere under welfare need, but he has consented for me to talk with him. Completed Risk Identification Checklist (RIC). Referral to vulnerable adult team. Marac referral. Wrote up notes.

5.00pm Checked emails and admin.

6.00pm Finished.

Victims' views of Idvas

Initial validation by a sympathetic Idva was crucial and precious to victims, which is in line with the type of feedback that community-based Idvas often receive. Victims supported by the hospital-based Idva also: gained confidence to access support in the future; could be empowered to make radical changes (for example, give evidence to police, ask perpetrator to leave, and/or move to new area); and could be enabled to access services more quickly (such as mental health and alcohol/drug services) or to access services that were not otherwise available (such as an immediate police response if they are a high-risk client).

> *"Hospital [Idva] has been helping me and referring me to places. Everything is getting sorted out. I have been waiting years to get help with my depression. My doctor now is a waste of space. He weren't interested"*
> **Victim of domestic abuse**

> *"Up until this point, I was trying so hard to get help but now I have had so much support and I know it's still there all the time. It has been wonderful, absolutely wonderful… My confidence is coming back. I feel like now I can be there for the children. And my mum, it has gone right round the family. I have seven children and grandchildren. It has touched the entire family. You have no idea what a mess you have been in and how it's affecting the entire family… I don't know what would have happened without that support. I think we would have seen somebody die"*
> **Victim of domestic abuse** (Abuse by teenage daughter to mother and sister)

> *"She's helped me so much with getting him to go to the [perpetrators'] course. Helped me write letters. She's been absolutely amazing. She is still working with me. I feel she's the only person I can be honest to"*
> **Victim of domestic abuse**

- Some victims would have liked earlier support, for example, at an earlier hospital visit, such as when giving birth. Some required longer support than offered, particularly if further harassed by the perpetrator or dealing with a family fall-out from the abuse – for example, child behavioural problems or children taken into foster care.
- One male victim greatly appreciated the help from his female Idva but would have preferred a male Idva, claiming he would have been better able to "relate to a man's way of thinking". He had felt that the police, and especially social services, were more sceptical than they would have been towards a female victim.

- Some victims didn't recognise they had been abused at first, and the Idva could raise awareness, giving skilled help in recognising healthy and unhealthy relationships.

"I didn't really think it was abuse. I thought it was quite normal. It was psychological – I didn't recognise it. I couldn't see it till it got really out of hand"
Victim of abuse

"You look back and think 'How did all that happen? How did you not realise that this wasn't living?' and carrying on like it was normal"
Victim of abuse

"Now, because I don't think anyone has taken it seriously, I feel I'm having to give up my home. I can't live like this. I have been pushed into an impossible situation. I can't live in fear for the rest of my life"
74-year-old woman abused for 40 years

Staff training in domestic abuse compared to hospital-based domestic abuse services

It could appear tempting for over-stretched services to invest in training, rather than incurring the cost of employing domestic abuse professionals directly in hospital. However, this would not be an effective or cost-effective alternative. This is demonstrated through SafeLives' consultancy research, which involved interviewing clinicians in one County Council area in 2015, and found the following:

- Generic safeguarding training failed to equip practitioners to safely and competently address the needs of people who have experienced domestic violence.
- When training did take place, there were not always supporting policies, standard operating procedures or pathways in place.
- Even Level 3 safeguarding training covered a very wide breadth and thus failed to deliver the necessary depth of understanding of domestic abuse.

- There were widespread variations in access to training. For example, in some organisations Level 3 safeguarding training was delivered to all clinical staff, whereas in others, only registered staff were trained to Level 3.
- Without a thorough understanding of the nature and dynamic of domestic violence, it was possible for clinicians to follow a process but potentially increase the risk to the victim.

Moreover, while there was a desire to ask patients about domestic abuse, A&E and midwifery clinicians suggested that there were barriers to doing so where there was not a rapid and robust referral mechanism once there had been a disclosure. It confirmed the Themis qualitative findings that busy clinicians, who may only have a 10-minute consultation, are unlikely to ask about domestic abuse if there is no referral pathway, or if that pathway would require them to spend much non-clinical time on the patient's behalf.

Chapter 5 – What creates an effective hospital-based domestic abuse service?

The Idva as a healthcare professional

The qualitative evidence from the interviews that follow demonstrate the Idva as a professional in the domestic abuse sector and highlight the knowledge and specialism involved in carrying out the role. Respondents convey the benefits that an Idva's expertise can bring to hospital staff and the organisation as a whole, which include: education and training; being a main point of referral and support to staff; and using their specialist knowledge to help save time for hospital employees; and preventing crises, making it cost-effective for the NHS overall. The wide-ranging and demanding nature of the hospital Idva role is also highlighted.

Establishing quality standards

Idvas highlighted the importance of guidance and training in enabling hospital staff to ask questions about domestic abuse. This expertise was recognised by hospital staff, who explained how this gave them confidence to support victims and equipped them to make enquiries about domestic abuse:

> *"Having [the Idvas] here and being able to discuss with them and having confidence to be able to question patients in terms of domestic and sexual violence – it is an incredible service"*
> **A&E Lead Nurse**

> *"For something that's quite a complex and emotive subject it is really nice to have a person when we know we have concerns… sometimes we have a hunch and we have somebody to say 'Can I just run it past you?'"*
> **Hospital Midwife**

> *"We train people to be brave enough to ask. Don't be frightened to ask the question because if the answer is 'Yes', it is OK because we are here"*
> **Idva Team Leader**

Although training is a key aspect of the Idva role, interviewees commented on the sheer scale of training in a large organisation with a constant turnover of staff. One respondent commented: "*It is like painting the Forth Bridge*" (**Commissioner**). Hospital staff noted their already difficult training schedules and Idvas mentioned how continuous training challenges their working practice:

"A&E has a high turnover of medical staff… sustaining, training people to understand the importance of asking questions… needs constant work or structures that enable that"
Team Leader Mental Health

