Notice of Meeting

CHILDREN'S SERVICES SELECT COMMITTEE

Monday, 18 January 2016 - 6:30 pm
Committee Rooms 1 & 2, Civic Centre, Dagenham

Members:  Cllr John White (Lead Member), Cllr Melanie Bartlett (Deputy Lead Member), Cllr Simon Bremner, Cllr Edna Fergus, Cllr Elizabeth Kangethe, Cllr Moin Quadri and Cllr Danielle Smith

Co-opted Members (for education related matters):
Faith Representatives: Mrs G Spencer (Roman Catholic Church) and Ms I Robinson (Church of England)
Parent Governor Representatives: Mrs T E Dahunsi (Primary) and Tracy MacDonald (Secondary)
Youth Representative: Rao Khan (Chair, BAD Youth Forum)

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AGENDA

1. Apologies for Absence

2. Declaration of Members' Interests

   In accordance with the Council’s Constitution, Members are asked to declare any interest they may have in any matter which is to be considered at this meeting.

3. Minutes - To confirm as correct the minutes of the meeting held on 16 November 2015 (Pages 3 - 7)

4. Health Visiting Update Report (Pages 9 - 22)

5. Work Programme (Page 23)

6. Any other public items which the Chair decides are urgent
7. To consider whether it would be appropriate to pass a resolution to exclude the public and press from the remainder of the meeting due to the nature of the business to be transacted.

Private Business

The public and press have a legal right to attend Council meetings such as the Children’s Services Select Committee, except where business is confidential or certain other sensitive information is to be discussed. The list below shows why items are in the private part of the agenda, with reference to the relevant legislation (the relevant paragraph of Part 1 of Schedule 12A of the Local Government Act 1972 as amended). There are no such items at the time of preparing this agenda.

8. Any other confidential or exempt items which the Chair decides are urgent
Our Vision for Barking and Dagenham

One borough; one community; London’s growth opportunity

Encouraging civic pride

- Build pride, respect and cohesion across our borough
- Promote a welcoming, safe, and resilient community
- Build civic responsibility and help residents shape their quality of life
- Promote and protect our green and public open spaces
- Narrow the gap in attainment and realise high aspirations for every child

Enabling social responsibility

- Support residents to take responsibility for themselves, their homes and their community
- Protect the most vulnerable, keeping adults and children healthy and safe
- Ensure everyone can access good quality healthcare when they need it
- Ensure children and young people are well-educated and realise their potential
- Fully integrate services for vulnerable children, young people and families

Growing the borough

- Build high quality homes and a sustainable community
- Develop a local, skilled workforce and improve employment opportunities
- Support investment in housing, leisure, the creative industries and public spaces to enhance our environment
- Work with London partners to deliver homes and jobs across our growth hubs
- Enhance the borough’s image to attract investment and business growth
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MINUTES OF
CHILDREN'S SERVICES SELECT COMMITTEE

Monday, 16 November 2015
(6:30 - 8:20 pm)

Present: Cllr John White (Chair), Cllr Melanie Bartlett (Deputy Chair), Cllr Edna Fergus, Cllr Irma Freeborn, Cllr Elizabeth Kangethe, Cllr Moin Quadri and Cllr Danielle Smith, Mrs I Robinson and Rao Khan

Apologies: Cllr Simon Bremner and Toluwalope Elizabeth Dahunsi

11. Declaration of Members' Interests

There were no declarations of interest.

12. Minutes - 20 July 2015 and 30 September 2015

The Children’s Services Select Committee (CSSC) confirmed that the minutes of the meeting held on 20 July 2015 were correct and noted the summaries of the issues discussed at the inquorate meeting on 22 September 2015.

13. School Performance and Results 2015

The Head of School Improvement (HIS) delivered a presentation, “School Performance and Results 2015” which provided data on the following:

- Early Years Foundation Stage Profile 2015
- Key Stage 1 (age 7)
- Key Stage 2 (age 11)
- Key Stage 4 GCSE
- Post 16

The Corporate Director, Children’s Services (CDCS) stated that this year’s GCSE Maths results were a key concern. Leadership for Maths did not appear to be as strong as it was for English and the Council’s school improvement team would be working closely with secondary schools to look at this. The HIS stated that there was also a national issue around Maths teachers leaving schools to work for other schools which were offering more financial incentive. Furthermore, Maths examinations had been more challenging this year due to the raising of standards in the specification, and there had also been a shift in the grade boundary, which meant many pupils who would have previously achieved a ‘C’ grade, achieved a ‘D’ grade. In response to questions the HIS stated that mock tests indicated overall, that the Maths results would generally be at similar level last year’s results.

In response to questions the HIS stated that GCSE science results had remained relatively positive despite problems in recruitment and that whilst a lot of work was being undertaken on getting spoken language strong, too many children were not using these skills in writing.

