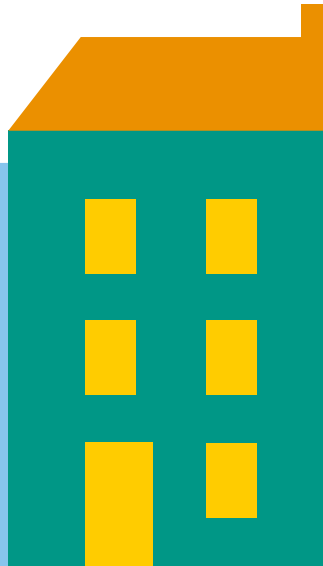
Start

Child House in a Box Toolkit



2nd Edition
January 2022

Contents

Back to main contents

click to this chapter

01 Foreword
02 Purpose of the Toolkit
03 How to use the Toolkit
04 Introduction: Setting the scene
05 Establishing the evidence base
06 Developing the vision for stakeholders
07 Making a multi-agency partnership work
08 Communications
09 Learning from victims, survivors and families
10 Delivering the Child House: Local Partnerships Guidance
11 Defining the operating model
12 Costing and budgeting
13 Commissioning and procurement
14 Governance
15 Estates and premises
16 Information governance in the Child House
17 Meeting the information technology requirements
18 Mobilisation
19 Evaluation/Measuring success
20 Long term sustainability
21 Ensuring continuity of care
22 Conclusions
23 Appendices

Back to previous view
Back to chapter page

Chapter 1
Foreword

Keeping children and young people safe from harm and providing support to those who have experienced some of the most traumatic events that can affect a child is one of my top priorities as Deputy Mayor for Policing and Crime.

I am delighted that the first Child House in the country, the Lighthouse, opened in North London in September 2018 as a pilot to see how the model could operate in this country. It represents a significant milestone for children and young people affected by child sexual abuse and exploitation. Based on the Child Advocacy Centres in the United States and the Barnahus in Europe, the Lighthouse has shown how children and young people can be offered the highest quality of care and support in a multidisciplinary environment, with several different agencies working together, based in one location.

The ambition to emulate international best practice and to see how the model might best be applied in this country could not have been met without the commitment and drive of a number of dedicated individuals working together across many different organisational boundaries. Despite the impact of the Covid-19 pandemic, the Lighthouse has continued to provide comprehensive support to vulnerable children and young people affected by sexual abuse.

I hope that this toolkit, which draws together so much of the learning from the piloting of the Lighthouse, and shows what we achieved in London, will help others elsewhere who are considering the establishment of Child Houses.

Sophie Linden
Deputy Mayor for Policing and Crime

Acknowledgements

This toolkit, produced by Claire Bethel of RedQuadrant for MOPAC, was developed with support from the Department for Education and the Home Office.

The toolkit draws on material set out in the CSA Hub Toolkit: a practical guide for commissioners and practitioners to establish a CSA Hub produced by NHS England published in March 2017. Many thanks are due to NHS England and the author, Emma Harewood, for giving permission to include this material and for her invaluable feedback and contribution to the development of this toolkit. Thanks are also due to the following for their painstaking comments:

Dr Deborah Hodes
Gareth Linington
Dr Victoria Mattison

Chapter 2
Purpose of the Toolkit

2.1 The purpose of this toolkit is to provide information and advice for areas on the journey to setting up and operating a Child House. The toolkit is not intended to be prescriptive but to present in one document what may be helpful, point to relevant guidance and to describe the lessons learned from setting up the first Child House in the country, the Child House in London, which is known as the Lighthouse.

2.2 Although much of the toolkit is based on the experience of developing the Lighthouse in London where the lead provider is a health trust, it is recognised that there may be other valid approaches to developing a child-friendly criminal justice and therapeutic response to child sexual abuse. It is for each area to develop its own approach taking account of the Child House Commissioning Guidance to be published by the Home Office and the framework set out in this toolkit.

Chapter 3
How to use the Toolkit

3.1 The toolkit is an interactive PDF which facilitates an easy way of linking to related sections of the document. The index at the start of each chapter provides an easy means of navigation around that chapter.

3.2 Chapters are divided into general issues for areas setting up a Child House followed by a description of what was learned from setting up the Lighthouse in London. Some chapters have a separate section on operating the Lighthouse. Key learning points and a checklist are included in each chapter. The toolkit also includes links to a series of short films which comprise interviews with members of staff, and children and young people who have used the Lighthouse and parents or carers.

3.3 Depending on your browser the films are viewable within the PDF. If not, there is a link to the side of all films which will take to you to YouTube for viewing.

3.4 The toolkit contains many useful links; many of the documents are hosted on the following website **www.london.gov.uk/mopac/child-house-toolkit-resources**

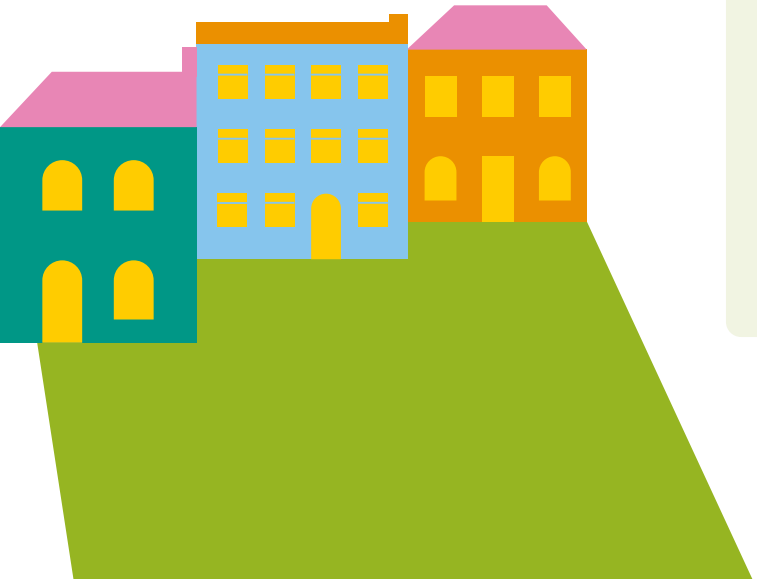
3.5 Wherever possible, references are given as both hypertext links and as a reference to the relevant document or website.

3.6 It should be noted that the toolkit is up-to-date at the time of being published but that it will not reflect subsequent developments at the Lighthouse in London or at Child Houses in progress elsewhere. This is the second version of the toolkit published originally in September 2022. It reflects the final outcome of the pilot and the last stages of the evaluation.

3.7 Children and/or Young People are abbreviated to CYP throughout this report.

Chapter 4
Introduction: Setting the scene

What this chapter tells you:



Chapter 4: Introduction

Setting the scene

4.1 Bringing together a range of services under one roof, the Child House is a child-friendly, multi-disciplinary service for children and young people (CYP) who alleged sexual abuse including exploitation (CSAE) at some time in their lives.

4.2 It aims to optimise criminal justice outcomes, provide timely access to medical and therapeutic support for victims and survivors and non-offending members of their families, and to reduce the risk of retraumatisation.

4.3 The first UK Child House in London opened in October 2018 and is based in Camden in North Central London. Called the Lighthouse, it serves the needs of CYP and their families from five London boroughs (Barnet, Camden, Enfield, Haringey and Islington).

4.4 The Child House is based on international models – in particular, the Child Advocacy Centre model developed in the US in the 1980s and the Barnahus (Children's House) model adapted from the CAC model used in Iceland since 1998. More detail is given on these models in **paragraphs 5.19-5.22**.

4.5 This toolkit is based largely on the experience of developing the Lighthouse in London, England, where the lead provider is University College London Hospital NHS Foundation Trust (UCLH). The Lighthouse is an all-encompassing Child House, bringing together a broad range of services into one setting – health services, criminal justice services and social care. It is not the only possible model for delivering a child-friendly criminal justice, medical and therapeutic response to child sexual abuse. For example, many of the Child Houses in Scandinavia are police-led and some of the Child Advocacy Centres in the US are set up as non-profit organisations. It is for each area to develop a service that takes into account existing services already in the locality and able to incorporate the **Child House: Local Partnerships Guidance**, published by the Home Office, see **chapter 10**.

4.6 The Government's **Tackling Child Sexual Abuse Strategy (2021)** sets out the overarching strategy for CSA in England and Wales.[1] Definitions of sexual abuse[2] and child sexual exploitation[3] are set out in the government guidance, **Working Together**. A **typology of child sexual abuse offending**[4] has been developed by the Centre of Expertise on Child Sexual Abuse setting out nine types of child sexual abuse.

The need for a Child House

4.7 CYP who have been sexually assaulted, abused or exploited need a range of services to help them on the road to recovery and to enable them to seek judicial redress easily and without being retraumatised. It has been recognised for some time that there are many challenges for CYP in this country in accessing the care and support that is needed[5].

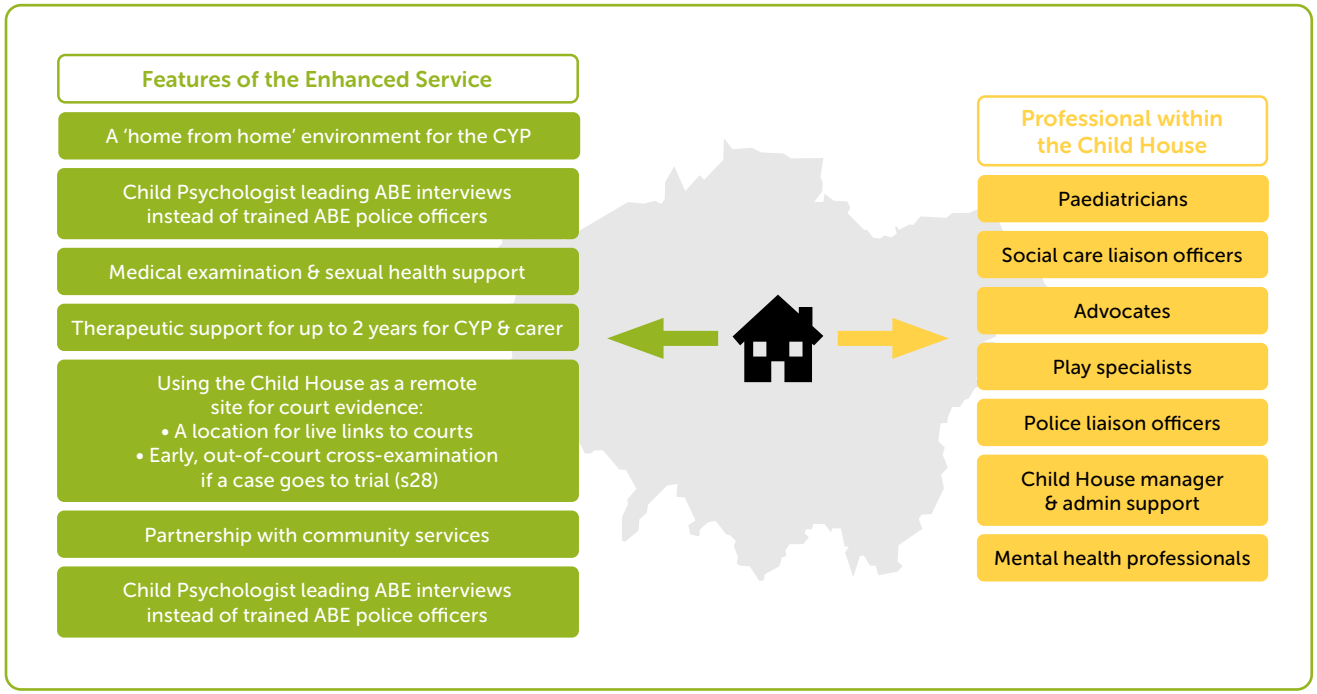
4.8 A number of reports have commented on the need for more specialist provision, the extent of unmet need, the varying rates of disclosure and the complexity of the services to be navigated in obtaining access to care and to seek justice through criminal justice processes[6,7,8].

4.9 In London, it was recognised that more support was needed to support survivors and victims of CSAE and to reduce the risk of retraumatisation through court processes and the need for the child or young person to constantly repeat their story[9]. The outcomes that the pilot was seeking to achieve included:

- Improved referral pathways into and out of the Child Houses;
- Improved CYP, family and carer experience of support received during and after disclosure;
- Improved health and well-being outcomes for CYP (mental and physical health);
- Improved professionals' awareness, competence and confidence in working with CSAE, in the Lighthouse, locally and nationally;
- Improved CYP experience of the criminal justice process post-disclosure from reporting to prosecution and conviction;
- Increased likelihood for CYP who received a Child House service to have cases charged by CPS;

- Better quality of evidence;
- Increased effectiveness of cases heard in court, increasing the likelihood of conviction;
- Improved partnership and interagency working.

4.10 The Lighthouse's **first and second annual reports** describe the first two years of service and give details of who has used its services and their experience of the support offered[10,11]. This includes data from the comprehensive evaluations being carried out by MOPAC (see **chapter 19**)[12,13].



Source: Child House Evaluation Plan, MOPAC Evidence & Insight February 2018

Covid-19

4.11 During the lockdown due to the Covid-19 pandemic, the Lighthouse building was closed except for CYP who needed an urgent examination or police interview, and all work moved to virtual appointments. During these times staff were creative and C&YP were offered support and therapeutic interventions by video call with one or more practitioners, telephone, text or voice memo. Virtual sessions were offered to new referrals though many chose to wait until the Lighthouse reopened to routine cases which it did in June 2020. However, the coronavirus pandemic resulted in 50% fewer referrals during April/May but this soon returned to normal rates of referral in June. This impacted on the pilot in terms of the numbers who were seen face-to-face and the way in which interventions were delivered as well as the ability to carry out the evaluation. Criminal justice interventions continued during the lockdown by virtual means. The final evaluation includes more details on the lessons learned during the pandemic.

End Notes

1 See assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973236/Tackling_Child_Sexual_Abuse_Strategy_2021.pdf

2 Sexual abuse Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children. See Working Together: A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children, HM Government, July 2018.

3 Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology. Ibid.

4 A typology of child sexual abuse offending, The Centre of expertise on child sexual abuse in collaboration with the Centre for Abuse and Trauma Studies, Middlesex University, March 2020. See https://www.csacentre.org.uk/documents/new-typology-of-child-sexual-abuse-offending/

5 See, for example, Protecting Children from Harm, A critical assessment of child sexual abuse in the family network in England and priorities for action; full report, pages 8-9; Children's Commissioner for England (November 2015).

6 Ibid.

7 Allnock, D. et al, Sexual abuse and therapeutic services for children and young people: The gap between provision and need, Executive summary; NSPCC www.nwgnetwork.org/wp-content/uploads/2017/11/6c0404f7ea1e4731f4c171d2619e79b280a3.pdf

8 Centre of expertise on child sexual abuse, Key messages from research on identifying and responding to disclosures of child sexual abuse, page 2 www.csacentre.org.uk/index.cfm/_api/render/file/?method=inline&fileID=7C7BB562-DB13-4C7E-B8C21D04920D6AEF

9 Goddard A, Harewood E, Brennan L, Review of Pathway following sexual assault for children and young people in London, King's College Hospital NHS Foundation Trust, NHS England (London), March 2015, see www.england.nhs.uk/london/wp-content/uploads/sites/8/2015/03/review-pathway-cyp-london-report.pdf

10 The Lighthouse Annual Report 2018-2019. See www.thelighthouse-london.org.uk/guidance-and-support-for-professionals/downloads-links-for-professionals/

11 The Lighthouse Annual Report 2019-2020. See www.thelighthouse-london.org.uk/wp-content/uploads/2021/04/lighthouse-Annual-Report-2020-web-version.pdf

12 The Lighthouse: London's Child House Initial Evaluation Report, MOPAC Evidence and Insight, December 2018, see www.london.gov.uk/sites/default/files/childhouse_jan19_report.pdf

13 The Lighthouse: 9 month evaluation report (September 2019), MOPAC Evidence and Insight. See www.london.gov.uk/sites/default/files/2019_117_childhouse_2nd_evaluation_report_for_publication.pdf

Chapter 5
Establishing the evidence base

What this chapter tells you:

Evidence of need

5.1 There has been an increase in reported cases of CSAE in England and Wales as well as other countries in recent years with abuse-related contacts to the NSPCC having increased[1]. There is no source providing the current prevalence of child sexual abuse[2]. The Crime Survey for England and Wales provides the best available indicator by measuring the prevalence of adults who experienced sexual abuse before the age of 16 years. This is likely to be an underestimate as abuse against 16 and 17 year olds is not included. However, it is thought that all types of sexual violence affect around one in five children before the age of 16 years.[3] According to ONS, 7.5% of adults are estimated to have experienced sexual abuse before they were 16 – approximately 3.5% of men and 11.5% of women[4,5]. Based on surveys that ask children and adults about their experiences of CSA, the CSA Centre suggests the prevalence could be higher[6]. Figures of the precise prevalence of CSAE are contested[7], partly due to its hidden nature but also because some victims are unable to recognise that they are being abused and adults do not always spot the signs that abuse is taking place[8].

5.2 There is also increased recognition of the impact of CSAE on CYP and that this constitutes a significant public health problem given its prevalence[9]. It is recognised that young people who have experienced abuse may have undetected health care needs including higher levels of post-traumatic stress reactions, depression, dissociation and physical health complaints[10]. The impact of Adverse Childhood Experiences (ACEs), including abuse, on many long-term outcomes including physical and mental health[11] is seen as highly significant. Attempts to measure the cost of all ACEs to the economy reveal that the cost to public services are likely to be extremely high (up to $581bn in Europe per year).[12]

5.3 Research on CYP's experiences of CSAE is a rapidly developing area, and knowledge and experience about best practice has advanced considerably. There is also growing interest in how to measure the scale of CSAE[13]. In recognition of the lack of meaningful high quality and up-to-date data to inform decision-making, the Centre of Expertise on Child Sexual Abuse (www.csacentre.org.uk) is aiming to increase understanding and awareness of the scale and nature of child sexual abuse. Work is also in hand to review the way in which the data currently collected in England and Wales could be improved.[14] The Centre provides a great deal of useful information which can be useful in forming a picture of need.

5.4 Approximately two thirds of child sexual abuse, where it is recorded, is shown to have taken place within the family[15]. Over recent years, there have been steep increases in reporting of CSA to the police. Over 83,000 CSA offences (including obscene publications) were recorded by police in the year ending March 2020, in England and Wales, an increase of approximately 267% since 2013. Of these, around 58,000 would be considered contact offences, which have increased by 202% over the same period.[16] It is not known whether this rapid increase is due to increased prevalence, improved police recording, or due to increased willingness to report abuse.

5.5 The impacts of CSAE are known to be significant and long-lasting, affecting the short and long term outcomes of the individual child or young person and many aspects of his or her life, including physical health[17]. Adult survivors are known to have an increased risk of mental health problems, with higher rates of PTSD, lower life satisfaction, greater likelihood of sexual risk-taking behaviours and an increased dependence on welfare[18].

5.6 Victims and survivors of CSAE[19] require specialist care and a response from a number of agencies including:

- NHS
- Police
- Other criminal justice agencies
- Children's social care
- Voluntary and community sector.

As a result of no single agency being responsible for all elements of the pathway, services can be disjointed with a lack of co-ordination between them.

5.7 In addition, it is thought that only 1 in 8 victims of CSAE are known to statutory authorities[20]. Concerns have been raised by many experts and organisations about the lack of support for CYP who have experienced CSAE[21]. A report published by the Children's Commissioner into child sexual abuse in the family network in 2015 found a range of reasons why it is difficult for CYP to disclose and for professionals to respond appropriately to allegations of sexual abuse[22].

Assessing need

5.8 Data from social care and police will contribute to an estimate of the level of need in an area in order to decide whether a Child House is needed and where it should be located. Whilst it is difficult to establish the precise level of CSAE as it is frequently hidden, many sources of information should be analysed to give an indication of the number of CYP affected and to build a profile of need.[23]

5.9 Undertaking a local needs assessment should start with collecting data and with seeking the views of local professionals, experts, adult survivors, children and families to find out their opinions, their perceptions of the gaps and their views on best practice models. This will direct the context and content of a local needs assessment which should map the current and future demand for services to support CYP (including those seen by the police and at the Sexual Assault Referral Centre) and their families who allege CSAE. National data sets and research can be extrapolated to local populations to give a local estimated prevalence. Local activity data from providers and other agencies can provide current known demand. Public Health teams can support the needs assessment as part of the development of the Joint Strategic Needs Assessments (JSNA), which sets out the epidemiology and local knowledge of health needs. In addition, this mapping should include a review of the current services and capacity within those services.

5.10 Demand and capacity mapping at a local level could include the following:

- Mapping all of the current physical and mental health services provided for child and adolescent victims of CSA, CSE and Female Genital Mutilation (FGM), including: CAMHS providers, sexual health clinics, community and hospital paediatricians, independent/voluntary sector services, school counselling services and others
- Undertaking a gap analysis of services considering location, service types (e.g. services that are age- specific) and identify elements of the pathway that are missing
- Estimating the existing capacity in provider services
- Estimating current demand from activity data and local audits
- Predicting future demand using national trends and impact of improved local pathway raising awareness amongst professionals and public.

5.11 The **Tackling Child Sexual Abuse Strategy (2021)** sets out the overarching government strategy for CSA in England and Wales.[24] Other useful data sources for mapping CSA services and need include:

National:

- **Survey of mental health in children and young people in England, 2017**[25]
- National prevalence statistics on CYP e.g. Department for Education **Children In Need national statistics**[26]

Local:

- Joint Commissioning Strategy for mental health services and/or children's services
- Bespoke surveys and case note audits from providers to identify CYP experiencing sexual abuse
- Joint Strategic Needs Assessment (JSNA)

- Ofsted reports for local providers
- CAMHS transformation plans
- Other reviews e.g. Review of the pathway following Children's Sexual Abuse in London[27] (see **paragraph 5.12**)
- Provider activity data e.g. KPIs Data Return, Local Authority Annual CSE report
- Information from local safeguarding partnerships[28] including their annual report

What works in treating children who have experienced CSAE

5.12 CYP and non-abusing family members need high quality, trauma-informed care following experience of CSAE. A multiagency response is required to support the child or young person, their siblings and family or carers. *Working Together to Safeguard Children* (2018) sets out the roles and responsibilities of all agencies involved in safeguarding and promoting the CYP in their area[29]. Although further research is needed into establishing what is effective in treating CYP who have experienced CSAE, the **NICE guideline on child abuse and neglect** summarises what treatment can be provided, including early help and therapeutic interventions for children, young people and families after child abuse and neglect[30]. Clinical examination of abused adolescents should include screening for trauma symptoms and physical health complaints[31].

5.13 One option for support following sexual abuse includes individual or group-based trauma-focused Cognitive Behaviour Therapy over 12 to 16 sessions for CYP who have been sexually abused and who are showing symptoms of anxiety, sexualised behaviour or Post-Traumatic Stress Disorder. However, group sessions are not recommended for CYP still in the criminal justice process and awaiting trial[32]. The NICE guideline on child abuse and neglect (paragraph 1.7.1) specifies that this should be discussed fully with the child or young person beforehand and it should be clear that other options are available if preferred.

5.14 If the child or young person has an open criminal justice investigation, then the option of individual therapy is preferable and should be discussed with the police and CPS, in line with **Pre-Trial Therapy Guidance** from CPS. The best interests of the child are the paramount consideration in decisions about the provision of therapy before a criminal trial.

5.15 For CYP who are aged 4-17 and living with a safe carer, an intervention such as *'Letting the Future In'* should be considered in keeping with the NICE guideline. For girls aged 6-14 who have been sexually abused and who are showing symptoms of emotional or behavioural disturbance, NICE recommends individual focused psychoanalytic therapy or group psychotherapeutic and psychoeducational sessions[33].

5.16 For CYP who may be at risk of or are experiencing sexual exploitation, an intervention such as the NSPCC's *'Protect and Respect'* may be used[34]. This provides awareness raising group work which includes learning about healthy relationships and consent, and support and protection where there are concerns that a child or young person is experiencing exploitation.

5.17 Separate trauma-focused cognitive behavioural therapy sessions for the non-abusing parent or carer should also be offered. This will help them to support the child's attendance at therapy and to address issues with the family[35].

5.18 The **NICE guideline on Post-traumatic stress disorder (PTSD)**[36] sets out a range of interventions appropriate for the prevention and treatment of PTSD in CYP.

5.19 There are many other NICE guidelines and quality standards that relate to CSAE and the impact of trauma. These include guidelines on depression, anxiety, self-harm, sexually transmitted infections, and domestic violence and abuse (see **www.nice.org.uk**). Further guidance is provided by the Royal College of Paediatrics and Child Health (including guidance on the Physical Signs of Child Sexual Abuse[37]) (2015) on CSA medicals. The Centre of Expertise on Child Sexual Abuse (the CSA Centre) contains many evidence-based reviews and helpful online resources (see **www.csacentre.org.uk**).

The NWG Network Child Sexual Exploitation Response Unit's website (www.nwgnetwork.org) also contains useful resources focusing mainly on child sexual exploitation.

Evidence on the Child House model

5.20 The London CSA pathway review recommended that there should be 3-5 Child Houses across London. This model is in line with international best practice. The aim of the Child House, based on the Child Advocacy Centres in the US and the 'Barnahus' in Iceland, is to provide a child-centred and holistic service across the whole pathway – from disclosure or suspicion of sexual assault or abuse, through investigation, medical examination and emotional support[38].

5.21 The Child Advocacy Centres (CAC) in the US, Canada and Australia have been operating since 1985 and are widely regarded as best practice in supporting CYP who have experienced all forms of child abuse. They offer safety, security and a range of victims services for children and families exposed to violence and abuse. They bring together a range of different agencies – law enforcement, child protection, prosecution, mental health, medical and victim advocacy professionals – 'to investigate abuse, hold offenders accountable and, most importantly, help children heal from the trauma of abuse.'[39] Research into CACs in the US has found positive results, particularly around reducing the trauma experienced by victims of CSA, and improving levels of satisfaction with the overall service for both children and parents[40]. To find out more about CACs see National Children's Alliance[41] which supports more than 900 CACs.

5.22 The Barnahus ('Children's House') model was developed in Iceland in 1998, inspired by the CAC model, and has since been adopted in many other European countries. Like the CACs, it brings together professionals from several different disciplines to provide support for CYP who allege or have experienced sexual abuse or exploitation. The Child House model spread from Iceland, initially into the other Nordic countries where there are now more than 50; there are now many throughout the EU with many more in development. Other countries, including Australia, Israel and Turkey, also have CACs. For further information about the Barnahus in Iceland and the Nordic Region, see the case of the Barnahus model in the Nordic region[42] and a comprehensive presentation on the Barnahus[43] (see also paragraph 5.25 – 5.27). A report by the Children's Commissioner[44] for England into the way that the Barnahus could improve the response to child sexual abuse in England and a visit made by her to the Barnahus in Iceland led to her strong support for the establishment and rolling-out of the model in England.

5.23 The Barnahus provides interviews and therapy for children from the age of 3 to 18 years of age. All children presenting at the Barnahus have already reported child sexual abuse or domestic abuse. Judges are allowed to assume responsibility for the interview process in cases of alleged CSA. The police refer the case to a judge, and a prosecutor and defence lawyer are immediately appointed. The interview occurs within one to two weeks of the allegation. Where the allegation is not clear, the case is referred directly to the Barnahus for an exploratory interview.[45] The Barnahus model has been found to play an important role in the treatment of adolescent abuse victims[46].

Children and young people with sexually harmful behaviour

5.24 Given that some CYP who experience CSAE can also display sexually harmful behaviour, a Child House will need to consider how it assesses and supports these CYP. Sexual behaviours can be defined as those expressed by CYP under the age of 18 years old that are developmentally inappropriate, may be harmful towards self or others, or be abusive towards another child, young person or adult[47]. As with other forms of child sexual abuse, online sexual abuse may also be a factor. Understanding what is normal sexual behaviour for the child or young person's age group is an important consideration (see the Brook sexual behaviours traffic light tool[48]). Working with specialist services with

expertise in this area, such as the NSPCC, may be helpful. See the NSPCC's **Harmful Sexual Behaviour Framework**,[49] **NICE guideline**[50] on harmful sexual behaviour among CYP and the Lucy Faithfull Foundation **harmful sexual behavious prevention toolkit**[51].

5.25 By placing the child or young person's needs at the centre and not labelling them as a perpetrator, a Child House can identify the most important support for a child or young person at a given time. This will necessitate a careful assessment and diagnosis as to where the child or young person falls on the spectrum of harmful sexual behaviour and whether he or she may also be a victim of CSAE. A Child House will also need to consider risk assessment when CYP attending the service are displaying sexually harmful behaviour to consider whether they may present a risk to other service users, to sibling groups and/or to his or her peers, including those in school and the wider community.

Learning from Child Houses overseas

5.26 A European initiative, **EU Promise**, brings together project partners from across Europe which have established, or are in the course of establishing a Child House (see **chapter 10**). This initiative provides standards, learning and best practice as well as invaluable information on the Child House movement[52].

5.27 The way in which the Child House model is adapted to each country is inevitably a consequence of its existing child care and legal systems. Importantly, Iceland has an inquisitorial legal system in contrast to the adversarial system in the UK, and some of the legal issues which have arisen in setting-up the London pilot have therefore differed from the Icelandic experience. Nevertheless, there is much that can be learned from the experience of Child Houses overseas and there have been some useful evaluations of their operations, funding and outcomes. See **Snapshot of CACs in the US**[53] and **the success story of the Barnahus model in Europe**[54] and Collaborating against child abuse: exploring the Nordic Barnahus model[55]. For evidence of the efficacy of the CAC model, see **Evidence for the efficacy of the CAC model**[56].

5.28 The key lessons from the CACs and Barnahus include the value of co-locating services on one site; the importance of designing a child and young person-friendly environment and ensuring that there is sufficient space for the activities that take place. The staffing model developed in the CACs and Barnahus was also adapted for use in the Child House in London (see **chapter 11**). The practice of holding a psychologist-led Achieving Best Evidence interview at the Child House was based on the Barnahus in Iceland where this has proved highly successful.

The London position

Evidence of need

5.29 Whilst it is difficult to obtain definite data on the number of children who report to health services because of CSA[57], there has been a 67% increase in reporting between 2011/12 to 2017/18 (from 2,208 to 3,685 cases[58]). The Metropolitan Police Service (MPS) carried out nearly 16,000 investigations into child abuse during 2016/17; nearly 1,600 children in London have been identified by the MPS as being at risk of sexual exploitation[59]. In the average London Borough, around 11,000 adult women and 3,500 adult men are thought to be survivors of CSE[60]. A review of a sample of rape cases in London found that 31% of rape and sexual assault victim-survivors were aged 18 and under[61].

Assessing need in London

5.30 In 2015, MOPAC and NHS England (London region) commissioned a report looking at the **various pathways for children and young people who had experienced CSAE in London**[62].

5.31 This coincided with an **independent review** into the investigation and prosecution of rape in London led by Dame Edith Elish Angiolini[63]. The pathways report identified variation in the services available across London and found that there were gaps in medical provision, emotional support and in the prosecution process.

5.32 In order to establish the level of need across London, MOPAC and NHS England (London) jointly commissioned a needs assessment on **sexual violence**[64] and **child sexual exploitation**[65]. The findings, published in 2016, were used to inform the **Mayor of London's Police and Crime Plan for 2017-2021**[66] and provided evidence of the challenges faced in London including the gaps in service provision that needed to be addressed. This was also then reflected in the Violence Against Women and Girls strategy for London which set out the Mayor's priorities for the next four years including the establishment of the Child House. The analysis of the gaps in provision proved to be valuable evidence in establishing the Child House pilot.

> *In partnership with NHS England and the MPS, MOPAC will open London's first Child House – providing investigative, medical and emotional support in one place to young victims of sexual violence.*
>
> A Safer City for Women and Girls – Mayor of London (page 85)

5.33 The report on pathways in London also identified inequity in the services commissioned for CYP in London who had experienced CSAE[67]. Difficulties in accessing child and adolescent mental health services (CAMHS) were also identified with long waits found to be a particular issue in some areas as well as difficulties in meeting the criteria for referral. Stakeholders had identified difficulties in accessing support for CYP as well as their families following sexual assault and workers found that young people often did not wish to engage with CAMHS following abuse[68].

5.34 The police had reported concerns about being able to access social workers, shift changes at the end of the school day and the need for the child to repeat their story several times[69]. Criminal justice outcomes were considered to be poor with low prosecution and conviction rates and it was felt that the court processes were the cause of significant retraumatisation for the child or young person. A trial had been established in the London Borough of Kingston under section 28 of the Youth Justice and Criminal Evidence Act (YJCEA) 1999 to pre-record the cross-examination of a child before the trial so that there was no need to give evidence at the time of the trial. This was in line with international models such as the Barnahus in Iceland.

5.35 In addition, the NSPCC were commissioned by the five CCGs across the sector to analyse data relating to CSAE[70]. This was intended to:

- estimate prevalence of CSA and CSE and, building on this information,
- to map the current demand and identify spare capacity for services to support victims of CSAE
- to make assumptions for staffing levels for a Child House.

The study found there to be potentially around 16,000 victims of contact sexual abuse across the sector based on a reported prevalence of 4.8% of children experiencing contact sexual abuse.

More recently, the number of victims reporting CSA to the police in North Central London (from October 2018 – September 2019) is recorded as follows[71]:

Barnet	157
Camden	105
Enfield	200
Haringey	197
Islington	113
TOTAL	**772**

Existing provision in London

5.36 The main source of support for people of all ages in the immediate aftermath of sexual assault in London is provided through the Police, Children's Social Care and the Children and Young People Havens service. The CYP Havens Service opened in April 2016 and was the first recommendation of the London CSA pathway review[72] (see Launch of CYP Havens Service[73]). It built upon the existing service which was limited to forensic examinations only for under 13 year olds, with adolescents also able to access medical and advocacy care up to one year post assault. The CYP Havens Service is a 24/7 one-stop shop which provides a range of services including forensic medical examinations, follow-up sexual healthcare, and access to child psychology and advocacy/ISVA services. It also runs a professionals helpline to triage children in appropriate local services where they exist. Originally commissioned to support children reporting a sexual assault that occurred in the last 3 weeks, the service now offers access for up to one year post-assault in line with the offer for young people and adults.

5.37 The Havens are jointly funded by NHS England (London) and the Mayor's Office for Police and Crime (the Police and Crime Commissioner for London) as they are (in London) primarily health facilities which provide access to high quality clinical care as well as forensic services where criminal justice proceedings may ensue. 718 CYP have used this service in the past year (2019/20)[74].

CSA Transformation Programme

5.38 The review of the London CSA pathway led to the setting-up of a three year CSA Transformation Programme looking at the provision of sexual assault services for CYP across London. This included the development of plans to set up CSA Hubs in each of the five geographical sectors in London. The CSA Hubs (see **paragraph 5.40** opposite) were recommended in the review of pathways as a precursor to the Child House approach[75]. In addition, the recommendation to set up a Paediatric Havens Plus (later called the CYP Havens Service) was accepted and the CSA Transformation Programme enabled this to be established in Camberwell in April 2016 for those who had experienced acute sexual assault (and therefore needed forensic services, including the gathering of DNA evidence). The CYP Havens service (see **paragraph 5.35**) provides services across London.

5.39 Some of the key differences between a CSA Hub and a Child House are the greater involvement of criminal justice, including judicial services, and the long term therapeutic support available for children and their family. As with the Child House model in other countries, the intention was to hold forensic interviews at the Child House and, if a court appearance was still necessary, for the child or young person to give evidence by live link from the Child House during the trial or pre-recorded under the section 28 model.

CSA Hubs

5.40 CSA Hubs were developed in order to provide a one stop shop for medical treatment, advocacy and early emotional support for CYP who have experienced sexual abuse where there is no need to collect DNA evidence. The hubs are also intended to support non-abusing family members and carers, providing case management, and offering advice and guidance to police and social care services[76].

5.41 CSA hubs were established in North Central London and South West London in 2016 (support for the other three sectors was provided in 2018, learning from the outcomes of the first two CSA Hubs). The North Central London CSA Hub proved an invaluable foundation for the Child House, providing a range of additional services that were not available on one site before, including the provision of a holistic team assessment with doctor, advocate and/or CAMHS practitioner as well as a 'case-holder' to provide early

emotional support and help in navigating local services[77]. The CSA Hub Toolkit provides further details and practical guidance for those wishing to establish a CSA Hub[78] and the review of the CSA Hub model, included in the CSA Learning Report[79], provides valuable insight into what works, the challenges and learning.

CYP Havens

5.42 The CYP Havens Service (which includes the Sexual Assault Referral Centre) provides a wide range of services for CYP who have been sexually assaulted within the last year (or last 3 weeks for under 13 year olds). The services provided include a holistic paediatric assessment with a paediatrician or crisis worker or advocate, sexual health screening, early emotional support, case management and referral out to local long term services.

5.43 Further details as to the differences between CSA hubs, CYP Havens and the Child House models in London are set out in the CSA Learning Report, see pages 12-13[80].

Learning about the Child House model

5.44 Several of the staff involved in the setting-up of the Lighthouse have visited CACs in the US and Canada and the Barnahus in Iceland to learn more about the way in which they operate and how they have improved outcomes for children who have been abused. They have established close links with the staff in those centres which have provided opportunities for joint learning across international boundaries.

Operating the Child House

5.45 During the first year of operation, 363 referrals were received. The referral rate to the Lighthouse for the different boroughs compared to the total number of offences reported to the police varied from 34 to 73%. This means that around 50% of CYP in the sector are now offered health and care support after reporting sexual offences (it was previously 1 in 4).[81]

Key learning points

- Establishing the level of need in an area is key to decide whether a Child House is going to be the most appropriate solution in an area and where it is best located. Many different sources of information should be used and analysed to indicate the number of children and young people affected and to establish need. Commissioning a separate needs assessment, if resources allow, can be useful in informing decision-making locally.
- National data sets and research can be extrapolated to local populations to give a local estimated prevalence of CSAE. Local activity data from providers and other agencies can provide current known demand.
- Children and young people and non-abusing family members need high quality, trauma-informed care following experience of CSAE. A range of guidelines and quality standards are available which show what is known to be effective in the provision of services for children and young people who have experienced CSAE.
- The Child House model is derived from best international practice, specifically Child Advocacy Centres and the Barnahus – there is a great deal of useful literature from the work that has been done overseas which can help to shape local models despite the differences between safeguarding and judicial processes between the different countries.
- Building on the work of local Sexual Assault Referral Centres as well as existing strategies on CSA and CSE and projects carried out locally will be helpful starting-points.

Checklist for setting up a Child House

- ○ What evidence is there of need (health including from the Sexual Assault Referral Centre, criminal justice data, children's social care) for both child sexual abuse and child sexual exploitation?
- ○ Have local professionals, experts, adult survivors, children and families been engaged in discussions to find out what they think is needed, evidence of any gaps in accessing services (eg: long waiting times) and their perceptions of the gaps and best practice models?
- ○ Have local data sources on demand for services and the capacity of existing services been analysed (including from health, public health, criminal justice and the local authority)?

End notes

1 Office of National Statistics, Child abuse extent and nature, England and Wales: year ending March 2019. Page 9. (14 January 2020). See www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/childabuseextentandnatureenglandandwales/yearendingmarch2019

2 Office for National Statistics, Child sexual abuse in England and Wales: year ending March 2019, op cit. Page 4. (14 January 2020). See www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/childsexualabuseinenglandandwales/yearendingmarch2019

3 Council of Europe campaign to stop sexual violence against children, one in five. See www.coe.int/t/dg3/children/1in5/default_en.asp

4 Office for National Statistics, Child abuse extent and nature, England and Wales: year ending March 2019. Page 4. (14 January 2020). See www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/childabuseextentandnatureenglandandwales/yearendingmarch2019

5 NSPCC, Statistics briefing: child sexual abuse April 2019, page 3.

6 Ibid, page 16.

7 Sexual violence against children and young people: the London sexual violence needs assessment 2016 for MOPAC and NHS England (London); MOPAC, NHS England, mbarc (November 2016).

8 Office of National Statistics, Child abuse extent and nature, op cit, page 8.

9 Brown J, O'Donnell T, Erooga M, NSPCC, Sexual abuse: a public health challenge (October 2011). See www.nspcc.org.uk/globalassets/documents/research-reports/sexual-abuse--public-health-challenge-evidence-review.pdf

10 Rueness J, Augusti E-M et al, Adolescent abuse victims displayed physical health complaints and trauma symptoms during post-disclosure interviews, Acta Paediatrica, 00:1-7 (March 2020). See https://onlinelibrary.wiley.com/doi/full/10.1111/apa.15244

11 Bellis M, Lowey H, Leckenby N, Hughes K, Harrison D. Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. Journal of Public Health Volume 36 Issue 1 (March 2014) pp 81-91

12 Bellis M, Hughes K, Ford K et al, Life course health consequences and associated annual costs of adverse childhood experiences across Europe and North America: a systematic review and meta-analysis, Lancet Public Health 2019.

13 Kelly L, Karsna K, Measuring the scale and changing nature of child sexual abuse and exploitation: scoping report, Centre of Expertise on CSA, London Metropolitan University (July 2017, updated August 2018). See www.csacentre.org.uk/csa-centre-prodv2/assets/File/CSA%20Scale%20and%20Nature%20full%20report%202018.pdf

14 Radford L, Connect Centre for International Research on Interpersonal Violence, Centre of Expertise on Child Sexual Abuse, A review of international survey methodology on child sexual abuse and child sexual exploitation, February 2018; page 39. See www.csacentre.org.uk/our-research/the-scale-and-nature-of-csa/measuring-prevalence/

15 Children's Commissioner (2015), Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action. The Office of the Children's Commissioner's Inquiry into Child Sexual Abuse in the Family. Final Report. Page 3.

16 Ibid, page 17

17 Fergusson D. M., McLeod G. F. & Horwood L. J. (2013). Childhood sexual abuse and adult developmental outcomes: Findings from a 30-year longitudinal study in New Zealand. Child abuse & neglect, 37(9), 664-674

18 Berelowitz, S. Et al (2013), 'If only someone had listened'. The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups final report. London: Office of the Children's Commissioner.

19 Referred to as victims where appropriate throughout the remainder of the Toolkit.

20 Children's Commissioner for England, 2015, op cit, pages 3 and 4.

21 Jütte, S. Bentley, H. Tallis, D. Mayes, J. Jetha, N. O'Hagan, O. Brookes, H. McConnell, N. (2015) How safe are our children? The most comprehensive overview of child protection in the UK, NSPCC.

22 Children's Commissioner (2015), Protecting children from harm op cit.

23 This and what follows is taken from the CSA Hub Toolkit, a practical guide for commissioners and practitioners to establish a CSA Hub, NHS England, page 13. See www.england.nhs.uk/london/wp-content/uploads/sites/8/2017/04/Child-Sexual-Abuse-Hub-Toolkit-March-2017.pdf

24 See Tackling Child Sexual Abuse Strategy (2021); HM Government. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973236/Tackling_Child_Sexual_Abuse_Strategy_2021.pdf

25 Mental Health of Children and Young People in England (2017), NHS Digital, Nov 2018. See https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017

26 Characteristics of Children In Need: 2018 to 2019 England, 31 October 2019, Department for Education, see https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/843046/Characteristics_of_children_in_need_2018_to_2019_main_text.pdf

27 Goddard Review, op cit.

28 See Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children; HM Government, July 2018. See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

29 Working Together to Safeguard Children, op cit.

30 Child abuse and neglect, NICE, NG76, October 2017, paragraph 1.7. See www.nice.org.uk/guidance/NG76

31 Rueness J, Augusti E-M et al, Adolescent abuse victims displayed physical health complaints and trauma symptoms during post-disclosure interviews, Acta Paediatrica, 00:1-7 (March 2020). See https://onlinelibrary.wiley.com/doi/full/10.1111/apa.15244, op cit

32 CPS, Home Office, Department of Health, Provision of Therapy for Child Witnesses Prior to a Criminal Trial 2001, practice guidance (2001) (revised guidance expected by the end of 2020). See https://lx.iriss.org.uk/sites/default/files/resources/069.%20Provision%20of%20Therapy%20for%20Child%20Witnesses%20Prior%20to%20a%20Criminal%20Trial.pdf

33 NICE guideline op cit, paragraph 1.7.18-19.

34 NSPCC learning, Protect and Respect. See https://learning.nspcc.org.uk/services-children-families/protect-and-respect/#heading-top.

35 NICE guideline on child abuse and neglect, ibid.

36 NICE guideline on post-traumatic stress disorder, NICE, NG116, December 2018.

37 Physical signs of child sexual abuse – evidence-based review, Royal College of Paediatrics and Child Health (2015), see www.rcpch.ac.uk/shop-publications/physical-signs-child-sexual-abuse-evidence-based-review

38 Goddard, A, op cit

39 National Children's Alliance, Snapshot 2017, Advocacy, efficacy and funding in CACs, December 2016. See www.nationalchildrensalliance.org/wp-content/uploads/2018/03/Snapshot-2017.pdf

40 Emquist et al, 2015.

41 www.nationalchildrensalliance.org/our-story/

42 Johansson, S. and Stefansen, K, Policy-making for the diffusion of social innovations: the case of the Baranahus model in the Nordic region and the broader European context, the European Journal of Social Science Research, Volume 33, 2020 – Issue 1. See www.tandfonline.com/doi/full/10.1080/13511610.2019.1598255

43 Presentation: Barnahus as implemented in Iceland, Bragi Guðbrandsson (2015). See https://rm.coe.int/1680700233

44 Children's Commissioner for England, Barnahus: Improving the response to child sexual abuse in England. See www.childrenscommissioner.gov.uk/wp-content/uploads/2017/06/Barnahus-Improving-the-response-to-child-sexual-abuse-in-England.pdf

45 Child protection services across the world, taken from Çocuk istisman ve ihmali (Child abuse and neglect), (2019) chapter 10.1, page 723-738, Emma Harewood. Cilt ISBN: 978-605-69649-3-0; Takım ISBN: 978-605-69649-1-6

46 Rueness J, Augusti E-M et al, Adolescent abuse victims displayed physical health complaints and trauma symptoms during post-disclosure interviews, Acta Paediatrica, 00:1-7 (March 2020). See https://onlinelibrary.wiley.com/doi/full/10.1111/apa.15244, op cit.

47 Harmful sexual behaviour framework: an evidence-informed operational framework for children and young people displaying harmful sexual behaviours, NSPCC, 2nd edition, 2019. See https://learning.nspcc.org.uk/media/1657/harmful-sexual-behaviour-framework.pdf

48 Brook sexual behaviours traffic light tool. See https://legacy.brook.org.uk/brook_tools/traffic/index.html?syn_partner=

49 Harmful sexual behaviour framework: an evidence-informed operational framework for children and young people displaying harmful sexual behaviours, NSPCC, 2nd edition, 2019, op cit.

50 Harmful sexual behaviour among children and young people, NICE guideline NG55 (September 2016). See www.nice.org.uk/guidance/ng55/chapter/Recommendations

51 See Tackling Child Sexual Abuse Strategy (2021); HM Government. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973236/Tackling_Child_Sexual_Abuse_Strategy_2021.pdf

52 EU Promise, see www.childrenatrisk.eu/promise

53 Snapshot – advocacy, efficacy, and funding in CACs, National Children's Alliance (December 2016). See www.nationalchildrensalliance.org/wp-content/uploads/2018/03/Snapshot-2017.pdf

54 Enabling Child-Sensitive Justice, the success story of the Barnahus model and its expansion in Europe, Promise Project Series (2018). See www.childrenatrisk.eu/promise/wp-content/uploads/PROMISE-Enabling-Child-Sensitive-Justice.pdf

55 Collaborating against child abuse: exploring the Nordic Barnahus model. Editors: Johansson, S., Stefansen, K., Bakketeig, E., Kaldal, A. (Eds.) (2017) www.researchgate.net/publication/321501731_Collaborating_Against_Child_Abuse_Exploring_the_Nordic_Barnahus_Model

56 Herbert J L, Bromfield L, Evidence for the efficacy of the Child Advocacy Center Model: a systematic review, Trauma, violence and abuse 1-17 (2015). See https://journals.sagepub.com/doi/abs/10.1177/1524838015585319?journalCode=tvaa

57 Goddard A, Harewood E, Brennan L, Review of Pathway following sexual assault for children and young people in London, op cit.

58 MOPAC E&I, The Lighthouse: London's Child House Initial Evaluation Report, December 2018, page 5.

59 Police and Crime Plan 2017-2021, A Safer City for All Londoners, Mayor of London (March 2017), page 87.

60 Police and Crime Plan, op cit, page 86.

61 The London Rape Review, Mayor of London, July 2017, page 17.

62 Goddard A, Harewood E, Brennan L, op cit.

63 Dame Elish Angiolini, Report of the independent review into the investigation and prosecution of rape in London, April 2015. See www.cps.gov.uk/sites/default/files/documents/publications/dame_elish_angiolini_rape_review_2015.pdf

64 The London sexual violence needs assessment 2016 for MOPAC and NHS England (London), MOPAC, NHS England (London), mbarc, November 2016. See www.london.gov.uk/sites/default/files/sexual_violence_needs_assessment_report_2016.pdf

65 Sexual Violence Against Children and Young People, the London sexual violence needs assessment 2016 for MOPAC and NHS England (London), MOPAC, NHS England, mbarc (November 2016). See www.london.gov.uk/sites/default/files/sexual_violence_against_children_young_people_needs_assessment_report_2016.pdf

66 Police and Crime Plan, op cit. See www.london.gov.uk/sites/default/files/mopac_police_and_crime_plan_2017-2021.pdf

67 Goddard A, Harewood E, Brennan L, op cit, page 2.

68 Goddard A, Harewood E, Brennan L, pages 2, 45, 46.

69 Goddard A, Harewood E, Brennan L, page 14.

70 Hodson D, Van Schaick R, Child Sexual Abuse, Review of provision of therapeutic services, estimates of prevalence and identification of gaps within the boroughs of Barnet, Camden, Enfield, Haringey and Islington, NSPCC (November 2016) (unpublished).