"Every 6 to 9 months nurses and doctors turn over… we do some training and awareness work with one lot and we have got them leaving and moving on"
Idva Services Manager

Opening Pandora's Box

Respondents talked of the value of having the Idva as a clear pathway for referrals, and how this encourages staff to 'ask the question', knowing that they have support and a means of action. Idvas noted the concern practitioners have in dealing with a disclosure of domestic abuse without clear pathways into support:

"Having an Idva means we have a very clear pathway of referral, which is very important… very big difference between identifying and knowing there is something they can do. We have [the] opportunity to take action at that point, even if just to send [an] email"
A&E Consultant

"Knowing that we are on site [is beneficial]. [A] lot of practitioners [are] worried about disclosures. 'We have opened a can of worms. What can we offer?'"
Senior Idva

Saving time, saving money

Hospital staff recognised that the expertise of the Idvas saved them time and hence made them economically worthwhile to the organisation. Domestic abuse professionals note the need to evidence savings, and one Commissioner cited the savings a hospital Idva service can make:

"We do leave lots of work up to them… they do so much more with patients [than] we could ever dream of doing because of time. Their role is so important, I don't know what we would do without them"
A&E Consultant

"It is really helpful to have input from an Idva… One of my nurses spent a whole day and I spent a whole afternoon trying to find one refuge"
Consultant Psychiatrist

"Evidence would need to show a reduction in repeat attendances to hospital… because victims, when suffering from domestic abuse, they keep turning up at A&E. If we can show a reduction in that, it can prove its worth… It would have to be [an] economic argument"
City Council Commissioner

"We can extrapolate the money saved by hospital Idva service, so we kept it [the Idva service] – it's a 'Spend to save' agenda"
Commissioner

The Idva-plus role

The hospital Idvas' role differs from the community Idvas' role, requiring some additional skills. On top of their usual demanding repertoire of knowledge, skills and empathy, they need familiarity with the hospital setting, confidence to walk into wards and liaise with staff, and they need to be skilled and flexible trainers. In addition, their needs for clinical supervision may be higher than community Idvas. If based in A&E, they are working in a setting where trauma is routine and often graphic. They face the challenge of working with more victims who have complex needs (including some whose partners are offenders, causing them to fear repercussions from approaching anyone for help), and with more victims who are at an earlier stage of change, who are more likely to return to the abuser.

"[Hospital Idvas] need therapeutic counselling because of the cumulative emotional stress of the job. This emotional strain is not so high in other Idva roles"
CEO, DVA Organisation

Out of sight, out of mind

The Idva needs to be seen and embedded in the hospital setting. Building relationships and networking are essential for the service to be successful. Also key is the need for the service to be visible and able to cope with the challenges associated with this, bearing in mind the size of the organisation and possible consequences of being prominent.

Building relationships

Hospital staff noted how networking and building relationships with hospital teams is crucial to achieving positive outcomes. Domestic abuse professionals corroborate this by highlighting how self-confidence and the ability to make contacts are important personal attributes for an Idva, and how Idvas may need support to do this.

> *"They (Idvas) have lunch in the staff room. They socialise with the team. That is where the success really comes from. They are not seen as a separate and aloof service that we just refer to"*
> **A&E Nurse**

> *"[It is] important to build rapport with hospital staff. Having [a] recognisable face… hospital Idvas need confidence to network and introduce themselves"*
> **Idva Team Leader**

> *"I felt really lonely just being there in the beginning. Trying to find people to introduce myself [to]. It still is lonely"*
> **Hospital Idva**

Putting down roots

Further to building relationships, staff mentioned that having an Idva based in the hospital setting prompted their awareness of the service. Idvas without a hospital base to engage with victims noted how this negatively impacted on their practice.

> *"Domestic violence is in your mind because we walk past their door. Having them here is a constant reminder to us"*
> **A&E Consultant**

> *"If I had [an] office – that might help…"*
> **Hospital Idva**

> *"I can't really see anybody here… [I've] not got a private room to see people in"*
> **Hospital Idva**

The visibility of the Idva

Hospital staff stressed the need for the Idva to be visible and accessible in order for them to remember to use the service. As indicated in the previous section, this can pose problems for Idvas if they do not have a base in the hospital to operate from. However, a more prominent presence can cause challenges for Idvas in prioritising their workload.

> *"They go around the department every day and speak to the staff… check for referrals. If they are not visibly there we don't remember to use the service because [the] department is very busy"*
> **Alcohol Nurse**

> *"[The] fact that she's instantly accessible. [The] role is very, very, very busy and it is constant… Medical staff expect if she is there, to be able to talk to her, get information from her, for her to act. Whereas [it] gives that role less time to prioritise… [it] is a real challenge of the role"*
> **CEO, DVA Organisation**

Another consideration of being 'seen' in the hospital setting is that patients also become aware that the service is there. This may be beneficial for victims as it creates an additional self-referral pathway, but there also needs to be consideration of the implications of being aware of the service and how this will be managed.

> *"In the past, we would get multiple victims turn up numerous times in A&E. They might be just to see us. Walk into reception: 'I'm here to see [XYZ] services'. [A] couple came out of the blue"*
> **Senior Idva**

> *"The question is whether to publicise… there is risk to the client if word gets out that we are running the study; a relative or friend see Idva with client and identify. It can put client and service at risk…"*
> **Research Nurse**

The scale of the task

A concern of both hospital staff and professionals was how to raise awareness internally of the domestic abuse service, given the large size of the hospital organisation. Idvas noted the importance of reaching all departments and staff highlighted the need for this to be organised and promoted for successful implementation and outcomes.

> *"The sheer scale of the place. All the different wards knowing about us and how to refer to us… I think we are missing quite a lot of opportunities"*
> **Hospital Idva**

> *"For any new Idva, going into any hospital, there has to be a plan… you have got to sell yourself… to get across what you are there for, in an easy-to-understand way. If just the Idva, [they] can be [the] lone voice in [a] massive organisation"*
> **Adult Safeguarding Lead**

One Idva noted how the support of senior hospital staff can act as a bridge between hospital teams and the service.