Members commended schools and the school improvement team for their
contributions to the very positive outcomes at the Early Years Foundation Stage. However, they expressed concern at a disappointing set of GCSE results and emphasised the importance of focusing on what could be done to improve results next year, particularly, the retention of good maths teachers. The HIS stated that it was common for teachers across subjects to leave London in their late twenties to start families in locations where accommodation was much cheaper. He added that the Council had developed a strategy to support teachers with accommodation, which would hopefully prevent some teachers from leaving the borough’s schools to work elsewhere.

14. Corporate Parenting Scrutiny

The Lead Member of the Committee, Councillor White, explained that the CSSC wished to obtain an understanding of the Council’s performance as a “Corporate Parent” at today’s meeting and at a later date, the Committee would consider what could be put in place to support all members of the Council be more familiarised with the Council’s corporate parenting function.

The Cabinet Member for Children’s Services and Social Care (CMCSSC) stated that given there were currently 417 looked after children in the Council’s care, he welcomed the opportunity for the CSSC to consider ways to embed corporate parenting into the mindset of all council members. He added that Corporate Parenting must be considered against the backdrop of a very difficult financial situation within Children’s Services, child poverty levels and welfare reforms, which made current times particularly challenging for many families in the borough as well as the Council.

The CDCS provided context and background to the governance of Corporate Parenting in the Local Authority and the various services and arrangements in place to monitor the progress and development of looked after children in different aspects of their lives, including health and education. She also explained the arrangements in place to listen to and where possible, give effect to the voice of looked after children.

In response to a question, the CDCS stated that a breakdown of how many children were placed within the borough and how many were placed outside of borough could be provided to members at a later date. The Group Manager for Looked after Children, Adoption & Prevention Services (GMLACS) stated that whilst the Council wished to place all looked after children within the borough, it inevitably had to place some children out of the borough. The average size of homes in the borough was significantly smaller than homes in neighbouring boroughs, which meant that many people, who were interested in fostering, could not foster because they did not have the space to accommodate an additional child. Furthermore, the borough had a relatively high number of sibling groups which exacerbated that problem. It was important to keep siblings together as far as possible so often siblings were placed in neighbouring boroughs within one family with foster carers who had larger homes. Nonetheless, the Council still worked hard to maintain a good level of foster carers within the borough to maximise opportunities for looked after children to be placed in the borough. Many children who were placed in neighbouring boroughs, still went to schools within Barking and Dagenham. It was hoped that as the Council built more homes as part of its growth initiatives, more children would be placed in the borough, in future.
Members asked whether the Council could offer financial help to potential foster carers for extending their homes to create more space to take on looked after children. The GMLACS stated that financial help for creating more space in homes was offered in a limited range of circumstances, for example, if the looked after child in question was disabled. Financial help for extensions was not offered more widely because the process could become very complicated and expensive. The Divisional Director for Children's Complex Needs and Social Care (DDCSC) stated that the Council would have to exercise caution in offering such help because it did not want to attract people to becoming foster carers merely for the financial incentives. She cited an example she had come across were extension works funded by a local authority to accommodate a looked after child had lead to an increase in value of approximately £30,000 to a person’s house.

The GMLACS stated that the borough was part of a fostering consortium in London and was the highest performer within the consortium for recruiting foster carers. The turnover of foster carers in the borough was very low due to the good quality training and excellent support that was available. Furthermore, the Council’s pay to foster carers was the same as agency rates so there was more incentive for people to become “internal” foster carers, rather than agency ones.

In response to questions, the CDCS stated that the turnover in social workers for looked after children used to be very high which would not have had a positive impact on looked after children. The turnover was currently relatively high but more stable than previously. The Council still used agency social workers; however, these staff had worked for the Council for a number of years so could offer continuity to the looked after children they worked with. She added that there was more instability in the teams that provided early support when compared with the Leaving Care team, for example.

Members asked what ‘other placements’ were in relation to information in the report which described the types of placements there were for looked after children and the number of looked after children in each category. The GMLACS stated that this category referred to children who were looked after by a connected person such as a relative or family friend and that these people were encouraged to apply for a special guardianship order, which offered a certain level of legal security.

Members asked what the arrangements were for supporting looked after children with their education. The CDCS stated that most looked after children went to mainstream schools so their lower performance in school (in comparison to other children) was generally, not down to the quality of teaching but rather, as a result of going through trauma and having to catch-up. A ‘Virtual’ School and Headteacher were in place to monitor and track the attainment, progression, attendance, exclusion of looked after children and put in place support where needed. Schools also received money in the form of the Pupil Premium Plus allowance which they should use to prevent looked after children from falling behind their peers in their education, or helping them to catch-up if they had already fallen behind. The Virtual School’s Head Teacher had responsibility and is accountable for ensuring that there were effective arrangements in place for allocating Pupil Premium Plus funding. Every looked after child should also have a Personal Education Plan (PEP), a plan for addressing their needs and to improve their attainment. The PEP is an individualised document with different individuals inputting into it, such as the young person’s social worker, teacher, foster carer...
and sometimes the young person themselves and is subject to scrutiny by the Virtual Headteacher. In response to a question, the CDCS stated that PEPs should be reviewed every six months. Currently, this was not happening in a timely manner for every looked after child and this was being regularly monitored by management.