71 The Lighthouse Annual Report 2018-2019, page 18. See www.thelighthouse-london.org.uk/guidance-and-support-for-professionals/downloads-links-for-professionals/

72 Goddard A, Harewood E, Brennan L, op cit.

73 Launch of CYP Havens Service. See **www.kingshealthpartners.org/latest/780-launch-of-cyp-havens-service**

74 Information provided by the Havens Service Manager, July 2020.

75 Goddard, A. op cit

76 London Child Sexual Abuse Services Learning Report, NHS England (November 2018).

77 See **https://tavistockandportman.nhs.uk/about-us/news/stories/transforming-services-children-and-young-people-who-have-experienced-sexual-abuse-final/**

78 Child Sexual Abuse Hub Toolkit: a practical guide for commissioners and practitioners to establish a CSA Hub. NHS England (March 2017). See **www.england.nhs.uk/london/wp-content/uploads/sites/8/2017/04/Child-Sexual-Abuse-Hub-Toolkit-March-2017.pdf**

79 See evaluation: Child Sexual Abuse Services Learning Report, NHS England (November 2018) **www.england.nhs.uk/london/wp-content/uploads/sites/8/2019/05/London-CSA-Services-Learning-Report-2018-v1.2-002.pdf**

80 Ibid, pages 12.13.

81 The Lighthouse Annual Report 2018-2019, page 18.

Chapter 6
Developing the vision for stakeholders

What this chapter tells you:

Identifying stakeholders

6.1 A great deal of work is needed to develop the compelling vision for change that is needed to set up a Child House and also in understanding how this fits into the overall sexual assault referral services pathway.

6.2 Knowing who the key agencies and personnel are is key, which can best be achieved by undertaking a stakeholder mapping exercise. This helps to identify and think through who the stakeholders are, who would have an interest in setting up a Child House, their degree of influence and their level of interest.

6.3 The following shows the likely categories of stakeholders who should be engaged in discussions about the setting-up of a Child House though this will vary from area to area. Giving some idea of the intended timeline as a part of these discussions may be helpful.

Having a compelling vision

6.4 The vision should be drawn up in active discussion with stakeholders. It should be easily understood and succinct, enabling people to understand and relate to the objectives, and setting out clearly the case for change. It may be enhanced by key data about local need, the gap between need and current service provision, and evidence of what works in providing support for CYP who have experienced CSAE. The vision should also demonstrate a clear commitment to engaging with CYP along the journey to develop the Child House. It should be sufficiently simple and succinct that it speaks to people from many different backgrounds.

6.5 Starting with the **EU Promise standards**[1] and the (UK) **Child House: Local Partnerships Guidance** (see **chapter 10**) will help to inform the drawing-up of the vision for setting up a Child House.

Vision for the criminal justice system

6.6 Part of the aim of the Barnahus model is to maximise the effectiveness of criminal justice processes. The following can be considered for inclusion at the Child House:

- the Achieving Best Evidence interview being carried out by a specially trained psychologist instead of police or social workers, within one to two weeks of the first report; and supported by Registered Intermediaries when required.
- having a live court link from the Child Houses in the same way that some SARCs and other buildings have live court links as part of a pilot. Where a child or young person does need to give evidence as a witness, this would enable them to do so from the familiar and child-friendly surroundings of the Child House, rather than having to appear in court.
- using the Lighthouse as a remote link suite for section 28 pre-recorded cross-examination, where a child or young person has their cross-examination from the familiar surroundings of the Child House using child-friendly questions agreed at the Ground Rules hearing. The cross-examination is pre-recorded and available to be played to the jury on the day of the trial so the child does not have to appear in court.

Developing the vision in London

6.7 The CSA Transformation Programme (see **paragraph 5.36**) was key to bringing stakeholders together in order to formulate the vision of what provision should be like across London. The Plan covered all services across the CSAE pathway in London with the Child House as one essential element alongside the CYP Haven Service and the CSA Hubs as a first step on the way to rolling out Child Houses across London.

The vision was drawn up with a wide range of partners and was based on the EU Promise standards – see **chapter 7 on partnerships** and **chapter 10 on Child House: Local Partnerships Guidance.**

Section 28 of the Youth Justice and Criminal Evidence Act 1999 put in place a series of special measures that can be used to facilitate the gathering and giving of evidence by vulnerable and intimidated witnesses. These are intended to help witnesses to give their best evidence in court and help to relieve some of the stress associated with giving evidence. These included pre-trial visual/visually recorded cross-examination or re-examination of the witness, recorded at an e arlier point in the process than the trial. This may be admitted by the court as the witness' cross-examination evidence in the Crown Court.

For more details, see guidance on **special measures** produced by the Crown Prosecution Service[2].

The vision for the Child House in London

The concept is simple and in line with best practice, the European PROMISE agreement and evidence from abroad. The aim is to provide a service which is centred around the child. Rather than the child/young person having no choice other than to go to numerous agencies and buildings to access different services the Child House will provide support 'under one roof'. The environment will be reflective of the circumstances with an emphasis on being safe, secure and focused around the needs of the child/young person.

During the pilot all acute Forensic Medical Examinations (FMEs) will continue to be undertaken at the Children and Young People's Havens ie. where the alleged abuse has taken place within the window for collection of DNA. The Child House will act as the central point for overseeing FME of all non-recent sexual abuse ie. where the alleged abuse has taken place beyond the window for collection of DNA. The specific protocol governing the referral arrangements between the Children and Young People's Haven and the Child House has been worked up during the implementation phase.

Most support will be offered at the Child House premises particularly the initial assessment, therapeutic programmes and sexual health, but advocacy can be accessed in the community eg. at school, in a café or the park. The particular circumstances will be informed by the child/young person's needs and wishes, together with those of their non-offending family members.

It is intended that the Child House will be a single point of access for the delivery of all the support CYP need including Health and Well-being Services, Social Care, and Criminal Justice Services. Specifically, this will include:

- Comprehensive medical examination including holistic paediatric assessment
- Sexual health follow-up and aftercare
- Emotional, mental health and well-being assessments
- Therapeutic services, including 1:1 sessions for the child, joint child and family sessions and parent education courses
- Specialist advocacy and support
- Achieving Best Evidence (ABE) interviews conducted by trained clinical psychologists.

Our aspiration is also to provide pre-trial cross examination interviews and/or live links to court all overseen by a presiding judge, for which we are waiting judicial approval.

It is intended that during the pilot the Child House will develop and establish a reputation for its expertise and be in a position to share learning arising from the project, including the most effective ways of working with/engaging CYP. Our long-term ambition is that more Child Houses will be established, becoming centres of excellence serving as a place for the advancement of child protection, safety and security as well as family supportive practices. In time, the aim is for the Child Houses to contribute to the international body of literature on all matters relating to child sexual abuse, help change societal attitudes, tackle and support the prevention of sexual abuse in its broadest sense.

6.8 Stakeholders were asked why they had thought the Child House pilot was needed.

Part of the vision for London was to maximise the effectiveness of criminal justice proceedings by using a specially-trained psychologist to carry out the Achieving Best Evidence or Visually Recorded Interview rather than police or social workers. Further details are set out at **paragraphs 11.54-11.56**. Following judicial approval, the Lighthouse offers a live court link as a remote site as well as being able to pre-record the cross-examination under section 28 of the Youth Justice and Criminal Evidence Act 1999.

6.9 The aim in London was to set up a holistic and comprehensive service, with the child or young person and family at the heart of decision-making. The intention was to empower the family and help them to feel safe by delivering a personalised service adapted to meet their individual needs and to give them more choices than are generally available in more traditional services.

Key learning points

- Undertaking a stakeholder mapping exercise can be useful to identify the key stakeholders who are likely to have an interest in setting up a Child House, their degree of influence and their level of interest.
- A compelling vision for change will be needed before setting up a Child House and in understanding how this fits into the overall sexual assault referral services pathway.
- The vision should be drawn up in discussion with a wide range of stakeholders including potential partners, taking account of the EU Promise standards for Child Houses and the local partnerships guidance published.
- The vision should also establish at an early stage what criminal justice measures will be put in place at the Child House.
- Although it may not be practicable to combine the Child House with the Sexual Assault Referral Service, consideration should be given as to whether the Child House could also provide forensic services.

Checklist for setting up a Child House

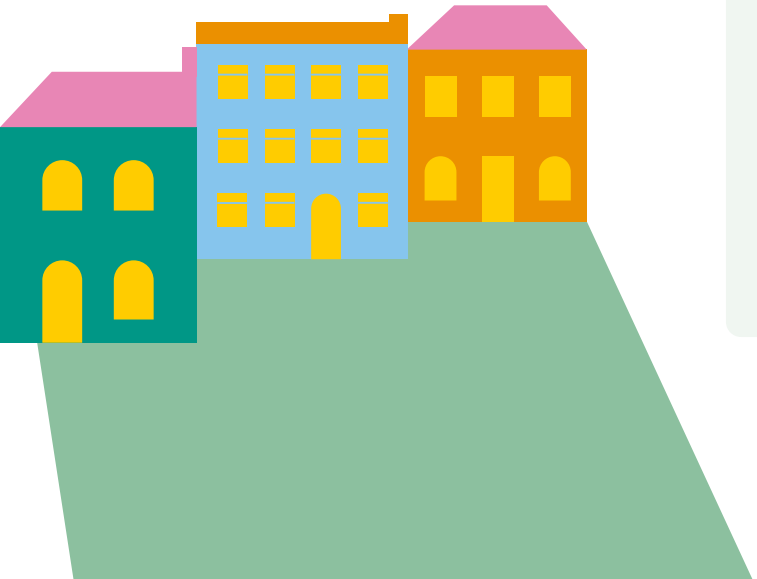
- [ ] Has there been sufficient engagement with the stakeholders shown in this chapter and any others who may be influential in the area?
- [ ] Is there a shared vision of the whole pathway for sexual assault services in the area and clarity as to how the Child House would fit into it?
- [ ] Is there agreement that the Child House would bring together all the relevant agencies in the area?
- [ ] Is there agreement with representatives of the local criminal justice system that ABE interviews can be held at the Child House and that there can be a live link to the court when the child or young person is giving evidence during any subsequent trial?
- [ ] Has the possibility of pre-recording the cross-examination or re-examination of the child or young person in line with section 28 of the Youth Justice and Criminal Evidence Act 1999 been considered and discussed with representatives of criminal justice services?

End Notes

1 EU Promise, Barnahus Quality Standards, Guidance for multidisciplinary and interagency response to child victims and witnesses of violence, see www.childrenatrisk.eu/promise/standards/

2 Special measures, Crown Prosecution Service, updated September 2010: www.cps.gov.uk/legal-guidance/special-measures

Chapter 7
Making a multi-agency partnership work



What this chapter tells you:

Why work in partnership?

7.1 Effective partnership working is fundamental to the success of establishing and running a Child House given that it aims to bring together many different agencies working towards a common set of goals. All areas are likely to have some experience of joint working between health, social care and police, which will be useful as the basis for establishing a Child House. Existing networks should be exploited as far as possible. Once the key partners have been identified, it is essential to engage with them all from the inception of the project and to make sure that they are all on board – failure to do so may mean that the project fails since all will need to make a vital contribution[1].

Local champions

7.2 Identifying a local champion in each of the key agencies as early as possible is essential. They should feel empowered to communicate the vision within their agency and to identify any blockages. Using existing networks, including clinical networks, can help to provide a forum for sharing the vision. Providing these local champions with updates on progress so that they can keep others in their organisation informed is important.

Clear lead

7.3 Each of the main agencies involved will need to have a clear lead (who may be the same as the local champion). This will be the 'go to' person who will be able to act on behalf of the agency they represent and to feed back any issues as they emerge and help to formulate solutions. The early establishment of clear governance arrangements to ensure that there is a forum for these discussions is essential (see paragraph 7.10 and chapter 14). Securing agreement from these key partners at an early stage is essential. Where there are several CCGs and LAs involved, it may be helpful for one to be nominated to lead for them all, acting as a conduit to all the others within the sector.

Strong leadership

7.4 Strong leadership in each of the key agencies and a strong programme lead to oversee and co-ordinate the whole programme is essential. In each agency, there should be someone who is able to influence key officers, overcome resistance and address challenges as they arise, to make decisions on behalf of the agency and to liaise with senior officers in partner agencies. A dedicated programme lead should be appointed from an early stage to lead the development of the Child House locally, to liaise with all the different agencies involved at a senior level and to drive the change across multiple agencies.

The role of the VCS

7.5 The local VCS organisations working in CSAE are likely to play an important role in supporting the setting-up of the Child House and in subsequent delivery of services. Which organisations need to be involved will depend on who the key VCS organisations are at local level since this will vary, but they should all be approached (including those that focus primarily on sexual violence) and their views and support sought. The possible involvement of these organisations in future commissioning and procurement processes should be borne in mind to ensure that no VCS provider is disadvantaged.

A voice for children and young people

7.6 Ensuring the voice of CYP is actively sought, listened to and fed into the partnership discussions from the start of the project is key. This can be achieved by working closely with youth councils, user forums in statutory services and VCS organisations who are in contact with CYP and which represent adult survivors of CSAE (see chapter 9).

Involving the criminal justice system (CJS)

7.7 As well as the police, early conversations should be held with all CJS parties: police, HMCTS, Witness Care Units, Witness Service providers and CPS. One of the aims of Child House is to provide psychologist-led

Achieving Best Evidence interviews which may subsequently be used in evidence. In some cases, it is also possible for the victim or witness to be cross-examined via a remote link (see paragraph 6.9). This is a key element of the Barnahus and CAC model and one that has been found to be successful elsewhere in improving criminal justice outcomes.

7.8 Building relationships with the Family Courts in the area will also pay dividends once the Child House is up and running and help to avoid difficulties in dealing with some complex cases involving the Family Courts.

Establishing a Steering Group

7.9 One of the first steps to bring partners together following bilateral discussions is to establish a steering group to represent the key partners and to act as an advisory forum for the establishment of the Child House. The Steering Group will lead the co-design, strategic development and commissioning of the new service. Clear reporting lines from the steering group to key decision-making forums will be needed and these should be clearly identified. Sub-groups may also be needed to ensure that discussions can focus on the views of particular professional communities though these may be time-limited and are likely to vary at different stages of the development of the Child House. See also chapter 14 on governance.

Key values

7.10 Two of the most important values underpinning the setting-up of a Child House are transparency and openness. Partners should be encouraged to share aspirations and to work together to identify and overcome any blockages. Being open with partners about any internal issues that have arisen and being able to share information freely will pay dividends.

Cultural differences

7.11 Given the nature of the different agencies involved, there will inevitably be differences of approach and also fundamental differences of culture. Different organisations will have different rules of engagement and different decision-making processes, some of which may vary in terms of their hierarchical structures and their risk appetites. Working together to develop the vision may help to identify and address some of these – particular issues may arise in relation to information sharing, for example, but also to the different perspectives in setting up the Child House. The police and criminal justice system may be more likely to recognise the Child House as a possible means of maximising the quality and effectiveness of prosecutions and convictions by making the process and setting less stressful for the child and family and reducing delays in the system. Health and social care staff, on the other hand, are more likely to see it as a means of improving short and long term responses to, and therapeutic outcomes for the individual child or young person and the family. However, all organisations will have safeguarding at their core and a shared objective of protecting CYP.

7.12 Both sets of outcomes are important, but the way that these different cultures, priorities and attitudes impact on every aspect of setting up the Child House – for example, on information governance – should not be underestimated. Similar issues have arisen and been overcome in comparable services such as Sexual Assault Referral Centres. The experience of dealing with these may help to forge strong working relationships locally between the different agencies concerned.

7.13 The time taken to develop the partnerships should not be underestimated but is essential groundwork for the whole project.

Partnerships in London

Creating the partnership

7.14 The initial aim of the pilot in London was to set up two Child Houses, each serving one complete sector in London (the sectors later became the Sustainability and Transformation Partnerships now Integrated Care Systems[2]). In South West London, the sector comprised six CCGs and Local Authorities[3] whilst in North London (formerly North Central London), there were five of each (for both sectors, LAs and CCGs were co-terminous)[4]. (The position has since changed with the merger of CCGs taking place on a national basis as part of the delivery of the NHS Long Term Plan.) In North London, Camden were nominated as the lead LA/CCG, and Croydon as the lead for South West London.

7.15 In North Central London and South West London, a great deal of work had already been done jointly between the key partners in establishing the CSA Hubs, including one in North Central London (based on two sites) which was subsumed into the Child House when it opened. The same was true in South West London where the intention had been to pilot a second Child House in Croydon. The CSA Hubs were intended to be a stepping-stone to Child Houses. They were established as one stop shops for medical, advocacy and early emotional support for children and their families, as well as offering advice and liaison to police and children's social care services[5]. (See paragraphs 5.38-5.39).

7.16 Similarly, the way in which the Sexual Assault Referral Services are run – commissioned by NHS England, working closely with MOPAC who co-fund the service – provided a solid foundation for the joint working between the same organisations which was needed to set up the Child House.

7.17 The list of stakeholders shown in paragraph 6.3 demonstrates how many agencies need to be brought together to establish the Child House. The resulting partnership arrangements in London inevitably proved to be highly complex. Engagement initially took place through a series of workshops in each sector, quarterly newsletters and senior bilateral discussions with a view to informing attendees as to the benefits of a Child House, how this would fit within the overall sexual assault referral services pathway in London, ascertaining the views and commitment of stakeholders and identifying local champions.

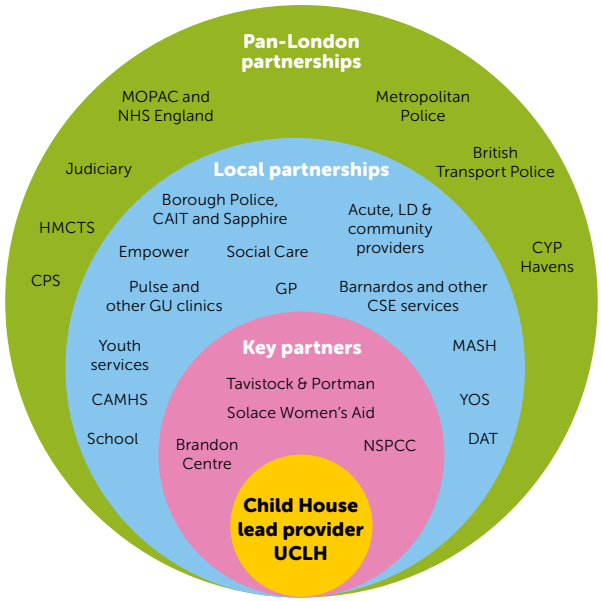
Pan-London Steering Group

7.18 A pan-London Steering Group to deliver all the recommendations in the CSA Pathways Review[6] and to bring all the partners together was set up initially, with membership drawn from each of the key organisations, chaired by NHS England. The role of this steering group was to oversee implementation of the Children and Young People's Haven, the CSA hubs and to create the Child House model. In addition, five local sector steering groups were also set up, chaired by Local Safeguarding Board chairs, to engage local stakeholders and decision makers.

7.19 Once the Steering Groups were established, a number of sub-groups were also set up which comprised:

- Paediatricians
- CAMHS and independent sector providers including those in the VCS
- MASH, police child abuse teams and children's social care.

Diagram of partners in London at the time the partnership was agreed



Setting up the Child House Steering Group

7.20 Once the Child House funding was secured, a pan-London Steering Group specifically to deliver and oversee the delivery of the Child House was established, chaired by MOPAC. This steering group included representation from national criminal justice partners and pan-London police, health, social care and VCS stakeholders as well as the Home Office and Department for Education as key funders. A great deal of work was done within this programme to establish how best to meet needs locally and to build relationships with stakeholders. Further details are set out in chapter 14.

Partnership agreement

7.21 Once the partnership was in place, a partnership agreement was drawn up and signed by all the partners. Although not a legal document, this was useful in clarifying roles, scope, who the partners were, and what was expected of each partner. In addition, as part of the contract negotiations, sub-contracts were drawn up between the NSPCC and the Tavistock and Portman NHS Trust as well as the Brandon Centre and Respond. The NSPCC also have a sub-contract with Solace Women's' Aid.

The Lighthouse health and wellbeing partners:

- **University College London Hospital NHS Trust** [lead provider]
- **Tavistock and Portman NHS Mental Health Trust** [CAMHS provider]
- **NSPCC** [provider of therapeutic services and advocacy]
- **Solace Women's Aid** [to provide advocacy]
- **Respond** [an organisation that works with people with learning disabilities, autism or both who have experienced abuse, violence or trauma]
- **The Brandon Centre** [to provide sexual health services]
- **Metropolitan Police**
- **London Transport Police**
- **Camden Local Authority** [to provide social care liaison officers]
- **The five Local Authorities in North Central London** [Camden, Islington, Barnet, Enfield, Haringey]
- **Local partner organisations** [those who come into contact with or refer into The Lighthouse]
- **Crown Prosecution Service**
- **Her Majesty's Courts and Tribunals Service**

Case study:

Aliyah was a 16 year old girl who had reported an attempted rape and was referred to the Lighthouse for support by the local Multi Agency Safeguarding Hub (MASH). During the Lighthouse intake process it became clear that no crime report had been documented by the police and that children's social care had stepped down the referral to the Early Help Team. The Lighthouse team were concerned about the risks of exploitation and other local safeguarding risks for Aliyah. The social care liaison officer requested this be escalated and a social worker was allocated. The police liaison officer worked with the MASH police team and suggested a local joint investigation and strategy meeting.

Engaging with the criminal justice system

7.22 Engaging with HMCTS and, through them, the judiciary at an early stage was essential though had some challenges. The approach to be piloted involved changes to existing criminal justice processes (ie: the psychologist-led Achieving Best Evidence interviews and the live link between the Lighthouse and the court). Securing agreement to the criminal justice system changes, ensuring that it was going to be a fair process for all concerned and overcoming the logistical/technical difficulties have proved to be amongst the more challenging aspects of the project.

7.23 In order to bring the criminal justice system into the partnership, early discussions took place in order to ensure that they were supportive. These involved talking to the CPS Strategic Policy Team and CPS London to see what was going to be feasible within the Child House pilot, and meeting the Lord Chief Justice and the Senior Presiding Judge, with the involvement of HMCTS (part of the Ministry of Justice), and the Regional Head of Crime.

7.24 A CJS sub-group was established to enable more in-depth discussion about the investigative and judicial changes. The sub-group, chaired by a representative of the CPS, included colleagues from CPS, HMCTS, senior judiciary, Criminal Defence Bar, Law Society, Met Police, MOPAC and the Lighthouse. Visits were also made to the Crown Courts to see what was being done on the section 28 pilots elsewhere and what could be learned from this.

7.25 Although relationships have been forged with the Family Courts in individual cases, it is recognised that it would have been beneficial to establish more formal relationships at an earlier stage. Some complex cases involving the Family Courts would have benefitted from a fuller understanding of the way in which they operate, particularly around findings after the facts and decisions to allow contact with an alleged perpetrator in the absence of a conviction or proof that meets the criminal prosecution threshold. The Lighthouse is planning to establish more formal links with the Family Courts in due course.

Listening to children and young people and adult survivors

7.26 Ensuring that children, young people and adult survivors had a voice was key to the early partnership conversations. Building on the work done previously for the Transformation Programme, this was achieved through inviting adult survivors to speak at some of the workshops and engagement events, as well as involving them in design of the service specification and the building 'look and feel'. CYP made written representations to the Steering Group. Further details are set out in chapter 9.

Liaising with partners during mobilisation

7.27 During the run-up to the opening of the Lighthouse, a great deal of work was done to engage with partners and wider stakeholders. This included a proactive communications strategy (see chapter 8) and the active engagement with key agencies and individuals including commissioners by staff already in post. The Social Care Liaison Officers and Police Liaison Officers appointed to the Child House were in post well before it opened its doors and were able to engage actively with their colleagues in the five local authorities and MPS to ensure that they were kept up-to-date. The Head of Integrated Children's Commissioning in Camden Local Authority played a pivotal role in liaising with all five local authorities and the five CCGs.

After mobilisation

7.28 After mobilisation, some of the sub-groups continued to function to address outstanding issues. This included the CJS sub-group. In addition, an Academic Advisory Group was set up at round the time the Child House went live (see paragraph 19.42) to advise MOPAC's evaluation team on the academic learning from the Child House and how this could best be exploited. Regular meetings of the social care leads and the children's services commissioners from all five boroughs served by the Child House in North London are held which provides an opportunity to discuss any issues arising and to plan for future developments.

7.29 A visit by the Senior Presiding Judge together with the Regional Head of Crime and the resident judges once the Child House had opened proved a useful means of demonstrating the benefits that the Child House could bring to the criminal justice outcomes. The open days proved helpful in attracting 200 staff, many of whom would be future referrers. Other notable visits were made by the National Director of Ofsted, the Commissioner of the MPS, the CEO of HMCTS, local judges and magistrates, the CPS RASSO team as well as Home Office and DfE policy leads. Open days are held every six months for local and national staff. Staff from the Lighthouse also participated in a Crown Court open day which provided a further opportunity for raising awareness and were visited by the local Crown Court judges.

Key learning points

- Effective partnership working is key to the success of a Child House given the need to bring together so many different agencies who will need to work together. Openness and transparency are essential values in establishing and operating the partnerships.
- Once key partners have been identified, they should all be engaged from the start of the project and their specific roles clarified. A formal inter-agency partnership agreement is a useful way of recording what each agency will do and in securing their commitment to future collaboration and service delivery. Sub-partnership contracts underpinning the main contract between the lead provider and the other providers may also be needed.
- All the relevant local VCS organisations need to be involved from the start of the project, some of which may become key partners.
- A champion in each of the key agencies should be identified as early as possible to communicate the vision for the Child House to their agency as well as identify and remove any blockages. Similarly, each agency will need a clear lead (who may be the same person as the local champion).
- Setting up a Steering Group early on will facilitate decision-making and secure the governance which will be needed to establish the Child House. Where there are several CCGs and LAs involved, it is helpful to nominate one to lead on the others' behalf. Sub-groups may also be needed (eg: on paediatrics, CAMHS, children's social care, police).
- Leadership in each of the key agencies as well as a strong dedicated programme lead are essential in overseeing and co-ordinating the development of the Child House and driving the changes needed across multiple agencies.
- Confronting the cultural differences between the agencies early will pay dividends later – in areas such as information governance, for example, different agencies (ie: health, police and social care) may take a very different approach, reflecting their different priorities, perspectives and regulatory frameworks. Regular reminders may be needed of the alternative perspective – and of the common commitment to improving outcomes for CYP who have experienced CSAE.
- Obtaining input from survivors of sexual abuse – both young people and adults – is essential. Their voice should be actively sought and listened to during the initial discussions with the partners; this will help to ensure that the service being created will meet the needs of victims and survivors.
- Engaging with the criminal justice system early on to ensure that they support the approach to be adopted in the Child House is essential, particularly if psychologist-led Achieving Best Evidence interviews are to be carried out at the Child House and if there is to be a live link connecting the Child House to the court.
- Ensuring that all the CCGs and LAs are supportive of the Child House and willing to engage in discussions will be key, not only to setting up the Child House but to ensuring referral patterns change once it opens.

Checklist for setting up a Child House

- ○ Is there a champion for the Child House in each of the key agencies who is willing to promote it to local agencies and steer it through any difficulties?
- ○ Is there early 'buy-in' at senior strategic level, for example, the Chief Executives of the Council and Clinical Commissioning Group, local Designated Professionals and the Police and Crime Commissioner?
- ○ Are there clear leads in the LA and/or CCG for the Child House project?
- ○ Are all the LAs and CCGs supportive of the project? If not, is there a plan in place to secure their support and agreement?
- ○ Have the key local VCS organisations, including the smaller organisations, been brought in to the project and do they feel they have a clear role?
- ○ Have representatives of the local court system been engaged in discussions on the Child House to see how they would be involved? Are they, broadly speaking, supportive? Has a decision been taken as to whether Achieving Best Evidence interviews will be undertaken by psychologists?
- ○ Are local clinical networks including paediatricians, mental health clinicians and sexual health involved in discussions on establishing the Child House?
- ○ Are Children and Young People and adult survivors being involved in the partnership discussions to ensure that the voice of the victim-survivor is heard?
- ○ Is there a Steering Group that brings together all the key agencies to be involved with appropriate sub-groups (eg: estates, IT and information governance, criminal justice system and commissioning)?

End Notes

1 Some of this section is drawn from the **CSA Hub Toolkit: a practical guide for commissioners and practitioners to establish a CSA Hub**, Emma Harewood, NHS England, March 2017.

2 Integrated Care Systems are intended to form an even closer form of collaboration than Sustainability and Transformation Partnerships. The aim is to provide better and more joined-up care for patients. See **www.england.nhs.uk/integratedcare/integrated-care-systems/**

6 Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth.

4 Barnet, Camden, Enfield, Haringey and Islington.

5 **Child Sexual Abuse Hub Toolkit, a practical guide for commissioners and practitioners to establish as CSA Hub**. NHS England. March 2017, page 8.

6 Goddard A, Harewood E, Brennan L, op cit.

Chapter 8
Communications

What this chapter tells you:

8.1 Communicating effectively both with stakeholders and partners, and the wider public is essential to the success of the Child House and subsequently.

Communications with stakeholders and partners

8.2 Internal communications with the partner agencies and key stakeholders, once identified (see **chapter 6**), are particularly important given that people who are in a position to refer CYP will need to know, once the Child House is up and running, what services are available and how to refer. Winning the hearts and minds of those who will be expected to change their referral patterns by outlining what the Child House will deliver will reap benefits once it opens. Internal communications routes are particularly important in a diverse multi-agency team that is creating a new operating model and new ways of working together.

Overarching communications strategy to help raise awareness and drive referrals

8.3 External communications are also key since securing public support for the public and disseminating awareness of the new facility to the public, including potential service users and families, will be key. An external communications strategy is therefore needed early on in the project to consider what needs to be done to raise awareness. The strategy should also include the messaging that will persuade external audiences of the need for the Child House, and how the Child House answers that need. The communications strategy should consider ways this information can be disseminated to all the partner agencies and externally to the wider public. Failure to do so might mean that the expected referral levels will not be met once the Child House opens.

8.4 Dedicated resources should be made available to deliver the communications strategy and to disseminate key messages. Once the communications strategy has been agreed, a range of media should be used to disseminate the key messages and report on progress, using social media, press releases, updates for internal staff in the agencies concerned and for senior management, as well as interviews with broadcast media. Segmentation analysis can be a useful way of ensuring that key messages are targeted towards key sectors of the community and partner agencies. A dedicated communications resource is essential, particularly towards the time of opening the Child House.

8.5 A month or so before the launch of the new facility, open days can be held to which staff in key agencies and the senior leaders of local agencies can be invited. The launch itself provides an ideal opportunity to showcase the new facilities and to encourage professionals to make referrals once it opens.

8.6 Once the Child House has opened, proactive communications with the local professional community will be needed. This can include feeding into local safeguarding training, members of staff attending meetings of practitioners such as teachers, police officers and social workers and dissemination through local VCS organisations.

Communication with children and young people

8.7 Separate channels of communication can be used to target CYP to inform them of the development of the Child House, let them know how they can be involved in its development and, once it is open, how they can access its services. (See **chapter 9**).

Communications in London

Managing communications in London

8.8 Once the decision was made to open Child Houses in London as part of the CSA Transformation Programme, an announcement was made publicly on 13th September 2016 which included a **commitment to setting up the UK's first two Child Houses** in London, as was the intention at that stage.[1] This was also referred to in the government's progress

report on child sexual exploitation[2]. It was subsequently decided to pilot only one Child House in London (see **paragraph 15.32**) and that this should be in North London. This was reflected in later communications.

8.9 Once the Lead Provider was appointed, it was agreed that the NSPCC would lead on communications and a communications plan highlighting the key messages was developed. The NSPCC formed a partnership with Morgan Stanley and a contribution of £1m was made as a result of this towards the Child House (see **paragraph 12.15**), some of which was used to fund the communications work. This enabled a Communications Manager to be appointed, dedicated on the project two days a week. Some UCLH Communications Team resource was also made available for the pilot.

Communicating with stakeholders and partners

8.10 There was already a communications strategy in place for the London CSA Transformation Programme of which the Child House was an integral part, including quarterly meetings with stakeholders in each of the five sectors of London and regular newsletters with a distribution of around 900 people. Events were held to keep senior stakeholders informed and to provide the opportunity for the programme team to speak to senior people across each of the two sectors where the Child Houses were originally going to be based.

8.11 Once the lead provider was appointed and the NSPCC had assumed responsibility for communications, a comprehensive and proactive comms strategy was developed and a Communications Manager appointed (see **paragraph 8.16**). This reflected the nature of the partnership and the appointed NSPCC comms lead worked closely with the communications leads in UCLH, TPFT, Solace Women's Aid, MOPAC, NHS England, Home Office, MPS and Camden Local Authority through a communications group based on an agreed 'Ways of Working' document.

External communications and marketing

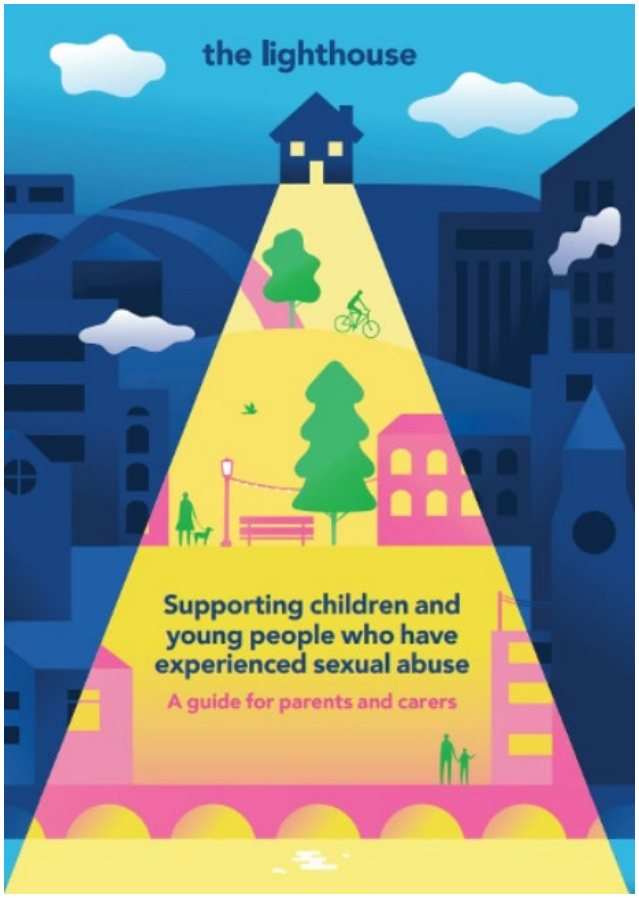
8.12 The communications strategy identified the need to create a unique and separate brand for the Child House. An external company was appointed following a tender exercise to design the products needed, including a website and all the written materials.

8.13 The development of the brand guidelines provided the framework for consistent communications products to be developed, which were developed with input from CYP and are all CYP-friendly. These communications products included:

- A new operational name for the Child House – the Lighthouse
- Leaflets for children, young people, parents and professionals (online and in hard copy)
- Easy read leaflets for CYP with learning difficulties

See:

- **Easyread version for children**
- **Easyread version for young people**
- **Advice from other young people**
- **Advice from other parents**
- Two short films were developed, one aimed at children and another at young people. The **short film for young people**[3], lasting a minute and half, and **a film for children**[4], provide CYP with insight into what to expect as they take a virtual tour of the Lighthouse.
- The hyperlink can be texted to CYP to watch at the point of referral or before they attend for their first appointment.
- The brand guidelines were used in the development of the website: **www.thelighthouse-london.org.uk**. The website has guidance aimed at **children**, **young people**, **parents** and **professionals** and includes links to the videos as well as audioclips. The funding made available by Morgan Stanley was used to enhance the communications strategy. Without this, there would have been insufficient funds available to produce high quality communications materials.



8.14 The Development and Service Manager, clinical leads, social care liaison and police liaison officers, and other senior team members also played a proactive role in communications. For example, they met stakeholders both locally and nationally on a regular basis, spoke at conferences, submitted contributions to relevant publications and used broadcast and print media (for example, an interview with the Guardian[5]) to raise the profile of the Child House once it opened.

8.15 CYP as well as adult survivors of CSAE were involved in the design of the Child House model and later the setting up of the Lighthouse – for further details (see paragraphs 9.14-9.17). During the CSA Transformation Programme, newsletters were written to keep them up-to-date with developments and let them know how their views were being taken into account.

Towards mobilisation

8.16 The allocation of an NSPCC Communications Manager during mobilisation was particularly key in the lead-in to opening the Lighthouse for both internal stakeholder and partner engagement, and for external communications. Her role involved disseminating key messages, keeping people up-to-date with progress and knowing what to expect once the Child House opened and how they would be able to refer.

8.17 User-friendly forms such as **referral forms for professionals** to use were designed and made available online[6]. Daily open days were held for two weeks before the Lighthouse was launched, attended by over 200 people. These were advertised widely and invitations sent to police leads in safeguarding teams, senior leads in social care e.g. DCS, ADCS, head of safeguarding, MASH managers, early help managers, local sexual health providers, children's and mental health commissioners, and local GPs. They included a presentation setting out what the Lighthouse would do and a tour of the facility.

8.18 A high profile launch event provided an excellent opportunity to raise awareness of the Child House in the media, showcase the work that had been done so far and to thank people who had made a contribution. The Lighthouse was **opened by the Mayor of London**, Sadiq Khan, on 5th December 2018, and attended by the Minister for Crime, Safeguarding and Vulnerability, Victoria Atkins MP[7].

8

After mobilisation

8.19 Key people who have visited the Lighthouse since it opened have included the Senior Presiding Judge, local Crown Court Judges, the Children's Commissioner for England, the Commissioner and Safeguarding leads from the MPS, Ofsted National Director, CEO of HMCTS, as well as the chairs and CEOs of the partner organisations. These visits have been helpful in demonstrating the work of the Lighthouse, enabling senior leaders to see for themselves what services are available and to engage with the staff directly.

8.20 Since mobilisation, the Lighthouse has had a high media profile with articles in the national press, specialist journals and many speaking engagements at local, national and international conferences. The five heads of safeguarding in the local authorities are updated each quarter. There are also regular visitors from other parts of the UK including Scotland[9], Northern Ireland and Wales, some of whom are establishing or considering establishing Child Houses, and international visitors who wish to see what is being done in the UK.

8.21 In addition, the Lighthouse has been nominated for, and won several prestigious awards which has helped to raise its profile.

8.22 Further work is planned to raise awareness about self-referrals and amongst professionals such as GPs, staff in higher education and adult learning disability teams who are able to refer, with a view to maximising referrals.

Internal communications

8.23 The Lighthouse has several routes of internal communication, including weekly senior team meetings, a monthly whole service meeting for all staff, a monthly newsletter, an employee of the month award and regular team leads meetings. There have also been improvement task groups in the first 18 months to review and refine new processes.

Key learning points

- Having a comprehensive and proactive communications strategy should be a priority. This will be needed to disseminate information to the partners and stakeholders initially and, later, to practitioners in a wide range of agencies and the wider public. This will also be crucial in changing referral patterns once the Child House opens. Sufficient funding is needed for communications and to deliver the strategy.
- The communications strategy will need to reflect the nature of the partnership; one agency may lead on this on behalf of all the partners. There should be a clear process for sign-off of external communications and media coverage.
- Communications products may include regular newsletters, leaflets for Children and Young People, parents and professionals, developed with input from CYP where appropriate. Other channels including social media and film may also be useful in disseminating key messages.
- Open days may be held shortly before the Child House opens as well as subsequently to publicise the work and encourage take-up of services. A high profile launch event may provide an opportunity to raise awareness of the Child House in the media and to thank those who have contributed to its establishment.
- Proactive communications will be needed once the Child House has opened to ensure that practitioners are aware of the services available and to feed back on early findings. Suitable fora include safeguarding training, meetings with teachers and social workers.

Checklist for setting up a Child House

- ○ Is there a communications plan in place for the Child House covering both internal and external communications?
- ○ Has there been any form of segmentation analysis?
- ○ Is there a dedicated communications lead for the project?
- ○ Are there existing communications channels on which the project can build or link to?
- ○ Has the branding and 'look and feel' of the products for the Child House been developed?
- ○ Is there a dedicated website or space allocated on an existing website to disseminate information about the Child House?
- ○ Are there leaflets available for children, young people, parents and professionals telling them who the Child House is for and what services it will offer? Are these available in languages other than English to meet the needs of local communities?
- ○ Have other media been explored to raise awareness, such as film, blogs or podcasts?
- ○ Are regular open days planned to provide the opportunity for people to see the facility and to meet the staff before the Child House opens?
- ○ Have key people been informed about the opening of the Child House and invited to the launch?
- ○ Have multiple internal communication routes been established with the team, to ensure space to review, reflect and development of new processes?

End Notes

1 www.london.gov.uk/press-releases/mayoral/uks-first-child-houses-to-launch

2 Tackling Child Sexual Exploitation – progress report, HM Government (February 2017) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592588/Tackling_Child_Sexual_Exploitation_-_Progress_Report__web_.pdf See pages 3 and 34-35.

3 See https://youtu.be/4pJ1TWcDDsU

4 See https://youtu.be/D2D-P8ucRWc

5 See www.theguardian.com/society/2019/jul/17/lighthouse-uk-first-safe-house-for-child-sex-abuse-victims

6 See www.thelighthouse-london.org.uk/guidance-and-support-for-professionals/downloads-links-for-professionals/

7 See www.london.gov.uk/press-releases/mayoral/lighthouse-offers-support-all-under-one-roof

8 See https://youtu.be/rEbmwcslEBs

9 See www.bbc.co.uk/news/uk-scotland-51154491

Chapter 9
Learning from victims, survivors and families

What this chapter tells you:

Involving children and young people in developing the Child House

9.1 Victims and survivors have an important contribution to make in the development and improvement of services for those who have experienced CSAE. They and the organisations that represent them should have a voice in service re-design and development in terms of their ability to help those responsible to recognise and understand the impact of CSAE.[1] Learning from the views and experiences of those accessing services and frontline organisations is essential to developing an informed and comprehensive understanding of local need.[2] Article 12 of the UN Convention on the Rights of the Child, to which the UK is a signatory, stipulates that children should have the right to express their views freely in all matters that affect them[3].

9.2 Involving CYP in projects such as the development of a Child House can help to enhance the quality of the services and facilities provided and ensure that they appeal to, and are accessible to CYP of all ages and abilities. Public involvement in commissioning is about enabling people to voice their views, needs and wishes, and to contribute to plans, proposals and decisions about services[4]. Different forms of engagement include participation (where CYP are involved in the process and enabled to actively influence the outcome) and co-production (whereby they work alongside the professionals involved as partners to take decisions and come up with shared solutions). See also the Ladder of Engagement and Participation[5].

Children have said that they need:

- **vigilance:** to have adults notice when things are troubling them
- **understanding and action:** to understand what is happening; to be heard and understood; and to have that understanding acted upon
- **stability:** to be able to develop an ongoing stable relationship of trust with those helping them
- **respect:** to be treated with the expectation that they are competent rather than not
- **information and engagement:** to be informed about and involved in procedures, decisions, concerns and plans
- **explanation:** to be informed of the outcome of assessments and decisions and reasons when their views have not met with a positive response
- **support:** to be provided with support in their own right as well as a member of their family
- **advocacy:** to be provided with advocacy to assist them in putting forward their views
- **protection:** to be protected against all forms of abuse and discrimination and the right to special protection and help if a refugee.

From Working Together to Safeguard Children, paragraph 13

Useful sources of guidance

Useful guidance on engaging with CYP in decision-making in health care and ensuring that facilities meet their needs includes:

You're Welcome: quality criteria for young people friendly health services. This includes standards for involving young people, not only in their own care but in the design, delivery and review of services. These standards have been refreshed from the 2011 version shown above and are expected to be published by Public Health England based on: **You're Welcome Pilot 2017, Refreshed Standards for Piloting, quality criteria for making health services young people friendly**

Amplified's website – Amplified is an NHS England-funded resource, run by Young Minds, to develop the participation of children, young people and their families at every level of the mental health system. **https://youngminds.org.uk/youngminds-professionals/our-projects/amplified/**

'Not just a phase – a guide to the participation of children and young people in health services' (Royal College of Paediatrics and Child Health 2010) **https://www.rcpch.ac.uk/sites/default/files/RCPCH-not-just-a-phase-2010.pdf**

Patient and public commissioning in health and care – statutory guidance for Clinical Commissioning Groups and NHS England (2017) **https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf**

Involving CYP in developing social care (Social Care Institute for Excellence, SCIE Guide 11, February 2006 – key messages **https://www.scie.org.uk/publications/guides/guide11/keymessages.asp**)

'Working Together' sets out what CYP have said they want from a safeguarding system, which may be useful when commissioning and delivering services (see **previous page**)

A guide to involving CYP in the recruitment process, NHS Employers, November 2015 **https://www.nhsemployers.org/-/media/Employers/Publications/Children-and-young-peoples-guidance-FINAL-PDF.pdf**

9.3 Under the National Health Service Act 2006, the NHS has a legal duty to ensure that public, patients /service users and carers are involved in the design and delivery of healthcare services[6]. For the purposes of the Child House, the requirement for service user involvement should extend beyond the NHS to encapsulate all aspects of provision including health and well-being, social care, criminal justice and voluntary sector services.[7]

9.4 Working with victim survivors directly, before a Child House is established, presents many challenges including the emotional risk of doing so at a time when they may be particularly vulnerable following the abuse, the risk of retraumatisation and concerns about interference in criminal investigative processes. Specialist input is needed when working directly with victims and survivors of CSAE.

9.5 It may therefore be beneficial to work with groups of CYP who have not experienced abuse themselves but may nevertheless have a valid contribution to make to the commissioning and development of the Child House and ideas about its future use. This could include working with groups of CYP who may be particularly vulnerable to CSAE – for example, Looked After Children, those in Pupil Referral Units and those using local mental health or sexual health services.

Adult survivors of childhood sexual abuse may also be willing to engage in discussions on the Child House, looking at what would have encouraged them to use a service of this kind and to contribute their ideas on its use. Approaching local groups representing CYP in the locality may be a good starting-point.

Ways of including victims and survivors in developing the Child House

9.6 The ways in which victims and survivors (adults as well as CYP) and their representatives can be engaged in the development and operation of the Child House can include:

- Forming an advisory group to advise on the commissioning and to enable them to give their views on what might best meet their needs;
- Participating in stakeholder events;
- Responding to well-designed surveys asking for their views on what services they would like to see and what would encourage them to use the Child House;
- Participating in one-to-one or group discussions on the development of particular aspects of the Child House such as the design of the building and selection of the furnishings, the naming of the new facility, the branding of the written materials or the procurement of the health and wellbeing service – see **paragraphs 15.16-15.19**;
- Involving CYP in the appointment of staff (such as the shortlisting and interviewing, for example – see paragraph 9.7 below);
- Setting up focus groups with professionals including VCSE organisations and advocates working in the area of CSAE.

9.7 Involving CYP in the recruitment process can help to provide a message to all involved that the involvement and views of young people will lie at the heart of decision-making in the Child House[8]. It may also help to improve service delivery by selecting candidates whose personal skills and qualities suit the needs of young people. Those responsible for recruitment will also be able to assess how the candidate interacts with young people.

9.8 Once up and running, feedback from service users will be useful in establishing whether the service is meeting their needs (see **chapter 19**). Setting up a Children's and Young People's Focus Group may be one way of ensuring there is a systematic way of obtaining feedback which can be used to enhance the services provided.

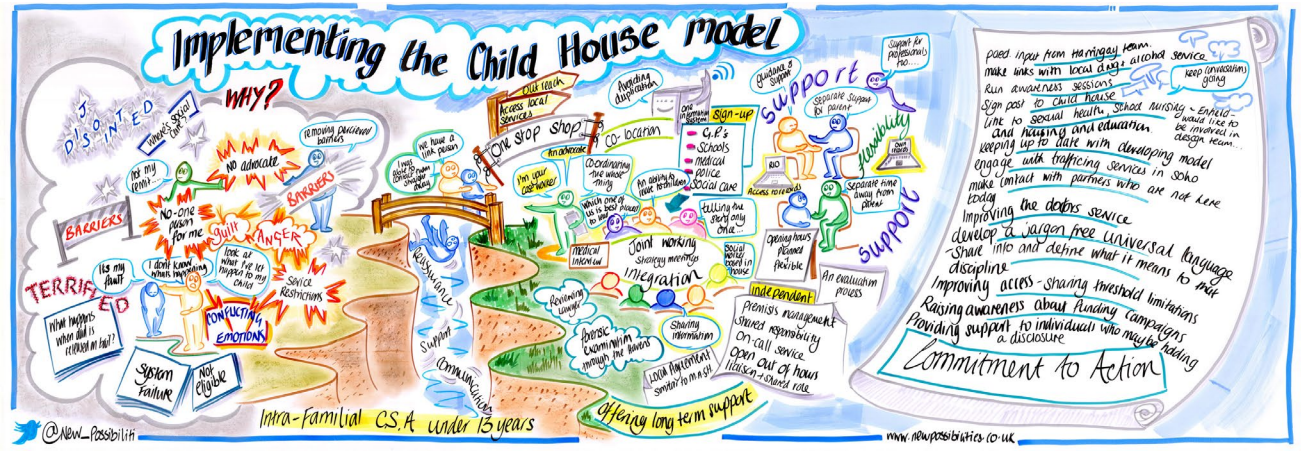
9.9 It is important to give feedback to those who have participated in these discussions, to let them know what will happen next and how their views will be taken into account. A separate newsletter can be produced to keep them updated with developments, or key messages disseminated through social media sites aimed at young people (see **chapter 8**). It is also good practice to offer CYP a small reward to thank them for giving up their time (for example, a voucher).

Learning from children and young people in London

Building on previous engagement

9.10 In London, the work done before the establishment of the Lighthouse on the CSA Transformation Programme had included engagement with groups representing victims and survivors to elicit their views on what was needed. This helped to inform the development of the vision and fed into the plans to develop CSA Hubs and subsequently Child Houses.

9.11 Adult survivor groups were asked to nominate representatives to attend and speak at the stakeholder events in North and South London. Many of the VCS organisations working in the area of sexual violence were invited to these events and received communications including a regular newsletter providing updates on the plans.