> *"For a hospital Idva service to run properly and be accepted by hospital staff, you need a medical champion – the higher up the better. Junior doctors want to impress them – they don't want to miss stuff. So if the senior medic says this is important, then they'll look for it"*
> **Senior Idva**

Following NICE guidelines

NICE published quality standards in February 2016 setting out how health staff should ask about domestic abuse. Quality Statement 1 suggests that "services should ensure that they can provide a safe and private environment in which people feel able to disclose that they are experiencing domestic violence and abuse."[93]

Our research highlighted a number of issues with asking victims about domestic abuse. For example: whether to make a targeted ask; the disparity between staff who do or don't ask; concerns about asking; and effective ways of asking about domestic abuse in a private space.

Asking about domestic abuse

Responses from hospital staff indicated a difference in opinion about whether all patients should be asked about domestic abuse, or whether enquiries should be targeted in line with NICE guidelines. Some consider that consistent questioning removes the taboo, whereas others have reservations about whether they should be building an evidence case, and whether this is sustainable or a priority for their role. Domestic abuse professionals who were interviewed mostly advocated asking all patients, but noted the varying practices for screening across hospitals.

> *"Routine enquiry is good because [it] gets rid of [the] fear of asking… we will pick up ones we wouldn't suspect and hopefully pick things up earlier and more subtly. It loses the supposed stigma in asking about these things"*
> **A&E Consultant**

> *"We do targeted enquiry… general screening is not as successful. The evidence shows we should ask certain risk groups"*
> **A&E Consultant**

> *"I don't know that [universal enquiry] is sustainable long-term… also not main priority of our roles. Our role is focused assessment, not screening"*
> **Emergency Medicine Consultant**

> *"The evidence is saying we should actually ask it, and ask it with confidence. Not 'I am really sorry, I have got to ask this'. Without an apology, as if it is a normal thing to ask"*
> **Council Commissioner**

While advocating asking everyone, some hospital staff felt that workload pressures and lack of resources prevent this.

> *"I actually think we should ask everybody… but our workload is too onerous… if we had more resource I think I would routinely screen everybody and I think we could pick up people. If we only screen people we think are at risk, we already miss half the people"*
> **A&E Consultant**

> *"If we were serious about really looking for this, we would find things we don't want to find. Unfortunately… we haven't even marshalled resources to deal with what we already see, so why triple our workload?"*
> **Consultant Psychiatrist**

The fear of asking

Staff indicate that there are some hospital employees who are cautious of asking patients about domestic abuse. This can be due to the difficulty of asking the question, or a fear of the outcome and potential of having to deal with a disclosure. Idvas note a common concern among hospital staff of 'opening a can of worms'. A further indication that emerged was the likelihood that there will be staff who have experienced or are dealing with domestic abuse themselves.

> *"I think staff are uncomfortable about asking unless it clearly relates to an injury or relationship issue… [They think] 'if I ask about their relationship, that will open up a whole can of worms, and I am not comfortable with that and haven't got the time'"*
> **Team Leader Mental Health**

> *"Some people feel really uncomfortable asking. [We] often do case studies: if we find someone who has disclosed, [we] look at last attendance. Go to staff, 'why didn't you ask?' No explanation given"*
> **Senior Hospital Idva**

> *"People would find a hospital Idva in the corridor and tell them quite powerful stuff. Obviously nursing staff are mainly female. Quite [a] high incidence of abuse... feeling was [that] quite lot of people were feeling uncomfortable because it brought up a lot for themselves"*
> **A&E Consultant**

> *"[Idva]… used to get a lot of disclosures from hospital staff… if you had experienced it and had survived or just got on with it, you might be less sympathetic in asking that question"*
> **Idva Team Leader**

Staff who don't ask

Hospital staff and Idvas also highlight the inconsistency across individuals and departments regarding the importance of asking about domestic abuse. Idvas note this disparity is also present in departments that have been advised to routinely screen.

> *"Some wards and departments are very much geared up to be aware of domestic violence… might get other wards where [domestic abuse] is not a huge issue... less part of the culture to ask about"*
> **Clinical Nurse Specialist**

"Some, especially male nurses, won't ask because they feel awkward… one said 'you just know, it is just obvious'… one won't ask because she wouldn't like to be asked herself. Ambulance staff don't ask… if they do, [they] don't do anything about it"
A&E Sister

"Dental have been quite unco-operative. They say that they don't see much domestic violence but about 30% [of] assaults we get through are facial/dental injuries"
Idva

"[Idva has] only had two to three referrals from [maternity ward in hospital] since June 2013. Few from community midwives and [a] couple from maternity discharge planning team"
Hospital Idva

The best way to ask

Staff acknowledged that the training given by Idvas about how to ask patients the question about domestic abuse was beneficial. Some of the most effective ways of asking concentrated on engaging around the issue rather than direct questioning.

"Asking around [the issue]... you can get a sense of their world. Gaining someone's trust and showing interest from that comment: 'I am cold at home… I'm not allowed to put the heating on because John won't let me. He says I am lazy'"
A&E Practice Development Nurse

"'Do you think there are any problems at home? We have seen these injuries that have been based on domestic violence in the past. Is there anything you would like to tell me?' You are not putting words in their mouth but empowering them to say it. A lot of that has come from our Idva here – empowered [us] to move from taboo to routine"
A&E Consultant

The golden window of opportunity

When a patient discloses domestic abuse, it is important to act immediately. Victims in the hospital setting are often at the 'point of crisis' and motivated to disclose. Once again, the importance of co-location is emphasised as it aids immediacy and promotes engagement.

In the right place, at the right time

Hospital staff and Idvas noted the benefits of co-location in order to have an immediate response for the victim so they do not lose the opportunity to engage with them. Staff noted how they would benefit from an out-of-hours service or helpline.