Members asked how children from ethnic minority or mixed race backgrounds were placed. The CMCSSC stated that the message behind the Government’s reforms around adoption was that ethnicity should not be a bar to adoption. However, many people still felt that there should be a ‘match’ between the adopters’ and child’s ethnicity. The GMLACS stated that in practice, most people wanted a child who reflected themselves and there was some research to show that transracial placements did not always work well. Before placing children from ethnic minority backgrounds, including children who were mixed race, the Service would consider a range of factors including, who the child loved with previously, for example. Therefore, whilst the ethnicity of prospective adopters was a very important factor in placing a child, each case would be decided based on the child’s best interest, and would not necessarily always be determined by ethnicity. There was now a national Adoption Register, which enabled local authorities to search across the country for people who were approved to adopt.

In response to a question, the GMLACS stated that the achievements of looked after children were celebrated and acknowledged in various forums, for example, through the Leaving Care Awards.

Councillor Bartlett suggested that councillors who were local authority school governor representatives could be encouraged to take corporate parenting issues to their school’s governing body meetings every so often. The CDCS said she would take this suggestion away for further consideration outside of the meeting.

Councillor White brought discussions to a close due to time constraints and members asked whether there would be an opportunity to receive answers to the further questions members had hoped to ask regarding the Council’s performance as a Corporate Parent. The CDCS replied that any pending questions would be answered in written form and supplied to the Committee at a future meeting.

Councillor White thanked officers and the CMCSSC for attending the meeting, answering the CSSC’s questions, and taking part in discussions.

15. Anti-bullying workshops designed by the BAD Youth Forum

The CSSC noted that at the last meeting, which was inquorate, members of the Barking and Dagenham (BAD) Youth Forum presented a report and delivered a presentation in relation to two anti-bullying workshops the Forum wished to be delivered in the borough’s secondary schools and youth groups. Members who were present at the meeting praised and supported the concept and delivery of the workshops.

Rao Khan, the Chair of the BAD Youth Forum, provided an update on the delivery of the workshops since the meeting to date, which had resulted in positive feedback from the schools and young people who had taken part.

Councillor White stated that the report made a number of recommendations and
as the last meeting was inquorate, it was important for the Committee to formally decide whether it supported the recommendations. The recommendations were as follows:

(i) “To raise awareness of the work of the Forum;
(ii) “Encourage schools across the borough to actively participate and ask them to nominate appropriate students to participate in each of the workshops;
(iii) “To contact schools to monitor their progress and gage how successfully they have integrated the workshop into their school, and if they are continuing to deliver it to students and;
(iv) “That the Corporate Director of Children’s Services, Helen Jenner, is to include the workshop in her regular update to Head Teachers, encouraging them to nominate a member of staff to liaise with the BAD Youth Forum.”

The Committee agreed that Councillor White should write to Councillor Carpenter, the Cabinet Member for Schools and Education recommending that she progress recommendations one and two. The Committee agreed that officers in Children’s Services should progress with recommendation three and report back to the CSSC in the next municipal year on progress.

The CDCS agreed to progress recommendation four. Furthermore the CDCS and Rao Khan agreed to write a joint letter to schools to raise awareness of the workshop and encourage its take-up.

16. Verbal Feedback from the Governor’s Conference

Councillor White and Ingrid Robinson provided verbal feedback to the Committee from their workshop at the Governors’ Conference on 19 September 2015 which focussed on the observations arising from three school visits CSSC members carried out between March and April 2015. Overall, governors who took part in the workshop were positive about what came out of the visits and said that they would take the observations back to their governing bodies for further discussions.

Ms Robinson asked whether the pack containing the notes from the visits could be used somehow for training governors. The CDCS stated that she would take this away for consideration with colleagues in the school improvement team.

