Open Agenda

Overview & Scrutiny Committee

Monday 4 April 2016
7.00 pm
Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

Membership
Councillor Gavin Edwards (Chair)
Councillor Rosie Shimell (Vice-Chair)
Councillor Anood Al-Samerai
Councillor Jasmine Ali
Councillor Maisie Anderson
Councillor Catherine Dale
Councillor Paul Fleming
Councillor Tom Flynn
Councillor Ben Johnson
Councillor Rebecca Lury
Councillor Johnson Situ
Martin Brecknell
Lynette Murphy-O'Dwyer
Abdul Raheem Musa
George Ogbonna

Reserves
Councillor Evelyn Akoto
Councillor Helen Dennis
Councillor Nick Dolezal
Councillor Eleanor Kerslake
Councillor Sunny Lambe
Councillor Maria Linforth-Hall
Councillor Adele Morris
Councillor David Noakes
Councillor Martin Seaton
Councillor Bill Williams

INFORMATION FOR MEMBERS OF THE PUBLIC

Access to information

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Contact Shelley Burke on 020 7525 7344 or email: Shelley.burke@southwark.gov.uk

Members of the committee are summoned to attend this meeting
Eleanor Kelly
Chief Executive
Date: 22 March 2016

PRINTED ON RECYCLED PAPER

Overview & Scrutiny Committee

Monday 4 April 2016
7.00 pm
Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

Order of Business

Item No.	Title	Page No.
	PART A - OPEN BUSINESS	
1.	**APOLOGIES**	
2.	**NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT** In special circumstances, an item of business may be added to an agenda within five clear working days of the meeting.	
3.	**DISCLOSURE OF INTERESTS AND DISPENSATIONS** Members to declare any interests and dispensations in respect of any item of business to be considered at this meeting.	
4.	**LEADER'S INTERVIEW** Councillor Peter John will be interviewed in respect of his portfolio. Themes to be raised will include: - the council's new Corporate Procurement policy - Impact of the Housing and Planning Bill - The future of the council's finances (2-3 years ahead) - Creating more jobs in Southwark LGA Peer Review of Southwark Council	1 - 19
5.	**REPORT ON PROCESSES TO SUPPORT OLDER AND MORE VULNERABLE TENANTS LIVING ON THEIR OWN**	20 - 28

DISCUSSION OF ANY OTHER OPEN ITEMS AS NOTIFIED AT THE START OF THE MEETING.

PART B - CLOSED BUSINESS

DISCUSSION OF ANY CLOSED ITEMS AS NOTIFIED AT THE START OF THE MEETING AND ACCEPTED BY THE CHAIR AS URGENT.

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Date: 22 March 2016

EXCLUSION OF PRESS AND PUBLIC

The following motion should be moved, seconded and approved if the sub-committee wishes to exclude the press and public to deal with reports revealing exempt information:

"That the public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in paragraphs 1-7, Access to Information Procedure rules of the Constitution."

Agenda Item 4

Item No. 12.	Classification: Open	Date: 27 January 2016	Meeting Name: Cabinet
Report title:		LGA Peer Review of Southwark	
Ward(s) or groups affected:		All	
Cabinet Member:		Councillor Peter John, Leader of the Council	

FOREWORD FROM COUNCILLOR PETER JOHN, LEADER OF THE COUNCIL

At the start of the New Year I talked about my absolute pride in being Leader of the Council. The progress that we have made over the last five and a half years to set balanced budgets, provide first-class services, build new homes and generate jobs and growth for our residents has been amazing.

That is why it is with some satisfaction and similar pride, that we are today receiving the peer challenge report from the Local Government Association (LGA). The report, based on a comprehensive, external review undertaken late last year by experienced elected members and officers from across local and national government, sets out its findings of Southwark Council.

The LGA found that we are a borough that is "ahead of the curve" with a can do, confident attitude and passion for the place that was impressive and unusual. Our commitment to addressing inequalities with partners is strong and we're told we have a good track record in engaging and involving local people. We have successfully met the very tough, unprecedented financial challenge that we have been dealt. At the same time we've made clear choices to invest, whether in new libraries, housing or through supporting local people into work making good on our council plan to deliver a fairer future for all residents.

Like any comprehensive review, there are also things to reflect on, watch out for and build on – "key pointers" as referred to by the LGA team. We will consider these carefully so they help inform our future delivery plans, whether that's about the wider regeneration of the borough or more specifically how we modernise the way we work as a Council.

Having an external eye cast over what you do is a very daunting experience, but it is ultimately the right thing to do. I'm incredibly pleased that by talking and listening to residents, staff, councillors and partners, reviewing our plans and progress and taking a look at what we're doing each day here in Southwark the LGA team found that there is much to be proud of, something which reflects my own pride in Southwark and in our ability to deliver a fairer future for all.

RECOMMENDATIONS

1. That cabinet note the feedback report from the corporate peer challenge of Southwark Council (Appendix 1) that was undertaken by the Local Government Association (LGA) between 16 and 19 November 2015.

2. That cabinet consider the findings of the report and instruct officers to develop

relevant plans and actions in response, reporting progress through the Council Plan.

BACKGROUND INFORMATION

3. The council is committed to continuous improvement and learning in order to achieve its aim to deliver value for money, high quality services and a fairer future for all as set out in the Council Plan 2014-18.

4. To help do this, the council opens itself up to external challenge and review. This is through for example the council's own overview and scrutiny mechanism, through external tests of assurance on service delivery, through internal and external audit and inspection of council processes, governance and service outcomes and importantly through resident feedback to inform future policy and service design.

5. A further mechanism is through external "peer to peer" review. This is where officers and councilors from across different councils are invited into an authority to undertake a review. This could take the form of a review of a single service, a set of related services or a more general corporate exercise that looks at a number of cross-council areas including leadership and management, performance, governance, partnerships and delivery. Peer reviews are improvement-focused and tailored to meet individual councils' needs. They are designed to complement and add value to a council's own performance and improvement focus.

6. The LGA acts on behalf of all local government to deliver the peer review process nationally.

KEY ISSUES FOR CONSIDERATION

7. On 16 to 19 November 2015, an LGA peer review team compromising one councillor and six officers from across various local and national government bodies was invited into the council to undertake a general corporate review.

8. The review work involved a mixture of desk based research, interviews and focus group discussion with different councillors from all party groups, officers from a range of service areas, residents, partners and other stakeholders. The peer team used their experience and knowledge of local government to reflect on the information presented to them by people they met, things they saw and material they read. The scope and focus of the review is set out on page 3 and 4 of the feedback report (Appendix 1).

9. The feedback report (Appendix 1) sets out the findings from the review.

Much to be proud of: "If anyone can, Southwark can"

10. The LGA found that there is a great deal for the Council to be proud of and in particular noted that 'we heard several times during our discussions the phrase "If anyone can, Southwark can"'. They found Southwark to be highly ambitious with a huge passion and pride for the place amongst everybody they met. This was judged by the LGA as impressive and unusual in its extent.

11. The LGA noted a number of good partnerships are in place and there is a strong

commitment by the council and its partners to addressing inequalities. Further, the council demonstrates a real 'can do' attitude and confident approach, and has successfully met the financial challenge to date whilst simultaneously protecting frontline services. At the same time, significant investment has been made in infrastructure and amenities in the borough.

12. Also, the LGA team found that there is a clear strategy for exploiting the economic advantages of land values, particularly in the North of the borough with the challenge being to make sure that the opportunity is taken in a way that is seen to benefit all local people.

13. In summarising their assessment the LGA noted a number of key pointers. These are the key aspects of the team's findings that the LGA feel would deliver the greatest benefit if the council were to focus on them. These are:

    a) Further develop the narrative for the future of the borough - being clearer how the benefits of growth assist the most vulnerable residents.
    b) Ensure that collaborations beyond the borough have flexible geography – determined by the nature of the issue being focused on and the nature of the opportunity.
    c) Design a future operating model that will underpin the redesign of the council.
    d) Develop the budget approach to take a longer term view and to enable the necessary organisational re-design and transformation.
    e) Enable the new management structure to be fully capitalised upon – building relationships, enhancing corporate working and ensuring a further development in collective leadership.

14. By it's very nature and as stated by the LGA in the peer challenge report, 'the peer challenge is a snapshot in time. We appreciate that some of the feedback may be about things the council is already addressing and progressing.' For example the peer review came just ahead of the autumn statement and spending review announced by the Chancellor of the Exchequer on 2 December. Some of the financial assumptions discussed on the review week were based on best guess, subsequently further clarified (although not perhaps extensively so) from government and reported to Cabinet as part of the wider budget setting process. In taking account of the LGA's observations it's important that the peer review report be analysed as a part of suite of factors and responded to accordingly.

Next steps

15. As noted within the report at Appendix 1, the peer challenge process is about highlighting positive aspects of the council and the borough as well as local challenges. The aim of the LGA has been to provide some detail on these to help the council understand and consider them and reflect further on findings before determining how best to take action. As a result, cabinet is now asked to consider the report including key pointers in paragraph 13, and ask officers to prepare relevant plans and/or adjust existing plans where appropriate.

16. Further, the Council Plan 2014-18 is now entering a mid point in delivery and it may be timely to consider any response to the peer challenge alongside a broader review of targets and actions within the plan.

17. Finally, in publishing the peer challenge report the council is inviting comment on the findings from residents, partners and other key stakeholders.

Policy implications

18. The council is committed to a fairer future for all as set out in the Council Plan 2014-18. A key organisational value is about being open, honest and accountable. The peer challenge process, undertaken by an external body in the form of the LGA, provided an opportunity for the council to open itself up to external challenge and act on any relevant findings to help support future organisational policy and service design

Community impact statement

19. The public sector equality duty requires public bodies to consider all individuals when carrying out their day to day work, in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people when carrying out their activities.

20. The LGA in particular noted that there is a strong commitment by the council and its partners to addressing inequalities. The LGA also noted that the council has a good track record of engaging and involving local people with this being reflected in discussions with tenants and residents representatives, partners and elected members. A key pointer identified was the need to further develop the narrative for the future of the borough and being clearer how the benefits of growth assist the most vulnerable residents.

21. This report asks that the cabinet note the feedback from the corporate peer challenge of Southwark Council (Appendix 1), consider its findings and instruct officers to develop relevant plans and actions in response. In doing so, the actions that follow will continue to demonstrate the commitment to advance equality of opportunity for the benefit of all local people.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS

Strategic Director of Finance and Governance

22. The strategic director of finance and governance notes the recommendations in this report to note the feedback report and to instruct officers to develop relevant plans and actions in response, reporting progress through the Council Plan. Any financial consequences of these actions will be managed and reported through the council's usual governance processes.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
None	N/a	N/a

APPENDICES

No.	Title
Appendix 1	Corporate Peer Challenge, London Borough of Southwark, 16 to 19 November 2015: Feedback Report

AUDIT TRAIL

Lead Officers	Eleanor Kelly, Chief Executive	
Report Author	Stephen Gaskell, Head of Strategy and Partnerships	
Version	Final	
Dated	14 January 2016	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments included**
Director of Law and Democracy	Yes	No
Strategic Director of Finance & Governance	Yes	Yes
Leader of the Council	Yes	Yes
Date final report sent to Constitutional Team		14 January 2016

APPENDIX 1

Corporate Peer Challenge London Borough of Southwark

16th to 19th November 2015

Feedback Report

1. Executive Summary

There is a great deal for the London Borough of Southwark to be proud of. The council is highly ambitious for the borough and there is a huge passion and pride for the place amongst everybody we met. This was both impressive and unusual in its extent. There are a number of good partnerships in place within the borough and there is a strong commitment demonstrated by the council and its partners to addressing inequalities.

The council demonstrates a real 'can do' attitude and confident approach. It has successfully met the financial challenge to date, achieving £156m savings since 2010 whilst simultaneously protecting frontline services. At the same time, significant investment has been made in infrastructure and amenities in the borough.

There is a clear strategy on the part of the council for exploiting the economic advantages of land values, particularly in the North of the borough. The challenge for the council is making sure that the opportunity is taken in a way that is seen to benefit all local people. Linked to this, we see the need for a clearer narrative around the future of the borough. It is important to be able to articulate more clearly the regeneration and housing ambitions and the challenges that they create and are intended to address.

The Leader and Chief Executive are held in very high regard and Cabinet and Chief Officer Team are respected and seen to work well together. The recent senior management restructure is seen by managers and staff as having had a positive impact. The streamlining that has been involved is felt to have established clearer accountabilities and provided greater focus. There are very clear organisational values within the council that are widely understood.

Across the three year period from 2016/17 to 2018/19, the authority faces a projected financial gap of £96m. With the economic advantages that the borough offers, the authority is in a position to adopt a strategic economic approach, based on exploiting land values, that in turn offers the opportunity to take a more strategic approach to its budget than it does at present. This sees the council being better placed than many to approach the financial challenge from a position of being able to invest where appropriate in order to secure savings further down the line and implement change over a longer period.

The financial modelling for the regeneration programme is coherent and the resources needed at this stage are in place. The council recognises the importance of carefully monitoring the position though. The financial modelling around the Housing Revenue Account (HRA) feels less robust. Given the scale of the ambition, the council needs to undertake the work necessary to be able to reassure itself that the current thinking remains right.

Southwark Council is seen as a good place to work. The council looks after its people and is keen to aid their development, reflected in the securing of the Investors In People (IIP) Gold standard. Performance management operates well at the level of the individual and within individual services. However, there is a need for a more systematic approach to performance management at the strategic level that drives organisational improvement,

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which entails managing performance through more cross-cutting measures and linking the reporting of finance and performance together.

A strategic approach to organisational change and transformation needs to be developed. As part of this, and to ensure opportunities are maximised from change, we see the need for the council to outline a future operating model for the organisation, which would serve to inform modernisation and enable it to be taken forward in a strategic way. The model and the design principles within it should be used to inform all investment and rationalisation decisions and their design.

The council is a solutions focused organisation, particularly when looking at issues centred on the borough. This becomes more challenging for it when the priorities of other organisations and places need to be considered as well. The council would benefit from considering the extent to which it is willing to do things in a way that is more aligned to the needs and approaches of others. This is not to suggest that the council needs to water down any of its ambitions. Rather, it is about recognising that the best way of fulfilling Southwark's ambitions may be through considering things more broadly and looking at them as part of a wider set of collective priorities.

2. Key pointers

The following are 'key pointers' that the peer team provided at the end of their feedback presentation. These are the key aspects of the team's findings that we suggest would deliver the greatest benefit if the council were to focus on them:

- Further develop the narrative for the future of the borough - being clearer how the benefits of growth assist the most vulnerable residents

- Ensure that collaborations beyond the borough have flexible geography – determined by the nature of the issue being focused on and the nature of the opportunity

- Design a future operating model that will underpin the redesign of the council

- Develop the budget approach to take a longer term view and to enable the necessary organisational re-design and transformation

- Enable the new management structure to be fully capitalised upon – building relationships, enhancing corporate working and ensuring a further development in collective leadership

The detail of these is contained within the main body of the report.

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3. Summary of the Peer Challenge approach

The peer team

Peer challenges are delivered by experienced elected member and officer peers. The make-up of the peer team reflected your requirements and the focus of the peer challenge. Peers were selected on the basis of their relevant experience and expertise and agreed with you. The peers who delivered the peer challenge in Southwark were:

- Adrian Lythgo, Chief Executive, Kirklees Metropolitan Borough Council
- Councillor Keith Wakefield, Portfolio Holder for Resources and Corporate Functions, Leeds City Council
- Tom Whiting, Corporate Director of Resources and Commercial, London Borough of Harrow
- Adrian Smith, Director of Strategy and Commissioning (Neighbourhoods), London Borough of Lambeth
- Sue Higgins, Executive Leader, National Audit Office
- Jonathan Owen, Executive Policy Officer, London Borough of Redbridge (shadowing role)
- Chris Bowron, Peer Challenge Manager, Local Government Association

Scope and focus

The peer team considered the following five questions which form the core components looked at by all corporate peer challenges cover. These are the areas we believe are critical to councils' performance and improvement:

- Understanding of the local place and priority setting: Does the council understand its local context and place and use that to inform a clear vision and set of priorities?

- Leadership of place: Does the council provide effective leadership of place through its elected members, officers and constructive relationships and partnerships with external stakeholders?

- Financial planning and viability: Does the council have a financial plan in place to ensure long term viability and is there evidence that it is being implemented successfully?

- Organisational leadership and governance: Is there effective political and managerial leadership supported by good governance and decision-making arrangements that respond to key challenges and enable change and transformation to be implemented?

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- Capacity to deliver: Is organisational capacity aligned with priorities and does the council influence, enable and leverage external capacity to focus on agreed outcomes?

As part of this, the council asked the peer team to consider the following questions:

- Is our vision clear and understood?
- Are the right financial plans in place to ensure long term viability and is there evidence that they're being implemented successfully?
- Is political and managerial leadership effective and is it a constructive partnership?
- Is governance effective and are decision-making arrangements in place to respond to key challenges?
- Are organisational capacity and resources focused in the right areas in order to deliver the agreed priorities?
- Is there more we could do in partnership to develop the right capacity and meet the financial challenges?
- Is the council well placed to capture opportunities for devolution?

The peer challenge process

It is important to stress that this was not an inspection. Peer challenges are improvement-focussed and tailored to meet individual councils' needs. They are designed to complement and add value to a council's own performance and improvement focus. The peer team used their experience and knowledge of local government to reflect on the information presented to them by people they met, things they saw and material that they read.

The peer team prepared for the peer challenge by reviewing a range of documents and information in order to ensure they were familiar with the council and the challenges it is facing. The team then spent 4 days onsite in Southwark.

This report provides a summary of the peer team's findings. It builds on the feedback presentation provided by the peer team at the end of their on-site visit. In presenting the feedback, they have done so as fellow local government officers and elected members, not professional consultants or inspectors. By its nature, the peer challenge is a snapshot in time. We appreciate that some of the feedback may be about things the council is already addressing and progressing.

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4. Feedback

4.1 Much to be proud of

There is a great deal for the London Borough of Southwark to be proud of. A huge passion and pride for the place exists amongst everybody we met. The extent of this was both impressive and unusual. Those same people also demonstrated a good understanding of the borough – its make-up, the way it is changing, the ambitions, the challenges and the opportunities.

There are a number of good partnerships in place within the borough, which see the council working well with the voluntary and community sector, business community, Southwark Clinical Commissioning Group (CCG) and the Metropolitan Police. There is a strong commitment demonstrated by the council and its partners to addressing inequalities. This is reflected in the council's 'Priority Areas' and 'Fairer Future Promises', which are outlined later in this report. The commitment and ambitions are leading to positive impacts, including improved educational attainment (Southwark is now in the top 20 of local authorities nationally for GCSE attainment), a significant and sustained reduction in the number of Looked After Children (from over 700 to around 500) and the supporting of local people into employment (over 2,700 since 2011).

The council demonstrates a real 'can do' attitude and confident approach. People are up for addressing the challenges being faced and not fazed by whatever is thrown at them. The council has successfully met the financial challenge to date, achieving £156m savings since 2010 whilst simultaneously protecting frontline services. Significant investment has been made in infrastructure and amenities in the borough, including new libraries and the refurbishing of a number of leisure centres. Since 2011, £250m has been invested in the council's existing housing stock through the 'Decent Homes' programme. The council looks after the people who work for it and is keen to aid their development, reflected in the securing of the Investors In People (IIP) Gold standard.

There is a clear strategy on the part of the council for exploiting the economic advantages of land values, particularly in the North of the borough. The challenge for the council is making sure that the opportunity is taken in a way that benefits all local people. This would include creating more employment opportunities for those furthest from the labour market, further linking jobs with local communities and ensuring that the delivery of the 1,500 new council homes that have been promised over the next three years is achieved.

4.2 Leadership of Place

The council is highly ambitious for the borough. This is reflected in the scale of the regeneration agenda, the 'Priority Areas' and the 'Fairer Future Promises'. The 'Priority Areas' include helping children to have the best start in life, providing people with access to quality affordable homes and establishing revitalised neighbourhoods. The 'Fairer Future Promises' include:

- 11,000 new council homes by 2043, with the first 1,500 completed by 2018

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- More and better schools
- A guarantee of education, employment or training for every school leaver
- 5,000 more local people being supported into jobs and 2,000 new apprenticeships or training placements
- Revitalised neighbourhoods in Elephant and Castle, the Aylesbury estate and Old Kent Road

We heard several times during our discussions the phrase “If anyone can, Southwark can”. There appear to be two dimensions to this statement. The first is a justifiable confidence, based on the council’s track record of delivery to date and the many positive aspects of how the authority operates, that it can deliver the agenda it has set. The second is a recognition that both the borough and the council are in a good position with the economic advantages that the area offers and which can be exploited.

The council has a good track record of engaging and involving local people. Community Councils are well attended and are seen as important to local communities. The council’s good work around engagement and involvement was reflected in our discussions with tenants and residents representatives, partners and elected members. Going forward, we see the need for a clearer narrative around the future of the borough. We also see a need for equalities impacts within communities to be more clearly considered on a cumulative as well as a specific, project by project, basis. All of this is important in ensuring local people both are, and feel, well informed about where the borough is heading and can see what the impact is likely to be for them. There is a need to articulate more clearly the regeneration and housing ambitions and the challenges that they are intended to address but which they also create. This includes explaining how the council is using its influence and economic strategy to create employment opportunities for those furthest from the labour market. There is also a need to communicate better with those directly affected by the housing changes, with some people we spoke to feeling unclear about what would be happening to them as tenants or residents, for example around when and where they might be moving to whilst the areas they live in undergo change.

Linked to the above, we see a need for an over-arching analysis of the impact of the regeneration changes. At present, it is unclear what the demography of the borough is likely to look like as a consequence of the housing changes and economic ambitions. It is important for the council to be in a position to outline the likely demographic and equalities impacts of the changes taking place. Within all of this is an acid test that faces the council. This acid test is about delivering the 1,500 new council homes that have been promised by May 2018. Meeting this test will address any scepticism about delivery head on and hopefully switch people to acting as advocates for change.

4.3 Organisational leadership and governance

The Leader and Chief Executive are held in very high regard both within and beyond the borough. The role they play standing up for and pursuing Southwark’s interests is

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recognised, and valued, by the business community, public sector partners and council staff. They operate in an open, transparent and engaging way which sets the tone for others to follow. Cabinet and Chief Officer Team are respected and are seen to work well together.

The council's governance arrangements are felt to be sound. Relationships between elected members and officers at all levels are positive, founded upon a mutual trust and respect. People are clear about their respective roles and responsibilities. Overview and scrutiny is seen to be independently-minded and effective, including by Opposition groups. That does not, however, disguise the fact that Opposition groups are unhappy that the majority group is now chairing overview and scrutiny. Innovative approaches to scrutiny can be seen, including the hosting of community events when considering the issue of female genital mutilation (FGM), and bringing in partner organisations, from the likes of health and education, to aid joined-up thinking. Scrutiny are currently undertaking a piece of work looking at the impact of the Housing and Planning Bill which is highly pertinent given the regeneration agenda.

There are very clear organisational values within the council that are widely understood:

- Treating residents as if they were a valued member of our own family
- Being open, honest and accountable
- Spending money as if it were from our own pocket
- Working for everyone to realise their own potential
- Making Southwark a place to be proud of

Staff that we spoke to at various levels of the organisation can recite these values in a way that, rather than just being words, demonstrates they know what they are about and that they believe in them. The staff survey undertaken this year revealed that 74 per cent of respondents understand the council's values. The way that they are clearly outlined and made relevant and meaningful to staff helps enormously in this. Eighty eight per cent of staff survey respondents understand how their role benefits Southwark residents.

The recent senior management restructure is seen by managers and staff as having had a positive impact. The streamlining that has been involved is felt to have established clearer accountabilities and provided greater focus. This now needs to be followed by ensuring individuals and cohorts at this level are supported and enabled to develop further. A key aspect of this is creating the means and the time to enable them to link together to build relationships and, through this, enhance corporate working. We believe middle managers would benefit from better networking opportunities and some shared development. There is also some work to be done around improving the visibility of senior management in the organisation. Progress has been made on this and there are some, including the Chief Executive, whose open and engaging approach

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with staff is excellent. However, this needs to be more consistently demonstrated by all of the managerial leadership.

4.4 Financial plans

The council has managed its finances well to date and has saved £156m since 2010. At the same time as securing these savings, the council has continued to invest in priority services and amenities, including libraries and leisure. Looking ahead across the three year period from 2016/17 to 2018/19, the authority faces a projected further gap of £96m. The budget challenge process that has been running in recent months has identified how around £60m of that amount could be delivered.

We highlighted earlier in this report the phrase "If anyone can, Southwark can" and the recognition this reflects of the economic advantages that the borough offers. The authority is ahead of the curve as a consequence, being in a position to adopt a strategic economic approach, based on exploiting land values, that in turn offers the opportunity to take a more strategic approach to its budget than it does at present. This sees the council being better placed than most to approach the financial challenge from a position of being able to invest where appropriate in order to secure savings further down the line and implement change over a longer period. Being able to invest in the technology that is integral to delivering the council's 'digital by default' ambitions would be an appropriate example. A further benefit for the council is that of being in a position to learn from others who have had to prioritise earlier in the economic cycle, in terms of the approach they have taken to disinvestment and avoiding the pitfalls they encountered.

There are different views within the council on how the remaining element of the £96m gap is best addressed. For some, a continuation of the existing incremental, year by year, service-based approach is preferred. For others, a cross-cutting and more strategic approach with transformation at its heart, offers better opportunities and would mean that, with new more transformative approaches identified and planned, some other potentially difficult service decisions may be able to be mitigated. Four cross-cutting themes have been identified through workshop sessions with senior managers, with each being led by a Chief Officer – demand management, multi-agency working, reducing duplication and digital by default. These have contributed to the current budget proposals to different degrees but it is recognised that none of them are acting currently as a real driver. The sense is that budget savings that are agreed will instead simply be 'retro-fitted' to reflect an alignment with the cross-cutting themes.

The future savings requirement, in the form of the remainder of the £96m and whatever may be required beyond 2018, will be much more challenging to deliver as a natural consequence of an ever-reducing range of options to pursue. The council's ambitions and priorities need to be geared accordingly and this should be reflected in a much clearer Medium Term Resources Strategy.

The financial modelling for the regeneration programme is coherent and the resources needed at this stage are in place. The council recognises the importance of carefully monitoring the position though. The financial modelling around the HRA feels less robust. Given the scale of the housing ambition and an estimated £63m gap as a result

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of changes to HRA funding, the council needs to undertake the work necessary to be able to reassure itself that the current thinking remains right.

4.5 Capacity and organisational design

Southwark Council is seen as a good place to work. The staff survey indicated 66 per cent of respondents would advocate the council as an employer. Seventy four per cent of respondents are proud to work for the council. There is a good track record of investing in people within the organisation, helping them to grow and develop – which is appreciated by managers and staff and is reflected in the IIP award.

The main council offices at Tooley Street are seen as a great place to be based, in terms of the quality of accommodation. With council staff working in a range of other locations throughout the borough, it is important to ensure the staff in those places feel similarly valued to those at Tooley Street. There are two aspects to this. One is ensuring their facilities are of a consistently decent standard. The other is concerned with the visibility of senior managers – which is an issue we have already touched on in this report.