9

Involving children and young people in the procurement

9.12 Once it was decided to set up Child Houses in London, representatives of CYP were directly involved in the commissioning of the health and wellbeing service. A group of four young people, aged 15 to 19, selected through a local youth organisation, Youth In Action, were invited to participate in the selection process. This process was led by the Commissioning Engagement Officer at Camden Council. The young people were invited in to discuss the Child House project and the tender process, what would be expected of them and to prepare questions in advance of the tender board. On the day of the tender board, the bidders were interviewed by representatives of the partner organisations including representatives of all those involved in the bid scoring. Both panels then compared notes and arrived at a decision on awarding the contract. In line with good practice, the young people were given vouchers for their participation in the procurement process.

Mobilising the Lighthouse

Involvement in the design and fit-out of the Lighthouse

9.13 Representative CYP were also engaged in the planning, design and fit-out of the building. A wide range of young people who were considered more vulnerable to CSAE were engaged in a variety of ways, including one-to-one discussions and Focus Groups. Not all were victims – some of the young people were selected by schools, but feedback was also obtained from child victims of sexual abuse and child victims of abuse who had been involved in the child protection system. Overall, the team had conversations with over 150 victims and survivors, both CYP and adult survivors. They were asked for their ideas about the location of the service, the look and feel of the premises, the design and facilities, and how to get the ambience right so that CYP would feel at home there. The technical consultants, Atkins, produced a number of options in the form of mood boards for them to look at and express their views on the look and feel of the building which were taken into account.

9.14 A newsletter was produced to inform CYP what was happening with the project and to show how their ideas were being taken into account.

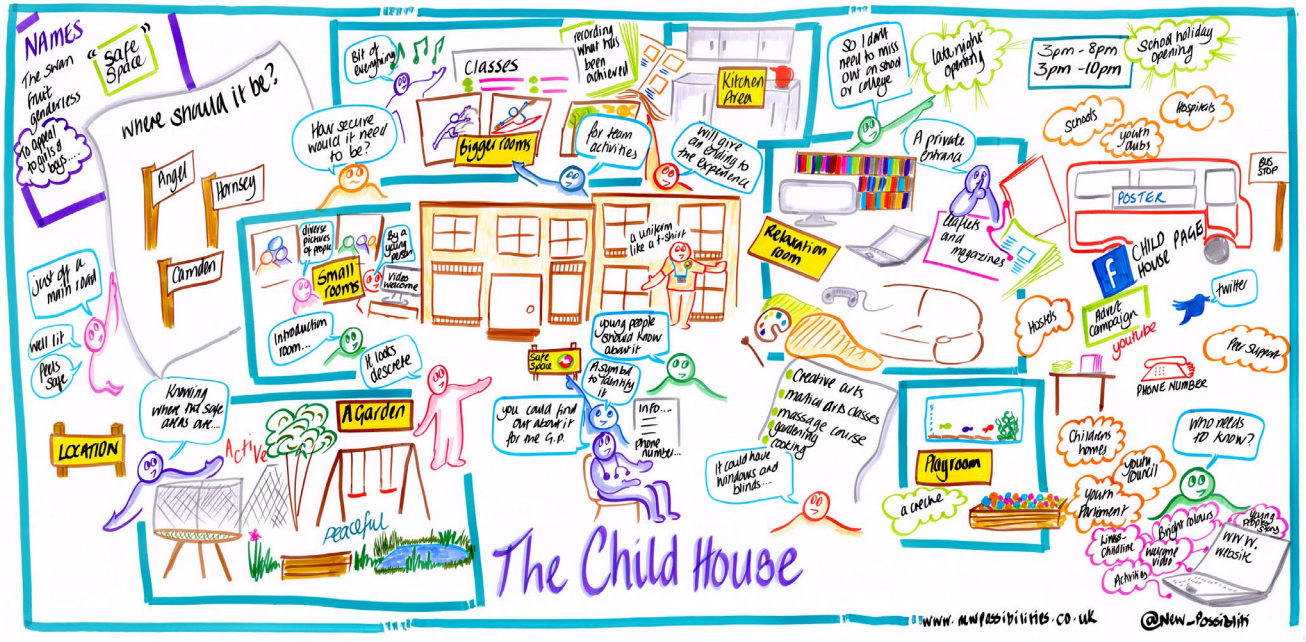
9.15 Although it was not feasible to take account of all of the views expressed throughout this process (for example, it was not possible to have access to an outdoor space which some of the young people suggested), the views they put forward during these discussions are very much in evidence at the Lighthouse. These include the name ('the Lighthouse'), the signage, the branding, design and decor, the furniture and furnishings, and the services available. Their view that the CCTV cameras were obtrusive and might be offputting for CYP were taken into account and smaller cameras found.

9.16 The team intended to involve CYP in the recruitment process for all child-facing roles, but there was insufficient time to arrange the panels and proceed with recruitment at the required pace to enable staff to take up in post within 6 months. However, CYP have been involved in recruiting CAMHS staff at the Lighthouse since it opened.

Operating the Lighthouse

9.17 Since the Lighthouse opened, CYP as well as parents and carers have been involved in Focus Groups. Young people have shared their views in age-appropriate feedback forms, in focus groups as well as contributing and selecting artwork as part of the Lighthouse Artwork Panel. Parents attending the parent education course have shared their feedback.

9.18 Using the young people's and parents own words, advice leaflets have been created to share with other young people or parents attending the service. Audio recordings of their experiences and advice are available on the Lighthouse website. (See links at paragraph 8.13).



Key learning points

- In line with the UN Convention on the Rights of the Child, children and young people have the right to express their views freely in all matters that affect them. Victims and survivors of CSAE and the organisations that represent them should have a voice in service re-design and development to enable those setting up the service to develop an informed and comprehensive understanding of their needs.
- Useful guidance is available on how to involve children and young people in the development of local services which, in the case of a Child House, should encapsulate all aspects of the services to be provided.
- Involving experts in participation, such as a Commissioning Engagement Officer in local authorities or specialists in VCSEs, may help to improve the quality of the engagement and ensure that it is meaningful and not tokenistic. Specialist input is needed when working directly with victims and survivors of CSAE. It may be beneficial to work with groups of CYP who may be particularly vulnerable to CSAE (for example, those in Pupil Referral Units and Looked After Children).
- It may be helpful to involve CYP in any procurement process for the Child House, such as the health and wellbeing service, by participating in interviewing those who submit bids. Their views should be taken into account in awarding the contract.
- Involving children and young people in the design and fit-out of the Child House will help to ensure that the look and feel of the premises and the services offered there are age-appropriate. The implementation team should consider working with a group of children and young people to enable them to express their views on the options available, and to ensure that the name, brand, design, furniture and furnishings, and the final look and feel of the facilities are CYP-friendly.
- Involving children and young people in the recruitment of staff will help to ensure that the staff selected are empathetic towards young people.
- A Young People's Focus Group and an Adult Survivors Group may be one way to elicit the views of representatives of service users and of adult victims and survivors with a view to enhancing the services available to reflect their feedback.

Checklist for setting up a Child House

- ○ Have CYP in the area been able to contribute their views on what services are needed? Are these representative of a range of CYP from different groups, including those who are more vulnerable (eg: those with mental health difficulties or disabilities, looked after children)?
- ○ Have CYP been involved in the selection of premises for the Child House?
- ○ Have CYP been engaged in the procurement processes for any services being commissioned, and in the design and look and feel of the Child House?
- ○ Have the leaflets and forms that will used by CYP been tested by CYP to make sure they are easily understandable?
- ○ Are CYP being involved in the recruitment of staff in the Child House?

End Notes

1 Strategic direction for sexual assault and abuse services, op cit, page 17.

2 Commissioning Framework: for all commissioners of support services for victims and survivors of child sexual abuse in England, Home Office, July 2019, page 19.

3 https://www.unicef.org.uk/rights-respecting-schools/the-rrsa/introducing-the-crc/

4 See Patient and Public Involvement in health and care, page 9.

5 https://www.england.nhs.uk/participation/resources/ladder-of-engagement-2/

6 See Patient and public commissioning in health and care, op cit, page 50.

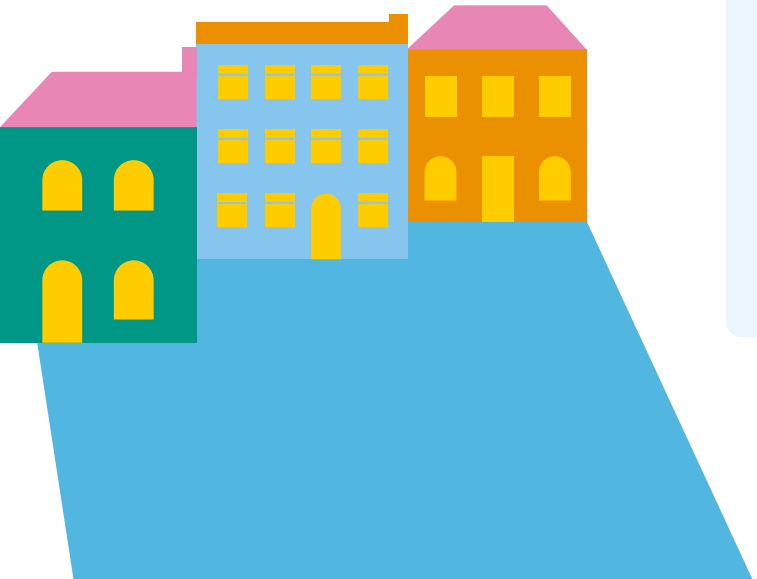
7 See commissioning specification, paragraph 3.7.1.

8 See A guide to involving children and young people in the recruitment process, NHS Employers, November 2015.

9 Other pictures, developed for a consultation event with young people, can also be found on https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/our-priorities/keeping-children-and-young-people-safe

Chapter 10
Delivering the Child House: Local Partnerships Guidance

What this chapter tells you:



Child House: Local Partnerships Guidance

10.1 The Home Office has issued guidance[1], **Child House: Local Partnerships Guidance**, to support local partnerships that are considering adopting a Child House approach to supporting CYP affected by sexual abuse. This sets out the core principles and key elements underpinning the Child House model.

10.2 The Home Office's guidance, published September 2021, builds on the Barnahus Quality Standards (see **paragraph 10.4**) for use across England and is a collection of cross-cutting principles and activities, core functions and multi-agency arrangements that enable child-friendly, effective, and co-ordinated interventions for CYP following sexual abuse. The principles are also relevant where implementing multi-agency approaches to address a broader range of adverse childhood experiences. Both this toolkit and the guidance should be considered when planning to establish a Child House.

10.3 The core principles are intended to underpin all decisions and actions in relation to setting up and operating a Child House:

Core principles:

1. Ensure a multi-disciplinary and holistic approach to assessing and responding to the needs of children affected by sexual abuse.
2. Ensure the safety of the child is paramount.
3. Ensure the best interests of the child. are the primary consideration in all actions and decisions.
4. Provide support to children and parents/carers, regardless of background or level of need.
5. Respect the child's right to be heard and kept informed.
6. Provide support to children as soon as reasonably possible .

The key elements for a Child House are as follows:

1. Multi-agency collaboration.
2. A child-friendly environment.
3. A child-centred approach to evidence gathering.
4. Holistic health assessment and examination.
5. Therapeutic support.
6. Practical support and advice.
7. Learning, improvement and sharing best practice.

The Barnahus Quality Standards

10.4 The guidance builds on the **Barnahus Quality Standards**[2] which were disseminated across European countries as part of the **EU PROMISE** initiative. EU PROMISE[3] is a multi-country partnership started in 2015 which brings together project partners in countries in Europe which have established or are in the course of establishing a Barnahus (children's house) model. Both Barnahus and Child Advocacy Centers in the USA are seen as examples of best practice for supporting CYP who have experienced abuse. These standards represented the first attempt to define the services delivered through Child Houses across Europe. PROMISE 2 was launched in 2017 to promote progress in establishing Child Houses (see **EU Promise 2**[4]).There is a further ongoing project, PROMISE 3, and establishment of the PROMISE Network which will provide a member-led platform for long term support. Drawing on the UN, EU and Council of Europe law and good practice, it followed the signing of the Lanzarote Convention (Council of Europe Convention on the Protection of Children Against Sexual Exploitation and Sexual Abuse) – see **Lanzarote Convention** – which is expressed in the EU Promise vision.

See also **Barnahus Quality Standards: Guidance for Multidisciplinary and Interagency Response to Child Victims and Witnesses of Violence**[5].

Delivering the EU Promise standards in London

10.5 EU Promise standards were instrumental in the work done to develop the operating requirement as they formed the starting-point for the vision and helped to set the aspiration for what the Child Houses in London would look like. Once the operating requirement was agreed (see **chapter 11**), the specification for the lead provider for the health and wellbeing service made it clear that the lead providers should establish services in line with these standards as well as other practice and recommendations arising from the Promise project.

10.6 There was therefore a clear commitment to achieving compliance with the model established overseas in recognition of the success of the Barnahus/CAC model which had been in operation for several years (in the US, for over 30 years).

10.7 These standards therefore formed the basis of many of the discussions held between the partners as well as helping to inform the vision.

> *The EU Barnahus Quality Standards were used to inform the specification for the Child House and were included in the contract. During our mobilisation phase we continued to learn from the standards and ongoing contact with the Barnahus in Iceland and Norway. We made sure that our operating model met these standards, with the exception being that Child House is only for victims of child sexual abuse and not all types of violence. We will be audited against the Promise Tracking Tool as part of the contract monitoring process.*
>
> Emma Harewood,
> Lighthouse Delivery and Service Manager

Measuring compliance

10.8 It was also a requirement that the lead providers should audit the service against these standards[6].The intention was to utilise the **Promise Tracking Tool**[7] and the data to be collected through the Electronic Patient Record. The Lighthouse team have reviewed the child-friendly justice at the Lighthouse compared with EU Promise Barnahus standards and the Lanzarote Convention. This can be found on the Child House toolkit resources page, see XXXXXXXX [hypertext link].

Key learning points

- The Child House: Local Partnerships Guidance, which is based on the EU Promise standards, will be useful when planning and setting up a Child House. These include a range of core principles which should underpin the way in which all Child Houses are developed and operate. The guidance also includes a number of key elements which should be used to inform commissioning of a Child House.
- The EU Promise standards and the underpinning principles may also be useful in informing the development of the operating model for the Child House. These can be used to apply what has been learned from the other Child Houses in Europe to the UK health, social care and criminal justice systems, adapted as appropriate.
- The EU Promise standards and the Home Office's Child House Local Partnerships Guidance may be reflected in any specification for the health and wellbeing service to ensure that the Child House complies with best practice and evidence of what works. The EU Promise Tracking Tool is useful in auditing the service once it is up and running.

Checklist for setting up a Child House

- ○ Does the planned Child House take account of the EU Promise Standards and the national Child House Local Partnerships Guidance?
- ○ Have the EU Promise Standards and Child House Local Partnerships Guidance been used to inform local discussions on the development and operation of the Child House?

End Notes

1 See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1014190/Child_House_Local_Partnerships_Guidance_-_September_2021.pdf

2 See Barnahus Quality Standards https://www.childrenatrisk.eu/promise/standards/

3 See https://www.childrenatrisk.eu/promise/

4 EU Promise 3 has started recently; although the UK is not involved in this project, the website may be useful, see https://www.barnahus.eu/en/wp-content/uploads/2020/03/Promise-II-Vision-FINAL.pdf

5 Barnahus Quality Standards: Guidance for Multidisciplinary and Interagency Response to Child Victims and Witnesses of Violence. See http://www.childrenatrisk.eu/promise/wp-content/uploads/sites/4/2018/04/PROMISE-Barnahus-Quality-Standards.pdf

6 Paragraph 3.1.2 of the Specification for lead provider and health and wellbeing service

7 Promise Tracking Tool, see https://www.childrenatrisk.eu/promise/trackingtool/

Chapter 11
Defining the operating model

What this chapter tells you:

Chapter 11: Defining the operating model

Principles in developing the operating model

11.1 The operating model should be developed in discussion with all the partners in order to develop the specification(s) for whatever the commissioned or procured services for the new Child House. This should reflect the results of any local needs assessment to provide services that fill the estimated current gap. Co-design workshops involving all the relevant agencies are an effective means of engaging practitioners by explaining what the Child House will do and what difference it will make. Local stakeholders and the partners will be encouraged to bring evidence of best practice and research to contribute to the service for that area. These workshops also provide an opportunity to celebrate what is working well in the area and to publicise information about local services.[1]

11.2 In order to offer a 'one stop shop', with several agencies co-located in one building,[2] many Child House models choose to appoint a lead provider, overseeing one operationl team. The lead provider would ideally manage a single shared electronic record and ensure adherence to shared policies/guidelines and ways of working.

Care pathways – the child's journey

11.3 Mapping the care pathways for CYP referred to the Child House should take place as part of the discussions on the operating model, involving all the partners and local agencies. This needs to address the following:

- how the interface between health, care, child protection, education and criminal justice aspects of the pathway will be achieved
- whether there needs to be an actual disclosure or allegation of CSAE for a child or young person to be referred, or whether a referral would be accepted following suspected CSAE (which may be verbal or non-verbal)
- what form of triage would be needed (including the search for additional information to support the referral)
- where referrals are expected to come from including whether self-referrals would be accepted
- how the service should support children who are victims of CSAE but who are also involved in sexually harmful behaviour
- the arrangements and scope for children with special needs/learning disabilities
- the appointments system to be used (whether this should be a bookable appointments system only or whether walk-ins would be allowed)
- what the initial response would be depending on the individual case (this could include a medical examination, an urgent medical assessment to collect forensic evidence where this is within the forensic window, an investigative interview, urgent care from social services)
- multi-disciplinary assessment and reviews processes
- whether any CYP currently supported in similar services will be transferred into the Child House
- how referrals would be made by the Child House for other support services for the CYP or their family (including following discharge). These might include referrals to domestic violence services and specialist CAMHS including crisis mental health services
- the arrangements for young people approaching the age of 18 who will need to transition to adult services
- what impact the Child House is likely to have on current referral routes and how they should be adapted accordingly to ensure the child is at the centre of the pathway.

11.4 It is important for the management of each case to be led by a 'primary case worker' to ensure that there is co-ordinated, efficient and relevant intervention by the respective multi-disciplinary practitioners and agencies. The primary case worker should arrange regular case reviews to enable the team to share information and manage risk, and

work together to support the child or young person's journey throughout the stages of the therapeutic recovery, investigative and judicial process. Case review also allows the multiagency team to monitor progress and outcomes of cases referred to the service.

11.5 The treatment offered needs to comply with **guidance on the provision of therapy for vulnerable or intimidated adult witnesses**[3] (for parents) and **practice guidance on the provision of therapy for child witnesses prior to a criminal trial**[4] (also see **paragraph 5.14**). This means that, in general, certain forms of therapy may be offered, where this is in the child's best interest, but participation in some forms of group therapy or individual therapy involving hypnosis or regression are proscribed.

Regulatory requirements

11.6 There are many regulatory requirements that will need to be taken into account in setting up a Child House. Formal recognition and regulation of the Child House by the local authority, police and healthcare system will be required. The requirements include:

- Complying with national and local child safeguarding and reporting policies and procedures (including appropriate clearance requirements such as DBS checks for all staff)
- Health and safety regulations
- Registration with the Care Quality Commission (CQC) (where appropriate – **paragraph 15.13**) which must be complete before the service begins to operate
- NHS regulations and guidance including NICE guidelines
- **Guidance** on, and the **response** to Joint Targeted Area Inspections on the theme of child sexual abuse in the family environment (JTAI)[5,6]
- Data protection laws (see **paragraph 16.6** in Information Governance)
- Building regulations (see **paragraph 15.13** in Estates and premises)
- Accessibility requirements
- The individual requirements of the partner agencies (eg: NHS, police and children's social care, voluntary sector and others).

Referral process

11.7 Procedures should be in place to receive referrals in from a range of agencies which should address issues such as whether the child or young person knows that they have been referred, whether the referral form has been completed, confirmation that the referrer has followed local safeguarding procedures which may include alerting the local MASH and police, for example. Procedures for accepting self-referrals, if applicable, should

Case study:

Samira is a 15 year girl, referred just for counselling but she had the opportunity to meet the Lighthouse team at her initial assessment. This created an opportunity to meet the paediatrician, when Samira had only intended to seek counselling support. During the holistic assessment, she shared concerns about self-esteem, severe eczema and her weight, including how they related to the sexual abuse she had experienced. The paediatrician was able to prescribe medicines to treat the eczema. There was also time in follow-up appointments to listen and then to refer to a specialist at the hospital for further treatment of her eczema.

Throughout this time, Samira was attending weekly therapy sessions, which have been led by her. Samira felt really valued that the team had taken the time to support her in all areas of her life; her eczema and self-esteem are improving, and she will be starting to see the dietitian for advice about weight and healthy eating.

also be drawn up, including a self-referral template to capture relevant information during the phone call, access to practitioners for advice and guidance. Arrangements will be needed as to who will then request information relating to the case. This may be the SCLO and/or the PLO who will be able to liaise with all the local agencies as well as conducting an initial risk assessment. Holding regular intake meetings is one way of reviewing all the referrals and ensuring that these are assigned appropriately.

Initial assessment and examination

11.8 Every CYP should be offered an holistic initial assessment with the chance to meet representatives from the wider multi-disciplinary team and for the CYP to direct the pace of the assessment. This usually begins with a professionals meeting before the family arrive, to enable the team to get more of a current perspective from the referrer. The time is also used to find out how the team can best position themselves and plan the assessment that will enable the family to feel comfortable and respected.

11.9 The assessment starts with introductions and finding out what is important for the CYP, family/parent and social worker/referrer as these can be very different. In order to engage the child or young person, it is best to start with their strengths and what they enjoy doing/hopes for the future. The team then move on to what worries them most (e.g. flashbacks, stomach aches, not sleeping, headaches). Depending on their response, the emphasis will change and can include a medical and mental health history taking, assessment and a medical examination ('health check') at the initial appointment. Often, the initial assessment process is done in several appointments. The whole team can include the consultant paediatrician, an advocate, an emotional health and wellbeing practitioner, a clinical nurse specialist in sexual health and a play specialist.

11.10 The medical examination should be carried out by a consultant paediatrician with specialist training in child sexual abuse and child maltreatment, supported by a clinical nurse specialist in sexual health and a play specialist. This should include reassurance, a general health check, a forensic medical examination with a colposcope (including the ability to securely save the recorded images) where applicable, sexual health screening and treatment, contraception and advice. The clinical team should have access to, and be able to use, equipment for child-friendly examination.

Therapeutic support

11.11 The clinical team will then meet separately to 'formulate' or gather their understandings of what has happened, what the need is and then share that understanding with the family. If the family agree, the team will then recommend whatever interventions are considered appropriate which may include:

- Consideration of any immediate child protection concerns – this is essential followed by (depending on the child or young person and the time available):
- Advocacy
- CAMHS support including counselling, therapy or psychological support for the child or young person. This support can also include consideration for the newly established courses for young people and parents affected by sexual abuse/ exploitation.
- *Letting The Future In* (LTFI) and *Protect and Respect* (P&R) (see **paragraph 11.33**)
- Psychoeducational support for the CYP (this could be through a young people's group if there is one), the wider family, sibling/s and parent(s) on an individual or group setting
- Medical follow-up including in relation to the abuse, e.g: somatic symptoms, concerns re physical health, weight management, medication
- sexual health treatment, contraception and immunisations

Case study:

Leah is a 14 year old girl with a learning disability who attended the Emergency Department at her local hospital after self-harming and was referred for a look around the Lighthouse after she disclosed sexual abuse. At her first visit, she met the advocate and she felt like she didn't need any support at that time, but when she attended a few weeks later for a medical follow-up, she did seek support for her sleeping difficulties and coping with bullying at school.

Following this slow introduction to the service, at her pace, she felt confident enough to text the advocate for support when she started significantly self-harming some weeks later – texting can be a much easier form of communication for some young people. This contact enabled the Lighthouse to offer support in the moment, when Leah would have previously found it hard to communicate her need to professionals. Leah started to access weekly joint sessions for her and her mum with the advocate and a CAMHS practitioner, as well as meeting the community psychiatrist at the Lighthouse instead of in the local CAMHS clinic.

- where needed, referral on to other services such as domestic violence services or specialist CAMHS etc.
- Referral and signposting for the parent
- Consultation/support to local services (eg CAMHS or school counsellors) in support of their ongoing relationships with CYP.

Advocacy and advice

11.12 The role of the advocate in providing support the child, young person and parents is key. They may work with the child before attending the Child House, provide support on the day of the ABE interview, ensure that the child's voice is heard during the initial assessment and play a key role throughout the police investigation.

Demand and capacity mapping, and staffing

11.13 Demand and capacity mapping should be carried out early on – **guidance from NHS Improvement** may be useful[7]. Analysing the expected demand and capacity will ensure that the service being set up will be appropriate for the level of need in the area and will help to ensure a smooth flow of service users through the system (ie: without creating bottlenecks). This will help to ensure that plans are based on an estimate of the number of CYP who might need the service in the area served, depending on how much is anticipated to be delivered in the Child House itself and how much will continue to be delivered by other existing services.

11.14 The analysis should be based on the following kind of calculations:

- how many cases there are likely to be based on the number reported to the police (though recognising that there will be unreported cases),
- what number/percentage of CYP would need each service, such as advocacy, counselling, CAMHS, play activity, *Letting the Future In*, or *Protect* and *Respect*,
- how many would require an ABE interview, medical examination,
- how many parents or carers are likely to require advocacy,
- the number requiring social care liaison support and police liaison support,
- the length of each appointment,
- how long on average each case is likely to take from presentation to the Child House to post-court support,
- how many cases each practitioner would be able to see each week.

Further capacity mapping will be needed at a later stage, including once the service is up and running, as well to reassess the level of staff that are needed and to ensure that this is appropriate.

Agreeing the skill mix

11.15 It will, however, be for the provider of the service to decide on the precise numbers and the exact skill mix of the staff to be employed within the financial envelope available. Staff are likely to include the following, depending on the outcome of local discussions:

- Child House Service Manager
- Clinical lead with a paediatric, mental health or safeguarding background (or, possibly, a joint appointment) to work jointly with the manager in a joint leadership role
- Consultant paediatricians
- Clinical Nurse Specialist for sexual health and healthcare assistant
- Mental health – CAMHS including clinical psychologists
- Wellbeing practitioners – VCS providers
- Advocates
- Play specialists
- Social Care Liaison Officers
- Police Liaison Officers
- Officer manager and administrative staff
- Data Officer

Case study:

Max, aged 11 and his sister Victoria, aged 10 who has a learning disability, were brought to the Lighthouse for their Achieving Best Evidence (ABE) interviews after Victoria disclosed to her teacher at school one day. She reported that her stepfather had been sexually abusing her and her brother. Usually the children would have been rushed to a police station for their interview, so arriving at the Lighthouse to be greeted by two advocates in a child-friendly environment and offered lots of hot chocolate was much better after a long day at school. Victoria gave an interview, but her brother, Max, was not so keen.

After several months of fun sessions and trips out, each with their own advocate, Max also felt able to give an ABE interview. The children's non-offending parent was helped to learn how to support the children in the parents' psychoeducation group. Both children were also able to continue with advocacy support, engage in health checks and child and adolescent mental health therapists. The Lighthouse were able to release all the notes (medical, therapeutic and advocacy) quickly to support a speedy police investigation. The high quality evidence gathered in the Lighthouse environment meant that within six months, the CPS was able to charge the alleged perpetrators. The perpetrator pleaded guilty and a conviction was reached without the need for the children to be cross-examined in court.

Max and Victoria's mother was invited to the course for parents and then continued to meet with a clinical psychologist for monthly sessions at the Lighthouse in order to continue to support with her 'containment' of both children.

Challenges of staff employment and contracts

11.16 Discussions should take place at an early stage as to the basis on which these members of staff are to be employed. This will depend partly on how the service has been commissioned and the duration of the funding. Staff can be employed directly, via sub-contracts with a partner agency or seconded to the Child House – not all need to be employed in the same way though there are additional complexities where staff are employed through different employers/ agencies, with different terms and conditions of service. In general, it is better for the Lead Provider to employ staff directly where they or a subcontracted provider holds the budget, assuming that the staff concerned wish to work for the Lead Provider.

11.17 Secondment may be more appropriate where someone else holds the budget. In the case of any Police Liaison Officers and Social Care Liaison Officers being employed at the Child House, for example, they are likely to be seconded and remain employed by the police service and local authority respectively. Where staff are not employed directly by the Child House, it is important that there is some line management and oversight of performance management of those staff wherever possible. Where staff are seconded, they should still be able to benefit from professional development from their employing organisation. Whatever the arrangements for employing staff, it is important that all staff are signed up to the ways of working and the guidelines used in the Child House.

Information Technology

11.18 Early consideration should be given to defining the IT requirements for the Child House. This should include the cabling and hardware, the electronic patient record or case management system and the telecommunications equipment. More detail on meeting the IT requirements is set out in chapter 17.

Use of video evidence

11.19 Part of the intention of the Child House model is to be able to build on international best practice and related trials in England and Wales on use of video links and recorded evidence. The research shows that repeated interviews can lead to the retraumatisation of child victims. Measures need to be taken to ensure that children are provided with opportunities to give evidence in an emotionally and physically safe and conducive environment by staff with specific training in forensic interviewing.

11.20 The Child House may therefore include the following:

- The psychology-led Achieving Best Evidence interviews based on the Icelandic Barnahus model;
- The use of a live link to the Crown Court for cross-examination, where the child witness was able to be cross-examined from SARCs or social care building with the presiding judge overseeing proceedings in person or via live link with the courts. This is already available at some SARCS including Manchester, Durham and Ipswich;
- The pre-trial recorded cross-examination of witnesses under section 28 of the Youth Justice and Criminal Evidence Act 1999 which had previously been trialled in Kingston, Leeds and Liverpool Crown Courts. This has been rolled out across England to a further 16 Crown Courts: Aylesbury, Bradford, Bristol, Carlisle, Chester, Durham, Leicester, Mold, Northampton, Oxford, Portsmouth, Reading, Sheffield, Swansea, Wolverhampton and Wood Green (which covers The Lighthouse).

The latter ensures not only a reduced time delay from reporting to trial, but also provides the opportunity at the Ground Rules Hearing to ensure the cross-examination questions are in plain English for the child to understand. The model reduces the need for the child or young person to attend the Crown Court to be cross-examined by the defence barrister which generally takes place many months or years after the alleged abuse. The London

Rape Review published in 2019 found that, on average, case progress from reporting to trial outcome took over 18 months[8]. The Children's Commissioner for England found that the investigative process for CSA cases is considerably longer than adult sexual offences (with a median length of 248 days compared to 147 days for adults)[9].

11.21 Not only is this approach intended to be less traumatising for the child, but it also avoids the difficulty of the child having forgotten the detail by the time the case comes to court. This will enable the child or young person to give a better account, resulting in enhanced quality of evidence.

11.22 Securing the engagement and approval of the judiciary at an early stage to the approach to be taken is essential. In the first instance, an approach should be made to HMCTS who are responsible for the approval of new sites. The **National Remote Link protocol** provides further details[10].

Consultation service

11.23 As well as seeing CYP directly at the Child House, it has been found that it is often helpful to offer expert advice in the form of a consultation and liaison service whereby professional staff can advise on particular cases without actually seeing the child or young person. The team have also learned from their relationships with local services that colleagues often want advice or signposting whereby professional staff can advise without actually seeing the CYP. This can include contextual safeguarding such as liaison with schools, housing and community safety. Sometimes this happens before seeing the CYP and also afterwards if they continue with local services. This can help staff locally working with those with complex issues and can include troubleshooting and care planning or help with assessment[11]. The referrer is positioned as an 'expert' on the family they have referred and the sessions are also used to ensure that the team can prepare as well as they can for those families who will access their services.

Training

11.24 The team are frequently invited by social care colleagues, local school staff, head teachers and local CAMHS services to provide some training around trauma and sexual abuse. The Lighthouse team have designed and delivered resources which they use, but each training session is shaped by the person requesting the training and the local context.

Case study:

A 7 year old boy called Tom was referred to the Lighthouse after reporting oral and anal rape by a teenage relative. He was interviewed by local police in the Lighthouse 'Talking Room' and met the Lighthouse team in a holistic initial assessment with the paediatrician, nurse and wellbeing team. Tom was supported with 20 therapeutic sessions, but the sexual abuse has impacted his whole family. His parents were able to attend the parent psychoeducation group and grew in confidence as to how to support Tom and his younger brother to talk about sexual abuse.

Using the NSPCC Pantosaurus film, the younger brother was able to allege abuse by the same relative to the family and also agreed to being interviewed by the police at the Lighthouse. The family members each had their own support from the Lighthouse and were able to support each other as the criminal justice process proceeded. Within 12 months, the perpetrator had pleaded guilty before the trial, meaning that Tom did not have to be cross-examined and the family did not have to experience the trial process.

Developing the operating model in London

Piloting the operating model in London

11.25 In London, the operating model for the Child House was one of the three key products of the work on the Pan-London CSA Transformation Plan. The model that was developed through this and subsequent work was derived from the capacity mapping carried out with the partners. This informed the operating model which later became the specification for the procurement of the health and wellbeing service. The Lighthouse service description[12] gives details of the services on offer and the way in which it operates.

Meeting the regulatory requirements

11.26 In setting up the pilot, the lead provider and the partner organisations had to comply with many regulatory requirements, such as the London Child Protection Procedures[13]. It was necessary to register with the Care Quality Commission as a community service even though the Lighthouse was part of UCL NHS Hospital Trust, since it was operating as a standalone service. This took around 8-12 weeks for the initial response from CQC (from May to October 2018) and was followed up by a visit to ensure that the Lighthouse would meet the standards required. This had to be done before the Lighthouse opened.

Referral routes and care pathways

11.27 Part of this work involved the drawing up of the referral and care pathways which show the child or young person's journey following disclosure of sexual abuse or exploitation, or suspicion by a professional that a child or young person had experienced CSAE. A series of workshops was held with practitioners from the organisations to be involved in the tender as part of the preparations for the tender (in North London, these comprised UCLH, the Tavistock and Portman NHS Trust, NSPCC, Solace Women's Aid, the Brandon Centre and Respond). Procedures for referring CYP on once they were discharged from the Child House were also agreed. It was agreed that self-referrals would be accepted and that referrals where there was a suspicion of CSAE but not actual disclosure would be accepted where there was a social care section 47 investigation underway.

11.28 As well as seeing CYP personally, the Lighthouse offers boroughs a consultation service provided by the SCLO and other professionals to support and advise the local professional network. This has proved to be a popular service. Sometimes an offer of consultation with the professional network is offered before the Initial Assessment which can be helpful and may result in a more productive Initial Assessment if that is taken up later on.

11.29 The SCLO and PLO roles are key in the time between the referral being received and the Intake Meeting. Within hours of the referral being received, the SCLOs triage to review immediate safeguarding issues and referrers are signposted to the CYP Havens service and police if necessary before coming to the Lighthouse. The SCLO ensures the professional has made a referral to the MASH and gathers the information to make a good referral. They can join the Strategy meeting and can hold a case until such time as there is clarity as to what is being requested. The SCLOs also liaise with the five Senior Leadership Teams in the five London boroughs as well as the five MASHs which helps to ensure good communication and reduce the need for having to escalate cases at a later stage. The PLOs will liaise with the local officer in the case to offer an ABE at the Lighthouse and to gather the information needed for the Intake Meeting.

It was decided that a bookable appointments system would be used rather than allowing people to walk in to help optimise use of staff time and for the safety of the children and staff.

Child's journey through the Lighthouse

Once a referral concerning a child or young person is received at the Lighthouse, the multi-disciplinary team review it at the Intake Meeting which takes place twice weekly. In the time between referral and the Intake Meeting, the SCLO will join the strategy meeting and ensure immediate safeguarding has been considered with referrals to Children's Social Care, CAMHS crisis team or Police as necessary. Requests for all the relevant information, with consent and knowledge of the family mean that the Lighthouse is fully informed. The SCLO will also often ask important 'relationship to help' questions on the family's behalf so we can learn what has worked well or less well in engaging this family with professionals in the past.

Sometimes prior to the child attending for an Initial Assessment (IA), the SCLO and some of the team will offer a consultation to the referrer and the local network. This can be valuable in gathering background information so that the team are more prepared when the child and family attend. These consultations are always evaluated by an anonymous feedback form to the consultee, and information gathered shapes the way the team requests that information.

Often further information is gathered or discussions initiated by the Social Care and Police Liaison Officers; they may also attend a strategy meeting. This sets the context for the referral and helps in deciding whether the Lighthouse is the right service for the child or young person at that time.

Before the first appointment, the Lighthouse team decide who will conduct the assessment. This may include the advocate, play specialist, Consultant Paediatrician, the clinical nurse specialist for sexual health and an emotional health and wellbeing practitioner (CAMHS or therapist from NSPCC).

Any immediate safeguarding concerns are addressed and an advocate allocated to the family.

Where appropriate, the child or young person is then referred for a psychologist-led ABE interview, supported by a Lighthouse advocate, which ideally takes place before the first appointment with the team.

At the first appointment, the child or young person attends the Lighthouse with their parent/carer and local social worker (if involved). Any immediate safeguarding concerns are addressed and decisions made (safeguarding action is also taken as required). Every child or young person is offered a paediatric consultation which may include examination then or at a further appointment. It is carried out by one of the paediatricians, usually supported by the play specialist, and the sexual health nurse where appropriate for screening. Treatment is given as needed. The assessment also includes mental health and wellbeing. It may take multiple appointments before the child or young person feels ready to attend for this appointment. The team always goes at the pace suggested by the child or young person.

After the first appointment, most children and young people choose to start an assessment with a therapeutic practitioner from CAMHS or NSPCC. Depending on the outcome of the assessment, the child or young person and the family members may be offered a range of support and interventions bespoke to each child and family, including:

- individual or child and family therapeutic support
- medical follow-up including sexual health treatment, contraception and immunisations
- a psychoeducational course for the parent/carer(s) and other family members (either individually or in a group setting – see diagram below)
- referral on to other services such as domestic violence services or specialist CAMHS
- consultation/training to local services (including school staff and local CAMHS)

After the assessment phase, the support usually lasts up to 20-24 sessions for the child and 6-8 sessions for the parent/carer.

Throughout this time, the child or young person is supported by the advocate to ensure that the voice of the child is heard and to help navigate the complex journey of returning to school, the police investigation or the court process.

Once the referral is accepted at the Lighthouse, the child or young person is assigned to a primary case worker. The primary case work or an advocate sometimes meets the child or young person for a look around before the first appointment to familiarise them with the service, and can support them when they attend for their Video Recorded Interview (VRI)/ABE interview. In the majority of cases, the VRI is done before the IA. Where appropriate, the child or young person is then referred for a psychologist-led ABE interview, supported by a Lighthouse advocate, which ideally takes place before the first appointment with the team.

Child's journey through the Lighthouse

11.30 The precise pathway (see page 72) of the child or young person will vary. A personalised approach is taken with the child or young person and their family at the centre of decision-making.

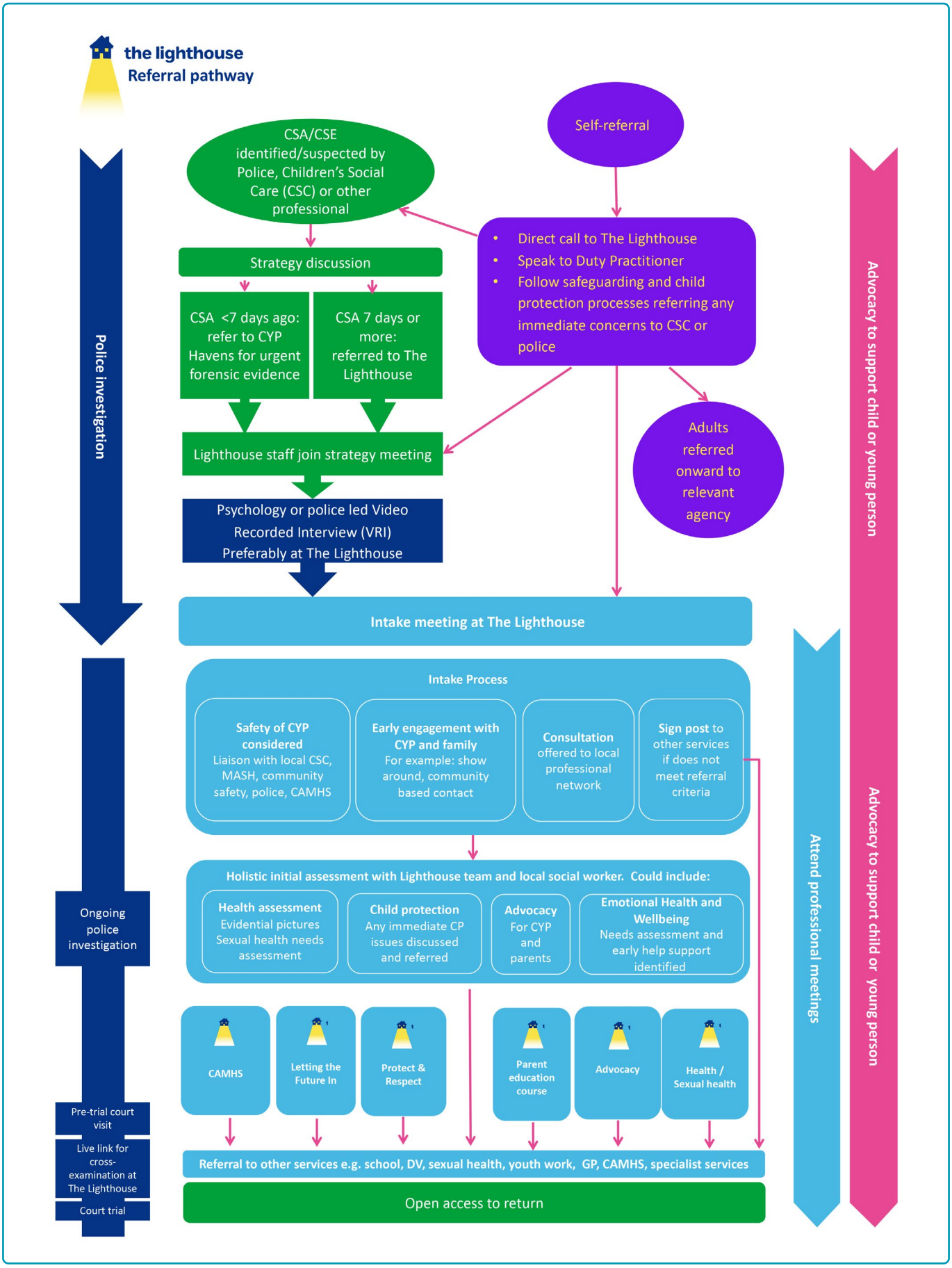
The approach is highly collaborative and adapted to the individual case, taking account of feedback received from the family in every case. The following describes the general pathway, with diagrams illustrating this set out below. However, this is likely to vary with the child or young person and family offered a range of choices and practitioners adopting a highly flexible approach.

11.31 The timeline for a typical journey through the Lighthouse is illustrated below[14]:

Timeline in months	1	2	3	4	5	6	7	8	9	10	.//.	Trial date
ABE interview – psychology led	ABE											
Initial Assessment		IA										
Health			Follow up, sexual health, immunisations									
Advocacy	Advocacy support with school, police investigation and court trial											
CAMHS			CAMHS support siblings									
CAMHS					Parent psychoeducation course							
NSPCC – *Letting the Future In*			LTFI assessment		LTFI programme							
Onward referral									Refer parent to adult MH			

- Local police and criminal justice system
- Medical
- Advocacy
- Emotional Support

Referral pathway for a child or young person following disclosure of sexual abuse or exploitation[15]



Treatment available at the Lighthouse

11.32 The therapeutic needs of the children and their wider family are assessed over a few sessions following the initial assessment. Some of the treatment interventions which are subsequently offered at the Lighthouse are described below.

CAMHS

The CAMHS team is a skill mixed team comprising psychologists and CAMHS practitioners (including a mental health nurse), with access to a psychiatrist for advice and ad hoc supervision. Individual supervisions of practitioners comes mainly from the lead and deputy lead psychologists in the service, with specialist advice and group supervision from the consultant psychiatrist. In common with other Lighthouse practitioners, members of the CAMHS team consult regularly with the professional networks around the young people and make significant contributions to child protection conferences, core groups and other statutory and more informal meetings. It is well known that being believed and supported by parents or carers is often crucial in promoting a young person's recovery.

The team have found that many of the parents who come to the Lighthouse also have a history of abuse or exploitation. Often, the experience of supporting the child leads parents to disclose their own experiences of abuse in the context of their child having disclosed. As a consequence, the CAMHS team work with parents in a variety of ways to help them understand and respond appropriately to their child's difficulties.

Siblings who have not been directly abused themselves may also need help. The CAMHS team offer a variety of more individual modalities including trauma-focused CBT, EMDR[16] and more narrative-based approaches. Groups for parents and for young people have been successfully piloted and evaluated.[17] There are a high number of CYP experiencing self-harm or suicidal thoughts, who can deteriorate quickly. The Lighthouse works closely with local CAMHS crisis teams, to manage the highest risks and some young people have required inpatient admissions. The CAMHS team supports the children, young people and families with the most complex mental health concerns and neurodiverse presentations.

Case study:

Josie is a 17 year old girl who was referred to the Lighthouse by her local sexual health service. Josie was referred to the Lighthouse as she was struggling with negotiating sexual relationships, after being abused between the ages of 7 and 12 by a close family friend. The perpetrator was eventually sentenced to 9 years, but Josie received no emotional help at the time of the investigation and trial. After her first assessment, Josie started to meet regularly with a CAMHS practitioner and it became apparent that her college had excluded her for disruptive behaviour and anger issues with the other students, without taking the time to speak with her or her parents about what might be the cause.

The CAMHS practitioner supported the college to understand the impact that Josie's developmental trauma has on her ability to ask for help and engage with education in a busy college environment. The college agreed to Josie re-starting her course and put in place mechanisms for Josie to seek help from a mentor and leave class when she needed to. The CAMHS practitioner also facilitated conversations with Josie and her parents about the experience of the sexual abuse, disclosure and resultant family changes. These joint appointments have been important in negotiating conversations around adulthood and growing independence for a young person who has experienced sexual abuse and a parent who was unable to protect her daughter from this abuse. Josie has also received support from the Lighthouse sexual health nurse who has supported her with information about sexual health, decisions about contraception and the immunisations that Josie missed while she was out of school during the trial.

Letting the Future In

Letting the Future In (LTFI) is a therapeutic intervention for children affected by sexual abuse and their carers. Developed by the NSPCC, it is a structured guide to therapeutic intervention grounded in an understanding of trauma, attachment and resilience[18]. It has been widely implemented across the UK since 2011 and is available to children aged between four and 17 who have made a disclosure and experience sexual abuse, live with a safe carer and do not have a diagnosed learning disability. It is largely psychodynamic in nature but draws on other methods including counselling and socio-educative approaches. Children receive up to four therapeutic assessment sessions followed by up to 20 intervention sessions, extended to 30 if needed. LTFI is recommended in the NICE guideline on child abuse and neglect for CYP (boys or girls) aged 8 to 17 who have been sexually abused[19].

Protect and Respect

Protect and Respect is the NSPCC's intervention for CYP who need support to learn about healthy relationships or who may be at risk of or experiencing sexual exploitation. The intervention uses a variety of trauma-informed approaches to improve wellbeing and promote resilience. It takes place over a six month period which can be extended to 12 months if needed, and offers a safe space in which to promote learning, reflection and support utilising trauma-informed and therapeutic approaches. It can complement and work alongside therapeutic support from child and adolescent mental health services (CAMHS).[20]

Parents' education course

The parents' course was established following agreement from the Crown Prosecution Service (CPS) and offers a safe space for parents to meet others going through similar situations. The course is based on the 'Circle of Hope' model from the US and delivered by an advocate and a CAMHS practitioner.[21] The course is a psychoeducational group rather than a therapeutic intervention. The course had 100% attendance by parents and feedback has been extremely positive[22]. The course has to comply with guidance on pre-trial therapy (see **paragraph 5.14**) – **parents are required to sign a contract**[23] which refers to the need to avoid identifying the perpetrator or the details of the abuse or assault.

> *It seems so daunting when you get the disclosure, but it's amazing how much progress you can make with the tools the Lighthouse gives you.*
>
> Quote from parent

Case study:

Jamelia is a 12 year old girl who told her school teacher that she had been raped by an older boy on her estate. At the Lighthouse, she was supported by an advocate, a practitioner from the 'Protect and Respect service', and the paediatrician. The close proximity of the alleged perpetrator meant that Jamelia and her family needed help with finding a new house, new school and how to manage the fallout on social media. The police investigation and upcoming trial was really hard for Jamelia and on many occasions she wanted to pull out altogether; however, she had very good support from her allocated advocate who explained the process clearly and listened to her anxieties. She and the paediatrician also wrote to the local housing association supporting the family's application by explaining the urgent need for the family to move with their consent. She feared the repercussions of what would happen if the perpetrator was found guilty; she was being pressured by other young people on the estate not to speak out and even bullied at her new school, where news of the rape had already travelled on social media.

The Lighthouse team supported her and her mother, who was also facing triggered memories from her own sexual abuse, to be strong together for the trial. Additional support was arranged for her mother from the local adult mental health team and the Lighthouse worked closely with local services to create safety plans for Jamelia. On the day of the trial (just nine months after reporting the rape), the advocate attended court with Jamelia and her family. Her father said "We wouldn't have been able to go through with this if it wasn't for the Lighthouse".