17. Work Programme

Members noted the latest version of the Work Programme and following discussions, agreed to make the following amendments:

- Answers to questions relating to Corporate Parenting, which could not be asked at today’s meeting due to limitations on time, should be provided to the 18 January 2015 meeting for noting.
- The Health Visiting report scheduled for the 18 January meeting should be for noting only.
- An item on the Safe Programme, which would focuss upon delivering the Council’s duties and priorities for children and young people, in the context of a very challenging financial situation, should be presented at the 14 March 2016 CSSC meeting.
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Title: Update on the transfer of 0-5 years’ Healthy Child Programme (health visiting) services to the local authority

Report of the Director – Children’s Services / Director of Public Health

Open Report For Information

Report Author: Michelle Williams (Interim Head of Pubic Health Commissioning) Contact Details: Tel: 020 8227 2311
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Accountable Divisional Director: Matthew Cole (Director of Public Health)

Accountable Director: Helen Jenner (Corporate Director for Children’s Services)

Summary:

On 1 October 2015, local authorities assumed responsibility from NHS England for commissioning the national Healthy Child Programme (HCP) for infants and children up to 5 years old under section 6C of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

Local authorities have a responsibility to promote and protect the health of their residents, tackle the causes of ill health and reduce health inequalities (Local Government’s new public health functions, Department of Health 2011). Commissioning high-quality public health services for children aged 0–5 as part of the HCP can help to achieve this. The HCP is available to all resident children and aims to ensure that every child gets the good start they need to lay the foundations for a healthy life.

The 0-5 HCP includes health visiting and the Family Nurse Partnership programme (a targeted support service for teenage mothers). Health visiting services are a key component of the 0-5 years HCP and support infants and children to achieve the best possible health outcomes. Public Health and Children’s Services play an important role in ensuring that children’s needs are identified in a timely manner and that families are supported to access the services they need.

The transfer of the commissioning responsibilities has been highlighted by the Barking and Dagenham Council’s Public Health Children’s Board as an opportunity to link the 0-5 HCP with the 5-19 HCP (school nursing and National Child Measurement Programme) that transferred to the Council in April 2013. It will also enable the services to link with wider systems including Early Years’ services and enable better integration of children’s services. This recognises the significant impact that a joined up approach to commissioning primary prevention, early identification of need and early intervention can have on ensuring positive outcomes for children and young families in line with priorities set out in the Council’s Ambition 2020 programme.
The purpose of this report is to update the Children's Services Select Committee on the progress following the transfer of commissioning responsibilities for the 0-5 HCP services (health visiting) to the London Borough of Barking and Dagenham (LBBD) from October 2015, and to set out the proposals for the development of an evidence-based service model for 0-19 services in Barking and Dagenham following appropriate provider market engagement and development of a procurement strategy, as outlined to Cabinet in June 2015 (see background paper).

**Recommendation(s)**

The Committee is recommended:

(i) To note the progress being made to deliver the national 0-5 Healthy Child Programme (Health Visiting) following the transfer of commissioning responsibilities to the LBBD on 1 October 2015, and

(ii) To note the proposals for closer integration of the Early Years’ services and 0-19 HCP offer.

**Reason(s)**

This report relates to the Council’s obligations to deliver the nationally mandated 0-5 HCP services under section 6C of the NHS 2006 (as amended by the Health and Social Care Act 2012) which is linked to the delivery of corporate priorities and indicators as set out in the Ambition 2020 programme, the Health and Wellbeing Strategy, Children and Young Person’s Plan and the Public Health Outcomes Framework.

1. **Introduction and Background**

1.1 On 1 October 2015, local authorities assumed responsibility from NHS England for commissioning the national Healthy Child Programme (HCP) for infants and children up to 5 years old under section 6C of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

1.2 The HCP is the Government’s prevention and early intervention evidence-based public health programme for children, young people and families. The 0-5 HCP includes health visiting and the Family Nurse Partnership programme (a targeted service for teenage mothers). It is central to the universal service for children and families and aims to support parents at this crucial stage of life, promote child development, improve child health outcomes and ensure that families at risk are identified at the earliest opportunity. It focuses on providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting.

1.3 The Council prepared for the transition of these functions via a transition steering group with representation from the Divisional Director of Children’s Services, the Director of Public Health, North East London NHS Foundation Trust (NELFT) and NHS England. Financial, reputational, contractual and organisational risks associated with the transfer were identified and managed via the project group, and highlighted to the appropriate strategic boards.
1.4 From 1 October, the 0-5 HCP services have been delivered by NELFT in Barking and Dagenham.

**Funding**

1.5 The funding for the 0-5 HCP also transferred to local authorities, and as of 1 October 2015 it is a stated resource allocation within the ring fenced Public Health Grant.

1.6 In 2014, NHS England undertook a baseline agreement exercise to establish the costs of the contracts that were to transfer to the Council. The Council had raised concerns as to whether the amounts transferring from NHS England were an accurate reflection of the lift and shift principles and to ensure that the service could be delivered effectively within the stated budget and that there would be no cost pressures to the Council at point of transfer in October 2015.

1.6 The final allocations were published in February 2015 to reflect any agreed adjustments. The LBBD allocation for 2015/16 (part-year commencing 1 October 2015) is £2,512,000 covering both health visiting and Family Nurse Partnership services. This equates to a full-year effect of £5,024,000. Therefore, the estimated contract value is £15,072,000 for 3 years.