The staff that we met indicated that they feel well communicated with and that they are involved and engaged. However, they also reflected that there is scope for greater consistency across the organisation and between the different tiers of management. This issue of inconsistency is borne out by the staff survey. Sixty five per cent of respondents indicated they felt their line manager would listen to their ideas and 67 per cent reported that their line manager would encourage them to find improved ways of doing things. However, only 44 per cent indicated they have the opportunity to approach and engage with senior managers and only 38 per cent felt they could be open and honest with senior managers about relevant issues. Fifty two per cent of staff indicated they feel sufficiently informed about what is going on within the council.

Whilst staff we met weren't specific in terms of examples, they indicated that they felt opportunities to work more effectively as a 'whole council' are being missed. A positive example, where the council is getting this right, and which involves also working with partners, is the joint enforcement team that is being established. It is important that other such opportunities of this type are identified and capitalised upon. As we have already highlighted, the recent senior management restructure needs to be followed by ensuring individuals and cohorts at this level are supported and enabled to develop further, including creating the means and the time to enable them to link together to build relationships and, through this, enhance corporate working. The organisational development activities being delivered by the council would also usefully be complemented by a clearer focus on collective leadership and management.

Performance management operates well at the level of the individual, with performance appraisals widely undertaken. The staff survey indicates 59 per cent of respondents regularly (as opposed to just once a year as part of an appraisal) review their learning and development needs with their line manager, whilst 66 per cent indicated they have access to the training needed to do their job well. Performance management within individual services is also seen to be good. However, there is a need for a more systematic approach to performance management at the strategic level that drives organisational

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improvement that entails performance being managed through more cross-cutting measures and linking the reporting of finance and performance together.

We highlighted earlier the potential for the council to take a more strategic approach to the budget than it does at present. The current incremental approach to the budget absorbs significant time and effort managerially and politically and exacerbates staff anxieties about the future. The council is well-placed to approach the financial challenge from a position of being able to invest where appropriate in order to secure savings further down the line and implement change over a longer period than many councils. A quote that we heard during our discussions that we found particularly enlightening was:

- "Every year we find new ways to modernise"

On the one hand, this reflects the energy, enthusiasm and creativity shown by the organisation in finding answers to the budget challenge. On the other hand, it indicates that there isn't yet a strategic approach to organisational change and transformation in the council – with this resulting in the authority limiting its opportunities. To help with addressing this, we see the need for the council to outline a future operating model for the organisation, which would serve to inform modernisation and enable it to be taken forward in a strategic way. This model should articulate over-arching design principles that are consistently followed, in relation to topics such as:

- Commissioning of external partnerships
- Community capacity and behaviour change
- Internal modernisation and organisational development
- Access to services and channel shift

The model and the design principles within it should be used to inform all investment and rationalisation decisions and their design.

In order to help move change and transformation forward, the respective roles of Chief Officer Team and the Leadership Network relating to responsibility for re-design and transformation should be increasingly clarified. At present, whilst Chief Officers are responsible for leading the four cross-cutting themes highlighted earlier, such as digital by default and reducing duplication, which have change and transformation at their heart, members of the Leadership Network are also expected to be involved in delivering change. The current 'fuzzy edges' reflect the stage of development, with the senior management restructure just having taken effect and there not yet being a strategic approach to organisational change and transformation in the council. Clarity over respective roles and responsibilities can therefore be expected to become clearer over time.

There are several key functions that need to be enhanced to drive improvement and change within the council. IT represents a major issue in the organisation – not least with the lack of resilience in the infrastructure inhibiting people's ability to work effectively on a not infrequent basis. Greater programme management capacity is required to support an

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organisational change and transformation programme by ensuring the work is planned, resources are coordinated and benefits are achieved across the council. Contracting and procurement is also an area that is felt could improve – although the newly established centralised procurement team is felt to be functioning well and making a good contribution. The quality of contracting is seen to variable and the council should consider how to get the maximum effect from all contracts, including through more robust monitoring and management. Another area is commissioning, where there are opportunities to improve the use of evidence, needs based assessment, strategic options appraisal and post-completion evaluation.

Finally in this section, we want to highlight the need for the authority to be gearing up to address anticipated staff retention challenges. This relates to areas that many local authorities are struggling with, including Planning and social care, but the challenge within Southwark – not dissimilar to other central London boroughs – is exacerbated by what staff highlighted to us as growing anxieties about their ability to afford to be able to continue to live in the area.

4.6 Partnership and devolution

There are good partnerships in place in Southwark involving the council, voluntary and community sector, business community, CCG and police. Partnership infrastructures have been streamlined in order to aid efficiency and improve join-up. A key aspect of this is extending the remit of the secretariat function for the Health and Well-Being Board to also support the Local Safeguarding Children's Board, the Safeguarding Adults Board and the Safer Southwark Partnership.

A clearer approach to the council's strategic relationship management with the National Health Service is required. The council's relationship with the South London and Maudsley NHS Trust and King's College Hospital NHS Trust operates at several different levels – including local service provider, major local employer and influential organisation of international repute. The council needs to be clear who is best-placed to engage with them depending on the issues and circumstances.

A key focus for the council's engagement with health needs to be on ensuring the planned transformation and integration is achieved. This is starting to take shape but needs to be driven hard. Mental health is a major issue in the borough – this is recognised and moves are being made to address it but things are at a very early stage. It needs strategic focus. Public Health offers good opportunities for the borough that need to be capitalised upon by ensuring a shared understanding of the best way it can contribute is established amongst key stakeholders. A key test for the council that some people within the health sector see is the extent to which the Health and Well Being Strategy informs the council's forthcoming budget decisions.

The skills agenda in Southwark is a key area to be taken forward. Across Southwark, Lambeth and Lewisham, six per cent of local residents have never worked and 16 per cent have no qualifications. One of the council's 'Fairer Future Promises' is that by 2018 every school leaver will be guaranteed education, employment or training. The council is playing a key role in the creation of a construction skills academy in the borough, in order to enable local people to capitalise upon the employment opportunities offered by the

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regeneration agenda. Something similar could potentially be explored for other sectors given, as an example, a local shortage of chefs. The extent of the small and medium sized enterprise (SME) sector in the borough means there is also significant potential benefit in looking at how to better link their skills requirements with local provision.

Further Education locally needs to be invested in as it has a vital role to play in enhancing the skills of local people and, to assist with achieving this, there is a need for clearer ownership of the issues it is facing in order to ensure they are addressed. The council has sought to play a role in this previously but no satisfactory outcome was achieved. The authority needs to look at the role the council might play going forward.

The council is a solutions focused organisation, particularly when looking at issues centred on the borough. This becomes more challenging for it when the priorities of other organisations and places need to be considered as well and shared priorities are developed that may need shared articulation. We believe collaborations beyond the borough should have flexible geography according to focus and opportunity – not least any devolution deal with government.

We also feel that the council would benefit from considering the extent to which it is willing to do things in a way that is more aligned to the needs and approaches of others. This is not to suggest that the council needs to water down any of its ambitions. Rather, it is about recognising that the best way of fulfilling Southwark's ambitions may be through considering things more broadly and looking at them as part of a wider set of collective priorities. This can be seen to be happening with the establishment of a joint committee with Lambeth and Lewisham to look at the employment and skills agenda – recognising the issues and the solutions extend beyond the boundaries of single boroughs. As another example, the case for the extension of the Bakerloo Line has the best chance of being won by looking to progress Southwark's interests as part of wider South London. These welcome collaborations are at an early stage of development and as such do not yet have the same level of maturity as the council's own ambition and programmes.

Following on from the peer challenge

Through the peer challenge process we have sought to highlight the positive aspects of the council and the area but we have also outlined some difficult challenges. It has been our aim to provide some detail on them through this report in order to help the council understand and consider them. The council's senior political and managerial leadership will therefore undoubtedly want to reflect further on the findings before determining how they wish to take things forward.

Members of the team would be happy to contribute to any further improvement activity in the future and/or to return to the authority in due course to undertake a short progress review. Heather Wills, as the Local Government Association's Principal Adviser for the region within which the council sits, will continue to act as the main contact between the council and the Local Government Association, particularly in relation to improvement and access to the LGA's resources and packages of support going forward.

All of us connected with the peer challenge would like to wish Southwark, both as a council and a place, every success in the future.

Local Government House, Smith Square, London SW1P 3HZ **T** 020 7664 3000 **F** 020 7664 3030 **E** info@local.gov.uk www.local.gov.uk
Chief Executive: Mark Lloyd

Chris Bowron
Programme Manager – Peer Support
Local Government Association

Local Government House, Smith Square, London SW1P 3HZ **T** 020 7664 3000 **F** 020 7664 3030 **E** info@local.gov.uk www.local.gov.uk
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Agenda Item 5

Item No. 5	Classification: Open	Date: 4 March 2016	Meeting Name: Overview & Scrutiny Committee
Report title:		**Report on processes to support older and more vulnerable tenants living on their own.**	
Ward(s) or groups affected:		Borough-wide	
From:		Director of Resident Services	

RECOMMENDATION(S)

1. Members note the report

BACKGROUND INFORMATION

1. Following the recent death of two council tenants living alone, the Leader of the Council asked Chief Officers to:

    a. Review the current policies, procedures and practices
    b. To consider whether any more proactive steps could be taken to identify trigger points of concerns.
    c. To review the response to such triggers.
    d. To consider the findings of the 2009 'Lambert' report

KEY ISSUES FOR CONSIDERATION

Case 1, Mr I

2. Mr. I (aged 74) was a council tenant in Camberwell SE5 from September 1977. In line with the council's programme of periodic tenancy visits Mr I was last visited on 5 July 2015. Mr I was in receipt of full Housing Benefit with payments of arrears being deducted by the DWP and paid directly to the Council. The last payment to his account was on 12 February 2016.

3. On 2 December 2015 the council was first alerted by a neighbour that Mr. I had not been seen or heard from since 28 November 2015. The neighbour also alleged there was a strange smell in the shared corridor coming from his property.

4. Consequently on 2 December officers took the following action:

    - called the tenant on his mobile (no response).
    - called the local Police team and left a voice message.
    - emailed the local Police team to request a welfare check.

5. On 3 December the Resident Services Manager (RSM) and Resident Services Officer (RSO) visited the address. No strange smell was detected as reported. The neighbour who initially raised their concerns was present during this visit.

6. The same neighbour also advised officers that the tenant's car was missing

which was usually parked in front of the property. Officers concluded that the tenant may have travelled and therefore a decision was made not to undertake a forced entry on that occasion. The decision was based on the fact there was no smell and the tenant's car was not present.

7. A letter was left at the property requesting the tenant to contact the office on their return.

8. On 4 December 2015 a repeat visit was conducted by the RSO. Again no smell was noted but the letter remained in its original position. The neighbour was again present during this visit was advised that checks would continue. Officers continued to leave messages for the tenant and kept the neighbour updated. The tenancy file was checked and no next of kin details were found.

9. On 7 January 2016 officers were contacted by a friend of the tenant who raised concerns as they had not spoken to the tenant since the end of November 2015. This information was discussed with the Police and it was agreed to undertake a forced entry.

10. On 7 January officers met the Police on site and a forced entry was carried out. The tenant was found dead in the bath with the tap still running.

11. Contact with the tenant over the previous 12 months was also reviewed as follows:

    - 23 April 2015 – Telephone conversation with Mr I regarding pest issues in his home.
    - 14 May 2015 – Office meeting with Mr I with SASBU present.
    - 5 July 2015 – Tenancy visit conducted at the property.
    - 10 July 2015 – Pest control team confirmed a home treatment visit.
    - 27 October 2015 – Office meeting with RSM and RSO.
    - 17 November 2015 - Telephone call from Mr I to discuss the mediation service.

Case 2 Ms G

12. Ms. G, aged 72, became a council tenant in Camberwell SE5 in April 1994, following succession of the tenancy from her mother. She had lived at the property since 1973. The last tenancy check was carried out on 22 September 2014. Ms G was in receipt of full HB.

13. The RSO was first alerted via email on 6 January 2016 by the Income Officer to advise that the tenant's rent account had gone into arrears and there was a missed appointment. The RSO was on leave at the time. (Recommendation in para 44).

14. On 21 January 2016 the RSO tried contacting the next of kin and a voicemail message was left. Adult Social Care was also contacted who confirmed the tenant was not known to them.

15. On 22 January 2016 the RSO visited the property and left a calling card. No sign of any cause for concern was found.

16. On 25 January 2016, the following action was taken by the RSO:

- The tenant's rent account was reviewed, the last payment was made in March 2015. (Recommendations in paras 41 and 42).
- Telephone call to next of kin. No response was received.
- Telephone calls to several hospitals to check recent admittance. None were recorded.
- Neighbours were called but no responses were received.
- The Police were contacted and a decision made for a welfare check and entry was forced at 3pm when the deceased tenant was found

17. The RSO made follow-up enquiries with other services to confirm if tenant was known:

    - 26 January 2016 – Enquiries made to the Sustain team, who confirmed the tenant was not known to their service.
    - 26 January 2016 - Enquiries made to the mental health team, who confirmed tenant was not known to their service or receiving support from any of the support services.
    - 26 January 2016 – Enquiries to the older persons mental health team who confirmed that the tenant was previously known to their service but the case was closed on 22 October 2014. The tenant had been under the care of the psychologist team for cognitive behaviour therapy (CBT) but with no allocated CPN or caseworker.

18. The information about the tenant's mental health was not disclosed by the tenant to the RSO during a tenancy visit on 22 September 2014. (Recommendations 40 44)

Policy implications

19. The Director of Resident Services has reviewed the existing processes and practice in respect of both cases and the existing processes in place to support older and more vulnerable adults living alone in council housing; as well as wider practice across the Resident Services Division and the Council as a whole focusing on adherence to procedures, joint working and continuous improvement.

20. The future vision for the service is to adopt a more collaborative cross-Council approach with agencies, working closer together to protect and support more vulnerable households. There are already a number of existing processes in place to safeguard adults in our properties including:

    - Improved joint working with internal and external departments on matters of adult safeguarding.

    - Having a clear adult safeguarding lead in each Division responsible for improved relationships and joined up working with other services.

    - A new multi-agency team who work to prevent individuals ending up in high need social care. This includes individuals who have a range of complex needs including antisocial behaviour, mental health, substance misuse, disrepair, hoarding, and high rent arrears. The team aims to deliver early intervention and a coordinated partnership response.

- A significant programme of periodic tenancy visits by Resident Services.

- When a new tenant signs up for a tenancy lettings staff record details of support agencies (social workers, probation officers, reablement and resettlement case officers etc) working with any vulnerable tenant.

- A monthly hoarding panel is held with key partners present. The panel reviews cases of neglect and safeguarding concerns some of which were picked up during tenancy checks or by operatives. The panel agrees action plans to safeguard those concerned.

- There is a programme of child and adult safeguarding training available through My Learning Source aimed at all Council staff. This training is mandatory for RSOs to ensure they have a better understanding of triggers and behavioural changes and the need to act quickly on any concerns.

- All opportunities are used to gather intelligence on safeguarding matters including established processes for front-line operatives to report any concerns they may have witnessed. Front-line staff (for example building operatives/estate cleaning staff) have a process for reporting safeguarding issues they have identified and this information is shared regularly with resident services staff.

21. A Steering Group has been established involving Mental Health Services, Adult Social Care and Resident Services, focused on delivering more effective joined-up working across the Council and partner agencies, utilising shared management information and systems at the point of service delivery.

22. There is an existing process in place for area housing management staff to initiate when a concern or alert is raised regarding a tenant not seen and not answering their door, or telephone calls. This includes welfare checks and where necessary forced entry in partnership with the Police. This is the process that was followed in both cases in question.

Periodic Tenancy Visits

23. During 2013/14 Resident Services Staff completed visits to 31,968 households, (93.1%), as part of a programme aimed at visiting every Council tenant under direct management. This included a verification check of the tenancy; the collection of demographic information; a compliance check and an assessment of any support needs for vulnerable households.

24. The tenancy check process includes an initial assessment of vulnerability and support needs which will trigger further activity under the cause for concern (C4C) process (below). The C4C process is also triggered from referrals from Council staff or other agencies.

25. Where visits were not successful during 2013-14 these were targeted for attention in the 2014-15 programme to ensure that all tenants are visited.

26. 2014/15 - This programme was designed to reinforce the work completed the previous year and 18,340 visits were completed.

27. 2015/16 - The current year is the second year of the programme and a further

11,402 visits have been completed to date (end Jan 2016).

28. During the course of a tenancy visit an RSO has to complete a paper questionnaire collecting information on a wide range of matters. On their return to the office this information then needs to be transferred onto different management systems and actions arising from the visit, undertaken. This builds in delays in updating systems and increases the risk of inaccurate or incomplete transfer of data from the paper questionnaire. This process is, therefore, the subject of phase 1 of the Council's mobile working project designed at ensuring a more robust, automated system of recording the outcome of these visits, including recording concerns and updating systems in real time as they are identified, giving us greater assurance that the C4C process is being triggered. Phase 1 is scheduled for implementation during April 2016.

29. As can be seen from the two case reviews, tenancy visits took place in compliance with this regime.

Cause for Concern

30. There are 4 main criteria in the process for identifying a 'cause for concern':

- contact from the public or a partner agency identifying concerns;
- staff highlighting concerns;
- incidents highlighting concerns;
- an online trigger report – this identifies all those tenants over the age of 65 where there has been no repairs raised in the previous 3 months and no rent paid over the same period.

31. Once a cause for concern is triggered a programme is agreed between the Resident Services Officer (RSO) and the Resident Services Manager for more frequent visits. This also triggers routine checks across the Council to ensure a multi-agency approach to addressing identified support needs. The RSO currently manages each case using manual systems.

32. Management oversight of compliance is delivered through Resident Services' performance reporting regime.

Forced Entry – Tenant Not Seen Recently Procedure

33. There is an existing process available online for Resident Services staff designed to ensure the well-being of vulnerable residents, ensure prompt and effective action when their well-being is in doubt; and ensure that forcing entry is a controlled and managed process.

34. The existing process is subject to a review which is expected to be completed by the end March 2016. The current process includes guidelines for staff for how reports of concern are to be recorded, reporting requirements to Adult Social Care, and on when and how to escalate matters.

35. Included are two process maps, one setting out the process between receiving the notification of a concern up to the decision to force entry if required; the second sets out the process once the decision to force entry has been made. There is also a checklist to guide staff through the process.

Case Summaries

36. Full reports have been completed detailing the circumstances surrounding the two cases.

37. In the case of Mr I the right steps were taken to locate him as soon as possible and prompt action was taken in respect of initial contact from concerned parties. Council Officers investigated the concern raised by the neighbour, visited Mr I's home on a number of occasions and saw no signs of an emergency before contacting the Police to carry out a welfare check.

38. The actions taken by officers in the case of the death of Mr I from the moment the concern was first raised by his neighbour was in line with standard practice.

39. The actions taken by officers in the case of Ms G from the moment the concern was first raised by the income officer was in line with standard practice.

40. In both cases neither resident was currently known to Adult Social Care.

Lambert Report

41. The Director of Resident Services also reviewed the Lambert report of 2009 which concerned the death of Ms Engelina Lambert. The circumstances surrounding Ms Lambert's death and that of the two cases under review are different. The report was a follow up to the concerns from the Coroner into how Mrs Lambert's case was handled by Adult Social Care following concerns raised by the Ambulance Service. No such concerns have been raised in the two recent cases under review. Once common theme, however, is the critical need to ensure that information is shared across agencies working with vulnerable households.

Findings

42. The vision of greater collaborative working and wider information sharing within the Council and with its partner agencies needs to be embedded into all working practices. This will include a note on 'The Source' reminding all staff of their responsibility to report issues of concern; included in the standard Southwark induction checklist, raised at team meetings and by letter to contractors and other partner agencies.

43. Cross Council working to better support vulnerable residents, especially those living alone, can be improved by better sharing of information between those responsible for assisting and supporting people through the use of a single database, or shared system to flag cases of concern. For example, work is underway with Adult Social Care on sharing information to ensure that the directorates of the Council dealing with vulnerable households have a shared view of vulnerable residents. In addition the scope for this work extending into SLAM/NHS will be explored.

44. The 'forced entry' procedure, 'tenant not seen' procedure used by Resident Services is being reviewed, particularly with reference to how information of concern is communicated and to what timescales.

45. The online trigger report for the C4C process, (para 30 above), has been

reviewed to ensure that a concern is triggered, either when no repair has been raised, or no rent paid for all those over the age of 65 and all those flagged as 'vulnerable', given age is only one factor, in the shared system. The 'rent paid' trigger is being reduced to 6 weeks and income staff are being briefed to ensure they highlight to the RSO, (copied to the RSM and Area Manager), any significant change in payment patterns for more vulnerable households. This will be added to the Rent Income and Arrears Procedure.

46. The process where main contractors inform Resident Services of vulnerable households or subletting concerns has been reviewed and will include sub-contractors as far as possible. This review also ensures that concerns are communicated between operative and RSO more quickly and that contractors are fully compliant with these processes. This process will also feed into the proposal for shared information across the Council.

47. Existing information held by colleagues in the Occupational Therapy Service, the Housing Adaptations Team and SMART will be shared and cross-referenced in a managed way initially, by sharing existing client lists, followed up with a new process. SMART have agreed to share their list by 4/3/16.

48. The Concierge service improvement plan will include additional support for vulnerable residents, based on assessed support needs for those blocks under their management.

49. Resident Services and Communities Division's will work to ensure TRA members and the wider community are aware of routes to report any cause for concern they may have regarding residents in their neighbourhood. This will be done through a programme of attendance at routine TRA meetings and using the Council's website. This will include advice on what to be aware of and potential triggers.

50. The Leader of the Council noted the report and supported the actions outlined.

51. The Director of Resident Services will review the outlined action plan periodically during 2016/2017 to ensure actions are carried out and completed.

52. Action Plan:

Ref	Recommendation	By whom and by when
Para 42	Include a note on The Source reminding all staff of their responsibility to report issues of concern and all managers to raise at team meetings.	Area Manager/ Communications by end March 2016
Para 42	All managers to ensure that all staff are briefed on their responsibilities in safeguarding, triggers to look out for and reporting routes as part of the standard Southwark Induction checklist.	Human Resources by end March 2016
Para 42	All repairs contractors to be reminded by letter of the need to report all safeguarding concerns through the standard reporting regime and ensure that this is cascaded to all sub-contractors (para 25).	R&M Manager/Head of Engineering by end of March 2016
Para 43	Put in place information sharing protocol with Adult Social Care.	Robertson Egueye by end April 2016

Para 43	Information sharing protocol with Health Services.	Robertson Egueye by end June 2016
Para 44	Review of forced entry procedure – tenant not seen' procedure.	Andrew Rogers by end March 2016
Para 45	Change parameters of trigger report as set out in para 24.	David Eatwell/Paul Montigue by end March 2016
Para 45	Amend Rent Income & Arrears Procedure to re-inforce requirement for Income Officers to report concerns to RSOs (copied to RSM/Area Manager). Instruction to staff to report concerns to RSOs (copied to RSM/Area Manager).	Martin Hilder by end July 2016 Martin Hilder by 4/3/16
Para 47	Shared data with OTs, Housing Adaptations and SMART service and protocol to ensure regular cross-reference against 'vulnerable' list.	Robertson Egueye by end April 2016
Para 48	Concierge staff to receive access to 'vulnerable list' and new instruction to door-knock in the event of service outage/incident.	Hazel Flores, Andrew Rogers, Abi Oguntokun by end March 2016
Para 49	Briefing note for RSOs for TRA meetings and completion of attendance at all associations to raise awareness.	David Eatwell by end September 2016
Para 49	Poster for TRA halls and publish Website content for TRA's.	David Eatwell/Comms by end March 2016

APPENDICES

No.	Title
	none

AUDIT TRAIL

Lead Officer	Gerri Scott, Strategic Director of Housing and Modernisation		
Report Author	Paul Langford, Director of Resident Services		
Version			
Dated	21 March 2016		
Key Decision?	No		
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER			
Officer Title		**Comments Sought**	**Comments Included**
Director of Law and Democracy		Yes/No	Yes/No
Strategic Director of Finance and Governance		Yes/No	Yes/No
List other officers here			
Cabinet Member		Yes/No	Yes/No
Date final report sent to Constitutional Team / Community Council / Scrutiny Team			

Agenda Item 6

Item No.	Classification: Open	Date: 4 April 2016	Meeting Name: Overview and Scrutiny Committee
Report title:		London Living Wage	
Ward(s) or groups affected:		All	
From:		Strategic Director of Finance and Governance	

RECOMMENDATIONS

1. That the overview and scrutiny committee note the information given on the council's approach to the London Living Wage.

KEY ISSUES

2. The chair of OSC has asked how the London living wage is written into contracts.

3. The council's guidance is shown in the attached appendix which covers:

- What is the London Living Wage
- Why does Southwark support the London Living Wage
- How is the London Living Wage to be implemented
- Legal Implications
- Frequently Asked Questions
- Factors to consider
- Sample contract clauses
- Example gateway report wording
- Flowchart for inclusion of London Living Wage

Resource implications

4. There are no direct resource implications in this report.

Consultation

5. There has been no consultation on this report.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS

6. None required.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact

APPENDICES

No.	Title
A	Application of the London Living Wage in contracts

Audit Trail

Lead Officer	Duncan Whitfield, Strategic Director of Finance and Governance		
Report Author	Jennifer Seeley, Director of Finance		
Version	Final		
Dated	22/03/2016		
Key Decision?	No		
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER			
Officer Title		**Comments Sought**	**Comments included**
Director of Law and Democracy		No	No
Cabinet Member		N/A	N/A
Date final report sent to Constitutional Support Services			

Application of the London Living Wage in Contracts

December 2012 (updated June 2014) **www.southwark.gov.uk**

This document sets out guidance on the Southwark Council commitment to encourage our contractors and sub-contractors to pay the London Living Wage to their staff when they provide works or services in council premises or in Greater London.

What is the London Living Wage?

The London Living Wage (LLW) is a campaign initiated by the community organisation, London Citizens in 2001 and is championed by the Greater London Assembly. It is also supported by trade unions and anti-poverty agencies. The LLW is a voluntary minimum hourly rate set by the Greater London Authority to ensure a decent standard of living. The London Living Wage is £8.55 per hour for 2012-2013.

Why does Southwark support the London Living Wage?

Economic Background: Southwark

According to the English Indices of Deprivation 2010, Southwark is the 41st most deprived local authority district in England, out of 326 local authority districts. In December 2011, it had an unemployment rate of 10.5%, compared with 9.3% across London and has a significantly high proportion of Job Seeker Allowance claimants who have been claiming over 2 years – 7% compared to an inner London average of 4% and regional average of 3%. The London Living Wage could improve those statistics by helping more residents out of poverty and into decently paid employment.