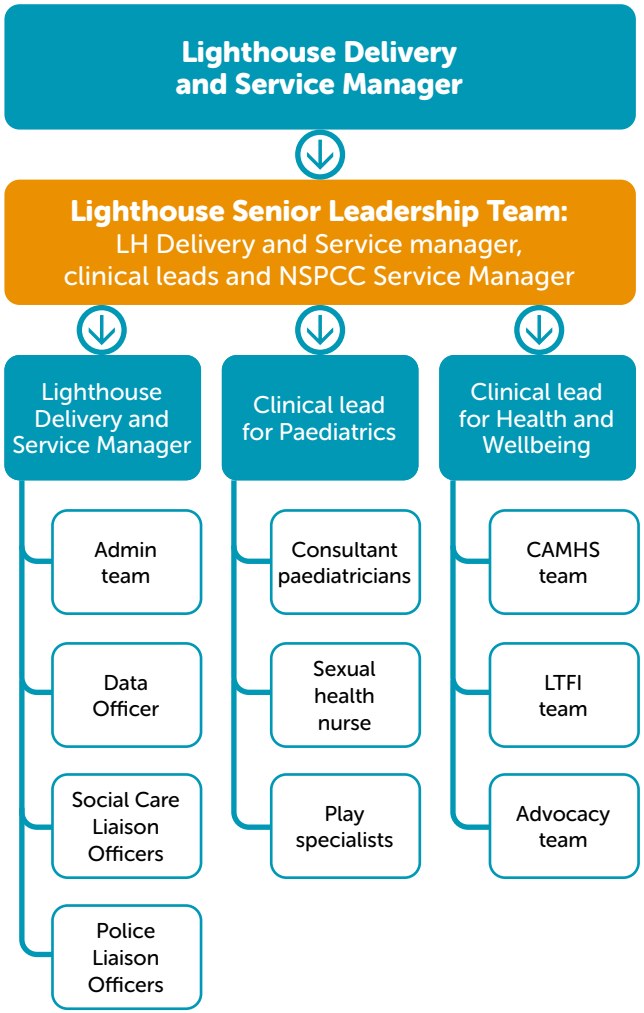
Developing the staffing model

11.33 A detailed demand and capacity needs analysis was carried out which looked at the anticipated caseload broken down to show how many CYP and parents were considered likely to require each of the services to be offered. This led to the development of a staffing model showing the workforce assumptions based on discussions about the likely level of demand for each staff group or service (eg: paediatrics, counselling/ therapeutic, advocacy, play activity, the number of parents likely to require advocacy, social care liaison and police liaison). This was reflected in the service specification for the lead provider but adjusted to take account of the resources available – for example, there was less funding available for advocacy than the capacity mapping exercise had calculated was needed.

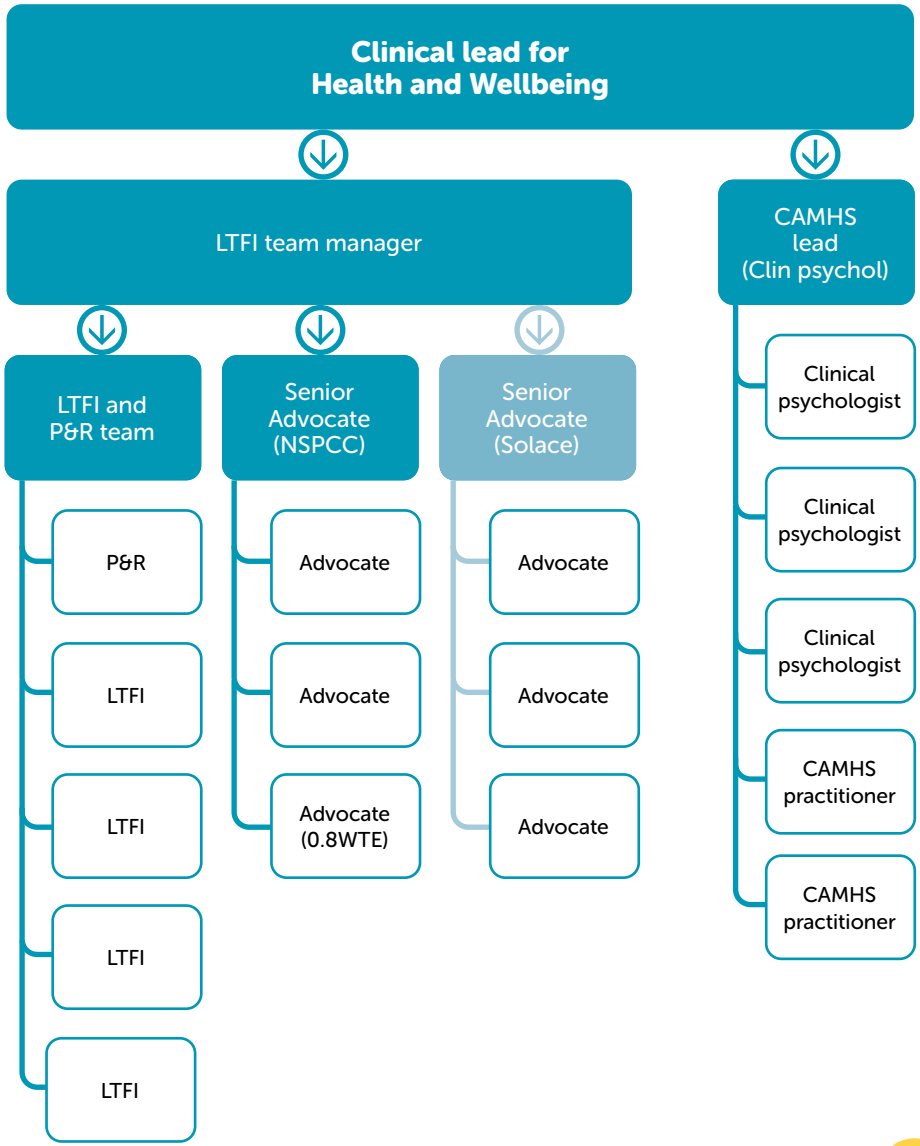
11.34 The diagram below shows the staffing model adopted by the Lighthouse which was adapted to fit within the resource envelope set out in the specification. This was used for the first two years of the pilot.

More detailed structure charts are shown over the next two pages.

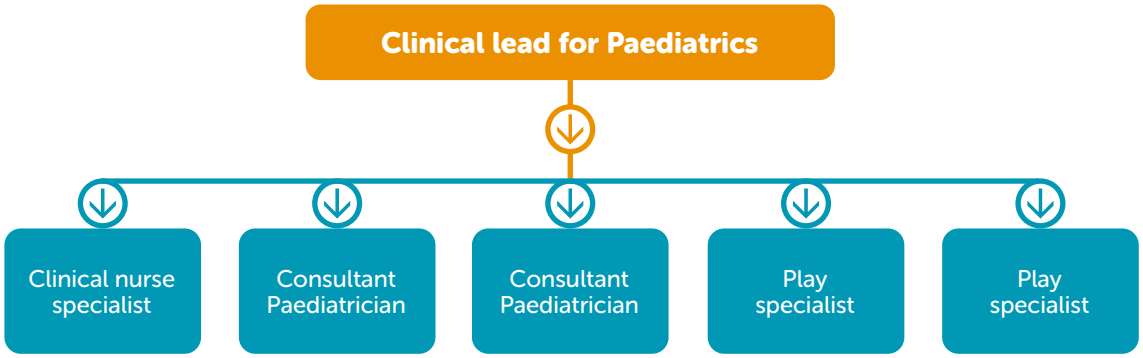
Initial structure chart for the whole service (for years 1 -2):



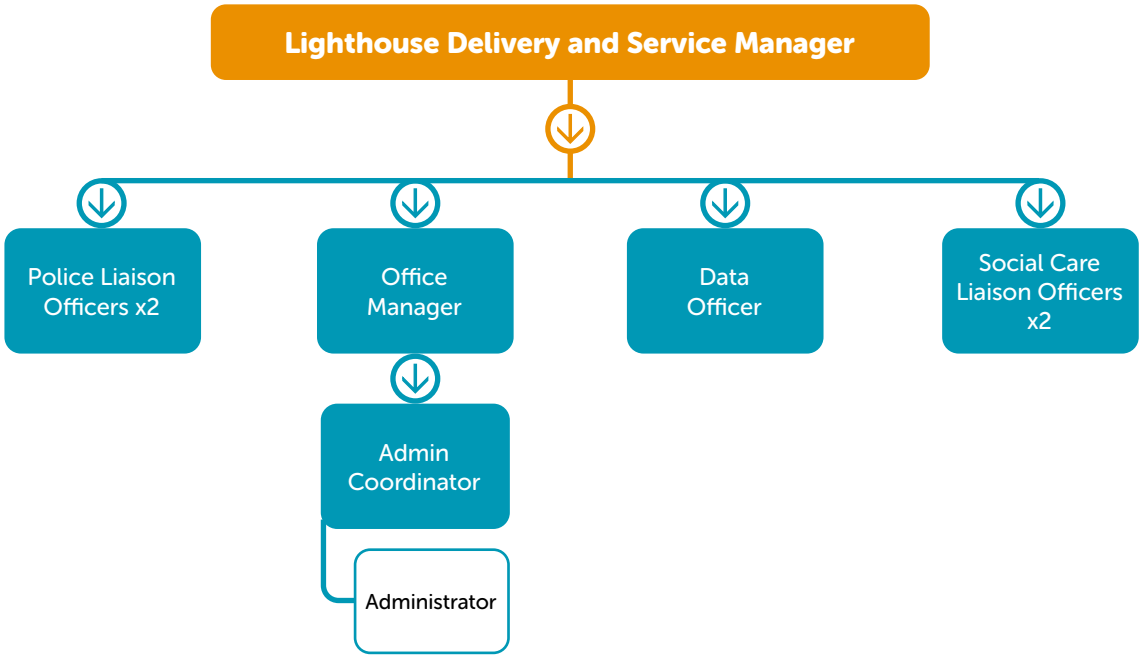
Structure of the health and wellbeing service:



Structure of the paediatric team:



Structure of the support team:



11.35 It was decided that the responsibility for clinical lead of the Lighthouse would be shared between a consultant paediatrician and a consultant psychiatrist, each of whom are based at the Lighthouse one day a week to carry out this role (the paediatrician also works at the Lighthouse two days a week in a clinical role). They are employed through the Lead Provider (University College London Hospitals NHS Foundation Trust) and the mental health trust (Tavistock and Portman NHS Foundation Trust) respectively.

11.36 The staff who deliver the paediatric clinical service including consultant paediatricians, clinical nurse specialist and play specialists, as well as the admin and management team, are all employed through the Lead Provider (University College London Hospitals NHS Foundation Trust).

11.37 The staff who deliver *Letting the Future In* and *Protect & Respect* (part of the emotional support provided at the Lighthouse as illustrated in the diagrams above – see **paragraph 11.32**) and the advocates are employed by the VCS partner organisations (NSPCC and Solace Women's Aid) and subcontracted by UCLH as Lead Provider. As with the psychiatrist, all CAMHS staff are employed by the Tavistock and Portman NHS Foundation Trust under a subcontract with UCLH.

Job descriptions

11.38 The role of each of these posts was summarised in the original service specification, with the exception of the two Police Liaison Officer and two Social Care Liaison Officer posts. These were essential elements of the service, but not part of the contract for the health and wellbeing service. Their day to day supervision was provided by the Lighthouse under a partnership agreement but they remained employed by the Metropolitan Police Service or Camden Council respectively rather than being employed directly or seconded to the Lighthouse. This was seen as the most appropriate model of employment for these posts given the need for them to be able to operate within a police service and local authority respectively, and because the budget was not held by UCLH. Job descriptions can be seen at **www.london.gov.uk/mopac/child-house-toolkit-resources**[24]. Further detail of these and some of the other roles, including the Service Manager role, is given below. Research will be carried out into the effectiveness of all of these roles, to determine the core skill mixed team needed in a Child House.

Development and Service Manager

The Development and Service Manager provides leadership to all staff at the Lighthouse and co-ordinates the day-to-day running of the service to ensure that the child is always at the centre of the service and that the lead provider's role is fulfilled. This includes the following:

- overseeing the effective operational functioning of the service and the management and monitoring of all sub-contracting and partnership arrangements;
- monitoring partnership working and the effectiveness of the Multiagency MoUs;
- ensuring that there is appropriate clinical and managerial supervision available to all staff working under the umbrella of the Child House;
- ensuring that all staff working under the umbrella of the Child House have undertaken appropriate training and have in place a programme of professional development;
- ensuring that information sharing agreements are put in place, adhered to, and reviewed as necessary.

Social Care Liaison Officer posts

11.39 There are two Social Care Liaison Officers (SCLOs) based at the Lighthouse. The SCLOs were employed by Camden Local Authority, who acted as the lead local authority for the sector. Funding from the DfE Innovation Fund paid for social care mobilisation resource to help in drawing up the SCLO job descriptions, assistance with the recruitment and help with developing the social care pathways during the service mobilisation. The role of the SCLOs is to bring expertise in safeguarding CYP and their families after disclosure of child abuse. They provide advice and challenge to staff in the Lighthouse and offer consultation to local social care teams, to optimise the child's pathway. Seen as essential to the multi-agency approach to be taken at the Child House, MOPAC bid successfully for funding for these posts to the Department for Education's Children's Social Care Innovation Fund. Funding was granted for the duration of the initial two year pilot and extended for the third year. They were contracted directly from MOPAC, not the lead provider, which means that there is no contractual relationship with the Lighthouse, only a partnership agreement setting out how they work together.

11.40 The Social Care Liaison Officers (SCLOs) represent social care from the five Local Authorities. They have a key role in providing expert advice and support in safeguarding to Lighthouse staff and local social care teams. The SCLOs ensure that the Lighthouse operates within Pan-London safeguarding procedures and are employed by the London Borough of Camden where they report to the Head of Quality Assurance. The SCLOs are two experienced Social Care Team Managers. They do not work directly with children/ families but work alongside the social care teams to offer consultation to local authorities regarding referral pathways, services offered and specialist advice on sexual abuse/sexual exploitation. Each child and family has a social worker in their borough Children's Social Care team.

11.41 Their specific responsibilities include:

- Triage for all referrals into the Lighthouse, carrying out the initial risk assessment;
- Gathering and collating information to present at allocation and supporting the review of Lighthouse cases with advice and guidance in the weekly case review meetings;
- Ensuring that Child Protection pathways are clear and running smoothly between the Lighthouse and the five local boroughs;
- Providing expert advice to individual social workers on the role of the Lighthouse , including links with services for 18-25 year olds with additional needs;
- Liaising with local social care teams and providing expertise in CSAE, assisting with complex decision making;
- Providing expert advice and safeguarding supervision, where needed, to individual staff in the Lighthouse.

11.42 SCLOs also offer expertise in child protection to the Lighthouse team to support timely and effective decision-making, especially with very complex cases and/or where a child/young person's wishes may be in conflict with best practice (e.g. consent). The SCLOs aim to promote and establish positive relationships between the Lighthouse, the five local authorities, police teams, MASH and partner agencies including public health and education to support a more coordinated approach in supporting CYP who have experienced CSAE.

11.43 The SCLO role has developed during the pilot as the Lighthouse has developed the care pathway, the referrals processes and the daily allocation meetings and the way they conduct the initial assessment. They play a more prominent role in relation to CYP being 'referred in' than anticipated including liaising with other professionals to gather information, consulting with and supporting the local social worker who is working with the child or young person, and identifying CYP who have been referred but are not ready for support who may wish to engage with the Lighthouse in future. They also provide expert advice and challenge to the Lighthouse team, provide training and awareness raising, and contribute to data analysis.

Case study:

Shane is a 13 year old young person and was referred to the Lighthouse in 2019 after disclosing sexual abuse by his maternal uncle. He first told his teacher and then the social worker and police when they came to see him at school, but did not want to be interviewed as part of the investigation. Shane has developmental delay and is under investigation for concerns around Autistic Spectrum Disorder. He first attended for an initial assessment with the Lighthouse team and was connected with local CAMHS, but he still did not feel able to disclose what had happened to him. After joint support from the Lighthouse advocate, local CAMHS and children's services, Shane came back to complete his Video Recorded Interview at the Lighthouse and supported the police investigation. Ongoing work with the Lighthouse advocate who he met at his initial assessment has resulted in Shane being able to hold eye contact, speak about likes and interests, be in a room without mum and express his feelings.

Police Liaison Officer posts

11.44 The Police Liaison Officer (PLO) role was an innovative approach developed for the Lighthouse and is not part of the original CAC/Barnahus model. Funded from the Home Office Police Transformation Fund during the first two years of the pilot, the PLO's role is to bring expertise in child abuse investigation and the criminal justice pathway to the Lighthouse. The PLOs are not case holders and have no responsibility for individual investigations. They are employed by the Metropolitan Police Service. There is no contractual agreement directly with The Lighthouse but the MPS and the Lighthouse have a partnership agreement describing how they should work together.

11.45 The PLOs are Detective Constables with substantial experience investigating child sexual abuse, from initial disclosure or professional suspicion to trial. They bring expertise at mentoring and supporting others, and the ability to teach, support and build relationships with outside partners. Their relationship with the CPS and judiciary is essential. Their specific responsibilities include:

- Providing support to young people/parents unsure about engaging with the criminal justice process
- Providing advice and police information in Allocation Meetings and Weekly Case Review – for example, giving advice on the forensic window and providing updates on the progress of investigations
- Providing support to Lighthouse staff on the criminal justice process – for example, sitting in during medicals to record disclosure
- Influencing the timeliness of the CJS pathway
- Overseeing disclosure of notes to the police when needed for an investigation
- Providing training including investigative advice to police colleagues and contributing to the training of Clinical Psychologists in leading ABEs
- Influencing best practice within the criminal justice system
- Contributing to research and best practice, including conference presentations.

Case study:

Martin is a 10 year old boy who had been sexually abused by his mother. There were marks on his body that needed to be documented as evidence and a medical examination was arranged within two weeks. At this point Martin had not yet agreed to go ahead with a police investigation and was worried about it. The Police Liaison Officer spoke to him and his foster carer about what they could expect from the police process and suggested that she could sit in on the medical and make notes of his disclosure to the Doctor.

Martin felt comfortable with this approach and the notes were transcribed into a statement. Afterwards the Police Liaison Officer offered Martin a tour of 'Talking Room' at the Lighthouse. Martin grew in confidence with the support he received at the Lighthouse and later gave a Video Recorded Interview. The Lighthouse was able to provide access to the notes for all the teams (medical, therapeutic, advocacy, police liaison) within 30 days, allowing his investigation to progress quickly and be submitted to the Crown Prosecution Service for a charging decision.

11.46 The PLO role has grown since it was originally conceived. More time has been spent on training psychologists to conduct the ABE interviews, advocates and Metropolitan Police officers than envisaged. The PLOs also provide training to staff in partner agencies to address the myths and lack of knowledge about the police, the CJS and their investigations. They have also provided training for officers in the MPS. Influencing policy and practice in the CJS has also been a more significant element of the role than was first anticipated. The PLOs have given several presentations sharing their experience thereby contributing to the Lighthouse as a national and international Centre of Excellence.

Paediatricians

11.47 The role of the paediatrician includes:

- taking the full history with questions about the CYP's health and wellbeing, vulnerabilities and disabilities
- examination as needed with photodocumentation of any injuries – new or old, anywhere on the body, including genitalia

- diagnosing other medical conditions previously known or new and identifying other maltreatment
- investigation as needed for STIs etc
- treatment of STIs
- advising on management of conditions abuse and non-abuse related
- considering the need for contraception and health and sex education
- answering questions and giving information
- reviewing where appropriate
- providing consultations on child abuse cases by telephone
- writing reports including for child protection plans, care and criminal investigation and proceedings, and attending when required.

Clinical nurse specialist, sexual health

11.48 The role of the nurse includes:

- supports initial assessment, medical examinations and medical follow-up in conjunction with the paediatrician
- undertakes sexual health follow-ups providing results and outcomes of tests in line with agreed pathways
- undertaking joint case planning and co-ordinating all care, including reviews with multidisciplinary colleagues
- delivery of the sexual health service to deliver STI screens (including blood borne virus testing), Hepatitis B immunisations, catch-up immunisation programme for young people (including HPV) and a contraception service
- providing relationship and sexual health education to CYP and advice for parents.

Mental health and wellbeing practitioners

11.49 There are a number of mental health and wellbeing practitioners employed at the Lighthouse who together are responsible for undertaking an initial assessment and development of an evidence-based and trauma-informed treatment plan.[25] Separate care plans are needed for the CYP and non-offending family members. The team will be responsible for providing bespoke therapeutic intervention based on the needs of the CYP and their family at a time when they are ready to engage. Support for all CYP and their non-offending families should be provided after the forensic interview. The team refer on to local or specialist services, provide reports and attend court proceedings as required.

Play specialist

11.50 The play specialist role falls under the paediatric team and has evolved to meet the needs of CYP attending the Lighthouse. The role of the play specialist includes:

- helping CYP to adapt to the new environment through play
- presenting information and advice to CYP of all ages who are about to have a medical procedure (including blood tests, medical examinations, vaccinations and swabs) and also to correct any misconceptions CYP may have about the procedure
- working with the service user to identify any anxieties relating to the procedures and to find suitable coping strategies
- supporting them during the medical procedure using toys and breathing techniques
- enabling the child or young person to have a voice
- advocating on their behalf so that their wishes are listened to before and during procedures
- offering advice on sleep hygiene to parents, and/or CYP. CYP receive up to 6 sessions; these are focused on breathing techniques, guided imagery, mindfulness or progressive muscle relaxation
- helping CYP to adapt to the new environment through play
- offering support play sessions before the service user is transferred to CAMHS or LTFI

- offering emotional support for parents and carers. CYP receive up to 8 support play sessions. These are focused on post-procedural play, therapeutic play and relaxation.

Primary Case Worker

11.51 An additional new role, which evolved during the first year of the pilot, is that of Primary Case Worker[26] who is nominated from the multi-disciplinary team to review and monitor cases, and to coordinate the team around the child. The role includes:

- being the main point of contact for the child, young person and family
- overall accountability for the case
- liaison with other professionals within the Lighthouse who have been allocated the child/young person to ensure case co-ordination and that the child/young person is seen regularly
- calling a case discussion if anyone is worried or concerned about a child or young person.

The Primary Case Worker is the lead practitioner for the CYP until they hand this role over to another practitioner or close the case, and is likely to attend strategy meetings or case conferences about the CYP.

Advocate

11.52 This post was based on the independent Sexual Violence Advocate (ISVA) roles common in SARCs and Rape Crisis, but goes further to support and advocate for children or young people throughout the length of their time with the Lighthouse or for as long as they need advocacy. They ensure the voice of the child is heard by professionals within and outside of the Lighthouse. They can be involved at any stage of the pathway including:

- a show around prior to first appointment
- work with the child or young person outside of the Lighthouse before attending
- support at the initial assessment and on the day of their ABE
- advocating with school, social care and the police, and
- a key role in support throughout the police investigation, court preparation and support during the trial.

Admin team and Data Officer

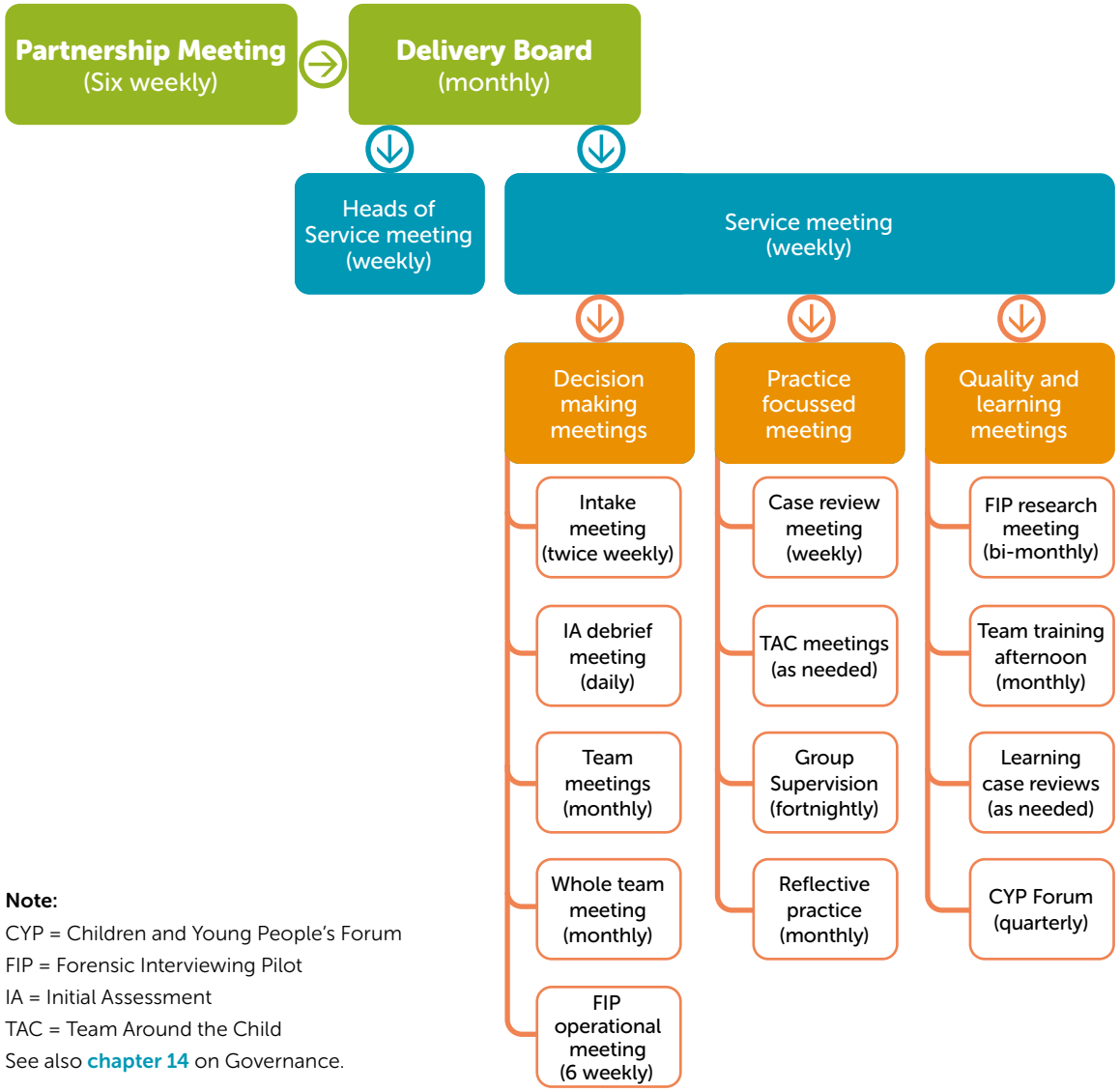
11.53 The admin team and the Data Officer have been essential in ensuring the smooth running of the Lighthouse. The admin team are the first point of contact for referrals as well as providing essential support for staff. Having a Data Officer on site has also proved invaluable in providing ongoing support for the clinical staff on data completeness, leading the redesign of the EPR and providing all the operational reporting.

Meeting the IT requirement

11.54 MOPAC led on the commissioning of the IT for the Lighthouse. Details are set out in chapter 17.

Meetings held in the Lighthouse

11.55 Many regular meetings are held at the Lighthouse which are summarised opposite:



Note:
CYP = Children and Young People's Forum
FIP = Forensic Interviewing Pilot
IA = Initial Assessment
TAC = Team Around the Child
See also chapter 14 on Governance.

Use of video and audio evidence

11.56 It was always the intention that the ABE interview would be carried out by specially-trained clinical psychologists in the Child Houses in London in line with the Barnahus model as part of a pilot (the 'Forensic Interview Psychology service'). This would mark a significant change from the interview being primarily police-led in a police interviewing room to being led by a specially training clinical psychologist at the Lighthouse. The aim of this is to reduce the chance of retraumatisation and to improve the quality and consistency of these interviews.

11.57 There was a strong commitment to piloting this approach and agreement was reached with representatives of the criminal justice system that this would be acceptable and that the recording could be used in court. This was therefore included as a key element of the operating requirement. However, it takes six to nine months to train and quality assure the psychologists and therefore the psychologist did not start leading ABE interviews independently until one year into the project.

11.58 The ABE interview is audio and video recorded in a comfortable interview room at the Lighthouse. Employed by the Tavistock and Portman NHS Foundation Trust, the clinical psychologists carry out a pre-interview assessment prior to undertaking the forensic interview later that day. The child or young person can be supported by their advocate or a play specialist during breaks. The officer in the case (the police officer leading the investigation) works closely with the clinical psychologist to agree the points to prove, supervises the interview and remains accountable for the interview throughout. A social worker may also observe the interview from a different room, by video link. Following the interview, the clinical psychologist completes an interview record and a form (MG11) setting out what support might be helpful in court.

Comfortable interview room at the Lighthouse

Also see **paragraph 17.20** on the technical requirements.)

Putting the Operating Model into practice

11.59 See also **chapter 13** and **chapter 18** on commissioning and mobilisation.

11.60 The capacity mapping (see **paragraph 11.13**) was revisited after a year with NEL CSU to help to review the capacity needed for various services provided in the Lighthouse. The example opposite shows the calculations for CAMHS.

11.61 The Lighthouse annual report (2018-19) notes that the assumptions used in the original capacity mapping were not reflected in the uptake of the service during the first year. More CYP than predicted were accessing CAMHS and fewer were accessing advocacy and LTFI or P&R.[27]

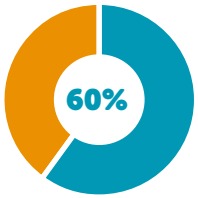
Estimating CAMHS capacity

It was originally estimated that 30% of CYP would be supported by CAMHS and 50% by NSPCC's *Letting The Future In* service, and 4WTE CAMHS practitioners were recruited accordingly. But the case complexity proved to be much greater than anticipated and more children as well as their parents were found to be in need of CAMHS support.

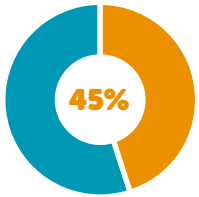
After one year, when the service had a better understanding of the case complexity, the following calculation and assumptions were used.

400 referrals
a year to Child House

75% attend
initial appointment



of 300 **children** need CAMHS



of 300 **parents** need CAMHS

Each child and parent

will be supported for **four months** on average

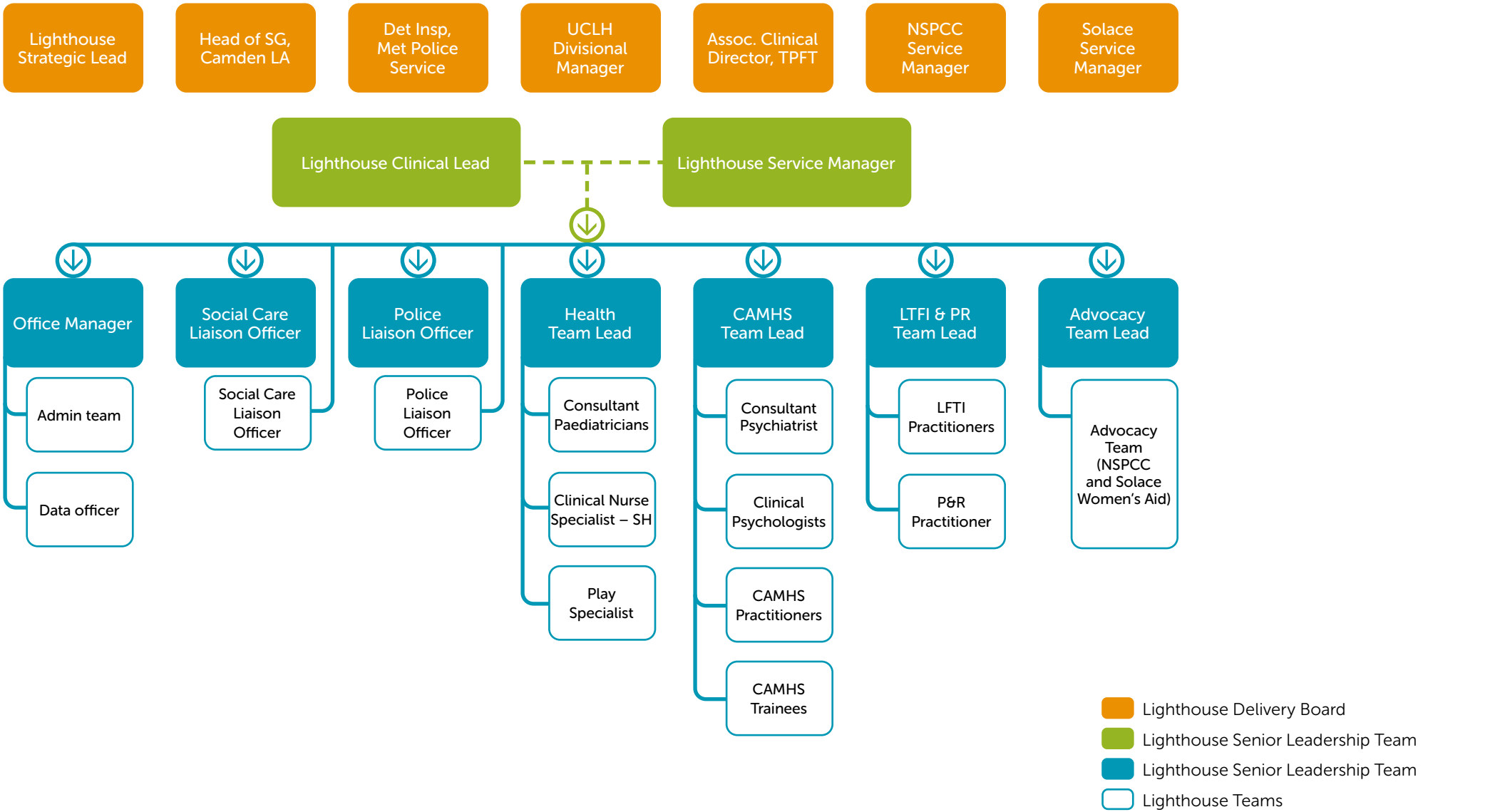
CAMHS workers can see **two children or parents a day** for face-to-face contact and hold a maximum caseload of 12.

8.8 WTE CAMHS practitioners

Plus to deliver psychology-led ABE interviews:

- 33 ABEs per year
- 1 day per ABE
- 0.2WTE clinical psychologist

Lighthouse Team Structure



Revisions to the structure

11.62 In the third year of the pilot, changes were made to the structure which were designed to promote greater clarity of roles, responsibilities and accountability for all the staff working at the Lighthouse. The changes were intended to enable an equal voice for all teams in decision making.

Opening hours

11.63 The intention was to open The Lighthouse late in the evenings in the week and on Saturday/ Sundays. Although weekend appointments were offered for the first three months, few children and families requested weekend appointments and the weekend opening was therefore stopped to maximise weekday capacity. However, the after school and evening appointments were popular, with many CYP attending in the 4-7pm period, with the final appointment at 6-7pm. The Lighthouse remains open until 8pm to allow for professionals to carry out any follow up work or respond to urgent safeguarding needs.

Key learning points

- The operating model should be developed with the involvement of all the partners with a view to developing specification(s) for the services to be commissioned for the Child House. Co-design workshops may be one way to achieve this. This should build on previous work on local CSAE services.
- Many regulatory requirements will need to be taken into account in setting up a Child House. Applying for CQC approval, if needed, takes some time and has to be completed before the Child House can open.
- Detailed capacity mapping can be used to inform decisions on what staff will be needed. This should be based on calculations of expected caseloads, how many CYP will require each service, the total expected number of cases and the average expected length of each case.
- The staffing model should be derived from the capacity mapping and care pathways as well as the needs assessment, in discussion with the key partners. Decisions will be needed on which staff will be employed by which agencies and the basis on which they will be employed (ie: directly or seconded from agencies such as the NHS, police and local authority).
- Mapping the care pathways should take place early on in discussions on the operating requirement though this is likely to evolve once the main contract is let and the staff appointed. This should address issues such as whether self-referrals will be accepted, whether only children and young people who have disclosed CSAE should be seen, where referrals will come from and what the initial response will be.
- Every child or young person should be offered a holistic initial assessment and be given the opportunity to meet the whole multi-disciplinary team including a medical and mental health history taking, assessment and a health assessment (which includes a medical examination and gathering of forensic evidence where found). The clinical team will then recommend which interventions may be appropriate.
- Decisions need to be taken at an early stage as to whether the Achieving Best Evidence interviews will be led by psychologists and held at the Child House in line with the Barnahus model. Planning for these requires careful and advanced planning and agreement with representatives of the CJS, including the police and courts service. Training the psychologists may take several months and this needs to be factored into the planning process.
- Use of a live link to the Court and applying for the site to be a remote links site may also be considered, as well as the recording at court of pre-trial recorded cross-examination of witnesses, depending on the national roll-out of the programme.
- Consideration should be given to the way in which social care and the police will operate within the Child House. Seconding Social Care Liaison Officers (SCLOs) and Police Liaison Officers (PLOs) may be one solution. Whilst they are not intended to work directly with children or families, they can work alongside the social care teams and police officers to offer consultation to local authorities and the police service, as well as to the Child House staff. These roles are likely to be integral to the running of the Child House.

Checklist for setting up a Child House

- ○ Has an operating model been drawn up in discussion with partners and agreed, based on the results of local needs assessment and how they intend to run the Child House?
- ○ Has capacity mapping been used to inform the planning on what staff are likely to be needed and on the skill mix?
- ○ Have all the regulatory requirements been identified including CQC registration if required?
- ○ Has the staffing model been agreed with the key partners? Is it clear which members of staff will be employed by which agency? If there are to be secondments, have these been agreed with the employing agencies?
- ○ Have care pathways been drawn up with professionals that fit with local referral patterns?
- ○ Has it been decided who will be the Clinical Lead for the Child House?
- ○ Is it clear where referrals to the Child House will come from and how these will be made and by whom? Has it been decided whether self-referrals will be accepted and whether there needs to be an actual disclosure of CSAE in order for referrals to be made?
- ○ Has a decision been made on the use of visual evidence and who will conduct the ABE interviews? Has this been agreed with representatives of the CJS? Will there be facilities for a live video link room to the court and/or for pre-trial recorded cross-examination of witnesses (if available)? Or will the child or young person always have to attend the court?

End Notes

1 Some of this taken from CSA Hub Toolkit, page 20

2 Barnahus Quality Standards, guidance for multidisciplinary and interagency response to child victims and witnesses of violence, op cit, page 12

3 Legal guidance on the provision of therapy for vulnerable or intimidated adult witnesses, Crown Prosecution Service

4 Practice guidance on the provision of therapy for child witnesses prior to a criminal trial, Crown Prosecution Service (2001)

5 Guidance for joint targeted area inspections on the theme: child sexual abuse in the family environment, August 2018, see **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/805562/Joint_targeted_area_inspection_child_sexual_abuse_in_family_environment_081018_a.pdf**

6 Multi-agency response to child sexual abuse in the family environment: joint targeted area inspections (4th February 2020); see **https://www.gov.uk/government/publications/the-multi-agency-response-to-child-sexual-abuse-in-the-family-environment/multi-agency-response-to-child-sexual-abuse-in-the-family-environment-joint-targeted-area-inspections-jtais**

7 Demand and capacity – a comprehensive guide, NHS Improvement (January 2018). See **https://improvement.nhs.uk/documents/2099/demand-capacity-comprehensive-guide.pdf**.
See also Demand and capacity – an overview, NHS Improvement (January 2018) **https://improvement.nhs.uk/documents/2223/demand-capacity-overview.pdf**

8 MOPAC, The London Rape Review: a review of cases from 2016, July 2019.

9 Children's Commissioner for England, Investigating Child Sexual Abuse, the length of criminal investigations (April 2017).

10 HMCTS, NPCC, CPS, National Remote Link sites protocol for use by criminal justice service agencies and partner agencies for witnesses providing evidence via live video links at locations away from a court building, December 2018.

11 See Future In Mind, Promoting, protecting and improving our children and young people's mental health and wellbeing, Department of Health and NHS England, March 2015, page 53.

12 See **www.london.gov.uk/mopac/child-house-toolkit-resources**

13 London Child Protection Procedures and Practice Guidance, London Safeguarding Children Board (2017) **https://www.londoncp.co.uk/**

14 Taken from the Lighthouse Annual Report 2018-2019, The Lighthouse, page 7.

15 The care pathway can be downloaded from **www.london.gov.uk/mopac/child-house-toolkit-resources**

16 Eye Movement Desensitisation and Reprocessing therapy. See NICE guideline 116 on Post-traumatic stress disorder 1.6.13: 'Consider eye movement desensitisation and reprocessing (EMDR) for children and young people aged 7 to 17 years with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 3 months after a traumatic event only if they do not respond to or engage with trauma-focused CBT'. [2018]

17 Washington Coalition against sexual assault parenting programmes. See **https://www.wcsap.org/advocacy/focus-areas/csa/parents**

18 Letting the future in: a therapeutic intervention for children affected by sexual abuse and their carers, an evaluation of impact and implementation, NSPCC, University of Bristol, Durham University, February 2016, page 7.

19 NICE guideline on Child Abuse and Neglect [NG76], October 2017, paragraph 1.7.18.

20 NSPCC learning, Protect and Respect, see **https://learning.nspcc.org.uk/services-children-families/protect-and-respect/#heading-top**

21 Reder P, Fredman G, The Relationship to Help: Interacting Beliefs about the treatment process; Clinical Child Psychology and Psychiatry, July 1996. See **https://www.researchgate.net/publication/244915478_The_Relationship_to_Help_Interacting_Beliefs_about_the_Treatment_Process/link/542a74ec0cf27e39fa8e94f9/download**

22 Taken from the Lighthouse Annual Report 2018-2019 December 2019, op cit, page 9.

23 **www.london.gov.uk/mopac/child-house-toolkit-resources**.

24 Job descriptions are accessible at **www.london.gov.uk/mopac/child-house-toolkit-resources**

25 Mattison V, Fredman G, Setting up consultations: how we begin in collaborative consultation in mental health; Collaborative consultation in mental health, Guidelines for the new consultant (Fredman, Papalopodou and Worwood, 2018).

26 The Lighthouse Annual Report, 2018-2019, page 35. See also Key elements, section 1.4.

27 The Lighthouse Annual Report, 2018-19, page 26.

Chapter 12
Costing and budgeting

What this chapter tells you:

Chapter 12: Costing and budgeting

Securing funding

12.1 Securing funding to set up and run a Child House is likely to be one of the most challenging aspects of the project, partly as a result of the number of agencies and wide range of services involved.

12.2 The Child House could be funded through grants or the commissioning route. PCCs receive funding to commission and deliver local support services for victims of crime[1] and are one possible source of funding. The Child House could be funded through grants or the commissioning route. Most services for victims of child sexual abuse are commissioned at the local level with local authorities, Clinical Commissioning Groups and Police and Crime Commissioners all playing a role. For example, PCCs receive funding to commission and deliver local support services for victims of crime. In 2020, MoJ invested an additional £4m in sexual violence support services throught the Rape and Sexual Abuse Support Fund. Some sexual assault services, such as SARCs, are funded by NHS England (though in some cases, funded jointly and co-commissioned with the PCC).

12.3 In addition, some sexual assault services, such as SARCs, are funded by NHS England (though in some cases, funded jointly and co-commissioned with the PCC). Local Authorities and CCGs fund the other key elements of a Child House including CAMHS services, community paediatrics, social workers, early help services and, in some areas, specialist services from VCS organisations. Discussions on setting up a new Child House and who might fund it should therefore involve all of the relevant local commissioners including the PCC and the relevant regional office of NHS England as well as commissioners of the other services to be provided, ie: the local authority/ies and CCGs for the area to be covered. Further details on possible funding sources are included in paragraph 20.6.

12.4 Any funding obtained from philanthropic sources can be used to enhance the service if the funding available from statutory sources is insufficient to cover all the costs involved – see paragraph 20.1. However, accepting philanthropic donations will be subject to organisational financial rules and regulations. In general, it is better for funding from such sources to be used to provide additional goods or facilities rather than core services. Even where there is considerable enthusiasm to set up a Child House, this should only be embarked upon where sufficient long term funding for the core services to be provided has been, or is thought highly likely to be secured.

Costed plans

12.5 To seek agreement for the development and investment in a Child House, each organisation's senior leadership team will require a fully costed, evidenced case setting out why it is needed with an impact analysis[2]. This should show the projected costings for at least three years to enable an evaluation of the possible improvements the Child House would make to outcomes for CYP and their families. Obtaining as accurate a picture of the costs to be incurred in setting-up and running the new service should be a priority. Having complete clarity and transparency as to which organisations will be funding which services in the Child House is essential to avoid confusion. There should be a clear audit trail recording what has been agreed.

12.6 Having clarity on costings will be necessary in order to measure which aspects of the Child House are most effective and provide best value-for-money which may affect the future funding.

Financial expertise

12.7 Putting together a summary of costings is likely to be highly complex given the range of services to be provided, the fact there may be multiple sources of funding and the uncertainty before the Child House opens as to the number of people who are likely to use it (which will have a significant effect on the cost of individual cases). Having access to financial expertise is essential to draw up as accurate a picture as possible and to monitor it once it is open.

Annuality

12.8 Once funding is secured, assuming this is from statutory sources, it will be necessary to spend it in the financial year(s) for which it has been awarded. If external funding has been awarded, there is rarely the flexibility to carry it over across financial years if programme slippage occurs. Internal funding will be subject to individual organisations' own rules about carry over. Failure to spend in the year(s) for which it is allocated may therefore lead to the funding being withdrawn. This can be challenging given the long lead time involved in setting up a Child House and the multiple workstreams involved. Agreeing a realistic timescale between the commissioners and the partner agencies is therefore essential to ensure that the programme timescales align with the funding profile. Being overoptimistic about the delivery timescale may jeopardise the project.

Opportunity/internal costs

12.9 In addition to the cost of the Child House itself, additional resources will be needed for the staff required to set it up (whichever agency they are employed by) and for mobilisation; these costs need to be estimated in advance to ensure that the necessary staff and resources will be available. Ideally, a dedicated programme team for the commissioners and service provider should be costed into any Child House budget for the set-up and mobilisation of the service.

Financial controls during mobilisation

12.10 Strong financial controls will be needed during mobilisation to ensure that the costs do not exceed the agreed levels. Any significant variation should be subject to a business case. Procedures for agreeing any variations will need to be drawn up by the partner agencies.

12.11 Building in contingencies, particularly where budgets are based on estimates, is essential. Appointing a service provider in advance of the building design and refurbishment as well as the IT procurement will help to ensure that the provider needs are clear in terms of the number of staff and preferred ways of working. This will minimise unexpected or additional costs at a later stage.

Financing the Child House in London

Securing funding

12.12 Securing the funding was one of the most challenging aspects of establishing the Child House pilot in London. It took time and resources to secure funding, including putting together likely costings and bids that were accurate and comprehensive, working to tight deadlines, and the need to secure agreement from the large number of agencies involved. Following the work done on the CSA Transformation Programme in London, funding was sought initially from the Home Office Police Innovation Fund (now the Home Office Police Transformation Fund) and a bid was secured for two years funding for 2016/17 and 2017/18 (ie: one year for implementation, and one year for delivery), which was later supplemented by MOPAC, NHSE and the Department for Education to allow for two years delivery. This included funding for capital to refurbish premises. Additional funding to extend the pilot to a third year (until September 2021) was found early in 2020.

Sources of funding

12.13 The pilot was funded from the following sources:

Funding Source	Funding contribution
Home Office Funding	£4,410,384
MOPAC	£1,250,000
NHSE (London)	£1,730,000
Department for Education	£554,500
TOTAL	**£7,944,884**

12.14 The annual running costs of the service are approximately £2.3 million.

12.15 In addition, the NSPCC partnered with Morgan Stanley to make a contribution to the Child House – employees from Morgan Stanley contributed £1.5 million towards the project. The additional funding made available from Morgan Stanley enabled some enhancements to be agreed that would not otherwise have been feasible. Although the funding could not be used to meet any of the core costs, it was agreed that it would fund additional staff resources to support mobilisation, staff to deliver *'Letting The Future In'* to support CYP across North Central London as outreach from the Lighthouse, and additional consultation rooms.

Costed plans

12.16 Although some costs were included in the initial bids for funding, there were difficulties in obtaining accurate costs about all the services to be provided, particularly the health costs. These were difficult to estimate with any degree of precision before the extent of demand and the service model had been finalised. Likewise the estates costs were difficult to estimate before the building had been identified. It is therefore important to involve estates and IT experts in addition to finance experts early on to accurately estimate these costs, and to build in a contingency budget.

Impact of delays

12.17 Due to the complexity of securing premises in London, it was not feasible to spend the funding as rapidly as set out in the timetable included in the bid. The constraints of annuality meant that the funding could not be carried forward into the next financial year which would have made it impossible to pay for the premises. The funding which was being made available from the Home Office Innovation Fund could not be reprofiled. The inability to carry over approved funding to the next financial year due to annuality rules presented a significant challenge in securing the necessary funding which was overcome by submitting a new funding bid.

12.18 The risk of slippage and of not being able to spend in year was therefore flagged and a further bid submitted to the Police Transformation Fund. This explained that the work had taken longer than originally anticipated and requested additional funding and an extension of the pilot for a further two years which was granted. Funding was also sought and secured from NHS England (London), MOPAC and the Department for Education (DfE) Children's Social Care Innovation Programme. The DfE funding was to fund two Social Care Liaison Officer posts at the Child House (see **paragraphs 11.40-11.44**), the costs of the Learning Strategy and the development of a sustainability plan.

Scaling back the pilot

12.19 Although the initial intention in London had been to set up two Child Houses (with a second one in Croydon in South London), there was insufficient funding to do so in the event and the Programme Board therefore agreed to focus on piloting one in the first instance (see **paragraph 15.32**). It was agreed that this should be the pilot in North Central London as the partnerships and other arrangements were further advanced.

Opportunity costs

12.20 As well as the direct financial resources shown above, considerable resources have been dedicated to the project, in particular, the time spent by all the people who have been working on it who are employed by several of the partner agencies and the commissioners. Whilst it would be difficult to calculate the cost of their contribution, many members of staff dedicated a great deal of their time to establishing the pilot – including initial work on the location that did not proceed. Many had to reprioritise to accommodate the workload. Whilst these costs have not been calculated precisely, they represent an important element of the overall costings.

Financial controls

12.21 Strong financial control was exercised during mobilisation to ensure that any changes

proposed were within the financial envelope available. Any application for significant variation in funding was subject to a business case which needed to be signed off by MOPAC and published as a formal decision in accordance with their delegation procedures to ensure that the pilot stayed within the overall financial envelope. For the Home Office and DfE funding, quarterly returns were submitted to keep track of spend for those funded elements and to ensure funders were sighted on progress and any risks and issues. Any significant financial risks amongst partners and funders were raised with the Programme Board.