> *"Key thing is, sometimes, I think we should have [Idvas] here as much as we are… when someone starts to open up, we really want to respond right there and then…[you can say] we have got specialist people here to give really good advice, options, pathways"*
> **Clinical Nurse Specialist**

> *"[A] woman in her 70s… disclosed a lot of abuse… by Monday morning, she denied everything. Even an on-call system for advice would be nice out of hours"*
> **A&E Sister**

> *"[You've] got to find windows of opportunity. The window stays open for about four hours and [you've] got to do everything you can within it"*
> **Idva Service Manager/Commissioner**

> *"We are catching people at point of crisis, at the time. Otherwise, they have gone home and been reluctant to engage. We are getting there earlier"*
> **Hospital Idva**

The motivation to change

Domestic abuse professionals note that presenting at a hospital setting at crisis point or with an injury may act as a motivating factor in the 'stages of change'.[94] Hospital staff also recognise a client's moment of bravery and an impulse to make change.

> *"Some, because injured, are very motivated. [It] drives them through stages of change. [It] can lead to emergency accommodation or injunction"*
> **Senior Idva**

> *"Because often that person will have momentary 'weakness'… in truth, that is a moment of bravery followed by deep anxiety about what they have done and said"*
> **Consultant Psychiatrist**

Sowing the seed

While the hospital setting can identify victims earlier, a client may not always be ready to engage. However, the initial contact gives professionals a chance to identify and pass covert information to a victim for further consideration.

> *"For me, meeting someone and advising them of their options… is a move in the right direction. I am happy with that… at some point when they are ready, then they know that there are options"*
> **Hospital Idva**

> *"When we close, we make sure they know who they can contact if it happens again. Knowing they can call us if they need to is really helpful"*
> **Hospital Idva**

> *"[Our intervention][95] gives them that bit of time. Quite often when we see people, there is so much happening. From a slightly personal point of view, you always feel slightly better that you have done a bit of a better deed than just send them back to some awful sort of situation"*
> **Clinical Nurse Specialist**

Working together to tackle domestic abuse

Hospital staff, departments and agencies need to work together to identify and assist victims of domestic abuse. This can range from alerting professionals about possible victims, to how the hospital location can make services more easily accessible to victims; from the issues of sharing information, to what Idvas can do to encourage a good working relationship with hospital staff.

Flagging and tagging

Hospital staff noted how 'flagging' cases can alert staff and other services to vulnerable patients. Idvas promote the benefits of this and show hospitals where flagging is not practiced how this can hinder partnership working.

> *"Now [you] must document on a hospital record. Now it's a computerised record, box you tick. If you suspect domestic violence but it's not disclosed, [you must] document that you asked. Continue monitoring and surveillance. A lot of what we do is fact-finding and info-sharing"*
> **Lead Nurse for Safeguarding**

"Repeat attendances at A&E as a result of the abuse will come up on the system… number of times in before, red alert, under Idvas. Red flag goes straight to Idvas – alert"
A&E Nurse

"In past jobs we haven't had info because people have been anonymous, talking to us on the phone. Here, if people don't want to engage, we can flag to hospital and GP and Marac without consent and feel we are more effective really"
Hospital Idva

"They [another hospital] can put flags on patient records. If Marac victims – flag, put referral to Idva on them. Here, unless there is a child or open SOVA[96] they wouldn't be able to do that… [not being] on the system makes it [a] lot more difficult for partnership working"
Hospital Services Manager

Fast-tracking

Idvas comment on how being in the hospital environment gave them the ability to have prompt access to other services and the ability to fast-track patients to appropriate interventions. Due to the emphasis put on safeguarding within hospitals and co-location, children can be referred to services immediately and plans can be put in place to protect new-borns.

"[There is a] lot more close liaison with other specialists, which can be harder to do in community-based [services] – we are in the same building"
Senior Idva

"We are identifying more domestic violence victims because we are here and therefore we are identifying more children… we [have] really good links with child protection on site in case children are abused"
Hospital Idva

"A lot of victims are pregnant, we do lots [of] good work with post-natal and some antenatal and labour wards to plan for birth and afterwards"
Hospital Idva

Working and sharing

Hospital staff note the unease of sharing information and how setting up Idvas with secure email, for example, can help overcome barriers.

"Info-sharing and confidentiality… I think there is always that level of discomfort and making sure you are disclosing only what needs to be disclosed. This is one of the biggest barriers"
A&E Consultant

"Previously the Idva had already worked on faxed referral process and went to email address but wasn't secure for NHS address… so I created nhs.net email address for referrals to be sent so that Idvas could use. So staff [could] email Idva and send referrals confidently – owned by Trust, so that staff never worry"
Adult Safeguarding Lead

Some Idvas note how co-location has assisted in forming good working relationships, whereas hospital staff highlight how operational differences between groups can hinder multi-agency working.

"I think co-location is critical… there is real information-sharing… being physically there makes such a difference. Amount of contact I have now and good relationships I have now with other professionals [is working well]"
Idva Team Leader

"Trying to marry services that are chalk and cheese"
Adult Safeguarding Lead

"Different thresholds for what would they [agencies] think is important. I spend quite a lot of time building up good networks. Sometimes people say…'we are on different planets'"
Lead Nurse for Safeguarding

Some staff mentioned how they would like feedback from the Idva on what happens with referrals to encourage a good working relationship.

"I'd like a bit more knowledge of what happens next… [I] make initial referral and never really find out what happens next… doesn't help motivate me to make referrals"
Consultant Psychiatrist

"Nice for the staff… what was the outcome? Nice to have a bit of feedback"
A&E Sister

Chapter 6 – Checklist for Commissioners of hospital-based domestic abuse services

- Idvas need to have **strong links with community-based provision** and be trained in community-based interventions to ensure they can refer victims appropriately. Idvas who have a mental health background would be particularly suited to working within this setting.

- Hospital Idvas should be valued and **integrated within hospital staff** – they need to be set up with an email, ID with access to wards, an appropriate room, access to hospital register/patient records, and an appropriate hospital manager (such as the Safeguarding Lead). Without access to medical notes on the hospital's database, it is difficult for Idvas to monitor key risk indicators that could be used to assess risk and share with Marac. These indicators could include repeat attendance, other types of attendance for other symptoms or injuries, or other mental health, physical health or drug/alcohol factors.