Improved Quality Of Service

Both the GLA Economic Development unit and London Economics have identified the benefits of implementing LLW including:

- easier recruitment and retention - reducing recruitment costs
- reduced staff turnover
- higher quality staff
- better attendance
- better productivity, motivation and loyalty
- Improved worker morale
- better quality of service
- improved reputation

A Fairer Future For All In Southwark

In the Council Plan agreed in July 2011 the Leader set out his vision for a fairer future for all in Southwark:

> *"The Council will create a fairer future for all in Southwark by: protecting the most vulnerable; by looking after every penny as if it was our own; by working with local people, communities and businesses to innovate, improve and transform public services; and standing up for everyone's rights. As a central London borough, our mission is to enhance the things that make Southwark special – its immense diversity and vast depths of untapped potential. Helping to unlock those talents, with nobody left behind, is what we are about as a Council. People in the borough should be able to enjoy the enormous benefits and seize the opportunities that living in central London offers. The Council has its part to play as one of many working to deliver a fairer future."*

We believe that to achieve this vision all staff working within our borough deserve a fair wage reflecting the environment in which they work, regardless of whether they are employed directly by the Council or by our contractors or sub-contractors. We also believe that the payment of a fair wage can improve the quality of service provided in a contract, reduce staff turnover and produce a more motivated and productive workforce. Including this issue within our procurement of works and services will enable us to perform our functions in a way which aims to achieve continuous improvement in their delivery and achieve key policy priorities.

How is the London Living Wage to be implemented?

Council Assembly on 29 February 2012 agreed its revenue budget with the introduction of clear plans to ensure that the London Living Wage (LLW) benefits not only the Council's directly employed staff but also those who work for the Council through contractors over the next three years. The presumption will now be that LLW will be included in new contracts where services/works are to be provided on council premises or in the London area, and where best value can be demonstrated on a case by case basis. This commitment will be subject to rigorous procurement processes linked to quality improvement in the services being delivered.

With effect from 29 February 2012,:

- There is a presumption that the London Living Wage will apply to all new contracts for the provision of services or works, which are to be performed either on council premises, or in the Greater London area.
- In such contracts, the London Living Wage will apply to all relevant staff working directly on the contract in question, and will also apply to any relevant staff employed by sub-contractors (excluding apprentices and interns).
- In the planning of all contracts, the appropriateness and best value/cost implications of including the LLW must be considered on a case-by-case basis, recorded in writing and set out in any required Gateway One Report. Where LLW is not appropriate it must not be included in the contract and detailed reasons why LLW is not appropriate should be set out in the Gateway One Report.
- Where LLW is included gateway reports and contract documents must include:
    - How the requirement for LLW will be evaluated
    - How the payment of LLW, associated quality improvements and cost implications will be monitored.

In November 2012 Southwark Council became an officially accredited London Living Wage Employer. This scheme is administered by Citizens UK and the Living Wage Foundation.

Legal Implications

The general power of competence under the **Localism Act 2012**, subject to the pre-existing limitations of **S17 Local Government Act 1988** as amended by **Local Government Best Value (Exclusion of Non-commercial considerations) Order 2001 (SI 2001 909)** enables the Council to have regard to minimum rates of pay in a contractual process to the extent they are ***relevant to the delivery of best value.***

S3 Local Government Act 1999 requires best value authorities to "make arrangements to secure continuous improvements in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness". This allows the council to require payment of LLW where we believe this will result in better value services being provided under the contract, on the basis that the contractor's staff will be more likely to be able and/or motivated if paid at least this rate.

Cl 2 Public Services (Social Value) Act 2012 [will impose] a duty on the Council to consider how to improve the economic, social, and environmental well-being of our area by what we are proposing to procure and how that improvement might be achieved through the procurement process for all services (or predominantly services) contracts subject to the EU procurement regulations. This legislation has amended s17 Local Government Act 1988 to enable non-commercial matters to be considered to the extent that the council considers it necessary or expedient to do so to enable or facilitate compliance with this duty.

The following points should be taken into account for each procurement and have also been taken into account when formulating this guidance:

- The council must determine genuinely and reasonably that the LLW is an appropriate way of ensuring a better value for money service;
- The council must be reasonably satisfied that the extra cost to the council is reflected in enhanced quality of service;
- In order to show it is acting reasonably the council can not make a blanket policy but must consider each procurement on a case-by-case basis;
- The LLW policy will apply only to contracts performed on council premises, or otherwise essentially in the London area;
- In the planning of the contracts, the relevance of LWW can be considered, but where it is considered inappropriate e.g. because the contract is not to be performed by staff living in London then there would be no grounds to require the LWW.
- A blanket policy of not inviting or considering tenders from contractors who are unwilling to agree to a LLW clause in their contract could be challenged as unlawful;

Frequently Asked Questions

When do I need to consider LLW and how?
Whether or not LLW is to be required must be considered for all new contracts from 1 March 2012. The issue will need to be addressed as early as possible in your procurement planning and set out in detail in your Gateway One Report.

What factors should I consider when deciding if LLW should be required?
The following are factors to be considered which may support the inclusion of a LLW requirement in contracts, or which may carry weight to decide not to include the requirement

Factors indicating LLW would be appropriate in the contract	Factors indicating LLW may not be appropriate
Service provided in Southwark premises	Service provided elsewhere than Southwark premises
Service provided in London	Service provided outside London
Service provided alongside Southwark staff	Service completely separate to Southwark staff
Contractor staff working on the same project as Southwark staff	
People providing the service likely to be drawn from local workforce	

Factors indicating LLW would be appropriate in the contract	Factors indicating LLW may not be appropriate
Mixed economy of contractors already paying LLW	No existing contractors paying LLW
Positive feedback from likely contractors on paying LLW	Clear indication that contractors are likely to withdraw from competition if LLW sought to such an extent that competition is distorted
Quality enhancements in service foreseeable and likely	No likely change in service quality
Specification enhancements can be built into contract	No opportunity to change service specification
Public facing service / involvement in customer care	Back office service
Southwark council led procurement	Use of framework or other contract arrangements

Where can I find out more information about the London Living Wage?
A Fairer London: The 2012 Living Wage in London | Greater London Authority – this explains how the LLW is calculated, the organisations which support it, case studies and background information.

I am procuring a large contract which bundles together different services. Some of them will be based within Southwark but others are not. Should I require LLW for all, none or part only of this contract?
It is unlikely that LLW will be applicable to discrete services which are located away from Southwark – however, there may be instances where the provision of those services is so inter-connected with "in-borough" services that a different view could be reached with legal advice. It is possible to draft your contract so that LLW is required only for the provision of specified services. Example clauses are available from **Corporate Services: Contracts** in Legal Services.

Which contractor or sub-contractor employees will this apply to? Some of the sub-contractors are likely to provide only very sporadic or one off services within council premises or Greater London. How do I address this in my main contract?
The accreditation licence which the council has entered into with the Living Wage Foundation sets out the criteria which must be applied to work out whether London Living Wage is to be paid to an employee or not. These requirements have been reflected in some standard contract clauses which are attached to this note. These clauses must not be amended without discussion with the Contracts team in Legal Services.

Further Information

Please contact **Corporate Services: Contracts** in Legal Services.

SAMPLE CONTRACT CLAUSES

1. London Living Wage

1.1. Definitions

For the purposes of this Clause:

"Relevant Staff"	shall mean all employees and other staff *(*including without limitation temporary and casual workers and agency staff as defined by Regulation 3 of the Agency Workers Regulations 2010 as amended by the Agency Workers (Amendment) Regulations 2011, and whether such staff are engaged or employed on a full or part time basis, but not including unpaid volunteers, interns or apprentices), who are employed or engaged on the [Works or Services] for 2 or more hours of work in any given day in a week, for 8 or more consecutive weeks in a year.
"Equivalent Hourly Wage"	shall mean the hourly wage paid to an employee and calculated using the same method as prescribed by the National Minimum Wage Act 1998 and related applicable law to assess whether an employee is at any time receiving the national minimum wage (as identified in that Act),
"the London Living Wage"	shall mean the most recently identified London Living Wage hourly figure (or equivalent set figure(s)) published from time to time by the Greater London Authority or any successor body with responsibility for setting this figure,

1.2. Contractors obligations

The Contractor will:

- ensure that all Relevant Staff employed or engaged by the Contractor are paid an Equivalent Hourly Wage which is equal to or exceeds the London Living Wage;
- ensure that all Relevant Staff employed or engaged by its subcontractors (if any) pay an Equivalent Hourly Wage which is equal to or exceeds the London Living Wage;
- provide to the Employer such information concerning the London Living Wage and the performance of its obligations under this Clause [ ] as the Employer may reasonably require and within the deadlines it reasonably imposes;
- co-operate and provide all reasonable assistance to the Employer in monitoring the effects of the London Living Wage including without limitation assisting us in conducting surveys and assembling data in respect of the affect of payment of London Living Wage to Relevant Staff.

1.3. Default

1.3.1. For the avoidance of doubt, any breach by the Contractor of this Clause [ ] may be a material breach in relation to which the Employer is entitled to rely on its termination rights under the Contract.

Example Gateway Report wording

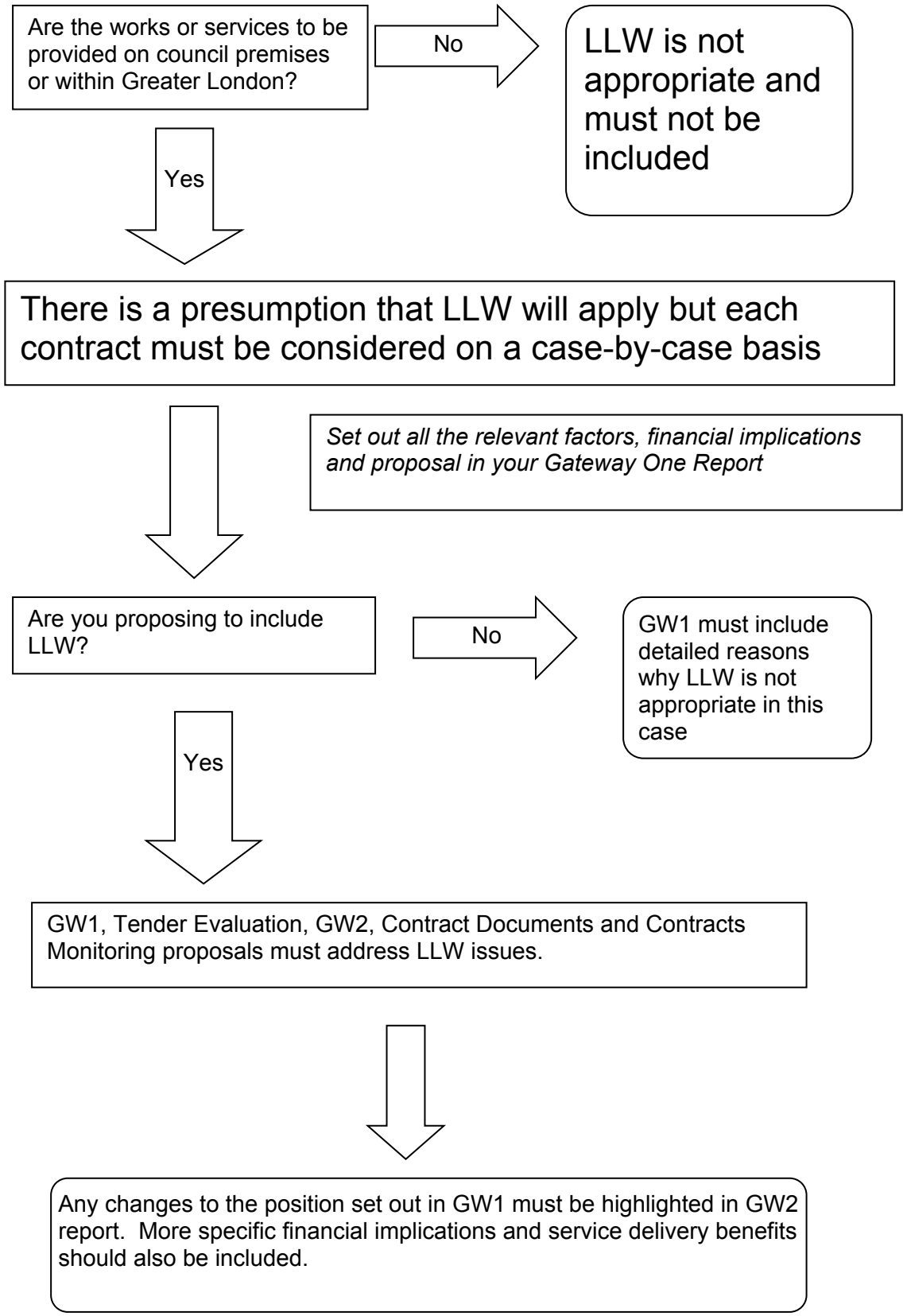
Gateway 1 - Social Considerations

Example1
The council is an officially accredited London Living Wage (LLW) Employer and is committed to ensuring that, where appropriate, contractors and subcontractors engaged by the council to provide works or services within Southwark pay their staff at a minimum rate equivalent to the LLW rate. It is expected that payment of the LLW by the successful contractor for this contract will result in quality improvements for the council. These should include [*examples: a higher calibre of multi-skilled operatives that will contribute to the [delivery of works on site/provision of the services within Southwark] OR more experienced staff OR continuity of service provision resulting from reduced turnover of staff]* and will provide best value for the council. It is therefore considered appropriate for the payment of LLW to be required. The successful contractor will be expected to meet LLW requirements and contract conditions requiring the payment of LLW will be included in the tender documents. As part of the tender process, bidders will also be required to confirm how productivity will be improved by payment of LLW. Following award, these quality improvements and any cost implications will be monitored as part of the contract review process.

Gateway 2 - Social Considerations

The council is an officially accredited London Living Wage (LLW) Employer and is committed to ensuring that, where appropriate, our contractors and subcontractors pay staff at a minimum rate equivalent to the LLW rate. The Gateway 1 report dated [ ] confirmed, for the reasons stated in that report, payment of LLW was an appropriate and best value requirement for this contract. [insert name of successful contractor] has confirmed that they [already/will] [meet/exceed] the LLW requirements. Following award, quality improvements and costs implications linked to the payment of LLW will be monitored as part of the contract review process.

FLOW CHART FOR INCLUSION OF LONDON LIVING WAGE



Time to Care: A future vision of care in Southwark
A report from the Healthy Communities Scrutiny Committee

Overview

The Healthy Communities Scrutiny Sub-Committee took an undertaking to look at the provision of care in Southwark. This issue was escalated as a result of announcements locally about care home provision in Southwark, and in the wider context of national debate about care homes.

This report provides an overview of the work carried out by the Committee and recommendations to the way in which we approach care in Southwark.

The Committee would like to thank all of those who submitted written evidence and presented oral evidence to the Committee as part of this inquiry.

This report has focused on care homes, home care, care in the community and the Ethical Care Charter. We have made a number of recommendations which look to ensure that we can continue to provide high levels of care to our residents, as well as supporting their families.

Our recommendations are as follows:

1. We recommend that HC One and the Council update the Committee on the re-homing of the residents of Camberwell Green Care Home, especially in relation to the re-homing to Tower Bridge and share with the committee any subsequent CQC inspection outcomes

2. The Committee believes that there needs to be a clear component of any future contract with the Council which clearly sets out training and development plans for staff. The focus on e-learning should be reduced, and there should be clear KPIs for organisations to achieve to ensure staff are supported.

3. The Committee recommends that the Council makes serious consideration of establishing our own Council-owned Care Homes. We believe that with the resource that the Council is currently having to put into our care homes, and the broader crisis in care homes and concerns over the viability of providers in the long-term, that having Council-owned services would allow the Council to retain control and implement a service in such a way as to provide excellence of care for our residents.

4. We would like to see more rigorous monitoring of the situation related to non-payment of London Living Wage for Home Care workers and a commitment to paying the London Living Wage within the new home care contracts when they are retendered in 2016.

5. The Committee recommends that the provision of zero-hour contracts, and bulk hour contracts should be carefully evaluated as part of the re-tendering process for home care in Southwark.

6. We would recommend that home care provider staff are provided with information about Southwark in regards to road maps, busy areas within the Borough, and approximate journey times to better help plan where workers should be sent for jobs.

7. The Committee recommends that as part of the re-tendering process, there should be stipulation that allows for trade union representatives to meet with staff and for them to be recognised within any contracted services.

8. The Committee believes that there are further areas for improvement and recommends that the Council look to develop an Ethical Care Charter II.

9. The Committee further recommends that issues around TU rights, joined-up services and training & development form a key part of the re-tendering process for the procurement of home care services in Southwark.

10. We would recommend that when a complaint is made in home care services, that the complainant is given a named Council officer, where possible, to lead the handling of the complaint, to help ensure continuity throughout the process.

11. The Committee would like to congratulate the team at Age UK for their lay inspection of home care services in Southwark and would recommend that funding is continued for this programme in financial year 2016/17.

12. We understand that recruitment of new volunteers for the Lay Inspectors Scheme is in decline, and would recommend that the Council assist with the promotion of the Scheme.

13. The Committee recommends that the care homes should create a partnership with Southwark Carers to ensure that they receive all necessary support and their services are flagged appropriately to family members.

14. We recommend that care homes provide comprehensive information to residents and their families about the community services that are available to local residents. This may involve care homes working more closely with community organisations to understand what services are on offer, and identifying opportunities for them to showcase their services to care home residents.

15. We recommend that any individual or organisation who raises a safeguarding alert with the Council should receive a case number so they can follow up if they do not feel the issue has been addressed, and should receive a full response about any action taken, taking into account data protection issues.

16. We further recommend that care homes clearly display information about the Safeguarding Board and highlight this information to families and carers for those in their care homes, as an independent avenue for raising issues and concerns.

Committee and witnesses

The Committee would like to thank all of those who made this report possible.

Councillor Rebecca Lury, Chair, Healthy Communities Committee

Councillor David Noakes, Vice-Chair, Health Communities Committee

Councillor Jasmine Ali, Member of the Healthy Communities Committee

Councillor Paul Fleming, Member of the Healthy Communities Committee

Councillor Lucas Green, Member of the Healthy Communities Committee

Councillor Maria Linforth-Hall, Member of the Healthy Communities Committee

Councillor Bill Williams, Member of the Healthy Communities Committee

Witnesses:

Councillor Stephanie Cryan, Cabinet Member for Adult Care and Financial Inclusion

Andrew Loxton, Commissioning Manager

Rochelle Jamieson, Quality and Performance Manager

Gwen Kennedy, Director of Quality and Safety, Southwark NHS Clinical Commissioning Group

Kate Moriarty-Baker, Head of Continuing Care and Safeguarding, Southwark Clinical Commissioning group

Jacky Bourke-White, Chief Officer, **Joan Thomas**, lead Home Care Lay Inspection project, **Miranda Okon** care worker representative , all of Age UK Lewisham & Southwark

Tom White, Volunteer Lay Inspector

Helen Wells, Inspection Manager for Southwark, Care Quality Commission (CQC),

Liz Whyte, Managing Director, **Mr John Ransford**, non-executive Director, both of HC-One

Mike O'Reilly, Risk Management Director, Four Seasons

Alex Evans, Director & **Cindy Glover**, facilitator for older people's groups, both of Time & Talents

David Stock, Chief Executive, Southwark Disablement Association

Clive Smith, Area Representative, GMB.

Verinder Mander, Chief Executive, Southwark Carers

Sue Plain, UNISON, with three care workers

Catherine Negus, Healthwatch

Peter Doye

Providing care homes for the future

To help our understanding of the situation in Southwark, the CQC presented to the Committee an overview of the four care homes in Southwark, two were rated as Inadequate, one as Requiring Improvement and contrasted this with an example of an Outstanding care home in Southwark. The Lay Inspectors also commented on the care homes We thought this would be useful to summarise below as it clearly demonstrates the problem that is being faced in some of Southwark's care homes

Southwark Care Homes rated as Inadequate or Requiring Improvement (provided by HC One & Four Seasons)	**Southwark Care Home rated as Outstanding (provided by Anchor)**
• People did not receive medicines safely • Standards of cleanliness were not maintained • People were at risk of infection • Staff were not always supported effectively • People who lacked capacity were not supported to have their needs and choices met • People were not supported to have food and drink in a timely manner • The management team needed strengthening and there was a high turnover • Systems to monitor quality were in place, but not used effectively	• People were treated with kindness, respect and compassion • Staff knew people well • People were involved in discussions about their care, including end of life care • Staff were motivated and supported • Open culture – people and staff could raise concerns • Sustained good leadership by the care home manager • Staff retention

This all falls against a backdrop of the ongoing 'care homes crisis' in the United Kingdom more broadly and stories continue to abound in the media about abuses in the system. As Paul Burstow says in his foreword to the Demos Commission on Residential Care, *'the brand of residential care is fatally damaged…linked in the public mind to a loss of independence, residential care is seen as a place of last resort.'*

In October 2015 it was announced that Camberwell Green Care Home, currently operated by HC One would be closing. At the time of the announcement of closure, there were 35 residents within the home (Camberwell Green had 3 residents with a NHS fully-funded place and 32 receiving NHS Funded Nursing Care (FNC), which is a NHS-funded nursing care contribution of £112 per week paid to residents in nursing beds The care home has committed to staying open until all the current residents have been re-located.

This announcement came at a time when Southwark's Care Homes are already under a great deal of pressure. Both Tower Bridge Road and Burgess Park are in special measures as they have been rated as Inadequate and Southwark Council has an embargo on both homes.

Both Burgess Park and Tower Bridge Care Homes are not at capacity, but whilst both continue to have significant challenges, from our evidence session, the Committee understood that they were not in a position to provide the extra support to re-home Camberwell Green residents.

Camberwell Green had its own issues, with a building that is not fit-for-purpose, and significant challenges with staff retention. Whilst a new manager and support staff were recruited, the home did not see the improvements needed, and this has resulted in its closure.

The Committee is concerned by the closure of Camberwell Green Care Home and is particularly concerned that residents were re-homed to Tower Bridge despite its Inadequate rating.

We recommend that HC One and the Council update the Committee on the re-homing of the residents of Camberwell Green Care Home, especially in relation to the re-homing to Tower Bridge and share with the committee any subsequent CQC inspection outcomes

At present, there are a large number of external organisations and services who are having to support the work of our care homes. This includes the CCG, Council and CQC. Between them, they are providing nursing and GP services in our care homes, as well as supporting staff training programmes, as well as supporting the placement of new residential managers. There is also the crucial role played by the lay inspectors, who are currently funded by Southwark Council. The Committee is very supportive of the role that they play in providing an independent scrutiny on our care homes, and would hope that the Council continue to fund the programme going forward.

The Committee however is concerned about this extra resource that is having to be put into our care homes to try and support private companies who are being paid to provide the care homes service in Southwark.

At the same time, we are concerned that these care homes keep coming up time and time again, and it appears that there is a more institutional problem with the service. Staff turnover remains high and the Council is having to support the introduction of new Managers to the homes.

The Committee is not convinced by the idea that Southwark's Care Homes are just an anomaly, and that for reasons that cannot be explained, the majority of homes that are in special measures are concentrated in Southwark.

We understand that staff all have their own training plans, which are reviewed on a regular basis. Training appears to be largely provided through e-learning and some observational studies. We understand that the work is highly skilled and high pressured, and this means that there is a large turnover in the sector. This has been helped by the introduction of the Ethical Care Charter which has guaranteed working conditions and wages for Care Workers, but more needs to be done.

The Committee believes that there needs to be a clear component of any future contract with the Council which clearly sets out training and development plans for staff. The focus on e-learning should be reduced, and there should be clear KPIs for organisations to achieve to ensure staff are supported.

We understand that the Council is in the process of developing a 10-year strategy for our care homes which will be published in Spring 2016. The Committee welcomes this focus on a long-term strategy for the provision of care in the Borough. We hope that this report goes some way to helping frame some of the challenges that local people and organisations are seeing in the care sector.

Currently the council has a long term block contract with Anchor Care homes, who provide residential care only for older people, whereas residents requiring both nursing and residential care are usually using the services of providers HC One and Four Seasons , and here care is paid for via spot purchasing. Residents requiring nursing care are the most vulnerable, with often multiple needs such as dementia & diabetes. We remain extremely concerned by the current provision for Southwark residents receiving nursing care as a component of residential care, and the lack of a guarantee from both HC One and Four Seasons that they will be able to keep open the remaining Care Homes in Southwark. This presents a significant risk to residents, who may ultimately end up having to go out of

the borough, and this in turn will lead to additional pressure on families who have to travel further distances to visit relatives.

The extra support being given to care homes in Southwark is welcome, but we are again concerned about the huge number of external resource that is having to be brought in to support services which continue to remain inadequate.

The Committee believes that there may need to be a much more radical reassessment of the way in which Care Home services are provided in Southwark. We believe that there is merit in assessing whether the Council should be looking to provide its own buildings and Care Home service which is then privately contracted out. This has worked well with the Anchor Homes in Southwark which provide retirement living assisted and independent living opportunities

The Committee recommends that the Council makes serious consideration of establishing our own Council-owned Care Homes. We believe that with the resource that the Council is currently having to put into our care homes, and the broader crisis in care homes and concerns over the viability of providers in the long-term, that having Council-owned services would allow the Council to retain control and implement a service in such a way as to provide excellence of care for our residents.

Giving our care workers the time to care

The current home care service is due to be retendered at the end of 2015, and the Council hopes to have the tendering process up and running by July 2016.

It has come to the attention of the Committee that whilst the Council pays its home care providers enough within contracts to pay staff the London Living Wage, the London Living Wage is not always paid to individual staff. Unison brought to our attention a number of individuals who saw a delay in payments of the London Living Wage and that this has not been backdated to the last financial year. We are particularly concerned by this assertion and understand that the Council is currently looking into this in more detail.

We would like to see more rigorous monitoring of the situation related to non-payment of London Living Wage for Home Care workers and a commitment to paying the London Living Wage within the new home care contracts when they are retendered in 2016.

The Committee is further concerned by issues raised around contractual working hours. Both Unison and GMB raised with the Committee that staff had to sign up to batches of contractual hours, where they were required on occasions to be available for double the amount of hours they were actually paid for. In one example a staff member had to be able to work 40hours, and arrange associated child care, but was only called in to work 20 hours. There was limited flexibility in when these hours could be worked. We are also concerned about the assertion that staff are being asked to work multiple consecutive weekends, or up to 14 days without a day off, and that cultural and religious needs were not sufficiently taken into account – for example the importance of Sunday church

Our home care workers are doing a fantastic job, and the Committee would like to wholeheartedly thank them for all of the work that they do in the Borough. We want to ensure that they are receiving fair pay, and fair working conditions for the services that they provide.

The Committee recommends that the provision of zero-hour contracts, and bulk hour contracts should be carefully evaluated as part of the re-tendering process for home care in Southwark.

The Committee also heard from Unison about the distribution of jobs that were allocated to staff. We understand that in some cases, staff are being asked to travel up to an hour between jobs. We believe that with a better understanding of the geography of the Borough that office staff may be better able to allocate jobs.

We would recommend that home care provider staff are provided with information about Southwark in regards to road maps, busy areas within the Borough, and approximate journey times to better help plan where workers should be sent for jobs.

We are further concerned about the availability of trade union representation within home care providers. Both Unison and GMB raised with the Committee that they had difficulty in accessing staff, in some cases, with unions being de-recognised. Added to this, we understand that staff are not always paid for staff meetings, so there is little opportunity for them to come together to discuss any issues that they might have.