1.7 Although the final allocation for 2015/16 is £102K greater than the amount initially announced by the Department of Health, there is a potential pressure of around £270K which will have to be contained within the reducing Public Health Grant. It should be noted that reductions in the future Public Health Grant allocations were announced in November 2015, following the Advisory Committee on Resource Allocation (ACRA) consultation and the Comprehensive Spending Review. There is a risk that funding of the 0-5 HCP at the required levels under the Government’s Call for Action (to increase health visitor staffing levels) will not be adequate to commission the existing services without putting further pressure on the Council’s Public Health Grant going forward.

1.8 Options for reducing the financial risk whilst ensuring that the Call for Action requirements and service outcomes are met have been discussed at the Council’s Public Health Children’s Board (see section 3 – Proposals).

**Scope of the 0-5 HCP transfer**

1.9 The scope of the transfer included universal and targeted elements of the 0-5 HCP, specifically:

- Health Visiting services (universal and targeted services)
- Family Nurse Partnership services (targeted services for teenage mothers).

1.10 The following commissioning responsibilities have remained with NHS England:

- Child Health Information System (CHIS) – this is in order to improve system functionality nationally, although a commitment has been made by the Department of Health (DH) to review the responsibility for commissioning in 2020.
The 6-8 week GP check (also known as Child Health Surveillance) - due to the nature and complexity of commissioning arrangements NHS England determined there is both a risk and little or no return to be gained from transferring this responsibility.

2. **Delivery of the 0-5 HCP from 1 October**

2.1 Following approval by the Health and Wellbeing Board on 17 March 2015 a new contract to deliver the 0-5 HCP was directly awarded to the incumbent provider, NELFT, for a period of 2 years with an option to extend for a further year (3 years in total).

2.2 The approval of a direct award was on the basis that the current market for suitable health visiting providers is relatively limited / under developed as these services have historically been performed within the NHS and as such there is a shortage of private sector and non-geographic NHS providers. The contract duration period allows for an assessment of the provider market and the development of a procurement strategy for the commissioning of more cost-effective services, as outlined in the Cabinet paper of June 2015.

2.3 From 1 October, the 0-5 HCP universal mandated service elements have continued to be delivered by NELFT, in line with the Department of Health's recommended service model.

**Health visiting service model**

2.4 There have been changes to both the design and delivery of health visiting services in recent years. In terms of delivery, the Department of Health have established a new Health Visiting ‘4-5-6’ service model (set out below and detailed in Appendix A), which is based on delivery of a 4 tier service, with 5 core health reviews mandated for a minimum of 18 months, and a focus on 6 high impact areas designed to improve access, experience, outcomes and reduce health inequalities:

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<th>5 universal health reviews*</th>
<th>6 high impact areas</th>
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2.5 Health visitors are seen as leaders of the 0-5 years HCP delivery and undertake a significant proportion of the development reviews and advice give around health, wellbeing and parenting. Health visitors also signpost parents to other services and participate in multi-agency packages of care for families with identified needs.
Family Nurse Partnership nurses specifically support first-time parents under the age of 19.

2.6 Currently the health visiting service delivers the universal, universal plus and safeguarding elements of the HCP in Barking and Dagenham. The new birth visit, perinatal mental health assessment by 12 weeks, and under one-year and two-year contacts are fully embedded. The ante-natal contact is currently only delivered to targeted families due to capacity. This is a mandated contact in the national service specification and NELFT have indicated that this will be delivered from April 2016. Other current key activities for the service are health reviews, health advice, looked after children assessments and group interventions. The health visitor is the key partner within child protection, child in need and looked after children. Currently the service does not fully meet the requirement of level 1 (Building Community Capacity) through projects across all health visiting teams but teams are working with the children’s centre to support the delivery of community based projects.

2.7 Work has taken place to align the 0-5 health teams with children’s centre localities and GP surgeries and the scoping of space in the children’s centres to progress co-location. It is likely to reflect a hybrid model as adequate space to accommodate the full team is not available. This could be a duty health visitor presence daily in some children’s centres, and some teams being co-located in others.

2.8 There is currently a named health visitor for each children’s centre and they are part of the children’s centre community forum (CCCF) which is the advisory board. The Strategic Lead for Health in Early Intervention and the Operational Leads in NELFT meet monthly to plan integrated work across the teams. Joint operational meetings between children’s centre locality managers and 0-19 team leaders have been implemented. These meetings have been successful in ensuring a joined up strategic approach in supporting integration as well as a forum to proactively develop joint solutions.

2.9 New birth data is now shared from health to children’s centre enabling the children’s centre to contact all new parents and invite them to attend services.

2.10 An early intervention project at Dr John’s GP practice has been set up with a Health Visitor and Early Intervention Worker being based at the surgery to support parents. GPs were invited to put in an expression of interest for this project to take place at their surgery and the service has now been rolled out to a further 6 GP practices.