12.22 Nevertheless, both the costs of the refurbishment and the IT proved to be higher than had been estimated.

Cost-benefit analysis

12.23 A cost-benefit analysis was commissioned before the Child House was up and running from RedQuadrant with a view to agreeing the methodology by which its cost-effectiveness would be measured. This was later revised to take account of data obtained from the Lighthouse once it was up and running. See **paragraphs 19.32 – 19.35** and **19.46** for further details.

Key learning points

- Securing funding to set up and run a Child House is highly challenging given the number of agencies involved and range of services to be delivered. The main sources of funding are grants, or contracts with commissioners. PCCs and the relevant regional office of NHS England as well as commissioners of the other services to be provided should be involved in any discussions as to how funding might best be secured.
- Embarking on setting up a Child House should be dependent on having assurance about the availability of long term funding for the core services to be provided.
- It needs to be clear from the outset which organisations will be responsible for funding which services to avoid any confusion or delays later on. Establishing accurate costings as early as possible, clarifying the services to be provided and having a clear audit trail is key so that there is a clear basis on which to proceed once approval is given.
- Given the complexity of the financial aspects of setting up a Child House, there is a need for dedicated financial support (as well as expertise on estates and IT).
- Depending on the complexity of setting up the Child House, which may involve the identification, securing and refurbishment of suitable premises, and the lead times involved, it may be challenging to spend the funding allocated during the financial years for which it has been allocated. It is therefore essential that the timescale agreed is realistic given the imperative to spend any public sector grants within the financial years agreed.
- Undertaking a preliminary cost-benefit analysis during the planning stage based on provisional costings with a view to revisiting this at a later stage when actual costings are known is worthwhile.
- Any additional funding from philanthropic sources can be used to enhance the service if the funding available is unlikely to cover all the costs of setting-up and running the Child House. This funding is best used to provide additional goods or facilities rather than core services.
- The opportunity cost of setting up a Child House in terms of the staff resources required for setting up and mobilising it is significant and should not be underestimated as these are likely to form a substantial proportion of the project costs. Funding therefore needs to be included for a programme team.
- Strong financial controls are needed during mobilisation to ensure that the costs are contained within the agreed financial envelope.

Checklist for setting up a Child House

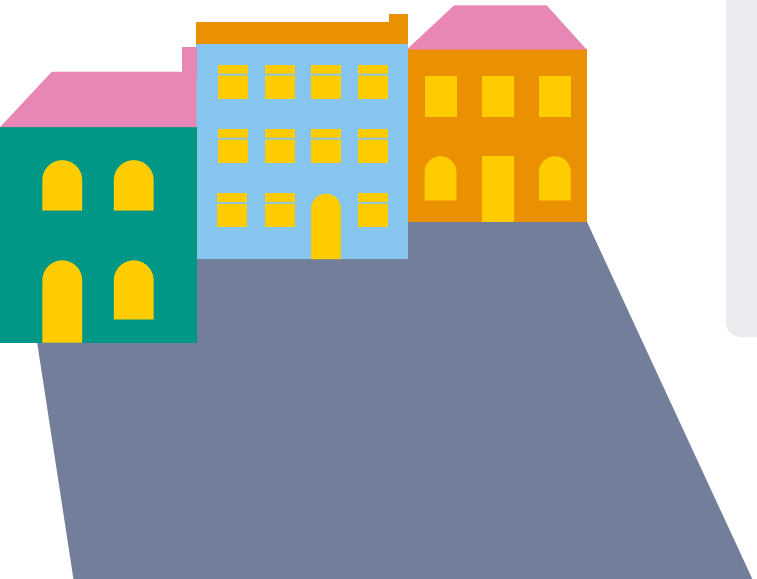
- ○ Has sufficient funding been secured to set up the Child House and are there sufficient staffing resources to deliver it?
- ○ Have a fully costed plan and an impact analysis been drawn up? Are the costs clear and each element attributable to a specific agency?
- ○ Is sufficient dedicated financial and subject matter (estates, IT etc.) expertise available to help put together the costings and to oversee the financial aspects of setting up the Child House?
- ○ Is there confidence that the funding will be spent during the years for which it has been allocated?
- ○ Is the timescale proposed realistic, bearing in mind the length of the lead times for the premises, IT, information governance and recruitment of the staff?
- ○ Has a preliminary cost-benefit analysis been carried out which can be revisited later on once actual costings are available?

End Notes

1 PCCs receive circa £68 million per year to commission and deliver local support services for victims of crime (MoJ have increased the investment in sexual violence support services funded through the Rape and Sexual Abuse Fund which has been increased to £12 million a year from 2020). The funding is distributed to PCCs using a population-based formula that uses data from the ONS population estimates from England and Wales (aged 0+) (2019). See https://www.gov.uk/guidance/victim-and-witness-funding-awards#police-and-crime-commissioners

2 See CSA Hub toolkit, op cit, page 20

Chapter 13
Commissioning and procurement



What this chapter tells you:

Who is responsible for commissioning sexual assault and abuse services?

13.1 There here are several areas where the criminal justice system and health work collaboratively together, including the commissioning of Sexual Assault Referral Centres and other sexual assault services which are the responsibility of NHS England regional teams and Police and Crime Commissioners. This collaborative approach is particularly important in relation to the Child House given the broad range of services and agencies that it brings together.

13.2 Commissioning responsibility for sexual assault and abuse services spans a number of different systems and organisations, including health, care and justice. Several different commissioners are involved, as well as a range of providers, including some specialist and third sector organisations. As a result, it is recognised that there is a risk of fragmentation in service delivery leading to frustration and poor outcomes for victims and survivors. This is one of the key challenges in commissioning as complex a service as a Child House – there is no clear or single organisation responsible for the commissioning of the service. The innovative service therefore requires an innovative approach to commissioning.

13.3 Commissioners and providers of the services to be delivered in a Child House need to work together to ensure that a seamless approach is taken and that there is no risk of fragmentation, duplication or gaps between services.

National guidance on commissioning sexual assault services

13.4 The government's strategy for CSA is set out in the **Tackling Child Sexual Abuse Strategy 2021**[1]. NHS England have set out the national approach for commissioning services for sexual assault and abuse in the **Strategic Direction for Sexual Assault and Abuse Services**[2]. Although this does not directly address the specifics of commissioning a Child House, the principles set out apply and many of the developments underway are intended to benefit people of all ages who have experienced sexual assault and abuse.

13.5 The Strategic Direction (see **Appendix B**) also sets out the commissioning responsibilities of:

- NHS England which includes Sexual Assault Referral Centres[3]
- Clinical Commissioning Groups including mental health services, sexual health services for CYP including paediatric care and support
- Police and Crime Commissioners who have specific commissioning responsibilities for victims, including victims of sexual assault and abuse, and specialist voluntary sector services
- Local authorities including sexual health services and specialist voluntary sector services
- The Ministry of Justice
- the Home Office.

13.6 **The Victims' Services Commissioning Framework** produced by the Ministry of Justice sets out useful guidance on how to commission services for victims[4]. In addition to the **Child House: Local Partnerships Guidance** (see **Chapter 10**), the Home Office have issued a Commissioning Framework for all commissioners of support services for victims and survivors of child sexual abuse in England[5]. This has been developed to assist commissioners with responsibility for CSA support services to navigate their way through the commissioning landscape. It emphasises the importance of jointly commissioning services for CSA based on clear responsibilities and robust governance. Derived from the overarching Victims' Services Commissioning Framework, the guidance sets out a number of commissioning principles which can usefully be applied to any Child House project (see **paragraph 13.7**).

13.7 Commissioning principles to be applied for CSA services including Child House:

- **Principle 1:** Commission services according to need
- **Principle 2:** Understand the local commissioning environment
- **Principle 3:** Put the victim at the centre of service delivery
- **Principle 4:** Services should be locally led and should involve multi-agency working
- **Principle 5:** Assess the value of services by measuring outcomes rather than activity.

13.8 The following documents may also be helpful:

- Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres Services, NHS England, 10 August 2015. See www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/05/SARCs-service-spec-contract-template-and-paed-framework.pdf
- Child Sexual Abuse Hub Toolkit: a practical guide for commissioners and practitioners to establish a CSA Hub. See www.england.nhs.uk/london/wp-content/uploads/sites/8/2017/04/Child-Sexual-Abuse-Hub-Toolkit-March-2017.pdf
- Commissioning Framework for all commissioners of support services for victims and survivors of child sexual abuse in England (Home Office) July 2019 www.gov.uk/government/publications/commissioning-framework-for-child-sexual-abuse-support
- Public health functions to be exercise by NHS England: Service specification No. 30 Sexual Assault Referral Centres www.england.nhs.uk/wp-content/uploads/2018/04/serv-spec-sexual-assault-referral-centres.pdf

Commissioning the Child House in London

13.9 The majority of the £8 million funding for the pilot was provided by the Home Office, initially through the Police Innovation Fund and then through the Police Transformation Fund, with contributions from MOPAC, NHS England (London) and the Department for Education. As a consequence it was agreed that the Child House should be commissioned jointly between MOPAC and NHS England (London region).

13.10 In London, NHS England (London) lead on the commissioning of the Havens (SARCs), but they are jointly funded by NHS England (London) and MOPAC. The experience gained by commissioning these services, including the Children and Young People's Haven established in April 2016, has been highly relevant to the Child House pilot.

13.11 As a result of the timing of the funding available, in particular, the Home Office grant, it was necessary to commission the Lead Provider (see below) in parallel with the IT system and the refurbishment of the premises. This was therefore undertaken by MOPAC and NHS England (London) jointly with MOPAC taking a lead on the procurement of IT and Estates, and NHS England (London) on the procurement of the Health and Wellbeing Service. The alternative would have been to appoint the Lead Provider and leave it for them to commission the IT and oversee the development of the premises, but this would have led to unacceptable delays and jeopardised the availability of the funding.

Health and wellbeing service

13.12 The majority of services provided at the Child House are commissioned as part of the health and wellbeing service which comprises:

- Initial assessment including holistic paediatric assessment and examination, as well as an emotional health and wellbeing assessment

- Sexual health treatment and aftercare
- Emotional health and wellbeing support and therapy for the child and wider family
- Advocacy and support
- Achieving Best Evidence interviews conducted by trained clinical psychologists.

13.13 MOPAC commissioned the IT including the development of the electronic patient service separately from NEL Commissioning Support Unit (see **chapter 17**). As well as co-ordinating the care pathway for an individual client, the Lead Provider is responsible for managing the overall operation of all cases eg: daily allocation meetings, weekly case reviews, case tracking and production of caseload/ management reports.

13.14 Although the emphasis is placed on the successful delivery of health and wellbeing services, the specification made it clear that the lead provider would also be expected to play a proactive role in advancing the criminal justice agenda (eg: overseeing the establishment and operation of the psychologist-led ABE interviews).

13.15 For more detail of these individual aspects of the service, see **chapter 11**.

Procurement process

13.16 It was agreed that NHS England (London) should lead on the procurement and hold the health and wellbeing contract. This was as a result of their experience in commissioning sexual assault services which are in this country fairly health-focused (rather than led by the CJS as in some other countries).

13.17 It was agreed that the health and wellbeing service which forms the greatest share of the services provided in the Lighthouse should be provided through a Lead Provider. The Lead Provider is required both to co-ordinate and lead services, and also to provide health and wellbeing services – some directly, and some in partnership or sub-contract with other providers, including the voluntary sector.

13.18 After some discussion, although there were a small number of likely providers who would be able to deliver the service, it was agreed that this would be subject to a tender exercise due to the value of the contract. A specification was issued in October 2017 and a period of four weeks allowed for bids to be submitted. Although the specification was detailed, it was not prescriptive and the detailed design as to how the service would be run was left to the bidders – see **Specification for lead provider and health and wellbeing service**.

13.19 A market engagement event was held before the tender was published to which potential bidders were invited. There was insufficient time to hold more of these events. A presentation was given which summarised what was required from those submitting a tender – see **Presentation on Child House for procurement**.

13.20 The contract was awarded in February 2018 to the North Central London Child House Partnership, led by University College London Hospitals NHS Foundation Trust, working with the Tavistock and Portman NHS Foundation Trust and the NSPCC. The contract was signed in September 2018 following detailed discussions on information governance and finance.

13.21 The contract commenced in September 2018 and the service went live in October 2018, after a six month mobilisation phase. The service was commissioned to be able to see up to 540 CYP to be seen each year. The Lighthouse received 363 referrals in the first year of opening (compared to 118 referrals received by the CSA Hub in North Central London the previous year).[6]

13.22 As well as the main contract with UCLH, UCLH have sub-contracts in place with the NSPCC and the Tavistock and Portman NHS Trust as well as the Brandon Centre and Respond. These are based on the standard

NHS contracts and the service specifications, and details the agreed contributions from each partner. Similarly, the NSPCC have a sub-contract in place with Solace Women's' Aid.

Clarification of roles

13.23 Commissioner and provider responsibilities should be clarified during the commissioning process. The commissioner will need to decide on accountability mechanisms for the provider by documenting future governance in the specification. The provider should consider and document the proposed internal service accountability across the delivery partners in their bid. This may need to be finalised and refined after the lead provider has been appointed.

Commissioning during mobilisation

13.24 Once the Lead Provider was appointed, the commissioners continued to work collaboratively during the six month mobilisation phase (see **chapter 18** for further details). Given the constraints imposed as a result of timing, the commissioners took the overall lead and retained overall financial responsibility for the following:

- oversight of the premises refurbishment, working with the Metropolitan Police
- commissioning and establishing the IT (which was separate from the health and wellbeing contract)
- financial control and budgeting (outside of the health and wellbeing contract), and
- project management.

The provider, once appointed, led on the information governance workstream. They also had a key role in:

- Designing the building look and feel, along with extensive CYP engagement.
- Overseeing the internal fit out/furniture/equipment.
- Designing the electronic patient record.

13.25 This meant that the accountability for the operational aspects of the project was fairly complex, as there were several layers between the Lead Provider and those providing individual services such as IT as well as the refurbishment of the premises. This also meant that the commissioners were closely involved in the project throughout.

Future commissioning arrangements

13.26 The future of commissioning in the NHS is changing. The North Central London Sustainability and Transformation Partnership brings together the commissioners and providers for the five boroughs in North Central London (Barnet, Camden, Enfield, Haringey and Islington). The NHS Long Term Plan committed to all areas having Integrated Care Systems (ICS) in place by April 2021. ICSs bring together local organisations to deliver primary and specialist care, physical and mental health services, and health with social care. They have a key role in working with local authorities at a 'place' level. The ICS will bring together the local financial contribution for the continuation of the Lighthouse, with NHS England, Police and Crime Commissioners and other partners making contributions under specialised commissioning arrangements.

Key learning points

- Allowing sufficient time for the tendering process is essential – ideally, this should be around 6 weeks. Less than that to respond to the tender for a service such as the health and wellbeing service would be very tight given the complexity of the service to be delivered and the number of partners required to contribute. Holding market engagement events to inform potential bidders as to what is required is helpful before the tender is issued.
- Although the health and wellbeing service may well need to be commissioned, some of the other services, such as the criminal justice and social care services may be directly provided. The disadvantage of this is that there may well be multiple accountabilities and several different employers with staff were working on different terms and conditions of service.
- Ideally, the IT service/electronic patient record and the health and wellbeing service should be commissioned together to enable the lead provider to take the key decisions on the design of the electronic patient record once the care pathways are finalised.
- The Lead Provider should have direct commissioning responsibility for the IT service and development of the electronic patient record if timing allows. If the commissioner takes responsibility for this, it is likely to lead to complications once the Lead Provider has been appointed as the system commissioned may not be suitable once they have finalised the care pathways.
- As well as the main contract with the health and wellbeing provider, sub-contracts may be needed with the other health partners, and VCSE providers.
- Commissioner and provider responsibilities should be clarified during the commissioning process. The commissioner will need to decide on accountability mechanisms for the provider by documenting future governance in the specification.

Checklist for setting up a Child House

- ○ Have the commissioning principles to be applied for CSAE services set out in the Victims' Services Commissioning Framework/Home Office local partnerships guidance been taken into account?
- ○ Is it clear which services will be provided directly and do not need to be commissioned?
- ○ Is it clear who will be commissioning which services in the Child House? Will any of these services be commissioned jointly?
- ○ Has a decision been reached on who will commission the health and wellbeing services and IT services including the development of the electronic patient record?
- ○ Is there sufficient time allowed for responding to any tendering exercise for the Child House, bearing in mind the number of potential partners involved and the length of time this is likely to take?

End Notes

1 See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973236/Tackling_Child_Sexual_Abuse_Strategy_2021.pdf

2 Strategic direction for sexual assault and abuse services: Lifelong care for victims and survivors 2018-2023, NHS England (April 2018): see https://www.england.nhs.uk/wp-content/uploads/2018/04/strategic-direction-sexual-assault-and-abuse-services.pdf

3 The responsibility for commissioning these services is set out in a section 7A agreement made under the NHS Act 2006 as amended by the Health and Social Care Act 2012. These services are directly commissioned by NHS England. See Public health functions to be exercised by NHS England, service specification no 30.

4 Victims Services Commissioning Framework, Ministry of Justice (May 2013) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/203979/victims-services-commissioning-framework.pdf

5 See https://www.gov.uk/government/publications/commissioning-framework-for-child-sexual-abuse-support

6 The Lighthouse Annual Report, 2018-2019, page 18.

Chapter 14
Governance

What this chapter tells you:

Role of steering group

14.1 Robust governance arrangements will be needed across the programme incorporating all partner agencies to realise the vision to establish a Child House and to ensure that there is consensus between them as to the scope of the Child House and the services to be provided. The **Child House: Local Partnerships Guidance** suggests that a partnership steering group, with representation from all agencies, should oversee and review the implementation of the partnership agreement (see **chapter 10**). See also **chapter 7** on Making a multi-agency partnership work. The group should have clear terms of reference. Depending on local arrangements, it is possible that an existing steering group that has responsibility for services for victims and survivors of CSAE might be suitable to oversee the development of the Child House rather than setting up a new one.

14.2 Although the steering group may not have decision-making powers, it will act as an advisory forum to oversee the necessary changes needed, champion the vision and drive forward implementation. Key decisions will be taken by commissioners of the Child House, local Health and Wellbeing Boards and, where available, other sector-wide collaborations including the Integrated Care System.[1]

14.3 The steering group will need to include key people from the partners and stakeholders (see **chapters 6** and **7**) who have authority to represent their organisation. The chair would ideally be a senior officer from the commissioning organisation, but could be from one of the partner organisations. Alternatively, it would be possible to have an independent chair, for example, with expertise in children's services or CSAE. The steering group will be responsible for:

- establishing the governance and decision making at a local level
- ensuring co-design of the local model includes commissioners and providers from all agencies, as well as independent sector experts and user representatives
- agreeing local key principles and aims of the model and associated timeline for delivery
- enabling leadership of system change
- bringing together inspirational local leaders who will promote improvements to the pathway for CYP in the sector following CSA
- advising local partners and decision making forums on improvements in operational delivery and commissioning of the CSA pathways[2]
- ensuring adherence to the national standards
- overseeing the commissioning process including any major procurements.

14.4 Reporting lines from the steering group to local decision-making forums should be established early on. Sub-groups should be set up to oversee delivery depending on local arrangements and to oversee the different professional areas to be involved (eg: clinical).

14.5 The steering group should oversee the management of risk and establish early on the appetite for risk between the partners which can vary. Clear mitigation strategies should be put in place to address the key risks identified.

14.6 Once the procurement stage is reached, it may be necessary to reform the steering group since some members may at that stage have a conflict of interest (if they are involved in responding to the bid, for example). The governance arrangements will need to be flexible according to the stage the project has reached. Setting-up a delivery group to drive forward implementation on a day-to-day basis may be helpful.

Representing victims and survivors

14.7 Ways of involving victim/survivor representatives should be considered to ensure that their voices are heard (see **chapter 9**). The 'Strategic Direction for Sexual Abuse Services'[3] emphasises the need to involve victims and survivors in the development and improvement of services. This can include involvement in governance arrangements

where considered appropriate.

Governance for the Child Houses in London

Child House Programme Board

14.8 The Child House Programme Board was set up at the inception of the project to oversee the delivery of what was (at that stage) intended to be the two Child Houses in London. This was chaired by the Chief Executive Officer of MOPAC on behalf of both MOPAC and NHS England.

14.9 In addition, a Child House National Strategy Group was set up in central government, chaired by the policy lead for Victims of Sexual Violence and Child Sexual Abuse at the Home Office to oversee the local and national policy implications and changes required and the scope for roll-out of Child Houses. This group has focused on the development of the commissioning guidance.

14.10 Since much of the funding for the London pilot came from the Home Office-led Police Transformation Fund, those responsible for the project needed to comply with reporting requirements relating to that Fund. Since MOPAC had been the original applicant, they assumed responsibility for this task.

14.11 Once the Programme Board was established, a number of sub-groups were set up which, over the lifetime of the pilot, comprised:

- Estates
- IT and information governance
- Commissioning
- Communications
- Evaluation
- The Criminal Justice System; this sub-group, chaired by the CPS, was formed to oversee any specific local criminal justice pathway, process or procedural changes that would be required and, in particular, to advise on the implementation of the psychologist-led ABE interviews and the use of a court link.

14.12 All the clinical commissioners and practitioners were involved in the governance of the pilot – not only the Joint Children's Commissioners, but also the local mental health (CAMHS) and sexual health commissioners.

Membership

14.13 The Board included representatives of the following:

- MOPAC
- Home Office, Department for Education, Crown Prosecution Service and Her Majesty's Courts and Tribunals Service in the Ministry of Justice
- NHS England
- Metropolitan Police Service
- NHS clinicians representing mental health and paediatrics
- CCGs in North and South London
- Local authorities
- IT provider (NELCSU)
- VCS organisations.

14.14 Once the health and wellbeing service was put out to tender, any Board member who was considering submitting a bid had to leave the Board temporarily given that they had a potential conflict of interest and this might have given them an unfair advantage.

During mobilisation

14.15 Once the contract for the health and wellbeing service had been awarded to University College London Hospitals NHS Trust (UCLH), they established their own governance structures to oversee the service start-up and implementation arrangements. Representatives of the lead provider (the delivery lead and the Divisional Manager for Paediatrics and Adolescents) and some of the other health and wellbeing providers (the Tavistock and Portman Mental Health Trust) joined the Board. The Head of Children's Integrated Commissioning for Camden, who was responsible for co-

ordination between the five CCGs and the five LAs) was also on the Board.

14.16 Specific governance arrangements were set up to oversee mobilisation including a contract mobilisation meeting chaired by NHS England (London) which reported to the Programme Board (see **chapter 18**).

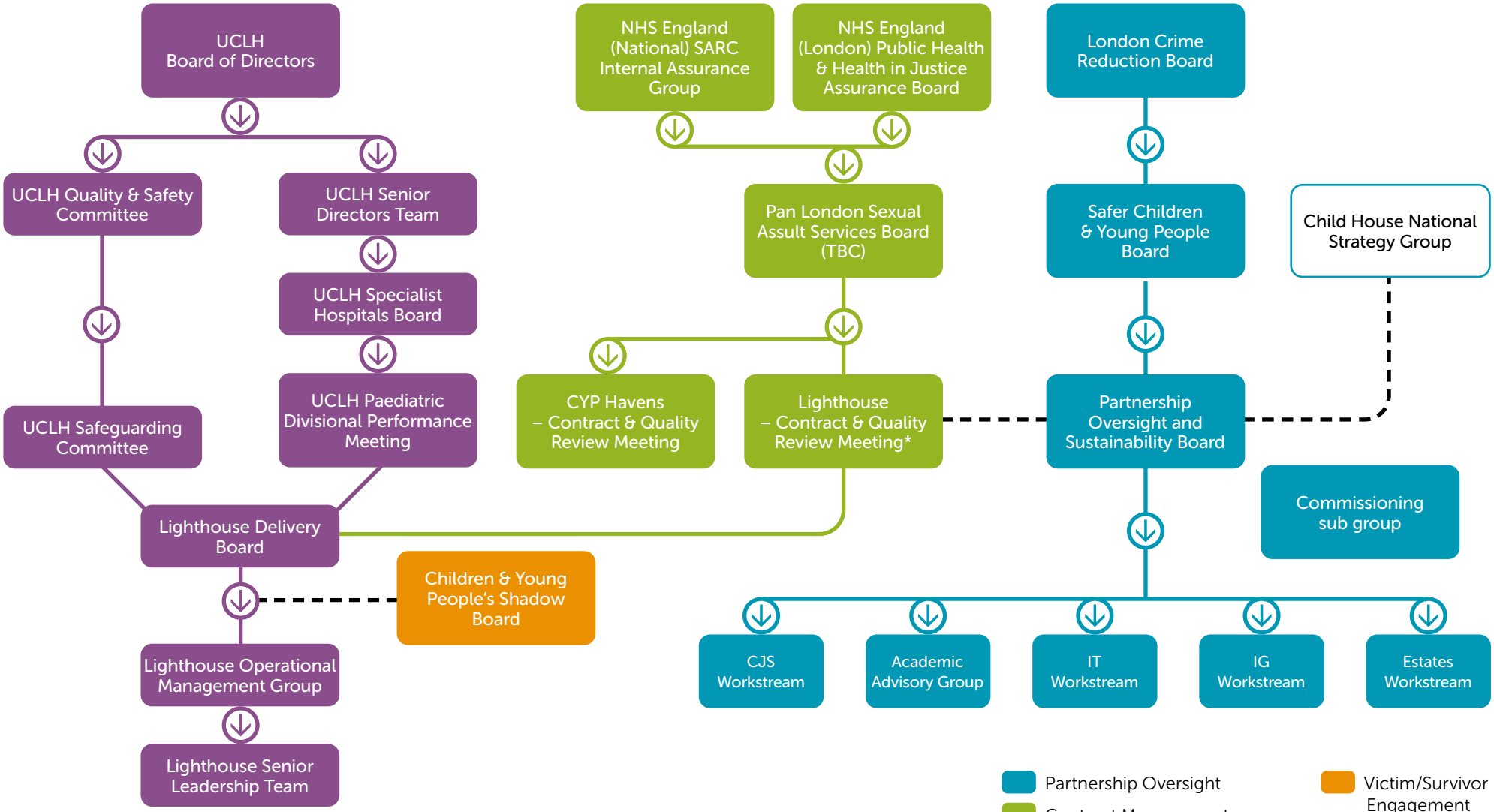
14.17 The Programme Board met monthly until the Lighthouse opened. Since one of the major issues going forward from then on was sustainability of The Lighthouse at the end of the pilot, the Programme Board was reformed into the Partnership Oversight and Sustainability Board with **revised terms of reference**[4]. This had four main pillars of governance:

- Maintaining oversight of the pilot and strategic partnership arrangements
- Upholding due diligence in terms of contract management
- Fulfilling operational management responsibilities across the provider sector
- Ensuring effective victim/survivor/public/

14.18 Following the go-live date, the newly-constituted Board started to meet bi-monthly. The key functions of the new Board were to:

- Make key decisions in relation to:
  - The service within the Child House;
  - The evaluation of the pilot; and
  - Sustainability
- Be an escalation point for partnership issues and also escalate issues further if appropriate.
- Ensure delivery of the pilot within budget.
- Regularly review risks and provide assistance and guidance in reducing these.
- Ensure that there is a robust approach to the evaluation of the pilot which addresses the key outcomes, including improved awareness of CSAE and experiences of health and CJS services, and increased likelihood of charges and convictions.
- Ensure a considered sustainability plan is in place.
- Ensure an effective communication (internal and external) and service user engagement strategy.
- Ensure that there is effective key stakeholder engagement, especially but not only with CYP, and that this can be evidenced in service provision.
- Ensure links with wider work within London related to violence against women and girls, child and adolescent mental health services, children's social services and the criminal justice system.
- Ensure the sharing of good practice and learning from the UK and internationally.
- Liaise with cross governmental advisory groups to keep them informed of progress and ensure the Child House pilot is developed in line with national policy direction.

patient feedback and participation throughout.



* Victim/Survivor representation incorporated in corporate management meetings

The following diagram shows the overall governance arrangements for the Child House:

14.19 A Delivery Team was set up to oversee the operational management of the project. This comprised the workstream leads and was chaired by the Project Manager. The Team met regularly throughout the mobilisation period and fed into the Programme Board.

Risk management

14.20 Risk management was led by MOPAC who compiled the register of risks and recorded mitigation strategies. A RAG-rated update of risks was presented to every meeting of the Programme Board for discussion with proposed mitigation and actions, as well as processes for escalation where needed. The themes of the risks varied as the project progressed with early significant risk resulting from the need to align the delivery timeline with the availability of funding and procurement processes. More recent risks arose from the need to wrestle with information governance and data management systems, grappling with organisational differences in approach, at the same time as changes were being made to data protection legislation.

14.21 By way of example, towards mobilisation and beyond, the higher level of risks identified included the following themes:

- Risk of the Electronic Patient Record not being ready on time and not being fit for purpose
- Risk of not being able to incorporate the criminal justice outcomes (section 28) into the pilot
- Risk of the clinical governance arrangements leading to delays in mobilisation
- Risk of not being able to secure data on individual cases to support the evaluation of the pilot
- Risk of not securing funding beyond the pilot.

Resources

14.23 Considerable resources were expended on servicing the Programme Board and its sub-groups. This was undertaken by a delivery team comprising representatives from MOPAC and NHS England (London). This included preparing the papers for the monthly, then bi-monthly then tri-monthly meetings, responding to requests from funders and to scrutiny enquiries intended to ensure that the project was on course.

Key learning points

- All the key clinical commissioners and practitioners should be involved in the governance arrangements: not only the Joint Children's Commissioners, but also the local mental health (CAMHS) and sexual health commissioners.
- A Programme Board will be needed, ideally from the inception of the pilot with clear terms of reference and representatives of the partners to provide a strong foundation for oversight and delivery of the pilot. Membership and the terms of reference may need to change as the project advances – for example, it may be necessary to temporarily exclude those who might have a conflict of interest if the health and wellbeing service is put out to tender.
- The Programme Board should be linked to several other strategic groups in the lead provider (once appointed), as well as to organisations such as NHS England regional offices and the PCC.
- Sub-groups may be needed in areas such as estates, IT and information governance, Criminal Justice Services, commissioning, communications and evaluation.
- A delivery group may be needed to oversee the day-to-day running of the operational aspects of the project. This should be separate from but feed into the Programme Board.
- Considerable resources are needed for governance of the pilot, including reporting on the funding and responding to scrutiny from funders.
- There should be a strategy in place for risk management with clear reporting arrangements, including mitigation and escalation procedures.

Checklist for setting up a Child House

- ○ Is there an existing steering group in place which could oversee the development of the Child House? If not, has a specific committee been established with clear terms of reference on which all the key partners are represented?
- ○ Does this steering group have clear links to other strategic groups in the area including cross-representation where this would be helpful?
- ○ Have sub-groups been established to oversee individual aspects of delivery (eg: estates, IT and information governance, Criminal Justice System, Commissioning, Communications and Evaluation)?
- ○ Are sufficient resources available to deliver on the governance arrangements for the project?
- ○ Are there separate governance arrangements in place to oversee operational management issues and the more systemic, strategic issues that need to be addressed?
- ○ Has thought been given to how users public, patient/service users and carers should be involved in the governance of the project and their voices heard?
- ○ Is there a strategy in place for managing risk with clear responsibilities for oversight and mitigation in place?

End Notes

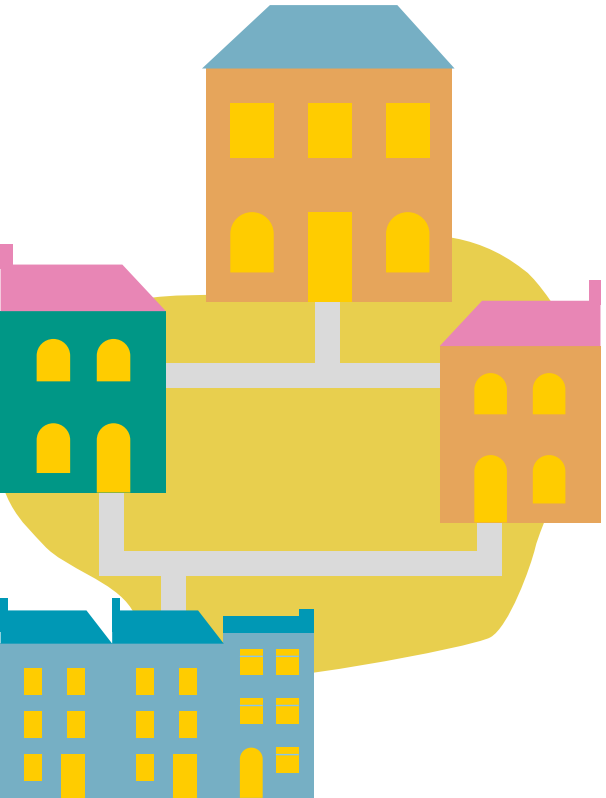
1 See Child Sexual Abuse Hub Toolkit, op cit Lesson 4.

2 CSA Hub toolkit Lesson 4, page 18.

3 Op cit, page 17.

4 Insert reference to document on microsite.

Chapter 15
Estates and premises



What this chapter tells you:

Finding and constructing suitable premises

15.1 A core element of the Child House concept is that it should be a safe place for providing support for CYP who have experienced abuse – a child-friendly, child-centred and supportive setting, as well as a place that is safe from anyone suspected of abuse.[1] A Child House should not feel like an institutional building such as a police station or hospital.

15.2 Separate guidance is given on estates and premises based on the experience of the Lighthouse in London – see **Design Guide**.

15.3 Finding suitable premises for the Child House that are geographically well-located and suitable for the services to be carried out there can be challenging. Key Element 2 in the Child House – Commissioning Guidance[2] says:

Co-location

15.4 Co-location of all the services in one building is the essence of a Child House. If one building cannot be identified due to costs or availability, then local services should start by co-locating themselves in existing health or care premises or establish links with local VCS organisations.[3] The **Child House: Local Partnerships Guidance** suggests that the location should be separate from the local hospital, CAMHS, social care or police buildings and that, where this is not possible, the key consideration is that the building is a child-centred environment without an overtly clinical or 'official' feel.[4] However, although physical co-location of services is a fundamental feature of the Child House model, there may be some areas where improvements will be made to local commissioning and provision of support to CYP following CSAE without co-locating services physically.

15.5 Existing contacts should be used to help to identify suitable premises for a Child House. Alternatively, an estate agent or property consultant could be engaged to search for suitable premises since it may be difficult to meet the specific criteria for a Child House.

15.6 Decisions should be taken early on as to who will be responsible for each aspect of the premises refurbishment and design as well as commissioning any building works. This should be communicated clearly to all the partners. Having a construction bidding process may be necessary to appoint contractors for the construction fit-out.

15.7 If the premises are rented, the rental agreement will need to make it clear who has responsibility for all aspects of facilities management, including cleaning, including clinical rooms which require special cleaning, the removal of clinical waste and provision of security and reception services.

> *Creating a child-friendly environment*
>
> Physical co-location of services is an important element of the Child House model. The location, type of premises and layout are all important factors in ensuring children can access the services they need to and in securing the privacy and safety of service users. Whether the Child House is developed from an existing service or set up in a purpose-built or renovated property, the key consideration is the ability to provide a safe, neutral and child-friendly environment that reflects the needs of all children who use the service. This is central to reducing anxiety and preventing retraumatisation. It will enable children to talk about what has happened to them, which is fundamental to ensuring their safety and protection, determining their support needs and, where appropriate, securing an effective criminal investigation and prosecution.

Selection criteria

15.8 In selecting premises for a Child House, the criteria should therefore focus on the key aspects identified above. The following should also be considered[5]:

- is the location accessible to people locally in a realistic timescale (eg central location with adequate public transport links)?
- Is it in a safe location?
- Is it easy to find?
- Is the external appearance discrete to protect the confidentiality of children and their families?

Key facilities required

15.9 The premises required will vary depending on local need and on what is available as well as the services to be provided there. Each relevant agency should be involved at an early stage to determine their precise requirements for the Child House in terms of space, facilities and equipment. It is likely that the following rooms will be required:

- a child and young person-friendly reception area;
- an ABE interview room with separate waiting room and live link rooms can be provided (to prevent ABE interview room being booked out for multiple court dates). There should be an observation room linked to the ABE interview room with sufficient space for multi-disciplinary team discussion and observations. This can be used by the police officer who is controlling the cameras and sound recording during the interview; the child's social worker can also listen to the interview in the observation room;
- waiting rooms (note that there may be privacy concerns as to where these are located –therefore the proximity to therapeutic rooms should be considered);
- meeting rooms which can accommodate full team meetings or team-building events as well as strategy and training events;
- therapeutic rooms suitable for:
  - young children where play, water and sand therapy can be used;
  - older age groups for providing talking and activities;
- if the Child House is providing forensic examinations, a forensic waiting area and adjoining shower facilities will also be required;
- ideally there should be sufficient space for playing and relaxing, including outdoor space if possible;
- storage facilities – each room needs the ability to store equipment out of the way. Therapists and therapeutic practitioners will choose before each session what they intend to use; too much equipment being visible can be distracting;
- staff facilities – including a break room, toilets, kitchen; staff storage for personal belongings;
- server room.

The space available in each room will need to take account of the equipment needed (including the clinical equipment) to be placed in it. The need for privacy during consultations needs to be taken into account in planning the space and location of these rooms (see 15.21 on soundproofing). Note that there should be a room with a panic/alarm bell near the reception area where therapists can take any young person who has the potential to become aggressive or suicidal.

Use of technical consultants and construction contractors

15.10 A technical consultant, responsible for design and project management, and a construction contractor are likely to be needed if there is likely to be a significant amount of work involved in refurbishing the premises. They should be appointed at the same time if possible since the work will need to be done in parallel. Commissioning a feasibility study of the building from the technical consultants will be helpful.

Lead time

15.11 Finding the right location that meets the above criteria is likely to have a long lead time, whether the premises are to be purchased or rented. It is likely that significant refurbishment will be required to make it fit for purpose. It should be noted that purchasing a property or negotiating a lease can take many months. Similarly, conducting a feasibility study and then developing refurbishment plans, the specification and the tender for construction contractors can also take some time. It will not be possible to begin the refurbishment until all these steps have been completed.

15.12 A decision should be taken early on as to whether to commission the service provider and the premises separately or whether the contract with the service provider will include the provision of the premises. Ideally, the service provider should be able to input into the building design (to make sure it fits the proposed staff model and range of services to be provided) depending on the time available.

Regulatory requirements

15.13 Planning permission may be needed for any substantive change of use of the property and this may take some time to secure. Building control may also be required. Other regulatory requirements and guidelines which apply include CQC registration (see paragraph 11.6), infection control, accessibility, health and safety compliance and fire safety. It is anticipated that the management of the premises would be run by an existing property management function.

Provision of forensics services

15.14 Not all Child Houses provide forensics services but it should be possible able to access these. If it is intended that forensic services should be provided at the Child House, there may be some additional regulatory requirements. It is feasible that some Child Houses could be co-located with SARCs if they are in suitable premises.

Governance of estates strategy

15.15 Robust governance will be needed to oversee the delivery of the building to ensure that the project runs to time, stays within scope and that all the contractual, financial and legal obligations are met.

Child and young person friendly design

15.16 The Design Guide and the Child House: Local Partnerships Guidance include details of the considerations for achieving a child and young person friendly design[6]. The premises need to be designed to meet the needs of CYP and need to be physically safe for children of all ages and fully accessible for children and adults with disabilities. Involving a range of CYP in the design (in particular, the look and feel) helps to ensure that the premises are likely to appeal to different age groups and genders, and those with different needs to be seen in the Child House – see also chapter 9 for more detail on how to work with CYP.

15.17 Guidance on child-friendly design for healthcare buildings may help to design the clinical facilities to be housed at the Child House. There is a body of evidence into what constitutes child and young person friendly design, recognising that children are not just 'mini-adults' and are 'entitled to healthcare which is specifically designed to meet their needs as children'[7].

15.18 'Studies clearly show that the design of spaces, together with sensitive lighting, colour, sound attenuation, texture and material specification, are essential to children's immediate well-being, healing process and ultimate outcome. Sense-sensitive design is key. The senses of sight, touch, hearing, taste and smell are all important, since it is through these that the total environment is experienced. These senses operate simultaneously to help children understand and navigate within their environment.'[8]

15.19 See also guidance on Friendly healthcare environments for CYP.[9]

Security

15.20 It is imperative that adequate security is provided for all areas of the Child House. Consideration could be given to internal and external CCTV, internal and external door access control, panic alarms and lone worker alarms. Safety should be paramount for CYP and staff, but should be proportionate to the services being offered and not appear intrusive for the CYP. Where possible, there should be separate entrances to the ABE interview suite (and forensic suite if provided) and other parts of the building.[10]

Soundproofing

15.21 The proposed function of each room needs to be looked at individually to consider the acoustic design that will be needed and its adjacencies. This is particularly true of the ABE room, live link room, clinical and therapeutic rooms where privacy should be maintained. The implications of flooring for noise transference will need to be considered if the premises have more than one floor. This issue is particularly important in the interview/ABE suite where careful consideration needs to be given to noise, not only from adjacent rooms, but from those above or below. Each agency may have different standards for acoustic design; for example, guidance is available on how to achieve good acoustic design for healthcare premises which should be adhered to[11]: The police will have a set specification for the ABE suite and HMCTS for the live link room.

IT infrastructure

15.22 IT infrastructure including the server room, cabling and connections into the building need to be planned as part of the design work so that these can be incorporated into the fit-out.

Facilities management

15.23 The future arrangements for maintenance and facilities management (eg: security, cleaning) should be considered early on and responsibilities clarified. A clear decision will be needed on who will be responsible for running the building so that there is a shared understanding of roles. Specialist requirements such as the disposal of clinical waste which may fall outside general facilities management arrangements may also need to be considered.

Provision of equipment and toys

15.24 Clinical equipment will be needed including a colposcope, examination couch, a refrigerator in the treatment room for samples and facilities for clinical waste. Toys and games should be provided for children to use both when waiting and during therapeutic play (for example, sandpits). It may be worthwhile approaching local charities to see if they are able to donate these.

Mobilisation

15.25 The timescale for mobilising the Child House will to a large extent depend on the readiness of the premises. If there is significant work involved in the procurement of the premises, this will need to go through appropriate routes which may take a considerable time. Sequencing the project plan is important to understand the order in which things need to be done (see chapter 18 on mobilisation). The IT design needs to be done in tandem with the refurbishment of the premises. This includes lead-in times for the procurement of the building work, negotiating the lease, ordering equipment including telephones, photocopiers and computers. The timescale agreed for appointing staff should take account of when the premises will be ready, since sufficient time will be needed for the new service to bed into the building and to address any snagging issues.

Finding and refurbishing the premises in London

Specification

15.26 The aim in London was initially to pilot two Child Houses, one in the South and one in the North of London, serving two of the (then) five health sectors in London. The Metropolitan Police Service Property Services Department was asked to assume responsibility for the estates aspects of the pilot and to find premises in both areas based on a brief specification:

Initial specification:

The space needed to be:

- Outdoor space
- Not a corporate building
- Multiple entrances
- Near public transport

The properties ideally need to be in the D1 planning category, available for rent immediately or very soon, preferably freehold, and ideally an adapted residential or commercial property – house style appearance, good transport links, parking available, near hospital with lab, pharmacy & GUM support.

The premises must provide:

- Clinical examination room x1 (with space for examination couches and colposcope)
- Adjoining clinic room (space for microscopy, incubator and two fridges)
- Consultation rooms for 3-4 mental health practitioners
- Interview room with adjoining observation room via video link
- Office hot desk space for Child House team, local CAIT and Sapphire officers, social workers etc.
- Two reception and waiting areas (for CYP)
- Admin base and storage
- Meeting room and staff facilities
- Access to local pharmacy and laboratory

The space requirement was estimated to be approx. 400 square metres in total.

Role of property consultant

15.27 Property consultant Knight Frank who provide property services to the MPS were commissioned to conduct searches for suitable premises to rent as it would not have been practicable to buy premises in London. They looked specifically for D1 categories of property (non-residential) since this meant that they would not need to apply for a change of use which would have held things up further. Members of the Delivery Team went and looked at potential sites themselves to assess whether they thought it would be suitable in terms of location and accessibility, and whether it would be possible to make the property child-friendly.

Locating the sites

15.28 Premises were located in a disused community health centre in Purley in the London Borough of Croydon in South London, and in an NSPCC facility in the London Borough of Camden. Consent was needed for the proposed building in Purley but the changes proposed were minor and planning consent was obtained fairly quickly. The NSPCC building was already in use, providing therapeutic and other services, but there was space within the building to dedicate to a Child House. The fit-out therefore had to be done whilst the building was in use. The lease was negotiated between the MPS and the NSPCC.

Use of technical consultants and construction contractors

15.29 Atkins were commissioned by the MPS as technical consultants to carry out the design and project management of the building. A construction project manager in the MPS oversaw the delivery of the construction project. Work was carried out to define more precisely what was needed in terms of the space and the rooms. An outline template for the building was then drawn up and agreed. Once decisions had been reached on the design, any subsequent changes requested had to be approved by MOPAC.

15.30 Overbury were appointed as construction contractors.

Lead time

15.31 Since the pilot was intended to be a two year project, it was hoped that the property could be found and made fit-for-purpose quickly to fit in with the initial timescale set for the project. However, this proved difficult and time-consuming given the complexities involved, the cost of finding suitable and affordable premises in London and the time needed to secure the necessary approvals. The timescale was therefore extended but it still took well over a year from the time the premises were identified to completion of the delivery of the facility.

Scaling back

15.32 It became clear that there were insufficient resources to pilot two Child Houses as initially planned and that a better option would be to proceed with the one based in Camden in North London (see paragraph 12.19). The decision was based on analysis against a number of criteria including need, strategic alignment of the wider health community, clinical leadership in relation to Child House principles, availability of premises, and performance and financial stability across the sector. The work on the site in Purley (Croydon) was therefore stopped. Although this relieved the financial pressures, there was insufficient funding to meet all of the requirements initially identified and there was some scaling back of the ambitions for the pilot; for example, having some outside space, which was one of the initial criteria, did not prove feasible.

> *What was really important in finding and securing the right premises and in making them fit-for-purpose was to develop a clear understanding of what was involved at each stage of the project. Getting the right team on board and getting all the different elements aligned was key to its success.*
>
> Tony Cooper, Metropolitan Police Property Services Department

Rooms and facilities at the Lighthouse

15.33 The rooms available at the Lighthouse are broadly in line with those recommended in paragraph 15.9.

15.34 The observation room for the ABE suite is used to control the three cameras to ensure there is an overall view of the room, view of the child or young person and a view of the table during drawing or play. It is also used for the professionals meeting post the Pre-Interview Assessment phase to refine and plan for the final interview.

Governance of estates strategy

15.35 Governance of the estates strategy was led by a dedicated sub-group of the Programme Board. Regular meetings were held to ensure that the project was on track and that legal and contracting aspects followed the existing MOPAC processes.

Involving young people in the building design

15.36 The CSA Transformation Programme worked with a group of CYP on the design of the building. Mood boards were produced to illustrate the options for the look and feel of the building and facilities and to inform the design. Several changes were made as a result of their input during the design phase and subsequently. For example, some of the CCTV cameras were felt to be obtrusive by the young people after they had been installed and were therefore changed. Further work on the furnishings and design was done after the building was complete, led by the NSPCC.

During mobilisation

15.37 Finalising the premises in time was a key element of the work on mobilisation (see chapter 18 on mobilisation).

15.38 Since the building was completed and handed over to the lead provider a fortnight before the Child House was due to open, there was no time left for addressing snagging. This therefore had to be done with the staff on site which was challenging.

Running the Child House

15.39 Soundproofing proved to be an issue, particularly in the room in which the ABE interviews were conducted and the therapeutic rooms, where there was concern that voices could be heard in the waiting area and that there was some noise transference between floors. In response, a noise consultant was commissioned to look at what could be done to mitigate the effects of the noise and the key recommendations were accepted.

Key learning points

- Designing and building a Child House is complex since it may need to meet the requirements and design standards of several different agencies (including health, police, social care and voluntary sector), all of whom are likely to have different requirements.
- Finding the right premises, obtaining the necessary approvals and fitting it out so that it meets the national standards may take a long time and significant resources. Allowing insufficient time for this may lead to delays later on or jeopardise spending of time-limited funding.
- The premises will need to comply with a range of regulatory requirements including those that are necessary to obtain CQC registration, infection control, health and safety, and fire safety. It is important that, where new premises are being built or there is a major refurbishment required before the Child House opens, the Lead Provider should be able to input into the design and fit-out. The time and resources needed to do this should be factored into the tender for the Lead Provider.
- Ideally, having a clear idea of the costs of providing premises for the Child House and of the timescales involved should be available before any bid for funding is submitted; this will be one of the most significant costs and will substantially affect the overall cost of the project.
- Commissioning a property search from a property consultant may be helpful as well as using any contacts to identify suitable premises. Members of the Project Team may also wish to inspect the properties themselves to ensure that they are suitable.
- Understanding the operating model to be applied in the Child House including what services will be provided and by which agency should be clarified early on as this will affect the plans for the premises.
- Technical consultants and construction contractors are likely to be needed to advise on the feasibility of premises once identified, and to oversee the design and construction. Ideally, they should be appointed at the same time as they will need to work in parallel to ensure the premises are fit-for-purpose.
- Working with CYP and practitioners on the design of the building, including the furnishings, may help to improve the look and feel of the premises and ensure that they are CYP friendly.
- The development of the IT facilities needs to be part of the estates specification and to run in parallel with the construction as this is fundamental to the building design. The IT infrastructure should therefore be installed during the refurbishment as far as possible to avoid having to retrofit the wiring later on.

Key learning points

- Ideally, the health and wellbeing provider should be responsible for the fit-out of the premises if timing allows. Sufficient clinical input will be needed to ensure that the premises are suitable for the clinical services to be delivered. Leaving this to the commissioners of the service may cause difficulties at a later stage as they are less likely to have an operational feel for what will be needed.
- Sufficient time is needed for the service to bed down into the new premises and to address snagging before the service opens.
- Decisions on facilities management and who will be responsible for what aspects should be taken early on. The management of the premises may best be run as part of an existing property management function.