With the continued cuts to local government, and the government's plans to introduce the National Living Wage, there will be a dichotomy between the local authority being able to find the money to be able to pay providers enough money for this to be passed onto staff. We therefore believe there is a

critical role for Trade Unions, to ensure that the rights of the workers are protected in these difficult times.

The Committee recommends that as part of the re-tendering process, there should be stipulation that allows for trade union representatives to meet with staff and for them to be recognised within any contracted services.

Progress of the Ethical Care Charter

Southwark Council was one of the first Councils (along with Islington) to sign up the Ethical Care Charter in December 2013.

The Committee wants to commend the Council on progress to date in adopting the Ethical Care Charter. We welcome the progress made to ensure that this is adhered to in our contracts with care homes providers, but would like to see that the Ethical Care Charter is appropriately followed in the home care sector.

The Committee welcomes the successful implementation of the Ethical Care Charter in the Care Home sector. We believe that enough time has now passed for us to be reviewing what has been achieved so far, and the areas where there needs to be further work. **The Committee believes that there are further areas for improvement and recommends that the Council look to develop an Ethical Care Charter II.**

The Committee therefore recommends that the following areas might form the main tenets of a new Ethical Care Charter.

1. **Trade Union rights**: The Council should ensure that contractors place the 'voice of the staff' at the centre of their ways of working, ensuring that there is Trade Union recognition and involvement with each organisation.
2. **Joined-up services**: KPIs should be introduced to contracts such that they encourage a joined-up approach to project delivery. We would like to see all relevant services providers brought together in discussions about service user care needs. This should include the CCG, local authority and social workers.
3. **Training and development**: KPIs should be introduced in contacts to ensure the delivery of quality training for staff involved in the delivery of care services.

The Committee further recommends that issues around TU rights, joined-up services and training & development form a key part of the re-tendering process for the procurement of home care services in Southwark.

Ensuring support for home care

Southwark Council currently commissions 520,000 hours of home care every year through contracts with MiHomeCare and London Care. They support 1250 users, with a further 420 users supporting through personal budgets, and 50 using them as spot providers.

Age UK currently runs a 2 day a week programme of lay inspection of Southwark's home care services. This service is currently funded by Southwark Council and the current contract is due to expire in April 2016.

The programme mirrors the lay inspection programme in Southwark Care Homes and uses the same criteria as the CQC uses to assess care homes.

The CQC approach has been one of phone calls and questionnaires without any face-to-face contact, and we believe that this sets the Age UK programme apart. During its work so far, the programme is identifying the issues and trends in the home care sector. The five key findings so far as:

- The need for regular carers and adequate handovers when carers do change to ensure continuity
- The welcome empathy that home care workers have for those that they are caring for, and the huge respect that they receive from those they are caring for
- The need for a bespoke service, focused around the individual
- The importance of social interaction, to make the person receiving care feel like a member of society
- A need for sensitivity around the cultural needs of the individual being cared for. This covers all ethnic groups.

The lay inspection programme provides a vital opportunity for service users, their families and home care workers to raise any concerns that they might have.

The lay inspection team have found that they regularly receive feedback, but that when they pass on complaints to the Council that these issues often take a long time to get fixed. The process itself is seen as very slow, although this is not necessarily due to any one specific part of the complaints process. One of the specific criticisms of the Council's complaints process is the constant changing of staff who deal with a specific complaint. This often leads to information having to be repeated on numerous occasions, and can lead to confusion.

We would recommend that when a complaint is made in home care services, that the complainant is given a named Council officer, where possible, to lead the handling of the complaint, to help ensure continuity throughout the process.

The Committee would like to congratulate the team at Age UK for their lay inspection of home care services in Southwark and would recommend that funding is continued for this programme in financial year 2016/17.

We understand that recruitment of new volunteers for the Lay Inspectors Scheme is in decline, and would recommend that the Council assist with the promotion of the Scheme.

The Committee commends the work of the large number of unpaid carers in Southwark, who dedicate large amounts of their time to caring for relatives. In most cases, external services are also commissioned for individuals by their families, who provide more structured care and support services.

We believe that the voices of the family however should not be forgotten and organisations such as Southwark Carers and Carers UK provide a vital service in ensuring family members are not forgotten.

However, we are concerned that support services for carers may be lacking in regards to end of life care. In many situations, the referral of the carer for support happens too late in the process, when large and often life-changing decisions have already been made.

The Committee recommends that the care homes should create a partnership with Southwark Carers to ensure that they receive all necessary support and their services are flagged appropriately to family members.

Supporting care in our community

The Council believes that residential care is not the only solution to providing services to residents who need extra support.

We believe that community links are incredibly important and can help people to live longer, and more fulfilling lives. As we heard through our discussions at the Committee, there are countless examples of individuals going into care homes, where their care quickly deteriorates. In many cases, those individuals had been part of community activities before entering the home and this link to the community was not maintained once they entered the home.

The Committee places a huge amount of importance on the role that voluntary organisations can play in supporting people to feel part of their community. We believe that this lack of continuity of maintaining community links has a detrimental effect on residents who have entered care homes, and there needs to be more done to ensure that they can access these services.

We recommend that care homes provide comprehensive information to residents and their families about the community services that are available to local residents. This may involve care homes working more closely with community organisations to understand what services are on offer, and identifying opportunities for them to showcase their services to care home residents.

We also recognise the importance role that voluntary and external organisations play in identifying issues and raising concerns that they may have about the care of individuals. We heard from participants at our roundtable, that when the voluntary sector raises issues to social workers and/or the Council, there is often no feedback as to any action that has been taken as a result.

We recommend that any individual or organisation who raises a safeguarding alert with the Council should receive a case number so they can follow up if they do not feel the issue has been addressed, and should receive a full response about any action taken, taking into account data protection issues.

We further recommend that care homes clearly display information about the Safeguarding Board and highlight this information to families and carers for those in their care homes, as an independent avenue for raising issues and concerns.

A Joint Mental Health Strategy for Southwark

A Joint Report of the

Education & Children's Services scrutiny sub-committee

and the

Healthy Communities scrutiny sub-committee

March 2016

Southwark Council

Contents

1. Introduction

1.1 The Education & Children's Services Scrutiny Committee and the Healthy Communities Committee carried out a joint inquiry into the development of the Joint Mental Health Strategy for Southwark.

1.2 This is being created jointly between Southwark Council and the Southwark Clinical Commissioning Group.

1.3 This report brings together the recommendations from both Committees as a single report for the Cabinet Member and Clinical Commissioning Group to consider.

2. Summary of recommendations

2.1 **Recommendation 1:** Both the Children and Education Scrutiny Committee and the Healthy Communities Committee would recommend that the best practice guidance developed by the Centre for Mental Health forms the cornerstone for the approach taken to developing the Joint Mental Health Strategy for Southwark.

2.2 **Recommendation 2:** Both the Children and Education Scrutiny and the Healthy Communities Scrutiny Committees would request that the final report is presented to scrutiny when finalised.

Education and Children's Services Scrutiny Sub-Committee

2.3 **Recommendation 3:** The Committee recommends that the Council and CCG detail the global CAMHS spend now and once the Transformation Plan is implemented and funds drawn down, year by year, with a budget for each service.

2.4 **Recommendation 4:** The Committee recommends that the Council and CCG provide more detail on Early Help investment, now and in the future

2.5 **Recommendation 5:** The Committee recommends that the Council and the CCG consult with the Headteachers Executive on the link arrangements with CAMHS and the Early Help provision, the Pilot project, to ensure the proposed Children and Young People's Emotional Wellbeing Strategy will deliver better communication and integration between schools with mental health practitioners and social care, including housing.

2.6 **Recommendation 6:** The Committee recommends that the adoption of a Whole School approach to mental health and emotional wellbeing in the Children and Young People's Emotional Wellbeing Strategy is well promoted and a plan is developed for its implementation in partnership with the Headteachers Executive and local schools. Case studies from Bacons College and schools with positive practice in this area should be promoted around Southwark schools.

2.7 **Recommendation 7:** The Committee recommends that a schools representative on the Health & Wellbeing Board is appointed. This could be done through the Southwark Headteachers Executive.

2.8 **Recommendation 8:** The Committee recommends that the Council and the CCG set out more clearly how the Transformation Plan will tackle

- Cyber bullying
- Gangs and work with schools on this
- Promote effective anti-bullying work in schools, particularly peer support

- Recognise the LGBT students are at particular risk of being bullied and need particular support e.g. anti-discrimination work and LGBT peer support

2.9 **Recommendation 9:** The Committee recommends that the Council and the CCG differentiate more clearly gender specific data and services that address specific risks, for example:evidence that that rising mental health needs are particularly affecting girls;anecdotal evidence that boys find it more difficult to speak about emotional problems; data that boys are less likely to access services but are more at risk of suicide completion or involvement in offending

2.10 **Recommendation 10:** The Committee recommends that the Council and CCG support outreach work with communities to break down taboos (e.g. Black Majority Churches Project)

2.11 **Recommendation 11:** The Committee recommends that the Council and CCG should ensure that mental health services meet the cultural needs of diverse communities and take steps to tackle institutional discrimination, particularly those most at risk e.g. Girls from FGM practicing communities, black & Asian communities from psychosis & schizophrenia

2.12 **Recommendation 12:** The Committee recommends that the Council and the CCG involve service users from a wide ethnic demographic in developing the Transformation Plan and getting the user voice, bearing in mind that disadvantaged groups are generally more at risk of mental health problems

2.13 **Recommendation 13:** The Committee recommends that the council and its partners should make every effort to ensure that the education of vulnerable children or young people is not disrupted through housing placements.

2.14 **Recommendation 14:** The Committee recommends that there needs to be a much more integrated approach to working between all partners for children and young people with mental health issues including the housing department.

2.15 **Recommendation 15:** The Committee recommends that a Housing representative is included on the Health & Wellbeing Board.

2.16 **Recommendation 16:** The Committee recommends that SLaM , Kings & GSST work with mental health users to assess the adequacy of the Paediatric A & E and Place of Safety and report back in six months' time on both user experience and patient wait times for admission when in crisis.

2.17 **Recommendation 17:** The Committee recommends that health and social care service managers in children's and adults' services must work together in an integrated way to ensure a smooth and gradual transition for young people. Good practice should involve, for example, developing a joint mission statement or vision for transition, jointly agreed and shared transition protocols, information sharing protocols and approaches to practice.

2.18 **Recommendation 18:** The Committee also recommends that the Council and CCG provide an update on the practical steps that will be taken to address Transition

2.19 **Recommendation 19:** The Committee recommends that the Council and CCG develop a mental health service for young people that spans the ages of 12-25, during the years of highest mental health prevalence, so that young people do not have to Transition at 18, during the peak of symptoms.

2.20 **Recommendation 20:** The Committee recommends that the Council and CCG add Permanently Placed children, LGBT young people, and children and young people experiencing economic and social deprivation to the cohorts of 'at risk' young people.

2.21 **Recommendation 21:** The Committee recommends that Southwark's strategic partnership must ensure that responsive services are in place to provide therapeutic support from Child and Adolescent Mental Health Services (CAMHS) to young people who were at risk of, or who had suffered, child sexual exploitation

2.22 **Recommendation 22:** The Committee recommends that there are good communication, training and awareness sessions across all of the partnerships required to bring the mental health strategy to life.

2.23 **Recommendation 23:** The Committee recommends a multi-layered communication campaign that can raise awareness amongst the partners and signal a need for a significant culture change to transform mental health from a 'Cinderella service' to one that places service users at the centre of an integrated service designed to improve outcomes of its most vulnerable residents.

Healthy Communities Scrutiny Sub-Committee

2.24 **Recommendation 24:** The Committee recommends that the Council looks to form partnerships with Housing Associations and Credit Unions, amongst others to be identified, in order to better identify people who would benefit from support with their mental health and improve the holistic support those with mental health issues receive

2.25 **Recommendation 25:** The Committee further recommends that the work of programmes such as the faith communities' project continues to be funded to help combat stigma around mental health and their work to date is reflected in the Joint Mental Health Strategy. This should include rolling out similar programmes to other ethnical minority groups including Irish, Asian and Latin American communities.

2.26 **Recommendation 26:** This Committee believes that as part of the Joint Mental Health Strategy, the Housing teams, Reablement teams and Community Support teams should be trained to identify mental health issues to further help support those older members of our community with whom they regularly interact with.

2.27 **Recommendation 27:** Furthermore, the Committee notes that the voluntary sector is taking an innovative approach to supporting the older population who have mental health needs and would task the Council with considering similar approaches.

2.28 **Recommendation 28:** The Committee would recommend that the Council and the CCG seek to understand the links between mental health and dementia and establishes a programme for supporting older residents who present with symptoms of either condition to ensure a correct diagnosis.

2.29 **Recommendation 29:** The Committee recommends that the Council seek to ensure that the Joint Mental Health Strategy dovetails with other relevant strategies, to ensure that every approach is taken to identify and treat mental health at the earliest opportunity.

2.30 **Recommendation 30:** The Committee recommends that as part of the Joint Mental Health Strategy, there is a focus on encouraging GPs to consider mental health concerns as part of their diagnosis of seemingly unexplained symptoms, and continue to assess for it as part of the management of long-term conditions.

2.31 **Recommendation 31:** The Committee recommends that the CCG works with GP surgeries throughout Southwark to provide signposting to voluntary and charitable organisations who can

offer support to those with mental health concerns and would ask that this is built into the Joint Mental Health Strategy.

2.32 **Recommendation 32**: The Committee recommends that the Joint Mental Health Strategy take into account the findings of the Joint Health Scrutiny into SLaM Places of Safety and incorporate these into their strategy as appropriate.

2.33 **Recommendation 33**: The Committee commends the MindBody programme and the work it is doing to up-skill the workforce. We would recommend that the Joint Mental Health Strategy evaluates the MindBody programme and incorporates the relevant elements of the programme into the plans for training for our workforce in Southwark.

3. A best practice approach

3.1 The Centre for Mental Health has developed a model approach for creating a mental health strategy at local level, and this committee believes that the learnings from this work should be incorporated into any future strategy.

3.2 As Jan Hutchinson set out in her presentation to the Healthy Communities Committee, the focus of any mental health strategy needs to be broad, and cross-cutting, encompassing all age groups, informed by data and with room for flexibility in adapting the strategy as the surrounding environment changes.

3.3 Any mental health strategy should also follow a number of core principles, as set out below

- Focus on early intervention
- Living experience voices
- Support for carers
- Evidence-based treatments and support
- Joined up provision, including physical and mental health
- Actions to reduce stigma
- Actions to promote equality[1]

3.4 The Mental Health Taskforce has been established to take a UK approach to mental health. This is focused on high level objectives, with some core areas of activity. This includes improved crisis care, with the expansion of Crisis Resolution and Home Treatment Teams; improvements in physical health; an increase in mental health liaison services both in emergency departments and in older-age acute physical health services. The five year strategy also focuses on specific groups, including a focus on reducing suicides, increasing access to evidence-based psychological therapies, an increase in access to IPS employment support and a focus on perinatal mental health services.

3.5 The Centre for Mental Health has also set out a number of ways in which consultation should take place to achieve the best overall strategy. This should include a variety of consultation exercises, including:

- Roundtables and consultation events
- Digital collection of information through apps and surveys
- A collection of stories 'a day in the life' collected through www.dayinthelifemh.org.uk
- An exercise that asks 'what if we didn't…'
- Establishing links with the schools for better mental health and asking staff their thoughts
- Considering the complaints and issues most frequently heard by MPs, Councillors, GPs and local Healthwatch providers[2]

3.6 *Both the Children and Education Scrutiny Committee and the Healthy Communities Committee would recommend that the best practice guidance developed by the Centre for Mental Health forms the cornerstone for the approach taken to developing the Joint Mental Health Strategy for Southwark.*

[1] Centre for Mental Health, Jan Hutchinson, March 2016
[2] Centre for Mental Health, Jan Hutchinson, March 2016

4. Background to the Joint Mental Health Strategy Development

4.1 The Joint Mental Health Strategy has come about following a recommendation from the Review into Social Care Mental Health, the findings of which were discussed by the Council in December 2015. The Council and Southwark NHS CCG have set out a number of core priorities for developing a Joint Mental Health Strategy. These are as follows:

Protection, promotion and prevention

Delivering effective, evidence-based, targeted mental health promotion through Public Health programmes, including mental health and emotional wellbeing in schools and colleges, community-based resilience programmes and peer/self-management programmes to more vulnerable citizens in the general population.

Primary mental health care

The local development of mental health primary care integrated to social care, with secondary care so that step down and step up to secondary care mental health services is achieved. Mental health and social care service delivery through Local Care Networks will require stronger shared care arrangements with primary care. The focus here is community-based service delivered in local neighbourhoods with less reliance on acute hospital care.

Better delivery of care for long-term conditions

Delivering more effective community crisis resolution, home treatment and peer support so that those who experience longer term mental health conditions maintain their tenure in the community. The focus here is on increasing quality of life and reducing demand for hospital and intermediate care.

Further development of the Southwark Dementia Strategy

To continue to improve dementia care pathway for individuals and families in Southwark and drive forward work to make Southwark a Dementia Friendly Borough. The focus here is on increasing understanding of dementia and care at home.

Further develop a Children and Young People's Emotional Wellbeing Strategy

This will have a specific focus on key vulnerable groups of children and young people, including looked after children (children in care); children and young people with neurological conditions; and children and young people in contact with the criminal justice system. Schools to be at the centre of this development. Focus here on resilience and safety, including understanding and responding to self-harming behaviours.

Focus on better responses to complex needs

This should relate to presence of mental health needs and substance misuse.

4.2 In order to develop a comprehensive Joint Mental Health Strategy, the Council and Southwark NHS CCG have developed an invitation to tender to invite expressions of interest from suitably experienced and qualified provider organisations.

4.3 The Healthy Communities Committee has been following the development of a Joint Mental Health Strategy over a number of years, having previously seen drafts, although this has never led to a full and final strategy. As Dick Frak told the Committee, during the course of the review into social care mental health, he discovered four mental health strategies in different stages in development. As he noted, there were good elements in each of these attempts but an issue as to

whether they were balanced between health and social care and different emphases in each version of the reports based on when they had been written.[3] It is hoped that this strategy will reach fruition through working with a partner organisation who can help to deliver an expert approach.

4.4 Both the Children and Education Scrutiny Committee and the Healthy Communities Committee are pleased to see that since the consideration of Southwark's Mental Health Social Care Review in December 2015 that the Council has taken forward the recommendation to bring into place with NHS Southwark Clinical Commissioning Group (CCG) a Joint Mental Health Strategy.

4.5 The Council and CCG have planned to put out their Invitation to Tender in the coming weeks, with the hope of finding an expert partner in mental health. This will be followed with a consultation exercise that will take the next 6 months, with a final strategy to be delivered at the earliest of October or November 2016.

4.6 *Both the Children and Education Scrutiny and the Healthy Communities Scrutiny Committees would request that the final report is presented to scrutiny when finalised.*

4.7 Alongside the development of a Joint Mental Health Strategy for Southwark, NHS England required CCGs to submit a transformation plan for 2015-2020 in relation to local children and young people mental health services. Southwark NHS CCG worked in partnership with Southwark Council to prepare this local Transformation Plan, with input from South London & Maudsley NHS Mental Health Foundation Trust and other key stakeholders, including education, youth offending and children's social care. It also took into account the key messages from consultation with young people on mental health and wellbeing. This Plan was approved by NHS England in December 2015. It will be used to feed into the overall Joint Strategy for Mental Health.

4.8 This plan was considered separately at the Education and Children's Services Scrutiny and section 5 and appendix 1 of this report focus specifically on this.

4.9 The Healthy Communities Committee has focused on the overall Joint Mental Health Strategy and this is covered in section 6 and appendix 2 of this report.

[3] Dick Frak, Healthy Communities Scrutiny Committee, March 2016

5. The Joint Mental Health Strategy for Southwark – Recommendations from the Education and Children's Committee

5.1 The Education and Children's Service Committee agreed to a joint scrutiny with the Healthy Communities Scrutiny, which would allow for a holistic look at mental health in Southwark.

5.2 The review from the perspective of the Education and Children's Committee set out with these objectives:

I. Influence the developing Joint Mental Health strategy and encourage it to complete its work in a timely manner
II. Enable the wider community, particularly the voluntary sector and services user forums, to input into the developing strategy
III. Track the recommendations of the Narrowing the Achievement Gap scrutiny report 2014/15 pertinent to mental health:
    - Improve communication and the links between schools and CAMHS, social care, housing, police and other services in order to better support children and families experiencing mental health problems and multiple deprivation
    - Increase funding to CAMHS
    - Promote the adoption of a 'whole school approach' to mental health and emotional well-being in schools
- Address the mental health needs of Permanently Placed children

5.3 In 2015/16 the Education & Children's Committee identified addressing the mental health and emotional wellbeing of pupils as a priority in improving educational progress during its review into Narrowing the Achievement Gap for pupils from disadvantaged backgrounds in Southwark. A whole school approach to mental health was one of the key recommendations of this report. In the same year, the committee reviewed the Council's Adoption service. A key recommendation of this review identified that there is a much-needed focus on promoting the good mental health of Permanently Placed children. This was perceived as being crucial in the promotion of good educational outcomes, given the early life experience of children and greater risks incurred.

5.4 A report in 2013 by the Education and Scrutiny committee on bullying had identified this as a key risk to good mental health, and made recommendations to promote resilience, protect children from cyber bullying and tackle gang related bullying and targeting, and do more to assist LGBT young people.

5.5 A summary of the relevant recommendations of all these reports is provided in Appendix 3

5.6 Mental Health is a priority issue for a number of scrutiny stakeholders. Southwark's Healthwatch is focusing on Mental Health as a priority area.

5.7 During the research with local schools for the Narrowing the Achievement Gap review, the mental health of children was identified as a key concern for schools; many are highly invested in improving the mental health and emotional well-being of children to improve educational outcomes. The Headteachers Executive identified better partnership as being important in improving the mental health of their pupils, and partnership was identified as an area that scrutiny is well placed to influence.

5.8 The Committee reviewed related plans and enabled the wider community to comment on these and identify priorities. Scrutiny engaged service user forums, the voluntary sector, Mental Health providers and mental health research organisations. It sought to promote dialogue between these stakeholders, elected members and lead officers, in order to influence the emerging Joint Mental Health Strategy in particular.

5.9 Several significant documents were considered during the course of the review, the most important of which was the Southwark Children and Young People's Mental Health Strategy and

Wellbeing Transformation Plan (frequently referred to in this report as 'Transformation Plan'). This was produced as a government requirement to enable further resources to be drawn down.

5.10 The requirement for councils and local CCGs to produce a local Children and Young People's Mental Health Strategy and Wellbeing Transformation Plan followed the government report published the previous year: 'Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing' which concluded that that there is emerging evidence of rising metal health need in key groups The report's data and audits reveal increases in referrals and waiting times, and this was particularly true for vulnerable children and families. The report said that providers are reporting increased complexity and severity of presenting problems. Changes to commissioning and the lack of clarity and accountability for child mental health service were identified as key problems. Following the report's publication the 2015 government budget allocated £1.25bn to mental health to improve provision for young people.

5.11 On 3 August 2015, NHS England published Guidance to support the development of Local Transformation plans for Children & Young People's Mental Health and Wellbeing, with an action for local NHS Clinical Commissioning Groups (CCG) to submit Transformation Plans and associated information for assurance. Southwark NHS CCG worked in partnership with Southwark Council in preparing the local Transformation Plan with input from South London & Maudsley NHS Mental Health Foundation Trust and other key stakeholders. It took into account the key messages from consultation with young people on mental health and wellbeing carried out in cooperation with Community Action Southwark in September 2014. The final version of the Southwark Transformation Plan was approved by NHS England on 18th December 2015.

5.12 **A Whole School approach to Mental Health & Emotional Wellbeing and CAMHS**

5.13 The Narrowing the Achievement Gap review 2014/15 found that the mental health needs of children in school was a consistent theme. A significant amount of Pupil Premium money was being spent on mental health with teachers reporting sharp increases in need. This finding was repeated in the Southwark Children and Young People's Mental Health Strategy and Wellbeing Transformation Plan consultation, where Southwark Headteachers Executive reported that their "overwhelming view is that we are massively neglecting the mental health and wellbeing needs of our children, and importantly their parents". They referred to an 'explosion' in the number of children suffering Mental Health problems.

5.14 The Narrowing the Achievement Gap report recommended promoting Bacon's College good practice in providing a whole school approach to wellbeing and in particular the use of therapeutic and targeted interventions to address the social, emotional and mental health needs of the most disadvantaged students, with a focus on ensuring the bottom 20% make good progress.

5.15 In its evidence to the Healthy Communities committee, The Centre for Mental Health gave as its top recommendation 'more integration and investment in the mental health of children in schools' .This is because schools are well placed to spot children in difficulty and formulate a response.

5.16 Scrutiny therefore particularly welcomes investment in Early Help and the Transformation Plan's objective of bringing 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. The Transformation Plan links this to work with 32 Southwark schools.

5.17 The briefing on the developing Joint Mental Health Strategy said there was an additional commitment to further develop a Children and Young People's Emotional Wellbeing Strategy, with a specific focus on key vulnerable groups of children and young people, including looked after children (children in care); children and young people with neurological conditions; and children and young people in contact with the criminal justice system. Schools will be at the centre of this development. The focus will be here on resilience and safety, including understanding and responding to self-harming behaviours.

5.18 These initiatives are very much welcomed and it is hoped that the planned Children and Young People's Emotional Wellbeing Strategy will also integrate with children and families social care needs, as during current and previous scrutiny review teachers and other respondents consistently reported that mental health needs intersected frequently with poverty, disadvantage and social needs, including housing. A number of schools had invested in professional expertise to meet the both mental health and social needs of young people in school, for example Bacons College employs a qualified in-house social worker. Schools wanted better integration with both mental health services and social care. The Transformation Plan's own consultation affirms this as the Headteachers Executive identified that schools are having to increasingly provide a range of support to meet the needs of children: physical, social and emotional, and they need support to do this.

5.19 The Transformation Plan details the 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 for Children in Care SEND and other vulnerable groups. The Transformation Plan says it is drawing down the additional funds to sustain the Early Help offer; it is unclear whether this refers to additional funds for Early Help & CAMHS or maintaining current funds for the present service.

5.20 A key recommendation in the Narrowing the Achievement Report is to increase investment in CAMHS. This was made as a result of evidence from teachers and that pupils were having to reach a higher and higher threshold to get access to CSMHS and the service had been decimated by recent cuts. The recommendation was also partly made in anticipation of recently announced increased government funding which was due for children's mental health services and the anticipated local Transformation Plans.

5.21 Schools also requested better communication with CAMHS to enable good quality discussions on referrals. During the committee session in February officers were asked if schools will have a link person in CAMHS, as requested. Officers responded that schools will link with the Early Help. Assurances are sought that this will meet the needs of the schools.