2.11 There are now joint training initiatives across health and children’s centre staff such as breastfeeding training, perinatal mental health, IAPT awareness and substance misuse.

2.12 Performance against HCP KPIs including the mandated elements are monitored via the Early Years Minimum Data Set (EYMDS) report and the monthly contract monitoring meeting with NELFT, with implementation of remedial action plans for areas of underperformance.

Health visitor workforce development

2.13 Delivering the service model requires a multi-agency and multi-professional team approach. The health visiting service workforce consists of specialist community
public health nurses (SCPHN) and teams who provide expert information, assessments and interventions for babies and children and families, including first time mothers and fathers and families with complex needs. Health visitors help to empower parents to make decisions that affect their family’s health and wellbeing and their role is central to improving the health outcomes of populations and reducing inequalities. Health Visitors also play a significant role in safeguarding children.

2.14 The national Health Visitor Implementation Plan 2011-15 set out a ‘call to action’ to expand and strengthen health visiting services including an increase of health visitor staffing numbers. The national HCP for 0-5 year-olds remained with NHS England to enable the significant expansion of the health visitor workforce to be completed by April 2015. (NB – unlike previous public health transfers it is only the commissioning that has transferred and not the workforce. Health visitors and Family Nurses will continue to be employed by their provider organisations; in most cases this is the NHS).

2.15 Under the Call for Action NELFT were required to recruit 83.5 FTE health visitors in Barking and Dagenham. Currently NELFT have 14 health visitor vacancies. Although recruitment and retention of the health visitor workforce has been more successful in Barking and Dagenham than other boroughs, there is a continued risk that NELFT will fail to recruit to the full allocation of health visitors and it will adversely impact on the ability to deliver all aspects of the service model. Furthermore, MASH posts are still being funded out of the allocation of health visiting posts, reducing the number of staff who can hold a generic caseload.

2.16 NELFT will be required to implement an improvement plan, identifying measures to recruit and retain the required staffing cohort, and reporting to the monthly contract monitoring meeting. Options for recruiting a mixed skilled workforce will also be explored. The newly qualified health visitors will be supported by the preceptorship programme that exists in NELFT and this will be integral to supporting new health visitors in the transition to the role.

3. Proposal and Issues

3.1 The Council’s priorities around enabling social responsibility commits it to providing fully integrated services for children, young people and families in need, protecting the most vulnerable and ensuring that everyone can access good quality healthcare when they need it. This can only be achieved through a commitment to commission high quality services that deliver outstanding early years’ outcomes.

Vision for children’s health services – transformation of Early Years’ and 0-19 HCP

3.2 The transfer of commissioning responsibilities has been highlighted as an opportunity to align 0-5 HCP with wider healthcare systems within the borough, including Early Years’ services, and enable integration of children’s services. The ambition is to develop a service model that incorporates the Council’s Early Years’ services and the 0-19 HCP services into an integrated healthcare model.

3.3 The intention is to develop a procurement strategy to commission a responsive and high quality provider(s) to deliver the Council’s ambition for children and young
people. These providers could be new market entrants or existing organisations who share our commitment to delivering the very highest standards of early years’ services in the borough. This strategy will ensure that a systematic approach is taken to understand the needs of the local population and to determine future market priorities. It will inform early years’ investment decisions in future years as well as drive further improvements in quality outcomes, choice and service redesign.

3.4 To this purpose, a 0-19 project steering group was established in October 2015 to steer the transformation process over the next 12 months and devise a market development strategy that describes the approach the Council will adopt in the analysis and management of the early years health and care system in the borough. This brings together partners from Children’s Services, Public Health and NHS Barking and Dagenham CCG. The project group will oversee the integrated planning and delivery of core services from pre-conception through to age 5, across the NHS and local authority. The aim of the partnership approach is to provide a strategic focus on collaboration and the development of an integrated Early Years service model, including the development of effective Early Years’ care pathways across services, information sharing protocols and a shared outcomes framework.

3.5 Key responsibilities of the steering group are to:

- Develop a service model for an integrated approach to commissioning and delivering 0-19 years’ health services, including development of a market-tested outcomes-based service specification
- Monitor and report progress on the subgroups (including risk management):
  1. Procurement subgroup – Review of services, provider market assessment and development of the procurement strategy for any proposed tender exercise
  2. Commissioning and data subgroup - Business intelligence and data analysis (current and future service demand) – this includes development of data access and information sharing protocols
  3. Operational delivery subgroup - Performance monitoring (via the monthly contract monitoring meetings with the incumbent provider) and health visiting workforce development.

4. Options Appraisal

4.1 The following three options were proposed:

Option 1: Do nothing – this option has been discounted on the grounds that the contract was directly awarded to NELFT on the basis that an assessment of the market would be undertaken to facilitate a competitive procurement exercise.