- Good **clinical supervision** for Idvas helps them to feel well supported in the complex hospital work environment. Within A&E, and the hospital generally, Idvas are far more exposed to the very visible effects of abuse, compared with community-based Idvas who may see clients after they have received medical care. Consideration should be given to whether an Idva needs an 'honorary' NHS contract so that they are given a salary band within the hospital which further embeds them into the structure.

- Think about the number of Idvas needed to cover a **seven-day service**. The number of victims visiting a hospital peaks on Friday and Saturday evenings (and in some cases on Sunday or Monday when victims come into a service having waited over the weekend). Commissioning a 24/7 service could help to ensure that victims receive support when they need it. Idvas should not be 'lone workers' and the number of Idvas employed should reflect the number of hospital patients, so caseloads can be managed appropriately.

- The service commissioned should be **sustainably funded** over the long-term rather than a 'one-off' – to ensure it successfully embeds in the hospital. The Commissioner should pay particular attention to how they hold the hospital accountable for how it embeds the Idva service, and ensure there is attendance at steering group meetings to help make the most of the service.

- The Lead Consultant in A&E/Maternity needs to be on board with the service right from the start, and every ward/department should have a **Senior Domestic Abuse Champion** who helps the Idva to make links with departments. Buy-in from safeguarding teams is particularly important.

- **Expectations** of the Idva need to be defined from the start, particularly in relation to staff training and referrals. Training in particular is demanding on Idvas given the number of staff in a hospital setting, and extra support needs to be planned to enable them to fulfil this vital part of the role. Hospital Idvas need to have a high level of confidence in order to carry out training at all staff levels in the hospital, and to make links with all departments.

- The first six months of the role need to **focus on setting up** the service, instituting policies and training, not taking referrals.

- All hospitals should have a domestic abuse policy in place for both patients and staff. Hospitals should be ready for high rates of **disclosure by hospital staff**, and recognise the challenges posed by disclosures from staff whose perpetrator is also employed by the Trust, particularly in relation to potential access to confidential information.

- Idvas need to be **embedded in the hospital**, ideally with an office in the A&E department, and highly visible with reach to all hospital departments. For example, the service could be advertised on payroll slips, on the intranet, on every ward, in waiting rooms and in toilet cubicles through posters and leaflets.

- All staff need **mandatory domestic abuse training**, ideally delivered by the Idva as part of safeguarding training at Level 1, and at any other training opportunities. Domestic abuse training should be part of the hospital induction.

- Hospital staff asking about domestic abuse should follow **NICE guidelines**. The presence of hospital Idvas makes this much more likely in practice.

- SafeLives estimates that one full time Idva costs **approximately £50,000**. This includes salary costs as well as associated costs, such as management and administration overheads, training and accreditation to ensure quality. It also includes clinical support to ensure an effective service can be delivered. Safe caseloads range between 65 and 85 for Idvas and outreach workers; typically Idvas are expected to support victims at high risk and some medium-risk cases (likely to require less intensive support). While all hospital Idvas will take referrals at all levels of risk, only some will go on to provide support to victims at all levels of risk. However, hospital Idvas will spend up to 25% of their time training other members of clinical staff, so their caseloads need to be commensurately smaller.[97]

Chapter 7 – Understanding the impact of hospital-based domestic abuse services

Increased safety

After an intervention by hospital-based domestic abuse services, according to the Themis Insights dataset, 9 out of 10 hospital and community victims reported feeling safer, with just over half (58% hospital, 51% community victims) saying they felt “much safer”. Similarly, 9 out of 10 hospital and community victims felt their quality of life had improved, half by “a lot” (53% hospital, 49% community victims).

Almost all victims felt confident to access help in future, with over half saying they felt “very confident” (56% hospital, 57% community victims). Idvas reported sustainable risk reduction (that is, moderate or significant risk reduction that is expected to be sustainable in the medium- to long-term) for similar numbers (64% hospital, 67% community victims).

For **hospital and community victims**, **improved safety** reported by Idvas increased if support was more intensive.[98] This includes:

- **more interventions accessed (6+);**
- **a longer period of support (i.e. case length); and**
- **more Idva contacts (5+).**

Improved safety from the abuse **dropped if patients had ever had suicidal behaviour** (i.e. plans/attempts).

For **community victims**, increased Idva-reported **safety was more likely** if:

- **the perpetrator had financial problems; or**
- **the victim had experienced more severe physical abuse at Idva intake.**

For **community victims**, improved Idva-reported safety was **less likely if the victim had alcohol or drug problems.**

In terms of improvements in reported safety, victims saw similar ‘success’ rates whether they accessed hospital or communicy Idvas. When we take into account the higher rates of complex needs and suicidality among hospital victims, these similar success rates are a notable finding.

A chance to identify victims earlier

Hospital victims had used all hospital services[99] more than community victims in the six months before Idva intake (perhaps partly because of their poorer physical health and worse depression, and partly because hospital Idvas are mostly picking up referrals from hospital staff). The difference was significant for inpatient nights and A&E visits, but not outpatient appointments. They had also used ambulances more often to get to the A&E.

A&E use

In the six months before they started working with an Idva, just over half of the hospital victims (N=41) had attended an A&E at least once (or, rarely, a walk-in Minor Injuries Unit), compared to less than a third of community victims. This reflects the fact that 38 of these hospital Idva victims had been referred to the Idva by the A&E; whereas none of the community Idva victims were referred by these means.

- **More hospital Idva victims** had attended an A&E (54% compared to 29% community victims).
- More hospital victims said they had visited A&E because of **domestic abuse** (38% compared to 18% of community victims).
- More hospital victims had visited A&E for **mental health reasons**, largely overdoses and self-harm, for which they would be considered for physical *and* mental health treatment (22% compared to 3% of community victims).
- One in six hospital victims (16%) had been taken to A&E after an **overdose**, compared to just one of the community victims (3%), perhaps reflecting hospital victims' higher rate of depression.