5.22 The committee noted with concern that Headteachers Executive do not consider that the Council and Health Service adequately include schools in the development of strategic plans for service development for children, young people and their families and noted that they have no representation on the Health & Wellbeing Board

5.23 *The Committee recommends that the Council and CCG detail the global CAMHS spend now and once the Transformation Plan is implemented and funds drawn down, year by year, with a budget for each service.*

5.24 *The Committee recommends that the Council and CCG provide more detail on Early Help investment, now and in the future*

5.25 *The Committee recommends that the Council and the CCG consult with the Headteachers Executive on the link arrangements with CAMHS and the Early Help provision, the Pilot project, and ensures the proposed Children and Young People's Emotional Wellbeing Strategy will meet the needs for better communication and integration with schools with mental health practitioners and social care, including housing.*

5.26 *The Committee recommends that the adoption of a Whole School approach to mental health and emotional wellbeing in the Children and Young People's Emotional Wellbeing Strategy is well promoted and a plan is developed for its implementation in partnership with the Headteachers Executive and local schools. Case studies from Bacons College and schools with positive practice in this area should be promoted around Southwark schools.*

5.27 *The Committee recommends that a schools representative on the Health & Wellbeing Board is appointed. This could be done through the Southwark Headteachers Executive.*

5.28 **Bullying**

5.29 Bullying can have a significant adverse impact on young people's mental health. Committee discussions and a previous scrutiny report (in 2013) identified two major risks: social media and gangs. Young people are at risk of becoming both perpetrators and targets, and on occasions some young people can be both.

5.30 Experience shows that social media is a double-edged sword. The evidence that the education committee heard in 2013 identified social media bullying is an area of growing concern. Although young people may also derive peer support from healthy forms of social media interaction, Southwark Youth Council in the Transformation Plan evidence identified bullying from other students, particularly emotional bullying, as a cause for concern and said that there is a need to identify the channels now used by students to bully others, remarking that 'social media is used a lot'.

5.31 Peer support work to tackle bullying was identified as effective in the presentation by officers on the Transformation Plan. This this was affirmed in the Narrowing the Achievement Gap report, and in particular the good work of Bacon's College in their use of peer support. Southwark Youth Council has also identified a need to develop better support in schools to tackle bullying and recommended peer support.

5.32 LGBT young people are particularly at risk of poor mental health and being bullied. The Transformation Plan identifies LGBT young people as a risk group and the previous scrutiny report provided a series of recommendation to strengthen the social support of LGBT young people and tackle institutional discrimination.

5.33 *The Committee recommends that the Council and the CCG set out more clearly how the Transformation Plan will tackle*

- *Cyber bullying*
- *Gangs and working with schools*
- *How to promote effective anti-bullying work in schools, particularly peer support*
- *Raising recognition that LGBT students are at particular risk of being bullied and need particular support e.g. anti-discrimination work and LGBT peer support*

5.34 **Gender Differentiation**

5.35 The Education & Children's Services committee noted that the Transformation Plan has little gender differentiation, although many of the mental health disorders it is particularly targeting (e.g. self-harm and eating disorders) are experienced more by girls more than boys. The Transformation Plan, in passing, also notes that boys are less likely to use services but more likely to complete suicide.

5.36 The government report: 'Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing', concluded that services are seeing increasing rates of young women with emotional problems and young people presenting with self-harm. In Southwark the Transformation Plan reached agreement to improve access to trauma focused work, including where there are presentations of Post-Traumatic Stress Disorder (PTSD) and self-harm. The Transformation Plan will also provide for additional investment in the Eating Disorder Services for Children

5.37 The Transformation Plan stated that 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% v. 26%). Young men are more likely to commit suicide than young women. The Transformation Plan states that 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. The current rate for suicide completion for Southwark young people is not given, nor is gender data supplied.

Suicide is also one of the leading causes of death among this age group: nationally after accidents it comes second.

5.38 The Transformation Plan has not identified work to increase access to services for boys to prevent suicide. The committee discussions with SGTO identified that boys and men are frequently not so good at expressing emotions, and noted that this could be a factor in violence that affects wives and children. Boys are over represented in Youth Justice.

5.39 *The Committee recommends that the Council and the CCG differentiate more clearly gender specific data and services that address specific risks – e.g. evidence that that rising mental health needs are particularly affecting girls; anecdotal evidence that boys find it more difficult to speak about emotional problems; data that boys are less likely to access services but are more at risk of suicide completion or involvement in offending.*

5.40 **BME and immigrant communities**

5.41 The SGTO youth forum brought up many issues around the relatively more economically precarious state of newly immigrant communities , their relative exclusion from democratic forums, and the particular challenges young people face negotiating dual heritages and cultures where mental health problems are more taboo and services less fit for purpose.

5.42 SGTO reported that migrant communities are more at risk of economic and policy shifts and less able to influence democratic debates. One Southwark example was given of the move to limit fast food takeaways. Whilst it was remarked this was a sensible policy, this unfortunately had impact more on immigrant communities who often service these industries. More work needs to be done to involve new communities in democracy and to mitigate the consequences policy shifts have on people existing more on the economic margins, and the consequent increase in stress that families are experiencing.

5.43 Young people negotiating different cultures are often receiving conflicting information on social norms, particularly around female gender role, and this can place young people under stress. FGM is an example of conflicting social norms and a particular risk to girls' mental and physical health, and isidentified in the Transformation Plan as an emerging issue.

5.44 There was a discussion on accessing counselling and therapeutic services and if some communities were more likely to try and solve problems within the community, and if mental health was more of a taboo in some cultures than others, or if some BME communities were excluded because services did not meet their needs. The Healthwatch report contained service user's views that some services were not culturally fit for purpose, and tht language is also a significant barrier. Representatives from the Black Majority Churches Project did think that mental health is more of a taboo in some communities and engagement and training is important to overcome this.

5.45 The scrutiny report on BME Mental Health identified that Southwark has relatively high rates of psychosis and schizophrenia which were set to rise. Psychosis is related to economic deprivation, disadvantage, racism, early experience of abuse and crime, and cannabis use. Diagnoses of schizophrenia among persons admitted to psychiatric hospitals are three to six times higher among African-Caribbean groups than among the white population. Asian males are three times more at risk. Black people are more likely to access services via A&E/ Place of Safety or the court than via GPs, and this often coercive experience of entering mental health service can have a negative impact.

5.46 *The Committee recommends that support outreach work with communities to break down taboos (e.g. Black Majority Churches Project)*

5.47 *The Committee recommends that the Council and CCG should ensure that mental health services meet the cultural needs of diverse communities and taks steps to tackle institutional discrimination, particularly those most at risk e.g. Girls from FGM practicing communities, black & Asian communities from psychosis and schizophrenia.*

5.48 *The Committee recommends that the Council and the CCG involve service users from a wide ethnic demographic in developing the Transformation Plan and getting the user voice, bearing in mind that disadvantaged groups are generally more at risk of mental health problems*

5.49 **Housing, homelessness and poor mental health**

5.50 The paper and presentation by SGTO youth forum explored the links between homelessness and mental health. They referred to a report by York University and the University of New South Wales, and their long term research on homelessness in the UK: Homelessness Monitor 2015. This found that almost three quarters of the increase in homelessness acceptances over the past four years was attributable to the sharply rising numbers made homeless from the private rented sector. In London this pattern was even more manifest, with the annual number of London acceptances resulting from private tenancy terminations rising from 925 to 5,960 in the four years to 2013/14.

5.51 SGTO pointed out that Welfare Reforms by the government will see under 25s removed from accessing housing benefit, making them additionally vulnerable. Without private sector or social housing young people turn frequently to the voluntary sector such as hostels and temporary shelters, but demand consistently outstrips supply. A report by the Mental Health Foundation found that 30%-50% of single people experiencing homelessness had mental health problems compared with between 10%-25% of the general public.

5.52 SGTO said that there is an increased proportion of young people who report being homeless and an ongoing rise in the incidence of mental health problems among the young and made connections between the two trends. Southwark Schools, as referenced above, also made links with poor mental health, social problems and housing, and the need for more integration here.

5.53 The evidence suggested that difficulties with housing are adding to the stress young people, families and children are experiencing, and research suggests that families who experience economic deprivation and poor mental health find it more difficult to access adequate housing. Parents experiencing poor mental health are also more likely to have children with poor mental health

5.54 SGTO recommended representation for Housing on the Health & Wellbeing Board to better address the correlations between inadequate housing and poorer mental health.

5.55 *The Committee recommends that the council and its partners should make every effort to ensure that the education of vulnerable children or young people is not disrupted through housing placements.*

5.56 *The Committee recommends that there needs to be a much more integrated approach to working between all partners for children and young people with mental health including the housing department.*

5.57 *The Committee recommends that a Housing representative is included on the Health & Wellbeing Board.*

5.58 **Crisis Care**

5.59 Last year the sub-committee heard in a presentation on Child Health Services that there is a concern about the top tier of Child & Adolescent Mental Health Services (CAMHS) nationally and

that there was a big demand locally for paediatric acute mental health crisis beds, with children having to access beds outside of London on occasions.

5.60 Additional funding from the Transformation Plan will go to establishing a Home Treatment service for children and young people as part of improving Crisis care, which is welcomed.

5.61 Healthwatch reported that crisis care was much discussed in their focus groups with service users. The clinical care provided by the psychiatric liaison team at King's A&E was described as very good and helpful by four people who had presented there. However, significant unhappiness was raised around the use of A&E for mental health crisis, with long waits and inappropriate waiting areas. These comments may have been directed more at adult services, however a father disliked the use of police vans to escort his daughter to A&E, and the waits there: 'I was in tears the other day, watching her being escorted out of her house into the cage of a police van - the ambulance service being too busy… I didn't realize she would still be sitting in A&E 10 hours later, still waiting for a bed."

5.62 Heathwatch suggestions for improving the experience of going to A&E for mental health problems included:

- Written information to be provided after A&E presentations outlining patient details, the process and next steps. Patients may not remember the detail of what happened.
- Light refreshments of food/water as people will arrive at A&E having not taken care of themselves [and this will only increase their unwellness]
- A separate space away from other patients [for Mental Health service users]
- Option of a volunteer or professional advocate to sit with or talk to patients.

5.63 The provision of adequate emergency facilities for people in mental health crisis is an on-going concern of scrutiny, and this started with the closure of the Maudsley emergency in 2006. At that time the emergency clinic was closed in the face of significant local opposition from local health users. Following a scrutiny referral to the Secretary of State additional money was made available to provide dedicated faculties at local A & E departments

5.64 The Healthy Communities scrutiny review of 2014 found them still inadequate. The sub-committee noted with concern the current facilities for patients presenting with mental health conditions at A&E wards. The committee's review report recommended that Kings College Hospital and Guy's and St Thomas' place the provision of safe, secure spaces for the treatment of patients presenting with mental health conditions as a key priority in their work plans for 2014.

5.65 The Transformation Plan on Crisis Care reported that there was a comprehensive well-utilised Paediatric Liaison service and as such presentations at the emergency department (ED) are responded to appropriately. The Transformation Plan went on to say that 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 hours services.

5.66 The evidence is therefore contradictory on crisis care. A recent tweet by the Police indicated problems with a young girl being held as there was no available Place of Safety, SLaM is currently changing its arrangements for provision of a Place of Safety as the current arrangements are not considered fit for purpose. It proposes to provide an expanded centralised Place of Safety in Southwark.

5.67 Currently Places of Safety are provided by South London and Maudsley NHS Foundation Trust (SLaM) locally for a number of people who are brought to hospital under Section 136 of the Mental Health Act (MHA). This is a power that police officers can use if someone is in a public place and the police have concerns about them. Across the SLaM there are currently four Place of Safety, or 136 Suites, where people can be brought, assessed and cared for. The four suites are located at each of SLaM's four hospital sites. There will shortly be a Joint Health Overview and Scrutiny committee formed that will scrutinise the proposal to change the current service

model of Place of Safety provision within SLaM from four separate Places of Safety, for the boroughs of Southwark, Lambeth, Lewisham and Croydon, to one centralised Place of Safety, provided in Southwark .

5.68 It is unclear whether service user experience of crisis care is problematic only for the Place of Safety or for Accident and Emergency, and whether this is true for both adults and children, and at all sites: both Kings Hospital at Demark Hill and St Thomas' Hospital, provided by Guys & St Thomas Foundation Trust (GSST). Paediatric waits for beds certainly seem to be a concern for both Place of Safety and accessing beds from A & E.

5.69 *The Committee recommends that SLaM , Kings and GSST work with mental health users to assess the adequacy of the Paediatric A & E and Place of Safety and report back in 6 months' time on both user experience and patient wait times for admission when in crisis.*

5.70 **Transition**

5.71 The Transformation Plan finds that Young People aged 12-25 years have the highest incidence and prevalence of mental illness. 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.

5.72 Transition is therefore a huge issue that is rightly flagged up, however there is still work to be done on this area. The Transformation Plan says that further scoping will be undertaken on how to implement the recommendations in the 14-25 mental health and wellbeing report and CAMHS needs assessment. There is recognition locally of the need for specific services supporting the transition from Children Services to Adult services

5.73 *The Committee recommends that health and social care service managers in children's and adults' services must work together in an integrated way to ensure a smooth and gradual transition for young people. Good practice should involve, for example, developing: a joint mission statement or vision for transition jointly agreed and shared transition protocols, information sharing protocols and approaches to practice.*

5.74 *The Committee also recommends that the Council and CCG provide an update on the practical steps that will be taken to address Transition*

5.75 *The Committee recommends that the Council and CCG develop a mental health service for young people that spans the ages of 12-25, during the years of highest mental health prevalence, so that young people do not have to Transition at 18, during the peak of symptoms.*

5.76 **Children at particular risk: Permanently Placed children & children who are economically & socially deprived and LGBT**

5.77 The Transformation Plan rightly identifies many at risk groups:

- 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

5.78 However it does not identify either Permanently Placed children, or young people experiencing economic and social disadvantage (e.g. poor housing or parents in precarious occupations), or LGBT as at particular risk, when there is strong evidence to support their

inclusion. The committee evidence strongly supported identifying at these as 'at risk' cohorts of young people.

5.79 The previous scrutiny review into Adoption and Narrowing the Achievement Gap identified children who are Permanently Placed as being at greater risk of mental health problems. Permanently Placed children include children who are adopted, have Special Guardianships, Residence Orders, are Fostered, Looked After or otherwise permanently placed.

5.80 The Adoption report detailed that DfE data released in 2014 showed that at key stage 2, educational outcomes for Permanently Placed children are more similar to Looked after Children than the general population. This is likely to be because of the attachment issues caused by grief, loss and the often traumatic experiences the permanently placed children have experienced in their early lives; 70% of those adopted in 2009-10 entered care due to abuse or neglect. According to PAC-UK, even children placed at a very young age can experience significant difficulties at school, perhaps due in part to their adverse in-utero experiences.

5.81 The evidence the committee received from Schools, and the Transformation Plan and research, all point to the links between social and economic deprivation and poor mental health. SGTO brought to scrutiny's attention longitudinal research from Mental Health Foundation, which found there is a negative correlation between childhood mental health problems and earnings, qualifications, employment, relationships and family formation, general health and disability in later life.

5.82 The Transformation Plan and the scrutiny review on Bullying all point to LGBT young people being at particular risk of poor mental health, with higher rates of bullying, self-harm and suicide.

5.83 *The Committee recommends that the Council and CCG add Permanently Placed children, LGBT young people, and children and young people experiencing economic and social deprivation to the cohorts of 'at risk' young people.*

5.84 **Child Sexual Exploitation**

5.85 Since 2014 there has been a renewed emphasis on protecting children from sexual exploitation. All local authorities and their partners must ensure that they have a comprehensive multi-agency strategy and action plan in place to tackle it. There is a growing number of reports which demonstrate the recently, and rapidly, escalating interest in securing a more effective response to Child Sexual Exploitation (CSE) ; two Parliamentary Select Committees have held inquiries on the subject, Home Affairs, and Communities and Local Government, and CSN will very shortly publish a briefing on their reports

5.86 Therapeutic support is key for children or young people who have been victims of CSE. The strategy should consider referral pathways for young people who are at risk of or who have suffered CSE to access therapeutic support.

5.87 *The Committee recommends that Southwark's strategic partnership must ensure that responsive services are in place to provide therapeutic support from Child and Adolescent Mental Health Services (CAMHS) to young people who were at risk of, or who had suffered, child sexual exploitation*

5.88 **Culture Change**

5.89 Problems with Children and Adolescent Mental Health Services have been long documented. Poor mental health services for children and families, children in care and young people were condemned in a 2008 report, 'Children and young people in mind', the final report of the National

CAMHS Review. The report detailed numerous areas where the service had been found to be conspicuously lacking in its provision of therapeutic care for looked-after children.

5.90 In this context the task of the mental health strategy is to enable all services across the Council, the CCG and the voluntary sector to work together in an integrated manner to improve services and outcomes for children, young people and their families with poor mental health.

5.91 The discussions in both the education and the children's scrutiny and heathy communities scrutiny sessions appeared to recognise the importance of integrated working between services. Comparisons were made between the new mental health strategy and the task of the Change for Children Programme which put the child or young person at the centre of its services.

5.92 In order for the mental health strategy to deliver improved mental health services for Southwark residents a new way of working will be necessary. Many of the partners emphasise breaking down 'silos'. Much more emphasis needed to be placed on the language of integration. This will help services understand that there is a gear change in language and culture when it comes to mental health.

5.93 Some of the partners represented at the scrutiny sessions welcomed the role of scrutiny in the development of the mental health strategy and hoped that its involvement would make sure the strategy was implemented in a timely manner.

5.94 *The Committee recommends that there are good communication, training and awareness sessions across all of the partnerships required to bring the mental health strategy to life.*

5.95 *The Committee recommends a multi-layered communication campaign that can raise awareness amongst the partners and signal a need for a significant culture change to transform mental health from a 'Cinderella service' to one that places service users at the centre of an integrated service designed to improve outcomes for its most vulnerable residents.*

6. The Joint Mental Health Strategy for Southwark – Recommendations from the Healthy Communities Scrutiny Committee

6.1 The Healthy Communities Committee undertook a roundtable with contributions from the Hospital Trusts, SLaM, charities and voluntary organisations, the Cabinet Member for Adult Social Care and officers, the CCG and local campaigners on mental health.

6.2 The following form the recommendations from the Healthy Communities Committee in respect of the formation of the Joint Mental Health Strategy. (NB. Please see appendix for full list of contributors)

6.3 **Identifying priority groups**

6.4 The Committee welcomes the broad focus of the Joint Mental Health Strategy but is concerned that identification of individuals with mental health needs is as focused as possible on hard-to-reach groups. We believe that, in contrast to many Council policies which can effectively support those most at need as they interact with council services regularly, that there will be a cohort of individuals who are slipping through the Council and CCG's net. All the approaches for identification that are currently discussed are institutional – whether that be through e.g. interaction with our local schools, or our housing department.

6.5 We welcome the work that has been done with some key groups, such as the BME church community, and welcome the support from the Council following recommendations from this Committee in 2013/14 in regards to funding Community Church projects.

Faith & Mental Health Training Project

SLaM has continued to run its Faith & Mental Health training project with a number of BME churches in Southwark.

The project has made links with both local and faith communities and increased mental health literacy as well as improved communication and understanding between mental health services and BME communities.

The project has concretely demonstrated the impact of taking a dual approach (spirituality and medicinal practice) to addressing mental illness within the BME community.

Pastors have spoken eloquently about how they have "seen the light" following the mental health awareness training. Armed with a better understanding of the causes and cures of mental illness, they have been able to provide a far better and pragmatic pastoral care for those in their congregation. The biggest change that these trained Pastors have initiated is that they no longer take the approach to mental illness as a form of demonic possession, but that members of the congregation must see a health professional, take their medication and that the church will also continue to support them spiritually. Some of the participants of the pilot said previously:

"I no longer see mental illness as incurable"

"I feel better to be around people who may have mental health issues"

"My response to suffering has changed. Prayer does not always make a difference"

"I will now not treat every individual regarded to have mental health issues with suspicion"

6.6 However, the council is concerned that there is a cohort of individuals who do not regularly interact with council services or interact with their local communities, and more should be done to identify those individuals. Stigma remains an issue with mental health, and this Committee believes that there are potentially individuals who feel that they should be coping on their own, and are not discussing their mental health needs.

6.7 *The Committee recommends that the Council looks to form partnerships with Housing Associations and Credit Unions, amongst others to be identified, in order to better identify people who would benefit from support with their mental health and improve the holistic support those with mental health issues receive'*

6.8 *The Committee further recommends that the work of programmes such as the faith communities' project continues to be funded to help combat stigma around mental health and their work to date is reflected in the Joint Mental Health Strategy. This should include rolling out similar programmes to other ethnical minority groups including Irish, Asian and Latin American communities.*

6.9 The Committee is also concerned about the support received by our older population. This Council is committed to being an Age Friendly Borough, and we therefore believe that more needs to be done to ensure that they are supported by the mental health services provided in Southwark.

6.10 There have been cases recently where older members of the community have been found deceased in their homes after a considerable period of time has passed. We believe that this is unacceptable, but note that this is symptomatic of an ageing population who frequently live alone and are increasingly isolated.

6.11 Whilst these people are more likely to interact in some way with council services, we believe that needs to be more done to help support their mental health needs and achieve an early diagnosis. The Committee notes the role that the voluntary sector plays in this regard, and wants to commend the work that they do. However, we believe that the burden should not rest with them, and the Council should be doing more to help support these individuals.

6.12 *This Committee believes that as part of the Joint Mental Health Strategy, the Housing teams, Reablement teams and Community Support teams should be trained to identify mental health issues to further help support those older members of our community with whom they regularly interact with.*

6.13 *Furthermore, the Committee notes that the voluntary sector is taking an innovative approach to supporting the older population who have mental health needs and would task the Council with considering similar approaches.*

6.14 **Timeliness of identification**

6.15 We note that many older people in our Borough are diagnosed with dementia as they advance in years. Whilst we note that there need to be provisions for these individuals, we also note that there are likely links between dementia and mental health conditions.

6.16 *The Committee would recommend that the Council and the CCG seeks to understand the links between mental health and dementia and establishes a programme for supporting older residents who present with symptoms of either condition to ensure a correct diagnosis.*

6.17 This identification of mental health issues is closely linked to issues raised by Healthwatch, who have found that access to services in a timely manner is a key concern.

6.18 Early intervention is key to being able to effectively manage mental health conditions. The Committee notes that there are a number of other strategies being developed by the Council and the CCG, most importantly in adult social care.

6.19 *The Committee recommends that the Council seek to ensure that the Joint Mental Health Strategy dovetails with other relevant strategies, to ensure that every approach is taken to identify and treat mental health at the earliest opportunity.*

6.20 Furthermore, the Committee heard that many people present at GP surgeries with medically unexplained symptoms. There is some evidence to suggest that there is interplay between mental and physical health, and we would question whether enough is being done to consider mental health as a cause for unexplained symptoms. This is also closely linked to the effect of long-term conditions on mental health.

6.21 *The Committee recommends that as part of the Joint Mental Health Strategy, there is a focus on encouraging GPs to consider mental health concerns as part of their diagnosis of seemingly unexplained symptoms, and continue to assess for it as part of the management of long-term conditions.*

6.22 **Voluntary sector support**

6.23 The Committee heard from voluntary sector providers, who have a key role to play in preventing the development of mental health conditions, and enabling those with a diagnosis to self-manage and keep well.

6.24 We believe that the voluntary sector has a critical role in providing a complementary service to clinical support and this would be recognised within the Joint Mental Health Strategy. A key role for the voluntary sector is in providing additional support which can reduce the burden on GPs.

6.25 As recommended previously by the Healthy Communities Committee, there is an ongoing pilot to provide financial advice in select GP surgeries in Southwark. Our previous work identified that many of those presenting at GP surgeries with mental health difficulties had financial difficulties, and vice-versa.

6.26 Signposting to voluntary services by GPs is a simple and cost-effective way of providing further support for those with a mental health diagnosis.

6.27 *The Committee recommends that the CCG works with GP surgeries throughout Southwark to provide signposting to voluntary and charitable organisations who can offer support to those with mental health concerns and would ask that this is built into the Joint Mental Health Strategy.*

6.28 **Presenting in crisis at A&E**

6.29 The Committee is aware that 70% of those who present at Accident & Emergency in a mental health crisis are already known to mental health services.

6.30 Mental Health services are under considerable amounts of strain, with long delays, and many 12 hour breaches taking place. There is also a concern about the increasing use of police vehicles for transporting individuals to A&E when they are picked up in a mental health crisis, due to having imbibed alcohol.

6.31 The Committee notes the excellent work that is done by those who treat patients presenting in crisis and commends them on their work. We note that there are increasing pressures on A&Es and would like to see Southwark hospitals taking a leadership approach to tackling this problem. We note that SLaM has recently announced proposed changes to its Places of Safety in Southwark, and the Healthy Communities Committee will be scrutinising this in more detail at a Joint Health Scrutiny with other affected Boroughs in April 2016.

6.32 *The Committee recommends that the Joint Mental Health Strategy take into account the findings of the Joint Health Scrutiny into SLaM Places of Safety and incorporate these into their strategy as appropriate.*

6.33 **Education & Training**

6.34 Dr Sean Cross spoke to the Committee about the MindBody programme which is being run by Kings College Hospital. The project aims to improve the interprofessional management of interacting physical and mental health needs in both mental health and acute trust settings.

6.35 One of the key aims of the programme is around bridging the gap experienced between different clinicians and equipping them with the skills needed to support those presenting with mental health symptoms.

6.36 *The Committee commends the MindBody programme and the work it is doing to up-skill the workforce. We would recommend that the Joint Mental Health Strategy evaluates the MindBody programme and incorporates the relevant elements of the programme into the plans for training for our workforce in Southwark.*

6.37 The workforce should be widely defined within the strategy and Southwark should be encouraged to up-skill as many relevant departments who interact with those who are likely to experience mental health conditions as possible.

7. Conclusion

7.1 It is widely recognised that mental health has been the Cinderella service for far too long. There is a public policy drive to improve mental health outcomes: establishing this across the board by 2020 is a national priority. On a national level mental health problems are widespread:one in four adults experience at least one diagnosable problem in any year.

7.2 Children and young people, nearly half of mental health conditions start before the age of 14, and 75 per cent by age 24. One in ten children between the ages of five and 16 have a diagnosable mental health problem with children from low income families three times more likely to be affected than those on a high income. However most get no support, the wait for psychological therapy was 32 weeks in 2015/16 and the small number of people needing inpatient care can be sent anywhere in the country.

7.3 Older people – one in five older people in the community, and 40 per cent of those in care homes, are affected by depression, but often do not receive appropriate support. There is a wealth of legislation and guidance to support a step change in mental health. Regulation and data collection will improve the information on this area.

7.4 In Southwark the Council and CCG are working together at a leadership level to establish a new strategy and local transformation plans to deliver improved mental health services.

7.5 Scrutiny has looked at the strategy and engaged with a number of stakeholders and users to help adults, children, young people and their families move forward in their lives, towards better mental health.

7.6 Scrutiny has acknowledged the need for a new approach based on solid partnerships across the services with new ways of working to better support adults, children, young people and their families

7.7 Underpinning this review and its subsequent recommendations is an acknowledgment of the need for a joined-up approach, which is understood as being integral to how we operate. Our metal health service must be structured to realise the benefits of multi-agency working.

7.8 Achieving real joint working means challenging culture and pushing boundaries, so we can provide the best services possible to patients and the wider community.