Option 2: Extend the contract with the existing provider - this option has been discounted as there is no option to extend the existing contract beyond the three years; the Council’s contract rules require that a competitive tender exercise take place.
Option 3: Develop new integrated service model - There are significant opportunities for improving outcomes for infants and children in the context of the transfer of commissioning responsibility for healthy child 0-5 services to the local authority, the re-procurement of 0-19 services and the development of integrated Early Years' care pathways. Although the final 0-5 budget allocation was £102K higher than the amount previously announced by the Department of Health, there is a potential pressure of around £270k which will have to be contained within the Public Health Grant due to increasing non-pay costs. The proposed integrated model will allow the Council to develop a more cost-effective model and achieve efficiencies.

4.2 In March 2015 the Health and Wellbeing Board recommended option 3 as part of the direct award to the existing provider. This paper outlines the next steps to deliver the proposed integrated service model.

5. Consultation

5.1 The progress and proposals highlighted in this report has been discussed and endorsed by the Public Health Children’s Board.

5.2 Highlight and risk reports are submitted to Children’s DMT on a quarterly basis.

5.3 Consultation will be undertaken with Members, the local community, unions, staff, external bodies, partners as appropriate as part of the procurement strategy and any consideration by, and recommendations from, the Select Committee.

6. Financial Implications

6.1 Not required for update report.

6.2 See financial implications highlighted in the June 2015 Cabinet paper (background documents).

7. Legal Implications

7.1 Not required for update report.

7.2 See legal implications highlighted in the June 2015 Cabinet paper (background documents).

8. Other Implications

Risk Management

8.1 The key business risks associated with the proposed procurement strategy are related to the recruitment and retention of the health visitor workforce and the cost pressures to financial allocation to the Council to support the future commissioning of the 0-19 HCP - in light of the recently announced reductions to the Public Health Grant in future years by the Department of Health.
8.2 As part of the procurement strategy a robust project plan and risk and issues log will be developed and maintained by the project steering group in or to identify and mitigate risks.

9. **Contractual Issues**

9.1 The Council agreed contract particulars with NHS England (London) to facilitate the transfer. The provision of a new contract with the Council for a 2 year period from 1 October 2015 with an option to extend for a year should give NELFT assurance of stability and continuity; we therefore do not anticipate such liabilities arising.

9.2 This will also provide the opportunities to assess and develop the provider market in preparedness for any procurement exercise.

9.3 Under the Council's Contract Rules all procurements above £500k as defined in clause 28.8 shall be taken before the Cabinet, or in some specific cases relating to Health and Social Care, the Health and Wellbeing Board for ratification.

9.4 The proposed procurement strategy will need to be presented to both the Procurement Board and Corporate Management Team prior to issue to the Health and Wellbeing Board.

10. **Staffing Issues**

10.1 Currently NELFT have 14 health visitor vacancies. Although recruitment and retention of the health visitor workforce has been more successful in Barking and Dagenham than other boroughs, there is a continued risk that NELFT will fail to recruit to the full allocation of health visitors (83.5 FTE) that would adversely impact on the ability to deliver all aspects of the service model. Furthermore, MASH posts are still being funded out of the allocation of health visiting posts, reducing the number of staff who can hold a generic caseload.

10.2 As part of the contract monitoring meeting health visitor recruitment and retention will be monitored and NELFT will be asked to implement a workforce recruitment and development plan.

11. **Customer Impact**

11.1 The Council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010).

11.2 The Council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons’ disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

11.3 In respect of this, the commissioning of the 0-5 year Healthy Child Programme (Health Visiting) Service and Family Nurse Partnership Programme is part of the
solution in developing a consistently high performing and sustainable children’s service. In this context a 12 month period is required to evaluate the current service landscape, decide on the specific role that health visiting will play and how this service may integrate with other relevant local services to improve and protect the health of young people and ensure that local families thrive. Also we need to ensure commissioning for children aged 0–5 is joined up with commissioning for those aged 5-19, so that the needs of everyone aged 0-19 are comprehensively addressed.

11.4 NHS England (London) has completed an impact assessment as part of their due diligence. As our plans for a new integrated Early Years’ model develop, we will be conducting a full assessment as part of this prior to a procurement strategy being published in April 2017 and hence it is still too early to conduct our equalities and customer impact assessment. A full equalities and other customer impact will be carried out prior to the procurement process.

12. **Safeguarding Children**

12.1 Health visiting teams provide expert advice, support and interventions to all families with children in the first years of life (National health visiting service specification 2014/15 NHS England 2014). They are uniquely placed to identify the needs of individual children, parents and families (including safeguarding needs) and refer or direct them to existing local services, thereby promoting early intervention. They can also have a role in community asset mapping, identifying whether a particular community has any specific needs.