Altogether, in the six months before accessing the Idva service, the 76 hospital victims made 103 visits to A&E (averaging 1.4 visits each), and the 38 community victims made 14 visits (averaging 0.4 visits each).

However, if an extreme outlier is omitted from the hospital sample (whose weekly A&E and ambulance use represented less than 0.05% of the UK population and strongly skewed results for this sample), 75 hospital clients had made 73 visits to A&E (averaging 1.0 visits each). The following findings exclude this outlier.

Community Idva victims showed a very different pattern of A&E attendance from victims referred by hospital Idvas. Fewer had been to A&E before starting to get help from an Idva, and nearly all attendances were for physical health reasons. Even so, the fact that 29% had been to A&E

in the six months before accessing a community Idva, and that almost all of their visits (86%) were related to domestic abuse – nearly two-thirds (64%) specifically because of injuries by the abuser – indicates the important potential for hospitals to identify these victims earlier.

It may also have been possible to identify some hospital victims earlier: 18 of the 41 (44%) hospital victims who had visited A&E in the six months before referral had visited more than once.

There is considerable potential, then, for hospital A&Es to identify victims of domestic abuse earlier – patients they are already identifying who have visited previously, and those they are not identifying, who later come to the notice of the police who then refer them to a community Idva. Not all victims would be prepared to disclose, but at least they would know where to go for help when they needed it.

Ambulance use

- At least half of the ambulance uses for both hospital and community victims were related to domestic abuse; considerably more for community victims (83% compared to 52%).
- Only one in six (16%) ambulance uses by hospital victims were because of physical injury by the abuser, compared to four in six by community Idva victims.
- Well over half of the ambulance uses were for physical health reasons, particularly for community Idva victims.
- Mental health (predominantly overdose) was a more common reason for ambulance use by hospital victims: accounting for one in three for hospital victims and one in six for community victims.

In two-thirds of the cases where a victim attended A&E for a condition related to domestic abuse (injury, overdose, or existing physical/mental complaint worsened by stress of the abuse), they travelled there by ambulance (63% of all 49 domestic abuse-related A&E visits by hospital and community victims). This puts ambulance crews in a potentially key position to identify domestic abuse victims, particularly as they see them soon after the health crisis, when victims may be more willing to disclose. This was the case for 29% of all victims later referred to a hospital Idva, and 13% of victims later referred to a community Idva. In some cases, the victim is not transported to hospital – in which case, the ambulance crew may be the only healthcare staff that victims see after an incident.

Ambulance crew should be included in domestic abuse training and understand the referral pathway for highlighting disclosure and the need for domestic abuse questions to be asked.

Use of hospital service post-Idva intervention

The number of hospital services used pre- and post-intervention was compared for 30 hospital victims (excluding the outlier) over a three-month period.[100] Caution must be exercised when interpreting these results because of the small size of the sample, but they can be regarded as indicative.

Before accessing support from an Idva, hospital victims had spent, on average, two nights as an inpatient in the past three months. Post-intervention, no victims had spent time in hospital as an inpatient. This emerged as a significant difference. Interestingly, the number of outpatient appointments increased by 30% post-Idva intervention. This may have been because victims had been put in touch with hospital services after accessing the Idva, particularly those related to mental health and substance misuse.

For the 30 hospital victims asked at Idva intake and three months after Idva exit, there were no significant differences in the use of community services and mental health services.[101] This perhaps illustrates the long-lasting effects of domestic abuse on victims' health.

Cost-benefits of the hospital Idva service

Despite the long-term impact domestic abuse has on health, this analysis identified that there could be a cost saving in health services once victims have accessed the hospital Idva service. On average, an individual accessing the hospital Idva service costs £4,000 in healthcare services during the six months before and after the Idva intervention. After receiving support, costs were reducing by 41% per client, equivalent to an estimated £2,050 annual reduction in health service use per client. Community Idva victims cost £1,066 per annum in their use of hospital, local and mental health services.

This study cannot identify how much of this drop in health service use was a result of the Idva intervention, however it does identify that the reduction in costs is largely based on the use of hospital services.

In a separate pilot of the Idva service at Saint Mary's Hospital, Manchester, the evaluation team calculated that the 28 cases referred to Maracs as part of the pilot saved the public sector £170,800, compared with the costs of £50,591 to the health service of employing a full-time Idva.[102]

Specific service savings

The health cost saving after a hospital Idva intervention is £2,050 per patient, per year. This consists of:

- **Saving in hospital service use** (i.e. inpatient, outpatient, A&E) of £2,184 per patient, per annum
- **Saving in ambulance use** of £200 per patient, per annum
- **Rise in local surgery use** (i.e. GP, practice nurse, nurse practitioner, health visitor) of £64 per patient, per annum
- **Rise in mental health service use** of £196 per patient, per annum
- **Rise in drug/alcohol service use** of £74 per patient, per annum

There is also a **rise in social services costs** (social worker and child and family support worker) of £282 per patient, per annum.

Higher use of mental health and alcohol/drug support services post-Idva may be because victims are in a better position to prioritise their own health, rather than simply survive in an abusive relationship. The rise in social services costs may be due to this agency often only getting involved with a family once a victim with children starts to receive Idva help.

Conclusion

Specialist domestic abuse services that are co-located within mainstream services, in this case hospitals, are likely to be a crucial part of a system that effectively responds to domestic abuse as quickly as possible to get the response right first time, for every family.

Hospital Idvas have a unique role to play in the response to domestic abuse in an area. The addition of a hospital Idva team to an area means 'hidden' victims (those aged 55+, for example) and vulnerable victims

(those who are pregnant or suicidal) are more likely to be identified and receive effective help.

Hospital-based services support earlier identification of victims of abuse. For example, in our evaluation, victims identified by the hospital Idva had experienced an average of 30 months of abuse, whereas victims identified by a community Idva had experienced an average of 36 months of abuse.