7.9 Staff must be given every opportunity to understand the national policy changes in mental health, the need to look at mental health services differently, and to work together to offer tailored services spanning everything from attention deficit hyperactivity disorder (ADHD), self-harm, to autistic spectrum conditions (ASC) and mood disorders. The involvement of adults, children, young people and their families is also encouraged - their ideas and opinions can improve the development of pathways, services and recruitment processes.

7.10 The scrutiny observations and recommendations are attached. We believe that they can add value and help to improve mental health in Southwark by enabling children, young people, their families and adults to access a quality mental health service whenever they need it.

8. Appendix 1: Activities and list of contributors to the Education and Children's Committee

8.1 The December 2015 Education & Children's Services review received a paper from Southwark social care reviewing its mental health services. This document was a council prelude to the Joint Mental Health strategy.

8.2 The Southwark Group of Tenants Organization (SGTO) Youth Forum provided a Mental Health paper, which they presented to the committee in December 2015

8.3 The February 2016 the committee discussed the Southwark Children and Young People's Mental Health Strategy and Wellbeing Transformation Plan.

8.4 The Committee would like to thank the following who contributed to the Education and Children's Services Communities Committee:

Councillor Jasmine Ali, Chair, Education and Children's Services Committee

Councillor Lisa Rajan, Vice-Chair, Education and Children's Services Committee

Councillor Sunny Lambe, Member, Education and Children's Services Committee

Councillor James Okosun, Member, Education and Children's Services Committee

Councillor Sandra Rhule, Member, Education and Children's Services Committee

Councillor Charlie Smith, Member, Education and Children's Services Committee

Councillor Kath Whittam, Member, Education and Children's Services Committee

Kay Beckwith

Martin Brecknell

Lynette Murphy-O'Dwyer

Abdul Raheem Musa

George Ogbonna

Julie Timbrell, Scrutiny project manager

SGTO Youth Forum and in particular the coordinator David McLean and, Rachel Tam, SGTO Youth Forum Secretary.

Dick Frak, Interim Director of Commissioning, Children's & Adults Services

Carole-Ann Murray,NHS Southwark CCG

9. Appendix 2: List of contributors to the Healthy Communities Committee

9.1 The Committee would like to thank the following who contributed to the Healthy Communities Committee roundtable which was held on 2 March 2016.

Councillor Rebecca Lury, Chair of the Healthy Communities Committee

Councillor Jasmine Ali, Member, Healthy Communities Committee

Councillor Helen Dennis, Member, Healthy Communities Committee

Councillor Paul Fleming, Member, Healthy Communities Committee

Councillor Lucas Green, Member, Healthy Communities Committee

Councillors Maria Linforth-Hall, Member, Healthy Communities Committee

Richard Adkins, Mental Health and Social Care Review Implementation Lead, Southwark Council

Rabia Alexander, Head of Mental Health, Southwark Clinical Commissioning Group

Jacqueline Best-Vassall, Lambeth and Southwark MIND

Graham Collins, Community Action Southwark

Stephanie Correra, Southside Rehabilitation Ltd

Sean Cross, Consultant Liaison Psychiatrist, Kings College Hospital

Cllr Stephanie Cryan, Cabinet Member for Adult Care and Financial Inclusion

Dick Frak, Interim Director of Commissioning, Southwark Council

Cath Gormally, Director of Social Care, SLaM

Jan Hutchinson, Director of Programmes, Centre for Mental Health

Gwen Kennedy, Director of Quality and Safety, Southwark Clinical Commissioning Group

Jo Kent, Service Director, SLaM

Nancy Kuchemann, Clinical Lead, Southwark Clinical Commissioning Group

Catherine Negus, Southwark Healthwatch

Matthew Patrick, Chief Executive, SLaM

Zoe Reed, Director, Organisation and Community, SLaM

Tom White, Southwark Pensioners Action Group

Julie Timbrell, Scrutiny project manager

10. Appendix 3: Previous recommendations from scrutiny reviews that relate to mental health

Bullying: October 2013

1. Cascade information to schools on the work of Kidscape and The Cybersmile Foundation on tackling bullying and cyber-bullying.
2. Promote training that brings together teachers, young people and their families to enhance communication and knowledge in relation to online media and cyber-bullying
3. Encourage initiatives such as Kindness Weeks and cyber-bullying awareness days, which promote the values of care and kindness. Initiatives such as these can also help develop emotional intelligence and an awareness of what constitutes acceptable behaviour online.
4. Encourage the use of role play in schools to develop emotional literacy.
5. Promote schemes that support bullied children to build self-esteem and develop assertiveness skills.
6. Support counselling services such as Place2Be.
7. Empower school children to raise issues and extend the box scheme and other schemes so that children, young people and the public can raise concerns easily, particularly with school bus routes.
8. Consider placing wardens and transport police on problematic bus routes, such as the 381.
9. Promote training to teachers on bullying and involvement with gangs/serious offending so that they are more able to work effectively with young people at risk. Ensure the training is done by people who are credible and knowledgeable.
10. Provide a forum for teachers to share concerns and information on young people involved, or at risk of involvement, with gangs/serious offending.
11. Encourage and provide support for schools to develop Gang Prevention Strategies.
12. Invite groups such as Safe 'N' Sound and Empowering People for Excellence to join the Safer Schools Steering Group.
13. Provide more accessible information on local LGBT networks for young people and consider developing a network for Southwark young people, possibly with the support of Southwark's LGBT forum.
14. Consult with Speakerbox, the Looked After Children Panel and the Children Safeguarding Board on anti-bullying work with children receiving care.

Prevalence of Psychosis and Access to Mental Health Services for the BME Community in Southwark: March 2014

1. At this time, the sub-committee has carried out some initial evidence and we strongly recommend that the next iteration of the Health Scrutiny Sub-Committee carries out a more in-depth look at access to mental health services by all service users, with a specific focus within the report on BME community access.
2. The sub-committee notes with concern that there are a large range of factors given for the increase prevalence of mental health conditions in the BME community. We recommend that Public Health carry out further work to understand the key drivers behind this increased prevalence, using Southwark specific data where possible to look at the borough's BME communities in more detail.
3. The sub-committee recommends that Healthwatch Southwark should collect more information of real life cases through a number of means including Kindred Minds - a Southwark black and minority ethnic (BME) user-led mental health project -and other relevant sources and organisations in Southwark.
4. The sub-committee notes that there is minimal understanding of the ways in which members of the BME community present with mental health conditions, other than from research. We recommend that Public Health undertake further work to understand the pathways which Southwark residents take to access mental health services. Where relevant, this should be undertaken jointly with SLaM and the Hospital Trusts.
5. We welcome the decision by SLAM to collate information on classifications of presentations to Emergency Departments and would recommend that this information is shared as part of the Joint Mental Health Strategy that is being developed.

6. We recommend that Kings College Hospital and Guys and St Thomas' place the provision of safe, secure spaces for the treatment of patients presenting with mental health conditions as a key priority in their workplans for 2014.
7. We recommend that the Mental Health sub-group of the Lambeth and Southwark Emergency Care Network presents its final Action Plan to the sub-committee for further comment. We recommend that the final draft of the Joint Mental Health Strategy is presented to the sub-committee ahead of publication for further scrutiny.
8. The sub-committee welcomes the services that are currently provided by SLaM to support those with mental health conditions in Southwark. We recommend that priority is placed by SLaM on supporting people with mental health in the community, and intervening ahead of any admissions to A&E wards.
9. Given the success of the Black Majority Churches Pilot, the sub-committee recommends that Southwark CCG and Southwark Council jointly consider commissioning a bespoke pastoral mental health awareness training programme across established BMCs in Southwark adapting SLaM's faith and mental health model.
10. The sub-committee further suggests that Southwark CCG and Southwark Council jointly consider commissioning further Mental Health First Aid training specifically aimed at established BMCs across Southwark.

Access to Health Services in Southwark:March 2014

1. The sub-committee recommends that Hospital Trusts should report quarterly on the number of beds available to A&E patients and how this compares to the number of beds needed, with particular reference to emergency admissions for older people and people in mental health crisis.
2. We recommend that the Mental Health sub-group of the Lambeth and Southwark Urgent Care Board presents its final Action Plan to the sub-committee for further comment.
3. We recommend that the final draft of the Joint Mental Health Strategy is presented to the sub-committee ahead of publication for further scrutiny.
4. We welcome the decision by SLAM to collate information on classifications of presentations to Emergency Departments and would recommend that this information is shared as part of the Joint Mental Health Strategy that is being developed.
5. We recommend that Kings College Hospital and Guy's and St Thomas' place the provision of safe, secure spaces for the treatment of patients presenting with mental health conditions as a key priority in their workplans for 2014.
6. The sub-committee welcomes the services that are currently provided by SLaM to support those with mental health conditions in Southwark. We recommend that priority is placed by SLaM on supporting people with mental health in the community, and intervening ahead of any admissions to A&E wards.

Narrowing the Achievement Gap report: June 2015

1. Continue to prioritize finding more local foster & care placements, particularly when it is needed most at year 10 & 11, given the adverse impact moving has on a child's education.
2. Ensure the needs of Permanently Placed children are highlighted to schools, alongside the training programme provided by PAC –UK.
3. Link the expertise of the LAC team to local schools with Permanently Placed children.
4. Assist schools in improving the provision for low income and deprived parents, in recognition of their pivotal role in children's education, particularly in areas where there is a high disparity of wealth. In particular take measures to assist schools engage parents, and improve the provision of parental literacy classes and community education. Take steps to assist families in housing need, especially the needs of displaced children whose families have had to move to access housing.
5. Promote Bacon's College good practice in providing a whole school approach to wellbeing and use of therapeutic and targeted interventions to address the social, emotional and mental health needs of the most disadvantaged students, particularly to ensure the bottom 20% make good progress.

6. Improve communication by Social Work teams with schools by ensuring that schools have a consistence link. Look at the deployment of school nurses as an example of good practice – schools praised the simple geographical model and clear communication lines.
7. Improve communication between schools, Housing, Probation Services and the Police.
8. Invest in further provision of CAMHSs and ensure that there is one consistent CAMHS link person for every school.

Southwark's Adoption Service report: June 2015

1. Ensure the needs of Permanently Placed children are highlighted to schools, alongside the training programme provided by PAC –UK
2. Link the expertise of the LAC team to local schools with Permanently Placed children.
3. Monitor the long term educational outcomes of all permanently placed children.

FGM

Report of the Education and Children's Services Scrutiny Sub-committee

March 2016

Southwark Council

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FORWARD Cllr Jasmine Ali, Chair of the Education & Children's Services scrutiny committee

The Southwark Education and Children's Scrutiny Committee is concerned with the high instances of Female Genital Mutilation (FGM) affecting women in our local communities.

Female genital mutilation, also known as female genital cutting or female circumcision, is the ritual removal of some or all of the external genitalia. The procedures are very different according to the ethnic group and the practice is rooted in gender inequality.

FGM has been outlawed or restricted in most countries that it is carried out in, but the laws are poorly enforced. Moves have been made since the early 1970s to stop this practice. In 2012 the United Nations General Assembly recognized the practice of FGM as a human rights violation. They voted unanimously to intensify efforts to prevent it.

More recently this issue has been given media attention. There is also increased willingness of women to come forward. There is of course an impact on our role, and on our legal responsibility for safeguarding.

Southwark is significant

Recent research reaffirms that Southwark has the highest rate of FGM in the country. The evidence we considered told us that a staggering 10. 4% of children in Southwark will have a mother who has been genitally mutilated. They are significantly but not exclusively from Somalia, Sierra Leone and Nigeria.

Stop FGM

The scrutiny committee is committed to preventing this practice and we have invited a wide section of professionals and the local communities to be part of the scrutiny committee's deep dive into the issue of FGM in Southwark. Our year-long research is driven by a commitment to better protect our women and children so that they are safe from FGM and those who have undergone FGM can access support services.

The following report details intelligence from leading experts and professional's like Dr Comfort Momoh from Guys and St Thomas', Alison Macfarlane – Professor of Perinatal Health and author of a recent report highlighting Southwark as having the highest incidence of FGM, Angela Craggs from Southwark Police, Clarissa Cupid of Southwark Clinical Commissioning Group and April Bald, Southwark Council social care lead on current work.

We held a 'scrutiny in a day' session and heard from community and voluntary groups, and then followed this up with a workshop from Coventry University on an EU wide community based behavior change action research programme. Our review activities and diverse participants all helped us develop our recommendations, the method and results of which are set out below.

The following report charts the results of the Education and Children's scrutiny committee's attempt to spotlight the services and partnerships set up to prevent FGM in the London Borough of Southwark, offer support to women who have undergone

FGM and make a serious contribution to ending genital mutilation of all women and children.

INTRODUCTION AND BACKGROUND

1.1 This is the draft report of the review of Female Genital Mutilation (FGM). The Education and Children's Services Scrutiny Sub-Committee decided to conduct a review on 12 July 2014, and this was carried over to the following year. The aim of the review is to make recommendations to the Cabinet, the Southwark Children's Safeguarding Board and NHS Southwark Clinical Commissioning Group (CCG)

1.2 The review set out to address these issues in particular.

- Promote good practice in tackling FGM
- Bring together statutory partners and the community in finding solutions to safeguarding girls from FGM
- Establish a clearer picture of the prevalence and risk to Southwark girls

1.3 The sub-committee chose this subject because FGM poses the risk of significant harm being done to Southwark girls. Southwark has the highest prevalence of FGM in the country. A report published in July 2015 by City University London & Equality Now found that the highest prevalence rates in were in London boroughs, estimated to be 4.7% of women in Southwark. An estimated 10.4%. of mothers of girls born to Southwark mothers are FGM survivors.

1.4 World-wide 100-140 million of girls and women have undergone some form of FGM. An estimated 6,000 are at risk per day worldwide and about 2 million or more undergo FGM each year. The European Parliament estimates that up to half a million women living in the EU have been subjected to FGM, with a further 180,000 at risk.

1.5 The work to tackle FGM globally has been going on for 35 years, however over that last few years there has been much greater publicity around the practice of FGM in the UK and London in particular. Awareness is much greater now and discussion of the issues is far less of a taboo. However the practice still raises difficult issues around sexuality, race, immigration, culture, poverty, privilege, gender equality, abuse, and violence within family systems. All these issues need to be dealt with if the practice is be ended and girls protected.

EVIDENCE CONSIDERED

Activities

2.1 The review first received a paper from Southwark social care and Southwark NHS setting report setting out current work being carried out by local statutory agencies to tackle FGM.

2.2 Following this a Scrutiny in A Day was held on 16 September 2015 to spend the day intensely looking at FGM and how to bring it to an end in Southwark. The first half of the day was devoted to looking at the current work of the NHS, social care, the police, followed by a presentation on recent research on prevalence. The afternoon was particularly dedicated to exploring community engagement as an important tactic in ending FGM, with the help of national and local voluntary providers specializing in ending FGM, alongside statutory agencies, frontline workers and the community.

2.3 The day was opened by leading FGM health professional, Dr Comfort Momoh, a pioneering midwife who in 1997 opened one of the first African Well Women clinics in St Thomas Hospital, which treats women with FGM. She now works internationally to support women with FGM and to prevent the practice.

2.4 A joint presentation was received from Southwark social care, NHS and Police on current work to tackle FGM, including examples of work being done to protect girls. Officers explained the statutory framework to safeguard girls and the plans of the created FGM steering group, a partnership established in June 2015 to tackle FGM.

2.5 Alison Macfarlane, Professor of Perinatal Health**,** City University London, then presented the recently published report on rates of FGM, 'Prevalence of Female Genital Mutilation in England and Wales: National and local estimates'. She provided an explanation of how the data had been arrived at and an overview of FGM prevalence and maternity rates in England & Wales, London and Southwark, drawing from data published in the report. She also provided further additional data, including the ethnic breakdown of the Southwark population at risk, including details of the types of FGM women & girls may be affected by.

2.6 The afternoon was focused on hearing from a woman who had experienced FGM, and the work of national FGM charities working to end FGM and the work of the local voluntary sector to tackle FGM. This was followed by a fishbowl discussion with the voluntary sector, officers from social care & the police, the committee and a broad range frontline practitioners (teachers, midwives) and community workers . The day ended with workshops exploring next steps and the scope for conducting action research with the community to end FGM.

2.7 Following the Scrutiny in a Day a workshop with the committee and some of the participants from the day was held on REPLACE 2 with Coventry University's Professor Hazel Barrett & Dr Katherine Brown. The programme is led by the university and is an EU wide community based behaviour change

programme to end FGM. The programme academics presented on the programme work since 2010 and the recently publish toolkit to conduct community participatory work with local communities.

Report contributors

Council & community partners:

2.8 Dr Comfort Momoh MBE , African Well Woman's Clinic at Guy's and St Thomas Foundation Trust in London, a support service for women and girls who have undergone FGM

2.9 Alison Macfarlane, Professor of Perinatal Health**,** City University London, joint author of the report on 'Prevalence of Female Genital Mutilation in England and Wales: National and local estimates'

2.10 Angela Craggs, Southwark Police FGM lead

2.11 Clarisser Cupid, Southwark Clinical Commissioning Group FGM lead

2.12 April Bald, Southwark Council social care FGM lead

2.13 Toks Okeniyi, FORWARD.

2.14 Agnes Baziwe & Shani Hassan, African Advocacy Foundation

2.15 Florence Emakpose, World of Hope

2.16 Hawa Sesey, FGM Campaign

2.17 Louise Robertson, 28 Too Many

2.18 Professor Hazel Barrett & Dr Katherine Brown, Coventry University

2.19 Kevin Dykes, Sarah Totterdell , Ebony Riddle Bamber – Community Engagement

Education & Children's Services scrutiny committee & officer support

2.20 Councillor Jasmine Ali, Chair
Councillor Lisa Rajan, Vice-Chair
Councillor Sunny Lambe
Councillor James Okosun
Councillor Sandra Rhule
Councillor Charlie Smith
Councillor Kath Whittam
Kay Beckwith
Martin Brecknell
Lynette Murphy-O'Dwyer
Abdul Raheem Musa
George Ogbonna

2.21 Julie Timbrell, scrutiny project manager and report author

Health impacts and the cultural reasons for FGM

3.1 Dr Comfort Momoh opened the 'Scrutiny in a Day' in September 2015. She is a midwife who set up the African Well Woman's Clinic at Guy's and St Thomas Foundation Trust in London in 1997. This pioneering service supports women and girls who have undergone FGM. She has won national and international recognition for her both her work with women FGM, and her work to end the practice in a generation.

3.2 Female Genital Mutilation (FGM) was introduced by Dr Comfort Momoh as abuse, and both a health and Human Right issues for girls and women.

3.3 There are different types of FGM. The WHO has classified FGM into four types:

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

Type 2: Excision – partial or total removal of the clitoris and the labia minora with or without the excision of the labia majora (the labia are the 'lips' that surround the vagina)

Type 3: Infibulation – narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris

Type 4: Other – all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area

3.4 Whilst some women report no ill effects at the most extreme can FGM can be deadly: 10 % of girls die from the procedure, and a quarter of women will experience significant disability.

3.5 The health impacts of FGM include the initial shock, pain and trauma, which can lead to later flash backs and psychological problems. Girls are often held down to perform the process and as a result of the ensuing struggle there can be fractures and dislocation of limbs and injury to adjacent tissues. Immediately following the procedure the cuts can lead to infection and failure to heal, with urinary retention. Longer term FGM can cause problems in childbirth and recurrent Urinary Track Infections and fistulae (rectum or vaginal).

3.6 As well as the adverse health impacts many women will also will suffer lifelong psychological & emotional trauma, as well as loss of sexual function & enjoyment.

3.7 FGM is popularly associated with the Islamic religion, however FGM is widespread in many countries, including Christian and Jewish communities, and is rarely practiced in some Muslim countries. FGM is not a religious requirement, although on occasions religious institutions have supported its continuation. In Britain the Muslim Council of Britain has issued an a strong statement explicitly condemning the practice: "FGM is not an Islamic requirement. There is no reference to it in the holy Qur'an that states girls must be circumcised. Nor is there any authentic reference to this in the Sunnah, the sayings or traditions of our prophet. FGM is bringing the religion of Islam into disrepute."[1]

3.8 FGM is more correctly described as a cultural practice that has many and complex meanings. FGM is a long-standing tradition, which has become inseparable from ethnic and social identity among many groups. Reasons given for practice vary and include:

- Tradition
- Religion
- Prevent Rape
- Income for circumcisers
- Preservation of virginity
- Promote cleanliness
- Aesthetic reasons : cultural perceptions of beauty
- Punishment

3.9 The age that girls usually undergo FGM is between infancy and 15, and it is most frequently performed on girls aged between ages 5-8, however occasionally it is carried out later.

3.10 FGM is associated with the curtailment of women's sexuality, and is frequently bound up with gender identity and with social rites of passage of girls to women. A women who has not undergone FGM in some communities may be considered less marriageable and not having attained full status as a women. In communities with a wide spread practice she and her family risk deliberate social exclusion to enforce the practice.

3.11 Dr Comfort Momoh emphasized that it is important to tackle FGM in a multifaceted way, as in some countries, such as Egypt, the procedure has become increasingly medicalized to counter wider appreciation of the adverse health outcomes. She also mentioned that practicing communities often raise the rapidly growing western fashion of designer vaginas, and how that can be very similar to Type 1, however they complained it is not described as FGM because it is associated with more privileged, white communities. Dr Comfort Momoh said that any procedure carried out for purely aesthetic reasons would be classed as Type 4.

3.12 She emphasised that FGM is a procedure that needs to be seen as violence against women, abuse and one that endangers safety, liberty, bodily and sexual integrity, as well as physical health, but in relating to communities sometimes it is better to use less loaded terms, such as cutting or female circumcision.

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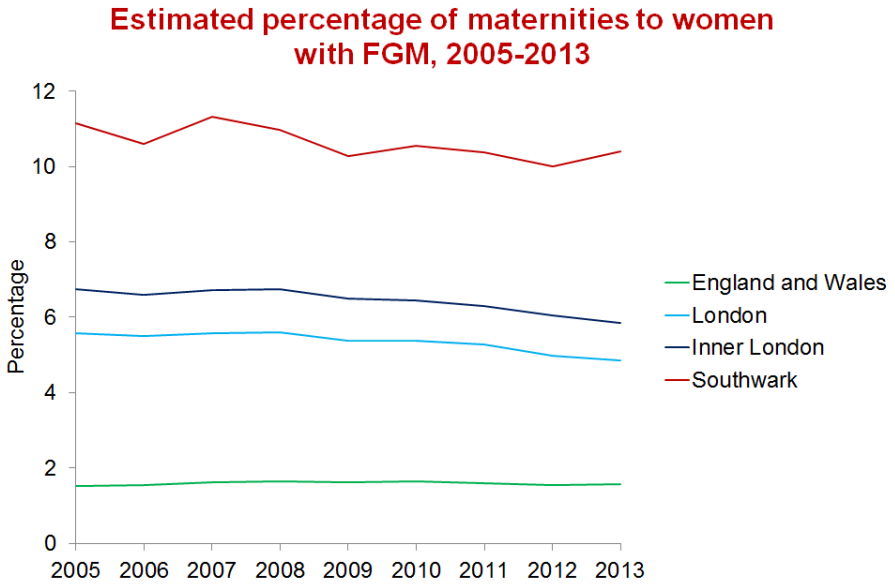
[1] http://www.theguardian.com/society/2014/jun/23/female-genital-mutilation-muslim-council-britain-unislamic-condemn

Prevalence data and emerging community profile of practicing communities

3.13 The review set out to establish a clear picture of the prevalence of FGM locally and the risk to young girls. Scrutiny in a Day received a presentation from Alison Macfarlane, Professor of Perinatal Health on the recently published report by City University & Equality Now: 'Prevalence of Female Genital Mutilation in England and Wales: National and local estimates'. This provided data on both prevalence and maternity rates, using the latest census data from 2011 and other data sources, included FGM surveys in countries of origin and birth registrations. Local statutory agencies also provided data.

Maternity

3.14 Proffessor Alison Macfarlane's data indicated that Southwark is the borough with the highest percentage of girls born who have a mother with FGM. In Southwark, an estimated10.4 % of girls born will have a mother with FGM, the highest percentage in England & Wales.



Source: ONS data, analyzed by Alison Macfarlane, City University London

Prevalence

3.15 Southwark is also the local authority with the highest prevalence rates in England & Wales. An estimated 4.7 % of women and girls born outside the UK and living in Southwark will have undergone FGM. This amounted to an estimated 6,901 women and girls. Data presented by the local statutory agencies estimated that 2055 girls will be either affected by FGM or at risk.

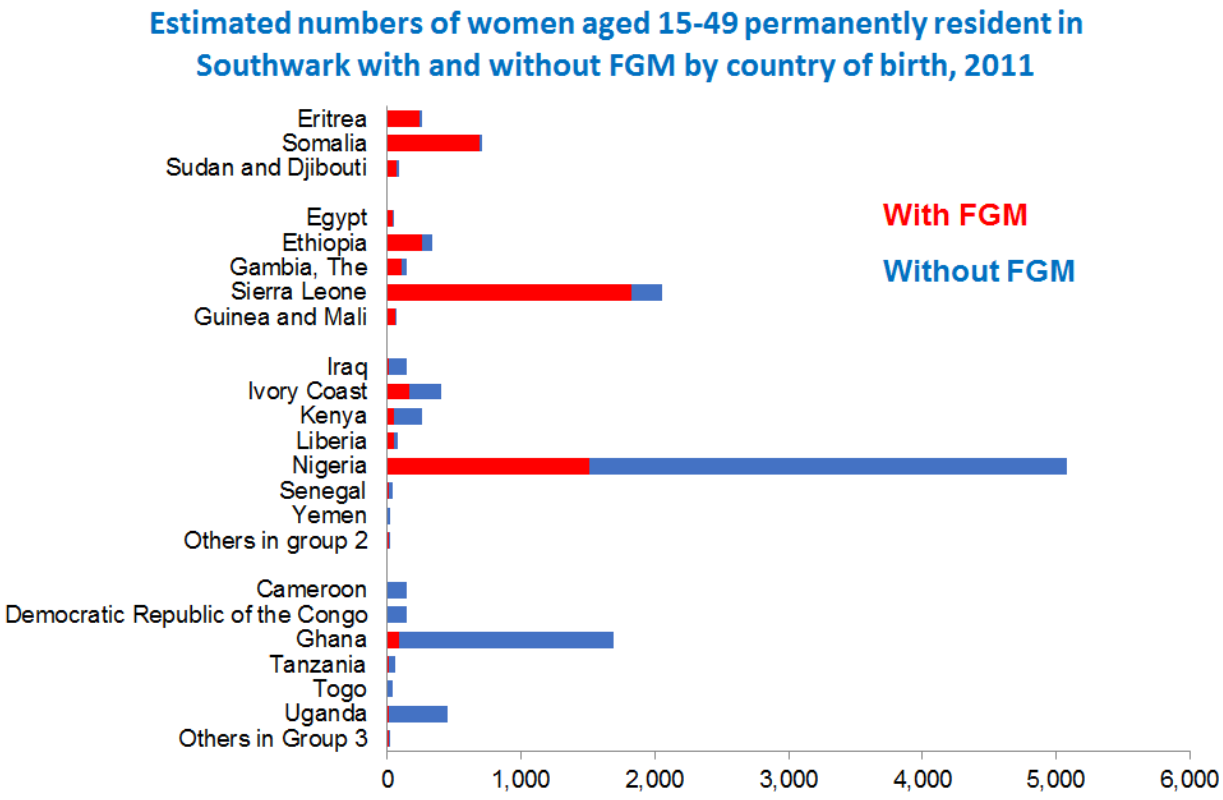
3.16 Southwark is of course not exceptional here, as many other urban areas with high immigrant populations have estimated rates which are nearly as high. These figures do need to be treated with some caution they as are extrapolated largely from secondary sources. However the both the national report and data provided by local statutory agencies highlight that Southwark is an area where FGM is a significant issue.