Checklist for setting up a Child House

- ○ Has a property consultant been appointed to help with the location of suitable premises?
- ○ Has a technical design consultant been appointed to help with the design of the facility and evaluation of the feasibility of the proposed premises?
- ○ Are all services to be provided in the Child House or will some be provided elsewhere?
- ○ Will the premises selected meet the national standards? Are they accessible, easy to find, in a safe area?
- ○ Is it clear who will be responsible for each aspect of the premises refurbishment and design and for commissioning any building works that will be needed?
- ○ Have decisions made as to who will be responsible for facilities management and is it clear what this includes?
- ○ Will the premises be run by an existing property management function?
- ○ If it is proposed to use a leasehold property, is it clear who will hold the lease?
- ○ Is a construction bidding process necessary to appoint contractors for the construction fit-out?
- ○ Is the financial strategy aligned with the premises strategy so that the finance will be available as soon as required for purchasing or renting the premises and paying for any refurbishment and fit-out?
- ○ Will there be sufficient funding for child and young-person friendly furniture in the Child House?
- ○ Will CYP be involved in the design of the premises? Are they representative of different groups of CYP who are likely to use the Child House, including disabled CYP?
- ○ Have all the regulatory requirements been met?
- ○ Are there clear governance arrangements in place for the management of the estates strategy?

End Notes

1 S. Johansson et al. (eds) Collaborating against Child Abuse, page 7.

2 Child House – Commissioning Guidance, op cit, Home Office.

3 Durham and Darlington, for example, have piloted a Child Advocacy Centre over two years. Because they were unable to find a base for the services to be provided, these were housed within the SARC. Whilst they made considerable progress towards meeting seven of the ten standards set for CACs in the US (which overlap with the Home Office's standards set for the UK), an independent evaluation concluded that 'sourcing dedicated premises to house an ongoing CAC would allow the project to build on its successes to date' (Hackett S. and Butterby K., An independent evaluation of the Child Advocacy Centre (CAC) Project in Durham and Darlington, Durham University, October 2018). The project was therefore hampered to some extent by the lack of dedicated premises.

4 The Child House model – Key Elements, op cit, paragraph 2.1

5 Home Office, Key Elements document, op cit, paragraph 2.1

6 Child House – Commissioning Guidelines, Home Office, op cit, paragraph 2.1.

7 Bristol Inquiry, Kennedy (2001).

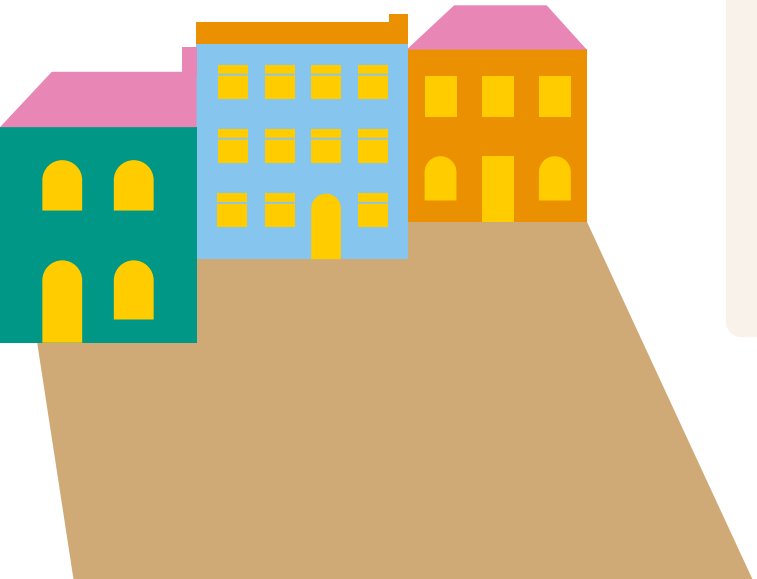
8 HBN23 Hospital accommodation for children and young people, NHS Estates, Department of Health, paragraph 1.44.

9 Improving the patient experience: Friendly healthcare environments for children and young people, NHS Estates (2004) **http://www.wales.nhs.uk/sites3/Documents/254/FriendKids.pdf**

10 Child House – Commissioning Guidelines, Home Office, op cit, paragraph 2.2.

11 Department of Health, Specialist services, Health Technical Memorandum, 09-01: Acoustics (2013)

Chapter 16
Information governance in the Child House



What this chapter tells you:

Information sharing

16.1 Effective sharing of information between practitioners, local organisations and agencies is essential for early identification of need, assessment and service provision to keep children safe.[1] The partners working together in the Child House need to share information effectively whilst complying with regulations, professional codes of conduct and organisational requirements.

16.2 The sensitivity of the information that will be handled by the Child House, the flows of personal data into and out of the health and well-being service, and the potential complexity of information sharing within the network of organisations working in the field require the highest standards of information governance (including information security).

16.3 Information sharing is an area frequently found to be challenging in tackling complex issues such as CSAE. Different organisations and professional groups have different requirements and priorities and these need to be recognised, identified and addressed early on in setting up a Child House.

16.4 All staff will need to be confident of the processing conditions under the Data Protection Act 2018 and the General Data Protection Regulation (GDPR) which allow them to store and share information for safeguarding purposes, including sensitive and personal data. Specific training is also likely to be needed to ensure that staff feel empowered and confident in seeking and recording consent.

16.5 Having the right staff involved from an early stage is crucial – both staff with a strategic overview and practitioners with operational experience as well as staff with technical/data protection expertise are needed to ensure that all the key issues are addressed.

Legal requirements

16.6 The Child House provider will be required to take account of the common law duty of confidentiality, the Data Protection Act (2018), the General Data Protection Regulation (GDPR), the Caldicott Principles, and NHS codes of practice as well as local safeguarding procedures, and Working Together to Safeguard Children. They are required to adhere to statutory codes of practice issued by the Information Commissioner's Office (such as the Data Sharing Code of Practice[2] and the Anonymisation Code of Practice[3]) and guidance issued by other relevant parties (such as NHS Digital) (see paragraph 16.7). A Data Protection Officer will be needed to ensure that the Child House follows data protection policies and complies with the Data Protection Act 1998. As this is a complex and highly specialised area, it will be important for partners to obtain advice from their own information governance leads to ensure all relevant legislation is followed.

Key guidance

16.7 Key pieces of relevant guidance on information governance include:

- Working Together to Safeguard Children[4]
- Guide to Data Protection[5] issued by the Information Commissioner's Office
- Guidance on Data Protection Impact Assessments[6]
- DPIA sample template[7]
- Data Security and Protection Toolkit[8] from NHS Digital
- Information sharing – advice for practitioners providing safeguarding services to children, young people, parents and carers[9] (HM Government July 2018)
- General Data Protection Regulation Guidance[10] issued by NHS Digital

Data Protection Impact Assessment

16.7 A Data Protection Impact Assessment (DPIA) is needed to assess, identify and minimise any data protection risks from a project involving personal information. The DPIA should:

- set out agreement on roles and responsibilities;
- describe the nature, scope, context and purposes of the processing;
- assess necessity, proportionality and compliance measures;
- identify and assess risks to individuals; and
- identify any additional measures to mitigate those risks[11].

16.8 Work on the DPIA will need to be undertaken by the service leads or the suppliers and overseen by the information governance leads for the partners involved. This needs to begin as soon as the lead provider is appointed. All the partners will need to be involved in assessing both the likelihood and the severity of any potential impact on individuals and also in agreeing who will lead on which aspects of data protection. Partners will need to have agreed the detail of what information they want to share, how they will share it and under which consent/information sharing agreement before they can define the information governance mechanisms and develop the DPIA. Risks on data protection will need to be identified and appropriate mitigation put in place. Once there is a shared understanding between the key organisations, Data Controllers and Data Processors would be identified. Further information is available on the Information Commissioner's website www.ico.org.uk.

Organisational approaches to information sharing

16.9 The different basis on which each organisation shares information needs to be recognised. Though all are bound by the overarching legislative requirements, there may be different professional and agency requirements as well as differences in cultural approaches to sharing information on individuals:

- **NHS:** the main principles governing information sharing follow the Caldicott principles[12]. A Caldicott Guardians in each health organisation is responsible for safeguarding the confidentiality of patient information. Different regulations apply to sharing data for secondary purposes (such as research or evaluation) than for data which needs to be shared between those responsible for a particular patient's care (primary purposes – see paragraphs 16.11-16.14);
- **Voluntary organisations:** information is only shared with the written consent of the child or young person and those with parental responsibility;
- **Police:** the police share information regarded as being in the public interest for the purposes of public protection;
- **Children's Social Care:** Information is shared in line with Working Together which is statutory guidance and applies to the organisations listed above as well.

The perspectives of each of the partners need to be shared at an early stage to ensure that a common way forward can be found.

16.10 In developing an integrated record system which can be accessed by all the partner agencies, it may be necessary to have some restrictions in place to comply with the information governance requirements of the different agencies, particularly the NHS and police. Any such restrictions should be kept to a minimum so that staff are able to share information relatively freely with those in other agencies.

Data for evaluation purposes

16.11 If it is intended to evaluate the Child House, consideration should be given at an early stage to the information governance requirements of using data collected on

individual CYP for this purpose. In the NHS, particular requirements apply to data collection for 'secondary uses' (as opposed to the primary use of data that needs to be collected for the purposes of caring for an individual patient), particularly if this data is in any way considered to be identifiable (rather than fully anonymised). See the **British Medical Association's advice on Requests for Disclosure for Secondary Uses of Data**[13] which makes it clear that explicit patient consent is needed for the use of confidential patient information for secondary purposes (with some exceptions which are specified in the guidance). Further details on consent and ethical considerations are set out below and in **chapter 19 on Evaluation**.

Consent to share information

16.12 *Working Together* states that all practitioners should aim to gain consent to share information, but should be mindful of situations where to do so would place a child at increased risk of harm. It is possible to share information without consent if a practitioner has reason to believe that there is good reason to do so[14] and this should be made clear to children that use the service in a child and young person-friendly agreement and privacy statement.

16.13 The issue of consent is of vital importance in the multi-agency environment of a Child House where it is essential to seek children, young people and/or their family/carer's agreement to access services. The sharing of identifiable information is particularly complex and, in most circumstances, relies on there being informed consent. Having well-designed consent procedures including documentation in place should be an early priority to ensure that there is explicit informed consent in every case. This should include not only consent to share information for the purposes of providing support to the child or young person and family, but also for the purposes of evaluation (see **chapter 19**). Separate consent for video-recorded colposcopy and for the psychologist-led ABE forensic interviews are also required in line with Article 9.2(a) of the General Data Protection regulation (GDPR) on Special Category data[15].

16.14 The agreement of service users to use the Child House services should be sought at their initial appointment, following the provision of service information and a privacy statement. This should be tailored to the age and understanding of the child or young person (ie: depending on whether they are considered to be Gillick competent – see **www.nhs.uk/conditions/consent-to-treatment/children/**).

Consent forms and procedures

16.15 Involving CYP in the design of consent forms and procedures may be helpful to ensure that the processes and forms will be understood by them and not deter them from giving consent to treatment or evaluation.

Information governance in the Lighthouse

Information governance requirements

16.16 The specification for the health and wellbeing service stated that the highest standards of information governance would be required, and referred to the many regulatory requirements which would apply in the Child House, including the GDPR which had at that time yet to be enacted. Local requirements for sharing information in relation to safeguarding in London which apply to the Lighthouse are set out in the **London Child Protection Procedures**.[16] The best means of obtaining consent was considered at an early stage in the development of the Lighthouse to ensure that legislative requirements were complied with – see **paragraph 16.26**.

16.17 The organisational and regulatory requirements and culture of data sharing of the police, NHS and Children's Social Care for sharing information were recognised as being different early on as was the need for all to comply with legal requirements.

Challenges

16.18 Ensuring that the way information is shared meets the needs of the police for criminal justice purposes whilst ensuring patient confidentiality and complying with NHS and local authority regulatory requirements presented some challenges. This illustrates the possible tension inherent in the different approaches to information sharing, since the police's emphasis on the need for public protection allows information to be shared at an individual level whereas in the NHS, data for individual use has strict requirements as a result of the need for confidentiality. Data for secondary purposes in the NHS (ie: not related to an individual patient or client) is shared only at an aggregate level, for example.

16.19 In addition, one of the issues that took time to resolve was the need to use the individually identifiable data collected on CYP for evaluation purposes, so that the information on each individual could be tracked through the Lighthouse, police and court record systems (see chapter 19). The need to evaluate the pilot was of paramount importance and relied on obtaining sufficient data to demonstrate that the service was being utilised and that outcomes were positive. However, there was some difference in approach between the agencies with the NHS in particular needing to comply with strict regulatory requirements relating to secondary use of patient-identifiable data (see paragraph 16.10).

16.20 As the Lighthouse is not a legal entity in its own right, it cannot be named as the data controller. The partnership agreed that the joint data controllers would be UCLH, – Tavistock and Portman, NSPCC and MOPAC. The data processors comprise NEL CSU, the Metropolitan Police and Excelicare.

During mobilisation

16.21 Although the need to share information was recognised from the inception of the pilot, the complexities of doing so were not fully recognised until mobilisation. In particular, it was clear that patient identifiable data was going to be needed for the purposes of the evaluation in order to track the child through the criminal justice process which is unusual. Once the health and wellbeing provider was appointed, MOPAC handed over responsibility for information governance to the new provider.

16.22 Once the detailed work started on the development of the electronic patient record (Excelicare) and the drawing-up of the DPIA, it became clear that there was a great deal to do during mobilisation to put the necessary arrangements in place and to secure agreement from all the partners. Work commenced on the drawing-up of the following:

Data Protection Impact Assessment (DPIA)

The Lighthouse Data Processing Agreement

Data Processing Agreement with Excelicare

Information Sharing Agreement between the partner agencies

Data Protection Policy

Subject Access Request guidance and application form

Request for Third Party Disclosure of material to Police

TL2 agreement, a form used by the police to secure consent from the child or young person to share the police's notes relating to their case.

Compliance with GDPR regulations

16.23 This coincided with the introduction of the General Data Protection Regulation in May 2018 which created additional workload for the organisational IG leads at the same time that they needed to focus on establishing a complex multi-agency DPIA for the Lighthouse. This meant that the Lead Provider (led by the Information Governance lead at UCLH) had to ensure compliance with the new GDPR regulations as well as meeting existing requirements.

Staff resources

16.24 The staff resources required to meet the information governance requirements and put the necessary infrastructure in place was considerable given the workload to be completed during mobilisation. Having a dedicated team with consistent staff members would have been helpful, particularly to agree the DPIA. Both practitioners and those with a more strategic role were needed to move matters forward and to understand the challenges presented by the different organisations' requirements as well as staff who were experts in information governance/ data protection. Agreeing the DPIA helped to highlight some of the key issues and this was the final barrier to the service starting. Having access to expertise on the legal requirements would have been helpful at an earlier stage – once experts were brought in, more rapid progress was made. Securing the appropriate level of response from all of the partner agencies also presented challenges. Decisions were therefore escalated within the partner organisations.

Governance

16.25 An Information Governance Advisory Group was established to draw up the necessary information sharing agreements between the partners, to map the data flows, co-ordinate the provision of fair processing information to service users, to contribute to Data Protection Impact Assessments and to facilitate the discussion of any issues or risks. Joint information sharing workshops were held between the partners once staff were in post which included scenario planning and hypothetical case studies to stimulate discussion.

Seeking agreement and consent

16.26 The Lighthouse policy on seeking agreement and consent set out the need to provide every child or young person and parents/carers with a privacy statement and the opportunity to agree to the service before any assessment, treatment or support was provided. It was agreed that this and the way in which their information would be recorded and used should be explained and a form provided for them to sign.

16.27 Given the need for explicit consent for the use of confidential patient information used for secondary uses (ie: evaluation), discussions took place as to how best to secure consent for the evaluation as well as the video-recorded genital examination and the forensic interviewing pilot. Separate consent procedures and forms were put in place for:

- the need to seek informed consent for a video-recorded genital examination to be uploaded onto the Electronic Patient Record System;
- the Forensic Interviewing Pilot (ie: to have a psychologist-led ABE interview)
- data to be included in the MOPAC evaluation
- the police to share the data on individual CYP, form TL2.

Led by the NSPCC, these were designed with CYP of different ages (which one is used depends on whether or not they are considered Gillick competent) – see chapter 9.

Operating the Lighthouse

Agreeing the DPIA

16.28 Due to the level of complexity, the late start and the differing attitudes and approaches to information sharing, the discussions took some time to resolve but the DPIA was agreed before the service went live.

Role of Data Officer

16.29 A Data Officer was appointed to support staff in recording details for each service user and to ensure compliance with the information governance requirements. This post was not one of the original posts agreed but was found to be necessary early on. His role is to work with the Lighthouse staff as well as practitioners across all the partner agencies to

develop, manage and maintain the electronic patient record. This helps to ensure data quality, provide training and oversee reporting for operational, evaluation, performance and research purposes. Ensuring system security and confidentiality requirements are met are key priorities for the Lighthouse.

16.30 Having a Data Officer in post has helped to improve the proportion of service users willing to consent to the evaluation, and enhanced the quality of the data available for the evaluation.

Securing consent

16.31 For each child or young person and or their parents/carers, agreement to use the Lighthouse service is sought at the first appointment. At the Intake meeting, a decision is made as to which member of the Lighthouse team is best placed to seek the service user's agreement or, where appropriate, his or her parent's/carer's, as well as how and when this should be done. Once the consent forms have been signed, these are scanned and uploaded to the Document Store in the Electronic Patient Record. The need to seek specific consent for the psychologist-led ABE interview is raised by the Police Liaison Officer who explains what will happen and how the video will be stored securely.

Consent for evaluation

16.32 There were initially issues about obtaining consent for the evaluation, due to a lack of confidence by the staff about how the confidential and personally identifiable data would be kept secure. It is an unusual requirement in the NHS and the voluntary sector to share personal information for this purpose. However, following a workshop with the evaluation team to give clarity and reassurance, a higher rate of consent to the evaluation has been obtained. (See paragraph 19.38.)

16.33 Other issues that have arisen have been the receipt of Subject Access Requests under the Data Protection Act 1998 including one from a parent who is an alleged perpetrator. New legislation, in the Data Protection Act 2018, limits the right of parents to access their child's records where abuse has been alleged. This learning will be shared with staff.

Information sharing between agencies

16.34 In developing the information sharing policies, the original intention had been to have an integrated record accessible to the partner agencies but with restrictions in place to comply with the information governance requirements of the different agencies, particularly the NHS and police. The system was therefore built with access rights imposed so that some staff were unable to access all fields for each child on the grounds that some information was highly confidential. However, once the Lighthouse had opened and personal and professional relationships developed, it was found that it was essential to share information between the staff in different agencies and therefore many of the original restrictions which had been considered necessary were lifted. The information governance leads were consulted and gave their written agreement to this change. There are now just a few remaining areas locked down to one team only (the police cannot access medical or therapeutic records).

Key learning points

- It is helpful to involve information governance leads from all the partner agencies and to share detail as early as possible as to what information will need to be shared and how. Detail is needed at an early stage to identify the complex issues which may arise during mobilisation to avoid delays in signing the Data Protection Impact Assessment. Awareness of the different organisational priorities and requirements which govern sharing data is needed, as well as different professional and regulatory codes.
- Timing pressures and sequencing may be an issue since it may not be possible to start work on the Electronic Patient Record until the lead provider has been appointed. Responsibilities for information governance should be clarified during the commissioning process and built into the contract.
- Many of the challenges which may arise in developing the IT systems for the Lighthouse may be due to a lack of understanding about the information governance requirements rather than the technical aspects of designing the Electronic Patient Record. This therefore needs to be addressed between the partners and relevant expertise and resources sought.
- Holding workshops with the key partners may help to establish how any organisational differences in information sharing would be overcome and to provide a firm foundation on which information could be shared once the Child House becomes operational. These should include scenario planning and case studies.
- Involving the partners in the drawing-up and agreement of the Data Protection Impact Assessment will help to articulate some of the key issues and enable them to reach agreement on how these should be resolved. Setting up an Information Governance Advisory Group with members from all the key partners may be helpful in overseeing the information governance arrangements.
- Having the right team in place to oversee the information governance aspects would help to prevent difficulties arising at a later stage. This should include staff with both a strategic overview and practitioners with operational experience of how the care pathways will operate. Access to expert knowledge on the technical and legal aspects of information governance and data protection are also essential when drawing up the DPIA.
- If the Child House will not be a legal entity in its own right, but a partnership of organisations with a lead provider, data will need to be controlled jointly by the individual partner organisations. Service users should be advised why information needs to be shared, that the Case Management System is multi-agency with a number of professionals inputting into a case file and sharing information with the rest of the team.

Key learning points

- Different written information and consent forms may be needed for the general service, for the Forensic Interview Psychology Service (the psychologist-led ABE interview), for undertaking video-recorded colposcopy (genital examination) and for information sharing for the evaluation. These forms should ideally be drawn up with the involvement of CYP to ensure that they are easily understood and acceptable to them.

- Experience at the Lighthouse has shown that sharing relevant information about individual CYP between the agencies pays dividends; keeping the number of restrictions to sharing information between the different agencies to a minimum will help to optimise results and facilitate operability.

Checklist for setting up a Child House

- ○ Have partners met to identify and address information sharing issues which may arise in the Child House and to identify potential barriers?
- ○ Has consideration been given to setting up an Information Governance Advisory Group with membership of all the key partners to oversee the information governance arrangements?
- ○ Has thought been given to what data will be needed for any evaluation of the Child House and whether this should be included in the procurement of the services being commissioned?
- ○ Is the way in which information is going to be shared compliant with regulations including the GDPR, professional codes of conduct and organisational requirements?
- ○ Has work started on drawing up the DPIA?
- ○ Have consent forms been produced covering the general services to be provided at the Child House; the psychologist-led ABE interview (if applicable); undertaking video-recorded colposcopy (genital examination), and for sharing information for any evaluation? And have they been co-designed with CYP of different ages for readability?
- ○ Is it clear who will lead on information governance issues once the Child House opens and how any issues arising will be resolved?
- ○ Will there be a Data Officer in post at the Child House to advise on completion of the electronic patient record and compliance with regulatory requirements?

End Notes

1 Working Together to Safeguard Children, HM Government, July 2018.See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

2 Currently under revision – see Information Commissioner's Office: https://ico.org.uk/about-the-ico/ico-and-stakeholder-consultations/ico-consultation-on-the-draft-data-sharing-code-of-practice/

3 Anonymisation: Managing Data Protection Risk Code of practice, see Information Commissioner's Office, November 2012.

4 Ibid

5 Guide to Data Protection, Information Commissioner's Office, see https://ico.org.uk/for-organisations/guide-to-data-protection/

6 Data Protection Impact Assessments, Information Commissioner's Office, see https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/data-protection-impact-assessments-dpias/

7 How do we do a Data Protection Impact Assessment? Information Commissioner's Office. See https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/data-protection-impact-assessments-dpias/how-do-we-do-a-dpia/

8 Data Security and Protection Toolkit, NHS Digital, see https://www.dsptoolkit.nhs.uk/

9 Information sharing – advice for practitioners providing safeguarding services to children, young people, parents and carers , see https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf

10 General Data Protection Regulations Guidance,NHS Digital, see https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/information-governance-alliance-iga/general-data-protection-regulation-gdpr-guidance

11 See https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/accountability-and-governance/data-protection-impact-assessments/

12 See https://www.ukcgc.uk/manual/principles

13 Disclosing data for secondary purposes, BMA (last updated 17 April 2019): see https://www.bma.org.uk/advice/employment/ethics/confidentiality-and-health-records/disclosing-data-for-secondary-purposes

14 Working Together to safeguard children, HM Government, July 2018, page 18.

15 See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/711097/guide-to-the-general-data-protection-regulation-gdpr-1-0.pdf page 8.

16 London Child Protection Procedures and Practice Guidance, 6th edition, updated September 2020, London Safeguarding Children Partnership, see https://www.londoncp.co.uk/

Chapter 17
Meeting the information technology requirements

What this chapter tells you:

Designing the technical infrastructure

17.1 Finding the right technical solutions for the Child House will be of fundamental importance once it becomes operational. This includes:

- securing a Case Management System (CMS) or Electronic Patient Record (EPR) that is fit for purpose for providing the service and for collecting contractual performance data and evaluation data;
- installing the infrastructure needed to record ABE interviews and to have a court live link if that is to be introduced;
- having efficient IT and telecommunications systems in place as soon as the Child House goes live.

17.2 Agreeing information governance arrangements is an essential pre-requisite to starting work on the IT solutions for the Child House (see **chapter 16**). Once agreement has been reached, a decision should be taken on how the IT will be provided and by whom. Procuring specialist project management is one way of delivering this given the level of resources and expertise required.

17.3 As well as any technical issues, the challenges which may arise in designing the technological infrastructure for the Child House derive from the complexity of bringing together the information systems of the NHS, Children's Social Care, the police and the Voluntary and Community Sector, all of whom have different security, interfacing and data protection rules and requirements. Each agency has its own individual way of working and these need to be mapped and understood prior to agreeing the system's parameters.

17.4 Ensuring that work begins on the IT infrastructure (eg: the cabling) at the same time as the premises are being built or refurbished is essential and needs to be built into the specification for fitting-out the premises. There will need to be sufficient server space and cabling for the IT and telephony. Therefore, the building refurbishment specification needs to make provision for these elements which should be installed during the building refurbishment.

Building the Case Management System (CMS) or Electronic Patient Record (EPR)

17.5 The CMS or EPR is an essential component in running the Child House and should be considered early on. It is important to understand what each partner and team will require from the system. The system required is more than a case recording system as it must be able to monitor and track the progress of cases and flag up when actions are due or have been missed. Just being able to record information will be insufficient given the complexity of the cases to be handled.

The system should therefore be able to:

- record all the data needed for individual CYP
- allow case tracking
- allow team leaders to manage caseload
- allow booking of appointments with multiple practitioners and rooms
- provide a case chronology, alerts and risk management
- produce evaluation data
- print labels
- issue appointment reminders.

The EPR provides a crucial link between the information systems of the key agencies and a common platform for all agencies to access as well as valuable information on outputs and outcomes that are needed to evaluate the success and efficacy of the model. Ensuring connectivity between all these systems should be considered at an early stage. The data will also be needed to inform any evaluation of the Child House (see **chapter 19**).

17.6 There is a clear difference between a case recording and a case management system. When there are multiple professionals working with families, it is important that families and children can be monitored and case progression tracked. There are likely to be a number of calls on any system in the Child House on recording initial calls, producing

evaluation data and monitoring safeguarding concerns and ensuring these are flagged to all professionals working with the family.

17.7 Child House staff should be involved in designing the CMS or EPR as far as possible since they will understand the commissioned care pathways to be followed. This will ensure that they have ownership of the system and that as many technical issues as possible are resolved before the new facility opens. Being clear about the business requirement early on and before any IT services are commissioned will pay dividends once the Child House opens. This may present challenges in terms of sequencing given that it takes some time to commission the system and may not be feasible to progress this until the lead provider has been appointed. However, until the care pathway has been drawn up by the lead provider and agreed between all the partners, it is difficult to make decisions on the design of the EPR. If possible, it should therefore not be purchased before the staff who are going to use it have taken up post.

17.8 Having access to an experienced expert to support the development of the system will be beneficial. A Business Analyst may also be useful to bring together operational requirements, map and describe the workflow processes so that the provider can understand what needs to be built.

17.9 It is estimated that it takes around 18 months to design, develop and refine a new CMS due to the level of complexity involved. Alternatives to developing a new system for all agencies to use before the Child House opens include:

- running each individual agency's IT or paper systems in parallel for the first year or so and then building the new system once the requirement becomes clearer;
- if time allows, developing a bespoke system before the Child House opens which is likely to take a full year;
- if the lead provider is to employ (or second) all the staff in the Child House, their IT system could be used by all rather than developing a new one.

Connectivity with other systems

17.10 It is important and can be challenging to ensure that there is connectivity between the different agencies' IT systems. If the lead provider is an NHS organisation, the system should be able to link to the NHS Patient Demographic Service (which provides details of every patient's demographic details including name, date of birth and NHS number) and the NHS Summary Care Record (which summarises information held on a patient by the GP). This will require approval from NHS Digital who will need assurance that only clinical staff (doctors, nurses and administrative staff) would be able to access information on the NHS spine (the digital central point allowing key NHS online services and the exchange of information across local and national NHS systems) and to know what safeguards will be in place.

17.11 The first step is to complete the **Target Operating Model form** linking the child's record to the Patient Demographic Service will enable better NHS data linkage including obtaining details of the NHS number. Linking to the Summary Care Record will give staff at the Child House access to clinical information about the child or young person, such as information on medicines, allergies and adverse reactions.

Operating the EPR

17.12 Once staff are in post, the development of the EPR is best overseen by a small team who are able to take an overview of the whole system. Having access to expertise on mapping data flow and the information required will help the staff to define their future needs and help to ease the process.

17.13 Sufficient training will be needed for the staff before the Child House opens and during the early weeks of operation. They are likely to require ongoing support and clarity especially when a new system is being put into place. Theoretical testing of the pathways will be

needed once the system is up and running in order to ensure that the full requirements of the system are identified. Once the system has been running for some time, a full review may be needed to ensure that the EPR is fit-for-purpose.

17.14 Thought should be given as to whether there will be a need to download the raw data from the EPR/CMS and to compile data reports. These elements are useful to assist with the service's own data analysis and performance monitoring as well as any contractual reporting and evaluation requirements.

Video facilities

17.15 Video facilities will be needed to record the psychologist-led ABE interviews and also to enable a live link to the court to be provided if this is to be a feature of the Child House. A live link to the courts with the presiding judge overseeing proceedings may also be feasible; this saves the child or young person from having to attend the court proceedings. The Justice Video System (to enable the live link to courts) will need to be commissioned via HMCTS. It should be borne in mind that this has a long lead time (currently 120 days) and will therefore need to be ordered well in advance of opening. A site survey will be needed before the order can be placed to ensure that the facilities meet the Court's requirements.

Telecommunications system

17.16 Having a fully functioning telecommunications system in place with both landlines and mobiles will be essential from the time the Child House opens. Testing these out before going live is helpful as it provides an opportunity to iron out any problems with the IT and telephones.

Meeting the technical requirement in London

Commissioning and delivering the IT for the Lighthouse

17.17 The partners, led by MOPAC, agreed at the outset to outsource the project management of the IT systems, including the development of the Electronic Patient Record. MOPAC, working with NHS England (London), initially took the lead on commissioning the IT service. The contract was awarded to NEL Commissioning Support Unit (NEL CSU) who started work in September 2017 to identify the technical requirements based on identifying the different constituent parts of the service and anticipating how the commissioners thought that the service would be run. NEL CSU appointed a project management company to design and implement the IT systems for the Lighthouse.

Electronic Patient Record

17.18 One of the main tasks was to commission the development of a bespoke Electronic Patient Record (EPR). Following demonstrations from potential bidders, this was contracted out by NEL CSU to an IT supplier, Axsys, who already delivered information systems to some of the SARCs. Although this was useful experience, the EPR in the Lighthouse differs considerably from the system used in SARCs given that is has greater breadth of services provided and more agencies involved. The EPR in the Lighthouse is therefore highly complex and bespoke to the service.

17.19 It was not feasible to carry out any detailed work on what the EPR would deliver until the lead provider was appointed in February 2018. Whilst a EPR should normally be designed with all the staff in post, because the Child House was not up and running and not all of the staff had been appointed by this time, decisions had to be made early on by the commissioning team on operational – including clinical – issues. This presented challenges later on as it effectively made it necessary to retrofit the EPR into the care pathways as these were developed. Although, with hindsight, it would have been beneficial for the Lighthouse team to commission the IT service themselves once the operating systems and the care pathway had been finalised, the timescale for implementation did

not allow this. It would not have been possible to get the EPR up and running in time if MOPAC had not initiated the work before the health and wellbeing provider was in place, but it is recognised that this did cause some difficulties.

Video and audio facilities

17.20 Having psychologist-led as well as police-led ABE interviews was intended to be an integral part of the pilot, as well as using the Child House for pre-trial recorded cross-examination of witnesses under section 28 of the Youth Justice and Criminal Evidence Act 1999. These developments as well as the live link to the Courts (see **paragraph 17.21** below and **paragraph 17.38**) rely on having highly effective video and audio facilities in place. These were therefore part of the specification for the ABE suite at the Lighthouse and provided by the Met Police Services IT department. The live link between the court and the Lighthouse was installed later due to time delays, with long lead times.

17.21 MOPAC was responsible for commissioning the ABE and live link facilities. North and East London Commissioning Support Unit commissioned the Justice Video System (live link to courts) from Vodafone via HMCTS which had a lead time of 120 days. A site survey was needed before the order was placed.

17.22 After the national pilot of Section 28 in Leeds, Liverpool and Kingston which was well- received in terms of the quality of recording and process, technical issues arose in some of the other areas where this was being piloted. The process evaluation of the Section 28 pilot gives more details.[1] The Lighthouse was approved as a remote site for a live court link in 2020. The Lighthouse was then additionally approved to pre-record the cross-examination until Section 28 of the Youth, Justice and Criminal Evidence Act 1999 in November 2021 following the development of a detailed protocol being agreed with Wood Green Crown Court.

During and after mobilisation

System design

17.23 Work began with Axsys to co-design the Excelicare system before the health and wellbeing team were appointed. This limited capacity and frontline expertise to be part of the co-design phase and was reliant on the goodwill of future partners.

17.24 The specification for the health and wellbeing service stated that the Lead Provider and its partner agencies would be expected to use both their own information management systems together with an overarching case management system designed specifically for the Child House. However, during the co-design, it became clear that the overarching system would only be functional if it contained all the data about the service user. Separate systems would have resulted in double data entry for staff and put up barriers against information sharing. User access rights were implemented where there was a need for some data with single service access only but, as the pilot progressed, it became apparent that most information should be shared across all services. The exceptions are detailed medical examination and information about alleged perpetrators in the police section.

17.25 What was commissioned for the Lighthouse was effectively an Electronic Patient Record rather than a full Case Management System which has greater functionality. The detailed design of the EPR was done with the involvement of the staff who had been appointed so far. This was led by the NSPCC Project Manager/Development and Impact Manager, with support from the Lighthouse Service Manager. Care pathway workshops were held in May 2018 to shape the products and define more clearly what was needed in the EPR. These covered the paediatric, CPS and CJS elements and provided the necessary process and management information that would be required for Excelicare to design the

bespoke system. These were based on a series of pro formas drawn up by the lead provider which formed the system templates for the build of the EPR. The system does not include an appointment system which the staff feel would have been a useful tool to help case management.

Provision of the EPR

17.26 Excelicare were asked to provide the EPR by July 2018 to allow time for any final changes to be made before the Child House opened. There were effectively two phases to the development of the EPR. In Phase One, once the EPR had been completed, user acceptance testing took place using dummy patients. Around 250 issues, many of which were critical, were identified which had to be addressed by Axsys before the system went live. Phase Two began six months after go live and took nine months to review and collect all the necessary changes to improve the functionality of the EPR and respond to user requirements. Phase two system changes are anticipated to be delivered by November 2020.

Connectivity with other systems

17.27 Ensuring that there was full connectivity between all the different agencies proved challenging. There were several demands on the system including the requirement to capture evaluation data and quality performance data as well as recording case information. The system also needed to be configured to capture the data needed by MOPAC to evaluate the pilot.

17.28 There was also a need to store large video files from colposcopies. However, the system could not hold the colposcope images as the file sizes were found to be too great. The service therefore continued to store the images on encrypted DVDs with unique reference numbers and stored them in a locked cupboard. The long term ambition is to store these images on a cloud-based secure server, as is also the ambition for the video recorded interviews.

17.29 As a health trust was the lead provider, it was agreed that links could be made to the Patient Demographic Service and the Summary Care Record (see **paragraph 17.10**). This was initiated by the completion of the **Target Operating Model** form[2]. However, the process to enable live updates from the Patient Demographic Service (national NHS Spine) has been complex and slower than anticipated, resulting in difficulties accessing NHS numbers and the most up-to-date GP and address details.

Finalising the EPR

17.30 The NSPCC seconded a Project Manager and a Development Impact Manager (who had helped to design the NSPCC's own information system) to work on implementation, part of whose role was to work closely with the developers on the new system. The timescale was extremely ambitious as the EPR had to be in place by the time the Lighthouse opened. Following the initial testing and raising of 250 issues, there were almost daily calls for a month to resolve outstanding issues to ensure there would be a basic system to record information in place on opening. This was time-intensive and needed substantial resources.

Dashboards

17.31 MOPAC had commissioned a dashboard from the system provider. This is used to collate and display information and can be designed specifically for the users' needs. The practitioner-facing dashboard shows cases open to the individual practitioner on first logging on. This was intended to allow practitioners to see the status of the cases they are involved in easily. The system also has the ability to download the raw data which will be used for the evaluation. The system can also generate its own reports which are used for management information.

17.32 The Lighthouse also developed a Quality and Assurance Framework report for the review of the contract which contained many KPIs, as well as a monthly operational reporting tool.

> *Prior to the Lighthouse, I had never been closely involved with the development of a case management system. A logical mind, the support of someone who had been involved in this previously at the NSPCC, flexibility, a good working relationship with the providers and ability to work on this almost full time for a month allowed us to turn 250 critical issues into a system that enabled us to record information when the Lighthouse went live. We recognised that further improvements were needed – but it was in itself a huge achievement to have a working system.*
>
> *We started off by looking at the overall pathway and developing the system from that – what we didn't do initially (we didn't have time to do it) was to understand each discipline's working practices in detail and therefore we didn't truly understand some of the potential areas of duplication or challenge. We did this after staff had been using the system for a number of months and this allowed us to understand in detail what staff's actual practice requirements were. It would have been hugely beneficial to sit down with staff and talk in detail about how they believed they would deliver the service to ensure the system was able to capture this.*
>
> Dawn Hodson, Development Impact Manager for Child House, NSPCC

Security equipment

17.33 The Lighthouse has CCTV for security and safety, which was originally installed on all floors inducing the therapeutic floor. After feedback from the CYP and the staff that the cameras were potentially intrusive and could be off-putting, these were reduced in number and now are only in reception and lift lobby areas for safety purposes.

Using the EPR

17.34 Towards the end of the mobilisation period, staff were provided with training on the system by Axsys. They wished to receive their training on the new system and this led to a delay in the 'go live' date. Axsys were onsite for a short period to provide face-to-face support and this helped staff learning to use the new system. They also provided support to the data analyst who was able to assure and support staff.

Challenges

17.35 One of the challenges in using the EPR has been the inability of the system to meet some of the case management requirements (ie: flagging to managers when something needs to be signed off, allowing teams leaders to manage caseload or reminding staff about a visit or appointment). The other major issue was a lack of confidence in using the system initially, a lack of compliance in completing the correct fields, but also a lack of clarity of the Lighthouse processes which led to confusion over what needed to be recorded where and by whom. Once these were ironed out and the data analyst was able to support staff onsite, these issues subsided.

17.36 Another significant challenge was the lack of appointment booking system that would allow for appointments with multiple practitioners and rooms. There was also no functionality to send out text appointment reminders to CYP, so a manual system of reminders was instigated following high DNA rates.

17.37 Unlike hospital EPR systems, the system chosen for the Lighthouse does not print patient labels, which can be time-consuming for the health team when undertaking multiple swabs and tests

Video equipment and links

17.38 The psychologist-led ABE interviews were introduced following a period of extensive training for the psychologists. These interviews are recorded for use as evidence later on. Discussions with the judiciary and HMCTS continued about the possible use of a live video link to the Child House during mobilisation,

and agreement was reached during year two with the remore link going live in year three.

Operating the Lighthouse

17.39 The EPR development required a proactive approach: weekly meetings initially and then conference calls were held with Axsys for some time after the Lighthouse opened, involving the Lighthouse, MOPAC and NELCSU. Service levels including response times were specified and monitored. Weekly teleconferences also took place throughout and after mobilisation to discuss the outstanding issues to be resolved in relation to the IT systems including the EPR.

17.40 Although the EPR proved suitable for recording and storing data on individual cases, it was less adept at driving cases (eg: flagging what needed to be done next, providing prompts, allocating cases to a member of staff or enabling managers to sign off individual cases).

17.41 As the service evolves, the Lighthouse is working with Excelicare to refine the data that is captured within the system for the service operation and for evaluation[3]. The current system was developed to be both a clinical note keeping tool and a data capture tool for research and evaluation, which limited its effectiveness.

17.42 It was recognised that changes to the system were needed soon after opening. As a result, some urgent changes to the system were made that were service-critical within the first six months. Further refinement and system development took place after the service had been operational for 12 months once ways of working had fully bedded in and been finalised.

Telecommunications equipment

17.43 Other issues that arose were the lack of a fully functioning telephone system which was not in place until a few weeks after the Lighthouse opened.

Key learning points

- Work on designing the IT solution for the Child House needs to begin as soon as the premises are identified and the lead provider appointed. Outsourcing the project management of the IT may be helpful because of the amount of work involved and the expertise required.
- Designing a bespoke Case Management System (CMS) Electronic Patient Record (EPR) takes a considerable amount of time (estimated as 18 months to design, develop and refine it). Alternatives include running the individual agencies' IT or paper-based system for a year or so, or – if all staff are employed or seconded by the lead provider – using the lead provider's IT system.
- If a bespoke system is developed, it may not be feasible to begin the detailed work until the health and wellbeing provider is appointed and the clinical pathway and operational systems agreed. Otherwise, there would be insufficient time for delivery, and development of the system would have to run in parallel with mobilising the service.
- Once appointed, the staff who are going to deliver the service should be closely involved in designing the EPR. It is helpful for the end users to be an integral part of the commissioning process in order to be 'intelligent customers', though this depends on timing and the capacity available during mobilisation.
- Build in budget for annual system developments to ensure the EPR can be adapted over time to reflect any changes to the service.
- Ensuring that there is connectivity between the different systems (eg: NHS, CSC and police) is challenging since they may have differing and sometimes conflicting requirements and regulations. Any areas of potential conflict need to be identified and resolved as early as possible.
- Links to the Patient Demographic Service and the Summary Care Record may be made if the lead provider is an NHS provider. This will provide better linkage to the child or young person's NHS data including access to the NHS number and clinical information about the child or young person, such as information on medicines, allergies and adverse reactions.
- The IT design and installation of the IT and telephony infrastructure should take place in parallel with the building refurbishment. There should be sufficient server space and cabling for the IT and telephony.
- Location of IT points needs to be linked to desk layout and room usage, to prevent future limitations on flexibility of layout. WiFi coverage is key to allow staff to work at hot desks and young people to access WiFi onsite.

Key learning points

- Sufficient time should be allowed for final user testing of the EPR and for signing off on the information governance.
- It is essential to train staff on the actual system once completed which will give them the confidence to use it as soon as the doors are opened. Having the IT service provider onsite during mobilisation to provide face-to-face support may prove beneficial. Appointing a Data Officer to address the issues raised by staff, enhance data quality and to assist on obtaining consent for the evaluation may be advantageous.

Checklist for setting up a Child House

- ○ Has a decision been reached on who will provide the IT facilities?
- ○ Is the business requirement for the Case Management System or Electronic Patient Record clear? Have the staff as the end users been involved in its development? Is expertise from a Business Analyst available?
- ○ Has enough time been allowed to develop and implement a bespoke EPR if this is the intention? Alternatively, is it feasible for all staff to use the lead provider's information system, or for individual agencies' systems to be used for the first year or so whilst the bespoke system is developed.
- ○ Have discussions on how connectivity will be achieved taken place with the key providers? Does this include links to NHS systems such as the Summary Care Record and the Patient Demographic Service?
- ○ Has sufficient time been allowed to train all the staff who will be using the EPR before the Child House goes live?
- ○ Have the video facilities that will be needed for the psychologist-led ABE interviews and to provide a live link with the courts depending on what has been agreed with the judiciary been included in the specification?

End Notes

1 Process evaluation of pre-recorded cross-examination pilot (Section 28), Ministry of Justice 2016. See **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/553335/process-evaluation-doc.pdf**

2 Target Operating Model – Connecting to PDS via SMSP relies on Suppliers and End Users completing the NHS Digital self-certification tool, known as the Target Operating Model (TOM): see **https://digital.nhs.uk/services/spine/spine-mini-service-provider-for-personal-demographics-service/target-operating-model-tom**

3 The Lighthouse Annual Report 2018-2019 page 32.

Chapter 18
Mobilisation

What this chapter tells you:

Starting out

18.1 Before embarking on the mobilisation phase, there needs to be an agreed plan in place and a team with the requisite skills to move it forward. Depending on local arrangements, the core team could include:

- Senior mobilisation manager (and a Deputy, depending on the scale of the operation)
- Project Manager
- Administrative support
- Wider team
- Representatives from all of the partners involved – police, health, local authority, CAMHS, third party providers.

18.2 The team developing the Child House need to be flexible in their approach and be able to turn their hands to the wide range of tasks in the areas addressed in this toolkit during mobilisation, rather than bringing in specialists in all these areas. They should be able to build on local knowledge and to tap into local resources wherever possible.

18.3 Mobilisation of the Child House should begin as soon as the lead provider is appointed. Both the contract signed with the commissioners and the operating model (if available) will provide the framework for delivery.

Planning and resources

18.4 Good project management will be required to keep the mobilisation on track, identify areas of concern and allocate work effectively. Each individual project will need a plan so that the totality of the project can be managed effectively. There are a great many workstreams that will need to be set up and run in parallel in order to prepare for opening of the Child House. These will vary according to local requirements including the scale of the work needed to prepare the premises. It is essential that there are sufficient resources in place for the mobilisation stage. However, they are likely to include some or all of the following:

Establishing governance arrangements including Mobilisation Board (see **chapter 14**)

Partnership working (see **chapter 7**)

- Stakeholder identification
- Drawing up Memoranda Of Understanding

Registration requirements

- CQC registration (see **paragraphs 11.6** and **11.27**)

Sub-contracting arrangements

- Identifying and putting in place the key sub-contracts required

Criminal justice pathway

- Develop ABE process for the Child House and install necessary equipment (see **paragraphs 11.57-11.59**)
- Agree and put in place process and equipment for pre-trial cross-examinations under section 28 and live links to Court
- Agree policies and procedures needed (see **paragraph 18.16**)
- Develop key operational policies and protocols with core partners
- Key policies to include referral and intake process, safeguarding, disclosure of notes

Estates (see **chapter 15**):

- Identify and design estates including room layout, furnishing, play and clinical equipment
- Establish engagement mechanisms for CYP in the detailed design and fit out
- Agreement and signing of lease
- Putting Facilities Management arrangements in place including clinical waste collection and chain of evidence

Information governance (see **chapter 16**):

- Development of information sharing agreement and other information governance policies
- Draw up and agree Data Protection Impact Assessment

IT mobilisation (see **chapter 17**)

- Design of electronic patient record, case management and appointment booking system
- Fit out of IT and telephony in conjunction with estates workstream

Staffing and Recruitment (see **chapter 11**)

- Agree final staffing and resourcing models
- Advertise and appoint to agreed posts with CYP involvement
- Agree and deliver bespoke induction and training programme for incoming staff

Designing the care pathways (see **chapter 11**)

- Agree referral, intake and allocation processes
- Agree types of therapeutic and advocacy support with caseloads and prioritisation criteria
- Agree referral pathways and transfer/ discharge pathways

Communications and marketing (see **chapter 8**)

- Agree and implement internal and external communications plans to include media announcements
- Brand identity
- Develop written service materials and resources including age appropriate leaflets, professional leaflets, privacy statement
- Launch event
- Local training
- Website development

CYP engagement/participation (see **chapter 9**)

- Involve CYP in design of building and recruitment
- Establish CYP feedback mechanisms
- Establish CYP forum for ongoing engagement

Evaluation (or measuring outcomes) (see **chapter 19**)

- Agree and implement the evaluation framework

Service delivery (see **chapter 11**)

- Agree provision of paediatric, mental health, advocacy and play services

Service user and referrer feedback (see **chapter 19**).

18.5 More detail of some of these is covered in the other chapters in this report as referenced above. Clear leads should be identified for each workstream.

Governance

18.6 Clear governance arrangements will continue to be needed throughout the mobilisation period to ensure effective communication with the key partners and that any decisions can be made at the appropriate level. A specific group should be set up to oversee mobilisation with appropriate sub-groups as required on individual aspects (see **paragraph 14.15** et seq). During mobilisation, regular weekly meetings are helpful in identifying the touchpoints for problem solving and agreeing what action needs to be taken, when and by whom.

Programme management

18.7 Effective programme management and oversight are essential to mobilising the Child House. Sufficient, dedicated resources will be needed for each of these workstreams as well as overall project management capacity, with functioning honest relationships. The importance of robust, honest personal and professional relationships between the team members with a shared vision amongst the core team cannot be over-emphasised for a project of this complexity. Project management tools may be useful in helping to oversee the process and to ensure that sufficient information on progress is fed into governance processes (ie: workstream highlight reports, gantt charts and risk registers, see **chapter 14**).

Accountability

18.8 Clear accountability for the operational aspects of delivery will be necessary during

mobilisation. Once the lead provider is appointed, responsibility for mobilisation and accountability for the delivery of the operation of the Child House and for leading the workstreams should be assumed by them as far as possible. They should also assume budgetary responsibility for mobilisation wherever feasible. The Lead Provider is likely to have direct knowledge of what services will be needed and the best way of delivering them. Close liaison with the commissioners of the service will continue to be needed throughout the mobilisation process. Strong financial control will need to be adhered to during mobilisation to ensure that costs remain within the agreed financial envelope.

Premises

18.9 Any Child House needs not only to ensure a child-friendly space but also has to be suitable for any health, criminal justice or therapeutic work that may take place within it. It will be important to ensure that the clinical rooms are large enough for the number of potential service users and the clinical equipment required, and that all the rooms have appropriate levels of soundproofing. The therapeutic rooms need to be suitable for small children, where play is likely to be the main tool used during the therapeutic process, or for young people who use talking therapies. The coordination of this work needs to be set out in a timeline and included in the project plan so that the sequencing is clear. Knowing how long it takes between ordering and delivering a specific piece of equipment is important and needs to be built into the project plan since it may have a significant impact if not available for the opening (see **chapter 15**).