Victims attend hospital for health reasons that may or may not be related to abuse. This is a window of opportunity to raise awareness and recognition of domestic abuse. Victims reported that the hospital Idva helped them to recognise that their experiences were domestic abuse and so prompted them to seek help. Missed opportunities to intervene are likely to result in later identification when a situation may have escalated and the impact on the victim and their family's health and welfare has increased.

Once victims have been identified, hospital Idvas provide effective help to improve safety for victims and their families. Nine out of 10 victims engaged with a hospital Idva said they felt safer following intervention. Our findings reinforce SafeLives' longstanding recommendation that all victims engaged with a domestic abuse service receive safety planning alongside other interventions.

Hospital domestic abuse services are most effective when they are embedded in both the hospital and the community. Within the hospital, this means day-to-day visibility, established referral routes across departments, and support from senior clinical staff. Within the community, links to outside agencies (including local domestic abuse services) improves outcomes for victims. Generally, good clinical supervision for Idvas helps them to feel well supported in the complex hospital work environment.

The presence of a well-embedded domestic abuse service has value over and above the direct services to victims that it provides. Health professionals throughout the hospital are more likely to engage in asking patients about domestic abuse (as recommended by NICE) and confidently make a referral to the domestic abuse service.

Strong referral routes in and out of a hospital domestic abuse service make an enormous difference to the likelihood of a victim receiving effective help from all relevant agencies. This is especially important for victims with complex needs who are more likely to be identified in hospital and who need additional health referrals (for example, those with mental health or substance misuse issues).

Basing Idvas in hospitals could deliver cost savings, but new research with a larger sample size would need to be commissioned to confirm this.

The health service has an obligation to safeguard adults and children in its care – hospital-based domestic abuse services are one effective way of fulfilling this role for victims of domestic abuse and their children.

Appendix A – Estimated number of staff within each hospital site who may have experienced domestic abuse in the previous year

Site	Total number of staff	Percentage of female staff	Number of female staff	Female staff estimated to have experienced domestic abuse in previous year	Number of male staff
1	8,395	75%	6,313	525	2,082
2	7,282	78%	5,651	475	1,631
3	4,489	84%	3,774	300	715
4	1,584	78%	1,250	100	334
5	6,730	78%	5,249	425	1,481
Total number	28,480	78%	22,237	1,825	6,243
Average number of staff across all sites	5,696	78%	4,447	365	1,249

Appendix B – Overview of hospital-based Idva services involved in Themis

Hospital Idva service – Case study 1

Type of hospital	Large metropolitan hospital
Number of staff	7,000
Emergency Department (ED)	70,000 patients per annum
Hospital Idva service	Five years old
Cost of Idva service 2014–15	£90,000
Funded by	NHS England, Local Clinical Commissioning Group, City Council Public Health
Idvas employed by	Hospital Trust
Institutional integration	Full (staff are Trust employees with NHS badges, access to NHS emails and hospital computer system, able to 'flag and tag' cases and receive real-time alerts when patients with a history of domestic violence or abuse attend the ED).
Visibility	Very high – based in room in ED, Idvas regularly use staffroom.
Publicity for service	Posters widespread in hospital – other materials include mousemats.
Number of Idvas	Two full-time, covering seven days a week 9am–5pm

Number of hospital staff trained in domestic violence and abuse 2014–15	271
Number of referrals 2014–15	365 (Commissioner's target = 300 from ED, 25 from other wards)
Domestic violence and abuse screening policy in ED	Patients from a number of high-risk groups are screened for domestic abuse, along with those reluctant to explain how their injuries occurred, or whose partner seems overbearing or unwilling to let them speak. In one consultant's words: "Think about it for everybody, and if you have to think twice, ask."
Method of referral	Often face-to-face by calling into Idvas' room, by phone, or (out-of-hours) by online referral form (including risk assessment). This gives Idvas information about the level and type of risk, which is supplemented by access to the patient's online hospital notes.
Casework length	By agreement with their Commissioner, Idvas work with high-risk cases for 4 to 6 weeks, medium-risk cases for two weeks, and standard risk cases for one week or in a one-off consultation.*
Information sharing	Idvas are regarded as part of the hospital team, with whom confidential information can be shared.
'Toxic trio' work	There are close links with the alcohol and drug misuse and mental health teams, with joint meetings commonly held and online joint Care Plans.

* SafeLives recommends that Idvas work with high-risk cases for 3–6 months and 6–12 months for medium-risk cases.

Profile

This service is **well-embedded**, with Idvas championed by senior ED staff and enjoying good relationships with staff in ED and in the psychiatric liaison unit. They are gradually spreading their reach throughout the hospital, appointing link nurses in other wards who can train those staff. There is good continuity – one of the Idvas has worked at the hospital since the service began.

Idvas here are regarded as having an equivalent level of **expertise** to Clinical Nurse Specialists – who are recognised as an important level of healthcare staff in this hospital (they specialise in alcohol misuse, drug misuse or mental health).

All ED staff receive at least 20 minutes' **training** on domestic violence and abuse, and Emergency Nurse Practitioners receive one hour. Idvas spend a third of their time training hospital staff – tutoring on Adult Safeguarding and Child Protection courses, along with study days on domestic violence, and updates on topics such as Female Genital Mutilation, Child Sexual Exploitation, and 'Honour-Based' Violence.

In the hospital seven days a week, Idvas are on hand to give **informal advice** to staff who are unsure about making a referral. They give staff feedback on cases that have been referred to them, and reassure staff who ask a patient about domestic abuse but are met with a denial, that by asking, they have signalled to the client that help is available, if and when they do feel ready to disclose.

When the Idva service was introduced at this hospital, the level of referrals of high-risk domestic abuse cases to Marac rose from 11 to 70 a year.

Hospital staff would like an **evening Idva service**, even if on-call.