Breakdown of prevalence by country of origin and type of FGM

3.17 The communities in Southwark practicing FGM are diverse: from different countries, practicing different types of FGM, with different religions and cultural traditions.

3.18 Professor Macfarlane provided some additional data for her presentation on the countries of birth of the communities practising FGM and this identified that the majority of women living in Southwark with FGM will be from Sierra Leone, Nigeria and Somalia, but there will be significant numbers of other women from other countries including Eritrea, Ethiopia, Sudan & Dhibouti, Egypt, The Gambia, Guinea and Mali, Ivory Coast, Kenya, Liberia and Ghana.

3.19 Women with FGM in Southwark come largely from the diaspora community originating from a group of countries from the Atlantic to the Horn of Africa, including parts of the Middle East. However FGM is practiced in other parts of the globe, particularly South East Asia. It is therefore important to keep in mind that there may well be some individuals and small pockets of communities who come from other countries.



Source: ONS data, analyzed by Alison Macfarlane, City University London

3.20 Women from Somalia, Sudan, Eritrea and Djibouti often have had the Type 3 FGM, the most severe form. Women from other countries are more likely to have had Type 2 or Type I.

Grouping of countries by level and types of FGM

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

3.21 Professor Alison Macfarlane advised that in undertaking work to stop FGM it is vital to know as much about your community makeup as possible as reasons for carrying out FGM vary from country to country and even within different countries. In Sierra Leone some tribes will not practice FGM. Although infrequent in Ghana it is practiced by the Northern tribes. In Nigeria it is more common amongst Christian, rather than Muslim communities. While generally FGM is associated with lower educational levels, in Nigeria it is associated with higher levels of education. She recommended starting by making use of the data she has produced and then doing further investigations locally into the ethnic make-up of Southwark community in order to plan interventions. Louise Robertson, of 28 Too Many also advised getting to know the Southwark FGM practicing communities well; by collecting good data and understanding the varying social norms that sustain the practice.

Recommendation one

Develop a community profile of the FGM practicing communities in Southwark, with communities, drawing on available statistical data and community knowledge. Update this regularly as more accurate primary data becomes available and local knowledge of practicing communities develops.

Social Care, Police & NHS work to end FGM

3.22 Statutory agencies presented work they are doing to get better primary data, improve child protection and increase the likelihood of a prosecution of perpetrators. Local efforts have been stepped up with the instigation of a multi-agency steering group in June 2015 and they are working on developing multi agency arrangements to share information and improve safeguarding.

3.23 The police reported that he law has recently been updated and strengthened. The first legislation was the 'Prohibition of Female Circumcision Act 1985, with a

penalty of 5 years imprisonment. With the introduction of The Female Genital Mutilation Act in 2003 the penalty increased to 14 years imprisonment and added extra offences of assisting someone in the UK to arrange or assist FGM outside of UK, even if carried out by a person who isn't a UK national or resident. New measures since May 2015 mean parents and guardians can now be held liable for failing to protect a child from FGM.

3.24 Despite these changes there have been no convictions under FGM legislation in the UK. Obtaining one was cited in the committee and Scrutiny in a Day discussions as important to send a strong signal out that FGM is a crime that will not be tolerated. This was tempered with reflections on the need to engage with practicing communities and take a more nuanced approach than just pursuing the criminal justice route.

3.25 Legislation changes from May 2015 granted lifelong victim anonymity, and introduced civil Female Genital Mutilation Protection Order.These had already been employed in Southwark by September 2015 to help safeguard girls at risk and there was commitment from the steering group to expand their use. At the final Education & Children's services scrutiny committee meeting, held in March 2016, Strategic Director detailed their further use in two recent cases to safeguard children, including a high profile case involving the child of a west African diplomat[2]. This was welcomed by the committee as indicative that Southwark is now more able to protect children by making better use of the new enforcement powers made available.

3.26 Mandatory reporting of FGM has been introduced for relevant professional. All clinical staff must now record in patient healthcare records when it is identified that a patient has had FGM and all acute hospitals must provide monthly returns of on FGM prevalence. Much better data is now coming through from health services: on 1st April 2014 the first FGM Prevalence Dataset was published. Local health data collecting has been improved and this will help provide more robust data on the local populations at risk in the future.

Community work to end FGM

3.27 35 years ago the World Health Organisation (WHO) called for end to FGM. The WHO, United Nations (UN), UNICEF, and other anti-FGM organisations have adopted various strategies in order to raise awareness and work towards ending FGM. These have centered on four main approaches:

- Bodily and sexual integrity;
- Human rights – as both an infringement of liberty & security and as discrimination & violence against women
- Legislative (outlawing the procedure)
- Health

3.28 More recently there has been increased investment in the a fifth approach of using community engagement to change the underlying beliefs that perpetuate the practice – Scrutiny in A Day sought to look at all these approaches and particularly dedicated the afternoon to exploring community engagement as an important tactic in ending FGM .

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[2] http://www.theguardian.com/society/2016/feb/29/african-diplomat-child-uk-protection-order-female-genital-mutilation-fgm

3.29 The afternoon was focused on hearing from a woman who had experienced FGM, the work of national FGM charities working to end FGM and the work of the local voluntary sector to tackle FGM in Southwark.

3.30 The Scrutiny in a Day heard moving testimony from a survivor of FGM, Hawa Sesey, who explained how an elder relation carried out the procedure on her in Sierra Leone, the traumatic impact it had on her then as a young girl, and how it later affected her married life. She has worked for many years with in her community to end the practice

3.31 Local organisations World of Hope and Africa Advocacy Foundation detailed their work with survivors and practicing communities.

3.32 World of Hope is committed to raising Youth Ambassadors that will become tomorrow's leaders through their mentoring, training, coaching, and citizenship programmes which equip young people to positively impact their communities. It works with young people on FGM directly seeking ambassadors to help end the practice and in July it held an African safeguarding children's conference, in partnership with CANUK, which in dealt with FGM.

3.33 Africa Advocacy Foundation has an established programme to support women with FGM and end the practice. The project employs a dedicated worker and their work includes training for FGM community champions and outreach with a wide range of Southwark faith based organizations (Muslim & Christian) and community groups. The project holds events that focus on a number of issues in an engaging way, for example FGM is often discussed within the context of sexual health to reach a wider audience. The community outreach includes work with Faith leaders, utilises sister circles, and also holds men specific discussions on FGM. Community awareness raising workshops are held tailored to the language of the people e.g. Somali, Swahili, Yoruba, and Arabic.

3.34 Africa-Advocacy Foundation said they have identified a lack of knowledge on the health effects of FGM. They also reported that communities frequently feel there is interference without insight into issues and a lack of trust means that communities sometimes feel targeted. They advised that there needs to be more training and education within practicing communities and there needs to be appropriate resources to facilitate learning in the community.

3.35 Scrutiny in a Day concluded with two workshops on next steps and conducting action research with practicing communities. Participants thought there needed to be further awareness rising through publicity on the adverse impacts of FGM, and more in depth work with different communities to change attitudes. As well as reaching out to women of child bearing age to offer them support and safeguard children who may be at risk, it was also considered important to engage with boys and men, and vital to engage with older women. Grandmothers and 'Aunties' are often the ones carrying out the procedure and it is the older generation who set the social norms of the community. Elders in African and Middle Eastern communities are frequently given a high level of respect and review participants familiar with practicing communities identified that changing elder views could be pivotal to ending the practice.

3.36 Africa Advocacy Foundation in depth work with a wide range of faith and community groups using community champions from practicing communities was noted as particularly valuable. However Africa Advocacy Foundation has

highlighted the need for continued financial support to continue and build on this work.

Recommendation two

Support the existing good work of community organizations, particularly Africa Advocacy Foundation.

3.37 A publicity campaign was suggested to highlight the impact of FGM , and participants discussed using blunter messages on the negative health consequences and more explicit information on the adverse impact FGM had on girls and women , however some review participants cautioned that this needed to be balanced with the need to build trust with communities and develop appropriate interventions which do not alienate communities .Experts advised that it is by knowing the community very well and always keeping the survivor voice center stage that these tensions can be resolved : the survivor voice is crucial to understanding the issues and building creditability.

3.38 Dr Comfort Momoh of the African Well Women's Centre is organizing a Female Genital Mutilation Music Festival to raise more awareness of FGM and to educate professionals and the public in a welcoming, friendly and fun environment. The aim is to make this a yearly event in July before school holiday and the cutting season. The event will include key people from the UK and abroad, as well as ambassadors, survivors and professionals.

Recommendation three

Raise local awareness of FGM through community events, publicity, media campaigns and via community champions. Work with the local voluntary sector groups & professionals; Africa Advocacy Foundation, World of Hope, FGM survivors and Dr Comfort Momoh of the African Well Women's Centre to support planned events and generate publicity material. Keep the survivor voice at the forefront.

3.39 The review participants identified faith communities, community groups, embassies, schools and front line workers as key groups to work with.

3.40 The teachers who attended the Scrutiny in a Day suggested training materials are developed for PSHE lessons and that the school Safeguarding Leads are fully briefed on how to respond to FGM. FORWARD, a long standing voluntary sector organization who contributed to the review, have a schools programme offering a comprehensive range of services for schools to engage and empower young people and a training programme for front line professionals. Young people and their peers need to have ways of raising alerts and getting support. It was noted that often it is siblings who raise safeguarding alerts. A confidential phone line was suggested, or exploring the Petals mobile-phone application which allows young people to find out more about FGM and source help discreetly on a smart phone. The Strategic Director brought the committees attention a safeguarding icon that one schools has developed to enable children to raise alerts and get help.

Recommendation four & five

Work with schools on integrating teaching on FGM as part of the PSHE curriculum development and ensure schools Safeguarding Leads

understand FGM and how to protect girls. Consider using the material developed by FORWARD and Integrate Bristol.

Develop ways for young people to get help, information or report concerns, making sure that it is particularly tailored for girls at risk, their siblings and peers who can help safeguard them e.g. via a confidential phone line and /or the phone application Petals and/or a safeguarding alert icon on school computer networks.

3.41 The Africa Advocacy Foundation said that survivors report there is a lack of FGM specialist knowledge making it difficult for women to seek appropriate advice and support and there needs to be more training for frontline professionals. The current FGM steering group has work both with schools and training of primary care professionals as an objective.

Recommendation six

Request a detailed report back in 6 months time of the FGM steering group work programme to train primary care professionals and other frontline professionals

3.42 Scrutiny attempted to engage with the Nigerian, Serria Leone and Somali Embassies; however none were able to attend the scrutiny in a day. It is unclear why this was; capacity may be an issue as all have small High Commissions. Participants recommended ongoing work with embassies to engage them in ending the practice, particularly as girls are at risk during the summer holiday of being taken back to their country of origin to undergo FGM during what is termed the 'cutting season' . Although FGM is now illegal in most countries, this is often very poorly enforced and the practice is prevalent in many countries of origin: it is very common in Sierra Leone and near universal in places such as Somalia. Girls visiting extended family could be at high risk: Hawa Sesey, FGM survivor, relayed a story of returning to her home country, Sierra Leone, with her daughter and needing to take steps to protect her child from harm from her extended family. A Southwark child with her mother was intercepted at Heathrow with instruments that may have been intended to be used to cut her child. Clearly there is a risk to girls being taken out of the country, though it is hard to quantify the extent of this.

Recommendation seven

The council should continue to seek to encourage the High Commission of the countries where most families originate from, particularly: Sierra Leone, Nigeria and Somalia, to engage in order to ensure that those affected communities are brought along in our quest to eradicate the practice of FGM and also to avoid those communities feeling isolated and wrongly targeted.

Community based behaviour change programme to end FGM: REPLACE 2

3.43 In November 2015 a workshop was held on REPLACE 2 with Coventry University's Professor Hazel Barrett & Dr Katherine Brown. Many of the committee attended and some of the participants from Scrutiny in a Day, including African Advocacy Foundation staff, FGM social care leads and community development lead.

3.44 REPLACE 2 is the second round of an EU wider behaviour change action research programme which focuses on community engagement to end FGM. The programme has worked with diaspora communities in Europe by engaging members of the practicing communities to understand the social norms that perpetuate FGM and then to provide intervention support to change beliefs and motivate social change. Coventry University lead the programme. The academic leads presented on the programmes work since its inception in 2010.

3.45 The academics explained that thirty years on since the World Health Organisation (WHO) called for the ending of FGM there is conflicting evidence as to whether the emphasis on a criminal justice, health and Human Rights approaches has led to a reduction in the practice. 15 years ago WHO called for application of behaviour change approaches to address FGM , however research concluded that there was a poor understanding of how to conduct this .

3.46 The REPLACE 2 programme uses a cyclic framework for Social Norm Transformation in relation to FGM. Community engagement is critical to the approach and focused on building trust and partnership with the community. The programme works with the community to design interventions whose content and messages align with those belief systems and norms that perpetuate FGM, in order to end the practice. The programme has recently published a toolkit to conduct community participatory work with local communities.

3.47 The workshop concluded with an offer by Coventry University REPLACE 2 programme to assist Southwark in adopting this approach, which was welcomed by attendees.

Recommendation eight

Conduct a community engagement programme to end FGM, in partnership with local voluntary sector and community organisations, using the expertise of the REPLACE 2 Coventry University programme and 28 Too Many.

4 Conclusion

FGM has a multitude of different reasons for its continued practiced; it is perpetrated and justified by reasons of perceived beauty, religion, health, to control women's sexuality, and as a rite of passage. This report has particularly emphasized the community engagement approach to change behaviour as the most underused approach in Southwark, however experts advised that to end FGM the practice needs to be tackled through a range of approaches: as a health hazard, a crime, abuse, and as a human rights and gender equality issue. Pursued all together they are most likely to end FGM.

The committee calls for more efforts and resources be geared towards using partnership working, community engagement and public awareness measures, which the evidence suggests will be central to the speedy eradication of FGM in the affected communities, both within the London Borough of Southwark and by working with the respective High Commissions of those countries. By adopting the below recommendations the committee believes that Southwark will not only be able to quickly eradicate the barbaric and outdated FGM practices but the council will also enable us to build community cohesion and a sense of togetherness.

RECOMMENDATIONS

1 Develop a community profile of the FGM practicing communities in Southwark, with communities, drawing on available statistical data and community knowledge. Update this regularly as more accurate primary data becomes available and local knowledge of practicing communities develops.

2 Support the existing good work of community organizations, particularly Africa Advocacy Foundation.

3 Raise local awareness of FGM through community events, publicity, media campaigns and via community champions. Work with the local voluntary sector groups & professionals; Africa Advocacy Foundation, World of Hope, FGM survivors and Dry Comfort Momoh of the African Well Women's Centre to support planned events and generate appropriate publicity material. Keep the survivor voice at the forefront.

4 Work with schools on integrating teaching on FGM as part of the PSHE curriculum development and ensure schools Safeguarding Leads understand FGM and how to protect girls. Consider using the material developed by FORWARD and Integrate Bristol.

5 Develop ways for young people to get help, information or report concerns, making sure that it is particularly tailored for girls at risk, and their siblings & peers who can help safeguard them e.g. via a confidential phone line and /or the phone application Petals and/or a safeguarding alert icon on school computer networks.

6 The council should continue to seek to encourage the High Commission of the countries where most families originate from, particularly: Sierra Leone, Nigeria and Somalia to engage in order to ensure that those affected communities are brought along in our quest to eradicate the practice of FGM and also to avoid those communities feeling isolated and wrongly targeted

7 Request a detailed report back in 6 months time of the FGM steering group training of primary care professionals and frontline professionals

8 Conduct a community engagement programme to end FGM partnership with local voluntary sector and community organizations and using the expertise of the REPLACE 2 Coventry University programmed and 28 Too Many.

9 The committee welcomes the increased use of civil Female Genital Mutilation Protection Orders, which have been used to effectively to safeguard children in Southwark. The committee supports this type of enforcement action which enables the authorities to intervene to protect girls, while working with the parents and wider family to challenge behaviour and change attitudes, and reduce the risk of unnecessary family breakup and disintegration. However any intervention must always place the needs of girls first, and recognize that while FGM is often practiced in otherwise loving homes, FGM is also associated, on occasions, with other forms of family domestic abuse, and the wider cultural oppression of girls and women.

5 Appendices

I. FGM Scrutiny in a Day

II. FGM workshop with Coventry University on REPLACE 2

Appendix one

SCRUTINY IN A DAY

FGM scrutiny in a day: programme

Address: HENRIETTA RAPHAEL FUNCTION ROOM, Henriette Raphael Building, GUYS CAMPUS, King's College London, London, UK SE1 1UL.

Wednesday 16th September 9am – 3:30pm

9am – 9:30am **Registration & refreshments**

9:30am **Welcome and opening remarks: Cllr Jasmine Ali, Chair** of the Education & Children's Services scrutiny committee

9:40 am – 10:30am **Dr Comfort Momoh MBE** will set the scene by explaining the reasons for FGM, and the implications. She will explain why she established the African Well Woman's Clinic at Guy's and St Thomas Foundation Trust in London, a support service for women and girls who have undergone FGM.

10:40am – 11:20am **Alison Macfarlane, Professor of Perinatal Health,** City University London, presenting a recently published report on rates of FGM, 'Prevalence of Female Genital Mutilation in England and Wales: National and local estimates', which estimates that Southwark has the highest rates of FGM in the UK

11:30am – 12:00noon **Work to tackle FGM in Southwark** Overview by Angela Craggs Southwark Police; Clarisser Cupid, Southwark Clinical Commissioning Group and April Bald, Southwark Council social care lead on current work.

12 noon – 12:30pm **Lunch**

12:30pm – 2:pm **How can community & voluntary groups and statutory agencies work together to end FGM?** Presentation by Toks Okeniyi, FORWARD, followed by brief presentations on local initiatives : Agnes Baziwe, African Advocacy Foundation and Florence Emakpose, World of Hope and then a survivor working for change: Hawa Sesey FGM Campaign. Fishbowl discussion with contributions by national, London and local community groups , and embassy representatives of countries where the practice is common.

2:10 – 3:20pm **Workshop 1 Action research** discussion with 28 Too Many's, Louise Robertson, and Southwark's community engagement lead, Ebony Riddell Bamber, on carrying out action research with communities at risk and with survivors to establish the extent to which girls are at risk and how to best protect girls.

2:15 – 3:20pm **Workshop 2: Facilitated discussion on next steps for the review**. What further lines of inquiry would it be helpful for the scrutiny review to explore, focusing on at risk girls?

3:20 – 3:30pm **Closing remarks**

Dr Comfort Momoh

Dr Comfort Momoh is a midwife who set up the African Well Woman's Clinic at Guy's and St Thomas Foundation Trust in London in 1997, which offers a support service for women and girls who have undergone FGM. The specialist clinic offers midwifery, obstetric and relevant gynaecological care for women who have undergone FGM, including reversal. She has won national and international recognition for her work both with women FGM, and her work to end the practice in a generation.

Female Genital Mutilation (FGM) was introduced by Dr Comfort Momoh as abuse, and both a health and Human Right issues for girls and women.

FGM is popularly associated with the Islamic religion, however FGM is widespread in many countries, include Christian and Jewish communities, and is rarely practiced in some Muslim countries. FGM is more correctly described as a cultural practice that has many and complex meanings. FGM is a long-standing tradition, which has become inseparable from ethnic and social identity among many groups. Reasons given for practice vary and include:

- Tradition
- Religion
- Prevent Rape
- Income for circumcisers
- Preservation of virginity
- Promote cleanliness

The age that girls usually undergo FGM is usually between infancy and 15, however occasionally it is carried out later. The scrutiny in a day heard that on occasions it can be used a punishment; one incident was relayed of a women in her 30's being assaulted and cut by her estranged husband's family.

FGM is associated with the curtailment of women's sexuality, and is frequently bound up with gender identity and with social rites of passage of girls to women. A women who has not undergone FGM in some communities may be considered less marriageable and not having attained full status as a women. In communities with a wide spread practice she and her family risk deliberate social exclusion to enforce the practice.

There are different types of FGM. The WHO has classified FGM into four types:

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

Type 2: Excision – partial or total removal of the clitoris and the labia minora with or without the excision of the labia majora (the labia are the 'lips' that surround the vagina)

Type 3: Infibulation – narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris

Type 4: Other – all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

Whilst some women report no ill effects at the most extreme can FGM can be deadly: 10 % of girls die from the procedure, and a quarter of women will experience significant disability. As well as adverse health impacts many also will suffer lifelong psychological & emotional trauma, as well as loss of sexual function & enjoyment.

The health impacts of FGM include the initial shock, pain and trauma, which can lead to later flash backs and psychological problems. Girls are often held down to perform the process and as a result of the ensuing struggle there can be fractures and dislocation of limbs and injury to adjacent tissues. Immediately following the procedure the cuts can lead to infection and failure to heal, with urinary retention. Longer term FGM can cause problems in childbirth and recurrent Urinary Track Infections and fistulae (rectum or vaginal).

Dr Comfort Momoh explained that health professionals need to be able to able to recognise FGM, be alert to the possibility of FGM, be able to protect and safeguard children and be able to act when a child is at risk or may already undergone FGM.

Dr Comfort Momoh emphasised that it is important to tackle FGM in a multifaceted way, as in some countries, such as Egypt, the procedure has become increasingly medicalized to counter wider appreciation of the adverse health outcomes. She also mentioned that practicing communities often raise the rapidly growing western fashion of designer vaginas, and how that can be very similar to Type 1, however they complained it is not described as FGM because it is associated with more privileged, white communities. Dr Comfort Momoh said that any procedure carried out for purely aesthetic reasons would be classed as Type 4, and it is important to be aware of culture bias. She emphasised that FGM is a procedure that needs to be seen as violence against women, abuse and one that endangers safety, liberty , bodily and sexual integrity, as well as physical health, but in relating to communities sometimes it is better to use less loaded terms, such as cutting or female circumcision.

Tackling FGM successfully needs a multi-agency approach, and the participation of religious and community leaders, and outreach to families at risk. All professionals need training and teaching needs to be part of the core curriculum, as well as a robust legal framework.

FGM is practised among migrant and refugee communities who tend to settle in urban areas, which is why ii is particularly concentrated in boroughs like Southwark and Lambeth . This concentration of communities does allow for specialised services to be developed. The government policy of dispersing refugees and asylum seekers to rural, isolated centres has major implications for women who have experienced FGM.

Dr Comfort Momoh concluded by saying better knowledge and understanding of the cultural factors relating to FGM is important in order to change people's attitude. It is also vital that FGM laws are fully implemented and that governments, agencies, professionals and communities work together to end FGM in one generation.

Alison Macfarlane, Professor of Perinatal Health, City University London, presented a recently published report on rates of FGM, 'Prevalence of Female Genital Mutilation in England and Wales: National and local estimates'. The report was produced to provide statistical estimates of the prevalence of FGM in England and Wales, and in local authority areas. Good data is needed to plan services for affected women and inform child protection for their daughters. As numbers of women resident in England & Wales who were born in countries where FGM is practised have increased, so previous estimates based on 2001 census and births from 2001 to 2004 are out of date.

The aim of the report is to produce data for both the whole of England & Wales, and for each local authority area, providing estimates of the:

1. Numbers of women with FGM in the population enumerated in 2011 census
2. Numbers of women with FGM giving birth, 2005-2013
3. Numbers of daughters born, 2005-2013 to women with FGM

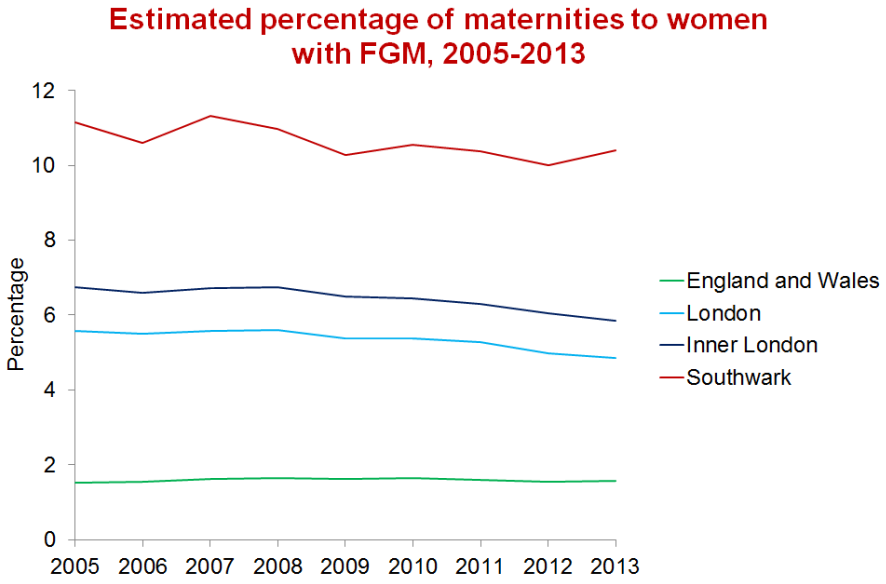
Prevalence

The report estimates that Southwark has the highest rates of FGM in the UK. Prevalence is measured by the numbers of women with FGM per 1000 of the population. Southwark has the highest FGM prevalence rates: 57.5 for women in the 15 – 49 age group, and 8.2 in the age range 0 – 14.

Southwark has rates which are similar to other inner London borough - detailed data estimates for England & Wales and each borough were produced for the report, and are available here: http://openaccess.city.ac.uk/12382/

Maternity

Maternity estimates were given for numbers of women with FGM giving birth and daughters born, with the caveat that the data is less robust as the ethnicity and religion are not recorded at birth registration. Southwark is the borough with the highest proportion of children born to mothers with FGM. More than one in 10 of girls in Southwark were born to mothers with FGM, the highest rate in England & Wales.