Information governance

18.10 Work on the Data Protection Impact Assessment needs to be prioritised and commenced at an early stage in the mobilisation process, with the involvement of the key agencies and practitioners who will be working in the Child House. Expert advice and support are likely to be needed during mobilisation. The core mobilisation team should be central to these conversations though will require guidance by specialist IG leads from each partner. Agreeing and putting in place the consent policies needed is an integral part of this process. The consent policies and processes need to cover several different aspects, including the forensic interview and the evaluation (see **chapter 16** on Information Governance).

IT

18.11 Involving the Lead Provider in the design or adaptation of the IT systems at as early a stage as possible is essential since they will be clearer about the detail of the requirements. Work on the IT and telecommunications systems should start at the same time as work on the premises given that the IT systems are fundamental to the building design, particularly if multi-agency systems are being installed in the building. The IT team will therefore need to work closely with the estates team in designing the necessary cabling for IT, telephony as well as any planned links to the courts (see **chapter 17**).

Recruitment and staffing

18.12 Once the staffing structure has been agreed, based around the specification and the care pathway, the job descriptions can be drawn up and the recruitment process can begin. Recruitment of staff, particularly clinical staff, is likely to take some time (depending partly on whether they are to be seconded or employed directly (see **paragraphs 11.16-11.17**).

18.13 Once the roles have been defined, the core team will need to review job descriptions against the requirement of the Child House and agreed by the recruiting organisation with oversight from the core mobilisation team. Each organisation will have its own terms and conditions, supervision requirements and working practices which need to be discussed fully before recruitment begins.

18.14 Staff are likely to be recruited from a wide range of organisations. Some may be recruited specifically, some may be seconded in and some may be paid for by one of the partners. Regardless of the way they have been recruited or their employing organisation, it is important that staff feel that they are all part of a single team whilst at the same time understanding the requirements of their host organisation

18.15 It is good practice to involve CYP in the recruitment process (see **paragraph 9.7**). Each organisation will have its own systems and processes for doing so; the core team should be involved as and when possible.

Guidelines, policies and procedures

18.16 A comprehensive set of guidelines, policies and procedures will be required once the Child House becomes operational; these will be needed to underpin the partnership working. These should be drawn up and agreed with partners, preferably during the mobilisation period (see **paragraph 18.39**). Shared operational guidelines will need to be developed and, in some cases, agreed for all new areas of working as a multi-disciplinary team, for example: referral in and allocation process, supervision guideline, 'did not attend' guideline, complaints, disclosure guideline, rapid transfer guideline for suicidal young people, equality and diversity, lone working. Depending on the operating model, some policies may only be relevant to individual organisations.

18.17 Whilst many organisations will have their own policies, it will be necessary to create a shared overarching guideline that describes how the multiagency Child House will work together whilst following individual policies on, for example, appraisal, annual leave, grievances and safeguarding. Individuals working in the Child House will continue to be required to adhere to the policy of their employing organisation, but applied within the overarching guidance.

CQC registration

18.18 If the lead provider is a health organisation, then it will require CQC registration which should be applied for during the mobilisation process (see **paragraphs 11.6**, **11.27** and **15.13**). These generally take longer than expected and should therefore be dealt with early in the mobilisation period. Advice and guidance can be sought from the Hospital Trust partner where applicable.

Timing

18.19 The timescale agreed in the contract for mobilisation and the type of refurbishment or build will determine the length of the mobilisation period. Getting the Child House up and running in the time available may be very tight, with many competing pressures and heavy workloads. Appointing the construction and IT companies may inevitably take some time. Sequencing the different delivery workstreams may be complex since all will also need to be prioritised in the first couple of months, which may be difficult to achieve simultaneously with the staff available. It should be borne in mind that the majority of the workstreams are likely to require both significant clinical input and subject matter expertise depending on the services to be provided. This should be taken into account in mobilisation planning since the scale of change means it cannot rely on goodwill alone.

18.20 Successful change management and implementation requires an ongoing process of plan, do, study, act. There should be periods of specific review and updates where the changes are monitored for their impact. Feedback loops from staff, parents, children and referrers are essential to ensure early identification of emerging issues or challenges. Once the Child House has been running for some time, the care pathways and operating framework should therefore be revisited regularly to see if refinements are needed.

Mobilising the Lighthouse

18.21 Once the lead provider was appointed, work started immediately on mobilisation including recruiting the staff. The premises for the Child House in Camden had already been identified and work had started on refurbishment to make them fit for purpose. The workstreams in **paragraph 18.4** were the basis for the programme plan.

Governance during mobilisation

18.22 Oversight was led by the Programme Board but changes were made to the membership to include representatives of the lead provider and the other partner agencies (who had not been able to sit on the Board during the commissioning process due to possible conflicts of interest) (see **chapter 14**). Progress was monitored via a contract mobilisation meeting chaired by NHS England (London) which reported to the Programme Board. The delivery of the Mobilisation Programme was led by the lead provider and included representatives from all provider organisations in the partnership and from the police as well as Camden local authority.

18.23 Much work had already been carried out to develop the operating model (see **chapter 11**) and a preliminary care pathway had already been drawn up. However, this needed to be revisited once staff were in post and changes made to show the proposed journey of a child or young person into and through the Child House. Getting the care pathway right was recognised as being critical to the way in which the Child House would operate, particularly in terms of the staffing structure. During the first year of operation, the operating model was reviewed quarterly to ensure that it met the needs of those using the service. Further changes to the care pathway were made subsequently as a result of learning and reflection during year one. Changes included the move from a daily allocation meeting to the twice weekly Intake Meeting (see **paragraph 11.56**), greater use of the consultation offer, and refinement of the Primary case worker role.

Programme management

18.24 Overall programme management was led by the lead provider working with provider partners. The NSPCC allocated three members of staff to work on the mobilisation team, funded by Morgan Stanley. This was over and above that which was identified in the tender. MOPAC led on programme management of the estates strategy, delivery of the IT, as well as the sustainability strategy. UCLH, the lead provider, programme managed the mobilisation of the health and care services, including staffing, information governance, IT system design, producing the operating policies and guidelines, engagement of CYP, delivery of the estates strategy (including furniture and fittings, equipment, resources and facilities management). UCLH, the lead provider, also led the development of the SCLO and PLO roles with Metropolitan police and Camden LA.

Accountability

18.25 The Child House had been commissioned jointly and this approach continued during the mobilisation stage. This helped to ensure that a multi-agency approach (between health criminal justice agencies and third sectors providers) was taken. Managing the contracts had also been undertaken jointly. Many of the operational services such as the refurbishment and IT were commissioned by the main commissioners who had instigated the pilot and this continued after the appointment of the Lead Provider.

18.26 The accountability for the operational aspects of the project was therefore fairly complex as there were several layers between the commissioners and the service providers (in relation to the IT requirements, for example). The main challenge which this presented was that the lead provider did not have autonomy or authority in decision-making since approval for any changes to the building or IT system required clearance from the commissioners.

There was a lack of oversight of the total budget and some lack of clarity over who was responsible for which aspects of, for example, design and refurbishment.

18.27 Several key decisions (around IT and the building, for example), had had to be taken prior to the appointment of the lead provider because of the long lead times involved and the constraints around the funding available. The complexity of multiple parties with a stake in estates such as commissioners, landlord, lead provider and delivery partners, meant that sign-off and decisions about estates matters were inevitably complex, for example: fire safety, health and safety, sign-off of works and the lease agreement. This highlights the critical nature of excellent project management and co-ordination as well as the need for robust financial accountability.

Timing

18.28 The main challenge faced in mobilising the service over a seven month period was that almost all of the work was frontloaded – many of the workstreams were urgent with no clinical staff or subject matter experts in post for the mobilisation team to work with. The subject matter experts came from eight different agencies and during mobilisation, there was limited access to frontline staff or experts to design the future Child House processes, pathways and electronic patient record. There were consequently heavy workloads for those concerned and it was not possible to focus on every workstream at once. Work on finalising the requirement for the building, recruiting the staff and developing the IT system therefore were given priority.

Premises

18.29 The lead provider was appointed in February 2018 and the intention was to go live in September 2018 (it opened its doors in October after a short delay). The contractors had been appointed to refurbish the building whilst the commissioning for the lead provider was in progress. Having secured the building, the design process and refurbishment were overseen by MPS Estates based on the original specification and the agreed operating model. They appointed Atkins to design the premises under their framework agreement and then went through a construction bidding process for the construction fit-out (see paragraph 15.29).

18.30 The lead provider took the lead to ensure CYP were involved in the interior design and ran an extensive engagement programme. The lead provider led on the selection of necessary equipment, resources, furniture and fittings, clinical waste and other FM functions. The staff moved in to start setting up the service as soon as the building was complete to minimise delay to go-live, which meant they were onsite while snagging issues were being resolved.

Information governance

18.31 As chapter 16 describes, information governance proved to be highly complex and challenging given the different approaches and perspectives of the organisations and staff involved. Agreeing the Data Protection Impact Assessment was challenging and impacted on the workload at a time when there was little capacity to take this on. Putting in place the policies on consent was also a major strand of work. With hindsight, this workstream therefore needed more dedicated resources and subject matter expertise.

IT

18.32 Work to commission a bespoke IT system for the Lighthouse had started prior to the contract being awarded to the Lead Provider because of the long lead times involved. This was undertaken by the commissioners who based the specification on their understanding of the clinical model but before the detailed design work had been carried out or the care pathways finalised. This made it necessary to carry out a complete design of the electronic patient record from scratch at the same time as designing the clinical pathway and processes, with no frontline staff in post.

Communications

18.33 The communications workstream, which was led by the NSPCC, and was very active during mobilisation as it as necessary to agree on the branding and produce all the necessary written information during this time. See chapter 8 for details.

Recruitment and staffing

18.34 The specification for the Child House had included details of the staff needed and work was started immediately following appointment of the Lead Provider on recruitment. The manager, clinical staff and administrative staff were employed by NHS organisations (the paediatricians by the lead provider, the mental health staff by the Tavistock and Portman NHS Mental Health Trust seconded to UCLH), the advocates by the NSPCC and by Solace Women's Aid. The two Social Care Liaison Officers (see Chapter 11) were employed by Camden Council and the two Police Liaison Officers by the MPS. Job descriptions were finalised and the posts advertised (see paragraph 11.39). The job descriptions were generally developed by each employing organisation and standard organisational job descriptions were used where available. However, those for the SCLO and PLO were developed specifically for the service (see paragraphs 11.40 and 11.45).

18.35 Whilst the team had intended to involve CYP in the recruitment process for all child-facing roles, there was insufficient time to arrange the panels and proceed with recruitment at the required pace to enable staff to be in post within six months. This has since been done for appointing staff to CAMHS posts within the Child House.

18.36 The lead times for recruiting staff were long, particularly where clinical staff were concerned, ranging from three to nine months depending on speed of recruiting teams and notice periods of one to three months.

18.37 The level and skill mix of staff had been derived from a capacity mapping exercise which had taken place before the specification was drawn up, based on estimates of the numbers of CYP who would be using the service (see paragraphs 11.13 and 11.61). This was revisited a year after the Lighthouse opened (by NEL Commissioning Support Unit) to see how many and what staff were needed to treat the actual number of CYP using the Lighthouse. The revised capacity planning based on 400 CYP being referred a year demonstrated more capacity was needed in advocacy and significantly more capacity needed in CAMHS. This was due to the complexity of the work, the numbers of suicidal young people and those with significant mental health needs; as well as the time needed for clinical psychology led ABEs. The Lighthouse continuously reviews capacity and skill mix and has adjusted the skill mix in the team to allow for more CAMHS funding in the second year of the pilot.

18.38 Additionally the NSPCC supported by Morgan Stanley, was able to provide additional therapeutic capacity to provide added value services such as family work and sibling work. This additional capacity was fully utilised by the end of year one.

Policies and procedures

18.39 A whole raft of policies and guidance is needed to set out how different organisations will work together. The main overarching document drawn up was a 'policy on policies' which showed how these would be agreed and what policies would be needed and by when, as some were considered a higher priority than others. Around 45 draft policies were drawn up before the Lighthouse opened but later underwent a ratification process at operational meetings. A list of the Lighthouse guidelines is shown opposite; in all other policy areas, the Lighthouse team refer to their employing organisation's policy.

- Annual leave
- Appraisal
- Communication Ways of Working
- Complaints and Compliments
- Data Processing Agreement
- Disclosure (guidance on disclosure of third party materials for police investigation and CPS charging decision
- Chain of Evidence protocol
- Consent
- DNA and non-attendance guideline
- Flexible working
- Freedom of Information requests
- Health and safety
- Incident reporting Guidelines
- Inclusion, Diversity and Equality
- Information Sharing Agreement
- Intake process (process of allocation and associated documentation)
- Lighthouse Staff Handbook
- Lone working, site safety and dealing with aggressive service users
- Mandatory training
- Missing children
- Operational management (guideline for operational management and accountability within the multiagency team in the Lighthouse)
- Peer review
- Professional conflict resolution
- Rapid Transfer Procedure (guidance on supporting CYP for the sake of transfer of an acutely unwell child or young person from the Lighthouse to a suitable healthcare setting for assessment and treatment (such as concern about the young person's mental health, particularly the risk of suicide or self-harm).
- Record Management Policy
- Resuscitation
- Safeguarding guideline (roles and responsibilities of management and staff, in the safeguarding and protection of children)
- Sickness and absence
- Soundproofing guideline (guidance on managing confidentiality where there is limited soundproofing between clinical rooms)
- Subject Access Request
- Supervision
- Toy cleaning
- Training, development and study
- Unannounced attendance (how to support young people who attend without a prearranged appointment)
- Volunteers
- Weekly case review meeting

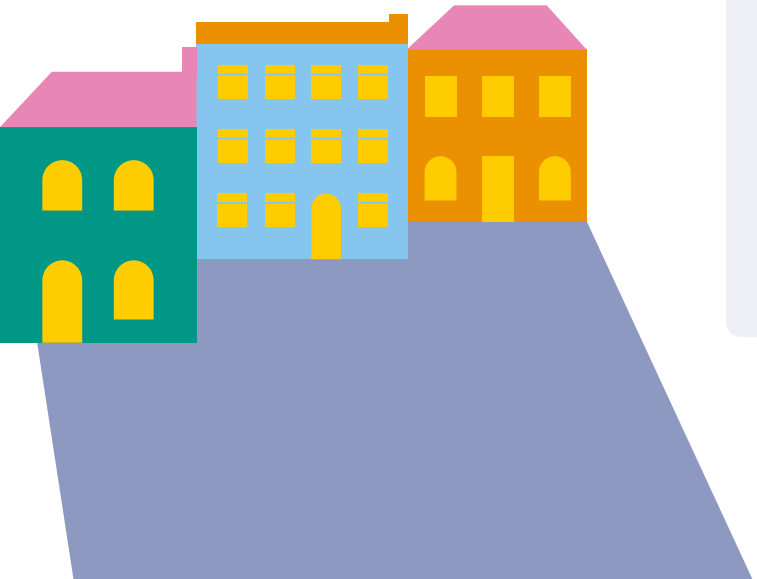
Key learning points

- A dynamic project team with drive, focus and ability to multitask will be needed, supported by an overarching plan and excellent oversight. Team members will need to be flexible and versatile and be able to turn their hands to activities which may not have previously been part of their role.
- Designing a new building, putting in place a completely new service, workforce and IT system all at the same time is both time-consuming and demanding. All of the workstreams are priorities but agreement will be needed on the order in which these should be tackled.
- Sufficient time needs to be built in for the mobilisation of the Child House once the main contract with the health and wellbeing provider has been agreed. Organisations should avoid being overambitious about when the service will be able to start. A full year would be ideal depending on the scale of the operation.
- Appointing construction and IT companies should be done as early as possible as this takes some time. Ideally, this should take place after a lead service provider has been appointed.
- There should be sufficient capacity to enable the Lead Provider to plan and progress the wide range of workstreams. Clinical input and other subject matter experts are likely to be needed for all of these workstreams.
- Agreeing the care pathway is one of the most important aspects early on during mobilisation since many decisions on staffing, information governance and the IT systems will depend on this.
- Clear governance arrangements will be needed during mobilisation to ensure effective communication with the key partners and that decisions are be made at the appropriate level. A specific group should be set up to oversee mobilisation with sub-groups as required.
- Effective programme management and co-ordination of the workstreams with dedicated resources will be needed throughout mobilisation, as well as robust financial accountability to ensure that the project complies with legal, financial and contractual requirements.
- The lead provider should assume responsibility for the operational workstreams as well as budgetary control if possible and be able to take key decisions on all operational aspects.
- Work on drawing up the policies and procedures that will be needed should begin as soon as possible during mobilisation.
- CQC registration should be applied for early on as this may take some time (even if the Child House is to be in an organisation that is already registered, registration is likely to be required).
- Once the Child House has been operating for a few months, the operating framework and care pathways should be revisited to see if refinements are needed.

Checklist for setting up a Child House

- ○ Are the commissioner and provider responsibilities including future governance clearly set out in the specification?
- ○ Has the provider considered and documented the internal service accountability across the delivery partners in their bid?
- ○ Have the workstreams for delivery of the Child House been drawn up and agreed with clear leads identified for each one?
- ○ Is there sufficient time and capacity in terms of staff resources to carry out all the work that is needed before the Child House can open including the work needed to get the building ready and to recruit the key staff?
- ○ Is there sufficient clinical and subject matter expert input available for mobilisation?
- ○ Have the governance procedures been adapted for the mobilisation phase of setting up the Child House? Are there sub-groups in place to oversee key workstreams?
- ○ Has the lead provider, once appointed, been given autonomy and the budget delegated to lead on all aspects of mobilisation of the Child House?
- ○ Have the Child House operating procedures and guidelines been developed and agreed by the relevant partner agencies?
- ○ Has CQC registration been applied for (if required)?

Chapter 19
Evaluation/Measuring success



What this chapter tells you:

Need for evaluation

19.1 The introduction of a Child House into this country provides a unique opportunity to conduct a robust evaluation of the model and its effectiveness and to explore the best ways of applying the model. Evaluation will help to find out what it is about the model that is most effective, to measure the extent to which outcomes for CYP and their families have improved as a result of the Child House and whether criminal justice objectives have been met.

19.2 A comprehensive evaluation will also add to the evidence base to enable others to learn from what has been achieved and to inform future planning of services for victims and survivors of CSAE, as well as future funding decisions, both nationally and locally. Evaluating the costs and benefits of the model will help to determine whether investing in Child Houses makes the best use of limited funding and gives the biggest return on investment.

19.3 In order to conduct a quantitative evaluation of the impact, comprehensive, accurate and robust data will be needed within the timescales of the project to measure outputs and outcomes. Sufficient data must therefore be available including data on individual service users which would need to be based on a suitable sample size. A qualitative evaluation will also be useful to assess the experience of victims, survivors and their families and, where feasible, to compare this with more traditional models of service delivery. Qualitative evaluations should also consider the impact on the agencies involved including the staff to see what impact the Child House has had on working practices, inter-agency working and staff satisfaction. More detail on the technical and the governance infrastructure required for data collection is given in chapters 16 and 17 – see also paragraphs 19.37–19.41.

Findings from overseas

19.4 Research into CACs and Barnahus models overseas has found positive results in terms of reducing the trauma experienced by victims and improving levels of satisfaction with the overall service for both children and parents[1]. Compared to before the Barnahus model was established, the model has yielded positive results since its inception: trebling the number of perpetrators charged, doubling the number of convictions and improving therapeutic outcomes for children and their families[2].

19.5 However, evaluations of the overseas models focus more on an assessment of the process, with few studies of CACs investigating the specific impact. In addition, economic analysis has been absent from previous evaluations of CACs. Whilst some improvements have been seen in the criminal justice process[3], improved therapeutic outcomes for children and their families, and social care elements of the model[4], other studies have identified few differences between the new model and any comparators[5]. Although international comparisons are helpful, a Child House needs to be seen in the particular context of the police, health and social care system and judicial framework in which it is located, which may limit the applicability of direct comparisons with other countries.

Planning an evaluation – ethical considerations

19.6 Planning the evaluation of the Child House should start early on given the need to agree what outcomes should be investigated and to set up the supporting infrastructure. This includes providing the IT and data required but also the information governance such as consent. Ethical approval may be required for the evaluation and this should be discussed at an early stage with local research ethical committees, particularly where it is intended to evaluate the health and social care impact of the services provided. See:

- Research Ethics Service[6]
- Governance arrangements for Research Ethics Committees[7]
- For online applications, see Integrated Research Application System[8].

19.7 In conducting any evaluation into an area as sensitive as CSAE, the risks of retraumatisation should be considered and care taken to mitigate them. The Health Research Authority will be able to advise on how to carry out an evaluation safely. Undertaking direct contact with CYP who have experienced CSAE for the purposes of research should only be done through specialist professionals who can ensure that the correct support and safeguarding processes are in place. See guidance issued on the **provision of therapy for child witnesses** prior to a criminal trial[9].

Obtaining consent

19.8 Consent procedures will be needed to collect data for the purposes of evaluation (separately from the consent required for therapeutic interventions or specific clinical procedures such as colposcopy). Information should be produced which makes it clear what data is being collected for evaluation, why the data is required and what it will be used for. To comply with the Data Protection Act 2018 and General Data Protection Regulation 2018 (see **chapter 16**), a separate Data Protection Impact Assessment may be needed specifically for the evaluation (see **paragraphs 16.8** and **16.22**).

19.9 Once the objectives for the Child House have been defined, the risks in obtaining the data needed can be identified and mitigation put in place to address them. Without obtaining consent, the evaluation will not be able to access personal data nor measure some of the key outcomes. Low levels of consent may hinder the analytical aspects of the evaluation and impact negatively on future decision-making around the Child House. In order to raise the level of consent for evaluation purposes, specific staff training may be needed to explain why this is needed and how it can be obtained in discussion with those using the Child House. Visual aids for staff to use when explaining consent may be helpful and increase the rate of consent to participate.

Components of the evaluation

19.10 In order to conduct a rigorous evaluation, it will be necessary to measure the inputs to the Child House (eg: the staff) the activities, outputs and outcomes. Which outcomes are to be measured should be agreed early on between the partners and the evaluation team involved. The following outcomes for the Child House to be included in the evaluation may include the following:

- Enhanced referral pathways into and out of the Child House
- Enhanced CYP's and the family/carer's experience of support received post-disclosure
- Enhanced CYP experience of the criminal justice process post-disclosure
- Enhanced mental health and wellbeing outcomes for CYP
- Enhanced professionals' awareness, competence and confidence in working with CSAE
- Increased likelihood for CYP who received a Child House service to have cases charged by CPS
- Increased likelihood for CYP who received a Child House service to have their case end in conviction
- Enhanced partnership working.

It should be noted that the evaluation should aim to cover all aspects of the services provided, including the therapeutic and the criminal justice outcomes.

19.11 Longer term outcomes may also change as a result of the Child House. Due to the timescales of implementation and evaluation, it would be difficult to measure them, but they are aspirations that Child Houses should aim to support:

- Providing CSAE victims with the care and support to reduce the long term impact of victimisation
- Organisations are committed to being victim-focused in their support of CSA victims.

19.12 Once consent has been given by the service user, the evaluation team are able to use individual level data to conduct a more in-depth analysis, and to present a broader picture of the background and specific needs of the clients seen in the Child House.

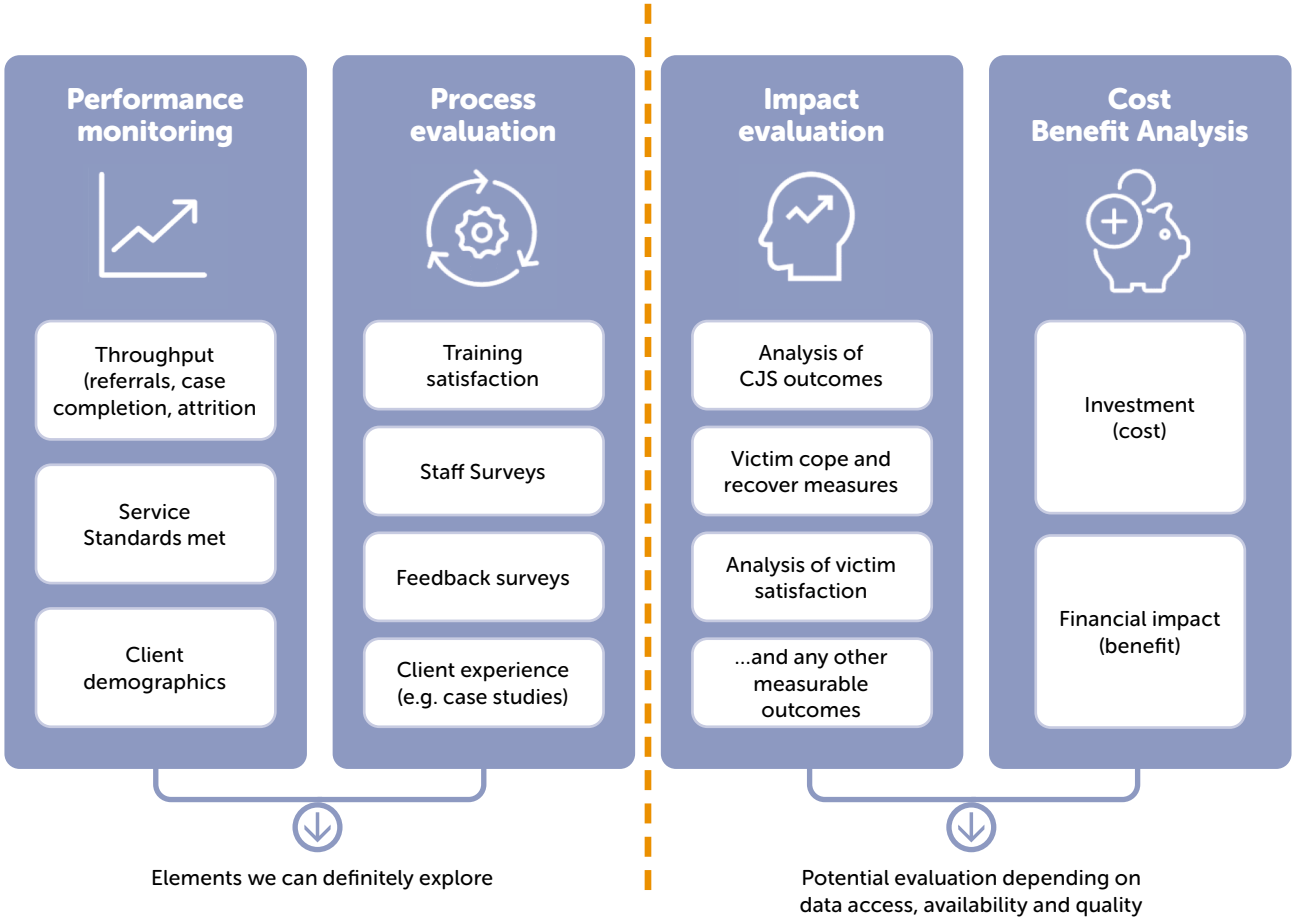
Methods of evaluation

19.13 In order to compare the Child House with existing models of service provision and to show that impact is a result of the services provided, it may be helpful to use a comparator or counterfactual to demonstrate the difference between the Child House and more traditional approaches to providing services. There has never been a randomised control trial (the gold standard for evaluating a new model) of a CAC or Child House/ Barnahus. This is presumably due to the methodological and ethical difficulties involved in running two concurrent models and randomly allocating children between the two.

19.14 Therefore, using a control group or counterfactual (ie: a matched group who do not receive the Child House services), such as a CSA Hub (see paragraph 5.40), to demonstrate the different approaches may be feasible and help to identify the outcomes and experiences of those who do receive the Child House services compared to those who do not. For example, it would be helpful to establish whether any changes in health and wellbeing are actually due to the quality of the therapeutic intervention provided or down to chance. Such information may help to inform future investment and planning decisions on Child Houses. Different options for a control include:

- A before and after design to compare outcomes and CYP's experience in the referral area before the Child House to those who receive the service of the Child House once it opens;
- A difference in difference evaluation where a 'natural' control group is identified and outcomes are compared for both groups before and after the Child House starts to provide services;
- Matched comparison with a service that is targeting a similar cohort of CYP who have experienced CSAE.

19.15 Thefollowing methods of evaluation may be used. (This is the model used at the Lighthouse – see paragraph 19.23[10].)



Source: MOPAC Evidence & Insight, Child House Evaluation Plan, February 2018

19.16 One aspect of the process evaluation is to assess the extent to which implementation is in line with the original Child House concept, demonstrated in the European Barnahus model or the US Child Advocacy Centres. Although the Child House model varies throughout the world and is not one to which there could be a high level of fidelity because of the differing contexts in which they are situated, some adherence to the model is worthwhile given the evidence that exists internationally.

19.17 One of the reasons for establishing Child Houses is the long term benefits of providing high quality multi-agency support for children, young people and their families. The CACs in the US (of which there are nearly 1000) from which the Child House model is derived have undergone a cost-benefit analysis which showed that there was a $3.33 to $1 benefit-cost ratio in comparison to a traditional child protection and law enforcement services model[11].

19.18 It needs to be borne in mind that many of the benefits of the Child House model are long term, for example, improving the health and wellbeing of the individual child along the whole of the life course resulting in improved engagement in education and training, reduced reliance on benefits, and lower rates of NHS services such as primary care and

hospital admissions. It is important to factor in these long term benefits even though they are difficult to quantify precisely.

19.19 Carrying out a preliminary cost-benefit analysis prior to the opening of the Child House based on provisional costings and predicted demand may be helpful. This should then be revisited once actual data is available. The following guidance may be useful in conducting a cost-benefit analysis:

- Our Place Guide to Cost-Benefit Analysis[12]
- Supporting public service transformation: cost benefit analysis guidance for local partnerships[13].

It should be noted that any calculation of unit cost (ie: the cost per service user) will be very sensitive to the number of CYP who use the service, which is unlikely to be known for some time after opening. It is therefore important to have some indication as to the level of likely demand for the service whilst recognising that there may be some variation from this once it opens (and to be aware that it will in any case take some time for demand to reach the expected level).

19.20 Once the Child House is up and running, means should be found of measuring cost-effectiveness based on actual costings and of assessing which aspects of the new service are making the greatest impact.

Data collection

19.21 The Centre of Expertise on Child Sexual Abuse have been working to improve agency data on CSA and have piloted a data collection template which could be used or adapted in a Child House[14].

Timing

19.22 The evaluation should start at the same time as the Child House opens its doors though preparation will need to start at the beginning of the project. Timing of the outputs will depend in part on the funding timetable as the outputs may be needed to influence decisions on commissioning and on continued investment.

Evaluating the Lighthouse

Approach to evaluating the Lighthouse

19.23 In London, MOPAC's Evidence and Insight Unit (E&I), a dedicated in-house social research function, conducted the evaluation of the Child House, working closely with the Child House Delivery team.

19.24 The E&I team used a logic model to analyse the outcomes of the pilot project. A logic model describes the theory, assumptions and evidence underlying the rationale behind a project and is a key tool to embed the evaluation within policy. This was selected because it:

- adds clarity to the conversation;
- ensures the project's motivations stay true;
- steers implementation and sets out clear outcomes for measuring impact;
- helps in setting a robust and cognitive data capture to allow evaluation.

The evaluation was designed across two years utilising a mixed methodology approach, balancing qualitative information derived from staff, stakeholder or client feedback, particularly in the shorter terms, with the 'harder' performance figures, indicating how the service is running on a day-to-day basis.

Inputs	Activities	Outputs	Outcomes
• Paediatricians • Advocate • Mental health/wellbeing practitioners • Lead provider • CJ practitioner • Centre Manager • Usher (potentially police officer) • Police Liaison Officer • Judge, defence (i.e. the court goes to the child) • Funding • Policy/governance infrastructure • Political will • Cross Government advisory group • Play areas • Suites • Breakout rooms • Clients – children and their families	**General** • Identifying and addressing needs of Child or Young Person (CYP) and families • Providing a safe and familiar environment to the CYP • Offering choice in therapeutic input and location • Ease of access, victim control • Holistic service provision • Providing longer term support • Time and effort into the experience = minimising stress on child • Raising profile/awareness of child abuse • Enabling people to challenge things when they don't seem right • Supporting child and their families • Offering advice to other professionals **CJS Activities** • Conducting ABE interviews by trained child psychologists • More effective evidence gathering process • Having the most appropriate person to interview the child • Either forensic or non-forensic interview **Health and Social Care Activities** • Offering 2 year support around: - Sexual health - Emotional/mental well being • Providing access to emotional support • Advocacy, low level support • Better informed safeguarding processes • Offering additional input into safeguarding • Offering different therapeutic services • Signposting for the child	**CJS Outputs** • Increase in ABE interviews in the child house with CYP conducted by trained child psychologists • Improved understanding by CYP and families of the CJ process • More ABE interviews will be conducted by appropriate professional (fewer by police officer) • Better quality evidence • Child giving evidence in Child House • Fewer withdrawals from the process • More instances in which child gets choice of location (could be court if they want to) • Increased understanding of CJ process • More prosecutions **Health & Social Care Outputs** • More CYP engaged in long term therapy • Increased number of CYP accessing sexual health follow up • More medical examinations, in CH and in general • More and longer counselling and therapeutic support • More children going through safeguarding procedures	**CYP/Family** • Fewer CYP re-victimised or re-traumatised by process • Increased satisfaction with the services provided • More children engaging and staying engaged for longer • Fewer withdrawals from the process • Value for money? • Less fear of the process for the victim • Mental health, well-being improves for children and non-offending families • Practitioners satisfaction with process, expertise of practitioners • More convictions, more people brought to justice **Wider measures – could be measured over time** • Increased reporting/disclosure to the police • Free up resources (in terms of police time on investigations) • Child House becomes a safe space • Public perception, high profile • More economic activity • Mention of CH pilots in policy reports, acknowledgements, etc. – compare number of times mentioned at beginning of funding, to at the end of the pilot? • Visibility and accessibility of the CH • Where/how was it accessed? Where was it advertised? • More effective route from disclosure to getting CH service and support.

Source: MOPAC Evidence & Insight, Child House Evaluation Plan, February 2018

> *We were aware of the importance of the Lighthouse right from the outset. There was a lot of interest in the service, and we knew that the evaluation was critical in establishing what had been delivered, and the benefits for service users. We also wanted to ensure that the evaluation encompassed the whole service and considered the variety of outcomes (health and well-being, and criminal justice) it was anticipated the Lighthouse would impact because previous evaluations of similar models abroad had tended to focus on limited outcomes.*
>
> *It was important for the evaluation team to be involved in the initiative right from its planning stage – well before the Lighthouse went live, so that the evaluation needs were considered alongside the design of the service. It was critical too that the Lighthouse staff understood why the evaluation was being undertaken, and the importance of collecting good quality data that accurately reflected their activities. Bearing in mind the vulnerability of the children and young people at the Lighthouse, the need to ensure that we had obtained informed consent from those service users who participated in the research, and that they were aware of their ability to opt out, was a central tenet of the evaluation.*
>
> Tim Read, Evidence and Insight team, MOPAC

19.25 The methods of evaluation (see diagram at paragraph 19.15) comprise:

(1) Performance monitoring

(2) Process evaluation

(3) Impact analysis

(4) Cost-benefit analysis.

Further detail on each of these is given below.

(1) Performance monitoring

19.26 The performance monitoring aspect used data and management information captured during the everyday running of the Lighthouse to track service delivery. It relied on extensive data collection in the following areas:

- Client data
- Health data
- General metrics
- Therapeutic data
- Investigation data
- Offence and criminal justice data
- Safeguarding data.

The bespoke electronic patient record system collected the information needed to support this aspect of the evaluation.

E&I aims to track the performance of the London Child House pilot. Data availability will be assessed and access/data sharing will be developed through working with the delivery team and key partners (including NHS, MPS, CPS and HMCTS).

The below data fields are not an exhaustive list and subject to change as the Child House develops to ensure all necessary information is captured.

Client data

- Age
- Gender
- Siblings
- Disability information
- Other vulnerabilities
- Family context
- Resident borough
- Borough offence took place
- Ethnicity
- Relationship with perpetrator
- Initial disclosure to whom
- No. of families engaged & which family members
- No. of repeat victims
- No. of CYPs who self harm following abuse
- No. with Social worker involvement
- No. in education
- Patient Measured Outcomes
- Risk assessment
- Consent to participate in research

Therapeutic data

- Number of referrals to therapeutic services
- Uptake of therapeutic services
- Number of CYP/Families engaged in long term therapeutic services
- Number of therapeutic services CYP/Family are engaged with
- Type of therapeutic services used
- Psychometrics
- Number & type of advocacy services engaged with
- Number of CYP offered ISVA support
- Uptake of ISVA support
- Timeliness of all therapeutic elements

General Child House metrics

- Number of referrals
- Where referrals are from
- No. of joint strategy meetings & attendees
- Client Throughput
- Timeliness of all CH elements (disclosure to joint strategy meeting, to psychology intervention, medical examination, etc)
- Attrition from Child House
- Number of services CYP engages with
- Borough referred from
- Number of risk assessments conducted
- No. of support plans created
- Adherence to standards/ principles
- Activity time of Child House (appts available offered, taken place)
- Activity location (within or outside of Child House)
- No. of onward referrals outside of Child House & to whom
- Any complaints or incident information (numbers, types, themes)
- Discharge details (numbers, timeliness, ongoing needs, referrals)
- No. of staff training sessions delivered & number of staff attended
- Cost / Financial data

Health data

- FME conducted at CYP Havens
- No. of medical examinations offered/conducted
- Timeliness of all health elements
- No. of sexual health referrals
- Uptake of sexual health referrals
- No. of sexual health screenings conducted
- Uptake of sexual health follow up appts
- No. of repeat presentations to sexual health
- No. with existing contact with mental health services
- No. of referrals to mental health services
- Uptake of mental health services
- Type of mental health symptom
- Timeliness of referrals to mental health/sexual health
- No. of CYP engaged in long term mental health services

Investigation data

- No. of incidents of CSA reported to the police
- Police offence category
- No. of arrests/cautions/ police charge/NFA
- No. of interviews conducted overall
- ABE interviews (number, location and interviewer details – psychologist or not)
- No. of intermediaries used
- Timeliness of all elements
- No. of CPS decisions to charge
- No. of CYP giving evidence via Live Link
- No. of vulnerable victims applications made by CPS
- No. of special measures applications made & granted & type of measure
- No. of cases subject to Section 28 (timely pre-recorded cross examination at Child House)
- Cross examination (number, location and who conducts cross examination)
- No. of guilty pleas
- No. of cracked trials
- No. of convictions /trial status
- No. of victim withdrawals (and reasons why)

Offender data

- Age
- Gender
- Resident borough
- Ethnicity
- Perpetrator status at time of referral
- Sentence received

Safeguarding data

- No. of cases discussed at Child Protection Conferences
- No. of CYP subject to child protection orders
- No. of children on Risk Register
- No. of Looked After Children
- No. of Child House CYP discussed at LSCB

Although this data was all collected, in the event, not all of it was used to inform the performance monitoring process.

Source: MOPAC Evidence & Insight, Child House Evaluation Plan, February 2018

(2) Process evaluation:

19.27 The aim of the process evaluation was to examine how effectively the Child House had been implemented in London. Feedback was obtained from all those involved to identify key learning and good practice (stakeholders, staff, health partners, teachers, CPS, social care, police and, where possible, service users and their families), as well as the challenges and suggestions for improvement. Methods were largely qualitative (surveys, interviews and/or focus groups) to better understand the implementation process, partnership working and integration of services as well as the experiences of those delivering the service. The evaluation was designed as a form of action research to fit with the key milestones of the Child House pilot, thereby providing a direct and timely feedback loop

19.28 A consultancy company, RedQuadrant, were commissioned to conduct interviews with stakeholders and the partner organisations alongside MOPAC about all aspects of the setting-up of the Child House and a detailed internal report produced which was used to record and share the learning and, later, to develop this toolkit. Surveys of professional stakeholders and Programme Board members were also used to capture opinions around the design and implementation of the Lighthouse. Focus groups were held with staff before the Lighthouse opened to ascertain their views of readiness.

(3) Impact analysis

19.29 The purpose of the impact evaluation was to examine whether the Child House delivered its key outcomes and how they affected those involved. It was considered important from the outset to identify a control group or counterfactual so that a comparison could be made. Different options for a counterfactual were considered (ie: a before and after design and a difference in difference evaluation) but the method selected was a comparison with another area of London (North East London). This was intended to provide a meaningful comparison and to show the difference in outcomes between CYP who received the services of the Child House and those in areas without this level of provision ('business as usual'). This compared the performance data from North East London with similar data from the Lighthouse, such as referrals, cases dealt with, therapeutic support and characteristics of service users; it also looked at therapeutic outcome data, criminal justice outcomes and service user perceptions.

19.30 One aspect of the evaluation was to track progress on criminal justice cases – the feasibility of this approach was explored using a small sample of 20 cases (both CSA and CSE) to look at the reasons for case attrition. Assessing case attrition refers to the process whereby cases drop out of the criminal justice system, at one of several possible exit points before an outcome at court. The journey through the criminal justice system is known to be lengthy and complex, and it was hoped that the Child House would help to streamline this by reducing some of the causes of case attrition. The analysis of 20 cases, though time-consuming, provided important learning on progression of CYP who have experienced CSAE through the criminal justice system. It helped to develop a methodology which was subsequently used to track the Lighthouse cases as well as establishing how the police record CSAE.

19.31 A separate piece of research into the effectiveness of the ABE interviews led by clinical psychologists was planned jointly with the London Havens, but funding had not been secured at the time that this toolkit was published. The research will look at the impact of the involvement of clinical psychologists, differentiated from the effects of the child-friendly environment, through the comparison of three groups of cases: 1) interviews conducted at the Lighthouse and Haven by clinical psychologists, 2) interviews conducted at the Lighthouse and Haven by police officers and 3) interviews conducted in standard police interviewing suites by police officers. The MOPAC evaluation also included feedback from CYP, police and the CPS as well as the criminal justice outcomes resulting from the clinical psychologist-led ABE interviews.

(4) Cost-benefit analysis

19.32 The key questions identified were:

- Does Child House provide value for money?
- What are the public value benefits and what are the fiscal benefits? Are there any marginal benefits?
- By investing in this approach, can we reduce traumatisation of the victim and therefore reduce costs to health, social care, and the criminal justice system – if so what cost savings can be made?
- What is the payback period for the project?

19.33 A report advising on the best way of approaching cost-benefit analysis was commissioned early on from RedQuadrant (before the Child House opened) which provided a cost-calculator based on learning from the wider evidence base. The report summarised the methodology used for base-lining service costs and testing against the benefits identified through the literature. The benefits identified were wide-ranging – outcomes were grouped from the literature into three categories of social value: wellbeing to the client, useful savings from public sector spend, and additional public sector spend on essential activity.

19.34 These principles were later used to inform cost-benefit analysis once data became available on set-up and running costs as well as actual service data on throughput and prevalence of relevant criteria (such as the numbers presenting with mental health needs). Data on costs was collected and monitored from the start of the project to inform this analysis

19.35 It was acknowledged that the cost: benefit ratio depends significantly on how many people use the service (given that the costs are calculated per service user), and that it was not known for many months after opening whether the actual utilisation would be in line with projections.

Ethical issues

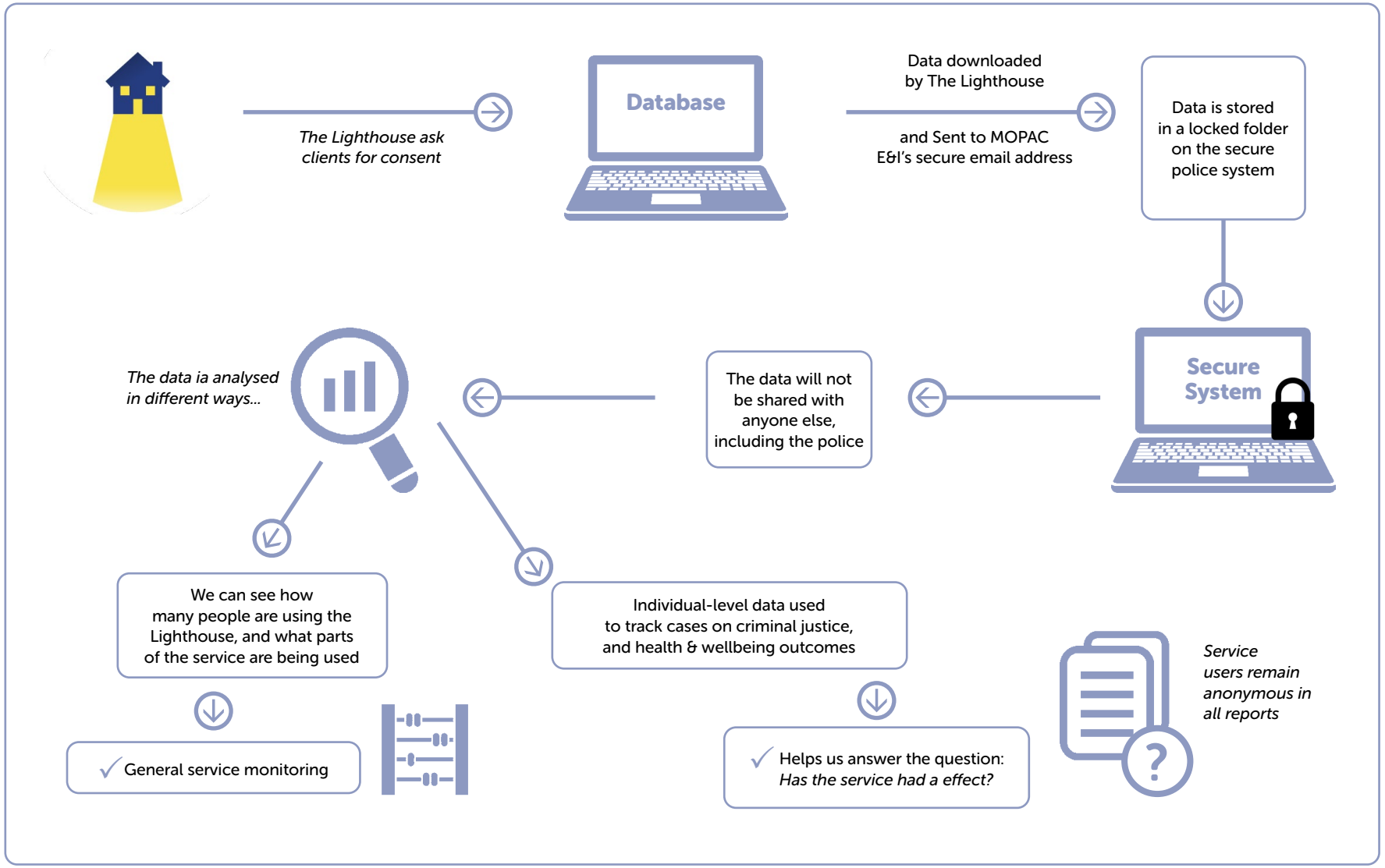
19.36 Ethical approval was sought for the evaluation aspects service-user element of the evaluation of the work of the Lighthouse following advice from the Academic Advisory Group and the Lighthouse's Research Group, and completion of the guidance on the Health Research Authority website[15].

Obtaining consent

19.37 Questions were raised early on about obtaining consent for the evaluation from CYP using the Child House which took some time to resolve. A separate Data Protection Impact Assessment was produced. A consent process was put in place for obtaining data for the evaluation and forms were designed for this purpose as well as leaflets to explain the reason for this to children, young people and their family members (see paragraphs 16.26-16.27).

19.38 To begin with, there was a low rate of obtaining consent for the evaluation. However, this increased significantly after specific training from the evaluation team as to why it was necessary to share personal data with the evaluation team. This demonstrated that, without consent and the data, it would not be feasible to conduct the evaluation or a cost-benefit analysis. Staff were also reassured that only information on participants who consent would be used. A consent rate of 80% was required so that the sample size would be large enough and would provide as accurate a picture as possible of the service and its clients. As a result of the training, the consent rate rose from around 24% to an average of 71% by June 2020 which enabled the evaluation team to use individual-level data for the analysis. This needed constant effort to optimise the chance of every service user participating in the evaluation.

19.39 The following diagram was used to explain how the data from the EPR would be used:



Source: MOPAC Evidence & Insight, Child House Evaluation Plan, February 2018

19.40 The following explains the process used for seeking consent for collecting the data required for the evaluation:

Process for obtaining consent for the evaluation

- Once rapport has been established with the Lighthouse team, the advocate will seek explicit informed consent for the service user's data to be included in the evaluation.
- The advocate will explain the benefits of the evaluation for future sustainability of the service
- The advocate will explain why personally identifiable data is required
- The advocate will explain how the service user's data will be kept securely and who will have access to the data for the evaluation
- The service user will be advised that they can withdraw consent if they wish to at any point
- The service user will be asked to sign the consent form, which will then be scanned and uploaded to the Document Store in Excelicare (the EPR)
- The advocate will update Excelicare consent section to note consent has been given for evaluation.

19.41 The Lighthouse worked with the University of Bedfordshire on the design of a **service user evaluation** which was based on interviews with service users of the Lighthouse and interviews with a control group using alternative services. The findings are reflected in the final evaluation report (see **paragraph 19.53**).

Eleven young people were interviewed and what they really appreciated about the Lighthouse service was that it is all under one roof, young people are at the centre, they felt welcomed and cared for, there was a holistic and individually tailored approach, and the service is flexible and unrestricted. They suggested communication when they first accessing the service could be better, with more time to understand information sharing and consent. They hoped that awareness of this unique service would spread and that more centres closer to home could be available. One young person said: *'They're not here to like fix you and make you better. They're here to give you like the resources that you need to get to your goal. So to get through the next chapter, through the next door, like they give you those keys and teach them how to use them'.* (Young person 5)

Research group

19.42 As well as the formal evaluation process, the Lighthouse Evaluation Academic Advisory Group was set up to act as an independent and interdisciplinary sounding board to the evaluation team, ensuring oversight of both the quality and robustness of the work conducted. The group meets quarterly and is intended to be a 'critical friend' for the Lighthouse evaluation, providing oversight and guidance for all research activity and to peer review outputs from the Lighthouse evaluation.

Findings from the evaluations of the Lighthouse

Note: The findings were valid at the time that the research was carried out; the final evaluation should be used to reflect the most up-to-date position – see 19.53.