Case study 2

Type of hospital	Smaller rural hospital
Number of staff	3,000
Emergency Department (ED)	42,000 patients per annum
Hospital Idva service	Three years old
Cost of Idva service 2014–15:	£40,720
Funded by	Primary Care Trust initially, then a charitable trust
Idvas employed by	Third sector domestic abuse organisation
Institutional integration	High – Idvas have an honorary NHS contract, enabling them to have an NHS badge, access to NHS emails and ability to 'flag and tag' cases on the hospital computer system. (However, when second Idva was employed, it took six months to get her an honorary NHS contract.)
Visibility	Very high – although based in a room outside the main hospital building, the Idva visited the ED and Maternity wards very regularly. Idva can see patients in a pleasant, quiet room in ED and Maternity.
Publicity for service	Leaflets and posters (after approval by six panels).
Number of Idvas	One full-time equivalent (two job-sharing), Monday to Friday office hours
Number of hospital staff trained in domestic violence and abuse 2014–15	200 (plus 35 GPs); 120 in 2015–16 (plus 27 GPs)
Number of referrals 2014–15	97
Domestic violence and abuse screening policy in ED	To ask all patients where possible domestic violence and abuse indicators are present.

Method of referral	ED staff mostly use paper forms, Psychiatric Liaison mostly use phone during office hours, Maternity mostly use phone or tell Idva face-to-face on her regular ward visits. However, Idva does not necessarily know level of risk or other medical details (for example, whether mental health or substance misuse difficulty are present) or social services involvement.
Casework length	Not known
Information-sharing	This is enabled by the Idva having an honorary NHS contract.
'Toxic trio' work	If patient has substance abuse or mental health issues, information is shared with these staff and services, with whom there are good relationships. Sometimes the Idva accompanies the client to their first appointment.

Profile

The service is now working very well and there is good continuity – one of the Idvas has worked at the hospital since the service began.

However, the Idva service took a while to bed in, possibly because the Idvas are not hospital employees. For instance, it took two years before the Idva was allocated an office base in the hospital grounds. It took six months before the second job-share worker obtained her honorary NHS contract, enabling her to have an NHS badge, email and access to the computer system. Six panels had to meet to approve a domestic abuse poster for the hospital.

It also took six months of educating and training hospital staff before the service could get off the ground, which is normal for hospital Idva services.

Training can be arranged very flexibly, for instance at the start of the morning shift (8am). ED staff are given a 45-minute training session on domestic violence and abuse during their initial Safeguarding Training. Full-day refresher training on domestic violence and abuse is also offered, though this is optional. Maternity staff can be trained in a half-hour handover period, with between three and 15 members of staff involved, and there is online e-learning.

There are very **close relationships** with both ED and Maternity staff. This includes joint working with Maternity staff, compiling joint care plans for when the mother returns home with her baby.

Hospital staff would like an **evening and weekend service**, even if on-call or telephone advice.

There can sometimes be difficulties in **liaison** between the hospital and the organisation employing the hospital Idvas.

Endnotes

1. Office for National Statistics (ONS) (2015), Crime Survey England and Wales 2013–14. Please notes that the ONS is currently reviewing its national datasets following criticism that its cap on violent crimes per victim was underestimating the extent of domestic abuse
2. HM Inspectorate of Constabulary (HMIC) (2015), Increasingly everyone's business: A progress report on the police response to domestic abuse
3. Victims at high risk are those who are likely to be seriously harmed or murdered by their partner. SafeLives has developed a DASH risk checklist for the identification of high-risk cases of domestic abuse, stalking and 'honour'-based violence www.safelives.org.uk
4. SafeLives (2015), Insights Idva National Dataset 2013–14
5. SafeLives (2015), Getting it right first time: policy report
6. Ibid.
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9. SafeLives Children's Insights Dataset 2014; based on a sample of 877 children's cases collected by specialist support services
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28. Data provided by the Care Quality Commission (CQC). We have been unable to obtain figures for the number of acute hospitals in England. There were 181 A&E Departments in 2012 www.whatdotheyknow.com/request/address_of_major_ae_departments and 152 Midwifery Units in 2013 www.nao.org.uk/wp-content/uploads/2013/11/10259-001-Maternity-Services-Book-1.pdf

29. A more detailed checklist for Commissioners of hospital-based domestic abuse services can be found in **Chapter 6** of this report.

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31. Department of Health (2010), Responding to violence against women and children – The role of the NHS

32. In one case, confidentiality was breached, following the appropriate procedure, out of concern for one client's suicidality.

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35. SafeLives (unpublished), Insights Outreach Dataset 2014/15

36. Crime Survey England and Wales 2014/15

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38. Lorenzon and Mueller (2004)

39. Fugate et al (2005)

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85. See **Chapter 2** for the policy context for more detail on the impact on children living with domestic abuse.

86. SafeLives (2015), All Welcome, www.safelives.org.uk

87. Of the 18.7 million adults admitted to hospital in 2015, around 7.6 million (41%) were aged 65 or over. www.ageuk.org.uk/Documents/EN-GB/Factsheets/Later_Life_UK_factsheet.pdf?dtrk=true

88. While there is little research on the use of services by higher-income victims, there is anecdotal evidence that they remain hidden: www.thedailybeast.com/articles/2013/02/28/domestic-violence-among-the-wealthy-hides-behind-veil-of-silence.html

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90. This is based on the victims' knowledge and may be an underestimation because perpetrators often hide previous criminal behaviour from new partners.

91. A physical disorder in which the symptoms have no known or detectable organic basis but are believed to be the result of psychological factors such as emotional conflicts or stress.

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95. Information about methods of communicating covertly with victims is concealed in this report to ensure they remain effective in the long-term.

96. Safeguarding of Vulnerable Adults

97. Descriptions and analysis of two models of hospital-based Idva services can be found at Appendix B

98. Controlling for gender, high-risk abuse and case length, except where case length was the correlating factor.

99. That is, inpatient, outpatient and A&E, but excluding antenatal services.

100. Number of uses at Idva intake was halved, to make the period equivalent to the three-month post-Idva period.

101. Number of uses at Idva intake was halved, to make the period equivalent to the three-month post-Idva period.

102. NHS Manchester (2010), PATHway: An independent domestic violence advisory service at Saint Mary's Maternity Hospital

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