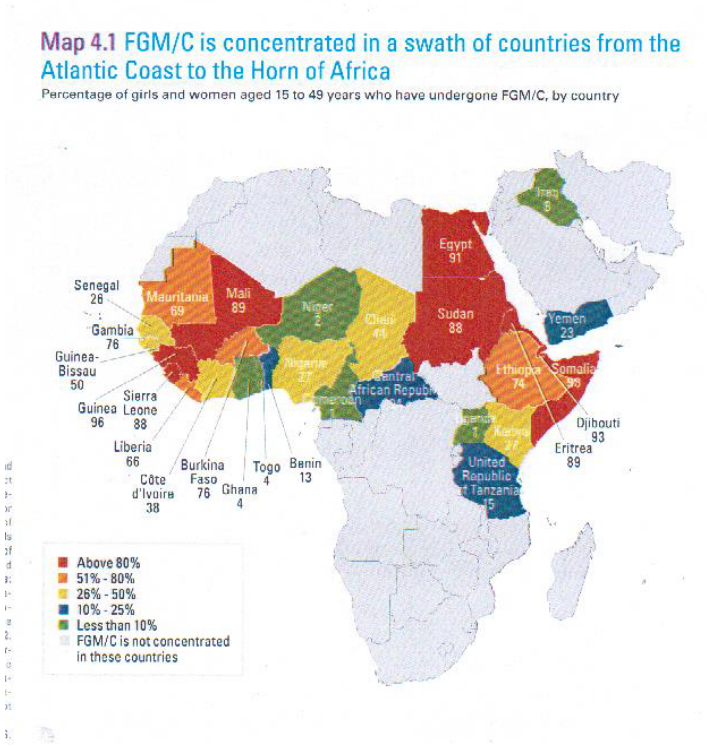


Source: Authors' analysis of ONS data

Mothers' countries of birth

FGM is concentrated in a group of countries from the Atlantic to the Horn of Africa, including parts of the Middle East, however it is also practiced in some other countries, particularly South East Asia.

Some countries have nearly universal FGM amongst the population, for example it is estimated that 98% of women born in Somalia have been subjected to FGM, whereas in others it is a minority, for example only 4% of women born in Ghana have been subjected to FGM.



Source: UNICEF
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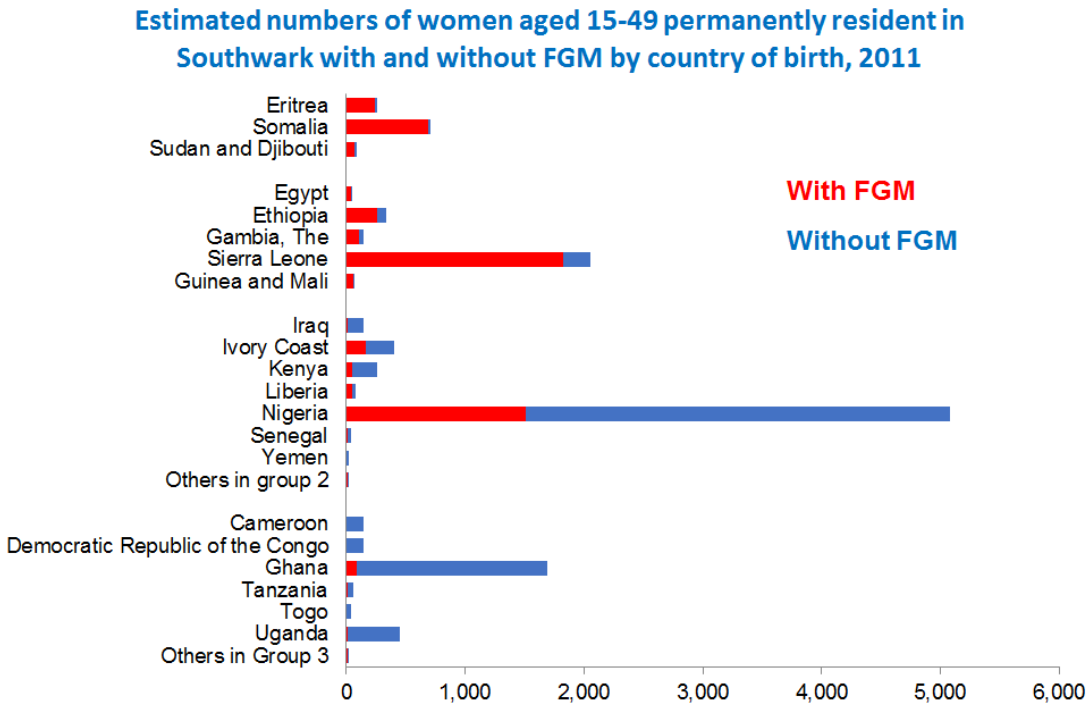
Southwark has high rates of FGM as it has a large immigrant population born in practising countries. More detailed estimates for the country of birth breakdown of the Southwark population were provided for the presentation. Data was obtained by indirect estimates of prevalence of FGM using data on age specific prevalence by country of origin from surveys in FGM practising countries, alongside census and birth registration data for England and Wales. Exclusions were then made for certain non- practicing populations e.g. Buddhist, Hindu or Sikh religion.



Source: Author's analysis of ONS data

The data shows that the majority of women living in Southwark with FGM will be from Sierra Leone, Nigeria and Somalia, but there will be significant number of other women from other countries including Eritrea, Ethiopia, Sudan, Djibouti, Egypt, The Gambia, Guinea and Mali, Ivory Coast, Kenya, Liberia and Ghana.

Women from Somalia, Sudan, Eritrea and Djibouti will often have had the Type 3, the most severe form of FGM. Women from other countries are more likely to have had Type 2 or Type I.

Grouping of countries by level and types of FGM

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

Professor Alison Macfarlane advised that in undertaking work to stop FGM it is vital to know as much about your community makeup as possible as reasons for carrying out FGM vary from country to country and even within different countries. In Sierra Leone some tribes will not practice FGM. Although infrequent in Ghana it is practiced by the Northern Tribes, and in

Nigeria it varies considerably between regions of the country. While generally FGM is associated with lower educational levels, in Nigeria it is associated by higher levels of education. She recommended making use of the data she has produced combined with further local investigation into the origins of the Southwark community in order to plan interventions.

Estimated numbers of women and girls born in FGM practising countries with FGM, Southwark, 2011

Country group	Under 15	15-49	50 and over
1.1	43	990	237
1.2	84	2,278	545
2	73	1,804	683
3	1	104	57
All	**202**	**5,176**	**1,523**

Source: Author's analysis of ONS data

Angela Craggs Southwark Police FGM lead
Clarisser Cupid, Southwark Clinical Commissioning Group FGM Lead
April Bald, Southwark Council social care FGM lead

The officer leads for Southwark Social Care, the Police and NHS Southwark Clinical Commissioning Group (CCG) gave a joint presentation on the multi-agency work being undertaken to stop FGM.

An explanation was given on how agencies respond to incidents, and the referral pathway. Five examples were given:

- 17 year old from Sierra-Leonean presented at Sexual Health clinic – who reported unprotected sex with older man. She had had FGM aged 10 whilst back home.
- Adult sister from Sierra-Leone, who had FGM, called concerned about her 10 year old sibling.
- A GP referral regarding a Somalia mother who was concerned about her daughter who had FGM aged 7 back home, whilst living with her father and his wife
- The police were contacted by a friend of a pregnant Polish woman expecting a girl. The Nigerian partner wanted her to have FGM
- Immigration at Heathrow intercepted a child travelling with her mother who had paraphernalia in bag indicating possible cutting instruments

An explanation was given on how a child at possible risk is tracked through their minority and the methods employed to safeguard children, such as being

moved into immediate police protection if a child or young person is considered to be an immediate risk of being cut.

The law has recently been updated and strengthened. The first legislation was the 'Prohibition of Female Circumcision Act 1985, with a penalty of 5 years imprisonment. With the introduction of The Female Genital Mutilation Act in 2003 the penalty increased to 14 years imprisonment and added extra offences of assisting someone in the UK to arrange or assist FGM outside of UK, even if carried out by a person who isn't a UK national or resident.

New measures since May 2015 mean parents and guardians can now be held liable for failing to protect a child from FGM. The legislation granted lifelong victim anonymity, and introduced civil Female Genital Mutilation Protection Order. Despite these changes there have been no convictions under FGM legislation in the UK.

Mandatory reporting of girls with FGM has been included in recent legislation, and came into effect in October 2015. Much better data is now being collected and coming through from health services: on 1st April 2014 the first FGM Prevalence Dataset was published. All clinical staff must now record in patient healthcare records when it is identified that a patient has had FGM and all acute hospitals must provide monthly returns of on FGM prevalence.

In Southwark an FGM Steering Group started in June 2015 with partner agencies and the voluntary sector. This group intends to:

- Listen to the voices of victims and survivors of FGM to inform practice and Strategy
- Detailed data collection and analysis to inform practice and commissioning
- Consider innovative ways for the commissioning of services, e.g. mental health
- Work together to create and encourage community awareness
- Train and develop champions to support the work in schools and the community (male and females).
- Strong partnerships and referral pathways with local support organisations
- Training of all frontline practitioners including Primary Care – ensuring a workforce confident in undertaking thorough risk assessments and robust monitoring of children at risk throughout their minority
- Raise awareness in schools to encourage critical thinking and empowerment of young people.
- Increased use of Orders to protect and increased focus on the offenders
- Promote the ethos that FGM is a safeguarding issue and therefore should be treated as such

Toks Okeniyi, FORWARD

FORWARD was founded in 1983 in response to the continuing practice of FGM among migrant communities in the UK. They have been working ever since to frame the practice as a human rights violation, informing affected communities about the health implications and laws.

Forward is now one of the longest standing organisations tackling FGM in the UK and continue to work to support women affected and girls at risk of FGM through these key programmes:

- Community Programme: engaging affected communities through events, training and community development approaches

- Young People Speak Out!: empowering young people to help create change in their communities by providing skills, peer to peer training and support for youth advocates

- Schools Programme: offering a comprehensive range of services for schools to engage and empower young people about issues that affect them and raising awareness about the role that everyone can play in supporting girls and ending the practice.

- Training Courses for Professionals: offering a range of FGM training sessions, including accredited training for front line professionals including health, education, social services and the police, as well as to organisations from FGM practicing communities, and the voluntary sector at large.

Agnes Baziwe, African Advocacy Foundation

Africa Advocacy Foundation is a registered charity established in 1996 with the aim of promoting health, education and other opportunities for disadvantaged African and other BME people mainly in London. They support and empower some of the most marginalised individuals who often feel they have no active part to play in the society.

This includes identifying appropriate pathways to enable beneficiaries to address issues such as isolation, poverty and ill-health leading to independence and better quality of life. The main activities are a HIV programme, sexual health promotion, training and employment skills, and tackling FGM.

The FGM work includes:

- Children and family support
- Training for FGM Community Champions
- Group support and counselling for women with personal experiences of FGM
- Faith leaders and men specific discussions on FGM
- Community awareness campaigns

- Outreach, 1:1 advice, information, guidance and referrals
- Referrals to statutory services and others

The community outreach includes utilising sister circles, and working with madrassas & cultural centres. Community awareness raising workshops are held tailored to the language of the people e.g. Somali, Swahili, Yoruba, and Arabic.

The project trains champions of different ages, faith and beliefs, and develops faith leaders as champions. It works with men and young people from practising communities and survivors of FGM. It has directly supported 243 women in Southwark during 2014/15 .The initiative works with a wide range of Southwark faith based organisations (Muslim & Christian) and community groups.

The project holds events that focus on a number of issues in an engaging way, for example FGM is often discussed within the context of sexual health to reach a wider audience.

The project said they have identified a lack of knowledge on the health effects of FGM. Communities frequently feel there is interference without insight into issues. A lack of trust means that communities feel targeted. They advised that there needs to be more training and education within practising communities and there needs to be appropriate resources to facilitate learning in the community. Victims report there is a lack of FGM specialist knowledge making it difficult for women to seek appropriate advice and support and there needs to be more training for frontline professionals.

Florence Emakpose, World of Hope

World of Hope is committed to raising Youth Ambassadors that will become tomorrow's leaders through their mentoring, training, coaching, and citizenship programmes which equip young people to positively impact their communities. The project offers one-one support services to young people as well as group work activities, on issues such carrying weapons, teenage pregnancy, building confidence and improving family relationships. It works with young people on FGM directly seeking ambassadors to help end the practice and in July it held an African safeguarding children's conference, in partnership with CANUK , which in dealt with FGM.

Hawa Sesey – FGM survivor

The Scrutiny in a Day heard moving testimony from a survivor of FGM, Hawa Sesey, who explained how an elder relation carried out the procedure on her in Sierra Leone, the traumatic impact it had on her then as a young girl, and how it later affected her married life. She has worked for many years with in her community to end the practice and refused community pressure to cut her daughter.

Workshop 1 – Next Steps

The workshop participants made the following recommendations for next steps:

- Check multi-faith involvement in anti-FGM work
- Can social care be funded to follow through on children who have been known to have suffered FGM?
- Ring fence the funding? Could safeguarding money be diverted?
- Shift the effort into prevention
- Check teachers' awareness
- More joined up practice across the relevant agencies
- Involve embassies
- Be blunter about the damage done to victims
- Make it personal – talk to men and boys about what could happen to women and girls in their lives as a consequence of FGM
- Target strategies to different generations
- Make a real effort to understand the mind-set that accepts FGM

What could the committee work on?

- Propose a Southwark strategy on FGM with suggestions about what works – focussing on education, awareness raising & prevention
- Look for good practice on PSHE teaching re FGM and propose that to the Southwark headteachers
- Consider whether shock value can be deployed – use of images, use of personal stories
- Push for better recording – harder data required
- Ask Health & Wellbeing Board to support strategy
- Propose confidential helpline for people who wish to report concerns

Workshop 2: Action Research

28 Too Many – Louise Robertson

- FGM is a global issue

- Important to know your data and community in depth – need to know ethnicity
- FGM has a multitude of different issues and reasons for its practice so needs to be approached in different ways: e.g. is perpetrated & justified by reasons of perceived beauty, health, to control women's sexuality, as a punishment. Therefor it needs to be tackled with reference to all those issues: health, human rights, gender equality, etc.
- 28 Too Many have detailed country specific information to help build plans
- Keeping the survivor voice centre stage is crucial to understanding the issues and building creditability

Action Research – Ebony Riddell Bamber, Community Engagement

- Has to be conducted by experienced people in the community
- Reason is to come up with concrete proposals
- It addressed two questions:
  What is happening out there?
  What can we do?

Discussion points

Important to work with local organisations (e.g. African Advocacy Foundation and World of Hope) to understand existing knowledge

Need to establish what we know about our local community, and where the gaps are.

The statutory agencies have lead responsibility, but what about dialogue with communities

What about leadership from existing communities. E.g. Somalia community, what are the barriers to this happening

What is going to bring about cultural and attitudinal change?

Some practicing communities are emergent in this country and therefor particularly vulnerable to poverty, discrimination and are not fully integrated.

African Advocacy Foundation has community champions from Somali and Sierra Leona

Community groups have managed to engage successfully with the Muslim community, partly as they wanted to disassociate from the practice given high profile media association of FGM and Islamic faith – a statement was issued clarifying that FGM is not part of Muslim faith - however less successful engaging Christian community e.g. Nigerian Pentecostal churches

FGM is being driven by older aunties (female elders) and faith leaders

Community change is more effective if there is a process of development that involves and empowers members of the community.

Discussion on building resilience with children in schools via PSHE curriculum & Pastor Power versus the responsibility for change residing with adults and the wider community

Community action research could address some of these issues and questions.

A multifaceted approach is important e.g. law, persecution, child protection, information, with community & attitudinal change being one of the most important levers for change to end FGM.

Appendix two

FGM workshop with Coventry University on REPLACE 2

11 November 2015

Professor Hazel Barrett & Dr Katherine Brown, Coventry University, presented on the REPLACE 2 programme, a community based behaviour change programme to end FGM. The programme academics presented and then held a discussion with participants. The workshop participants were a mixture of committee members, community engagement officers, the social care FGM lead and staff from a local voluntary organisation, African Advocacy Foundation, which is working in Southwark to end FGM.

Participants:

- Cllr Jasmine Ali – Chair, committee member
- Cllr Sandra Rhule - Committee member
- Cllr Kath Whittam - Committee member
- Cllr Sunny Lamb - Committee member
- Martin Brecknell - Committee member
- Agnes Baziwe – African Advocacy Foundation
- Shani Hassan – African Advocacy
- April Bald – Social care FGM lead
- Sarah Totterdell – Community Engagement
- Kevin Dykes – Community Engagement

Summary of the presentation:

The European Parliament estimates that up to half a million women living in the EU have been subjected to FGM, with a further 180,000 at risk. 35 years ago WHO called for end to FGM. The WHO, United Nations (UN), UNICEF, and other anti-FGM organisations have adopted various strategies in order to raise awareness and work towards ending FGM. These have centred on four main approaches: bodily and sexual integrity; human rights; legislative; and the health approach.

Thirty years on since the WHO called for the ending of FGM there is conflicting evidence as to whether these approaches have led to a reduction in the practice. 15 years ago WHO called for application of behaviour change approaches to address FGM , however research concluded that there was a poor understanding of how to conduct this .

The original REPLACE project was initiated to explore existing applications of Behaviour Change to FGM and worked with affected communities to explore belief systems –and through this work a theoretical framework developed based on

behaviour change strategies A toolkit was produced in 2011 and this approach has been adopted by a number of European projects, as well as UK local authorities.

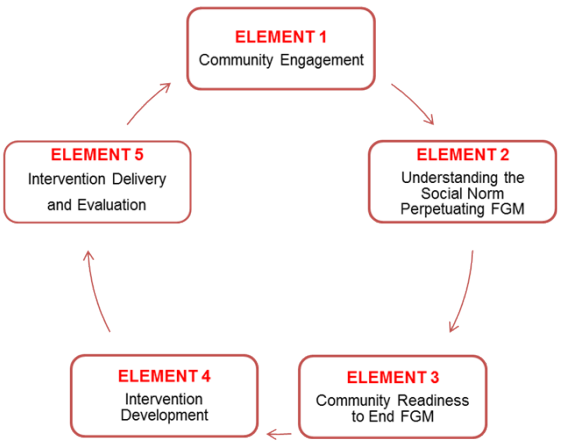
REPLACE 2 is the second round of an EU wider behaviour change programme which focuses on community engagement. The aims and objectives of REPLACE2 are to implement the REPLACE approach with 5 FGM affected African migrant communities in the EU, and following evaluation to develop and update the REPLACE approach applying recent and relevant developments from behaviour change and behavioural science.

There are seven European partners with different roles:

- Coventry University, UK – lead partner
- FORWARD UK – Sudanese women based in London
- FSAN, Netherlands – Somali women in Rotterdam
- Cabinet d'Estudis Socials, Spain – Senegalese & Gambian men and women in Banyoles
- APF, Portugal – Guinea Bissauan men and women in Lisbon
- CESIE, Italy – Eritrean & Ethiopian (Habesha) men and women in Palermo, Sicily
- ICRH, University of Ghent, Evaluation partner

The programme has worked with the above diaspora communities in Europe by engaging members of the practicing communities to understand the social norms that perpetuate FGM and then to provide intervention support to change beliefs and motivate social change. Coventry University lead the programme and Professor Hazel Barrett is the community participation expert and Dr Katherine Brown's speciality is behaviour change.

The REPLACE 2 programme uses a cyclic framework for Social Norm Transformation in relation to FGM.



Community engagement is the first step which is sustained throughout the programme. It is critical to the approach and focused on building a partnership with the community. The programme leads emphasised that building trust and relationships with communities takes time and it helps to identify key people from the community to come with you on the journey through the cyclic framework.

The second step seeks to understand the Social Norms that are perpetuating FGM. It is important to recognise that different communities have different beliefs systems and social norms and that these change over time. It is only possible to design interventions whose content and messages align with those belief systems and norms once these have been understood. The programme recommends use of Community-based Participatory Action Research methods (CPAR) to achieve this.

The third stage is an assessment of community readiness to end FGM. REPLACE use a model of 9 stages of readiness to change. Stages range from 1 'no community awareness of the issues associated with ending FGM' to stage 9 'high level community buy in to end FGM. Identifying the stage helps identify target actions or behaviours for intervention development.

The fourth stage is focused on Intervention Development. It involves considering all of the possible target intervention actions that may help to move community to next stage of readiness to change and selecting those that are most feasible and acceptable to community, but that will push the community to change. The programme works with the community to develop support to address their needs, drawing on what is known about their underlying beliefs systems and norms. Help is given to devise materials and content to help community members carry out the target intervention action

An example is the Dutch Somali community. They identified as between community readiness stages 3 and 4 at project start (3: Vague community awareness to 4: Preplanning). The target intervention action agreed was for that Koranic school teachers deliver lessons in Koranic school addressing the belief that FGM or 'little Sunnah' is not a requirement of Islam. Work with the community identified that Koranic school teachers' needed support to know how to deliver such lessons. Training and support was provided including helping them to develop a lesson plan and asking an Islamic scholar to talk to them about the core arguments.

The fifth and final stage is the Intervention Delivery and Evaluation. As the intervention is implemented, so evaluation is conducted. The REPLACE approach recommends a mixed methods approach that incorporates assessments, pre & post focus groups, questionnaires or scaled measures of beliefs that are targeted by intervention content and keeping records of actions, numbers of people reached, and numbers of new community members who want to get involved in future work based on engagement with each target intervention action.

A new toolkit has been produced as a result of REPLACE 2, and copies were distributed to attendees and are available here www.replacefgm2.eu

Conclusion

The workshop concluded with an offer by Coventry University REPLACE 2 programme offering to assist Southwark in adopting this approach, which was gratefully received by the attendees.

The session concluded with an agreement to undertake a following up meeting and to bring more partners in, including the Southwark's FGM Health lead, as a project like this would need a longer time frame and additional capacity than is possible for scrutiny to deliver in isolation.

Joint Health Overview and Scrutiny Committee
SLaM Place of Safety

Terms of reference

The Joint Health Overview and Scrutiny Committee (JHOSC) is constituted in accordance with the Local Authority Public Health, Health & Wellbeing Boards and Health Scrutiny Regulations 2013 (the "Regulations") and Department of Health Guidance to respond to a substantial reconfiguration proposal covering more than one Council. The JHOSC will scrutinise the proposal from South London and Maudsley NHS Foundation Trust (SLaM), and their commissioners, to change the current service model of Place of Safety provision within SLaM from four separate Places of Safety, for the boroughs of Southwark, Lambeth, Lewisham and Croydon, to one centralised Place of Safety, provided in Southwark for all four boroughs. The relevant commissioners for this proposal from SLaM are Croydon, Lambeth, Lewisham and Southwark Clinical Commissioning Groups (CCGs) and the Local Authorities social care commissioners from all four boroughs.

Context

Places of Safety are provided by SLaM for a number of people who are brought to hospital under Section 136 of the Mental Health Act (MHA). This is a power that police officers can use if someone is in a public place and the police have concerns about them. Across the SLaM there are currently four Place of Safety, or 136 Suites, where people can be brought, assessed and cared for. The four suites are located at each of SLaM's four hospital sites. Following an assessment in one of these suites, by a doctor and an interview with an Approved Mental Health Professional (AMHP), the person can either be discharged with or without referral for further mental health support, or admitted for further treatment.

The Joint Committee's terms of reference are:

1. To undertake all the functions of a statutory Joint Health Overview and Scrutiny Committee in accordance with the Regulations and Department of Health Guidance. This includes, but is not limited to the following:

    (a) To consider and respond to the proposals from SLaM for the provision of one centralised Place of Safety

    (b) To scrutinise the commissioners of the SLaM proposal and to seek assurance that the proposal is supported and that partnership arrangements between health & social care and across the boroughs are adequate

    (c) To scrutinise any consultation process

    (d) This does not include the power to make a report to the Secretary of State (under regulation 23(9) of the Regulations) in relation to the proposal from SLaM for Croydon, Lambeth, Lewisham and Southwark Councils. However, any individual authority may make a specific delegation to the JHOSC in

relation to their own power to make such a report on their behalf. The JHOSC will undertake to go through all the necessary steps needed to enable either collective or individual councils to exercise their power to refer to the Secretary of State

Membership

Membership of the Joint Committee will be two named Members from each of the following local authorities:

London Borough of Lambeth;
London Borough of Lewisham;
London Borough of Southwark;
London Borough of Croydon.

Members must not be an Executive Member.

Procedures

Chair and Vice-Chair

1. The Joint Committee will appoint a Chair and Vice-Chair at its first meeting. The Chair and Vice-Chair should be members of different participating authorities.

Substitutions

2. Substitutes may attend Joint Committee meetings in lieu of nominated members. Continuity of attendance throughout the review is strongly encouraged however.

3. It will be the responsibility of individual committee members and their local authorities to arrange substitutions and to ensure that the lead authority is informed of any changes prior to the meeting.

4. Where a substitute is attending the meeting, it will be the responsibility of the nominated member to brief them in advance of the meeting

Quorum

5. The quorum of the meeting of the Joint Committee will be 3 members, each of whom should be from a different participating authority.

Voting

6. It is hoped that the Joint Committee will be able to reach their decisions by consensus. However, in the event that a vote is required each member present will have one vote. In the event of there being an equality of votes, the Chair of the meeting will have the casting vote.

7. On completion of the scrutiny review by the Joint Committee, it shall produce a single final report, reflecting the views of all the local authorities involved.

Meetings

8. Meetings of the Joint Committee will normally be held in public and will take place at venues within South London. The normal access to information provisions applying to meetings of the Overview and Scrutiny committees will apply. However, there may be occasions on which the Joint Committee may need to make visits outside of the formal Committee meeting setting.

9. Meetings shall last for up to two hours from the time the meeting is due to commence. The Joint Committee may resolve, by a simple majority, before the expiry of 2 hours from the start of the meeting to continue the meeting for a maximum further period of up to 30 minutes.

Local Overview and Scrutiny Committees

10. The Joint Committee will encourage its Members to inform their local overview and scrutiny committees of the work of the Joint Committee on the SLaM Place of Safety proposal

11. The Joint Committee will invite its Members to represent to the Joint Committee the views of their local overview and scrutiny committees on the SLaM Place of Safety proposal and the Joint Committee's work.

Communication

12. The Joint Committee will establish clear lines of communication between itself, SLaM, the CCG, and local authorities. All formal correspondence between the Joint Committee, local authorities and the NHS on this matter will be administered by *Julie Timbrell , Southwark Council)* or *(other)* until such officer is appointed.

Representations

13. The Joint Committee will identify and invite witnesses to address the committee, invite comments from interested parties and take into account information from all the local Healthwatch organisations. It may wish to undertake further consultation with a range of stakeholders.

Support

14. Administrative and research support will be provided by the scrutiny teams of the 4 boroughs working together.

Assumptions

15. The Joint Committee will be based on the following assumptions:

    (a) That the Joint Health Scrutiny Committee is constituted to respond to SLaM Place of Safety proposal.

(b) SLaM, and their commissioners, will permit the Joint Health Scrutiny Committee access to the outcome of any public consultation.

OVERVIEW & SCRUTINY COMMITTEE **MUNICIPAL YEAR 2015-16**

AGENDA DISTRIBUTION LIST (OPEN)

NOTE: Original held by Scrutiny Team; all amendments/queries to Shelley Burke Tel: 020 7525 7344

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Councillor Catherine Dale	1	Norman Coombe, Legal Services	1
Councillor Paul Fleming	1	Aine Gallagher, Political Assistant	1
Councillor Tom Flynn	1	Niko Baar, Political Assistant	1
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Councillor Ben Johnson	1	Scrutiny Team SPARES	10
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Councillor Anood Al-Samerai			
Councillor Maisie Anderson			
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Reserves			
Councillor Evelyn Akoto			
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Councillor Helen Dennis			
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