13. **Health Issues**

13.1 The Council’s vision and priorities for Barking and Dagenham are intended to reflect the changing relationship between the Council, partners and the community, and our role in place shaping and enabling community leadership within the context of a significantly reducing budget. Children having the best possible start in life from conception, so breaking the link between early disadvantage and poor outcomes throughout life is integral to the delivery of our joint Health and Wellbeing Strategy.

14. **Crime and Disorder Issues**

None.

15. **Property / Asset Issues**

None.

**Background Papers Used in the Preparation of the Report:**

- Transfer of 0-5 children’s public health commissioning to local authorities: 0-5 public Health allocations 2015/16:


List of Appendices:

Appendix A Department of Health 4-5-6 health visitor model
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The Health Visitor Service Model

The Health Visitor Improvement Plan 2011-2015 outlines the four level (sometimes known as tiers) model as the basis to develop and expand health visiting services in England. The four levels, which are based on assessment of children’s/families’ needs, are:

**Community Services** - linking families and resources and building community capacity,

**Universal Services** - primary prevention services and early intervention provided for all families with children aged 0-5 as per the HCP universal schedule of visits assessments and development reviews,

**Universal Plus Services** - time limited support on specific issues offered to families with children aged 0-5 where there has been an assessed or expressed need for more targeted support,

**Universal Partnership Plus Services** - offered to families with children aged 0-5 where there is a need for ongoing support and interagency partnership working. Particularly for families with more complex needs.

**The Healthy Child Programme (HCP)**

Health visitors lead delivery of the HCP, this is a prevention and early intervention public health programme that lies at the heart of the universal service for children and families and aims to support parents at this crucial stage of life, promote child development, improve child health outcomes and ensure that families at risk are identified at the earliest opportunity. It is underpinned by an up-to-date evidence base such as set out in Health for All Children (Hall and Elliman, 2006) and is aimed at children up to the age of 19 and their families.

The programme is offered to all families and core elements include health and development reviews, screening, immunisations, promotion of social and emotional development, support for parenting, and effective promotion of health and behaviour change. It provides significant opportunities for highly skilled professionals to identify and deliver appropriate interventions to those with specific needs (including in some families, safeguarding needs).

Delivery of the universal elements of the HCP will see a team led by health visitors working in ways most appropriate to local public health needs and across a range of settings and organisations including; general practice, maternity services and children’s centres. Where families are accessing FNP a family nurse will take on this role until the child is two years old.

In addition to the core universal programme, the HCP schedule includes a number of evidence-based preventive interventions, programmes and services. Commissioning public health services includes joining up with other services supporting children and families, other local authority commissioning services, local safeguarding and children’s boards, Health and Wellbeing Boards, Clinical Commissioning Groups, etc. to determine which services are offered locally and by whom.
The 6 High Impact Areas

Six early years High Impact areas have been developed that focus on the universal service areas having the biggest impact on a child’s life. They also align with a number of the public health priority areas and have been identified to support the transition of commissioning to local authorities - helping inform decisions around the commissioning of the health visiting service and integrated children’s early years services. They aim to:

- articulate the contribution of health visitors to the 0-5 agenda and improving outcomes for children, families and communities;
- describe areas where health visitors have a significant impact on health and wellbeing and improving outcomes for children, families and communities.

The universal contacts provide the opportunity to engage families on these issues at the time when they are most receptive to advice and support.

The 6 areas are:

- transition to parenthood and the early week
- maternal mental health (includes post natal depression)
- breastfeeding (initiation and duration)
- healthy weight, healthy nutrition (includes physical activity)
- managing minor illness and reducing accidents (reducing hospital attendance/admissions)
- health, wellbeing and development of the child aged 2 – two year old review (integrated review) and support to be ‘ready for school’.
## Children’s Services Select Committee Work Programme 2015/16

<table>
<thead>
<tr>
<th>Meeting date</th>
<th>Agenda item</th>
<th>Presenter</th>
<th>Final Papers deadline</th>
<th>Members’ Friday post circulation</th>
<th>Deadline for statutory publication of agenda</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 Mar 2016</td>
<td>Responses to the CSSC’s questions on arrangements for, and performance on,</td>
<td>Joanne</td>
<td>Wed 2 Mar</td>
<td>Fri 4 Mar</td>
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<td>Monitoring report - recommendation from Primary school visits</td>
<td>Von Edomi/Lorraine Shaw</td>
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<td>Application of the Prevent Strategy locally</td>
<td>Gareth Tuck</td>
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<td>Mental Health Needs Assessment</td>
<td>MH HWB Sub-group reps/Public Health rep</td>
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<td></td>
<td>Safe Programme</td>
<td>Helen Jenner</td>
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<td>Recommendations arising from Corporate Parenting scrutiny</td>
<td>Chair</td>
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