First interim evaluation

19.43 The first evaluation of the Lighthouse[16] was published in December 2018, only three months after the Lighthouse opened, and looked at the initial stages of the pilot based on early results from fieldwork , a report into the setting-up and mobilisation of the Lighthouse carried out by RedQuadrant on behalf of MOPAC and an assurance review carried out by the Home Office.

19.44 The key findings were:

- There was clear agreement about the vision for the Lighthouse and common goals supported by partners and stakeholders;
- Stakeholders were positive about the strong leadership which helped to set direction for the project;
- There was clear evidence of commitment and passion exhibited by the clinical consultants who played a key role in mobilising the Lighthouse;
- The design of the Lighthouse was clearly grounded in the evidence available from CACs around the world;
- The governance arrangements were effective in overseeing delivery of the pilot, ensuring stakeholder relationships and allowing a collective understanding to be developed;
- A thorough approach to stakeholder engagement has paid dividends and ensured that the right people and organisations were included throughout. This helped to ensure that the partners worked well together;
- The previous experience of working together collectively through the existing CSA Hubs as well as early links with LSCBs and the MASHs proved to be key enablers;
- The inclusion of the voice of victims and survivors of CSAE was influential in the development of services and the look and feel of the infrastructure;
- The co-location of services is thought to have facilitated multi-agency working given its convenience and the improved communication that resulted from it. It also helped to enable greater staff support in dealing with emotionally demanding cases.

19.45 Some of the challenges identified in the initial evaluation included:

- the lack of an exploratory interview where there are concerns of CSAE but no actual disclosure of abuse. This was an exclusion in the original specification but some delivery stakeholders felt that this was one thing that was missing. The Lighthouse currently accepts referrals from agencies only where there is significant suspicion or disclosure of abuse;
- The delayed national implementation of Section 28 and the use of the Lighthouse as a 'live link location' enabling a child or young person to give evidence without needing to attend Court in a physical place that is familiar and safe;
- Implementation challenges such as the procurement, design and implementation of the bespoke electronic EPR which was not started until the lead provider had been appointed. This meant that time was short and development ran in parallel with mobilisation which was not ideal.

Outcome of cost-benefit analysis

19.46 The cost-benefit analysis report proved useful in identifying a selection of potential benefits which covered the child, family members, organisations and wider society. It recognised

that there may be short term benefits whilst others would not be apparent for many years. The outcomes were identified from the literature and grouped into three categories of social value:

- Wellbeing to the client;
- Useful savings from public sector spend, and
- Additional public sector spend on essential activity. The areas considered were as follows:
  - Health (sexual health, physical health and substance misuse)
  - Wellbeing (from the perspective of the NHS and local authorities, the individual child or young person and the family)
  - Children's services (possible impact on child protection action and on the need for any additional school support)
  - Employment (possible impact of the Lighthouse on loss of earnings and take-up of benefits otherwise resulting from CSAE)
  - Criminal justice (costs of crime and enforcement action against alleged perpetrators, and the impact on possible criminal activity committed by victims of CSAE during adulthood because of their abuse). The possible reduction in the number of 'cracked trials[17], is also estimated, and
  - System effects (improved productivity because of better co-ordination of multi-agency services at the Lighthouse).

This will eventually enable a financial benefit as a result of the introduction of the Lighthouse to be calculated per client.

Findings from the second interim evaluation

19.47 The second evaluation was published in January 2020[18]. This focused primarily on the performance monitoring and process aspects of the evaluation based on the first six to nine months of the Lighthouse's operation. This drew on performance management data (which is provided to the service commissioners as well as data taken from the EPR), focus groups and interviews, with a wide range of staff and an online survey to stakeholders.

19.48 The key findings were:

- The Lighthouse received an average of around 35 referrals per month (approximately 420 referrals in its first year) with some variation between the five authorities. This is lower than the number of cases of sexual assaults in children reported to the police (approximately 700);
- Half of the referrals to the service came from Children's Social Care;
- 78% of those referred were female and just over half were aged 13-18 years old;
- Around 21 Initial Assessments (IA) were carried out per month (equating to around 252 within the first full year) which is less than the estimated demand of 544 per year);
- The reasons why the remaining referrals did not reach an IA were varied (including some who did not want the service and others not meeting the criteria for referrals);
- Respondents felt very positive about the service received, the facilities available and the convenience of the location and appointment. They felt listened to and that the staff were easy to talk to;
- Professionals also showed a positive response to the opening of the Lighthouse.

19.49 Some of the challenges identified included:

- The difficulty in obtaining consent for the evaluation which meant that the results were based on a limited number of cases (see below);
- The challenge of obtaining the data needed from the EPR which was not really designed to support research;
- The lack of progress made in some of the anticipated features of the Lighthouse particularly those under Section 28 of the Youth Justice and Criminal Evidence Act 1999. Specifically, these were the pre-recorded cross-examination taking place

at the Child House and the use of the Lighthouse as a Live Link location allowing children to give evidence remotely without attending court. The former was delayed for national roll-out because of technical issues and while these have been resolved, it is not anticipated that section 28 will be available in London in the near future; the Live Link is planned but has yet to be approved;

- The intention that the ABE interviews should be conducted by psychologists rather than police was a key part of the plans for the Lighthouse. These took longer than expected to start as the training required by the psychologists took longer than anticipated.

Completeness of data

19.50 Ensuring that staff complete the EPR consistently was recognised as essential for the evaluation. The Data Analyst employed at the Lighthouse helps to ensure that staff are inputting data accurately and comprehensively.

19.51 A separate evaluation of the ABE interviews is also planned.

Third interim evaluation report

19.52 The third interim evaluation report was written in November 2020 and published on the MOPAC website in 2021[19]; the key findings are summarised below:

- There were 639 referrals between the end of October 2018 and the end of July 2020, with referral numbers per month varying between 23-35 though there was a large drop from March to April 2020, coinciding with the Covid-19 lockdown;
- 392 Initial Assessments were carried out during this period, with an average of 3 professionals in attendance;
- Social care is the most common referrer to the Lighthouse;
- 81% of all referrals are female; the most common age range is 13-17; 130 clients were recorded as Black and Minority Ethnic groups (BAME) and 120 as non-BAME;
- The majority of service users (87%) were recorded as having vulnerabilities with an average of 2.7 different types per service user (anxiety and/or depression was the most common vulnerability followed by a history of domestic abuse); 28% had a recorded disability with mild or moderate learning difficulties being the most common forms;

  Risk assessment data for 184 clients showed that for 61%, there was some concern or risk of further abuse. There was concern about self-harm for 81 of these clients, and concern of suicide for 58 of these clients; there was concern for 19 clients of there being a risk to others;
- A qualitative evaluation of the roles of the PLO and SCLO found high levels of support for both roles;
- The report also examines other aspects of the learning from implementation in terms of the consistency to the model (particularly with respect to the impact of Covid-19); ways of working (looking at themes such as the need for sound proofing); partnership working (including continuing cultural/organisational differences and how these were being mitigated), and looks at the challenges ahead.

Final evaluation report

19.53 The final evaluation report[20] was published in 2022. The key findings were:

- Between the end of October 2018, when the Lighthouse launched, and the end of March 2021 there were a total of 889 referrals to the service, an average of around 30 referrals per month. Out of the total referrals – 82% were female, with 57% in the older age group between 13-17 years.

- Between the end of October 2018 and the end of March 2021 the service carried out 510 Initial Assessment (IA). This is an overall conversion rate – this was fewer assessments than expected.
- Across the Lighthouse lifespan there was a considerable amount of delivery, ie:
  - A total of 4,780 telephone, video or face-to-face sessions.
  - 936 professional meetings (excluding strategy and consultation meetings).
  - There were 29 psychologist-led ABE (Achieving Best Evidence) interviews that took place at the Lighthouse (averaging at 1.6 per month).[21] Over the same period there were 43 police led ABE interviews at the Lighthouse.[22]
  - The Lighthouse made 91 onward referrals to local services, most commonly within the voluntary sector (34%, n=31), followed by Social Services (26%, n=24).
  - Between April 2020 and March 2021, 137 strategy discussions that took place and 118 consultations were delivered by the Social Care Liaison Officers (SCLOs).
- The report summarises the learning from implementation concluding that:
  - The pilot was well-implemented with staff, partners, C&YP and parents positive about the general service.
  - The Covid-19 pandemic heavily disrupted the implementation of the Lighthouse pilot although the service was able to continue. Overall staff felt that virtual working whilst necessary, was lacking therapeutically than when delivered face-to-face.
  - The partnership working which was key to the Lighthouse was found to bring a wide range of benefits to the service and to clients. However, it is acknowledged that there were tensions as a result of organisational cultures and working practices, not all of which were fully reconciled during the pilot.
- The report explores the impact of the service based on examination of several datasets including a comparison with a 'Business As Usual' (BAU) service in North East London, and found that:
  - A far larger number of clients was reached and there were more outputs than the other (BAU) site;
  - Although emotional wellbeing data is variable across the sites, 89% of Lighthouse goals were achieved/ partially achieved compared to 47% of outcomes at the North East London site;
  - Comparing across a range of investigative actions between the two groups, there were some positive and encouraging findings. For example, the Lighthouse had significantly higher instances of positive investigative actions such as increased suspect arrests, and proportion of cases submitted to the CPS.
- The report also looked at the economic impact of the Lighthouse based on an economic analysis carried out by RedQuadrant. The key findings were:
  - The overall costs of the Lighthouse pilot comprise the annual operating costs of £2.387m per year plus the one-off capital costs of refurbishment, installation of IT and infrastructure (£3.9m allocated to cover a period of eight years at £0.49m per year). This equates to £2.88m per year in total.
  - With this overall cost, and 420 clients per year, the unit costs for the Lighthouse are of the order of £6,860. Costs of a Havens service were estimated at £4,925 per case.
  - Unfortunately, despite development of a comprehensive dataset for monitoring performance and utilisation rate, accurate data on many outcomes is not available.
  - Outcome measurement is particularly challenging for CSA services due to the complexity of the recovery with every child's journey likely to be different.
  - This total cost can then be set against

the wider social value identified across three broad areas: wellbeing to the client, useful savings from public sector spend and additional public sector spend on essential activity.

- These results show that there is a financial return to the public sector from the operation of the Lighthouse, with a net gain in public expenditure per client of £14,570.
- The calculations suggest that the use of the Lighthouse compared to the Haven costs perhaps £1,935 per case more, but saves an additional £7,000 on future public expenditure, and improves wellbeing by an additional £10,300.

Key learning points

- Evaluating the Child House model is essential to establish an evidence base in this country and to see whether this is an effective and cost-effective way of delivering services for children and young people who have experienced CSAE and their families.
- Both quantitative and qualitative data are required to inform a rigorous evaluation. It will be necessary to measure the inputs to the Child House (eg: the staff), the activities, outputs and outcomes. Which outcomes are to be measured should be agreed early on between the partners and the evaluation team. Measuring outcomes, both of the therapeutic and the criminal justice aspects of the Child House, will inform planning on the future of individual Child Houses, as well as the development and roll-out of the model in England.
- Four distinct areas can be evaluated: performance monitoring, process, impact and economic analysis. The ability to successfully complete each element will depend on the quality and quantity of data available. Establishing whether there is adherence or fidelity to the initial vision and model is also worth evaluating given the importance of programme integrity.
- As well as finding out whether the model as a whole is effective, evaluations should seek to establish which aspects of the Child House make the most difference. This will help to plan Child Houses in the future and to know what is likely to give the largest return on investment.
- It may be helpful to use a comparator or counterfactual (such as an existing service) to demonstrate the difference between the Child House and more traditional approaches to providing services.
- Any evaluation should be ready to start at the same time as the Child House is opened – the timing of outputs from the evaluation needs to align with the funding timetable as the outputs may influence decisions being taken on commissioning and continued investment in the new service.
- A separate Data Protection Impact Assessment is likely to be required specifically for the evaluation to comply with legislative requirements on data protection and to outline the risks and how they will be mitigated.
- If individual patient data is to be used for the evaluation, separate consent procedures will be needed and the consent of the child or young person and/or their family members obtained and recorded. Without consent, the evaluation will not be able to access personal data nor measure some of the key outcomes – low levels of consent are likely to hinder the analytical aspects of the evaluation. Specific training for staff on this and tools to help them present this to service users may be helpful.
- In conducting any evaluation in this area, the risks of retraumatisation should be considered. These can be avoided by undertaking direct contact with children and young people who have experienced CSAE only through specialist professionals to ensure that the necessary support and safeguarding processes are in place.

Checklist for setting up a Child House

- ○ Has consideration been given as to how the Child House is going to be evaluated?
- ○ Are there plans to collect the data needed (quantitative and qualitative) that will be needed for the evaluation and will the infrastructure be in place to do so? Does this include plans to assess the experience of victims, survivors and their families?
- ○ Have the information governance aspects of the evaluation – including the possible need for a separate Data Protection Impact Agreement and a clearly defined consent process if personal data is to be used – been addressed?
- ○ Has the need for ethical approval been considered and advice sought from the Health Research Authority?
- ○ Have the outcomes to be measured through the evaluation of the Child House been agreed?
- ○ Are there plans for the evaluation to include performance monitoring, process evaluation, impact evaluation and a cost-benefit analysis?
- ○ Will the evaluation begin as soon as the Child House opens?

End Notes

1 Elmquist J, et al, A review of Child Advocacy Centers' (CACs) response to cases of child maltreatment in the United States, Aggression and Violent Behavior (2015)

2 Office of the Children's Commissioner, 2016

3 Cross et al, 2007, Smith et al, 2006

4 Edinburgh et al, 2008; Smith et al, 2006

5 Joe & Edelson, 2004 ; Jones et al, 2007

6 Research Ethics Service, NHS Health Research Authority, see https://www.hra.nhs.uk/about-us/committees-and-services/res-and-recs/research-ethics-service/

7 Governance arrangements for Research Ethics Committees, see https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/governance-arrangement-research-ethics-committees/

8 The Integrated Research Application System (IRAS) is a single system for applying for the permissions and approvals for health and social care/community care research in the UK. See https://www.myresearchproject.org.uk/

9 Provision of therapy for child witnesses prior to a criminal trial, practice guidance; Home Office, Crown Prosecution Service, Department of Health, 2001, see https://lx.iriss.org.uk/sites/default/files/resources/069.%20Provision%20of%20Therapy%20for%20Child%20Witnesses%20Prior%20to%20a%20Criminal%20Trial.pdf

10 Evidence and Insight Team, MOPAC

11 Formby, J., Shadoin, A. L., Shao, L, Magnuson, S. N., & Overman, L. B. (2006). Cost-benefit Analysis of community responses to child maltreatment: A comparison of communities with and without Child Advocacy Centers. (Research Report No. 06-3). Huntsville, AL: National Children's Advocacy Center

12 Our Place Guide to Cost-Benefit Analysis, Pro Bono Economics, 2015, see https://mycommunity.org.uk/files/downloads/2019.07.04-My-Community-Cost-Benefit-Analysis.pdf

13 Supporting public service transformation: cost benefit analysis guidance for local partnerships, HM Treasury, Public Service Transformation Network, New Economy, April 2015, see https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/300214/cost_benefit_analysis_guidance_for_local_partnerships.pdf

14 Christine C, Karsna K, Improving agency data on child sexual abuse: a pilot study of the child sexual abuse data collection template, Centre of expertise on child sexual abuse, Chanon Consulting (July 2019), see https://www.csacentre.org.uk/csa-centre-prodv2/assets/File/Data%20collection%20template%20pilot%20-%20English.pdf

15 NHS Health Research Authority, see http://www.hra-decisiontools.org.uk/research/

16 The Lighthouse: London's Child House Initial Evaluation Report, MOPAC Evidence and Insight, December 2018, see https://www.london.gov.uk/sites/default/files/childhouse_jan19_report.pdf

17 A cracked trial is a trial that has been listed for a not guilty hearing on a particular day but does not proceed, either because the defendant pleads guilty to the whole or part of the indictment, or an alternative charge, or because the prosecution offer no evidence

18 The Lighthouse: 9 month evaluation report (September 2019), MOPAC Evidence and Insight. See https://www.london.gov.uk/sites/default/files/2019_117_childhouse_2nd_evaluation_report_for_publication.pdf

19 The Lighthouse: 2-year interim evaluation report (November 2020), MOPAC Evidence and Insight. See https://www.london.gov.uk/sites/default/files/childhouse_nov_2020_interim_evaluation_report_for_publication.pdf

20 The Lighthouse: Final Evaluation Report, MOPAC Evidence and Insight, June 2021, see https://www.london.gov.uk/sites/default/files/childhouse_june_2021_final_evaluation_report_for_publication.pdf

21 There were more psychology led ABEs planned between April and June 2020, but a number were cancelled due to family anxiety about travelling in for an interview during COVID lockdown.

22 The Lighthouse is contracted to offer 3 psychologist-led ABEs a month.

Chapter 20
Long term sustainability

What this chapter tells you:

Securing long term funding

20.1 Agreeing how long term funding will be secured for any Child House needs to be considered early on in the lifetime of the project. As with many projects of this kind, funding may be available for a 2-3 year pilot to assess whether the model is likely to meet the needs identified in the area. Once the funding for the pilot comes to an end, even if it has been successful, securing longer term funding may present problems and jeopardise the future of the Child House. The long term sustainability of the project therefore needs to be considered from its inception.

Funding sources

20.2 Funding for establishing a Child House may come from a range of public sector sources, including Police and Crime Commissioners, central government grants, NHS bodies (such as STPs or Integrated Care Systems, CCGs and the regional offices of NHS England) or local government. Contributions to funding may also be available from philanthropic sources such as voluntary sector funding, and corporate organisations. Funding can come either through the commissioning route for specific services or, in some instances, through grants. There may also be scope for voluntary or corporate donations to be used to fund some of the services to be provided or for some of the equipment or facilities.

20.3 All options should be considered before committing to the project; each has advantages and associated risks. The drawbacks of a commissioning model, for example, include the necessity of taking a short term approach which can be a challenge for small organisations and involve uncertainty for staff. It may not be feasible to use philanthropic funding for the core services to be provided in the Child House. Grants are also, by their nature, limited in duration which again may cause some uncertainty for staff.

Who's responsible?

20.4 The **Strategic Direction for Sexual Assault and Abuse Services**[1], published by NHS England in 2018, set out the plans for improving access to and the quality of services for victims and survivors of sexual abuse and assault of all ages. This document, which was produced in consultation with many voluntary and community services organisation working in sexual violence, shows how the landscape for the commissioning and provision of sexual assault and abuse services is wide and complex. It spans a number of different systems and government organisations, including health, care and justice, and requires them to work together.

20.5 Having such a wide range of potential commissioners and providers, including some specialist and third sector organisations, may pose a challenge, with different bodies finding it difficult to work together effectively to meet the lifelong needs of victims and survivors. Support for victims and survivors encompasses a wide range of statutory and non-statutory services funded by several different national and local commissioners. Unfortunately, victims and survivors are not always able to access the support they need and can find it difficult to navigate this array of often disjointed services, resulting in fragmentation in service delivery, frustration and poor outcomes for victims and survivors of sexual assault and abuse over their lifetime[2]. The government has committed to ensuring access to high quality support for victims and survivors of child sexual abuse, wherever they live in the country and regardless of when the abuse occurred. Improving the quality and consistency of support for victims of sexual abuse is central to both the **Strategic Direction for Sexual Assault and Abuse Services**[3] and the cross-government **Victims Strategy**[4].

20.6 Appendix B sets out the commissioning responsibilities of different commissioners for sexual abuse and assault services (see Appendix B). This includes many of the individual services which are likely to be provided by a Child House, ie:

- **Police and Crime Commissioners (PCCs)** are increasingly responsible for commissioning the majority of emotional and practical support services for victims of crime, including victims and survivors of sexual assault and abuse, and specialist voluntary sector services. PCCs in five areas including London have been given full commissioning responsibilities for sexual violence and abuse services;[5]
- **NHS England's** commissioning responsibilities include Sexual Assault Referral Centres (SARCs) responsible for forensic medical examinations, medical care/support and follow up services in SARCs with Police and Crime Commissioners/Police and tier 3 CAMHS;
- **Clinical Commissioning Groups** are responsible for commissioning mental health services including services for those with depression and Post-Traumatic Stress Disorder (PTSD) whose staff understand the specific needs of victims and survivors of sexual assault and abuse, including the third sector; as well as community paediatric health services;
- **Local authorities** are responsible for sexual health services including specialist voluntary sector services for child sexual abuse, child sexual exploitation and sexually harmful behaviour;
- **Ministry of Justice** are responsible for rape support services with emotional and practical support services for victims of rape and other forms of sexual abuse aged 13 or over. They have contributed an additional £24m funding [10% increase] from 2018 for three years for rape and sexual abuse victims;[6]
- **Home Office** are responsible for some national services for victims of child sexual abuse.

Funding Child Houses in England

20.7 Since a Child House by its nature brings together many different services into one setting with the aim of providing a holistic service, this is complex when seeking funding given that many of the services are provided by mainstream statutory services including health, children's social care and the criminal justice system. Others, including some of the long-term therapeutic interventions, are provided by the voluntary sector. Knowing where to go to access long term funding may therefore be complex.

20.8 Discussing the need for a Child House with the organisations listed in paragraph 20.5 above to establish what could be achieved within existing resources is the first step. Some of the statutory services may be provided by diverting existing services for victims and survivors of CSAE to the Child House and may therefore not require additional funding though it is inevitable that some additional investment will be required. Talking to the key partners about what could be provided within existing funding envelopes and what additional services would be needed is therefore a good starting-point. Local plans may be helpful in determining how the Child House would help local organisations to deliver on their objectives, including the Health and Wellbeing Strategy and the plans of the Sustainability and Transformation Partnership/Integrated Care System for the area.

20.9 **Central government:** government departments may fund specific programmes of work. The Home Office, Ministry of Justice (MoJ), the Department for Education and the Department of Health and Social Care have all made contributions to funding services to support victims and survivors of sexual violence. However, whilst central government grant funding may be available to fund innovations and to pump prime new developments, it is unusual for government

departments to meet the ongoing costs of projects, however innovative and well-supported they may be, though there are exceptional cases such as the Ministry of Justice's grants for victims of sexual violence and abuse. The Tackling Child Sexual Abuse Strategy (2021) sets out a range of additional investments made in support services for CSA including the CSA Support Services Transformation Fund.[6] The MoJ have allocated additional funding to PCCs to specifically commission services for victims and survivors of recent and non-recent CSA across their communities, as well as additional funding to recruit more ISVAs across England and Wales.

20.10 **Police and Crime Commissioners:** Since PCCs are increasingly responsible for services for victims and survivors of sexual violence, approaching and engaging with the PCC to establish their views and willingness to contribute financially should be a priority.[7] Additionally, PCCs or the police could be approached to fund or second officers for the role of Police Liaison Officer.

20.11 **NHS England:** Discussions should take place early on with NHS England's regional office to seek their views on the need for a Child House and how funding might be found. In some cases, it may be that some of the services to be provided could be delivered in combination with other services in the sexual assault referral services pathway including those delivered by the SARC.

20.12 **Local Authority:** Local authorities fund children's social care including MASH, early help services and CSC teams. LAs could be approached to fund or second social workers for a Social Care Liaison Officer role.

20.13 **Integrated Care Systems:** NHS organisations and local councils came together in 2016 to form sustainability and transformation partnerships (STPs) covering the whole of England, and set out their proposals to improve health and care for patients. These have now evolved to form integrated care systems throughout England. In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for meeting health and care needs across an area, co-ordinating services and planning to improve population health and to reduce inequalities between different groups of the population. ICS' plans may be helpful in establishing how a Child House would fit within priorities for that area.

20.14 **Charitable funding:** Financial support may be available from corporate or philanthropic funders. Although there is in theory no clear demarcation between which services can and cannot be funded by corporate or charitable sources as opposed to public funding, there are some services which would generally be considered more acceptable to be funded from outside statutory funding sources. These include services and equipment that is seen as being over and above what the NHS and other statutory services would generally provide, such as furniture and furnishings as well as staff such as advocates (rather than the clinical staffing which would be more difficult). It may also be possible to seek funding from appropriate grant-giving agencies, such as the Big Lottery Fund.

Alternative models of delivery

20.15 There may be alternative models of delivery that could be used to fund services at the Child House. Examples include Special Purpose Vehicles such as services being delivered through social enterprises or Social Impact Bonds (SIBs). The government has encouraged the take-up of SIBs through the development of a series of funds including the Life Chances Fund, the Social Outcomes Fund and Commissioning Better Outcomes Fund (run by the Cabinet Office and Big Lottery Fund). Although it is not entirely clear how such a mechanism could be applied to fund a Child House, given the lack of an obvious single outcome to support a Payment By Results approach, these options may be worth further consideration.

Learning from overseas

20.16 Despite the major differences between CACs/Barnahus overseas, it is possible to learn from these systems to see how they have overcome some of the challenges encountered in securing long-term funding.

20.17 The context for Child Houses is different in every country and each country's safeguarding, legal and health care systems are unique, tailored to their own requirements and evolved over many years. The way in which the Child House model is developed will inevitably be a consequence of the way in which these systems have developed and how they interrelate. For example, Iceland (where the original Barnahus is based) has an inquisitorial legal system in contrast to the adversarial system in the UK and some of the legal issues which have arisen in setting-up the London pilot have therefore differed from the Icelandic experience. The way in which health and social care systems are funded will also have a significant impact on the way in which Child Houses are financed.

20.18 The literature on CACs shows the following, some of which may be helpful in considering future funding of Child Houses in England[8,9]:

- The advantages of having several sources of funding to avoid over-reliance on a single source and to spread the risk;
- The ability for Child Houses/CACs to raise funds from charitable sources even if they are primarily government-funded has helped to draw in additional income sources;
- The advantages of deriving income from a mixture of public and non-public finance including in-kind contributions in order to meet common objectives – protecting, defending and healing children. Some of the models studied have involved seconding staff from other agencies rather than employing them directly;
- The need for flexibility after the opening of the Child House so that there is scope to respond to evolving needs and the requirements of funding agencies. Allowing the Child House to meet needs other than support for those who have experienced CSAE has been beneficial and led to a broader scope than they envisaged originally (including CYP who have experienced physical abuse and the provision of community education);
- Ensuring that there is clarity about which agency is funding the Child House/CAC as early as possible;
- The importance of having government support including some initial funding, irrespective of whether the government is one of the key funding agencies in the long term. Where CACs have been successfully implemented, this has usually been with support from the government.

Importance of evaluation and data

20.19 Having comprehensive and accurate information on costs, utilisation and outcomes will be essential in securing long term funding – see chapter 12 and chapter 19. Having a plan in place to evaluate the Child House as well as the results of any evaluation showing how it impacts on CYP who have experienced CSAE will be essential to provide evidence to possible funders

Sustainability of the Child House in London

Funding the Lighthouse

20.20 The funding for the Lighthouse in London came from central government (the Home Office and the Department for Education), MOPAC and NHS England (London). In addition, £1m was contributed by Morgan Stanley as the NSPCC's Charity Partner for 2017/18.

20.21 The piloting of the Lighthouse was initially to be for two years though, because of the delays in securing the premises which meant that the service did not open until October 2018, NHS England and MOPAC agreed to provide additional funding to extend the pilot by a further 18 months. This was to allow the final evaluation findings and outcomes from the pilot to inform the key decisions about the future of the service and funding.

20.22 In anticipation of the difficulties of securing longer term funding at the end of the pilot, assuming that it was successful in terms of meeting its key aims, MOPAC commissioned RedQuadrant to carry out an options appraisal to try to find a long term funding solution. Two reports were produced which considered the possible contribution of a range of agencies with recommendations and a work programme which helped to shape the work that was carried out to secure funding.

Charitable funding

20.23 The charitable funding provided by Morgan Stanley were over and above the services commissioned as part of the Health and Wellbeing contract. It was used to pay for staff including a Development Manager, a Project Manager and Communications Manager, and five staff to deliver 'Letting the future in' (see paragraph 11.21) to support CYP in the CSA Hubs in the five London boroughs served by the Lighthouse. The funding is also being used to pay for extra rooms at the Lighthouse which can be used if demand for space exceeds demand, and to pay for the development of the website.

Community support

20.24 As well as the funding referred to above, the Lighthouse has developed strong links with the local community (voluntary organisations and local businesses) which has led to the donation of fresh fruit and milk. Members of the local community have also provided some services on a voluntary basis including decorating, and quilts which have been sewn for the CYP.

Future funding of the Lighthouse

20.25 It was agreed in January 2020 that the pilot would be extended for a further 18 months to bring it in line with the usual commissioning cycle. A sustainability sub-group was set up which met regularly to create the necessary business cases for continuation of the Lighthouse, with each partner being asked to see if they could commit recurrent funding. It took a while to secure the significant funding needed from partners, which was due in part to the timing and impact of the Spending Review as well as the continuing challenging public sector financial landscape.

Key learning points

- It is important that the long term sustainability of any Child House project is considered from its inception. Even if a pilot project proves to be successful, this does not guarantee that long term funding will be secured successfully; this needs to be addressed with all the partners at an early stage.
- A range of sources should be considered in setting up a Child House including public sector organisations (PCCs, central government grants, NHS bodies such as Integrated Care Systems and local government), philanthropic sources including the voluntary sector and corporate organisations. Donations may also be a possible source of funding for equipment and facilities. Multiple funding sources help to spread the risk though adds to the complexity of delivery.
- The difficulties of securing buy-in from such a wide range of potential commissioners and providers should not be under-estimated. Effort will be needed to address the challenges of agencies working together to deliver the services which will be available at the Child House.
- Some existing statutory services could be diverted to the Child House and therefore may not require additional funding. Commissioners may be able to provide some funding from within existing funding envelopes and advise on what additional services should be provided.
- Potential sources of funding include PCCs, LAs, ICS and NHS England though financial support may also be available from corporate or philanthropic funders.
- Lessons from Child Advocacy Centres overseas include the advantages of deriving income from public and non-public sources; the need for flexibility in being able to respond to changing needs; the importance of having government support, and ensuring that there is clarity about which agency will be providing funding as early as possible.

End Notes

1 Strategic direction for sexual assault and abuse services, lifelong care for victims and survivors, 2018-2023, NHS England.

2 Strategic direction for sexual assault and abuse services, ibid, page 9.

3 Ibid

4 Victims Strategy, HM Government, September 2018: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/746930/victim-strategy.pdf

5 Government increases funding for rape and sexual abuse victims, press release published 7th November 2018, see https://www.gov.uk/government/news/government-increases-funding-for-rape-and-sexual-abuse-victims

6 Tackling Child Sexual Abuse Strategy 2021, HM Government. See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973236/Tackling_Child_Sexual_Abuse_Strategy_2021.pdf

7 See Ministry of Justice, Victim and Witness Funding Awards, https://www.gov.uk/guidance/victim-and-witness-funding-awards

8 National Children's Alliance, Snapshot 2017, Advocacy, efficacy and funding in CACs, December 2016. See http://www.nationalchildrensalliance.org/wp-content/uploads/2018/03/Snapshot-2017.pdf

9 Promise project series, Enabling Child-Sensitive Justice, the success story of the Barnahus model and its expansion in Europe. June 2017. See http://www.childrenatrisk.eu/promise/wp-content/uploads/PROMISE-Enabling-Child-Sensitive-Justice.pdf

Chapter 21
Ensuring continuity of care

What this chapter tells you:

Transfer into the Child House from existing local services

21.1 When the Child House opens, the possibility of transferring in existing cases from other local services should be considered, particularly if the Child House is intended to replace them. Ensuring that the information needed is transferred to those working with the child or young person in the Child House will be an important element in ensuring that there is continuity of care.

21.2 Once the Child House is open, arrangements and procedures will be needed to offer the option of transfer to the Child House for CYP already receiving existing services, including SARCs, CAMHS, sexual health clinics, CSA hub services, community paediatricians, early help services.

21.3 The child or young person may wish to come for a look around first to meet the team and to help them decide whether they wish to attend for support. Alternatively, the child or young person may wish to remain with their existing support services, and the Child House could offer expert advice and guidance to the professionals working in local services.

Transfer out from the Child House to other services

21.4 Local arrangements should be made to facilitate the smooth transfer of children, young people and their family members to other local services which may be required such as specialist mental health services (for example, eating disorder services), substance misuse services, housing, domestic abuse services, adult mental health services for parents, children's social care services including social work teams, targeted youth and CSE services and family intervention early help services.

21.5 CYP may prefer their long-term support to be provided locally and not in the Child House. In these cases, local arrangements should be made to facilitate their transfer to other local services such as CAMHS, school counselling. The Child House should continue to offer advice and guidance to those local services as required. There should be agreements in place with these other services which cover, for example, waiting lists – ideally, a child or young person who is referred to another service should not have to wait to receive that service.

Transfer of the young person to adult services

21.6 How long young people can be treated at the Child House and the age groups covered will depend on the arrangements agreed with commissioners. This may be up to 18 for new referrals but with a higher upper age limit for those with learning disabilities who would benefit from receiving services in a young person-friendly facility. Agreement should be reached as to how long after the age of 18 (or 25) young people will be able to continue to receive treatment at the Child House.

21.7 Some young people may require referral to adult services such as adult mental health (including specialist) services, adult social services or sexual health services as they reach the upper age limit for receiving services in the Child House. Preparations will need to be made well in advance and discussed with the young person and his or her family. Those of the principles set out in the NICE guideline on transition [NG43] to adult services[1] and in the Quality Standard[2] which are relevant should be observed. Support should be given to the young person to ensure that the transition works effectively and is planned with them and their family members.

21.8 Work is currently in hand to develop a new approach to young adult mental health services for people aged 18-25 to support the transition to adulthood. The new model will deliver an integrated approach across health, social care, education and the voluntary sector. This may affect the way in which young people receiving treatment for mental health conditions at a Child House transition to adult mental health services.[3]

Referral of parents and carers

21.9 Many of the parents and carers presenting will have needs of their own which may become apparent, particularly if the abuse experienced by their child triggers memories of their own abuse. It may be necessary for some of these issues to be addressed before it is possible to embark on therapeutic work with the child or young person. In these circumstances, it may be helpful for a referral to be made to trauma or adult mental health services. Independent domestic and sexual violence advocates may also have a role in providing support for some parents; these pathways should be set up and supported, especially as it may be beneficial for the parent to be accessing help separately from the child or young person.

21.10 Good links with voluntary sector organisations will be needed to provide support for non-abusing parents on a wide range of issues (for example, to provide advice on benefits, domestic abuse, housing and immigration).

Availability of outreach services

21.11 The possibility of putting in place outreach services for the Child House should be considered, particularly in areas where there would otherwise be a need to travel long distances to the Child House (particularly in rural areas or where the Child House is intended to cover a large geographical area). Providing outreach services, though time-consuming for the staff who are required to work away from their main base, is likely to increase the number of CYP accessing the Child House's services, thereby ensuring continuity of care and improving outcomes.

21.12 The option of a Hub and Spoke model should be considered for larger geographical areas, with the expertise of clinical leadership, expert practitioners, medical and sexual health examinations, Video Recording interview (VRI) and live link facilities centralised in the Hub. The 'Hub' could provide expertise, training and resources and learning for the whole area as well as interventions for acute presentations of CYP across the whole area (including forensic services where these are being provided in the Child House) and longer term support for CYP who are geographically closer. After the VRI in the Hub, the immediate assessment and long term support for local CYP could be provided by the spokes, including advocacy, therapeutic support and medical/sexual health (assessment outside the forensic window and follow-up). Support from the Hub may be sought as required. Each spoke will need to develop effective relationships with providers, including Local Authorities, on their patch with support from the Hub sought as required.

Transfer of criminal justice cases

21.13 In sexual offences cases, the police area in which the victim reports the crime is responsible for providing support and for capturing the evidence. This includes obtaining physical evidence (such as telephones, and clothing), forensic evidence (using an Early Evidence Kit, swabs, and any evidence obtained in the SARC) and the interview (including the VRI and completion of the MG11 form). If a child or young person reports the assault in one part of the country but the offence has been committed elsewhere in the UK, it would be passed to that Police Service/Constabulary to progress. This is governed by Home Office rules concerning the transfer of crimes from the reporting force to the investigating one. The PLO in a Child House where a child or young person was referred who had been assaulted elsewhere would need to liaise with the police in the area in which the assault had taken place. The SCLO in a Child House where a child or young person was referred who had been assaulted elsewhere would liaise with children's social care undertaking the Section 47 investigation.

21.14 If the offence has been committed overseas, there are circumstances in which a prosecution could be brought in the UK.

However, the 'home' (UK) police may assist in the transfer of this crime to another jurisdiction if needed. Support could still be provided at the Child House, however, irrespective of where the abuse had taken place and the Police Liaison Officer's role would remain the same.

Continuity of care in the event of closure of the Child House

21.15 In the event that the Child House closes, arrangements should be made to ensure continuity of care for those receiving services with the aim of minimising disruption. Referrals to other services should be made in discussion with the child or young person and the family to ensure that there is continuity of care and that it is accessible as possible.

Continuity of care in London

Transferring cases from the CSA Hub

21.16 Some of the initial caseload at the Lighthouse (29 cases) was derived from cases transferred from the CSA Hub which was based on two sites in North Central London. This meant that the staff taking up post had a readymade workload from the time the Child House opened and CYP had continuity of care when the Lighthouse opened. Additionally the CSA hub staff applied for and were given new roles in the Lighthouse and so, for most CYP, there was also continuity of worker. There were also 10 CYP transferred to the Lighthouse from the CYP Haven during the first year of operation.[4]

Outreach services

21.17 The advocates and therapists at the Lighthouse offer sessions in the child or young person's local area once they are referred if there are difficulties with travel distances or the ability to pay for travel. This enables them to access services where they might otherwise find it difficult to do so and may also be helpful in ensuring they do not miss school (for example, where they are able to meet the advocate in school). This has helped to increase referral numbers, particularly from the more distant London boroughs.

21.18 Advocate engagement in the child's local area has also helped develop effective partnerships between the local schools and safeguarding leads within the school and the Lighthouse. This has built confidence amongst school staff and managing CYP who have experienced abuse.

Age of young people seen at the Lighthouse

21.19 CYP are not turned away if they are nearing 18 years, but the Lighthouse will not accept a referral of a young person 18 or over, except for those who have a learning disability up to

Case study:

Esme was a 16 year old girl who had been sexually abused in Africa by an elder in the village. She was trafficked to the UK and, at the point of referral from the unaccompanied asylum seekers service, Esme was struggling alone with post-traumatic stress disorder (PTSD), depression, anxiety and was malnourished. She did not know how to access community health and care services. Before attending the Lighthouse, the advocate spent time out in the community meeting Esme: visiting her at home, sharing meals together, or in cafes.

As she built up trust with the advocate, Esme attended the Lighthouse for an initial appointment with the team and was able to access ongoing therapeutic support, sexual health treatment, to gain weight and build self-esteem. The advocate continued to work closely with Esme, ensuring her voice was heard when other services were planning for her future such as a housing move and transition to adult services at 18 years old. Esme is currently attending college and starting an apprenticeship.

the age of 25. If a young person is referred at the age of 17, they can carry on receiving treatment until the case is closed, irrespective of their age.

Referral to local services

21.20 CYP and their parents are referred on to local services in a variety of situations. CYP with significant suicidal ideation or intent are referred to local CAMHS who can provide 24 hour access to support through their Crisis Teams. Parents are referred on to specialist services such domestic violence services or adult mental health services for those who disclose their own childhood sexual abuse which may be triggered by their child's own experience of abuse. CYP who prefer a more local service are sometimes referred to local school counsellors or youth workers. CYP and their carers are also referred to Children's service for safeguarding support as well as the CSC specialist services.

Key learning points

- Arrangements should be agreed in advance of the opening of the Child House about the transfer in of CYP from other services.
- Procedures and criteria should be agreed for referrals into the Child House so that local teams can be trained and appropriate referrals encouraged.
- Referrals to other services from the Child House are also likely to be needed, for both the child or young person and for other family members. Local arrangements should be made which determine how these are effected and agreement reached about issues such as waiting times.
- Agreement should be reached based on the contract as to the age ranges of the CYP to be served by the Child House, including those with learning disabilities for whom there may be a higher upper age limit. Clarity is needed as to what happens to young people being seen when they reach the upper age limit.
- Some young people may require referral to specialist services such as domestic violence or sexual health services; arrangements will need to be made to ensure that preparations are made to do so well in advance and support offered to the young person and his or her family.
- Some parents/carers may require referral to adult mental health services or specialist services that can support with domestic violence, housing or immigration.
- The provision of outreach service, particularly for the therapeutic interventions, should be considered depending on the geographical footprint of the area – this may help to enhance accessibility and increase update of services, particularly in rural areas.

Checklist for setting up a Child House

- ○ Have arrangements been made to transfer cases to the Child House and have these been agreed with local services?
- ○ Have procedures for referring CYP into the Child House been agreed and are these clear?
- ○ Is there clarity about the age groups to be offered services at the Child House? Are there different arrangements in place for CYP who are learning disabled?
- ○ Depending on the geographical characteristics of the area, has consideration been given to the possible use of outreach services to promote accessibility across the area covered by the Child House?
- ○ In the event of closure of the Child House, are there clear arrangements in place to provide ongoing care for those who are currently being seen?

End Notes

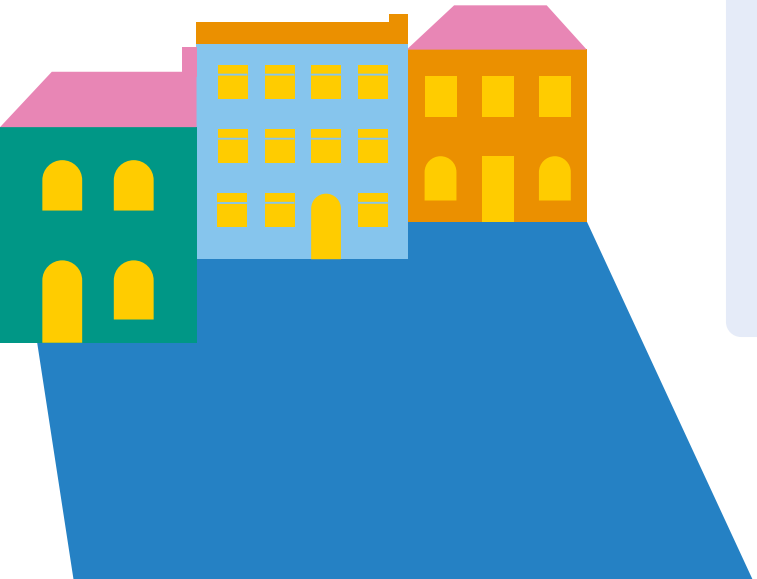
1 See NICE guideline on transition from children's to adults' services for young people using health or social care services [February 2016] https://www.nice.org.uk/guidance/ng43/chapter/Recommendations

2 See Quality Standard on Children's to Adults' Services [December 2016] https://www.nice.org.uk/guidance/qs140

3 NHS Long Term Plan, see www.longtermplan.nhs.uk, page 51.

4 The Lighthouse Annual Report, 2018-2019, page 19.

Chapter 22
Conclusions



Chapter 22: Conclusions

22.1 This toolkit sets out what local areas need to know as they embark on the journey to establish a Child House. It is drawn from a wide range of documents and guidance as well as the early experience of the Lighthouse in North London.

22.2 As the first Child House in the country, the Lighthouse was intended as a step change in the services available to children and young people affected by child sexual abuse and exploitation. The evaluations will show to what extent the intended aims have been met.

22.3 Much has been learned, and will continue to be learned along the way. However, whilst it is still early to reach firm conclusions about the effectiveness of the Lighthouse, it is worth noting that it has delivered a service broadly in line with the vision conceived by stakeholders. Some additional services were included which were not part of the original plan including:

- a consultation and liaison service, whereby practitioners working with children and young people locally are advised by staff at the Lighthouse but without a direct consultation with the child or young person;
- working with schools to train and support staff;
- sexual health and contraception service
- parent education courses
- young people's group.

22.4 It is also worth noting that the complexity of the cases has been far greater than envisaged initially – the CYP attending have a greater range and depth of vulnerabilities than was anticipated. This has necessitated a change in skill mix in favour of therapeutic support from CAMHS. Most children and families access multiple services in the Lighthouse.

22.5 Although the number of referrals to the Lighthouse so far is lower than was initially estimated, it is assumed to be meeting previously unmet need, with a range of agencies delivering a comprehensive range of high quality multidisciplinary services in one place.

22.6 Decisions will be needed over the next year as to the long term funding of the Lighthouse for which funding has been secured until March 2022. The final evaluation will also be available which will consider the outcomes for those using the Lighthouse.

22.7 The future of the Lighthouse relies on recurrent funding from muliple agencies which has yet to be finalised.

Chapter 23
Appendices

Appendix A: Timeline for establishing the Child House pilot

Event	Timing
Barnahus opened in Iceland	1998
Lanzarote Convention ie the Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse	October 2007
Start of section 28 pilot	Piloted in three Crown Courts in 2014
London CSA Transformation Programme launched (three year programme funded by NHS England (London) and hosted by Kings College University Hospital NHS Trust)	April 2014
Establishment of EU Promise project	Promise 1 2015-2017 Promise 2 2017-2019
Review of pathway following sexual assault for children and young people in London – review by Dr Andrea Goddard, Emma Harewood and Dr Lauren Brennan	March 2015
Protecting children from harm: a critical assessment of child sexual abuse in the family network in England and priorities for action (2015): final report of the Children's Commissioner inquiry into child sexual abuse in the family environment	November 2015
Bid submitted to Police Innovation Fund 2016/17	December 2015
Notification of Home Office funding	March 2016
Children and Young People's Haven opened at King's College Hospital	April 2016
Department of Health £90K funding made available for a one-year pilot to create two hubs of medical and emotional support for victims of CSAE in North Central London as part of a wider project looking at how to deliver a joined up and transformative service to CYP who are sexually abused and how the support should be case-managed for every child user.	2016/17

Event	Timing
Confirmation of funding from Police Innovation Fund	March 2016
Barnahus: Improving the response to child sexual abuse in England – report by the Office of the Children's Commissioner	June 2016
CSA Hub in North Central London opened on two sites (St Ann's Hospital in Haringey and University College London Hospitals NHS Foundation Trust)	July 2016
Children's Social Care Innovation Programme bid submitted	July 2016
Publication of the Office of the Children's Commissioner's report, Barnahus: Improving the response to child sexual abuse in England	September 2016
Sexual violence against children and young people – the London sexual violence needs assessment 2016 for MOPAC and NHS England (London) – report by mbarc research and consultancy	November 2016
CSA Hub opened in South West London	December 2016
Second bid submitted to Home Office's Transformation Fund	March 2017
Confirmation of funding from Transformation Fund	Summer 2017
Decision to go out to tender for health and wellbeing service	July 2017
MOPAC (Rebecca Lawrence) took over as Chair of Programme Board	October 2017
Service specification for lead provider of health and well-being services for Child House Pilot issued by NHS England (London)	October 2017
Award of contract to Lead Provider for health and wellbeing services	February 2018
UK Government ratified the Lanzarote Convention	June 2018
Lighthouse opened	October 2018

Appendix B: Commissioning responsibilities for sexual assault referrals services

Commissioning responsibility	Service
NHS England	Sexual Assault Referral Centres (SARCs) responsible for forensic medical examinations, medical care/support and follow up services in SARCs with Police and Crime Commissioners/Police
	Child and adolescent mental health services Tier 4 (CAMHS Tier 4)
	Contraception provided as an additional service under the GP contract
	HIV treatment and care (including drug costs for HIV post-exposure prophylaxis following sexual exposure (PEPSE))
	Promotion of opportunistic testing and treatment for sexually transmitted infections (STIs) and patient-requested testing by GPs
	Sexual health elements of prison and Immigration Removal Centre health services
	Cervical screening
	Specialist foetal medicine services
Clinical commissioning groups	Mental health and Improving Access to Psychological Therapies (IAPT); services for depression and Post-Traumatic Stress Disorder (PTSD) that understand the specific needs of victims and survivors of sexual assault and abuse, including the third sector
	Most abortion services
	Sterilisation
	Vasectomy
	Non-sexual health elements of psychosexual health services
	Gynaecology, including any use of contraception for non-contraceptive purposes
	Secondary care services, including A&E

Commissioning responsibility	Service
Clinical commissioning groups (continued)	NHS 111
	Sexual health services for children and young people including paediatric care/support
	Specialist voluntary sector services (in some areas)
	Ambulance/blue light services
Police and Crime Commissioners	Specific commissioning responsibilities for victims, including victims of sexual assault and abuse
	Specialist voluntary sector services
	Police 101
	In some forces, the police lead on the procurement of SARC services
Local authorities	Comprehensive sexual health services, including most contraceptive services and all prescribing costs (excludes additional services commissioned from primary care)
	STI testing and treatment, chlamydia screening and HIV testing
	Specialist sexual health services, including young people's sexual health teenage pregnancy services, outreach, HIV prevention, sexual health promotion and services in schools, colleges and pharmacies
	Specialist voluntary sector services
Ministry of Justice	National Male Survivor helpline
	Rape support services with dedicated emotional and practical support services for victims of rape and other forms of sexual abuse aged 13 or over
Home Office	National services for victims of child sexual abuse

Appendix C: List of abbreviations

ABE	Achieving Best Evidence
CAC	Child Advocacy Center
CAIT	Child Abuse Investigation Team
CCG	Clinical Commissioning Group
CJS	Criminal Justice System
CPS	Crown Prosecution Service
CSA	Child Sexual Abuse
CSAE	Child Sexual Abuse and Exploitation
CSE	Child Sexual Exploitation
CYP	Children and Young People
DAT	Drug and Alcohol Team
EMDR	Eye Movement Desensitisation and Reprocessing therapy
HMCTS	Her Majesty's Courts and Tribunals Service
KPI	Key Performance Indicator
LA	Local Authority

MASH	Multi-Agency Safeguarding Hub
MPS	Metropolitan Police Service
NELCSU	North East London Commissioning Support Unit
PCC	Police and Crime Commissioner
RASSO	Rape and Serious Sexual Offences
SARC	Sexual Assault Referral Centre
STI	Sexually Transmitted Infection
STP	Sustainability and Transformation Plan
YOS	Youth Offending Service